# Haringey Mental Health Services

## Reorganisation of Community and Rehabilitation Mental Health Services

## 1. Introduction

1.1. This paper is a discussion document in two parts. Part I is about proposals to reorganise Haringey Adult Community Mental Health Services, in a way that provides stronger and sustainable interface between specialist services and primary care services. Part II sets out proposals concerning changes to the Rehabilitation and Recovery Services at St Ann's Hospital (SAH).

1.2. If the two proposals are approved it should be noted that the timescales for implementation will differ with the changes in Rehab being actioned as quickly as possible whereas a lot more work will be required to put in place the operational policies to set up the new community structures. This will involve full participation from service user and carer reps.

1.3. The Trust is mindful that Primary Care Trusts across North Central London are currently reviewing the need for and availability of low secure services with a view to bringing back to local care service users currently in out of area placements. If the proposal to close one of the three Rehab Units goes ahead then one option could be for the new local secure service to be provided by the Haringey Division of BEHMHT within the vacated space. This would not only utilise vacated space but more importantly take up the skills of staff that have long worked with this client group.

1.4. This paper should be read in the context of the Haringey Mental Health Strategy (copies available from siobhan.harper@haringey.nhs.uk and the Haringey Directorate Business Plan (copies available from sherma.johnson@beh-mht.nhs.uk).

9.5 The Haringey Mental Health Strategy for 2005-2008 has been developed
over the last year with stakeholders by the Haringey Partnership Board and Executive. Key to this strategy is the development of a clearer vision for community mental health teams, including how they interface with other parts of the mental health system (CATT and HOST) to meet the needs of the local communities. The core values underpinning the strategy are social inclusion and recovery.

9.6 The Haringey Joint Health And Social Care Mental Health Strategy has been developed in the context of national policy relating to:

- Modernising mental health services (National Service Framework, Policy and Implementation Guidance)
- Improving ethnic minority patient experience (Delivering Race Equality)
- Reducing stigma associated with mental illness (From Here to Equality)
- Promotion of social inclusion and adoption of a recovery model for mental health (Mental health and Social Exclusion report)
- Changing role of adult social care with greater emphasis on maintaining independence and preventing problems (Independence, Wellbeing and Choice)

9.7 There is a duty of partnership for health and social care to plan, commission and deliver mental health services together. These proposals have been discussed at the Mental Health Partnership Executive.

9.8 The Directorate's Business Plan sets out the Trust's strategic context and framework for efficiency and effectiveness within a very difficult financial climate.

9.9 The Haringey Mental Health Strategy sets out a number of key principles underpinning the model of care to be developed in the Borough. These are:

- Prevention to promote mental health and well being to the general public and to promote health and well being for those with a mental illness.
- Early Intervention to develop an approach across all providers which offers a service to individuals to prevent an escalation of mental health problems
- Single point of Referral wherever possible to simplify the access routes to services for service users, families and carers and referrers.
- Comprehensive Single Assessment taking full account of the individual's social and health care needs, including physical, psychological and occupational needs. To include the needs of carers and families within this assessment. Services to work across boundaries to ensure that service users can move through the system without unnecessary duplication or multiple assessments
- Range of Evidence Based Treatment Options to respond to the needs of patients and carers as identified through individual comprehensive assessments of need in a way that ensures access to the widest range of possible treatments and interventions

9.10 The work recently carried out within the context of the Haringey Mental Health Strategy and the Mental Health Services Model for the redevelopment of services at St Ann's identified clear gaps in Rehab Services at both ends of the spectrum: gaps in the amount of support for individuals living in high support accommodation to help them move to more independent living and gaps at the "other end" for low secure services (locked services).

# Part I

# Reorganisation of Community Mental Health Services in Haringey

## 2. Community Services: Current Position

2.1 Since 2003/4 there has been major investment in new services in line with national priorities and objectives. This has resulted in increases in community service provision - development of Assertive Outreach and Crisis services - and to partial integration of the CMHTs under single line management. Closer working relationships have developed between the Crisis Team and the Alexander Road Crisis House and that has delivered a real alternative to admission for people in crisis. The implementation has been monitored through the Mental Health Partnership Board (formally the LIT).

