Haringey Council

NOTICE OF MEETING

Scrutiny Review – Mental Health; Proposed Acute Services Reconfiguration

WEDNESDAY, 17TH DECEMBER, 2008 at 18:00 HRS - CIVIC CENTRE, HIGH ROAD, WOOD GREEN, N22 8LE.

MEMBERS: Councillors Adamou, Aitken (Chair), Beacham and Mallett

AGENDA

1. APOLOGIES FOR ABSENCE (IF ANY)

2. URGENT BUSINESS

The Chair will consider the admission of any late items of urgent business. Where the item is already included on the agenda, it will appear under that item but new items of urgent business will be dealt with at item 6.

3. MINUTES (PAGES 1 - 4)

To confirm the minutes of the meeting held on 2 September 2008.

4. DECLARATIONS OF INTEREST

A member with a personal interest in a matter who attends a meeting of the authority at which the matter is considered must disclose to that meeting the existence and nature of that interest at the commencement of that consideration, or when the interest becomes apparent.

A member with a personal interest in a matter also has a prejudicial interest in that matter if the interest is one which a member of the public with knowledge of the relevant facts would reasonably regard as so significant that it is likely to prejudice the member's judgment of the public interest **and** if this interest affects their financial position or the financial position of a person or body as described in paragraph 8 of the Code of Conduct **and/or** if it relates to the determining of any approval, consent, licence, permission or registration in relation to them or any person or body described in paragraph 8 of the Code of Conduct.

5. RECONFIGURATION OF ACUTE MENTAL HEALTH SERVICES BY BARNET, ENFIELD AND HARINGEY MENTAL HEALTH TRUST (PAGES 5 - 22)

(i) To consider progress with proposals by Barnet, Enfield and Haringey Mental Health Trust (MHT) to reconfigure adult acute services in the Borough in the light of the recent report by the National Clinical Advisory Team (NCAT) on the clinical implications (attached).

(ii) To consider further the consultation arrangements for the proposed changes and any changes to the terms of reference for the scrutiny review that may be necessary in response to the NCAT review. A copy of the scope and terms of reference for the review, as approved by the Overview and Scrutiny Committee on 6 October, is attached.

6. NEW ITEMS OF URGENT BUSINESS

To consider any items of business admitted at item 2 above.

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Agenda Item 3

MINUTES OF THE SCRUTINY REVIEW - MENTAL HEALTH, PROPOSED ACUTE SERVICES RECONFIGURATION
TUESDAY, 2 SEPTEMBER 2008

Councillors: *Aitken (Chair), Adamou, Beacham and *Mallett

*Member present

LC1. APOLOGIES FOR ABSENCE (IF ANY)

None.

LC2. URGENT BUSINESS

None

LC3. DECLARATIONS OF INTEREST

None.

LC4. CHAIR'S OPENING REMARKS

The Chair stated that he wished to ensure that discussion was kept directly relevant to the issue for which the Panel had been set up – the proposed closure of Finsbury Ward. There would be opportunities elsewhere for the wider issue of the future of St Ann's Hospital to be debated. He thanked the Mental Health Trust for delaying the consultation in order to ensure that the Overview and Scrutiny Committee, and others, had the necessary opportunity to consider the case for change and respond accordingly.

LC5. IMPROVING MENTAL HEALTH SERVICES IN HARINGEY - CASE FOR PROPOSED CHANGE

Lee Bojtor and Andrew Wright from Barnet, Enfield and Haringey Mental Health Trust, introduced the Trust's case for the proposed change. He stated that the consultation document was a final draft and it was planned to begin the formal consultation period from Monday 8 September.

The main objective of the proposed change was to increase the capacity for home treatment. Teams within the Trust responsible for providing this were meeting targets and had exceeded them for this year. However, they were currently under resourced and could treat even more patients if they had additional staff.

Benchmarking had revealed that there was a disproportionately high number of acute beds in Haringey and people were also staying in hospital for longer then elsewhere. The average hospital stay in Haringey was in excess of 70 days whilst in Barnet this figure was nearer 50. In other areas, the figure was around 21 days. Haringey patients were therefore staying in hospital up to 3 times longer then in other parts of the country. As there were less staff to support patients in the community, it was necessary to keep them in hospital for longer.

The Trust hoped to initially address the problem by reducing the length of stays. They were intending to look firstly at internal procedures, such as addressing delayed transfers of care. These would be focussed on during the consultation period as the

Trust wished to demonstrate that it was able to manage stays more effectively. Their own administrative systems had a role as assessments needed to be completed before patients could move on and they required speeding up. Improvements were already being made with delayed discharges down by 25%. The Trust was also reviewing all other reasons for delays. However, housing was not a major issue – they were not aware of a single case of delay where housing was the sole issue.

It was more problematic finding appropriate packages of care for patients. In addition, the role of consultant psychiatrists was a major factor and the Trust was looking at also improving their current systems of working. The money saved by the closure of the ward would be re-invested in home treatment and providing additional resources for the remaining wards. The resources freed up would enable 14 additional staff to be taken on by the Home Treatment teams and 2 staff per ward on the remaining wards. It would also help to reduce the amount of money spent on temporary and agency staff, which was currently £3 million per year. This money would be far better spent on improving support for patients. The changes were not about saving money but using resources better.

