Report for:	Overview and Scrutiny Committee	Item Number:	

Title:	Mental Health and Accommodation: Adults & Health Scrutiny Panel Project Report

Report Authorised by:	Cllr Gina Adamou, Chair, Adults & Health Scrutiny Panel

Lead Officer:	Melanie Ponomarenko Senior Policy Officer (Scrutiny) Melanie.Ponomarenko@Haringey.gov.uk 0208 489 2933

Ward(s) affected:	Report for Key/Non Key Decisions:

1. Describe the issue under consideration

1.1. Under the agreed terms of reference[1], the Adults and Health Scrutiny Panel can assist the Council and the Cabinet in its budgetary and policy framework through conducting in depth analysis of local policy issues.

1.2. In this context, the Adults and Health scrutiny panel may:

- Review the performance of the Council in relation to its policy objectives, performance targets and/or particular service areas;
- Conduct research, community and other consultation in the analysis of policy issues and possible options;
- Make recommendations to the Cabinet or relevant non-executive Committee arising from the outcome of the scrutiny process.

[1] Overview and Scrutiny Protocol, 2012, Haringey Council

1.3. Cabinet Members, senior officers and other stakeholders were consulted in the development of an outline work programme for Overview & Scrutiny Committee and Scrutiny Panels. Project work undertaken by the Adults and Health Scrutiny Panel on mental health was agreed as part of this work programme by the Committee on the June 17th 2013.

1.4. The Panel therefore undertook two mental health projects – mental health and accommodation and mental & physical health.

2. Cabinet Member introduction

N/A

3. Recommendations

3.1. That the Overview & Scrutiny Committee:

(i) Note the contents of the attached final report;

(ii) Agree the recommendations contained in the final report.

4. Alternative options considered

N/A

5. Background information

5.1. The Terms of Reference for the project were as follows:

To review housing needs and availability along the whole care pathway for people with mental health problems in order to make recommendations to assist people with mental health needs maintain*, return to and/or access appropriate housing to support and maintain recovery from ill mental health (whether this is high level supported housing, housing as part of the pathway to recovery e.g. recovery houses or mainstream housing.)*

5.2. The Panel heard from a range of stakeholders, both in project meetings and externally. These included BEH MHT, Haringey CCG, Mind, Haringey User Network, Mental Health Support Association, Camden & Islington NHS Trust, St Mungos, service users and carers.

5.3. A number of themes emerged from the project, which are outlined in more detail in the main body of the report. In summary:

- **Preventing Tenancy breakdown** – there needs to be greater emphasis placed on preventing a person from losing their tenancy due to ill mental health.
- **Discharge from BEH MHT** – There can be up to 40% of patients on a ward at any given time who are clinically ready to be discharged but who are not able to be for a variety of reasons, including housing issues. Processes need to be much more effective in order to free up beds for those who need them.
- **Housing Related Support** – There is a proportion of people who have been in Housing Related Support placements for up to 5 years; the service is intended to be used for 18 months to 2 years. This is creating a blockage in the pathway. Work is being done to work through these cases and the Panel supports this work, and feels that greater impetus should be placed on it, again to un-block the pathway.
- **Step Down** – Projects such as Truro Road are seen as good value for money and offer service users' independence whilst ensuring they have the support they need. The Panel feels that properties which can be used for similar projects should continue to be sourced.
- **Recovery Houses** – Recovery Houses have an important role to play in preventing a person from deteriorating and having to be admitted to an acute Ward. However, due to strains on acute beds these are being used for purposes which they are not intended. The Panel also felt that 7 beds for Haringey residents are not enough given the high level of need.
- **Bed and Breakfast** –The use of bed and breakfast accommodation on discharge from BEH MHT is seen as a sign of a failure within the mental health and housing pathway.
- **Communication/Partnership working** – There was a need for closer partnership working across the organisations involved in the mental health and housing pathway, in particular in sharing information in a timely manner, which would prevent delayed discharge from BEH MHT.
- **Commissioning** – Joint commissioning based on current and projected needs would offer value for money and a better experience for mental health service users. This will need close collaborative working between health, adults and housing services. The Panel was pleased to hear that work would be done in this area through the Better Care Fund.
- **Decision making Panel** – The panel was pleased to hear of the changes to the Panel policy in order to streamline processes and improve decision

making and felt lessons could be learnt from the way the Panel works in relation to Learning Disabilities to further improve the process.

- **Housing Benefits** – There is a need to ensure that information on a person's housing situation, particularly in relation to Housing Benefit is shared by BEH MHT with the Housing Benefits service so that housing benefit payments can continue to be paid, and to prevent a person losing their tenancy due to non rent payment whilst they are in hospital.
- **Care Coordinators** – The Panel has concerns over the work load of the Care Coordinator service and feels that the current level of risk being managed is unsustainable.

6. Comments of the Chief Finance Officer and financial implications

6.1 This report makes a number of recommendations, some of which have fairly minimal financial implications and should be able to be funded from within existing resources. (Recommendations 5, 7,and 17.) However others could have more significant cost impacts.

6.2 Recommendations 1, 18, 19 and 16 concern improvements to information sharing between organisations – this could increase administrative burdens depending on the scale of the changes required but could also bring benefits and improved efficiency. Recommendations 3 and 21 relate to training provision which will have a small cost falling on the budget and the Mental Health Trust. This will require some prioritisation of resources.

6.2 Recommendations 8, 13, 14 and 15 suggest ways in which BEHMT and the Council could work more closely together including joint commissioning and integrated work on housing issues. This may require additional resources to be identified.

6.3 Recommendations 4, 6 and 11 concern changes to Housing policy and although seem to require little new resource they may have indirect effects which should be assessed before any changes are finalised.

6.3 Recommendations 2, 9, 10, 12 and 20 propose the creation of new services or the extension of existing services. This will require the identification of new resources or the reprioritisation of existing budgets. However through improving the overall service and experience of people with mental health needs, they may provide longer term efficiencies. If these proposals are taken further a business case analysis of their costs and benefits should be carried out.

6.4 At this stage, the proposals are high level recommendations. If adopted further work will need to be undertaken to identify resources and put in place appropriate control arrangements. It will be important that any proposals that are put before Cabinet for formal adoption are fully costed and the risks properly assessed before Cabinet are asked to agree to them.

7. Comments of the Assistant Director of Corporate Governance and legal implications

7.1. The Assistant Director Corporate Governance has been consulted on the contents of this report.

7.2. The report makes a number of recommendations on a range of services and arrangements, in particular, relating to the accommodation needs of patients. The recommendations are intended to promote the physical and mental health and the general wellbeing of patients. Under Section 117 of the Mental Health Act 1983, the Clinical Commissioning Group (CCG) and Local Social Services Authority (LSSA) have a duty to provide, in co-operation with relevant voluntary agencies, after-care services for patients detained or admitted in hospital for treatment under relevant sections of the Mental Health Act.

7.3. This duty to provide after-care services continues as long as the patient is in need of such services. The services provided under section 117 can include services provided directly by CCG or LSSAs as well as services they commission from other providers. For individual patients, the services provided should reflect their assessed needs and could include provision for continuing mental healthcare, physical healthcare, day time activities, specific needs arising from drug, alcohol and substance misuse, assistance in welfare and managing finances, the involvement of other agencies and the provision of appropriate accommodation.

7.4. The Mental Health Code of Practice provides that “After-care is a vital component in patients’ overall treatment and care. As well as meeting their immediate needs for health and social care, after-care should aim to support them in regaining or enhancing their skills, or learning new skills, in order to cope with life outside hospital” (Paragraph 27.5). Further, “Although the duty to provide after-care begins when the patient leaves hospital, the planning of after-care needs to start as soon as the patient is admitted to hospital. CCG and LSSAs should take reasonable steps to identify appropriate after-care services for patients before their actual discharge from hospital (Paragraph 27.8).

