Brent Acute Mental Health Services
Park Royal

Report for Brent Health Overview & Scrutiny Committee

March 2014

1. Outline of Acute Services based at Park Royal

Brent Acute Mental Health Service consists of four wards, a Home Team and support services i.e. AMHP/ social worker team, therapies service and various administrative support staff.

The wards are as follows:
18 bed Triage (assessment) Ward - Shore
24 bed Treatment ward - Pine
24 bed treatment ward - Pond
13 bed male Psychiatric Intensive Care Ward (PICU) - Caspian
79 beds in Total

Please note - there is also a Low secure Ward, Tasman and a step down rehabilitation ward, Java, based on the Park Royal site. In addition to this there is a Mother and Baby unit and Memory Clinic. All of these are managed separately from the Brent Acute Service so will not be included in the report below.

2. The Acute Service Model

2. 1 Home Treatment Team

This team offers those referred to the acute service with an alternative to admission and facilitates and supports early discharge of patients from the ward. It is available 24/7 service and provides patients with intensive support at home for a limited period of time. This can be for up to three months. The team gate keeps all referrals to the Acute Service to ensure only those who require an acute inpatient stay are admitted.

The team works in close partnership with the wards and with the services that refer patients i.e. the community teams, the Emergency Duty Team (Social Care), A&E, Court Diversion, 136s(police), Psychiatric Liaison and Assessment and Brief Treatment Team.

2.2 Triage Ward

This model supports a clear, pathway from the point of assessment in conjunction with the Home Treatment Team to admission where the patient is assessed on a daily basis including weekends by a multidisciplinary team for a maximum of 14 days. The patient, at any stage when safe and appropriate to do so may then be either discharged under the care of the HTT, or to other parts of the pathway such as to the care of the Recovery Team (Community mental health team).

Patients are also, where needs and risks indicate, transferred to Treatment wards to continue the recovery process. This model offers the assurance that staff are skilled in assessment, recovery approach and risk management and that prompt decisions are made by senior staff regarding a patient's care within 24 hours. The Triage ward also employs a Social Worker who provides assessments regarding wider social care needs. This role is key to supporting clear, robust and holistic discharge plans, which begin to be formulated for all patients at the point of admission. This is to ensure that where possible discharge arrangements are communicated clearly to all those supporting the patients in the community and minimises the risk of delayed discharges.

During the course of the last year approximately half of the patients admitted to the Triage ward have been discharged home within two weeks, some with the support of the Home treatment team, whilst the other 50% are transferred to the Treatment wards. Another key change and improvement in our care delivery has been the reduction of Consultant Psychiatrists to a single consultant post per ward. This supports effective team working, daily decision making, robust communication sharing

and clinical leadership. For many patients the amount of time spent in hospital has reduced considerably and we have received positive feedback regarding this from patients and carers in the triage evaluation completed in January 2013.

2.3 Treatment Wards

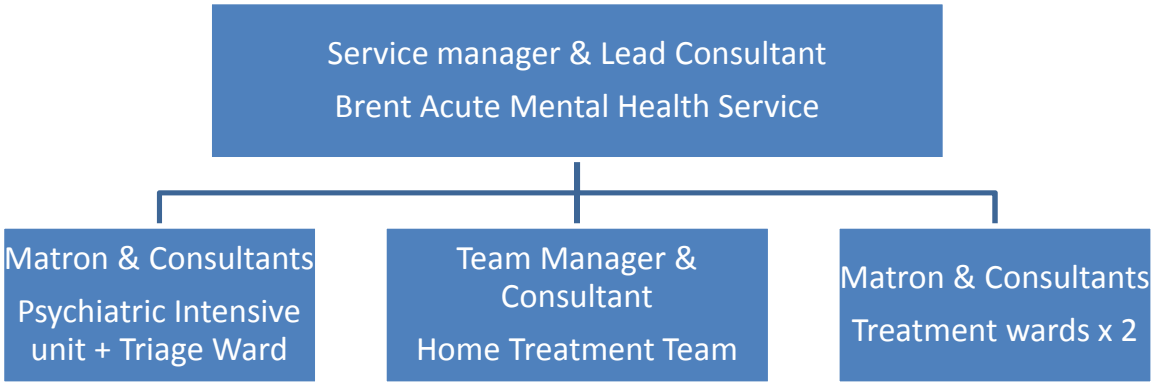
For those patients who require a more prolonged stay than that cannot be fulfilled through a two week period on the triage ward are transferred to a treatment Ward. The principles of a treatment ward are recovery focused, supporting collaboration and partnership working with patients and their families, building on the patients' strengths and skills and facilitating patients to recognise their potential for development. The model recognises the importance of moving away from the 'patient in the sick role' towards supporting patients to regard themselves as autonomous people. The teams' focus is in the identification of realistic life goals for patients and supporting the patient to achieve these.

