East Sussex Health Overview and Scrutiny Committee

Review of proposals for mental health services for adults

Final report

July 2010

The final report of the Health Overview and Scrutiny Committee (HOSC) Review of proposals for mental health services for adults

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Preface

In March 2010, NHS East Sussex Downs and Weald and NHS Hastings and Rother, in conjunction with Sussex Partnership NHS Foundation Trust, published proposals for making changes to mental health services for adults in East Sussex.

The Health Overview and Scrutiny Committee's role, as a group of councillors representing local people, is to review the healthcare available for East Sussex residents and, where appropriate, make recommendations for improvement. Where a significant change to services is proposed, the local NHS is expected to consult with the Committee and take our recommendations into account when making a decision on the best way forward.

The recommendations we make are not just based on the opinions of the Committee Members. We seek out the views and experiences of service users and carers, staff providing the services and managers responsible for planning and improving services. We also look at national guidance on the best way to provide care and see how well local plans compare to this. We base our recommendations on weighing up all these factors and assessing what they tell us about how the needs of East Sussex residents can best be met now and in the future.

The Health Overview and Scrutiny Committee formed a Task Group of four Members to examine the proposals for mental health services and make recommendations to the main Committee. This report summarises our findings and recommendations, which the Committee has endorsed. We will submit these to NHS East Sussex Downs and Weald, NHS Hastings and Rother and Sussex Partnership Trust, ask for their response and monitor progress.

I would like to convey my thanks to the service user and carer representatives who spoke to us so openly about their experiences and the NHS staff who told us about the challenges and opportunities in improving services. I would also like to thank the Members of the Task Group for the time they devoted to meetings, visiting mental health facilities and compiling this report.

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Chairman, Task Group on Mental Health Proposals

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Councillor Peter Pragnell

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Summary of recommendations

Recommendation		Page
1	**HOSC fully supports the review of Crisis Resolution Home Treatment (CRHT) and the need to enable the teams to focus on their specific remit. As part of this review, the establishment of further 'sanctuary' facilities should be examined, funded through potential savings in reduced admissions, A&E attendances and/or GP out of hours calls. The conclusions of the CRHT review should be reported to HOSC in due course.**	10
2	**Efforts to establish mechanisms, similar to Patients Councils, by which groups of service users can influence the way community services (e.g. Community Mental Health Teams) work should be revisited, within the next 6 months, as part of the proposed improvements.**	11
3	**The approach to supporting carers, particularly in terms of their involvement in care planning and crisis management, should be reviewed to ensure an appropriate balance is being struck between confidentiality and involvement. Access to respite care should also be examined.**	11
4	**Once measures have been put in place against each of the 10 commitments outlined in the consultation document, clear information, beginning with a baseline of current levels, should be made available on a regular basis to HOSC and service user and carer representatives as part of the monitoring process. This transparency is important in building confidence in community services and HOSC would expect to see appropriate measures and baseline information in place within 6 months.**	12
5	**A strong consensus on the best option for the configuration of beds has not emerged. However, HOSC would expect to see the following factors taken into account by the Primary Care Trusts in making a decision:** • **Maximising access for carers and families through geographically balanced provision;** • **Ability to re-open beds should that become necessary** • **Ability to provide an enhanced therapeutic environment** • **Ability to improve the quality of clinical care for inpatients**	13
6	**NHS East Sussex Downs and Weald/Hastings and Rother and Sussex Partnership Trust should undertake further engagement and consultation with staff, service users and the public, and review learning from the first phase of proposed changes, prior to taking any decisions about longer term options.**	14
7	**The NHS should take the learning points highlighted by HOSC into account when planning future consultations.**	16

Introduction

1. In March 2010, NHS East Sussex Downs and Weald and NHS Hastings and Rother, in conjunction with Sussex Partnership NHS Foundation Trust, published proposals for making changes to mental health services for adults in East Sussex.

2. The proposed changes fall into three areas:

- The development of community mental health services including proposed key measures/commitments.
- A reduction in inpatient beds within units in East Sussex over the next 12-18 months and 3 options for how the remaining beds are provided.
- Further reduction in inpatient beds over the next 3-5 years and reprovision of these beds in a new unit or units in East Sussex.

3. The proposals were outlined in more detail in the document titled *'Public consultation on mental health services in East Sussex'* which formed the basis of what was initially planned to be a 12 week period of public consultation from 8th March to 1st June 2010. This was later extended by a week to close on 8th June 2010 as a result of extended restrictions on publicity following the general election in May.

4. Similar proposals were put forward concurrently by NHS West Sussex. The proposals in West Sussex which relate to community services are very similar to those in East Sussex, but the proposals on inpatient care differ in that they relate to the specific facilities located in each county. West Sussex proposals also include inpatient care for people with dementia. Dementia care was not included in the East Sussex proposals. Because of these differences there was a separate consultation process in West Sussex, running to the same timetable.