8. Equalities and Community Cohesion Comments

8.1. Overview and scrutiny has a strong community engagement role and aims to regularly involve local stakeholders, including residents, in its work. It seeks to do this through:

- Helping to articulate the views of members of the local community and their representatives on issues of local concern
- As a means of bringing local concerns to the attention of decision makers and incorporate them into policies and strategies
- Identified and engages with hard to reach groups
- Helping to develop consensus by seeking to reconcile differing views and developing a shared view of the way forward
- The evidence generated by scrutiny involvement helps to identify the kind of services wanted by local people
- It promotes openness and transparency; all meetings are held in public and documents are available to local people.

9. Head of Procurement Comments

N/A

10. Policy Implication

1.1. It is intended that the work of the Overview & Scrutiny Committee will contribute and add value to the work of the Council and its partners in meeting locally agreed priorities. In this context, it is expected that the work of the Committee may contribute to improved policy and practice for the following corporate priorities:

- Safety and Wellbeing for all: A place where everyone feels safe and has a good quality of life.
  Priority – Reduce health inequalities and improve wellbeing for all

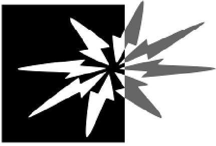
11. Reasons for Decision

1.2. The reasons for the recommendations are laid out in the main body of this report.

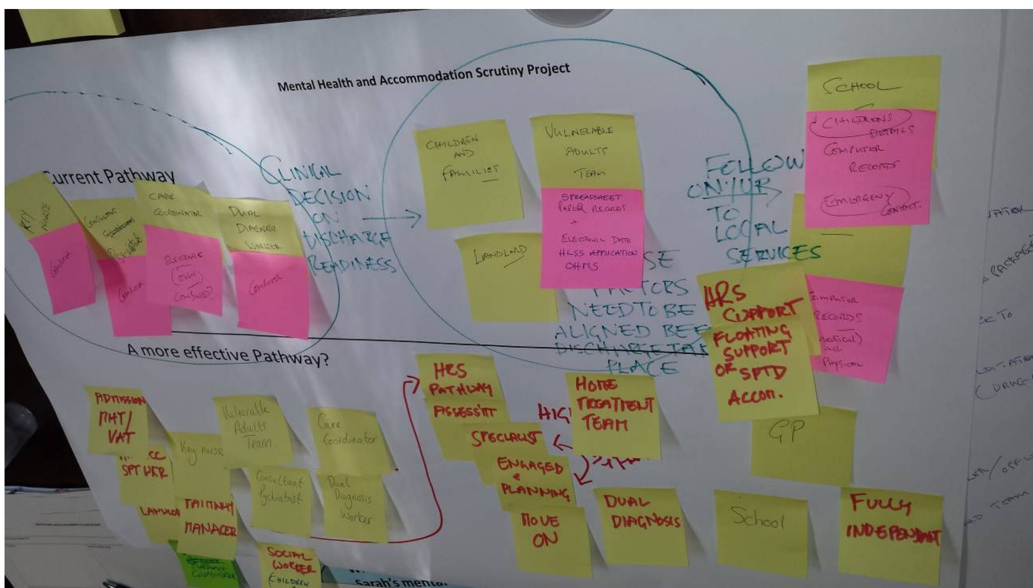
12. Use of Appendices

1.3. Appendices are listed in the main body of this report.

13. Local Government (Access to Information) Act 1985



Project report
Mental Health and accommodation



A PROJECT BY THE ADULTS AND HEALTH SCRUTINY PANEL

April 2014

www.haringey.gov.uk

Chair's Foreword

Having access to appropriate and good quality accommodation at the right time is extremely important to ensuring mental health recovery. The right environment, support and move-on opportunities are key to this, as is organisations working together at the earliest opportunity to provide a seamless and, where appropriate, an integrated mental health housing pathway.

The right mental health housing pathway should ensure that patients and service users are able to access preventative services in a timely manner, are able to access acute care when needed, are able to leave hospital transferring to appropriate accommodation when they are clinically ready and maintain long term tenancies during recovery.

I hope that the recommendations laid out in this report assist in the development of a seamless and effective mental health housing pathway.

On behalf of myself and the Adults and Health Scrutiny Panel I would like thank all of those who took time to contribute to this timely and important project and to all staff who support mental health patients, service users and their carers in Haringey.

Cllr Gina Adamou
Chair, Adults & Health Scrutiny Panel

Panel Members:
Cllr Gideon Bull
Cllr Sophie Erskine
Cllr Anne Stennett
Cllr David Winskill
Helena Kania (co-optee)

For further information on the project please contact:
Melanie Ponomarenko
Senior Policy Officer (Scrutiny)
0208 489 2933
Melanie.Ponomarenko@Haringey.gov.uk

Contents

Recommendations	Page 11
Methodology	Page 15
Policy Context	Page 15
Local picture	Page 19
Main report	Page 21
Appendices	Page 42

Appendix A – Mental health and accommodation survey
Appendix B – Contributors to the project
Appendix C - Delayed discharge snapshot from BEH MHT

Recommendations

The £3.8 billion Better Care Fund (formerly Integration Transformation Fund) was announced by the Government in the June 2013 spending round to ensure a transformation in integrated health and social care. The Better Care Fund is a single pooled budget to support health and social care services to work more closely together in local areas[2].

Haringey intends to focus on mental health Better Care Fund Integration Plan on mental health services in 2015/16. Whilst recognising that this is not new money recommendations below are made with the opportunities this presents in mind.

N.B Housing – means Homes for Haringey and Registered Social Landlords operating in the borough.

Prevention

1) We recommend that there is greater focus on the preventative elements to prevent tenancies being lost once a person has been admitted to an acute Ward. This includes:

- A system being put in place to enable appropriate information about the clients accommodation, circumstances and needs to be shared in a timely manner between BEH MHT and Housing Support & Options and in turn with the Housing Benefit Service. (See recommendation 18)

2) We recommend that consideration is given to establishing a Re-ablement Service, based on the older people re-ablement service model, as part of the Better Care Fund work to focus more intense support on those who need it for the initial 6-8 weeks after discharge from hospital to prevent a relapse.

3) We recommend that mental health awareness is raised with housing staff who are likely to come into contact with mental health service users.

- This should include Estate Managers in order to help them to identify and signpost anyone who may be having housing problems due to their mental health needs e.g. struggling to maintain their tenancy.

Permanent housing

4) We recommend that an annual mental health housing social quota is established and agreed with Homes for Haringey and RSL's.

---

[2] http://www.local.gov.uk/health-wellbeing-and-adult-social-care/-/journal_content/56/10180/4096799/ARTICLE#sthash.XD4CAk4F.dpuf

- The number of properties per year should be based on a projected needs analysis.

5) We recommend that private sector housing opportunities for people with mental health needs are better utilised based on best practice schemes in order to increase the number of private sector tenancies available.

6) The Panel felt that it would be beneficial if pathway moved towards a model whereby the service user is able to access more permanent housing and maintain this tenancy through the rest of their mental health recovery pathway and therefore recommends that, where appropriate, the mental health housing pathway moves to a more permanent housing model in order to provide stability to the service user.

7) We recommend that the Haringey Housing Allocations Policy reflects and promotes parity of esteem between mental and physical health to ensure that mental and physical health are weighted equally.

Move on Project

8) We recommend that there is greater collaboration and continued impetus across the whole partnership (both within the Council and partnership) on the Supported Housing Move On project and that any lessons learned on issues which have prevented move on be regularly shared and learnt from across the partnership.

Step Down

9) We recommend continued identification of suitable properties which can be used for step-down projects, like Truro Road, based on an ongoing needs analysis.

Recovery House

10) To reflect current demand we recommend that BEH MHT commissions a recovery house in the East of the Borough.

Bed and Breakfast accommodation

11) We recommend that the use of Bed and Breakfast accommodation for mental health service users on discharge from BEH MHT is phased out as soon as is practical.

Mental Health Housing Pathway

12) We support the Better Care Fund focus for 2015/16 on Mental Health and the planned integrated Mental Health Recovery Pathway and recommend that the Health and Wellbeing Board ensure that housing forms an integral part in this pathway.