This work is supported by a wide range of disciplines on the ward including nursing staff. Each ward has an Occupational Therapist providing assessments and ward and community based activities. The wards have Activity Co-ordinators - these roles focus on a wide range of individual and group work to enhance the therapeutic experience for the patient. There are plans to recruit Peer Support Workers who have lived experience; evidence suggests that these workers can offer invaluable interventions to our patients.

3. Workforce & Leadership

All patients admitted to the Brent acute service are cared for by a multidisciplinary team. The workforce for acute is a mix of medical, nursing, therapies, psychological, administrative and social care staff.

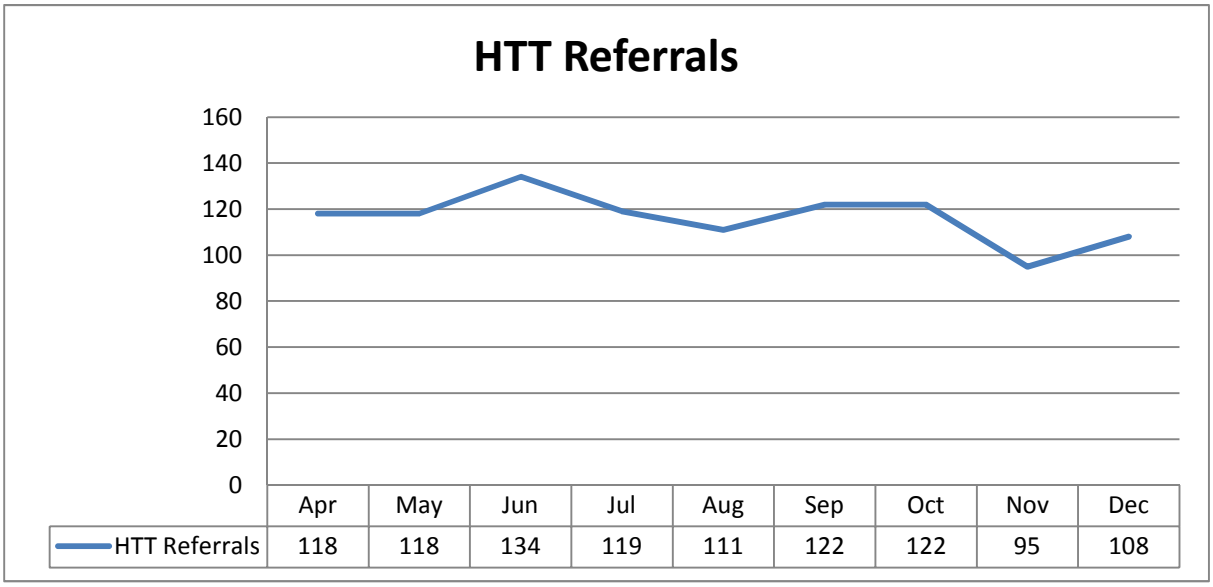
The leadership and management structure for Brent Acute Service mirrors that of the Trust i.e. it jointly led and manager by a Lead clinician and manager. Please see the leadership & management structure for Brent Acute Service below.