The role of the Health Overview and Scrutiny Committee

5. The East Sussex Health Overview and Scrutiny Committee (HOSC) is a group of elected local councillors from East Sussex County Council and the five district and borough councils in the county, together with three co-opted Members representing local voluntary and community sector organisations. The Committee's role is to review and make recommendations about local health issues and health services which are of concern or importance to East Sussex residents. Local NHS organisations are required by national legislation to consult with HOSC about any proposed major changes to heath services, and must supply information and attend HOSC meetings to help the Committee do its job.

6. The Committee Members are not expected to have specialist health knowledge. Their role is to look at issues from a lay perspective and to gather evidence from service users, staff, expert witnesses, data and documents to inform their recommendations to the NHS or other organisations involved with improving health.

7. HOSC agreed in March 2010 that the proposals for changes to mental health services are significant and the NHS would need to consult the Committee and take into account the Committee's response when making a final decision. The Committee formed a Task Group of four Members to investigate the proposals further and report back their findings and recommendations. This report has been prepared by the Task Group for that purpose.

Objectives and scope of the review

8. The Task Group's objective was to consider whether or not the proposals, or specific aspects of them, are in the best interests of the health service for East Sussex residents and to make recommendations to HOSC on this question.

9. To do this, the Task Group needed to review the evidence to support the proposals and the extent to which service users, carers, other stakeholders and the public had been engaged and consulted on the development of the proposals. It also needed to consider whether consultation with HOSC was adequate.

10. As similar proposals were also put forward concurrently by NHS West Sussex, the Task Group liaised with West Sussex HOSC to examine common aspects and issues linked to patients crossing the county borders to access care. A joint meeting was held with the West Sussex HOSC Task Force to examine these issues.

11. The Task Group identified five key questions to form the focus of the review:

- Are the proposals in line with best practice/policy for mental health services?
- Will community services be sufficiently developed to support a reduction in inpatient beds?
- Will the proposed inpatient capacity be sufficient to meet future need?
- What is the financial impact of the proposals?
- How do the proposals fit together across Sussex?

12. Further detail on each of these questions is contained within appendix 1 – methodology. This appendix also contains details of how the Task Group went about investigating these questions – the people interviewed, the facilities visited and the documents reviewed.

13. This report sets out the Task Group's findings and recommendations in relation to each of the key questions.

Findings and recommendations

Are the proposals in line with best practice and policy for mental health services?

14. The NHS proposals for change centre around getting the right balance between hospital-based inpatient mental health care and services provided outside hospital in the community. The overall thrust of the proposals is that as community services continue to improve, the balance will change, meaning that fewer people with mental health problems will need to be admitted to hospital in future, and those that are admitted will not need to stay in hospital as long. This will mean, it is argued, that it will be possible to reduce the number of inpatient beds needed in the future.

15. There are several other main aims of the proposals, including:

- Offering consistently high quality support close to people's homes – a common set of standards for quality and performance across the county
- Introducing new services for people with mild to moderate mental health issues, working closely with GP practices
- Helping people stay at work and participate fully in their local communities – an emphasis on helping people to get support as early as possible and to manage their own recovery
- Providing 24 hour support from specialist community services for people with more severe conditions who would, in the past, have been likely to need hospital admission

16. Nationally and locally there are some key plans and guidance documents which should inform the way mental health services develop (see box below). These have been developed in consultation with clinicians, service users and partners such as voluntary organisations and social care, drawing on national and international good practice. HOSC would expect the local NHS to take into account national policy and guidance when developing local services and to ensure that specific proposals for services are in line with strategies that have been agreed locally with partners, clinicians and service users.

Some key plans and strategies guiding mental health services:

National Strategies	***Local Strategies***
National Service Framework for Mental Health	East Sussex Joint Commissioning Strategy for Mental Health
New Horizons: A shared vision for mental health	Better by Design
NHS 2010-2015: From good to great	

17. The Task Group reviewed these documents to check whether the proposals outlined in the consultation document were in line with their aims. The proposals to reduce the number of inpatient beds in Sussex impact chiefly upon those service users whose condition is severe enough to warrant acute care. For over a decade, Department of Health policy has been to encourage provision of this type of care by community-based mental health services rather than through admission to hospital. The first *NHS Plan (DH, 2000)* observed that "at the moment [2000] the only option in many areas is to admit people with an acute mental illness to hospital", and it announced that, by 2004, Crisis Resolution Teams "would treat around 100,000 people a year who would otherwise have to be admitted to hospital". It envisaged that, as a result, "pressure on acute inpatient units will be reduced by 30% and there will generally be no out of area admissions which are not clinically indicated".

18. This direction was reinforced more recently in *NHS 2010-2015: From Good to Great (DH, 2009)* which spoke of "the increased use of community teams to avoid admission or reduce length of stay, by reducing the number of out-of-area placements, or by improving the way independent sector services are procured".

19. The UK is not alone in this approach. A National Audit Office Report, *The role of Crisis Resolution and Home Treatment services (NAO, 2007)* cited research indicating that the move towards "prompt and effective help in times of crisis … as close to home as possible" was being adopted by other European countries.