13) We recommend that Public Health map the mental health and housing pathway across the partnership so that it is clear which organisation/team is responsible for each step along the pathway.

- This should include a short high level protocol with agreed roles, responsibilities and accountabilities and which is signed up to by all organisations.
- The Pathway should be signed up by all relevant organisations.

14) We recommend that the new BEH MHT Enablement Officers form a close working relationship with the Haringey Vulnerable Adults Team as early as possible. In order to achieve this we recommend that:

- They meet as part of the Enablement Officers induction;
- Within 4 weeks of their start date to have agreed communication processes to ensure that Vulnerable Adults Team and Housing Benefit know who has been admitted to a Recovery House/Ward and are able to begin work on any possible housing issues, as near as possible to admission, which may prevent a timely discharge.

Commissioning

15) We recommend that there be joint commissioning arrangements across health, housing and social care throughout the pathway to ensure a seamless pathway for mental health service users.

16) We recommend that there is a JSNA deep dive in order to model future housing needs across the mental health population.

Haringey Adult Panel – mental health

17) We recommend that a joint health and social care Mental Health Panel is established, with a mental health clinician as Deputy Chair, as per the arrangements currently in place for Learning Disabilities.

- This should include a Multi Disciplinary group which sits under the panel and which meet prior to the Panel meeting to discuss cases, ensure all paperwork is present and make recommendations to the Panel.
- We recommend that the Panel meeting frequency be increased on a temporary basis to clear the backlog of cases.

Housing Benefit

18) We recommend that BEH MHT put a process in place to ensure that the Housing Support & Options team are fully aware of a person's housing circumstances within 7 days of admission.

- This information should specifically be shared between the BEH MHT Enablement Officer and the Vulnerable Adults Team so that they can liaise with the Housing Benefits Service to prevent Housing Benefit payments being stopped, and a patient subsequently losing their home.

19) We recommend that there is a named person in Housing Benefits who has responsibility for Mental Health matter and who can be a point of contact for BEH Mental Health Team /Vulnerable Adult Team.

Care Coordinators

20) We recommend that the Care Coordinator service should be assessed as soon as possible with a view to alleviating the work load and increasing the number of posts, capacity and skill mix.

21) We recommend that Care Coordinators receive ongoing training in:

- Welfare and benefits in order to assist them in keeping up to date with welfare reforms.
- Housing pathways, particularly in light of the planned Recovery Pathway.

Methodology

1. The project was led by the Adults & Health Scrutiny Panel:
   - Cllr Gina Adamou (Chair)
   - Cllr Gideon Bull
   - Cllr Sophie Erskine
   - Cllr Anne Stennett
   - Cllr David Winskill
   - Helena Kania (co-optee)

2. The project consisted of a number of Panel meetings, external meetings with stakeholders & service user engagement.

   2.1. A survey was also designed with service users and the voluntary and community sector with a view to providing a snap shot of the current discharge pathway. This was sent out via BEH MHT to people who had recently been discharged from Recovery Houses/Wards, however no responses were received. A copy of this can be found at Appendix A.

   2.2. Evidence from a wide range of stakeholders was presented at Panel meetings (See Appendix B for a full list of review contributors). Following presentations the panel and other attendees had the opportunity to ask questions.

   2.3. Panel Members attended a number of external meetings with stakeholders to follow up information and to collect additional evidence to inform the project.

Policy Context

3. National Context

   3.1. The **Health and Social Act of 2012**[3] put a responsibility on the health secretary to secure improvement "in the physical and mental health of the people of England".

   3.2. The government's mental health strategy, "**No health without mental health**[4]" aims to mainstream mental health. The strategy includes a number of objectives to improve the mental health of the population. Most relevant to this project is objective 2:

[3] Health and Social Care Act 2012, www.legislation.gov.uk
[4] No health without mental health, 2011, HM Government

More people with mental health problems will recover – More people who develop mental health problems will have a good quality of life:

- Greater ability to manage their own lives;
- Stronger social relationships;
- A greater sense of purpose;
- The skills they need for living and working;
- Improved chances in education;
- Better employment rates; and
- **A suitable and stable place to live**.

3.3. A **Mental Health Network** NHS Confederation briefing[5] makes the following points:

- Good housing is critical for good mental health.
- 'No health without mental health' stresses the importance of housing for mental health and particularly for those recovering from mental health problems.
- Without a settled place to live, recovery can be significantly impeded.
- People with mental health problems, particularly those with a serious mental illness, can sometimes find it difficult to secure and maintain good quality accommodation.
- Mental health is frequently cited as a reason for tenancy breakdown.
- Housing problems are often given as a reason for a person being admitted or readmitted to inpatient care.
- Cooperation between commissioners and making good use of new structures such as Health and Wellbeing Boards are essential to ensure that there is a more strategic approach to commissioning health and housing support.
- Safe, secure and affordable housing is critical in enabling people to work and take part in community life.
- A lack of settled accommodation for service users can lead to unnecessary admissions and increase overall costs to the public purse.
- A national evaluation (Capgemini for DCLG, 2009) estimated that investing £1.6 billion annually in housing related support services generated net

[5] Mental Health Network, NHS Confederation, Briefing 2011 Issue 233 Housing and Mental Health

savings of £3.41 billion for the public purse. This includes an estimated £3153.2 million in health, £413.6 million in costs associated with the costs of crime and £95 million in the costs of homelessness.

- Cooperation between commissioners is essential to ensure there is a strategic approach to commissioning that includes housing.

3.4. Mental Health Crisis Care Concordat: Improving outcomes for people experiencing mental health crisis

3.5. "This Concordat is a shared agreed statement, signed by senior representatives from all the organisations involved [including the Association of Directors of Adult Social Services, Care Quality Commission, College of Social Work, Local Government Association, NHS England, Public Health England and Mind]. It covers what needs to happen when people in mental health crisis need help – in policy making and spending decisions, in anticipating and preventing mental health crises wherever possible, and in making sure effective emergency response systems operate in localities when a crisis does occur.

3.6. The Concordat is arranged around:

- Access to support before crisis point
- Urgent and emergency access to crisis care
- The right quality of treatment and care when in crisis
- Recovery and staying well, and preventing future crises

3.7. The Concordat expects that, in every locality in England, local partnerships of health, criminal justice and local authority agencies will agree and commit to local Mental Health Crisis Declarations. These will consist of commitments and actions at a local level that will deliver services that meet the principles of the national concordat"[6].

4. Local context

4.1. The Haringey Health and Wellbeing Strategy is the Borough's overarching plan to improve the health and wellbeing of children and adults in our borough and to

[6] http://www.nhsconfed.org/Networks/MentalHealth/LatestNews/Pages/Crisis_Care_Concordat.aspx

reduce health inequalities between the east and west. The strategy is informed by the Joint Strategic Needs Assessment and supported by a delivery plan.

4.2. The Strategy sets out three objectives:

- Outcome 1 - Every Child has the best start in life;
- Outcome 2 - A reduced gap in life expectancy;

and of particular reference to this project;

- Outcome 3 - Improved mental health and wellbeing.

"We want all residents to enjoy the best possible mental health and wellbeing and have a good quality of life – a greater ability to manage their own lives, stronger social relationships, a greater sense of purpose, the skills they need for living and working, improved chances in education, better employment rates *and a suitable and stable place to live*."

4.3. Priorities for outcome 3:

- Promote the emotional well being of children and young people
- Support independent living
- Address common mental health problems among adults
- Support people with severe and enduring mental health problems
- Increase the number of problematic drug users in treatment

5. Better Care Fund

5.1. "The £3.8 billion Better Care Fund (formerly Integration Transformation Fund) was announced by the Government in the June 2013 Spending Round, to ensure a transformation in integrated health and social care. The BCF is a single pooled budget to support health and social care services to work more closely together in local areas"[7].

