North Central London Sector Joint Health Overview and Scrutiny Committee

Notes of a meeting of Barnet, Enfield and Haringey Members held at Barnet Town Hall on 3 February 2014

Present

Councillors	**Borough**
Gideon Bull (Chair)	LB Haringey
Alev Cazimoglu	LB Enfield
Alison Cornelius	LB Barnet
Graham Old	LB Barnet
Barry Rawlings	LB Barnet
Anne Marie Pearce	LB Enfield
David Winskill	LB Haringey

Other Councillors	**Borough**
Councillor Helena Hart Cabinet Member for Public Health	LB Barnet

Support Officers	
Linda Leith	LB Enfield
Andrew Charlwood	LB Barnet

1 WELCOME AND APOLOGIES:

Cllr Don McGowan (LB Enfield Cabinet Member Health & Adult Social Care) and Deborah Fowler (Chair Healthwatch Enfield)

2 DECLARATIONS OF INTEREST

No interests were declared

3. BARNET, ENFIELD & HARINGEY MENTAL HEALTH TRUST KEY ISSUES

Maria Kane (Chief Executive), Andrew Wright (Director of Strategic Development), Dr Jonathan Bindman (Medical Director), Dr Marc Lester (Deputy Medical Director), Stephen Cook (Deputy Director of Nursing) and Lee Bojtor (Chief Operating Officer) attended from the Barnet, Enfield and Haringey Mental Health Trust to deliver a presentation on the key issues facing BEH-MHT.

- The Chief Executive welcomed the opportunity to discuss issues and the support the Trust may need going forward.
- Despite meeting operational and financial performance targets for the last years the Trust was at a crux point with financial pressures and increasing patient numbers.

- Feedback from patients had been good with scores of 90-91% satisfaction.
- A number of independent reviews of quality have been good. However, concerns had been raised by the Care Quality Commission (CQC) in a recent inspection that the Trust was in the process of addressing.
- Staff feedback had been positive.
- A Clinical Strategy had been developed, but there was an affordability gap between what the Trust wants to achieve and what they are funded to do.
- Service improvement targets (savings) totalling £53m had been delivered.
- A significant amount of work on compassion in care had been undertaken and the Trust had held a patient experience summit.
- Regular engagement took place via health scrutiny committees.
- Innovation in services is proceeding and new specialist business contracts have been won.
- Integration of mental and physical health services is continuing such as the Rapid Assessment Intervention and Discharge (RAID) service with Barnet and Chase Farm Hospitals and the North Middlesex Hospital.
- Staff within the Trust are being supported and developed to improve patient care.
- The Trust is also working with the Barnet, Enfield and Haringey Clinical Commissioning Groups to address the historic low funding for mental health services. The Trust and commissioners were looking at benchmarks and mental health needs in the three boroughs. Independent consultants had been appointed to review services and funding and their findings would be reported in mid-March. The Trust offered to return to the NCL Joint Health Scrutiny Committee and discuss the findings of the report.
- Patient access has improved through the new Urgent Care Service where patients in crisis are visited in their home and there is a single point of access for the non-urgent referrals.
- Support for GPs has developed including the introduction of a telephone advice line and a Primary Care Academy which focussed on supporting primary care practitioners to deal appropriately with mental health issues.
- Activity and funding were the key issues facing the Trust. Population had increased by 130,000 in the three boroughs and referrals had increased by 11% over the last three years, whilst funding had decreased in real terms by 13%.
- Dementia referrals had increased by more than 40% in some areas. De-stigmatisation of dementia had been a positive development, but this has placed pressure on block contracts leading to increasing waiting times.
- There was significant pressure on in-patient beds due to the number of patients being sectioned.
- In-patient wards were currently operating at a 100-105% occupancy rate, with no slack in the system. It was reported that national guidelines for occupancy identified an optimum bed occupancy rate of 85-90% to provide a more therapeutic environment and more staff time for patients.