20. Locally, the *East Sussex Joint Commissioning Strategy for Mental Health (NHS East Sussex Downs and Weald/Hastings and Rother/East Sussex County Council, 2008)* identifies an optimum model for providing services based on a 'stepped' approach which offers community based alternatives to inpatient care, with hospital admission focused on the most acutely ill. *Better by Design*, the strategy published by Sussex Partnership NHS Trust in 2009, makes a commitment to "invest further in specialist services outside hospitals, increasing our capacity to support people at home" by 2014, adding that "this means we will need fewer hospital beds".

21. Based on this evidence, The Task Group concludes that the direction of travel described in the consultation document is in line with national and local policy on mental health services. We have also noted and welcome the involvement of service users and carers, mental health clinicians, GPs and other staff in the development of the local commissioning strategy and *Better by Design*. Feedback to the HOSC Task Group from GP and service user representatives suggests a general acceptance of the shift in balance towards community based care (where this is appropriate for the service user) and a recognition that this is the direction advocated nationally and locally.

22. However, the evidence from policies and strategies, and local feedback, also emphasises that the move towards increased support of people with acute mental health problems in the community rather than in hospital is dependent on strong, responsive and tailored community services, particularly those aimed at supporting people at a time of crisis. It is recognised in the consultation document and within *Better by Design* that community services need to be further strengthened if a further shift towards out of hospital care (and consequent reduction in beds) is to be safely enabled. The issues surrounding community services are explored further in the next section.

Will community services be sufficiently developed to support a reduction in inpatient beds?

Current services

23. The lead commissioner for mental health explained that a number of new or redesigned community based mental health services had been introduced in recent years in response to national policy and guidance and local need, including:

- Crisis Resolution Home Treatment (CRHT) teams – These provide acute home treatment for people whose mental health crisis is so severe that they would otherwise have been admitted to an inpatient ward. CRHT teams should also allow people to be discharged earlier from inpatient wards and receive treatment in their homes whilst still in the acute phase of their illness.
- Early Intervention in Psychosis Teams - Responsible for monitoring and assessing people showing psychotic symptoms, referring to secondary care services when necessary.
- Assertive Outreach Teams - Responsible for providing care, treatment and support to people with serious mental health problems who are difficult to engage. Services may be offered in people's homes or other community settings at times to suit users: it is envisaged that this could reduce rates of referral to crisis services or acute in-patient admissions
- Community Mental Health Teams, now known as Recovery Teams - The role of these teams is not so much to intervene in crisis conditions as to focus on setting objectives for recovery, reviewing progress and monitoring for signs of relapse.

24. Recently, new services have been introduced targeted at mild to moderate mental health problems and at linking with primary care:

- Improving Access to Psychological Therapies – A programme to train 72 additional therapists across East Sussex and provide easier access to talking therapies for people identified in primary care with mild to moderate mental health problems such as mild to moderate anxiety and depression.
- 'Health in Mind' – Introduced in East Sussex from April 2010, this service provides an allocated primary care mental health worker to a group of GP practices. The aim is to support appropriate referral and co-ordination with secondary (specialist) mental health care and to support and educate GPs on managing mental health problems.

25. These services represent a significant investment in the mental health care system in recent years, but it is recognised that there is real scope for the various services to work more effectively together to provide a consistently high quality experience for service users, as well as making more efficient use of resources. This is seen as the focus of the improvements to community services.

26. Evidence from service user representatives confirmed that current community services appear to be significantly stretched and can be difficult to access. Discussion focused on the CRHT teams in particular, where the experience of some service users has been that the team have been unable to respond as quickly as required. GP feedback indicated that there can be a lack of clarity on which part of the system is leading the care of a service user in crisis, illustrating the need for better links between services.

27. The lead commissioner acknowledged that despite spending more on CRHT in East Sussex than neighbouring areas of Sussex, feedback from service users is less positive. Indications are that the team's role has broadened beyond its original remit, as it has been called upon to support Accident and Emergency (A&E) departments and GP out of hours services in managing mental health needs. A review has begun to look at how the team can be refocused on the original aim to prevent unnecessary admission to hospital and support people to leave hospital earlier. This may mean commissioning other services to meet the needs the CRHT teams are currently called upon to support.

28. For service users and carers, the reassurance that support is available 24 hours a day, 7 days a week in case of a crisis is fundamental to having the confidence that the number of inpatient beds can be safely reduced. As well as access to CRHT teams by phone or in person, it was suggested that a safe place to go in a time of crisis builds trust that support is easily available, as well as potentially reducing the number of hospital admissions. The 'sanctuary' facility in Hastings was given as an excellent example of this, and there was a strong desire amongst service user and carer representatives to see a similar facility in Eastbourne. It was suggested that access to such a place of safety could help avoid hospital admissions and A&E attendances as well as potentially offer some respite or support for carers. Access to this type of 'safe space' or 24 hour support for service users in rural parts of East Sussex, away from the coast, should also be considered.

29. The Task Group welcomes the investment in community based mental health services in recent years, particularly the new primary care based initiatives for mild to moderate needs, which offer the potential for earlier intervention and recovery, and prevention of more serious problems. However, we also recognise that there is significant scope to improve the way community services operate, particularly in terms of the links between different parts of the system, and in developing consistent quality standards.