5.2. The Adult & Health Scrutiny Panel received a report in February 2014 outlining Haringey's Integration Plan. The report states that "Integrated services will be inclusive. They will be available to all adults living in Haringey but, based on an analysis of the Joint Strategic Needs Assessment (JSNA) and GP Collaborative profiles we will prioritise frail older people, and older people with dementia in 2014/15 and adults (of all ages) with mental health needs in 2015/16. These are

[7] http://www.local.gov.uk/health-wellbeing-and-adult-social-care/-/journal_content/56/10180/4096799/ARTICLE#sthash.XD4CAk4F.dpuf

the groups for whom integration will have the greatest and most immediate impact”[8].

Local picture

6. Throughout the project has heard evidence of the current wider context of mental health in the Borough. These points are noted below as useful background/context:

6.1. Mental health pressures across the country have increased over the past 6 months, including in Haringey. This is believed to be due to the economic situation.

6.2. The nearest bed available for a Haringey resident recently[9] was in Pontefract. To avoid the person having to go to Pontefract they stayed in the S136 suite overnight until a bed became available.

6.3. BEH MHT is currently running at a 105% bed occupancy rate. The national guidelines for optimum bed occupancy rate are 85-90%.

6.4. BEH MHT is using approximately 19 private beds per night at an approximate cost of £400,000 per month. BEH MHT is currently over spending due to a gap between funding and need and the £400,000 per month was on top of this[10].

6.5. BEH MHT had also opened some additional beds, but these were unfunded measures which would cost the Trust approximately £5m the 2013/14 financial year[11].

6.6. Increased activity and a commensurate funding gap were the key issues facing BEH MHT. Population had increased by 130,000 in the three boroughs and referrals had increased by 11%, whilst funding has decreased in real terms by 13%[12].

7. Mental Health Strategies Report

7.1. Barnet, Enfield and Haringey Clinical Commissioning Groups have commissioned Mental Health Strategies to report on:

[8] Better Care Fund: Local Health and Social Care Integration Plan, Haringey Council, As presented at the Adult & Health Scrutiny Panel, 27th February 2014
[9] A&HSP Project meeting, October 2013
[10] Barnet, Enfield & Haringey Scrutiny meeting on BEH MHT, February 2014
[11] Barnet, Enfield & Haringey Scrutiny meeting on BEH MHT, February 2014
[12] Barnet, Enfield & Haringey Scrutiny meeting on BEH MHT, February 2014

- An assessment of any potential gap between what commissioners are able to invest and the expected cost of providing current range of services
- Recommendations for high level options to address that potential gap.

7.2. Mental Health Strategies' high level conclusions of nature and scale of funding as reported at a meeting of the Barnet, Enfield and Haringey Scrutiny component of the NCL JHOSC[13] are:

- "BEH-MHT Trust is forecasting an overspend on additional acute activity, including external placements, of £6.5 million above budget for 2013/14
- Adult acute inpatients forms the largest area of this overspend. In particular, BEH-MHT has a high proportion of patients experiencing a delayed transfer of care.
- This, together with very high Cost Improvement Programme expectations, means that BEH-MHT has higher expenditure than income.

7.3. This report is due to be discussed at the CCG Cabinet meetings and presented to BEH MHT Board shortly".

8. The report and recommendations are made with the above points in mind, as well as the opportunities which come with Haringey's commitment to integrate mental health services as laid out in the Better Care Fund Integration Plan.

[13] Barnet, Enfield & Haringey Scrutiny meeting, 24th March 2014

9. Preventing Tenancy Breakdown

9.1. The Panel heard from BEH MHT that when a patient is admitted onto a Ward their housing need is identified within 72 hours. However, this information does not always get passed on to the relevant service at this point, and often not until the point at which a person is ready to be discharged. This, in turn can lead to the person not being discharged when they are ready to be and thus preventing the bed from being used by another patient. Examples shared with the Panel included:

- Housing Support and Options being informed of a patient being ready for discharge that needed a new front door to enable them to return to their property. As the door was a specialist size it took some weeks to be delivered meaning that the patient could not be discharged until weeks after they were ready.
- It can take 4-5 weeks to re-connect utilities to a property if the patient has been away for a long period of time.

9.2. As BEH MHT informed the panel, not only is it not clinically good for the patient to stay on a ward once they are well enough to be discharged, but at a cost of approx £285 per night it is not an effective use of resources.

10. Discharge from BEH MHT

10.1. The Panel heard from BEH MHT that there are a proportion of people on the wards and in recovery houses every day that should not be there as they are ready for discharge. This can be up to 40% of the total people on a Ward at any given time, at a cost of approximately £285 per night for a Ward and £115 a night in a Recovery House[14]. The Panel also heard that it is not clinically good for the patients to be on the Ward/in the Recovery House when they do not need to be.

10.2. Whilst it was noted that there are two bed management meetings per day to try and ensure the availability of beds and to solve any issues there may be with

[14] Figures supplied by BEH MHT

discharge, there are factors which may need stronger collaborative working across the organisations involved in the pathway in order to unblock the pathway.

10.3. A snap shot of data was shared with the Panel showing patients on BEH MHT Wards, in Recovery Houses and in Bed & Breakfast Accommodation whose discharge was delayed between April and September 2013 (See Appendix D). There were a total of 60 cases with a large number of delays being associated with accommodation needs (including awaiting a supported housing placement, being unable to return to previous accommodation due to family reason and refusing offers of accommodation). The length of the delay varied considerably from a couple of weeks to 7 months.

10.4. As mentioned above the nightly cost on a Ward is approximately £285 and £115 a night in a Recovery House. An example of the cost of the some delays to BEH MHT is shared below.

Dates of delay	Length of delay	Location	Reason for delay[15]	Cost to BEH MHT
10/12/12 - 16/04/13	13 weeks, 5 days	Ward	Long wait for supported accommodation. Eventually moved him to a temporary accommodation.	£27,360
14/01/13 - 11/09/13	34 weeks	Recovery House	Was on a waiting list for a supported placement for a very long time.	£27,370
16/04/2013 – 30/06/2013	10 weeks, 5 days	Recovery House	Needed to establish immigration status and entitlements. Eventually found place via private rental.	£8,625
18/12/12 - 15/06/13	25 weeks, 4 days	Ward	SOVA issues - could not return to family home. Eventually wife requested	£51,015

[15] As cited on the BEH MHT Snapshot data submission, Project meeting, October 2013

			for him to return.	
			Total	**£114,370**

10.5. It is important to note that there are other issues around moving people on from Ward/Recovery Houses including a person not wanting to move on as they feel secure, are being fed and kept warm etc.

10.6. The Panel heard that there is a 'Top Delays' meeting every Monday at BEH MHT which is attended by the Vulnerable Adults Team (Haringey Council). An issue which has been raised at these meetings is that there is a lack of places to discharge people to. However, in discussions at the Panel attendees felt that the issue is not the number of supported housing placements, but that the pathway is also blocked with some people in supported housing placements who no longer need to be there. It was felt that if the whole pathway was un-blocked then there would not necessarily be an issue with supported housing placement availability.

10.7. However, it was felt that there was a need to ensure housing options were available for the end of the pathway and that these needed to be in appropriate environments and communities to ensure recovery.

10.8. The Panel felt that a number of appropriate properties across the borough should be identified per year specifically for mental health patients who are well enough to leave housing related support or who have been discharged from BEH MHT but do not need a residential supported living placement.

10.9. The Panel felt that it would be beneficial if pathway moved towards a model whereby the service user is able to access more permanent housing and maintain this tenancy through the rest of their mental health recovery pathway with any floating support needed 'floating' in and out rather than the patient moving to different levels of supported housing. Whilst the Panel recognises that this is not suitable for all cases, it feels it would provide greater stability for the patient and would ensure that they are able to access suitable and appropriate accommodation at the best time for recovery in the pathway.