2.2 With the full implementation of the Crisis Resolution & Home Treatment Teams, there has been a reduction over the last two years in inpatient admissions, accompanied by a reduction in beds. In terms of patients that are admitted to wards, the profile indicates that they are more seriously ill.

| Adult Acute Services | | | | | |
|---|---|---|---|---|---|
| | **2003-04** | **Reduction** | **2004-05** | **Reduction** | **2005-06** |
| ***Admissions*** | 861 | 21% | 680 | 18% | 557 |
| **Discharges** | 878 | 25% | 658 | 8% | 609 |
| **OBD** | 52,990 | 8% | 48,848 | 7% | 45,325 |

***Data Source HIS Information Team (note Haringey only ie excluding Edmonton)***

## 3. Primary Care

3.1 The 3 year local Mental Health Strategy, referred to above recognises that GP practices are a key component of a mental health care system. It has been estimated that around 90% of mental health care is provided solely by primary care. Within Haringey it is recognised that the provision of primary mental health care services varies across the borough. The Haringey TPCT have been working with GPs to create a Primary Care infrastructure that strengthens individual GP surgery abilities, confidence, and competence to assess and provide quality interventions for their patients with mental health difficulties. This has resulted in the commissioning of a Locally Enhanced Service (LES) for primary care mental health services.

3.2 Through the LES, the PCT will commission a primary care provider in each cluster to lead on the development of primary care mental health services within that cluster. Each of the cluster leads will work in collaboration with a Primary Care Mental Health Clinical Specialist, employed through the LES to co-ordinate the development of best practice across the four clusters and will lead on the development of clearer agreed care-pathways within primary care and into specialist mental services.

3.3 The LES will cover four categories of patient/service user:

(i) Patients registered with a GP who have mild to moderate emotional and mental health symptoms
(ii) Registered patients who are beginning to suffer with complex and wide ranging emotional needs and require a specialist assessment from tier 2 and/or tier 3 mental health services
(iii) Registered patients who have a previously diagnosed Severe and Enduring Mental Illness (SMI), have received an effective package of care from specialist mental health services resulting in a reduced level of on-going need.
(iv) Registered patients with a previously identified and/or ongoing Severe and Enduring Mental Illness (SMI) who do not have their physical health needs met appropriately.

3.4 In considering options for change a key aim is to reorganise services in secondary care in a way that supports and facilitates primary mental health care to support those with common mental health problems as well as those with more enduring mental illness who no longer need the medical input from specialist services but may still require other support.

## 4. Community Mental Health Teams (CMHTs)

**4.1** Recent benchmarking across the London Mental Health Trusts shows that the caseload per CMHT trust wide is the third highest among London CMHTs. Even allowing for data quality issues this would suggest that BEH caseloads are in the upper quartile of London boroughs. Haringey achieves the national target of 80% of caseloads to be for patients on enhanced CPA.

4.2Over the past three years the new teams, HOST and CATT, have been introduced into the mental health system and the patient pathway with much thought given to their impact on inpatient services. However to date relatively little consideration has been given to the impact on the pre-existing CMHTs. A number of concerns have been raised via user and carer feedback, as well as from recent external inspections of the CMHTs. These issues include:

- Concern about the length of time that service users stay within the mental health system; this is either as an inpatient or a user of other services. This can be most starkly seen in terms of the use of outpatient clinics within the CMHTs and the management of care.
- Improvement of efficiency through implementation of the recent revisions to CMHT and CPA eligibility criteria, timely reviews, and more integrated services, which would reduce workload in the specialist mental health services, with a corresponding reduction in cost.
- Concern about the quality of care planning which needs to be more outcomes focussed
- A need to be able to demonstrate the benefits of recent investment in services – identifying successful performance against agreed performance indicators.

- Imbalance in the current CMHT GP catchment areas between the teams thus raising concerns that resource allocation does not match the levels of need and referrals. All the teams have similar numbers of staff and skill mix despite the differences in morbidity within the borough.

## 5. Drivers for Change

5.1 There are some major pushes for this review of Community Services. These can be summarised as:

- The need to revisit the impact of the new services on pre-existing services. This is in the context of the focus of attention over the last three years being largely on inpatient services and it might be said that Community Services (including Community Rehab) have been over looked.
- A very complex patient pathway with multiple entry points: CMHT Intake Service, Crisis Teams, ERC and A&E.
- Opportunities arising from the LES for primary care mental health. As stated above, as part of the LES, there will be an initial four GP clusters with lead GPs identified for mental health practice and care.
- Findings of external inspections of the CMHTs
- A number of service users who qualify for 'enhanced level' of care receiving care at 'standard level' seeing only the medical staff in out patient clinics. (This is currently under active review to reallocate patients appropriately but speed of work is constrained by lack of caseload information and throughput within the teams).
- Lack of community rehab services to maximise the appropriate usage of supported accommodation in the community.
- A lack of psychological therapies and occupational therapy within the CMHTs.
- A need to work within available resources within all three organisations and to ensure best value for money from services.

5.2 To be acceptable a revised service configuration must also do the following:

- Improve efficiency and target services on those most in need
- Deliver a service that is proactive and skilled in 'keeping people well'
- Balancing of workloads between sectors and matching of resources both in terms of headcount and skill mix);
- Establish sustained strong working links with Primary Care
- Improve interface and working practice between CMHTs, and other teams e.g.: CATT and wards, HOST
- Establish a community rehabilitation function (either within existing teams or as a new service) – subject to a separate consultation.