Dr. Peter Sudbury, the Clinical Director of the Trust, stated that admitting people to hospital was very bad for their welfare. Mental health in-patient wards were both terrifying and dehumanising places. People began to display institutionalised behaviour after only 21 days in hospital. The benchmark for in patient care should be around 28 days, with most people discharged within 21 days. The expansion of home treatment would help to prevent admissions and enable people to return home earlier. Suicide rates amongst patients were at their highest levels immediately after discharge and the involvement of home treatment teams after discharge would help to address this. Home treatment services in Haringey were relatively poorly developed compared with elsewhere. Users and carers were generally very positive where change had successfully been implemented.

Mr. Bojtor stated that there were currently 3 male and 2 female wards and that maintaining a suitable gender balance between bed numbers was a challenge. He noted that the Council was currently re-tendering its Supporting People provision. He stated that the Trust could find it difficult to identify suitable support for higher levels of need. Current figures showing high levels of occupancy on the wards were due to the current model of care. When people were getting better, they were often sent home on leave and, whilst they were away, additional patients were admitted to take their place.

The Chair thanked the Mental Health Trust for their presentation.

LC6. IMPROVING MENTAL HEALTH SERVICES IN HARINGEY - DRAFT CONSULTATION PLAN AND PAPER

The Panel considered the Mental Health Trust's draft consultation document and plan. The Panel noted the consultation period had been amended and was now due to finish on Wednesday 3 December.

A representative from the Mental Health Carers Support Association noted that the timescale for the consultation was three months, which was the minimum and asked why a longer period had not been considered. He also felt that more information

needed to be provided on the number of patients and carers potentially affected, patterns of illness and rates of relapse, the financial implications of the changes proposed and the potential affect on supported housing. He encouraged the Panel to give further consideration to these issues during their work. The recent reorganisation of community mental health teams had not gone smoothly and had resulted in a fragmentation of services that was disconnected from patients. Acute services could at least provide a degree of safety and stability. The respective roles of home treatment and crisis teams needed to be clearer and the approach to dealing with crises could be somewhat bureaucratic. Community based teams needed to be able to provide the same safeguards for patients as acute services.

Carers and user representatives present at the meeting made the following points:

- Concern was expressed at the possibility that there might not be beds available for people when required.

- A range of facilities to better support people in the community needed to be provided so that the proposed changes could be implemented effectively.

- There needed to be a clear timetable for implementation.

The Mental Health Trust stated they saw no need to extend the consultation period beyond 12 weeks and they were confident that this period would be adequate. During the period, there would be a chance to test the feasibility of their proposals. They would also be increasing the permanent establishment of the home treatments teams from 7 to 10 during the consultation period. They would respond in due course to the other issues raised. The changes were not aimed at one particular group of patients but were about improving the care pathways for them all.

The Chair thanked the Mental Health Trust for their presentation and carers and user representatives for their responses.

AGREED:

That the Trust address the issues raised above in their consultation document and the Panel give particular consideration to them during their work.

LC7. SCRUTINY REVIEW OF PROPOSED RECONFIGURATION OF ACUTE MENTAL HEALTH SERVICES

The Panel considered the draft scope and terms of reference for the review of the Mental Health Trust's proposals. The Chair gave the Mental Health Trust notice that the Panel would be asking for specific information on the likely number of patients affected in due course. In addition, the Panel also wished to consider, as part of the deliberations, the adequacy of systems for reducing delayed discharges. They were of the view that supported housing was a significant issue in relation to the proposal.

It was agreed that external input would be sought on the proposal by the Mental Health Trust from the National Clinical Advisory Team.

In reference to stakeholders to be interviewed by the Panel, it was agreed that input would be sought from the four GP mental health leads within each commissioning cluster. In addition, Haringey User Network would be invited to provide input.

AGREED:

That subject to the above mentioned amendments, the draft scope and terms of reference be agreed and submitted to the Overview and Scrutiny Committee for formal approval.

LC8. NEW ITEMS OF URGENT BUSINESS:

None.

Cllr Ron Aitken

Chair

National Clinical Advisory Team Report on the Reconfiguration of Adult Mental Health Services in Haringey provided by Barnet, Enfield and Haringey Mental Health NHS Trust

1. INTRODUCTION

I was asked through the National Clinical Advisory Team (NCAT) to provide an external clinical expert opinion on a proposed service change in Haringey. The proposal had been reviewed by the Overview and Scrutiny committee and identified as needing formal Public Consultation. In line with the guidance as set out in Leading Local Change this necessitated an external clinical expert review of the clinical case for change.

In preparing this report I had briefing documents from Barnet, Enfield and Haringey Mental Health Trust (BEH), communications with Trust staff, discussion with NHS London (the relevant Strategic Health Authority SHA) and Haringey TPCT (the local NHS commissioners), reviewed a number of papers and databases and on the day of my visit, spoke to a range of people and visited units on the site in Haringey.
As a result of a number of queries and points raised during my visit, I asked for further information from the BEH and incorporated answers to this into my opinion as set out in this document.
This report is prepared for NHS London in line with NCAT procedures. The expectation is that NHS London will share this document with relevant stakeholders to assist in the consultation and review process.
NCAT request that an SHA or PCT representative accompany the clinical expert on the visit to help record issues on the day and support the process. NHS London had understood that the PCT would do this but this did not happen. I understand from the wider news that very significant events were underway in Haringey at this time and these may have led to this situation.
I would like to thank all of those who contributed to this review (names listed on visit schedule Appendix 1.) Everyone that I met came across as sincere, motivated by a desire to improve mental health services to the people of Haringey, being open and caring in their discussions. In this report I will briefly set out the background as I understand it from the written and verbal communications from BEH, then cover findings on the day, then set out my opinion before reaching my conclusion.