- The Trust had been forced to contact other mental health trusts for emergency beds even though most other trusts were experiencing bed shortages. Private sector placements had been used. However, the Trust had been forced to used side rooms and seclusion rooms for patients due to the shortage of beds. It was reported that the Trust has also opened some additional beds, but these were unfunded measures which would cost the Trust approximately £5m the 2013/14 financial year.
- The CQC stipulated that seclusion rooms must not be used. However, the Trust felt it had no alternative and in some cases had been forced to use seclusion rooms. It was reported that the Trust had now complied with a CQC enforcement notice and was using private sector beds to accommodate patients who required admission when there was not a suitable bed available within the Trust or in other NHS providers. The average number of patients in private sector placements was 19 per night which was costing the Trust in the region of £400,000 per month. It was noted that the Trust had been forced to place some patients up to 100 miles away due to the shortage of beds locally.
- The November CQC report on the Older People's Services based on the Chase Farm site had noted major improvements at The Oaks unit. However, improvements had not been extended to the other areas.
- The Trust stated that staffing on the older people's wards had been difficult and they were reliant on agency and bank staff to a high degree.
- The Trust reported that they had put place in staff training, a full time consultant, changed the clinical leadership model and amended service lines.
- There was on-going discussion at Board level in relation to these quality issues which were taken very seriously by the Trust. However, it was highlighted that improvement measures would take time to implement. The Trust's priority was to deliver a high quality service for patients. However, it could not continue to safely meet the increases in patient numbers without additional funding and/or changing the way services were delivered.
- The Trust reported that delayed transfers of care had been a problem. Some patients had spent six months in the Haringey Recovery House where three beds out of the seven short-term beds had been taken up by delayed transfer of care of patients who lacked recourse to public funding.

The Chairman thanked the officers for their presentation on the issues facing BEH-MHT. The Committee questioned the Trust as follows:

In response to a question on whether the on-going issues arose from underfunding or management issues, the Chief Executive emphasised that there had been historic under-investment year on year. Where NHS England commissioned specialist services which were properly funded, the Trust had performed well. It was reported that the Trust faced issues with recruitment as they were operating in outer London and not able to pay inner London weighting to staff.

The recently appointed Medical Director of the Trust reported that he considered that the staff at the Trust were of a high quality. He added that there were fewer staff at the Trust in comparison to his previous mental health trust. A combination of Quality, Innovation, Productivity and Prevention (QIPP) savings, historic underfunding and service reconfigurations had impacted on staff morale.

Since there had been a lengthy run up for the problems in terms of historical underfunding, a Member questioned what has the Trust done to bring the issue to the attention of the CCGs and partners. The Chief Executive stated the CCG commissioners were very aware of the issues and committed to working with Trust. Issues had been raised over the last year as voluntary sector and local authority funding had decreased, with knock on effects on the Trust. Population had increased and there had been a movement to outer London of people with complex mental health problems, due to Government benefit charges. Beds had been previously reduced in line with national guidance. The Trust had met Council colleagues, Healthwatch and attended scrutiny meetings to highlight the current challenges it faced. The Trust stated that the whole health economy was not funded as it should be. Due to the block contract payment mechanism in mental health, rather than payment on intervention per patient, there was no parity with the acute hospitals. It was reported that the Trust's Foundation Trust application (which requires a five year financial sustainability plan to succeed) had stalled due to the likely financial deficit in the current financial year and the inability to produce a sustainable long term financial plan at present.

A Member asked what was the scope of the independent consultants project, whether their recommendations would be accepted and what capacity the Trust has for improvement. The Chief Executive explained that the consultants had been appointed and funded jointly by the Barnet, Enfield and Haringey CCGs and BEH-MHT to look at and validate the scale of the gap in terms of funding and local need for mental health services. In relation to capacity to improve, the Trust would continue with service innovation and patient care and would seek to consolidate estates and review service lines to make every effort to reduce the financial challenge.

The Medical Director highlighted that debate was needed on why there has been an 11% increase in demand over the last three years. He noted that this could be attributable to social and environmental circumstances, a culture of patient expectation and the impact of recent welfare changes. It was emphasised that people needed to be seen earlier in primary care settings. If primary care treatment were effective, then would be reduced demand on acute mental health services. The Deputy Medical Director added that an increase in admissions was a national issue. New admissions could be from patients with psychotic illnesses who did not have a home to return to (e.g. asylum seekers in Enfield and Haringey who are found on the street in crisis). It was reported that sections under the Mental Health

Act were also increasing. As the Trust was commissioned at 100% capacity (rather than the 85% optimum capacity), the Trust has had to open two additional wards which were not funded by commissioners, as well as the additional use of private sector placements, which were also not currently funded by commissioners.

The Trust were questioned whether GPs should have more training in mental health and the relevant authority with responsibility for this. The Deputy Medical Director stated that GPs were independent contractors. However, a Primary Care Academy had been established by BEH-MHT to try and improve GPs skills in mental health. In addition, dementia training sessions had been introduced and have covered two thirds of the GPs in Barnet, Enfield and Haringey. This would be expanded to online training, to reach all GPs who found it difficult to attend sessions. The CQC were supportive of the Primary Care Academy and each CCG had a mental health lead.