5.3 However a new service configuration will not in itself deliver the other essential ingredients for a better service including:

- A more skilled workforce with staff trained in CBT, nurse prescribing, working with families, group work etc.
- Appropriate premises and facilities

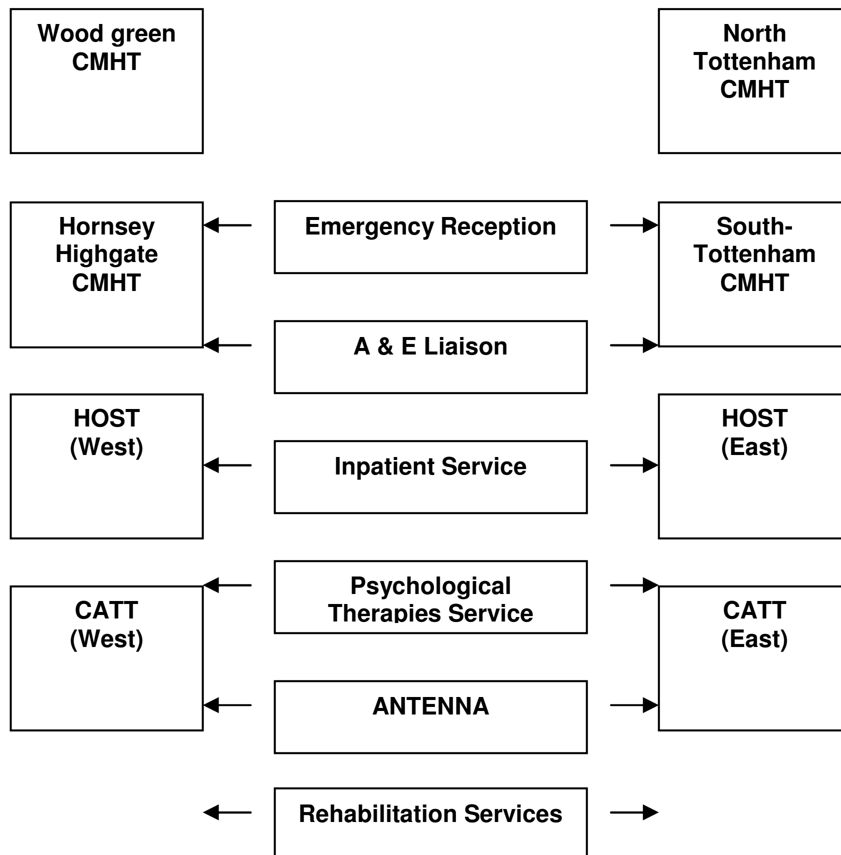
- Patient information system with good ICT (phone and data).

5.4 The plans to reconfigure community services will address these three areas as well as the criteria 1 to 6 above.

5.5 A summary of the recommendations in the Trust wide "Modernisation of CMHTs" paper is attached as appendix 1.

5.6 The proposals presented here for discussion will impact on the current organisation of:
- CMHTS
- ERC
- Crisis Teams
- Psychological Therapies Services

## 6. Current Structure




## 7. Options For Change

7.1 Three options are presented here for consideration. Option 3 is presented as the preferred option and is described in more detail.

1. Reduce number of CMHTS from 4 to 3, no other changes
2. Merger of Crisis Teams and ERC, no other changes
3. **Reorganisation of services into 3 Complex Case Teams and an Intermediate Care Mental Health Team – preferred option**

7.2 In other parts of the Trust the merger of the assertive outreach function into the CMHTS is being proposed. This is **not** presented as an option here as it is the view of the Directorate Management and Clinical Staff and of Commissioners that these teams currently met a clear demand and are working well.

**Option 1: reduce number of CMHTS to three and align with GP clusters/localities**

7.3 This option is the closest to the do-nothing option and would represent a realignment of the CMHTS with the GP clusters. The Duty and Assessment function would remain as three separate functions within each of the three teams alongside CATT and Assertive Outreach Services. Antenna would remain a borough wide service. The Emergency Reception Centre would remain unchanged. The budget released from the closure of a CMHT would be used to meet the identified efficiencies and the remainder reinvested into the community services.

7.4 This option means no change to ERC and Crisis Teams.

***Advantages***
- Aligns CMHTS with new Primary Care LES configuration which at the moment is organised in four clusters
- Releases resources
- Opportunity to re-skill mix within the CMHTS

***Disadvantages***
- Unlikely that this model would have sufficient capacity to meet workload requirements
- Does not achieve single entry point into service – entry points through CMHTS, ERC, Crisis and A&E
- Does not provide additional support or necessarily strengthen the interface with primary care mental health services

**Option 2: Merger of Crisis Teams and ERC, no other changes**

7.5 In this option the Crisis Teams and ERC are merged which effectively means the closure of ERC. In this option everything else stays the same, i.e. the current arrangement of 4 CMHTS is retained.