2. BACKGROUND BRIEFINGS FROM BEH

This is based on discussions as well as the written submissions. The key written submission evidence is set out in the paper which went to BEH Board on 10th November 2008 – Reconfiguration of Mental Health Services in Haringey – this is included as Appendix 2 so I will not reiterate all aspects contained within it. Essentially, the proposal is to close a 16 bedded male acute admission ward (adults of age 18-65) and use freed up resources to

enhance HTT and staffing on remaining acute wards. Issues for me to consider were the clinical case for change and the 5 principles set out in leading local change

1. Change will always be to the benefit of patients
2. Change will be clinically driven
3. All change will be locally led
4. You will be involved
5. You will see the difference first.

The Trust case can be summarised briefly, as too great a proportion of the money being invested by Haringey commissioners was being spent on inpatient services, meaning that too little was being spent on community services. The Trust plan is therefore to not change the total expenditure on mental health services (the total cake) but to increase the portion given to community services by reducing the proportion spent on inpatient services (making the community slice bigger and inpatient slice smaller).

The Trust case is that a number of benefits to the people of Haringey will arise from this including:

1. More people with significant mental health problems being successfully treated in the community by community services including the home treatment team.
2. Shorter length of stay for those requiring inpatient mental health care by ensuring that the home treatment team can support people ready for discharge through transition back into the community when they are ready to do so – reducing delays to discharge
3. Better response in the community by the home treatment team when people with mental health problems and/or their carers feel they are deteriorating to a point where hospital admission in crisis used to be the only option – increased choice
4. The impact of the above being further reduction in the pressure on beds such that the problems with high bed occupancy which were a feature earlier this year are less likely to occur
5. Focussing revenue and capital resources on a smaller number of inpatient wards will allow better skill mix on the wards thus reducing need for agency staff and associated issues of discontinuity of approach, and allow the Trust to deliver refurbishment of the physical environment of remaining wards.
6. Stop overspend on inpatient wards (which are overspending compared to budget) eliminating need to take money out of other clinical services to cover the ward overspend.

The risks to not doing it are essentially the opposite of the 6 benefits above.
The Trust identified no benefits to not doing it. The Trust identified that the following would be evidence that the risks of the action outweighed the benefits:

1. If people from Haringey could not get admission, when clinically required, to an appropriate Haringey acute adult bed
2. If bed occupancy on Haringey acute adult wards became excessive

3. If people were being discharged inappropriately from an acute adult ward due to bed occupancy pressures
4. If the resources identified to transfer to home treatment team and remaining acute wards did not transfer
5. If service user and carer feedback indicated that people were being poorly supported by home treatment team or receiving care and treatment not at least as appropriate as existing inpatient care.

The Trust had done benchmarking which identified that there was considerable evidence that the Trust was definitely spending a much higher proportion of income on inpatient care in Haringey and thus a much lower proportion of income on community treatment in Haringey than multiple comparator services in London and around England. A reduction of bed complement by 16 male acute adult admission beds would reduce this disparity but still leave Haringey as an outlier. Most people with mental health problems never need inpatient care and even those who require inpatient acute care typically need it for a few weeks whilst typically community care is required for months or years.

Thus, the Trust has made the case that the service delivery and spending model in Haringey does not benefit the majority of people with mental health problems requiring them to get a service from the Trust. The greater good is not in itself a necessary or sufficient reason to change service delivery. If the greater good was the only criteria then those with the greatest problem and most severe need could lose out.

The next test is therefore whether the model addresses the needs of those with such severe problems that they have previously required admission. The plan recognises that not all people will benefit from a home treatment approach and so will retain acute adult inpatient beds. The plan envisages that the increased staffing to the home treatment team will enable that team to appropriately meet the needs of more than 16 people at any given time i.e. the increased capacity will ensure more appropriate treatment for more than the 16 people who would currently have access to the inpatient ward. The plan further envisages increased staffing to the remaining inpatient wards i.e. improved care to those who will need admission as well as to those successfully treated at home by home treatment team. The plan also involves closing the ward which is in poorest physical state to provide modern mental health care, meaning that all people admitted to adult acute wards get access to better quality ward environments and by having fewer wards more money can be spent on improving the remaining wards over time (by using the same budget but spending it on fewer wards). Thus, the Trust case is that the benefits outweigh the risks and are deliverable and necessary. In effect only one option is proposed i.e. close a ward to free up resources to enhance community and inpatient care.

Between the original request to NCAT and the visit, two significant events occurred to the Trust. One was a fire in a forensic unit at another site requiring a change of use of the Psychiatric Intensive Care Unit in Haringey to provide a temporary unit for people displaced by the fire. The second was a flooding on an acute mental health ward in Haringey leading to its emergency closure. By the time of my visit (31st October 2008) BEH had therefore closed a male acute admission ward, moved staff to the home treatment team and the other wards and in effect put in place the plan which was to be the subject of the consultation.