A Member suggested that the mental health trust covering Camden and Islington may have foreseen the situation better, noting the forthcoming agenda paper for the 7th February JHOSC meeting. The Director of Strategic Development pointed to the difference in funding between inner and outer London, highlighting that Camden and Islington NHS Foundation Trust were working in a different financial environment to BEH-MHT. It was noted that they had a significantly greater level of funding; they had reduced from four to two sites and had been able to keep the proceeds from the land sales due to their foundation trust status.

A Member questioned whether the CQC had suggested alternative solutions in relation to the bed shortage or whether only criticism was given.

A Member suggested that the Trust needed to be more proactive in seeking help from scrutiny committees and other local stakeholders. The Trust felt it had communicated with Cabinet Members, scrutiny and stakeholders over the past two years about these issues. Members suggested that quarterly meetings of the Barnet, Enfield and Haringey JHOSC sub group could take place, with invitations to Cabinet Members and the CQC. A proposal to meet to discuss the independent consultants' report, expected on the 14th March, was agreed. ACTION: Committee Secretary

A Member questioned whether trying to win new business was wise if the core business was not solid. The Chief Executive felt that winning new business was a motivator which brought innovation and contributed to core costs, it therefore subsidised local core services.

A Member felt there was an issue of trust and transparency and asked why seclusion rooms had been used for several nights, despite the criticism of this practice in the original CQC inspection report. The Trust was asked if it took the decision to ignore the CQC. The Chief Executive reported that she was aware of the use of seclusion beds, but that difficult clinical decisions had had to be taken, sometimes at night,

about whether to admit a patient to a seclusion room for a short period of time, or whether to use a private placement, often a long way away.. She added that using a seclusion room in this way for 12 hours had to be logged as a serious incident. If rooms were used for more than 12 hours, it was flagged to the Chief Executive, although it was acknowledged that this did not always occur. On re-inspection, the CQC had issued an enforcement notice to suspend the use of seclusion rooms by 31st March 2014 to comply. The CQC had provided the Trust time to discuss the issue with commissioners. The Trust accepts responsibility that it should have flagged this issue with the CQC before they returned to undertake the follow-up inspection. It was stated that an Interim Director of Nursing had been in post at the time.

A Member suggested that extra funding may not actually deal with the problem. The Medical Director agreed that closing inpatient wards was good practice, but the Trust was now facing a difficult position with increased demands for admission and a reduction in mental health funding in real terms.

The Chief Executive of Healthwatch Enfield raised the importance of the patient focus. The CQC reports were not related to finance. She added that the awareness of patients as to whether they were sectioned or not was an issue. It was highlighted that if the Chief Executive of BEH-MHT did not know seclusion rooms were being used as much as they were, then was there was an internal communication problem.

In response to a query on the possible adaptation of seclusion rooms to allow flexibility of use, it was stated that this had been considered but was not feasible as it they were not a suitable environment. In answer to whether the continued use would have been picked up if the CQC had not returned, Members were informed that the CQC always re-inspect where previous failings had been reported.

A Member questioned why there was no hospital discharge action plan in the CQC report since delayed discharge is a significant problem, involving accommodation in the community and patients with no recourse to public funds. The Director of Operations responded that there was a patient tracker system, “Jonah”, which followed patients through the patient pathway. Regular meetings were held to pick up delays such as where support or accommodation was required. Discussions are currently being held with the CCGs and Councils.

Despite the poor environment at St Ann’s Hospital, a Member suggested that re-opening a ward may be preferable to using seclusion rooms. In response it was pointed out that the 19 patients in crisis needing a bed might have different illnesses and could not all be placed on single ward.

Two recent letters were tabled (Cllr Hart’s letter to BEH- MHT and a response from the BEH-MHT Trust Chair). Cllr Hart felt she had not taken the CQC report out of

context and wrote as a result of on-going complaints from service users and carers in Barnet. By not implementing the initial CQC improvements, this indicated a culture that wasn't seen to be caring enough and should not be allowed to be unchecked. Cllr Hart had written to the Trust as the Cabinet Member with safeguarding responsibilities and also Chair of Barnet Health and Wellbeing Board which had discussed the Francis Report at its recent meeting. It was noted that all other Trusts had been present to discuss the Francis Report, but there had been no representation from BEH-MHT. The Chair advised that NHS Trusts should attend meetings in future when requested as there was a need to work in partnership. Another Member disagreed with Cllr Hart's comparison with the Winterbourne View case where there was evidence of institutionalised, criminal violence against vulnerable people.

