Scrutiny Review – Mental Health; Acute Services Reconfiguration Issues for Panel Discussion

1. Introduction

1.1 The Panel was originally set up by the Overview and Scrutiny to consider proposals by Barnet, Enfield and Haringey Mental Health Trust (BEH MHT) to reconfigure acute services within the Borough through closing one male acute ward (Finsbury ward) and expanding provision for home treatment. The consultation has since been broadened. It is now being led by both the MHT and NHS Haringey and proposed further permanent reductions in bed numbers to be made once it has been established that these can be made safely.

1.2 The Panel has so far met four times and received evidence from a wide range of stakeholders. In addition, visits have been undertaken to St Ann's Hospital and to meet with the Patients Council. The proposals have also been subject to external review on their clinical implications by the National Clinical Advisory Team (NCAT). This paper seeks to bring all the relevant evidence that has been received to date and highlight the key issues for consideration by the Panel in order to assist in reaching conclusions and making for inclusion in their response to the consultation

2. Background

3.1 The consultation currently being undertaken with the Mental Health Trust and NHS Haringey is a formal one undertaken under Section 7 of Health & Social Care Act (2001). This states that NHS trusts are required to consult overview and scrutiny committee on what are considered to be 'substantial variations' in service.

3.2 The Overview and Scrutiny Committee (OSC), on 2 June 2008 approved the recommendation that proposals constituted a "substantial variation" to services due to:

- The number of patients affected. Although the numbers of patients directly affected are comparatively small, the proposals involve the closure of a third of the male bed capacity at St Ann's Hospital, which is likely to have a significant impact on those people suffering from acute mental illness within the Borough.

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

3. The Reconfiguration Proposals

Initial Consultation Proposals

3.1 The Panel first received the case for change from the MHT at its meeting on 2 September 2008. The main objective of the proposed change was to increase the capacity for home treatment, which is now recognised national policy. The Trust was of the view that admitting people to hospital was detrimental to 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.

3.2 The view of the MHT was that 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 the 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.

3.3 There were 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.

3.4 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. The role of consultant psychiatrists was also a major factor and the Trust was looking at also improving their current systems of working. These and other relevant issues would be addressed during the consultation period as the Trust wished to demonstrate that it was able to manage stays more effectively. They felt that 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. The money saved by the closure of the ward would be re-invested in home treatment and providing additional resources for the remaining wards.

3.5 Teams responsible for providing home treatment were not only meeting their targets but exceeding them. However, they were currently considered by the Trust to be under resourced and could treat more patients if they had additional staff. Care Services Improvement Partnership **(**CSIP) standards suggested that the Home Treatment teams were 14 staff short. The resources freed up would enable 11 additional staff to be taken on by the 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.

Pre Consultation Review

3.6 Immediately following the meeting on 2 September, the MHT's proposals were called by NHS London for a pre-consultation review. This is now required in all cases where an overview and scrutiny committee designates a proposal to be a "substantial variation" to local services. Both the Overview and Scrutiny Committee and the MHT had been unaware of this requirement beforehand.

3.7 In addition, it become necessary to close a ward at St Ann's in October due to flooding. Although the problem has been resolved, the ward remains closed. The Trust has nevertheless provided assurances that beds are available if required. However, they reported to a meeting of the Panel on 17 December that demand had reduced due to the measures that the Trust had been taking to discharge people more quickly. In the meantime, further steps had been taken to increase safety and prompt discharge, including:

- Dividing support and recovery teams into two for the east of the Borough and two for the west. Each team has one dedicated consultant psychiatrist

- Locating Home Treatment Teams at St Ann's Hospital near in-patient wards

- Notifying all service users individually of the new arrangements

3.8 The pre-consultation review included an independent assessment of the clinical implications by the National Clinical Advisory Team (NCAT). This was undertaken by Dr Ian Davidson. His report was broadly favourable to the proposals but suggested that the scope of the consultation be widened to include further possible changes to acute services. In addition, some service users suggested that, in view of the fact that the issues had been in the public domain for some time already, the consultation period be reduced from 12 to 8 weeks.