3. FINDINGS ON THE VISIT – 31st OCTOBER 2008

As noted above, the day was well organised, people were open and helpful and a wide range of views were expressed. There was no one who felt that improving community mental health services in Haringey was a wrong option. The issues seemed to be:

1. Was this an attempt to cut costs rather than improve community services?
2. Could the current community services cope with reduced access to beds?
3. Would the change create greater bed pressures with people being placed out of area?
4. Would people be discharged before clinically appropriate or to inappropriate community care?
5. Wider issues of the future of mental health services in Haringey including rehabilitation and longer term recovery services and carer support.
6. Wider issues about the general health and well being approaches in Haringey e.g. adequate availability of social housing, meaningful activities, effective working with the local authority
7. Whether people with physical health care problems got appropriate access to mental health care and vice versa in a timely and proactive manner
8. The overall future of the St Ann's site

Items 5 to 8 were clearly wider than the remit of the review or proposed consultation, but I list them, as they were clearly important to local stakeholders and so can't be ignored in planning and consultation at least as background issues.

I therefore sought to clarify the above issues and the 5 principles in my discussions and visited some wards on the day and then asked BEH for supplementary information on certain points.

4. OPINION

1. BEH have made a powerful argument that Haringey spends a considerably greater proportion of commissioner spend than most other areas in England on inpatient services. The Trust in its report (attached as Appendix 2) states that CSIP argues for 16-20 adult acute mental health beds per 100,000 population, whilst Haringey (pre ward closure) had 42 per 100,000. The BEH paper goes on to say that figures as low as 11 acute adult beds per 100,000 population are in use in parts of England. To guard against the risk that BEH might selectively present figures, I used the CSIP database for 2008 LIT (Local Implementation Team) comparisons to compare inpatient bed numbers per weighted 100,000 population i.e. nationally and objectively weighted to take account of factors known to impact on the range and type of mental health needs in local communities. On this measure Haringey came out at 42.93 beds per 100,000 population. The lowest rates in England were 12.37

in Norfolk. Only one other LIT was below 16 per 100,000. The English average is 27.13 and the London average 34.19. Haringey was virtually the highest area in England. My finding on this is that in using national benchmarked data, Haringey is investing well over 3 times the lowest level in England and well over 20% more than the London average in inpatient services. This is money that is therefore not available for community services. Closing 16 beds therefore leaves Haringey well above current London average which in turn is well above national average for those with greatest percentage of community service investment.

Finding - my finding on this is that closing a ward and transferring resources to the community is a step towards best national practice. My finding is that BEH have appropriately used available national data.

2. Will the resource transfer to the community or is it just a way of bringing in cost cutting?

I raised this issue with BEH and the commissioner from Haringey TPCT. I am told that the commissioning strategic intention is to increase mental health service provision in Haringey, that investment is already underway e.g. into improving access to psychological services in the community in 2009-10 and that the PCT would expect the Trust to reinvest any savings from the ward closure into services in mental health for Haringey. BEH confirmed that the monies paying salaries would be protected and reinvested in the home treatment team and in improving staffing on the other wards. They also confirmed that with fewer wards the refurbishment and maintenance programmes would be maintained to improve overall physical quality of the wards. As per the Trust paper some money which is currently supporting an overspend on inpatient services can't be released but if the ward didn't close this money would have to come out of other clinical services by year end to balance the budget i.e. this corrects the overspend and protects other services.

Finding – on the evidence given to me I am of the opinion that the ward closure is to release monies to improve clinical services and not for cost cutting purposes.

3. Can services cope with fewer beds?

There is no doubt that there are bed pressures In Haringey. This has been noted and commented upon by the Mental Health Act Commission (Appendix 3). The Trust supplied me with a year's data on this as part of the supplementary information that I requested. This shows bed occupancy at over 100% on a regular basis (based on patients allocated to a ward not numbers sleeping on it) and regular numbers sleeping out on other wards. I am told that Haringey patients do not get sent out of Borough for acute admissions. The data shows a service that is operating at below best practice (which would be 85% bed occupancy and no one sleeping out). The October data shows that this had not got worse due to the ward closure and there appears to be an overall trend towards improvement across the 12 months. The increased staffing to the home treatment team should allow up to 30 extra people to be treated i.e. once staff are established an extra 14 capacity over that offered by the ward. I was also told by clinical and managerial staff that the trial of the "Acute Care Model" (where consultant psychiatrists specialise

in either inpatient or community work) had been so successful in half the borough that it was going to extend to the whole borough in the next few weeks. National evidence suggests that this, plus the increased staffing, should further reduce inpatient bed usage by improving the care pathway through the inpatient stay.

Finding - in my opinion the moves undertaken will not make the situation worse and should, over coming months, significantly improve bed pressures.

4. Are people being discharged prematurely or to inappropriate accommodation?

Again, I asked the Trust for supplemental information on this. With the changes having been only recently introduced, it is not easy to determine definitively, but the evidence supplied to me by the Trust does not give me any reason for believing that there have been inappropriate discharges. I did not seek to access individual people's records for confidentiality reasons, so my opinion is based on anonymised data.