Recommendation 1

HOSC fully supports the review of CRHT and the need to enable the teams to focus on their specific remit. As part of this review, the establishment of further 'sanctuary' facilities should be examined, funded through potential savings in reduced admissions, A&E attendances and/or GP out of hours calls. The conclusions of the CRHT review should be reported to HOSC in due course.

Future commitments

30. The NHS consultation document recognises the need to develop clear and measurable standards for all community mental health services in order to give people confidence that the services are up to the job of supporting service users to avoid hospital admission. The document lists 10 'commitments' which, if delivered, "will ensure that services are in a position to support the reduction in inpatient beds proposed". These cover areas such as single assessment, care planning, support in a crisis, appropriate inpatient care and support in primary care.

31. The Task Group noted that many of these proposed commitments require new measures to be developed, meaning data is not currently available to show how services are performing, and therefore how much improvement is needed. However, it is positive to see clear standards and new measures being put in place, and more information becoming available to service users, carers and professionals such as GPs as a result.

32. The consultation document suggests that it is only when the proposed commitments are met that it will be possible to reduce the number of beds as proposed. Monitoring progress against the commitments is therefore crucial in determining when and how beds should be reduced. The Task Group noted that a process is being put in place to enable service user representatives to participate in the monitoring of community services. GPs have also expressed a desire for an ‘early warning system’ to be in place so that concerns could be raised and addressed quickly, particularly after any bed reduction.

33. The Task Group noted that whilst good arrangements (Patients Councils) were in place to enable service users to influence the management of inpatient facilities in Eastbourne and Hastings, less progress had been made in establishing mechanisms by which service users are able to directly feed into the management of community teams. The Task Group’s view is that establishing these sort of arrangements should be a part of the proposed improvements to community services. Integrating the gathering of feedback on patient experience into day to day care may be the best way to ensure the widest range of service users are able to influence the way services are run. Such feedback would provide valuable data to inform monitoring against the 10 commitments, alongside input from service user representatives and groups.

Recommendation 2

Efforts to establish mechanisms by which service users can influence the way community services (e.g. Community Mental Health Teams) work should be revisited, within the next 6 months, as part of the proposed improvements.

34. The impact on carers from increased community based provision was evident to the Task Group. As well as the (often very time consuming) emotional and practical support carers provide, there can be a significant impact on the household finances if a carer is prevented from undertaking usual paid employment, particularly during a period of crisis where intensive support is needed. The Task Group was concerned to hear examples of carers being excluded from involvement in care due to patient confidentiality concerns. Whilst confidentiality is clearly important, carers also need to be involved as far as possible in order to provide effective support, and for their own wellbeing.

Recommendation 3

The approach to supporting carers, particularly in terms of their involvement in care planning and crisis management, should be reviewed to ensure an appropriate balance is being struck between confidentiality and involvement. Access to respite care should also be examined.

Conclusions – Community Services

35. The quality and capacity of community services and their ability to support a reduction in inpatient beds was by far the biggest issue raised with the Task Group. Overall, the commitments, particularly in relation to crisis support, were welcomed but there is a high degree of scepticism as to whether they will be achieved and a feeling that current services are some way off the standards set. The Task Group’s conclusions are similar – the commitments are to be welcomed, but their achievement will need to be closely monitored and clear progress demonstrated prior to changes to inpatient services being implemented. Trust and confidence in community services is essential in building support for change to inpatient care.

Recommendation 4

Once measures have been put in place against each of the 10 commitments outlined in the consultation document, clear information, beginning with a baseline of current levels, should be made available on a regular basis to HOSC and service user and carer representatives as part of the monitoring process. This transparency is important in building confidence in community services and HOSC would expect to see appropriate measures and baseline information in place within 6 months.

Will the proposed inpatient capacity be sufficient to meet future need?

36. The Task Group noted that the *East Sussex Joint Commissioning Strategy for Mental Health* is based on an assessment of the need for mental health care in East Sussex. This includes the type and prevalence of mental health problems in the county and the type of care which would ideally be needed to meet these needs. As mentioned above, the strategy advocates a stepped model of care where people are cared for in the community as far as possible, and only the most acutely ill are admitted to hospital.

37. Looking specifically at inpatient care, the Primary Care Trusts (PCTs) in Sussex commissioned a report (published in 2009) from Professor Keith Wilson of Whole Systems Strategies to examine the use of inpatient beds in Sussex. The report compared various factors (such as the average length of time people stay in hospital and the proportion of beds occupied at any one time) with other areas of the country to see whether there was scope to improve, and therefore reduce the number of beds needed. The report concluded that there was considerable scope for reducing hospital admissions in East Sussex, which has a higher rate of admission than West Sussex or Brighton and Hove. This reduction, together with bringing the average time people spend in hospital in line with national guidance, would, the report suggests, make it feasible to reduce the number of beds needed. The Task Group noted that the proposed bed reductions in both the short-medium term (next 12-18 months) and the longer term (3-5 years) are informed by this analysis.