Formal Consultation

3.9 The consultation was eventually given approval to proceed by NHS London in January. The changes to the terms of reference were agreed by the Overview and Scrutiny Committee on 12 January, as well as the reduction in the period of consultation. In addition, the MHT's consultation became a joint exercise with NHS Haringey, although managed by the Mental Health Trust.

3.10 The consultation period began on 26 January. The consultation document was circulated and a series of public meetings arranged and publicised by the MHT. This included meetings with carers and service users. The feedback from these is being submitted to an independent external organisation who will report back on the outcome.

3.11 The updated proposals outlined in the consultation document involved:

1. Reducing the length and number of hospital stays;

2. Treating more people in or close to their own homes;

3. Permanently closing sixteen beds in an adult male acute ward and further reducing permanent bed numbers in a planned way over time as we are sure that the changes can be made safely.

3.12 The MHT stated at the meeting of the Panel on 12 February that the proposed changes were about improving services and increasing investment for providing services in community settings. All of the staff affected directly by the proposals would be re-allocated to either the home treatment teams or other wards. All posts within the Home Treatment Team were established and fully funded. The changes had allowed the trust to reduce the number of agency staff being used by replacing them with established staff.

3.13 Services provided by the MHT had improved and the average length of stay had gone down from 76 to 32 days. There was now no difficulty in accommodating patients who needed beds. People would not be asked to leave hospital until they had somewhere to live. However, it was not desirable for people to be left in hospital who did not need to be there.

3.14 It was recognised that there were significant concerns, particularly amongst carers, about the proposed changes but it was felt that these were not concerned with the policy but its implementation. In response to these, it was stated that:

- Improvements were being made to support for carers. This included the

provision of a carer's assessment for everyone.

- Home treatment would be undertaken in partnership with carers. If the carer was not able to cope, the patient would be admitted to hospital.

3.15 It was noted that there had been concerns expressed by other agencies. It was emphasised that the changes just affected *acute* patients. They would receive the same care from the same staff as before but in a different setting. Patients would be visited several times a day and would still be treated as a priority. The MHT did not believe that the proposals had significant implications for other agencies.

3.16 The MHT reported that they had set up a practical support team that could intervene and assist patients in quickly resolving domestic problems. The proposals would have no impact on single sex occupancy. There would still be two female only wards and treatment of patients in their own home enhanced their privacy and dignity. Both Southwark and Lambeth had similar levels of mental health need but had fewer in-patient beds. Haringey had one of the highest numbers of acute beds, both in London and nationally. The proposal would not lead to any reduction in costs for the Trust overall. Sleeping out was sometimes due to patients going "on leave" and, in other cases, it was due to patients awaiting discharge. Going on leave was an essential part of the rehabilitation process and people were not actually present on the ward when this was happening.

3.17 The MHT acknowledged that they would need to demonstrate that the changes could be implemented successfully. No permanent changes would be made that were not safe. If there was sufficient demand to justify it, the ward could be re-opened.

4. Stakeholder Views

NHS Haringey

4.1 Liz Rahim from NHS Haringey stated that they very much supported the proposals. They were not about moving people from one institution to another but reducing the length of stay in hospital. The proposals would improve the care throughout the pathway and would entail a comparatively small reduction in the number of beds.

Adult Services

4.2 Lisa Redfern from Adult Services stated that the overall direction of travel was welcome. However, there had not been many opportunities to discuss the potential impact of the proposals. The service did not concur with the view that the proposals would have no impact on partners. The infrastructure necessary to support the changes needed to be put in place and this took a lot of prior planning. The proposals were likely to impact on the Adults Services budget and there was a need for the budget for supplementary community care to be looked at again.

4.3 Acute patients needed a lot of support from a range of professionals including social workers and Community Psychiatric Nurses (CPNs). Although mental health services were good in some areas, her view was that they were fragile in others. There was likely to be a particular impact on housing and ensuring that there was sufficient capacity to respond to the potential additional demands on services took time. The position within the Supporting People service was currently causing concern and getting provision right was slow and problematic. Residential

placements could cost £800 per weekend this had a considerable impact on budgets. These were often required until such time that suitable housing was available.