11. Housing Related Support

11.1. Housing Related Support offers accommodation based and floating support for a range of client groups, including mental health which are commissioned through organisations such as St Mungos and Circle 33. Accommodation based schemes deliver services in properties with shared and self contained units. Floating support is delivered to users who have attained a level of independence in some move-on schemes, but more usually to service users living independently in general needs council or private sector accommodation.

11.2. Services are designed to support service users to maintain independent living through tenancy sustainment and connections to health, care, training, employment.

11.3. The Panel heard that the aims of these services are to provide support so that each service user acquire or enhance the skills they already possess, in the following areas:

- Be able to manage an effective budget, shop on a budget and prepare fresh and healthy food
- Medication management
- Be able to deal independently with a crisis
- Be able to demonstrate an understanding of the safe use of household equipment
- Be able to identify a GP and register, contact utility companies and register for council tax independently
- Increase the number of people leaving institutional care in order to live more independently
- Reduce the incidence of tenancy breakdown and/or individuals losing their homes
- Reduce the number of emergencies amongst people living independently which might result in more intensive services being required
- Increase the number of people who are living in their chosen environment
- Maximize the number of people who are supported to achieve employment

- Enable Service Users to make decisions in relation to their own lives, providing information, assistance, and support where needed[16].

11.4. Benefits of housing related support

11.4.1. The Housing Related Support Commissioning Plan[17] refers to a report by Local Government and Information Unit and Circle Housing Group ('Promoting Independence: the future of housing related support') which includes a tool to calculate savings which can be realised by the use Housing Related Support services and which is used in the Haringey Housing Related Support Commissioning Plan. For mental health services it was estimated that the net benefit was £1.7m (see table below).

Client Groups	Cost Category Totals (£M)		
	With Housing Related support	Without Housing Related Support	Net Benefit
Offender and Substance Misuse*	£3.8	£10.2	£6.3
Domestic Violence	£5.8	£10.5	£4.7
Mental Health	£8.2	£9.9	£1.7
Young People*	£4.5	£4.6	£0.1
Homeless households	£34.7	£39.9	£5.2
Learning Disabilities	£7.7	£9.4	£1.6
Physical Disabilities and sensory impairment	£5.0	£5.5	£0.4
Older People *	£59.8	£62.5	£2.8
Total	£129.6	£152.4	£22.8

Table 5-1 SCENARIO FINANCIAL SUMMARY

11.5. Longer term supported housing units are intended for approximately 18 month to 2 years after which the tenant should be moving on as per the aims of a recovery pathway. At this point Pathway co-ordinator and a member of the Vulnerable Adults Team would discusses options with the tenant. Options can include finding housing through mainstream routes e.g. private renting or thorough housing options. The Panel was reassured that floating support would still be available to a person once they have left supported housing.

11.6. As mentioned above, long term housing related support units should be for 18 months to 2 years. However, approximately 50% of the units have people in them who have been there for over 2 years, where the benefits of

[16] HRS submission, October 2013
[17] Haringey Housing Related Support Commissioning Plan, 2012-2015, Haringey Council

housing related support have been exhausted, and often where the service user has care or health needs that exceed the service provision of housing related support. The Panel heard that some of these cases are historic, with tenants being in the units for some years. Some of the cases are due to the care element, for example where the care coordinator does not believe a person is ready to be moved on. The above mentioned 50% are being considered on a case by case basis with Adults Services and the Community Mental Health Rehabilitation Team in order to move them on. As part of this project a needs analysis will be undertaken and any gaps in provision found will form part of future commissioning plans.

11.7. The Panel was supportive of the move-on project work being undertaken as it felt that in order to un-block the whole pathway, as well as focus on a recovery model for the patients then ensuring that there is a focus on move on was important.

11.8. The Housing Related Support service is in the process of commissioning a new pathway for substance mis-use, offenders and mental health which will extend the availability of accommodation by 36 units (up from the current 109[18] units). Phases 1 & 2 of the pathway for substance mis-use and offenders will be new implemented in January and April 2015 and the mental health services in phase 3 in 2016. The role of Pathway Manager was being recruited to at the time of the project.

11.9. The Panel supports the work being done by Housing Related Support, Vulnerable Adults Team, Adults and BEH MHT to identify people who have been in housing Related Support Placements for some time, and for who the placements are no longer appropriate. The Panel recognises that this requires that all parties co-operate in moving on service users; establishing referrals and transition arrangements to new care and support packages and accommodation as appropriate in many cases.

12. Step Down

[18] HRS submission, November 2013

12.1. A supported living arrangement for 6 mental health service users at Truro Road is being developed and should be ready for March 2014. Following this there are plans for further developments.

13. Floating Support

13.1. The primary client group is men and women aged 18+ with an eligible presenting mental health need living in the London Borough of Haringey. The support offered is flexible and caters to service user's specific needs and aspirations. They assist service users in developing life skills including building a daytime structure, accessing benefits, budgeting, tenancy sustainment and maintaining appointments. Service users are supported to follow a weekly routine including regular key work sessions with their support worker and have access to a wide variety of activities and training.

- The service offers support in relation to the following needs:
- Referrals to and working in partnership with Drug and Alcohol services
- Arrears Reduction, Income Maximisation and Financial Inclusion
- Assistance with Welfare Benefit applications
- Assisting tenants with complex correspondence
- Encouraging tenants to budget and handle their finances responsibly
- Accessing statutory services e.g. Primary Health Care, Mental Health, and Social Services Etc.
- Supporting service users into Employment or training
- Referring service users to other support services e.g. long term mental health support, befriending, advocacy, meals on wheels etc.
- Developing and executing move on plans within a multi-disciplinary context.

14. Recovery Houses

14.1. BEH MHT commissions Rethink to run three Recovery Houses across BEH MHT. The service is for adults, 18 years and over experiencing a mental health crisis that do not require hospital admission but are still not suitable for treatment within their own home. It is for people with mental illness experiencing an acute psychiatric crisis of such severity that without the involvement of crisis intervention, hospitalisation would result.

14.2. The aims of the service are as follows:

- To support service users on their recovery journey, achieve and maintain their best possible level of mental health wellbeing, within the shortest possible time and enable them to live as normal a life as possible during their stay, taking into account health-related needs.
- To provide a stepping-stone between hospital discharge and community care.
- Minimise the effect of ongoing psychological symptoms and facilitate the development of coping skills, knowledge, confidence and motivation in service users.
- Promote and support service users to maintain their own wellness in the community and in line with the needs identified in their care plan.
- To provide optimum care to service users in a multidisciplinary environment.

14.3. The service is able to provide:

- An alternative to hospital admission, in a therapeutic and non- stigmatising environment.
- Comfortable, clean and en-suite rooms.
- 24hr staff presence.
- Emotional and practical support in order to achieve positive outcomes; with one to one support and group settings.
- Signposting to and information on appropriate agencies/services
- Support in identifying triggers to crisis and developing new coping strategies.
- Support in completing a physical health check.
- Support, supervision and prompting with personal care.
- Encouragement that supports compliance with medication.
- The BEH MHT will also support users of service by offering support from OT on site, either individually or as a group, as part of the agreed support[19].

[19] http://www.beh-mht.nhs.uk/mental-health-service/mh-services/recovery-houses.htm

14.4. There is one Recovery House in Haringey, this is situated in Fortis Green and has only 7 beds. The Panel was in agreement with representatives from BEH MHT that this is not enough for Haringey and ideally there should be more Recovery House beds situated where the need is e.g. in the East of the borough.

14.5. The Panel noted that some patients had spent six months in the Haringey Recovery House where three beds out of the seven short-term beds had been taken up by delayed transfer of care of patients who lacked recourse to public funding.

14.6. The Panel felt that Recovery Houses have an important role to play in the housing pathway, and that a concerted effort should be made to ensure that they are used for the purpose which they are intended, particularly given that there are only 7 beds for Haringey residents. Again, the Panel also noted that should the service be used for what it is intended then this would again un-block an element of the pathway to enable the flow through the whole pathway to work a lot better.

14.7. The Panel felt that Recovery Houses have an important place in the recovery model housing pathway and that 7 beds for the level of need in Haringey is not enough.