38. The recent temporary closure of Woodlands, a 33 bedded mental health inpatient unit in Hastings has provided an opportunity to see how the system has coped with a reduction in beds (albeit more beds than initially proposed in the consultation). Although the Task Group fully recognises that this closure was unplanned, that the proposed community services improvements are not yet in place and that the closure of the whole of Woodlands is not an option being considered in the consultation, it is relevant to look at the learning gained from the situation. Feedback from staff and GPs suggested that the loss of beds had not resulted in a crisis situation, although other services had been stretched as a result. For example, the Department of Psychiatry in Eastbourne had seen an increase in occupancy levels (often fully occupied) and an increased number of service users had been placed in units outside the county boundary, further from their home than the nearest facility.

39. Service user representatives confirmed that the impact had been felt. The consequences of out of county placements were highlighted, with difficulties for visiting families and carers potentially slowing recovery. The effect on CRHT teams, and other community services such as day centres, in supporting more acutely ill patients who were not admitted to hospital was said to be impacting on the services' ability to support their usual caseload.

40. The overall conclusion drawn by the Task Group was that, although the system had managed to cope with the loss of beds, the situation clearly demonstrated the need for significant further development of community services before a planned reduction in inpatient capacity could be implemented. The need for close monitoring of the number of service users placed in inpatient care at a considerable distance from their home was also evident, given that this is an indicator of insufficient local bed capacity and action should be taken to minimise such placements. The bed reductions proposed concurrently in West Sussex make this particularly important and a pan-Sussex approach to monitoring access to local inpatient care would be appropriate.

Specific options for inpatient care

41. The Task Group heard limited comment on the relative pros and cons of the three options for organising inpatient beds in the short-medium term (next 12-18 months). Service user representatives suggested that the limited detail in the consultation document made it difficult to make a judgement between options, and the Task Group concluded that the need for confidence in community services outweighed the strength of feeling in relation to specific options.

42. Having said that, factors such as access for visiting carers and families were thought to be important in promoting recovery. The Task Group recognised that there may be potential benefits to option 3 (which includes beds in Hove) in terms of access for those in the west of the county, although we were not made aware of significant problems with access to the current services.

43. Representatives from Sussex Partnership Trust, and the lead commissioner for mental health, described plans (under any option) for a phased withdrawal of beds as improvements to community services begin to show demonstrable results, for example in reduced bed occupancy or reduced length of stay. HOSC supports this phased approach – it is important to demonstrate there is capacity in the system to reduce beds, and this safeguard will reduce the possibility of out of county placements, at some distance from service users' homes, being required. The 12-18 month timescale for the reduction in beds is challenging, given the significant change and development in community services required to support this. The Task Group is also mindful of GP concerns that, particularly during the transitional period, there should be an ability to reopen additional beds if that became necessary.

Recommendation 5

A strong consensus on the best option for the configuration of beds has not emerged. However, HOSC would expect to see the following factors taken into account by the PCTs in making a decision:

- **Maximising access for carers and families through geographically balanced provision;**
- **Ability to re-open beds should that become necessary**
- **Ability to provide an enhanced therapeutic environment**
- **Ability to improve the quality of clinical care for inpatients**

44. In relation to the longer-term proposals for further reduction in beds and reprovision of the remaining beds in one or two new units within East Sussex, again comment was limited. The Task Group visited the new Langley Green Hospital in Crawley, a purpose built mental health hospital opened within the last year where the quality of the environment and facilities for therapeutic activities are impressive. In contrast, the Eastbourne Department of Psychiatry was built as a traditional acute hospital facility and, although staff had clearly made significant efforts to adapt the environment in Eastbourne to the needs of mental health services, the facilities are not able to meet best practice standards for new mental health units. (N.B. the Task Group did not visit the Woodlands Unit and so cannot comment on facilities there.)

45. Staff and service users clearly see some potential benefits from having a purpose built inpatient unit or units in East Sussex. However, this would have to be balanced carefully with the need for access, particularly if only a single new build facility in one location proved feasible financially. The impact of travel for service users, and particularly families and carers, is significant and must be a key consideration. Clearly, further consideration and consultation on the longer term vision is required, building on learning from the first phase of proposed changes.

Recommendation 6

NHS East Sussex Downs and Weald/Hastings and Rother and Sussex Partnership Trust should undertake further engagement and consultation with staff, service users and the public, and review learning from the first phase of proposed changes, prior to taking any decisions about longer term options.

What is the financial impact of the proposals?

46. The consultation document points to savings of varying levels being achieved by each of the proposed options. Although specific costings were not made available, which limits the Task Group's ability to comment, the relative savings levels provided unsurprisingly show a clear link between the number of beds removed under each option and the level of savings. As a rough indication, the National Audit Office in their 2007 report cited calculations that cost per inpatient was £207 per day, compared to £21 to £43 per day for home visits.

47. East Sussex currently spends above the national average on mental health services, reflecting the increased investment in recent years mentioned above. In the current financial climate, there is no guarantee that any savings from the proposed reduction in inpatient beds will be available to reinvest in mental health services. However, as all services are likely to be required to make efficiencies, savings in inpatient care do represent an opportunity to protect the budgets of community services. If efficiencies can be made through improving the way care is provided, this will minimise the impact on service users.