4.4 An integrated plan was first needed in order to ensure that the changes could be implemented successfully. The potential cost needed to be worked out and appropriate provision adequately funded. There were currently no pooled budgets for commissioning and the necessary preparatory work had not yet been competed.

Housing Issues

4.5 Denise Gandy from Housing Support and Options stated that tests had to be applied in order to determine whether people were eligible for housing. If they did not fulfil the criteria, the service was unable to assist. Levels of homelessness could be difficult to predict. In some cases, admission to hospital could be the trigger for homelessness and allowing people to remain in their homes could therefore help. However, that needed to be balanced against the possibility that keeping patients at home might raise family tension. There was also concern that people might end up in temporary accommodation. There needed to be a range of housing options and this was not yet the situation.

4.6 Nick Crago, the Supporting People Commissioning Manager, stated that there were currently 300 housing units available. Supported housing provided a range of options for supporting clients. Acute patients would not be suitable for supported housing as their needs were too great. However, as people became more able, they might then become appropriate for supported housing. Floating support could be provided for people in their own homes but this would not happen when home treatment was in place. If people suffered a relapse and had to be admitted to hospital, their tenancy was normally protected.

MIND

4.7 Diane Arthur from MIND stated that people were currently being discharged from hospital without a care co-ordinator. She was not convinced that services were yet in place to support the proposed changes. There was already considerable stress on them, particularly in relation to issues such as employment and benefits advice. She was not convinced that current systems could cope.

Metropolitan Police

4.8 The view of Eric Monk from the Metropolitan Police stated that he was not convinced that there were yet enough resources in place to provide the levels of care needed across the Borough. Response teams were being called to addresses in the Borough on a daily basis to deal with disturbances involving people who were mentally ill. Emergency out of hours care was not yet resilient enough to cope with any additional demands. There was frequently only one Approved Social Worker available out-of-hours to deal with such problems, which could cause additional pressures on police cells. It was particularly important that there were sufficient trained staff available to cover the emergency reception centre. Staffing levels on wards were also important so that any incidents that took place on them could be contained adequately.

4.9 There were problems with missing patients at St Ann's and it was not clear how home treatment teams would deal with this problem. Home treatment staffing levels

needed to be such that there was no additional need for police involvement caused by the changes. It was also important that they were able to attend the scene quickly i.e. within the hour. There could be an additional problem with home treatment in that people were at liberty to not let them into their homes if they so wished. Mentally ill people could also be targeted by drug dealers and be vulnerable to exploitation.

4.10 He was not aware of the Police Service being involved in discussions with the MHT on any possible additional support needs in the community that the proposed changes might lead to. His view was that although the principles behind the changes were laudable, it was essential that home treatment teams were properly resourced for them to be successful.

Mental Health Act Commissioners (MHAC)

4.11 The Mental Health Act Commission have commented on the proposals as follows in their Annual Report for 2008 as follows:

"The Commission is aware of the Trust's proposal to close a 16 bedded male acute admissions ward at St Ann's Hospital. The proposal has been reviewed by the Overview and Scrutiny Committee of Haringey Council and identified as needing formal public consultation. This necessitated an external clinical expert review of the clinical case for change which has very recently been published as a National Clinical Advisory Team (NCAT) Report. As the report acknowledges significant events have occurred in the Trust which have a bearing on this proposal. Firstly the fire at Camlet Lodge 3 required a change of use of the Psychiatric Intensive Care Unit (PICU) in Haringey to provide a temporary unit for people displaced by the fire. Secondly, there was a flood of an acute mental health ward in Haringey leading to its emergency closure. Therefore by the end of October 2008 the Trust had closed a male acute admission ward, moved staff to the home treatment teams and other wards and in effect put in place the plan which was to be the subject of consultation.