***Advantages:***
- Minimal service dislocation in terms of number of staff and teams affected by change
- Releases some resources towards savings targets but unlikely to be sufficient flexibility for any reinvestment

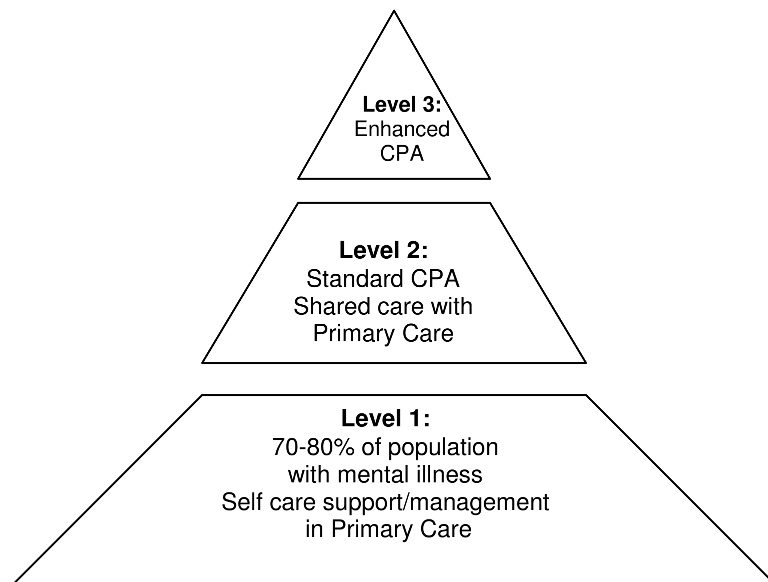
***Disadvantages***
- Does not achieve better links with primary care

- Dilution of role of the Crisis Team into even more assessment work and less home treatment which is contrary to the purpose of Crisis Teams and DoH targets
- Releases relatively little resource

**Option 3: Reorganisation of services into 3 Complex Case Teams and an Intermediate Care Mental Health Team – preferred option**

7.6 This option reduces the number of CMHTs to 3 but creates a centralised
assessment and brief intervention team, which has been called an "Intermediate Care Team" which would work across into primary care. In this model entry into secondary services would be via this team (for the majority of people) or for emergencies via A&E Liaison at NMH or the Crisis Team. The 3 CMHTs would focus on complex cases. The rationale for three CMHTs is based on anticipated workload.

7.7 The model put forward is based on "the NHS and Social care Long Term
Conditions" model as described in the NSF for Supporting People with Long Term Conditions (DoH Jan 2005).



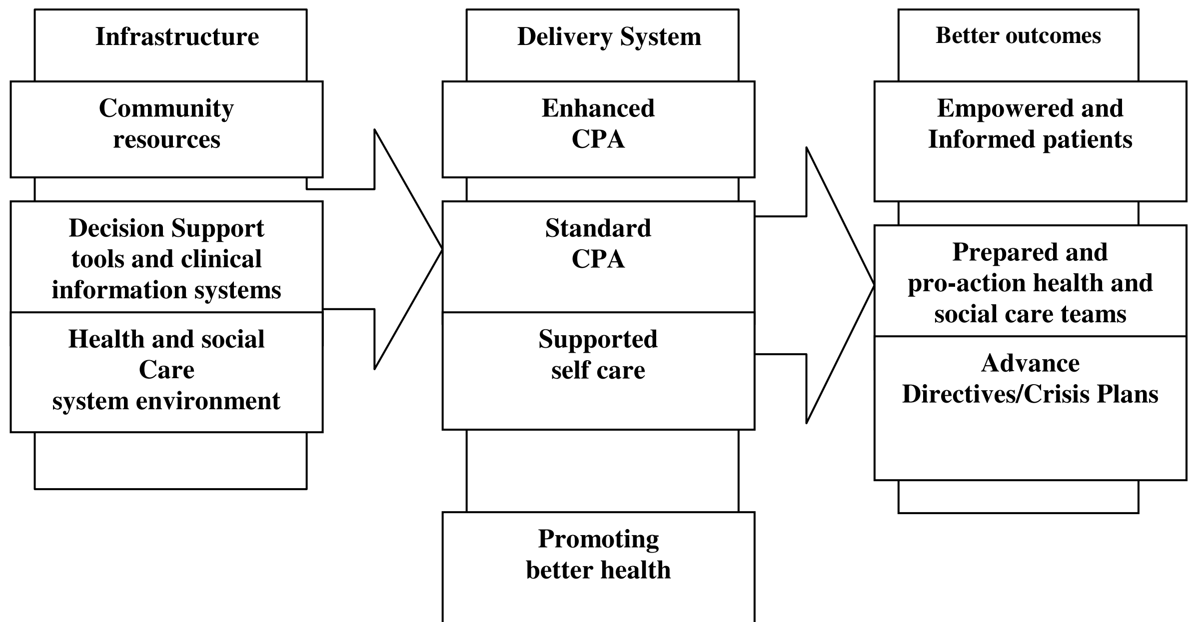
7.8 The diagram above is the Kaiser Permanente triangle adapted for mental
health. In this model the three levels work as follows:

- **Level 1: Supported self-care/primary care** – collaboratively helping individuals and their careers to develop the knowledge, skills and confidence to care for themselves and their condition effectively. People within level 1 would be solely looked after by Primary Care or would have been under secondary care services but now typically have stable conditions, a care plan shared with primary care and a clear route back into secondary care (usually through a "Crisis Plan/Advance Directive").

- **Level 2: Intermediate Care**: working with individuals as a route into specialist complex case management, i.e. enhanced CPA and a route into primary care following assessment and maybe brief period of treatment. Typically service users would be on standard CPA. Services working "in the middle" at this level are in some places called a "Primary Care Mental Health Team" and in other places a "Centralised Assessment and Brief Intervention Service". Whatever the service is called the nature of the interface with primary care and the facilitation of movement between parts of the mental health system is the essence of this team. The team becomes the main portal of entry into the secondary care system.

- **Level 3: Complex case management – enhanced CPA**. This level serves the very high intensity users of services (planned and unplanned). Care for these patients is managed by a care co-ordinator under CPA, to anticipate, co-ordinate and provide joined up health and social care. The complex case teams that would replace the current CMHTs would not operate duty/intake systems. The Assertive Outreach Teams can be considered as part of level 3. These teams would be responsible for discharge planning for individuals in hospital and for moving service users from high level supported housing (e.g. residential care) to lower levels of support as appropriate for the individual.

7.9 The model is underpinned by ensuring that proper attention is given Choosing Health agenda with respect to diet, physical activity, and smoking cessation.




7.10 The above diagram, adapted from the NSF for Long Term Conditions illustrates the importance of the infrastructure to support such a system of care. Part of the planning of a reorganisation of services will be sorting out the current issues around accommodation, information systems (eg agreement on one system of health and social care in the community teams), and full integration between health and social care.

## 8. The Intermediate Care Team

8.1 This team would be new compared to the current configuration and would work as a centralised assessment and brief intervention service, working across into primary care. The service would be developed from resources released from the reconfiguration of one of the current 4 CMTS, the incorporation of ERC, input from the PTS service, and the alignment of the 6 primary care mental health workers. It is envisaged that this team would take approximately between 25 and 35% of the current workload of the 4 CMHTs. In the first instance this would be those individuals on standard CPA seen only in outpatients, but also any others with care coordinators within the teams.

8.2 The team would comprise a range of dedicated workers, including medical staff, that would be able to provide more support in the primary care setting, working with the new Mental Health Leads appointed as part of the LES agreement. Improved prevention, detection and earlier intervention together with consistent advice and help for people with severe mental health problems, will allow more people to have their longer term mental health needs integrated with their primary healthcare needs ensuring that not only are their mental health, but

physical health needs more effectively met. The service would aim to create capacity and deliver two priority outcomes:

***Reduction of non-essential referrals to secondary care services.***

8.4 There is a wide range of services in the community able to offer a variety of advice, support, practical, emotional and psychologically based help and intervention designed to meet a plethora of needs. Many of these can be accessed to provide appropriate support to individuals without the need for intervention from secondary care services. A centralised service would be established with an ethos of supporting and facilitating primary care mental health services. The service would include full medical services as well as psychological therapies and social care.

***Support for individuals with longer-term mental health problems to access services at a primary care level.***

8.5 Many people with longer term illnesses achieve a level of stability, recovery and concordance which no longer requires the intervention of more specialist services but can receive appropriate long term maintenance and monitoring from their primary care practitioner if supported by ready access to expertise and advice of skilled mental health professionals. Specialist mental health services can then focus resources on those with more complex needs and higher degrees of disability requiring the input of dedicated teams equipped to provide intensive and assertive support to individuals with higher levels of disengagement, dual-diagnosis and increased levels of risk requiring multi-faceted, integrated care processes.

