Well-Being Partnership Theme Board **Item No: 7**

Date: 14th December 2006

Report Title: Update from Mental Health Partnership Executive

Report of: Chair, Helen Brown, Director of Strategy and Performance, HTPCT

Summary

To update Well-being Partnership Theme Board on the Mental Health Partnership Executive Board's strategies.

Recommendations

That the Well-being Partnership note progress and key issues.

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Introduction

1. This paper is an update to the Well-being Partnership Board on current key priorities for improvement within the Mental Health Services. These priorities are set by the Joint Mental Health Strategy, CSCI Inspection Action plan, the findings of the Haringey Council Mental Health Scrutiny Panel last year, and the continuous learning the lessons from serious untoward incidents. Although the report separates out the operational service delivery from commissioning, the interdependency between the two areas should be noted.

2. The CSCI report on Mental Health and the Action Plan was presented to the Council Executive on 31st October 2006. It was agreed that there would be a progress report to the Executive in 6 months time. It is therefore proposed that a report specifically about the CSCI Action plan be put to the March Well-being Board by which time many of the measures initiated over the last few months should be well under way.

Commissioning

Supported Accommodation

3. Working jointly with the Supporting People service, Mental Health Commissioners are prioritising the move towards a modernised model of community based living for people with mental health problems. The preferred option is intensive floating support services and intensive accommodation based services to enable service users to live more independently and outside of traditional residential care settings. A comprehensive plan is under development and will dovetail into the work of the CMHTs and the modernisation of day services in the borough.

Day Opportunities

4. The day opportunities strategy was widely consulted on earlier this year and the next stage is to issue a plan in three-phases to implement the changes. A key part of the strategy is to ensure access to specialist support is available when needed but also to support individuals to use mainstream services in line with their identified personal goals.

5. The Haringey Therapeutic Network (HTN) opened in 2005 and provides group activity within the Canning Crescent Community Mental Health Centre and also within other mainstream community based centres. Many clients who have used the service have returned to training or employment.

6. A recent joint application by BEH MHT and HTPCT for NRF funding was successful for the “Health in Mind” project. This project will be fully operational in January, with a mix of exercise referral for client groups at risk of Coronary Heart Disease (mental health clients have high risk), dietary advice, with graduate workers in Wood Green Library offering open access and the HTN running groups in the three most deprived wards in

Haringey. The project will link to specialist mental health employment advisors already in place in the Borough.

Review of Rehabilitation Services

7. HTPCT is undertaking a review of existing inpatient rehabilitation services with a view to the development of a comprehensive strategy early next year.

Early Intervention Services ("EIS")

8. EIS services are the subject of specific recommendations within both the CSCI Report and in the Council's own Scrutiny Report. Plans are being developed to commission an EIS during 2007. In addition a joint application with voluntary sector partners for £800,000 over three years has been made to the Treasury for Invest to Save funding. This has the support of the Haringey Strategic Partnership.

Interpreting Services

9. The HPTCT are leading a joint tendering process on behalf of a number of organisations including the MHT for a new interpreting service. This is expected to be in place by late Spring 2007. However it should be noted that, as a joint Health/Local Authority the MHT is able to access the Council interpreting services as well as those provided through the NHS.

Service Delivery

Redevelopment of St Ann's Hospital

10. There is little progress to report on this since the submission of the Strategic Outline Case ("SOC") to the Strategic Health Authority in May 2006. This document sets out at a very high level the strategic case for change without commitment to a particular preferred option (although the SOC showed "Rebuild at St Ann's" as the leading option). The document outlines, at a high level, the service model for which the case for the capital project is required. A recent meeting of the SHA requested some additional information that will be put with the SOC to an early Board of the new NHS London for approval to proceed to the next stage. This is unlikely to be before March 2007.

Inpatient Services

11. A key principle underpinning the Joint Mental Health Strategy is the reduction in reliance on hospital-based services with more community-based provision of services. An investment of £2m some three years ago into new Crisis Services and Assertive Outreach Services has enabled beds to be reduced from 128 beds (1st April 2005) to currently 95 beds, a reduction of 33 beds (26%). There are now 5 19-bedded wards, two female and three male wards.

12. It is important to note that whereas three years ago benchmarking Haringey Services against London authorities showed Haringey as an outlier in terms of use of beds this is no longer the case and that

Haringey's bed usage is as expected for a borough with a very high level of morbidity – see attached appendix.

Delayed Transfers of Care (DTOCs)

13. These remain an issue for the inpatient services at St Ann's due to a range of reasons including access to housing (temporary accommodation and supported accommodation) and entitlement to stay in the UK. A significant amount of work has been done by partners to improve processes around discharge planning, the allocation of housing, and the operation of the Panels.

14. Although this has not resulted in a big reduction in the number of patients whose discharge is subject to delay, there has been a considerable reduction in the average length of time a patient's discharge is delayed. This means that there are no longer any DTOCs of length in excess of one year. This requires the sustained attention of partners (MHT, PCT, Social Care and Housing) to continue and build on the gains of the last year.

Reorganisation of Community Services

15. The imperative to look at the organisation of community services has been driven largely by the changes described above: the reduction in inpatient services and the introduction of 4 new teams – (two Crisis and Assessment Teams and two Assertive Outreach Teams). These changes have created a complex system with multiple points of entry. Feedback from service users and GPs say the current system is very now difficult to navigate.

16. Other drivers for change include:
    - The desire to shift the ethos of services to one that is geared to early Intervention that enables the prevention of the unnecessary escalation of mental health problems. Many if not most service users and their carers know when things are not going well and early intervention can head off break-down.
    - The need for a comprehensive single assessment that takes full account of the individual's social and health care needs, including physical, psychological and occupational needs. This should encompass the needs of carers and families within this assessment.
    - Improvement of the interface between primary and specialist services.
    - The need to make the most efficient use of resources and therefore these changes should yield savings of the order of £500,000.