15. Bed & Breakfast accommodation

15.1. BEH MHT is funding Bed and Breakfast placements where they are placing people who are clinically ready to be discharged from an acute Ward, but who do not have access to accommodation as this is more cost effective that keeping a person on an acute Ward at £285 per night.

15.2. BEH MHT estimates that they will spend approximately £170,000 this year on hostel / B & B type accommodation across the three boroughs.

15.3. BEH MHT acknowledges that the use of bed and breakfast accommodation is not ideal and is not best practice, however, noted that on

occasions this has been necessary in order to create capacity on wards to admit new patients. The Panel heard that BEH MHT has been reviewing its bed management procedures to try and make improvements and reduce the need to use bed and breakfast accommodation. However, given the current demands on services BEH MHT does expect to need to continue to use, and pay for, bed and breakfast accommodation.

15.4. Whilst the Panel recognised the pressures which BEH MHT is currently under it felt that B&B accommodation was not necessarily appropriate accommodation for someone who had been discharged from an acute Ward and that that the use of Bed and Breakfast accommodation is a symptom of failure within the housing pathway. If the correct processes are in place across the pathway then their use will not be necessary.

16. Pathway workshop session

16.1. The Panel held a workshop session with service providers and commissioners to focus on the housing pathway. The objectives of the session were:

- To understand the pathway to settled appropriate accommodation.
- To understand how different agencies fit into the pathway.
- To identify blockages along the current pathway and opportunities to improve these pathways.
- To identify an improved pathway.

16.2. Given the work that was ongoing in Housing Related Support on Move On (see paragraph 15.6 above), it was felt that the most valuable part of the pathway to focus on was relating to hospital discharge.

16.3. The workshop session was facilitated by the Corporate Consultation Manager and had a number of stages:

Stage 1 – Understanding the service user

- Attendees were asked to build a picture of a ‘typical’ service user and note down the different agencies and professionals that the person would likely to be in contact with.

Stage 2 - Identifying information

- Attendees were asked to identify what information the agencies and professionals would be likely to hold on the service user.

Stage 4 – <u>Mapping current pathways</u>

- Attendees were asked to map the ‘As Is’ pathway.
- Panel Members were asked not to participate in this stage, but just to take note of how the pathway currently works.

Stage 5 – <u>Mapping ‘ideal’ pathways</u>

- All attendees were asked to now map an ideal/’To Be’ pathway

Stage 6 – <u>Taking Action</u>

- Attendees were asked to identify the key differences in the pathway and to note down what needed to be done to get from the ‘As Is’ pathway to the ‘To Be’ pathway.

Figure 1 – As Is and To be Pathway from Group 1

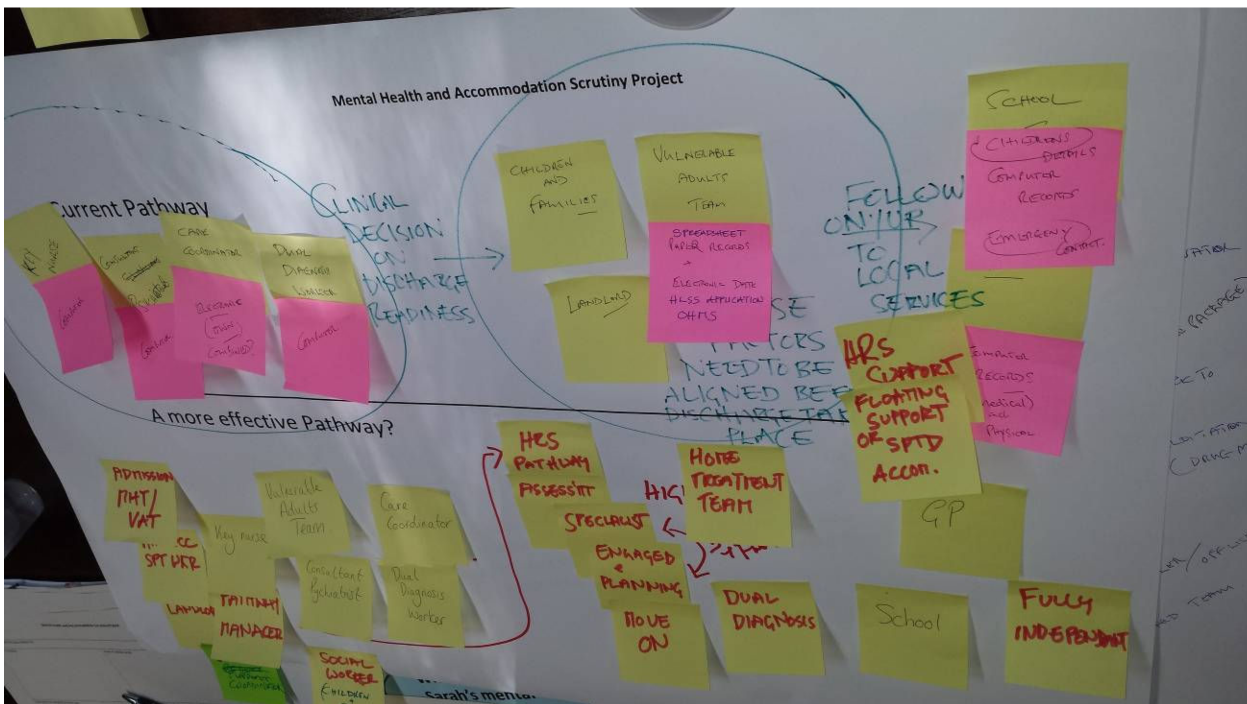
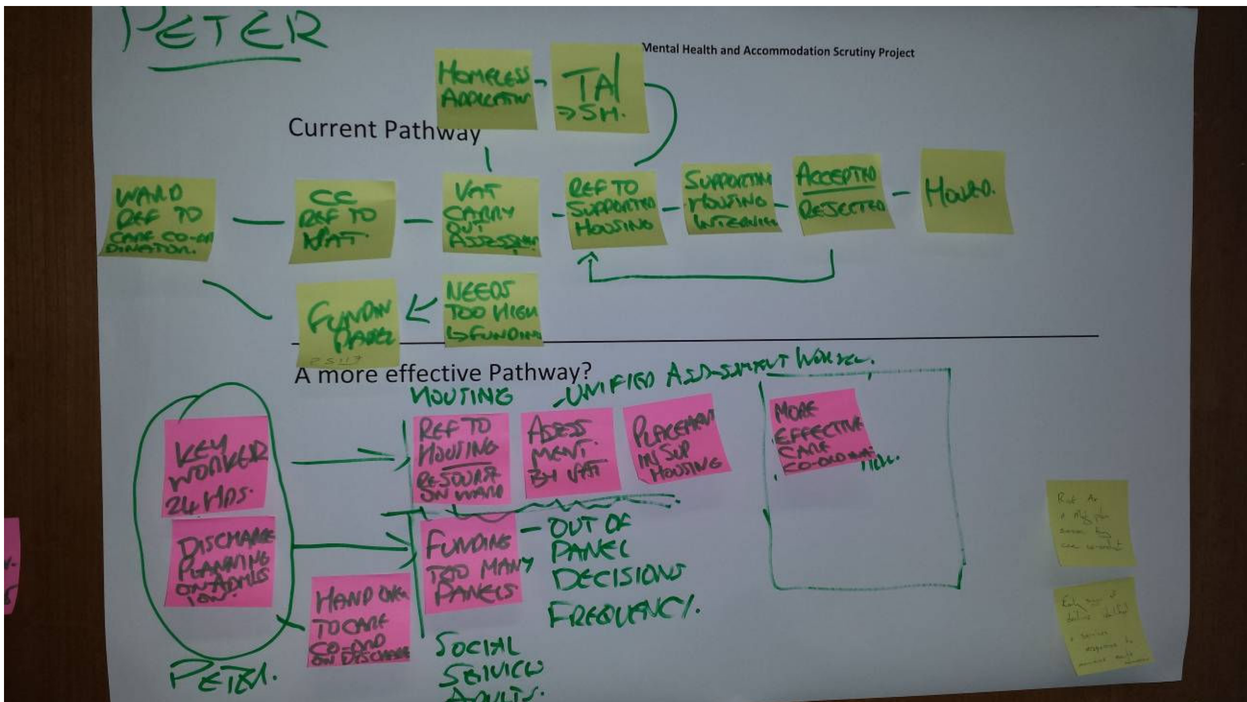