8.6 People with longer-term mental health needs experience a range of health and social inequalities that can ultimately lead to a reduction in life expectancy of up to 15 years. Many do not receive an equal level of physical health care and find themselves excluded from everyday social and community activity. Raising the profile and understanding of serious mental ill health within primary care can help to tackle such inequalities and ensure that individuals receive a level of physical health care relative to the rest of the population.

## 9. Complex Case Management Community Teams

9.1 The community teams delivering specialist services within secondary care will focus their work in providing treatment and enhanced care co-ordination to people with complex needs identified as being on an enhanced level of CPA. This will include health and social care as within the present CMHT arrangements. The teams will work within an ethos of recovery and social inclusion.

9.2 It is envisaged that the majority of cases identified as requiring a standard level of CPA will no longer be supported within these community teams, having been screened out and appropriately treated and/or signposted to other providers by the Intermediate Care Team, or returned back to the Primary Care once stabilised and no longer in need of active intervention from a specialist service.

9.3 At present, from some limited audits of clinics, it is estimated that at least 50% of outpatient work falls within this category. In terms of overall outpatient work, extensive data cleansing work is going on to produce accurate outpatient caseloads. Findings so far are that the numbers available at present overstate the volume of service users to whom care is being provided.

9.4 Taking into account the removal of a large proportion of outpatient work (either by way of transfer to the Intermediate Care Team, discharge to Primary Care – probably via the Intermediate Care Team, or through improvement in data), in order to be able to sustain the capacity to work with this level of complexity it is envisaged that there will need to be 3 such teams working across the borough.

9.5 The Mental Health Policy Implementation Guidance on CMHTs[1] suggests that a typical team should have a caseload between 300 and 350 with a maximum caseload of 35 service users per full time member of staff. Our returns currently show numbers on enhanced CPA as approximately 1,200 cases but with a number of cases that require review that might be managed within the Intermediate Team. In addition under this model of service, more dedicated medical time would be available for these service users on enhanced CPA as the large numbers of standard CPA service users who are seen only in outpatients at infrequent intervals would pass to the Intermediate Team.

9.6 The capacity to work with up to 35 service users would depend on complexity of the case mix but this would be balanced by the removal of the duty function from the Complex Case Teams that is very time intensive.

9.7 The skill mix of the teams will be reviewed to provide the required capacity at the appropriate level of skill. All care co-ordinators will be trained to be able to provide a service for people with dual diagnosis needs with a specialist member of the Dual Diagnosis Team allocated to each Complex Case Team. More support workers will be employed within the teams than at present and there will be clinical psychology within the team skill mix.

9.8 The care co-ordinators will assess, develop, and implement care plans and will be complemented by the support workers (whom they will supervise) and who will provide extra input, together with help in managing practical tasks. The care co-ordinators will be able to focus on the Individual needs of service users and the quality of care

[1] Department of Health June 2002

planning will be expected to improve. The new configuration will include working towards the Royal College of Psychiatrists 'New Way of Working'. This is a more flexible and responsive method of supporting people in the Recovery model.

***Advantages of Option 3***

- A single point of entry into the "whole system" of specialist community services for non-emergency cases. This could be refocused under a "managed system of care" with tighter eligibility criteria, predetermined lengths of treatment and outcomes agreed with service users, and resulting shorter lengths of treatment
- Supports primary care and enables better use to be made of resources in primary care and in specialist services
- Gives the opportunity to review skill mix within the teams to allow development of more psychological treatments and a greater
- Establishes a clearer relationship of CMHTs to other parts of the service
- Optimises efficiency by developing clear pathways and outcomes for community services
- Releases resources

***Disadvantages of Option 3***

- May be difficult to operate a single centralised assessment service which may result in duplication of assessments and delays in treatment for service users
- "Brief intervention" may be illusory
- Popularity with staff of working in an "assessment" or a "treatment" service but not doing both types of work untested
- Most organisational upheaval in terms of service users, numbers of staff and teams affected by change.

## 10. Criteria to assess Options

| | Option 1 | Option 2 | Option 3 |
|---|---|---|---|
| Single point of entry | | | |
| Improved interfaces with other parts of MH system | | | |
| Improved interface with primary care | | | |
| Greater movement of patients between sector | | | |
| Does not reduce capacity | | | |
| Increases capacity | | | |
| Disruption to service users and carers | | | |
| Disruption to staff | | | |
| Disruption to Primary Care | | | |
| Achieve greater balance in distribution of workload between parts of the system | | | |

## 11. Implications for Service Users

11.1 If this proposal is approved for implementation, then all service users and their involved carers will be consulted and involved in the way the changes are implemented. Representatives from service user and carer organisations will be invited to participate in the development of the operational policies.

11.2 In establishing the new teams all service users would be reviewed and updated care plans put in place before any move of team i.e. from a Complex Case Team to the Intermediate Care Team. Transfers would be done on an individual basis and **not** on a "group basis" with service users invited to support from either carers or advocates.