4. Patient Flow Activity

4.1 Home Treatment Team Referrals

In Brent, there is one Home Treatment Team (HTT). The team helps to avoid admission to a mental health inpatient ward by supporting people in acute mental crisis in their homes. The team also helps people who have been discharged from hospital as they make the transition back into the community. From April 2013 to December 2013, the team have had a fairly steady rate of referral as demonstrated in Graph 1.



Cases as at 31/12/2014	Total = 259

The number of patients deferred from admission to an inpatient bed through effective gate keeping by the Home Treatment Team is shown below.

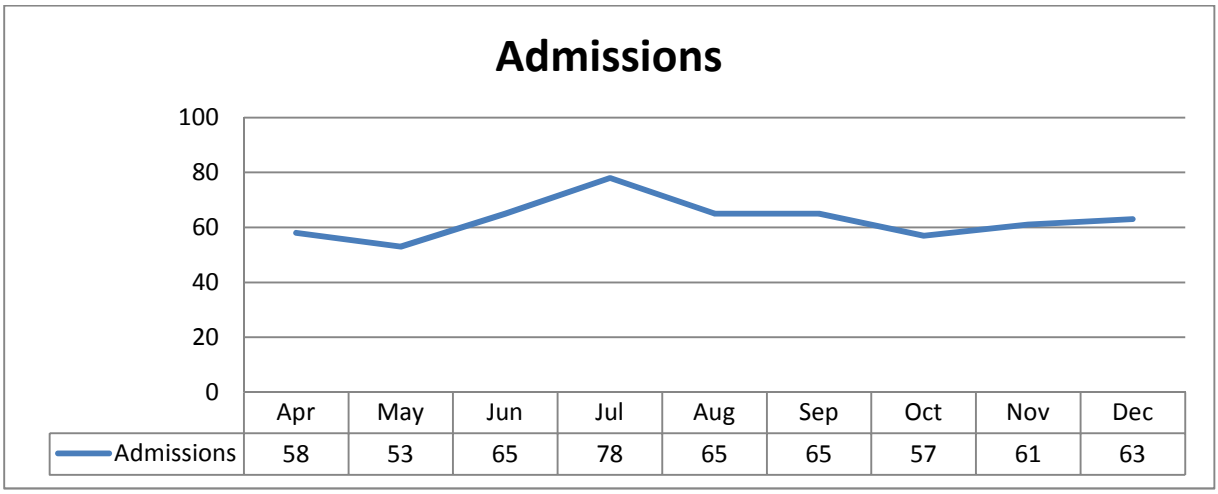
	HTT Referrals	No of admissions	% prevented admissions
Apr	118	58	51%
May	118	53	55%
Jun	134	65	51%
Jul	119	78	34%
Aug	111	65	41%
Sep	122	65	47%
Oct	122	57	53%
Nov	95	61	36%
Dec	108	63	42%

The primary sources of referral to the Home Treatment Team come via the pathways listed below.

Referral Source	Total	% of Referrals
Accident And Emergency Department	551	53%
Other service or agency	281	27%
Other Clinical Speciality	121	12%
Police	68	6%
Social Services	10	1%
Self	7	1%
Courts	4	0%
Permanent transfer from another Mental Health NHS Trust	4	0%
Education Service	1	0%

4.2 Admissions

Graph shows the total number of admissions per month from April 2013 to December 2013, for all four Adult Inpatient Wards in Brent. This includes 2 treatment wards, 1 triage ward and 1 psychiatric intensive care unit (PICU). Apart from the peak in number of admissions in July, there has been a fairly consistent rate of admissions throughout the period with slight variations as would be expected.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Admissions	58	53	65	78	65	65	57	61	63

4.3 Emergency Re-admissions

Emergency re-admissions are those patients who were re-admitted within 30 days of being discharged. Monitor has set an upper threshold of 7.5% for this. The re-admissions mostly relate to patients with a personality disorder, patients who relapse due to non compliance with medication and those who have substance misuse needs.

	2012	2013
% Emergency Re-admission	9.4%	8.7%

Brent has slightly higher than national average re-admission rates, which in 2012 was 8.7%. Other London Trusts had an average re-admission rate of 8% in 2012. National data for 2013 is currently not available.