Figure 2 – As Is and To Be Pathway from Group 2



16.4. Responses to stage 6 are listed below

	One	Two	Three
Idea in a nutshell:	Recovery Model ethos across the whole pathway	Discharge planning on admission	Active management from the point of admission
How would it work?	Move on would be the main priority. There would be simpler and delegated decision making focused on the individual rather than the provider.	Having key people such as an Accommodation Support Worker at the start of the pathway	Pathway – high to low needs
Outcome for patient/service user?	Greater control and autonomy	Certainty that all of the decisions will be taken in time.	Targeted, good quality services which deliver recovery to be being fully independent.
Outcome for provider/commissioner?	Movement throughout the system. Payment on level of need.	Quicker process Less frustration Clearer lines of responsibility	No revolving door syndrome Savings Increased provision available
Issues which need to be worked out?	Trust Engagement	New Accommodation	Protocol to support relationship of

	Budgets Panels Greater transparency of systems, procedures and budgets Clarification of care coordinator role	Support Worker and Pathway Manager Governance of process	different parties throughout the pathway Better coordination Information sharing Decision making Funding decisions Software that tracks needs and outcomes

16.5. Based on what the Panel heard throughout the project, they felt that there is a need to have more vigour, joined up working and pro-activeness throughout the pathway to settled appropriate housing. This should involve 'stepping stones' along the pathway for the patient rather than silos of working, which the Panel heard evidence of throughout their work.

17. Communication/Partnership working

17.1. The Panel was of the view that Housing Support and Options need to be informed much earlier than is currently happening so that they can address any problems with a person's accommodation for example, if a front door needs to be replaced or the accommodation needs a deep clean. This would prevent these issues only coming to light once a person is ready for discharge, or coming to light when their case is being discussed at a Delayed Transfer of Care meeting. The Panel felt that planning for discharge should be done as near to admission as is realistically possible.

17.2. Feedback from service users who access Mind in Haringey also fed back that they do not feel that organisations communicate well with each other[20].

17.3. The Panel felt that overall there is a need to build a closer working relationship across the organisations earlier and as an ongoing part of the process in ensuring a person is able to access settled and suitable accommodation. BEH MHT has acknowledged that there are issues with processes for the housing pathway and had been working with Re-Think to employ a dedicated accommodation case worker/Enablement Officer who will solely focus on people's accommodation needs ready for discharge. It was felt

[20] Mind in Haringey submission, November 2013

that the new Enablement Officer post which BEH MHT, which is now being recruited to ,would be key to this relationship.

17.4. The Job Description for the two Enablement Officer roles being recruited to work across BEH MHT states the job purpose as "*To lead the way to a better quality of life for people affected by mental illness by:*

- *Working as part of a multi disciplinary team to improve the pathway and effectively plan complex discharges, working to reduce length of admission on wards and enable a smooth transition to the Recovery Houses or to suitable accommodation.*
- *Provide an interface between the ward and the Recovery Houses ensuring robust communication channels and act as the contact point for all enquiries regarding discharge and housing therefore aiding continuity of care*
- *Provide dedicated case management to co-ordinate discharge and move on were complex social/domestic needs are identified, such as access to benefits, housing or immigration status*
- *To increase the availability of accommodation by building relationships with local landlords, RSLs and housing departments*
- *Work as part of a rota covering 8am until 8pm seven days per week to ensure proactive discharge planning*[21]"

18. Camden and Islington NHS Foundation Trust (CANDI)

18.1. During a discussion on mental health at North Central London Joint Health Overview and Scrutiny Committee it was noted that Camden and Islington NHS Foundation Trusts housing pathways were very good and that their delayed discharge figure was just 1%, which may be the lowest in the country. It was also noted that they are very connected with the local authorities in their area and have been integrated with social care services for 20 years.

18.2. This was followed up by a meeting with the Director of Integrated Care where the following points were noted which may be of use as an example for integration in mental health with a view to reducing delayed discharges[22]:

- There is a strong commitment and support for a close link between social care and mental health services from both Camden and Islington Council and Clinical Commissioning Groups.
- Commitment and trust is needed both at a structural level and by attending joint meetings. For example the Director of Integrated Care at CANDI

[21] Enablement Officer (Discharge and Move On Co-ordination), Job Description as at March 2014
[22] N.b. closer, more integrated working in Camden and Islington started with a mental health strategy in 1999.

attends social care and housing management team meetings in both boroughs. This should be continually worked on.

- Strong, joint commissioners with joint commissioner posts employed by the Local Authority, but who have 'dotted line' management links to the Clinical Commissioning Groups.
- Quarterly contract review meetings are held jointly where both the Council and NHS mental health contracts are looked at.
- There are multi-disciplinary teams which are managed by one management structure.
- Care Coordinators have 20-25 cases each[23].
- There is a need to invest to save as well as making the most of opportunities for closer working as and when they arise.

Delayed discharge and good housing pathways come out of the above points. Also:

- Ensuring that a person has the right element of support as they progress through the pathway.
- Formulating a plan for discharge from Day 1 and ensuring that housing elements are in this as well as any potential housing problems that may arise.
- Housing pathways need to be embedded into the wider health and social care pathway.
- Both Camden and Islington have a high number of supported housing units with a variety of support available.
- Contracts are designed to encourage a patient moving through the pathway to recovery.
- Need to ensure that the right people are sharing information in a timely way.
- Need to ensure that there is an understanding of relevant housing law across the organisations.

19. Homelessness

19.1. The Panel heard from BEH MHT at a project session that there could be up to ten people on a given day on BEH MHT mental health wards who could

[23] They also do Approved Mental Health Professional work

be deemed as homeless. BEH MHT questioned whether the Council would have places for these people should they be deemed as in priority need and was informed that the Council has a statutory duty to house these people and they would therefore find places.

19.2. It was noted that the Vulnerable Adults Team provide support to clients making a homeless application and that Care Coordinators do pass clients onto the Vulnerable Adults Team for this support.

19.3. The Panel noted that there are not a huge proportion of people who have been in St Ann's hospital who are living on the streets. People with mental health needs coming out of St Ann's are mainly picked up by services.

19.4. The Vulnerable Adults team works with Street Rescue. Street Rescue is a service which goes out and looks for homeless people. It is an intelligence led service e.g. relying on information they are given on those who are homeless. Street Rescue takes people to a crash pad which is 4 beds in a hostel for the night before services try and engage in the morning.

19.5. There is a lead borough worker with the service. Cases are then referred to the Vulnerable Adults Team who do a needs assessment and as part of this housing eligibility is considered.

19.6. There is a London wide database (CHAIN) where information of those who come into contact with services is stored; this ensures people can be tracked around London.

20. Commissioning

20.1. The Panel was of the view that effective joint commissioning based on needs provides better value for money and a more seamless pathway for the service user. There needs to be a good data set of current and projected need to inform commissioning decisions to allow this to happen. This data is readily accessible across the partnership and therefore needs to be collected and collated to enable the most appropriate level of care and support to be commissioned, and the correct number of permanent housing stock to be sourced.

21. Decision making – Panel process

21.1. The Haringey Adult Panel is a joint health and adult social care panel "responsible for considering individual applications for funding of care and support in the following areas:

- Establishing eligibility for NHS continuing healthcare (CHC),
- Section 117 – CCG/LA responsibilities
- Joint funded cases – CCG/LA responsibilities
- Managing appeals"

21.2. The purpose of the Panel is to establish consistency and quality of decision making against a set of core values and principles these being:

- Person centred decisions
- Clear and transparent process
- Cultural sensitivity
- Needs led decisions
- Robust recording of decisions
- Availability of information to users and their carers
- Robust governance of process
- Jointly agreed and ratified decisions (across health and social care)"[24]

21.3. The Haringey Adult Panel is chaired by a GP, this was felt to be good practice as the GP is both on the front line and also not involved in commissioning decisions.

