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.

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Member of National Clinical Advisory Team
November 2008

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APPENDICES

Appendix 1.

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Appendix 2.

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Appendix 3.

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