Finding - on the basis of reasonably available information I do not believe that the Trust is inappropriately discharging people to reduce bed pressures. If the changes in 3 above work then any rationale for inappropriate discharge would be further reduced.

5. Will closing the ward improve inpatient care?

Ward names had changed during the refurbishment and emergency closure. The ward that I was shown, where the leak had happened, was poorly designed for modern mental health care e.g. had a 6 bed dormitory with only 1 wash basin and circulation routes that cut through patient recreation and lounge area. This ward might be suitable for emergency use or with some refurbishment for short term use as a decanting ward but would not be suitable for continued inpatient use without considerable redesign and refurbishment. I was shown 2 other wards; one refurbished and one awaiting refurbishment. These were better, especially the refurbished ward. Long term the building lay out will make it very difficult to use these wards and meet best national practice, but in the short to medium term, the refurbishment is a considerable improvement.

Finding – in my opinion the Trust is investing money to make best use of the existing building and the remaining wards.

5. CONCLUSION

In my opinion on the 5 principles:

1. Change will always be to the benefit of patients - this changes move clinical services in Haringey towards best practice and are to the benefit of patients
2. Change will be clinically driven - I was satisfied that the change was clinically driven and clinically evidenced

3. All change will be locally led - I was satisfied that the change was being locally led to address the identified needs of Haringey and in line with the commissioning strategy
4. You will be involved - I think that there has been involvement effort and that the consultation process, if properly done, will enhance this. There is a degree of distrust arising from previous changes undertaken by BEH although all were clear that this preceded the current senior management team and that they were willing to work with the new senior management team to deliver meaningful local involvement
5. You will see the difference first – this did not happen due to the emergency ward closure. I am satisfied that in the circumstances the Trust deployed the resources as per the plan as quickly as they could reasonably have done so.

In my opinion, proceeding to a full public consultation, which asks the public to say whether or not the changes put in place should remain, is at risk of appearing tokenistic as the clinical case for change is overwhelming and to reverse the process would be unjustifiable from a clinical perspective. Given some of the history, I think that this would be damaging as well as a poor use of public resources. It was clear that there was genuine interest, concern and hope about wider issues related to mental health service delivery in Haringey. It is also going to be clear to any interested observer that there is an opportunity to further reduce acute admission ward numbers in Haringey and thus further improve investment in community services. There are understandable anxieties about the pace, rather than direction of these changes, and particularly, the need to demonstrate the benefits do outweigh the risks including for carers. I recognise that it is not my place to determine what the consultation should cover or how it should best be done and this is a decision for the commissioners, the OSC and BEH. Acknowledging that, I wonder if the consultation could be on whether the direction of change is right, with this as the first step, and what might the public want to see in terms of benefits before proceeding further. I think that this could be given in the form of options to promote a real choice in the consultation.

Finally it is my opinion that the trust in collaboration with the commissioners could undertake to produce a report at agreed time intervals demonstrating that the benefits intended had been realised including data on bed occupancy, numbers sleeping out, numbers of acute admissions having to be admitted to a bed outside Haringey, length of stay (average and range), delayed discharges (delayed transfers of care) and discharge destinations (in particular how many people were able to return to address from which admitted or if not then that address to which discharged is in some way better than address from which admitted given the person's circumstances), numbers receiving treatment from the home treatment team.

Dr Ian A. Davidson
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Member of National Clinical Advisory Team
November 2008

National Clinical Advisory Team Report on the Reconfiguration of Adult Mental Health Services in Haringey provided by Barnet, Enfield and Haringey Mental Health NHS Trust

APPENDICES

Appendix 1. **Appendix 2.** **Appendix 3.**


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Dr Ian A. Davidson
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November 2008

Haringey Council

Agenda item:

[No.]

Overview and Scrutiny Committee on 6 October 2008

Report Title: Scrutiny Review of Proposal by Barnet, Enfield and Haringey Mental Health Trust to Restructure Haringey Mental Health Acute Care Services – Scope and Terms of Reference	
Forward Plan reference number (if applicable): N/A	
Report of: Chair of Overview and Scrutiny Committee	
Wards(s) affected: **All**	Report for: **N/A**

1. Purpose

1.1 To approve the scope and terms of reference for the scrutiny review set up to respond to the proposal by Barnet, Enfield and Haringey Mental Health Trust to close an acute ward at St. Ann's Hospital.

2. Introduction by Cabinet Member (if necessary)

2.1 N/A

3. Recommendations

3.1 That the scope and terms of reference for the review, as outlined in the report, be approved.

3.2 That the temporary suspension to the work of the Panel caused by the delay in the commencement of the formal consultation period on the Mental Health Trust's proposed changes to services be noted.

Contact Officer: **Rob Mack, Principal Scrutiny Support Officer, 020 8489 2921**
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4. Local Government (Access to Information) Act 1985

4.1 Background Papers:

Improving Mental Health Services in Haringey – Draft Consultation Plan and Document – Barnet, Enfield and Haringey Mental Health Trust

5. Report

5.1 As previously reported to the Committee, Barnet, Enfield and Haringey Mental Health Trust have recently made proposals to make changes to their inpatient services within the Borough. The proposals involve the closure of an acute adult inpatient ward at St. Ann's Hospital. This is intended to allow re-investment of resources into (i). their Community Home Treatment Team to enable more people to benefit from Home Treatment and (ii). the remaining in-patient wards in order to improve establishments and reduce reliance on temporary staffing.