The NCAT report finds that the clinical case for change is overwhelming. However, the Commission does have ongoing concerns about occupancy levels at St Ann's which, in the Commission's view, need to be below 100% for a consistent period before consideration of a permanent reduction in the number of acute inpatient beds. Over occupancy of inpatient beds at St Ann's has been an ongoing concern of the Commission over a prolonged period, as highlighted in this report (and previous Annual Reports). The NCAT report itself notes that there are bed pressures in Haringey and that data over a year shows bed occupancy at over 100% on a regular basis which indicates a service operating at below best practice. Although the report then goes on to note that the October data shows this had not got worse due to the ward closure, given the long term nature of this concern, the Commission counsels caution in relying on such short term data."

4.12 The report goes on to say:

"Overcrowding on wards has been a significant issue of concern to the Commission at the St Ann's Hospital site over a prolonged period. The Commission has been reporting concerns about overcrowding in all its Annual Reports going back to 2005. It remains a serious matter of concern. The issue of over occupancy and bed pressure appears to remain unresolved.

Occupancy levels are usually dealt with by patients sleeping out on other wards (despite the Trust stated aim that sleeping out is avoided as far as possible on all sites) or sleeping on sofas in the day rooms of wards. This creates considerable problems on the wards, for example, it being difficult to facilitate escorted Section 17 leave.

This has occurred, during the period covered by this report, in:

- Northumberland Ward (in April 2007, 23 patients allocated to 19 bedded ward; in January 2008, 26 patients allocated to 19 bedded ward)
- Lea Ward (in July 2007, 25 patients allocated to 20 bedded ward).
- Lordship Ward (in Aug 2007, 21 patients allocated to 19 bedded ward; in May 2008, 32 patients allocated to 19 bedded ward).
- Downhills Ward (in Aug 2008, 30 patients allocated to 19 bedded ward).
- Alexandra Ward (in Nov 2007 33 patients allocated to 20 bedded ward; July 2008, 27 patients allocated to 20 bedded ward).
- Finsbury Ward (in Oct 2007, 32 patients allocated to a 20 bedded ward; July 2008 22 patient allocated to 16 bedded ward).

There were also difficulties on those wards 'sleeping in' patients due to overcrowding.

The Commission understands the commitment of the Trust to rebalance its investment towards community based services away from inpatient care. However, it remains concerned that disinvestment in in-patient care can only be justified within the context of a proven sustained diminution of demand for in-patient beds. It also urges the Trust to recognise that a smaller number beds will have the consequence of a more ill and distressed in-patient population. This increased level of acuity will make increased demands both on clinical staff and the fabric of the building. Systems must be put in place to ensure that those patients who still need inpatient care receive treatment of a standard that they deserve."

4.13 They recommend that: "the Trust works to urgently improve bed availability with a view to easing pressure on beds and continues with efforts to desist from 'sleeping out' whilst ensuring that those patients who require admission continue to be admitted."

5. Service User, Carer and Staff Views

Mental Health Carers Support Association

5.1 The view of the Mental Health Carers Support Association, as expressed at the meeting on 2 March, was that the Borough could not currently afford to permanently loose a male ward. There were not yet enough resources in the community to support the change. There was little evidence of prior collective planning with mental health partners. The proposals had changed since they had first appeared. Home treatment teams were now linked to specific wards. The proposals, if approved, might lead to the closure of another ward. There had been continual change in services and reassurances needed to be provided that stakeholders would have a genuine opportunity to influence change.

5.2 They noted the view of the NCAT report that service users and carers should be able to see the benefits of the changes. Patients and carers needed to be offered

irrefutable evidence of the benefits that would come as a result of the changes. This could then be used as a precedent for further change.

5.3 A carer reported that family and friends could need to provide much of the support when patients were being treated at home. She had found that the home treatment team could sometimes only be able to monitor medication. There was not enough overall support provided. Hospital was safe and food and activities were provided. Home treatment teams did not have the time to do much with patients. The presence of a sick relative in the house could cause tension and was hard for relatives to cope with.