## 12. Implications for Staff

12.1 There will inevitably be implications for staff of these changes and staff would be fully involved and consulted about the operational detail of the changes in organisation. The Trust, as employing organisation, is committed to the redeployment of staff and the avoidance of redundancies wherever possible and would work with staff to try to avoid this. This process would be managed under the Trust's Policy on the Management of Change and there would be separate consultation will employees in accordance with this policy.

## Appendix 1 – Extract from BEH Modernising CMHTS March 2006

1. Modernise the organisation of the work of CMHTs to provide services within a managed care framework. This involves developing care plans with service users around pre-agreed lengths of stay in service and defined expected outcomes. Separate out the functions of assessment (duty/intake) and treatment more formally, with clear mechanisms to review progress with service users and outcomes.

2. Modernise the structure of CMHT within current resources, recruit and develop a range of mental health and social care professionals to deliver services within a context of the different skills required for assessment, care planning and ongoing treatment. With staff at band 6 and above care co-ordinating and utilising the skills of unqualified staff to carrying out day-to-day activities with patients.

3. Develop the level of group skills within the staff group to provide more therapeutic interventions to groups of service users as well as individuals. This in itself can be of great value to service users as well as being more cost effective.

4. Create and develop posts of clinicians with specialist skills e.g. CBT, dual diagnosis worker, drug workers etc.

5. Develop the role of the psychiatrist specifically and in teams generally, to incorporate 'New Ways of Working' which moves the focus for consultant psychiatrists towards the assessment of service users and advice in their care plan and treatment.

6. Incorporate the principles of the CPA policy to ensure patients receive the level of care under the CPA as per their assessment and to facilitate their discharge from services as appropriate. To achieve 80% of patients on Enhanced Level of CPA.

7. Strengthen the model of care co-ordination to ensure community teams and in-patients teams work closely together and in partnership to ensure continuity of service delivery and care planning which is outcome focused. Using the principles of the CPA policy ensure that service users have advance directives and crises plans which set out their wishes in the event of a crises or early signs of relapse. Ensure services are focused to manage these crises as necessary.

8. Work closely with carers to ensure explicit involvement in care plans and improved assessment of carers needs to facilitate their role as carers.

9. Individuals with post traumatic stress and common mental illnesses that make them "vulnerable" in terms of Social Services eligibility can absorb a lot of time and resource from mainstream MH services because there are no standalone Social Services for vulnerable

adults. The strategy would be to work with Social Services colleagues to develop alternatives for vulnerable adults whereby they can be supported in primary care with the appropriate back up from Social Services. PCTs and local authorities to consider needs and service provision of people who do not meet the eligibility criteria for CMHTs.

**10.** Develop closer working links with primary care to ensure the smooth transition of patients between secondary and primary care. Put structures in place e.g. link worker role and shared care arrangements to ensure the delivery of quality care for patients within primary care. Primary care to develop SMI registers and the role of gateway workers to ensure adequate follow up of patient's physical and mental health care needs.

**11.** Ensure the roll out of the new patient information system (RIO) which will have a major impact to the Trust's retrieval of case load information, easy access to care plans and crises plans and to activity data as required by managers in understanding team and service performance and to enable benchmarking locally and nationally.

# Part II

## Proposals for Rehabilitation and Recovery Services at St Ann's Hospital

## 13. Summary of Proposal

13.1 It is proposed to move Edmonton patients within the SAH Rehabilitation Services to the new Enfield Rehab Service at Somerset Villa, at Chase Farm Hospital. Following that it is then proposed to close the vacated places within the SAH service with the intention of moving on to the subsequent closure of Highgate Ward (11 places). If this proposal is agreed, then the pace of change will be dictated by the speed at which appropriate placements can be found so that the overall number of places within the Rehab Services is reduced by a total of 11.

## 14. Introduction

14.1 The Royal College of Psychiatrists' Faculty of Rehabilitation and Social Psychiatry in a position statement in October 2005 proposed that Rehabilitation be defined as *'a whole system approach to recovery from mental ill health which maximises an individual's quality of life and social inclusion by encouraging their skills, promoting independence and autonomy in order to give them hope for the future and which leads to successful community living through appropriate support.'*

14.2 As a concept however, Rehabilitation, is not something that just occurs in inpatient settings on hospital sites but operates across all mental health care. Undergoing rehabilitation should be an active process that results in movement towards achievement of goals and sustained recovery. Rehab Services should not be used as a "static placement" for those for whom it is difficult to find appropriate placements. It is important to think of Rehabilitation and Recovery Services in terms of the whole system of care ranging from the lowest levels of support in the community to the highest level of support in inpatient units.