5.2 The Trust is of the view that their Home Treatment Teams, as currently established, are meeting their national targets and could treat more people at home, prevent more admissions and support people to return home earlier if there were more staff available to enable this. The proposed change was identified as a requirement of the Haringey Joint Health and Social Care Mental Health Strategy 2005-2008, which cited the Haringey model as being over-reliant on institutionalised, hospital based care and requiring a shift of resource from hospital to community. This has been confirmed by benchmarking undertaken by the Trust. They also feel that the current inpatient staffing establishments are insufficient to meet modern requirements.

5.3 The Trust feels that the changes will improve the quality of care to service users within the Borough. National audits identify that people prefer the opportunity to receive their care at home rather than having to be admitted to hospital. They feel that avoiding admission also improves opportunities for recovery. Research has shown that some communities, particularly black and minority ethnic communities, also prefer home treatment where this is appropriate and available.

5.4 Individuals will be assessed for their suitability for home treatment. Risk assessment will form part of the process for deciding whether hospital admission or home treatment is appropriate. Some people will benefit from an increased opportunity to receive their treatment in their own environment. The Trust comments that this is not a new method of delivery in itself but a proposal to re-allocate further resources to more modern and effective models of service delivery. These are effective for a particular group of users who require care for an acute episode of illness but not necessarily hospital care if an alternative to admission can be provided.

5.5 The Trust feels that the changes will contribute to the delivery of local targets, increase, choice for patients and provide better value for money. In particular:

- There are local and national targets set for the number of home treatment episodes and a requirement for services to be delivered as close to home as possible.

- Increasing the resource in Home Treatment Teams will enable more people to receive their care at home and more people to return home earlier in their stage of recovery.

- Not only is hospital admission expensive, it has a big impact on the individual's chance of recovery. The Trust feels that keeping people connected with their networks reduces the possibility of dependency.

5.6 The Trust accepts that the change does mean that there will be a fewer number of male acute admission beds. There are currently 92 adult acute beds and closing 16 male beds would reduce this to 76. The resources freed up will be transferred to enable more home treatment episodes and an improved level of staffing on the remaining wards to improve the therapeutic environment. Increasing the number of staff on the remaining wards will reduce the need for additional temporary staffing to cover periods of sickness absence, training etc, resulting in some efficiencies and improving continuity and quality on the wards.

5.7 The Trust reports that it has undertaken some consultation with users already. Whilst there is support for the direction of travel, there is also concern about how the transition of resources is undertaken.

5.8 The Director of Adults, Culture and Community Services (ACCS) has previously commented that, in broad terms, the MHT proposal to reduce inpatient capacity and redeploy resources into community Crisis services is in keeping with the existing Joint Mental Health Strategy. The proposal has caused some concern amongst service users and carer organisations in the borough due to a perception that community services are still adjusting to the service reconfiguration which took place in October 2007. Whilst there are still some difficulties, the service is continuing to improve and there has been some positive feedback on the single point of access to services now in place. Management support and action is under constant review to ensure that the teams are pro-actively working with the service users and carers affected by the changes.

5.9 ACCS considered that the proposal to close the ward needs to be reviewed in the context of the whole system of community services and current planning across the partner organisations. The areas for consideration include the possible impact on the existing community teams; the relationship between this development and plans to enhance and define community rehabilitation services and the potential for unplanned demand against purchasing budgets. In addition, for the council, ACCS will need to work closely with Housing colleagues to ensure that the pathways for Mental Health service users to obtain independent accommodation remain effective.

Consultation Arrangements

5.10 There is a general requirement for NHS bodies to consult with patients and the public, including a duty to consult with Overview and Scrutiny Committee (OSC) under Section 11 of the Health and Social Care Act 2001. In addition, there is also a specific duty to consult on what are termed as "substantial variations" to local services under Section 7 of the Act. Legislation and relevant guidance does not define exactly what is a "substantial development" in service. Instead, NHS bodies and overview and scrutiny committees are advised to aim for a local understanding of the definition, taking into account;

- Changes in accessibility e.g. reductions or increases of services on a particular site or changes in opening times for a clinic

- The impact of the proposal on the wider community e.g. economic, transport, regeneration

- Patients affected e.g. changes affecting the whole population or specific groups of patients accessing a specialist service

- Methods of service delivery e.g. moving a particular service into a community setting rather then being hospital based.

5.11 Overview and Scrutiny Committee on 2 June 2008 approved the recommendation that this proposal be designated as a "substantial variation" to services and therefore subject to a statutory consultation process with OSC. This was due to:

- The number of patients potentially affected

- The nature of the changes in the method of service delivery, which involves moving a significant proportion of services from a hospital setting into the community,

5.12 The purpose of formal consultation with the Overview and Scrutiny Committee is to consider:

(i) whether, as a statutory body, the OSC has been properly consulted within the consultation process;

(ii) whether, in developing the proposals for service changes, the health body concerned has taken into account the public interest through appropriate patient and public involvement and consultation; and

(iii) whether, a proposal for changes is in the interests of the local health service.