48. As outlined above, the NHS proposals focus on improving the way community services work to deliver higher quality care and increased capacity, rather than on additional investment. An example of this is the review of CRHT where significant additional spending in East Sussex is not resulting in the reduced admissions and more positive service user experience seen in some other areas with lower expenditure.

49. Transitional or 'double running' costs may be less significant given that the proposals are based on using existing community services budgets more effectively rather than reliant on the savings from reduced inpatient beds. However, a phased reduction in beds may result in wards which are under-utilised for a time, meaning any savings take longer to be fully realised. Conversely, some savings may be released which could, at least in the short term, be used to support redesign of community services.

50. HOSC would ideally like to see savings from mental health inpatient care reinvested in mental health services, but recognises that this may not be possible given the financial outlook. As a minimum, HOSC would look to see mental health spending maintained in line with national averages. The financial outlook also raises concerns over the availability of capital funds to support longer-term proposals for a new inpatient unit or units in East Sussex. This will need to be examined carefully as part of further work on the longer-term plans, but the Task Group recognises a clear need to improve facilities within the county and believes that this should continue to be prioritised within Sussex Partnership Trust's programme of investment in facilities.

How do the proposals fit together across Sussex?

51. The Task Group had concerns that, by developing separate proposals and consulting on these separately, commissioners and Sussex Partnership Trust may be failing to maximise the benefits of a Sussex wide view. These concerns were explored at a joint meeting with a Task Force of the West Sussex HOSC. The Task Group was reassured that proposals and commitments in relation to community services are very similar across Sussex, and that the aim was for a consistent model and standard of care. It is recognised that each county starts from a different point in terms of existing services, but HOSC still believes that commissioners must work closely together and with the Trust and voluntary sector providers to ensure the benefits of a Sussex wide Trust are fully realised, whilst recognising differences in local needs.

52. The Task Group's primary concern in looking at these issues was for those service users living near the boundaries between East and West Sussex and Brighton and Hove. There may also be issues for those living near the Kent border. It is important that these service users are not unnecessarily disadvantaged in terms of access to inpatient care, and in terms of follow-up care if they attend inpatient units or A&E departments located outside East Sussex. GPs in the north of East Sussex also want to be reassured that they have access to the same services as those nearer the coast, where the main inpatient units are located.

53. The Task Group recognises that one of the options for inpatient care is specifically designed to offer access to beds in Hove for service users in the west of East Sussex. This option is, however, the most expensive and relies on space being made available in the Hove hospital. The potential benefits in terms of access must therefore be weighed up against other factors, including any impact on follow-up care, when making a decision.

The consultation process

54. The significance of the proposed changes led NHS East Sussex Downs and Weald/NHS Hastings and Rother and Sussex Partnership Trust to undertake a 12 week public consultation, as well as to consult formally with HOSC. The Task Group also recognises that a period of engagement with service users, carers, staff and interested parties had already been undertaken prior to the public consultation period.

55. Although the consultation was publicised to the general population of East Sussex and three public meetings were held, the engagement plan developed by the local NHS specifically targeted those who would have a greater interest in mental health services – service users, carers, voluntary organisations/groups working in mental health and staff.

56. The consultation was launched two months before a widely anticipated general election and the consultation plan took into account the limitations that would be in place on publicity in the month preceding the election. The plan was to re-publicise the consultation immediately after the election, to maximise awareness. In reality, due to the national political situation, publicity restrictions were extended by the Department of Health beyond the election date, which significantly restricted the planned publicity. This resulted in the NHS extending the consultation period by 1 week to allow extra time to write to interested parties once restrictions were lifted and to allow additional time for people to respond.

57. The Task Group's view is that, setting aside the election issues, the NHS made good efforts to consult with groups who would have an interest in the proposals. There was evidence that a good debate had taken place at meetings and that people had been able to ask searching questions which were responded to. However, some concerns were raised by service user representatives about the extent to which individual current service users (as opposed to those involved in representative groups) had been made aware of the consultation, for example through making the consultation document or summary available via community mental health teams or day centres. Sussex Partnership Trust confirmed that documents had been circulated twice during the consultation period to its sites in East Sussex, with instructions for them to be displayed and service users made aware. However, the Task Group's view is that this could be improved on in future consultations.

58. As mentioned above, the other concern raised with the Task Group was the lack of specific information in the consultation document, particularly to enable people to compare the pros and cons of the three options for inpatient care. Phrases such as 'significant savings' versus 'modest savings' and 'would require creative planning of the day service areas' are not very informative for readers attempting to weigh up options. There is a balance to be struck in terms of level of detail against readability for a lay audience, but information should be more specific and meaningful where possible.

59. Overall, the Task Group would highlight a number of learning points from this process to be taken into account for future consultations:

- Consultations over election periods should be avoided wherever possible, and consultations over a general election period should not happen unless there are very exceptional circumstances. This is in recognition of the significant limitations caused by pre-election publicity restrictions.
- More efforts should be made to contact current individual service users (as opposed to those involved with representative or voluntary sector groups) at the places they routinely access services, particularly via community teams and day centres (including sites run by voluntary sector organisations).
- More detail should be provided on the options proposed to enable people to weigh up pros and cons. There is a limit to the amount of detail suitable for a consultation document, but the NHS could make a more detailed options appraisal available as a separate document.
- Particular efforts should be made to reach service users in the less urban parts of East Sussex, given the lower response from these areas (see below).