## 15. Current St Ann's Based Services

15.1 The current configuration of inpatient provision at St Ann's is shown in the table below.

| *Name of Unit* | **No. of beds** | **Service** | **No. of Edmonton service users** |
|---|---|---|---|
| Mayfield House | 13 | Intensive rehabilitation | 1 |
| Highgate Ward | 11 | Long Stay | 1 |
| Orchard House | 12 | Challenging Behaviour | 2 |
| Total no. of beds 36 | | | |

15.2 In addition at the time of writing there was 1 Islington patient in the Rehab Services.

15.3 Figures for bed usage over the last two financial years (04-05, and 05-06) show average bed usage by Edmonton patients as totalling 8 places - there were 8 or more Edmonton patients across the three units in 18 out of the 24 months. The maximum number of service users was 9[2].

***The Orchard Unit***

15.4 This is a unit for people with challenging behaviour who are difficult to place in most services. Treatment works to create change in behaviours as well as increasing the levels of daily living skills for a return to the Community. The service is provided by a well-established multi-disciplinary team. The length of stay of service users is highly variable ranging from a few months to several years.

15.5.This means that the overall "throughput" of residents can be low with some individuals requiring relatively high levels of support for long periods of time.

***Mayfield House***

15.6.This is a unit for people who need a period of stabilisation and preparation for more independent living before being discharged from hospital altogether. The length of stay is again variable but is normally less than a year and rarely more than two years. Throughput on this unit is far greater than The Orchard Unit and the Unit works closely with the Community Mental Health Teams in discharge planning for individuals on this Unit.

***Highgate Ward***

15.7.This is a unit for people with long term needs whose behaviour presents some challenges but is highly resistant to change. The majority of the residents were directly transferred from long stay hospital in 1993 rather than accommodated in the community and of the 11 current patients 7 are aged over 65, 2 aged between 55 and 65, and 2 aged under 55. It is generally agreed that the needs of these individuals have changed over time if nothing else because of increasing physical frailty and it was because of this that the service was relocated to ground floor accommodation last year. 3 of the current patients use Zimmer frames and 3 others have general mobility problems. All have high levels of need with respect to personal care.

## 16. Drivers for Change

16.1 The key driver for change is the current reconfiguration of the Rehabilitation Service in Enfield that will create capacity of 7 beds within a refurbished Somerset Villa to cater for all the Borough of Enfield's Rehab needs within the Enfield Services. This means that that the services at SAH will no longer need to provide 7 places for

[2] Source: PIMS information system.

Edmonton patients. If 7 places are removed from the above configuration then it is no longer an effective us of resources to operate the remaining number of places across three inpatient units at SAH.

16.2 Other drivers for change relate to the work recently carried out within the context of the Haringey Mental Health Strategy and the Mental Health Services Model for the redevelopment of services at St Ann's. These pieces of work identified clear gaps in Rehab Services coming from both ends of the spectrum: gaps in the amount of support for individuals living in high support accommodation to help them move to more independent living and gaps at the "other end" for low secure services (locked services). It is therefore even more imperative to use current resources as effectively as possible.

## 17. Implications for Service Users

17.1 If this proposal is approved for implementation, then all service users and their involved carers will be consulted about moves. Independent advocacy will be made available for service users. For Edmonton service users it will be proposed that they move to Somerset Villas. For others it will be a case of continuing with existing care plans and where it is appropriate to move individuals on then this will be actioned in the normal way. Priority will continue to be given to moving patients on the Delayed Transfers of Care list: at 23rd June there were 8 patients on this list occupying Rehab beds.

17.2 Finally given the age and frailty of some of the residents on Highgate Ward it would be proposed to re-assess all these residents for move on to less institutionalised care especially where their physical mobility meant that they required ground floor accommodation.

## 18. Implications for Staff

18.1 The closure of one of the Units would mean the lose of jobs. The Trust, as employing organisation, is committed to maximising redeployment opportunities for staff and the avoidance of redundancies wherever possible and would work with staff to try to avoid this. This process would be managed under the Trust's Policy on the Management of Change and there would be separate consultation will employees in accordance with this policy.

## 19. Conclusion

19.1 The proposals and the rationale for the closure of Highgate Ward, one of three inpatient rehab units on the St Ann's site is set out here. Based on the current usage across the 3 Rehab Units by Edmonton patients the net loss of places to Haringey residents will be 7 places. However based on the average use of places by Edmonton residents over the last two years the net loss is 3 places.

19.2 It also has to be taken into account that Highgate Ward has ceased to function as an "active rehab" unit. A review is currently being undertaken by the Local Health Service into the numbers of patients in out of area "active low secure" placements with the intention of commissioning a local service for such patients. The location of such a service would be one possibility for the re-provision of Highgate Ward following closure.