5.13 The above matters are therefore the issues that the Panel will need to consider in making its formal response.

5.14 Cabinet Office guidelines recommend that full consultations should last a minimum of twelve weeks and that they should ensure that groups that are traditionally hard to engage are involved, in addition to the wider community and OSCs. The guidelines set out the basic minimum principles for conducting effective consultation and aim to set a benchmark for best practice. However, the guidance states that it may be possible for OSCs and NHS bodies to reach agreement about a different timescale for consultation, if appropriate.

5.15 In the event of the Committee finding that the consultation has not been adequate or a proposal is not in the interest of the local health service, it has the power to refer the issue to the Secretary of State for Health. Such powers should however only be used as a last resort and if it has not been possible to reach a local resolution.

Timescale

5.16 The MHT originally set a consultation period to run from Monday 8 September to Wednesday 3 December. However, following the first meeting of the Panel, on 2 September, the Trust was informed that it was required to submit the proposal to NHS London for a pre-consultation review in order to test the soundness of the case of the change. NHS London is now requiring a pre-consultation review to be

undertaken by all Trusts proposing changes which local Overview and Scrutiny Committees have designated as being "substantial variations". This process is likely to take form 6 to 8 weeks. As part of this process, the proposals will be considered by the National Clinical Advisory Team.

5.17 In the light of the changes to the consultation timetable, the Panel has decided that it would be prudent to wait until the consultation formally begins before resuming its work. This is because it is possible that changes to the proposals will be recommended by NHS London and, in addition, local circumstances may change in the interim period. It is possible, for instance, that the work that the Mental Health Trust is currently undertaking to reduce the length of hospital stays may yield results and this may change the views of stakeholders and users.

Terms of Reference:

5.18 It is proposed that the terms of reference be as follows:

"To recommend to the Overview and Scrutiny Committee an appropriate response to the proposal by Barnet, Enfield and Haringey Mental Health Trust to restructure acute mental health services within Haringey and in particular;

(i) whether, as a statutory body, the OSC has been properly consulted within the consultation process;

(ii) whether, in developing the proposals for service changes, the health body concerned has taken into account the public interest through appropriate patient and public involvement and consultation; and

(iii) whether, a proposal for changes is in the interests of the local health service."

5.19 Key areas for consideration by the Panel in reaching conclusions and recommendations will be the following:

- The potential impact on the existing community mental health teams and other support required for the increased numbers of patients that will be treated in the community

- Whether the necessary community infrastructure is in place to support the proposed changes and, in particular, whether factors relating to clinical risk and performance and investment have been addressed sufficiently by the Trust.

- Arrangements by the Trust for ensuring that the training needs of all key professionals currently working in inpatient care are addressed.

- The relationship between this development and plans to enhance and define community rehabilitation services

- Whether the changes will ensure that the remaining number of beds is sufficient to meet demand nor compromise the requirement for single sex accommodation for patients.

- The potential for unplanned demand against purchasing budgets

- The implications for carers/relatives.

- The availability of suitable housing provision for patients leaving hospital and the adequacy of systems to reduce delayed discharges.

- Clarity on plans for reinvestment in the community therapeutic, treatment and assessment teams and, in particular, how funds will be transferred from their inpatient funding to community based care.

- The potential cost implications for other stakeholders, such as the Council, and any other clinical and financial risk implications

Sources of Evidence:

5.20 In undertaking this exercise, the Panel will consider the following:

- Research documentation and national guidance and targets

- Local strategy documents and statistical information, such as current and projected occupancy levels

- Comparison with other areas such as neighbouring boroughs

- Interviews with a range of stakeholders including the MHT, the Council's Adults, Culture and Community Services and Haringey TPCT

- Views of patient, user and carer representatives

5.21 It is proposed that the following organisations and individuals will be approached for their views on the proposals:

Barnet, Enfield and Haringey Mental Health Trust

Maria Kane, Chief Executive, BEH MHT
Lee Bojtor, Borough Director - Haringey
Andrew Wright – Director of Strategic Development
Penelope Kimber – Engagement Manager
Dr. Peter Sudbury – Clinical Director

Council Services

Lisa Redfern – Assistant Director, Adult, Culture and Community Services
Douglas Maitland-Jones –Mental Health Service Manager, Adult, Culture and Community Services
Matthew Pelling – Housing Commissioning Manager, Adult, Culture and Community Services
Siobhan Harper - Head of Mental Health Commissioning Haringey TPCT/LBH Adult, Culture and Community Services
Phil Harris – Assistant Director Strategic and Community Housing, Urban Environment
Manager – Alexandra Road Crisis Centre

The Cabinet

Cllr Bob Harris – Cabinet Member for Health and Social Services

Partners

Helen Brown – Deputy Chief Executive, Haringey TPCT
Lead mental health GPs within commissioning clusters

Voluntary Sector

MIND in Haringey
Rethink
HAVCO
Haringey Racial Equality Council
Ethnic minority/refugee and asylum seeker organisations
Tulip
Open Door
The Polar Bear Community

User/Carer Groups

Haringey LINks
Haringey Mental Health Carers Support Association
Day Hospital Campaign Group
Haringey User Network
The Patients Council at St Ann's Hospital