The reasons for readmissions can be complex and whilst this time of year is difficult for patients and the wider social economic environment does play a part there does seem to be more that could be learnt about the patterns and triggers for readmission. To gain a greater understanding of the contributing factors behind these numbers the Acute Service Line Is planning to do a detailed analysis of all incidences of emergency readmissions within the Acute Service Line over the last year.

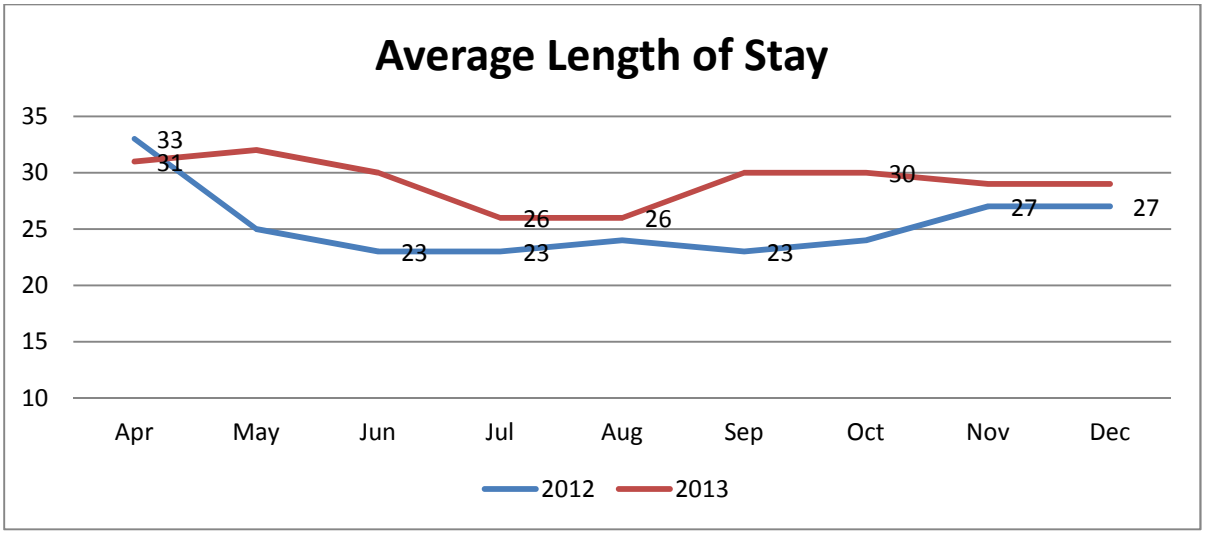
4.4 Average length of stay (LOS)

The Acute Service Line is committed to reducing length of stay for inpatients. In Brent there was a steady reduction in length of stay from April to July, however this steadily increased again until October. However, this relates to complex issues which make it hard to discharge patients even when they may be clinically ready for discharge.

As part of the implementation of the ambitious programme of work to redesign clinical pathways under the Acute Service Line, it was identified that the systems around patient flow / bed management needed to be transformed. The Patient Flow model was rolled at Park Royal in November 2011, initially as a pilot that has subsequently become embedded and forms the foundation for the management of patients in and out of acute and PICU beds. It differs from operational bed management by taking a proactive approach in managing demand and patient flow and utilises demand and bed management principles to synchronise and sustain patient flow throughout the entire Acute Service Line

The patient flow model that has been successfully implemented here in Brent and has positively supported us in our commitment to ensuring patients are only in for as long as they need to be. The Patient flow model incorporates the following elements:

- Triage Ward
- Single consultant per ward
- Daily Multidisciplinary clinical reviews
- Date of discharge identified on day of admission
- Dedicated patient flow manager and discharge coordinator working as part of the Home treatment Team
- Onsite provision of a CAB worker and housing (Brent Council) worker
- Daily patient flow meetings
- Contingency planning for out of hours