17. There is a three stage project plan under implementation now to move from the current service configuration of 4 all-purpose Community Mental Health Teams and a stand-alone Emergency Reception Centre to 3 Complex Case Teams and an Intermediate Care Team which will include the Emergency Reception Centre. This will create a single point of entry to services through the Intermediate Care Team.

Training and Development of Staff

18. There are many references within the CSCI report to the quality of assessment and care planning and coordination. These are issues that also recur in Serious Untoward Incidents reports and feedback in the Trust's Patients Survey. To strengthen support to staff the following measures have been put in place:
    - Creation of a "Community Matron"/Senior Nurse post in mid 2006 with the express remit to work on the quality of nursing professional practice
    - A management development programme for frontline managers started in November 06 and will run over the next year.
    - There is also separate off-line group supervision for managers and whole team training in place to establish team systems.

19. It is intended to create a post of CPA (Care Programme Approach) Manager within the local services with the specific remit to address the training and development needs of staff.

Performance Information Systems

20. Mental health services across the country have to grapple with working with two information systems. In Haringey the two systems are Framework-I for the Council and within Health, the Rio System (part of the wider NHS Connecting for Health programme). It is agreed that it is not possible or reasonable to expect care practitioners as an ongoing requirement to double-key the same information twice into two different systems. It is also the case that some 80% of the Mental Health Services caseload does not access Social Care Services.

21. Framework-I was implemented recently and Rio is expected to go live in Haringey next March, replacing an old legacy system that has never been a "clinical system" with the functionality of either Framework-I or Rio. The upheavals created by these changes, which are ongoing with the later implementation of Rio, have not assisted improvements in the collection of performance information for either the Local Authority or Health.

22. It is therefore being recommended by the Haringey Mental Health ICT Board to the Senior Management Teams in the Adult Services Directorate in the Local Authority and to the Haringey Operational Management Group that an immediate strategy be adopted whereby Rio is the principle clinical information system and the only system used by practitioners. *Administrative* staff will enter all social care data onto Framework-I. In this way double keying by practitioners will be avoided. Detailed work is being initiated to ensure that any changes incorporate the information and recording requirements of both the local authority and the Trust.

23. Running behind this strategy, urgent if performance reporting is to improve, is work at local level to develop an electronic interface and work at London-wide level to develop local authority functionality on Rio. In reality electronic solutions are likely to be at least a year away and cannot be relied on in the short term.

Diversity

24. The Trust is currently recruiting its first Community Development Worker ("CDW") and is seeking a Turkish-speaking person to work with young people, primary care, and the Trust's services to facilitate better access to mental health care.

Management of Crisis Services

25. At present the two Crisis and Assessment Treatment Services are managed within the Trust with the Alexander Road Crisis House managed within the Adult Social Care Directorate. The fragmentation of the management of services is commented on within the CSCI Report and early attention is being given to transferring the management of the Alexander Road Crisis House to the Trust to bring the three services under single line management.

Mental Health Morbidity in Haringey

The demographic profile of Haringey means that one can expect a higher than average number of people to need mental health services per head of the population than the national average. Furthermore, one would expect a higher portion of these to have a serious and enduring mental illness. This is substantiated within the Haringey's PCTs publication – ***Haringey Health 2004***. This is well correlated against factors such as age, ethnic mix, deprivation, homelessness, employment and numbers of Refugees/ Asylum Seekers.

A summary of key information in relation to need follows:

a) Suicide: an analysis of suicides in Haringey since 2001 suggests that the rate is at least 50% higher that the national suicide rate. To quote from Haringey ***Health 2004***, "this can be explained in part by the relatively high levels of factors increasing the risk of suicide in the borough such as unemployment, substance misuse and social exclusion, and by the relatively large number of people with mental illness."

b) Levels of homicide: along with suicide, this is an index of mental disturbance within the borough.

c) 33% of acute inpatient admissions in Haringey are for people diagnosed with schizophrenia, schizotypal and delusional disorders. This is against a London average of 23% and an England average of 14%, demonstrating the higher than average levels of serious mental illness in the borough. (Source: ***Dr Foster report on London's Mental Health Services, 2004***)

d) There are also higher than average admissions for substance misuse and mood effective disorders. (Source: ***Dr Foster report on London's Mental Heath Service, 2004***)

e) Refugees and Asylum seekers make up 10% of the population in Haringey. Research across London shows that this group are likely to be over-represented in inpatient facilities by more than twice their presence in the local community. This therefore represents a very significant additional pressure on Haringey's mental health services. For example, refugees and asylum seekers represent 15% of referrals to psychological therapy: these referrals require interpreters that double the length of the consultation as well as the extra cost for the interpreter.

f) Numbers of Forensic Patients: again, this is an index of serious mental illness linked to other social and demographic factors. The number of Haringey residents in medium secure beds is 40 (compared with Islington - 48; Camden - 57; Enfield - 29; Barnet - 13). It is clear that the needs index is of an inner London nature.

g) The ***London Health Observatory Benchmarking*** Report has developed a sophisticated analysis for projecting need. It places Haringey in the top 6 neediest boroughs in London. Within this comparator group, the Haringey services are average or above average in performance.

h) The **Haringey Welfare to Work for Disabled People Strategy** highlights the level of need for Haringey as in the top 6 most needy boroughs in London:

- Unemployment claimant rates: 3rd highest in London
- Adults on income support: 5th highest in London