Recommendation 7

The NHS should take the learning points highlighted by the HOSC into account when planning future consultations.

60. Apart from some restrictions on information available on options as highlighted above, the Task Group was satisfied that the NHS organisations were responsive to HOSC's requests to provide additional documents, attend Task Group meetings and organise visits.

Consultation responses

61. In total there were 99 responses to the consultation, 72% from individuals and 28% from organisations. The highest level of response was from the Eastbourne area (31%) followed by the Hastings area (19%). Responses from the Lewes, Rother and Wealden areas combined totalled 30%, suggesting that additional efforts may be needed in future to reach service users, carers and interested parties in these less urban areas of East Sussex (see learning points above).

62. NHS East Sussex Downs and Weald/Hastings and Rother commissioned an independent organisation, The Evidence Centre, to analyse the responses received and draw out common themes and issues raised by respondents. The Evidence Centre's report highlights six key themes in the concerns raised by respondents:

- Capacity of services to address local needs;
- The need to build up community services significantly;
- Access to hospital and community services;
- The impact of changes on carers;
- Practicalities of implementation; and
- The importance of evidence and measurement.

63. The report sums up the general feeling from the responses as follows:

- In favour of the principles underpinning the commitments;
- In favour of the potential to strengthen care in the community and offer more services outside hospital;
- Not necessarily opposed to the possibility of reducing the number of inpatient beds if significant improvements were made to community services (although there were some strong feelings against this too);
- Concerned about ensuring that changes to community mental health services are implemented fully prior to progressing with any reductions in inpatient beds.

64. The Task Group found that many of the themes and issues raised by respondents were very similar to points made by service users, carers, staff and managers who had spoken to the Group direct, thus strengthening these points. The consultation responses also highlight the high degree of scepticism as to whether community services will be improved sufficiently to support bed reductions and whether sufficient improvement can be delivered within the 12-18 month timescale envisaged. This reinforces the need for robust and close monitoring of the delivery of commitments and whether the experience of service users and carers is improving. HOSC's recommendations particularly focus on these areas.

Conclusions

65. Having considered a wide range of evidence and views, the Task's Group's conclusion is that the direction of travel outlined in the consultation document is the right one. The evidence suggests that there is scope within East Sussex to reduce admissions and improve the way community services work together to better support service users at home. Improvements to community services should release capacity within the system which will enable a reduction in inpatient beds.

66. However, there is also evidence that community services are stretched and there is a significant amount of work to be done to bring community services to a point where they are able to meet the 10 commitments outlined and have the capacity to provide consistently high quality support. The need to improve access to 24/7 crisis support is a priority here, particularly as trust in this support is fundamental to the confidence of service users, carers and other key groups such as GPs, that inpatient capacity can be safely reduced.

67. For these reasons the Task Group's recommendations focus on robust and transparent monitoring of the development of community services and a carefully managed, phased approach to implementing bed reductions when the time is right. With these safeguards in place, the risks associated with change can be minimised.

68. Although the proposals are consistent with national guidance and local strategy, it is understandable that some service users and carers have reservations about the ability of community services to support the planned changes to inpatient care. They are being asked to put their faith in improved models of care they have yet to see in place and cannot yet have full confidence in. HOSC will be watching closely on their behalf to see that commitments on community services are fulfilled.

Appendix 1: Methodology

Scope and terms of reference of the review

The Task Group was established to consider and make recommendations on the proposals made by NHS East Sussex Downs and Weald, NHS Hastings and Rother and Sussex Partnership NHS Foundation Trust to make changes to mental health services for adults in East Sussex. The Task Group focused on the following key questions and sub-questions:

a) ***Are the proposals in line with best practice/policy for mental health services?***

- Can commissioners and SPT demonstrate that the proposed service model is supported by evidence?

- How will the longer term proposals take account of any changes in practice/policy over the next 3-5 years?

- What are service user concerns/complaints about current services and their views on the proposals?

b) ***Will community services be sufficiently developed to support a reduction in inpatient beds?***

- Do the proposed commitments cover the right areas?
- How well are the commitments currently being met e.g. initial response to a crisis within 4 hours?
- What will be the impact of the new ‘Health in Mind’ primary care mental health service and what capacity will the workers have to support all GP practices in managing care and referrals?

c) ***Will the proposed inpatient capacity be sufficient to meet future need?***

- What needs assessment has been undertaken?

- Have potential trends such as impact of drug (e.g. cannabis) use been considered?

- What is the current occupancy level of inpatient beds and the average length of stay, and how does this compare to other areas?

- What has been learnt from the recent temporary closure of 33 beds at the Woodlands unit in terms of capacity to reduce beds?

- If the Woodlands closure caused significant pressure, why, and how can this be addressed?