Staff/Professional Organisations

UNISON
Royal College of Nursing
Royal College of Psychiatrists

Others

Mental Health Act Commissioners

Membership of Panel:

- Councillors Ron Aitken(Chair), Gina Adamou, David Beacham and Toni Mallett

Provisional Evidence Sessions:

Meeting 1 – 2 September 2008:

Purpose:
- To consider the draft consultation plan and document and approve terms of reference and scope for the review.
- To consider the MHT's proposals for the reconfiguration of acute services and, in particular, the closure of Finsbury Ward

Background Information:
- Draft scope and terms of reference for review
- BEH MHT's draft consultation document and supporting evidence;

Possible Witnesses:

Maria Kane, Andrew Wright, Lee Bojtor and Penelope Kimber - BEH MHT

Meeting 2 – Date TBA:

Purpose: To obtain the views of key stakeholders and other mental health partners on the MHT's proposals

Possible witnesses:
Helen Brown – Deputy Chief Executive, Haringey TPCT
Lisa Redfern – Assistant Director, Adult, Culture and Community Services
Douglas Maitland-Jones –Mental Health Service Manager, Adult, Culture and Community Services
Matthew Pelling – Housing Commissioning Manager, Adult, Culture and Community Services
Siobhan Harper - Head of Mental Health Commissioning Haringey TPCT/LBH Adult, Culture and Community Services
Cllr Bob Harris – Cabinet Member for Health and Social Services
Phil Harris – Assistant Director Strategic and Community Housing, Urban Environment
MIND in Haringey

Meeting 3 – Date TBA:

Purpose: To obtain feedback on the proposals from relevant voluntary sector, user/patient, staff and other relevant organisations

Possible witnesses:
Rethink
Ethnic minority/refugee and asylum seeker organisations
Haringey LINks
Haringey Mental Health Carers Support Association
Day Hospital Campaign Group
Haringey User Network
UNISON
Royal College of Nursing
Royal College of Psychiatrists
Mental Health Act Commissioners

Meeting 4 – Date TBA:

Aim:
- To receive preliminary feedback from the MHT on the results of its consultation exercise.
- To question further the Trust on its plans in the light of feedback from stakeholders, service users and carers.

- To agree a response to the proposals by the MHT to recommend to the Overview and Scrutiny Committee.

Background Information:
- Interim feedback on consultation results from BEH MHT
- Paper highlighting key issues and evidence from the review

Visits

5.22 Members of the Panel have indicated that they wish to meet members of the Home Treatment Team, if possible, to hear from the about their work. In addition, the Chair has already undertaken a visit to St. Ann's Hospital together with other Members of the Overview and Scrutiny Committee. However, Members of the Panel are planning to visit the hospital again and, in particular, meet with the Patients Council at the hospital to obtain their views.

Independent External Advice

5.23 As part of the review being undertaken by NHS London, the National Clinical Advisory Team will be considering the Trust's proposals. The team is chaired by Professor Sir George Alberti and provides a pool of clinical experts to support, advise and guide NHS organisations on local service reconfiguration proposals. In addition, the Panel may give consideration to commissioning its own external independent input should it feel that this would be appropriate and subject to the availability of suitably qualified individuals or organisations.

6. Legal and Financial Implications

6.1 Whilst there are no direct financial implications for the Council, there are likely to be long term indirect affects as the move to provide more care away from hospitals and closer to the community has the clear potential to place additional demands on social care services provided by the Council, for which no additional provision has yet been made.

7. Chief Financial Officer Comments

7.1 The Director of Adults, Culture and Community Services has indicated that more detailed discussions on the proposal to close an acute adult inpatient ward at St. Ann's Hospital and to reinvest resources into the Community Home Treatment Team and remaining inpatient wards will take place at the Mental Health Executive. At this stage he is unable to comment more meaningfully on the possible implications of the ward closure. Similarly, it not possible at this stage to provide detailed financial implications for the Council although there is a risk that the closure will place additional demands on social care services.

8. Head of Legal Services Comments

8.1 Regulation 2 of the Local Authority (Overview and Scrutiny Committees Health and Scrutiny Functions) Regulations 2002 allows the Overview and Scrutiny Committee to "review and scrutinise any matter relating to the planning, provision and operation of health services in the area of its local authority". Thus the Overview and Scrutiny Committee is empowered to consider the proposals of Barnet and Enfield and Haringey MHT. The committee is further empowered 'to make reports and recommendations on such matters'. These regulations are made under section 21 of the Local Government Act 2000 as amended by section 7 of the Health and Social Care Act 2001.

8.2 The 'long term indirect effects' stated above have to be considered in light of the After Care duties placed on the Primary Care Trust and the local social services authority under Section 117 of the Mental Health Act 1983 . The duties applies to those persons who having been detained under section 3 of the Mental Health Act 1983 cease to be detained and leave hospital.

9. Equalities Implications

9.1 Disproportionate numbers of people from some black and ethnic minority communities suffer from metal illness, such as the African Caribbean community. The proposals are therefore likely to have particular impact on them. In addition, mental illness can be source of particular stigma within some communities, which the proposals aim address through reducing reliance on hospital base care.