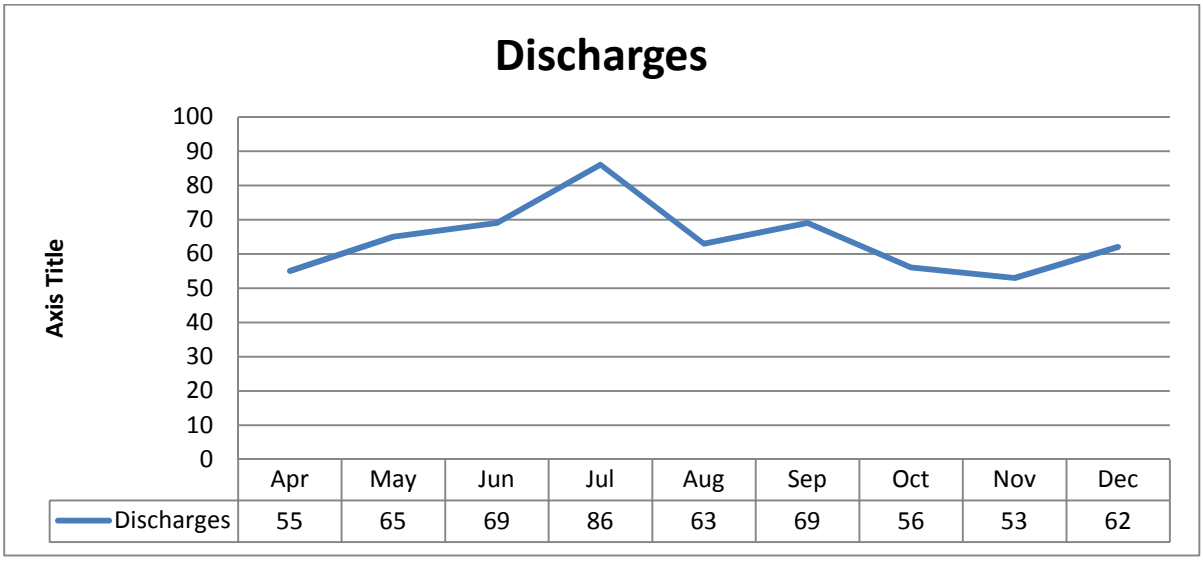


4.5 Access to beds

Patients are guaranteed access to a bed in the acute service when they need it. Whilst there are some patterns to the demand for beds the nature of an acute mental health service is that there is an element of unpredictability. The Patient flow model ensures there is sufficient flow within the system to meet any demand for beds as and when it is needed so that people requiring admission do not experience a wait for bed.

4.6 Discharges

Graph below shows the discharges by month from April 2013 to December 2013.



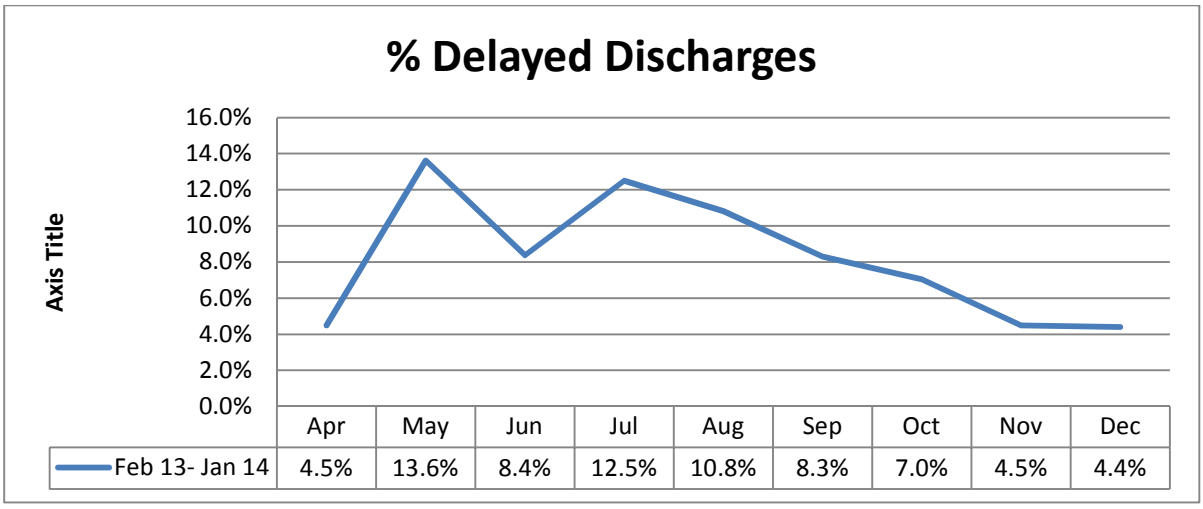
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Discharges	55	65	69	86	63	69	56	53	62