21.4. A&H Scrutiny Panel Members met with Dr Jaydeokar, Deputy Chair of the Haringey Adult Panel to gain a better understanding of the decision making process which can have an impact on a person accessing accommodation.

21.5. The Panel was pleased to hear that the policy had been recently reviewed in order to streamline processes and improve the decision making on the funding stream. The Panel heard that it had also been felt that commissioners were too close to decision making, which should be clinical and that there may be unintentional yet undue influence on the decision making from a financial

[24] Haringey Adult Panel, Terms of Reference, Haringey Council & Haringey CCG, December 2013

perspective of the commissioners. Commissioners were therefore no longer part of the Panel.

21.6. Panel Members heard that there are differences in processes for Learning Disability cases and Mental Health cases:

- Learning Disabilities - a Multi-Disciplinary Team will meet prior to the Haringey Adult Panel to discuss the case, with the involvement of the family/carer. The Multi-Disciplinary Team will then present their recommendations for the Haringey Adult Panel to consider and base their decision on.
- Mental Health – Continuing Healthcare Nurse and Care Coordinators attend the Haringey Adult Panel to input to discussions.

21.7. Both at the meeting with Dr Jaydeokar and throughout evidence gathering Scrutiny Panel Members heard examples of delays in decisions due to those attending for Mental Health decisions not being prepared, for example Care Coordinators attending without the necessary paperwork to enable a decision to be made. Delays in the decision making process can ultimately mean that a person has to stay on a Ward/in a Recovery House longer, possibly until the decision making panel meets again a month later, and also that there is a risk that a placement is lost due to the time delay.

21.8. Scrutiny Members felt that there are lessons which can be learnt from the learning disability model in order to improve the efficiency of the decision making panel and also to prevent any delays in a patient being able to be discharged from hospital/recovery house.

22. Housing Benefits

22.1. "The temporary absence from home rules is that claimants, who are patients in hospital, or receiving medically approved care, can receive Housing Benefit/Council Tax Reduction for up to 52 weeks as long as they intend to return to their normal home"[25]. In order for Housing Benefit payments to continue the Housing Benefit service needs to be informed that the person is in hospital and that this situation applies. However the Panel heard that

[25] Email from Housing Benefit Service, March 2014

approximately 50% of people of people lose their Housing Benefit whilst in hospital; this means that they risk losing their home.

22.2. The Housing Benefit payments are stopped because the service is not informed that a person is in hospital. In the main the only notification that the service get is from the Department of Work & Pensions or through ATLAS (Automated Transfers to Local Authority Systems). The DWP itself could receive the information from a number of sources, including from the patient/claimant or third party or it could be that they have stopped signing on.

22.3. Housing Benefit may also be stopped if no one knows where the person is for a long period of time e.g. it may appear to the landlord that a person has abandoned the property, they therefore take it back and re-let it to someone else meaning that when a person is ready to be discharged from hospital back to the property it is no longer possible.

22.4. The Panel felt that should the information be shared between BEH MHT and Housing Support & Options then this situation could be avoided, again ensuring that a patient is not left on a ward when they are clinically ready to be discharged.

23. Care Coordinators

23.1. The Panel heard that the role of Care Coordinators is to join up the planning of those accessing more than one service by assisting with accessing and planning services for example around physical health (including nutrition), support networks, health treatment (including medication side effects). The work is done in partnership with others who are involved in a person's needs. It is important to note that the role of the Care Coordinator is to coordinate services, and not to provide them directly.

23.2. Throughout the project the Panel heard examples of the role of Care Coordinators and the pressure that the service is under. The Panel therefore invited BEH MHT representatives to talk to the Panel about the role of Care Coordinators. The Assistant Director, Psychosis, CRHT Night Manager/Trust-wide Bed Manager and the East Team Manager attended a project meeting.

23.3. The Panel heard that the case load per Care Coordinator is 30-35 clients, whilst the recommended case load is 28 – the service is therefore managing a risk and has been doing so for some time. The Panel are heard that:

- There has been an increased demand in recent years along with more people with higher needs;
- Staff are working longer hours than they are being paid for in order to try and manage the case load;
- Staff had been trying to review case loads to ensure focus on those with the highest need due to resource and pressure issues; and that
- More appointments are being offered in the Community Rehab Team base rather than in a client's home as this means that more people can be seen in a day if staff do not have to spend time travelling.

23.4. Every person known to the MHT has a Care Coordinator assigned to them. It was acknowledged that there may be issues around the work loads of Care Coordinators and that there is a need for an increased focus to get the service overall back on track.

23.5. The Panel has concerns about the management of risk with the current service and felt that an unsustainable level of risk was currently being carried. The Panel felt that the longer this goes on for the higher the risk to client and community and therefore urgent consideration needs to be given to increasing the numbers and/or reassessing the skill mix.

23.6. There is not a large resource in the Care Coordinator team on welfare reform and benefits. Therefore organisations such as Mind are relied on for support and advice in this area. It was noted that training for Care Coordinators in this area would be useful. It was also noted that benefits are only considered by Care Coordinators if this is an area identified in a person's Care Plan. If it is not in the Care Plan then it is not focused on due to resource issues and the need to focus resources on the most vulnerable.

APPENDICES

Appendix B – Review contributors

Name	Job Title/Role	Organisation
Cllr Gina Adamou	Chair of Panel	Haringey Council
Cllr David Winskill	Panel Member	Haringey Council
Cllr Sophie Erskine	Panel Member	Haringey Council
Cllr Gideon Bull	Panel Member	Haringey Council
Cllr Anne Stennett	Panel Member	Haringey Council
Helena Kania	Panel Co-Optee	Haringey Forum for Older People
Melanie Ponomarenko	Senior Policy Officer (Scrutiny)	Haringey Council
Diane Arthur	Advocacy Services Manager	Mind in Haringey
Sarah White	Carer	Mental Health Support Association
Peter Johnson		Mental Health Support Association
Nuala Kiely		Haringey User Network
Elaine Peters	Carer	
Mike Wilson	Director	Haringey Healthwatch
Fiona Wright	AD, Public Health	Haringey Council
Tamara Djuretic	AD, Public Health	Haringey Council
Claire Drummond	Commissioning Manager, Housing Related Support	Haringey Council
Shaun Needham	Vulnerable Adults Team Manager	Haringey Council
Denise Gandy	Head of Housing Support and Options	Haringey Council
Oliver Treacy	Service Director	BEH MHT
Andrew Wright	Director of Strategic Development	BEH MHT
Colin Plant	Director of Integrated Care	Camden and Islington NHS Trust
Leigh Saunders,	Assistant Director, Psychosis and CRHT	
Gerard Comey,	Night Manager/Trust-wide Bed Management	
Pravish Sidhari	Trust Wide Bed Manager	BEH MHT

Dr Jaydeokar	Consultant Psychiatrist and Vice Chair of Adult Panel	
Dipika Kaushal	Head of Project Development	Rethink Mental Illness
Keith Elliott	Corporate Consultation Manager	Haringey Council
Staff Members		St Mungos
Tristan Brice	Adult Commissioning Manager (MH and LD)	Haringey CCG
Amer Akber	Interim Haringey CCG Mental Health Lead	Haringey CCG
Beverley Tarka	Deputy Director of Adult & Community Services	Haringey Council
Jennifer Plummer	Team Manager, Mental Health Services	Haringey Council
Mhairi McGhee	Disability Representation Worker	Haringey Disability First Consortium
Also:		
Service user, patients and carers who all contributed to the project via email submissions, telephone submissions, one to one meetings and local organisation groups.		