- What are the pros and cons of the three options for configuration of inpatient beds?

d) ***What is the financial impact of the proposals?***

- How will savings from bed reductions be used?
- What are the relative costs/savings of the 3 options?
- How will transitional/double running costs be managed?
- How secure is the capital required to build the new facility envisaged in the longer term proposals?

e) ***How do the proposals fit together across Sussex?***

- Where do people living around county borders access care? How are inpatient beds commissioned in each area?
- Is SPT effectively operating services consistently at a pan-Sussex levels and maximising the benefits of being a county wide Trust?

Task Group Membership and project support

Task Group Members: Councillors Carolyn Heaps, Peter Pragnell, David Rogers (Chairman) and Sylvia Tidy

The Project Manager was Claire Lee, Scrutiny Lead Officer. Additional support was provided by Kenneth Fox, Temporary Scrutiny Support Officer.

Martin Packwood, Joint Commissioning Manager for Mental Health, NHS East Sussex Downs and Weald/Hastings and Rother/East Sussex County Council provided ongoing input to the Task Group throughout the review.

Task Group meeting dates

1 April 2010 at County Hall, Lewes

14 May 2010 at Langley Green Hospital, Crawley (joint meeting with West Sussex HOSC Task Force), including a tour of the hospital

27 May 2010 at the Department of Psychiatry, Eastbourne, including a tour of the inpatient facilities

2 July 2010 at County Hall, Lewes

Witnesses providing evidence

The Task Group would like to thank all the witnesses who provided evidence in person :

NHS representatives

Martin Packwood, Joint Commissioning Manager for Mental Health, NHS East Sussex Downs and Weald/Hastings and Rother/East Sussex County Council

Joel Hufford, Communications Manager, NHS East Sussex Downs and Weald/Hastings and Rother

Jessica Britton, Deputy Director of Assurance and Engagement, NHS East Sussex Downs and Weald/Hastings and Rother

Richard Ford, Executive Commercial Director, Sussex Partnership NHS Foundation Trust

Kate Noakes, Deputy Director – Change Management, Sussex Partnership NHS Foundation Trust

Dr Shaquil Malik, Clinical Director for Working Age Adult Mental Health Services, Sussex Partnership NHS Foundation Trust

Dr Lucy Locks, Acting Assistant Chief Operating Officer, Sussex Partnership NHS Foundation Trust

Dr Mandy Assin, Clinical Director for Older People's Mental Health, Sussex Partnership NHS Foundation Trust

Sue Brace, General Manager, Eastbourne Department of Psychiatry, Sussex Partnership NHS Foundation Trust

Jenny Pickett, Modern Matron, Eastbourne Department of Psychiatry, Sussex Partnership NHS Foundation Trust

Neil Waterhouse, Service Director for Older People's Mental Health, Sussex Partnership NHS Foundation Trust

Rebecca Hills, Associate Director for Working Age Mental Health Services (East Sussex), Sussex Partnership NHS Foundation Trust

Staff at Langley Green Hospital, Crawley, Sussex Partnership NHS Foundation Trust

GP representative

Dr Richard Blakey, GP and Chair of the Professional Executive Committee for East Sussex Downs and Weald

Service user and carer representatives

Sue Barnicoat, Development Manager, Activ8 (Hastings and Rother MIND)

Alan Stenning, Co-ordinator, Hastings Carers' Group, Rethink

Richard Dartnell, Patients Council representative

Sue Plant, Patients Council representative

Ambrose O'Boyle, East Sussex Local Involvement Network (LINk) Core Group

Other evidence

The Task Group also received phonecalls from a GP and a practice manager/carer whose views also informed the review.

Evidence papers

The Task Group reviewed the following documents

Item	**Date**
Independent Summary of Consultation Feedback, The Evidence Centre	June 2010
Letter from David Nicholson, NHS Chief Executive entitled 'Service Reconfiguration', Department of Health	20 May 2010
Public consultation on mental health services in East Sussex (consultation document and summary document), NHS East Sussex Downs and Weald/Hastings and Rother/Sussex Partnership NHS Foundation Trust	March 2010
National Clinical Advisory Team report on the East and West Sussex proposals	March 2010
Better by Design, Sussex Partnership NHS Foundation Trust	Dec 2009
New Horizons: A shared vision for mental health, Department of Health	Dec 2009
NHS 2010-2015: From Good to Great, Department of Health	Dec 2009
Whole System Strategies Review (Professor Keith Wilson's report)	2009
Joint Commissioning Strategy for Mental Health, NHS East Sussex Downs and Weald/Hastings and Rother/East Sussex County Council	2008
Monitoring of financial returns for mental health services in East Sussex (extract from Department of Health reports)	Autumn 2008
Helping people through mental health crisis: The role of Crisis Resolution Home Treatment services, National Audit Office	Dec 2007
NHS Plan, Department of Health	2000
National Service Framework for Mental Health, Department of Health	1999

The Task Group also reviewed specific data and additional information supplied by NHS East Sussex Downs and Weald/Hastings and Rother/Sussex Partnership NHS Foundation Trust:

- Comparative savings levels for options
- Inpatient bed days broken down by units in Sussex covering the period during which the Woodlands Unit was closed.
- Reports on the public consultation process
- 'Under one roof': A new approach to adult community mental health services – HOSCs brief

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