When comparing the number of discharges to admissions, there has been an average of one admission for every discharge throughout the year, demonstrating that throughput has been maintained.

4.7 Delayed Discharges

Delayed Discharges relates to the patients who are clinically fit for discharge but due to a number of reasons, were not discharged at that point. This is measured in terms of the number of bed days which were occupied by patients who were identified as delayed discharges compared against the total number of occupied bed days.

From May 2013 until July 2013, there were high levels of delayed discharges. Monitor has set an upper threshold of 7.5% for Delayed Discharges, and though delayed discharges remained higher than this until October, there is in steady decline month on month. From October to December, delayed discharges have remained fairly low. This is due to the patient flow measures described above and the work of the Mental Health Project which has begun to create a flow across the whole pathway.



The table below detail the reasons for delayed discharges and the number of patients who were delayed due to those reasons.

The most common reason patients are delayed are due to waits for supported accommodation or repairs / deep cleaning to their accommodation.

Reasons for Delay	No of patients
Awaiting Care Package in own home	3
Awaiting Completion of Assessment	2
Awaiting Hostel/Supported Accommodation	10
Awaiting Permanent Housing	2
Awaiting Funding	1
Benefit Problems(s)	1
Client Does Not Accept Plan	1
House to be Made Fit	8
Funding Delayed	1
Team Not Agreed Plan	1

Reasons for Delay	No of patients
Awaiting Community Equipment & Adaptations	1
Disputes	1
Grand Total	**32**

The Acute Service has a range of options used to monitor and resolve delayed discharges. These include:

- Weekly Patient flow tracker circulated widely to all clinical staff in Acute and to key partner service lines and colleagues
- Strategic weekly patient flow management meeting with a specific remit to identify and plan for potential delays in discharge
- Monthly Trust wide patient flow Forum
- Acute staff attend key clinical forums and the funding panel

5. Housing options

There is a range of housing available in Brent for service users dependent on need. In borough there are 121 Supporting People supported housing beds (31 high support, 60 medium support and 121 low support) and 52 supported living schemes (16 high support, 12 medium support and 6 low support + 18 new schemes recently). If the service user is able to manage a tenancy there is access to a social housing quota of 20 for Adult Social Care per annum and support to access private rented accommodation.

If a service user has more complex, high needs an out of borough spot purchased placement will be sought which will be agreed via the Funding Panels.

Over the last 9 months CNWL has been working with the London Borough of Brent on a Transformation Project. This project had 5 work streams and one has focused specifically on reducing the numbers of people in 24 residential care and unblocking in borough 'step down' provision and the supporting processes to help people move through the system smoothly as soon as they are ready. Part of this work stream was reviewing the Panel processes to ensure they do not lead to delays in placements and resulting delays in discharging service users from hospital. The redesigned process will have one Social Care Needs Panel which will look at all requests for social care funded services. The joint Funding Panel with the CCG for joint packages of care will continue.

Alongside this work, focussed work has been undertaken with Care Co-ordinators improving the quality of assessments which clearly identify the eligible needs that are to be met by the recommended care package. The quality of the assessment and required clarity on the need for the placement was often a reason for delay in the panel process.

The next steps of this project will look at further alternatives to residential care, speeding access to the Adult Social Care quota, working with the Housing department to look at private rented options for our service users and looking at how we could better support people's tendencies while in the community and when they are admitted to an acute bed.