User Views

5.4 Other user views, including those of members of Haringey User Network, were as follows:

- After a period of reduction, the trend of occupancy levels and delayed discharges to now seemed be upwards.

- No one should remain in St Ann's who did not need to be there. People sometimes had to stay there because they had nowhere else to go. However, this was a partnership issue and not something that the MHT could resolve on its own.

- It was felt that proper opportunities had not yet been provided for the public to air their views. One consultation event had been so far held during working hours and had only attracted 5 people, of whom two were service users, one was a volunteer advocate, and one was a member of the LINk forum for older people. It was considered that the MHT had not yet explained fully what support was available in the community.

- Additional support opportunities needed to be available in the community, such as crisis units. Haringey Therapeutic Network also needed to be expanded.

- It was not realistic to expect the ward in question to re-open nor was it necessarily desirable. Some of the money saved by closing the ward appeared to be being used to offset savings. There needed to be clarity and clear evidence that appropriate re-investment would take place. The Committee could, if it felt appropriate, say that permanent closure should only take place when certain conditions have been met.

- It was emphasised that service users were not against change but it had to be good for users. The consultation needed to focus more on the change in the type of care provided then on the ward closure and loss of beds.

- The view of patients at the Patients Council was that a lot of effort is put into discharging people. Doctors would discharge patients early as they feel under pressure and there is no space on the wards.

UNISON

5.5 UNISON at St Ann's stated that there had been a lot of disquiet about the proposals amongst staff. The last reorganisation, which had taken place two years ago and involved the reduction of 20 community posts, had proven to be disastrous. Staff

viewed the current proposals as part of the Trust's efforts to make savings ahead of its application for foundation status. This had been stated by management. It was felt that some nurses had been pressurised to discharge patients in order to reduce occupancy levels. It was not being said that the model of care was not good but that the pace of change was too quick and its implementation too soon. There was a high relapse rate, some patients were living in unfit accommodation and families could have difficulty supporting relatives. The Trust needed to plan ahead to ensure that that the necessary infrastructure was in place to support change. The posts of Delayed Discharge Co-ordinator and Benefits Advisor had both been deleted. Although there was now a Practical Support Team, they had not yet received specific training on benefits, which was a complex area. Her view was the MHT had not done the necessary preparatory work for the proposed changes.

5.6 A consultation event for staff had been poorly attended following late changes to the arrangements. A lot had missed the event and UNISON felt that another event was required.

5.7 It was considered that a consultation event for staff had been poorly attended following late changes to the arrangements. A lot had missed the event and UNISON felt that another event was required.

6. Panel's Response to the Consultation

6.1 In formulating its response to the proposals, the Panel is required to consider:

- Whether the Overview and Scrutiny Committee has been properly consulted within the consultation process by the health body;

- Whether, in developing the proposals for service changes, BEH MHT and NHS Haringey have taken in to account the public interest through appropriate patient and public involvement and consultation;

- Whether proposals for change are in the interest of the local health service.

6.2 Relevant guidance states that there are four requirements for lawful consultation:

- At the formative stage, the consulting body must have an open mind on the outcome;

- There must be sufficient reasons for the proposals, and requests for further information should be supported;

- Adequate time should be allowed for consultation with all key stakeholders, i.e. NHS bodies should not delay consultation until a situation is urgent;

- There should be evidence of 'conscientious consideration' or responses by the consulting body.

6.3 Following consideration of these issues, the OSC should respond to the consulting organisation(s) with its comments and views in writing. Responses should explain the process that the OSC has undertaken, and the evidence that has been considered, including identifying the witnesses that have attended. If the OSC is unhappy with the process or proposals, and discussion during the consultation process has not enabled the OSC and NHS to reach agreement, the written

response should summarise this and include recommendations and suggestions for reaching a consensus.

6.4 The OSC ultimately has the power, if not happy with either the consultation process or the proposals and unable to reach a local resolution with the NHS body in question, to refer the issue to the Secretary of State for.