The Chief Executive responded that non-attendance at the above mentioned meeting was due to an administrative problem. She added that the Trust wished to work co-operatively and welcomed the proposal to have quarterly meetings in the future and committed to attending. She was pleased that Cllr Hart had clarified her Winterborne comments. She highlighted that the Trust had very vulnerable patients in its care and that in her view, it had caring staff.

4. BARNET, ENFIELD & HARINGEY CLINICAL COMMISSIONING GROUPS

Liz Wise (Chief Officer) and Ian Kent (Mental Health Commissioner) attended from Enfield Clinical Commissioning Group. Enfield CCG is the lead mental health service commissioner for the Barnet, Enfield and Haringey CCGs. The presentation outlined CCG finance and quality issues.

- Local partnerships in each borough were important in commissioning.
- The existence of different rules for commissioning mental health services was one of the problems. Block contracts were used, rather than units of activity, as in the acute sector.
- What happened to patients before they need an in-patient bed, early intervention and primary care services needed to be reviewed.
- Enfield CCG and Council were currently consulting on a joint mental health strategy. In Enfield, only 4% of secondary care service users were in employment which would have an impact on their support network.
- Partnership based solutions were needed to get sustainable improvements in mental health.
- CCGs were at the forefront of commissioning and have changed the way mental health commissioning was working by having congruent strategic priorities across the three CCGs.
- In addition, NHS England buys some mental health services on behalf of the CCGs.

- The three boroughs have different needs, funding levels and histories. The contract value of CCG investment into BEH-MHT in 2013/14 was £30,576,536 for NHS Enfield, £27,028,609 for NHS Barnet and £31,053,098 for NHS Haringey.
- The three CCGs and BEH- MHT were facing financial challenges.
- In Enfield, £4m of funding is spent on out of area placements in Enfield. The CCG is trying to get better value using step-down rehabilitation services and repatriation whenever possible.
- Enfield CCGs new funding allocation has received some growth, but will still be £20m adrift after 2 years (currently £33m adrift).
- 2011/12 benchmarking figures for adult and older adult services were provided which demonstrated variations in health and social care funding for mental health services in Barnet, Enfield and Haringey. These figures showed higher levels of spending for both categories in Haringey.
- There was more collaboration now between BEH- MHT and CCGs than with PCTs.
- The three CCGs and BEH-MHT had commissioned independent consultants to benchmark current levels of investment, the financial viability of the BEH-MHT's Clinical Strategy and the three borough commissioning strategies and to identify options to align service provision to funding available. Options may include a focus on early intervention, providing services another way, decommissioning of services, estates rationalisation and further efficiencies. Whether primary care takes on more patients was highlighted as a factor. It was reported that the CCG did not commission primary care, but had a responsibility to improve primary care and commission improved services. Members were informed that the consultants would report by 14 March and this will inform the 2014/15 commissioning strategy. There was an undertaking that the report would be shared with scrutiny committees.
- With regard to quality issues, a Clinical Quality Review Group (CCRG) worked across stakeholders including commissioners, Trusts, Quality Leads and GP Leads. It had been meeting monthly and was chaired by Enfield's Director of Quality and Safety. Quality reports were also seen at each CCG's board meetings. The CCRG annual workplan included action plans, complaints, incidents, CQC visits, patient experience and a Francis Report action plan.
- When Trusts or the CQC brought incidents to the CCGs attention, a group was formed to work jointly on an action plans, as in the case of issues in The Oaks Unit. The CCG were pleased with results, but added that improvements had not been followed up with other older people's wards in the Trust.
- The BEH-MHT Chief Executive stated that a nurse consultant had been appointed to work across older people's environments to embed learning from The Oaks. Regular meetings of carer support groups and work to improve patient experience was on-going. There was an issue about provision of Continuing Care which the Trust may not continue to provide. There was

discussion with CCGs on this issue. It was noted that Haringey had decommissioned Continuing Care from BEH-MHT.

- The Deputy Medical Director described the improvements needed: more consultant time on wards; more supervision of junior doctors; and improved recording of information. Most patients had very severe needs. Records were important and should not be overlooked.

The Chair asked how the CCG worked out how much to spend on mental health services. The Chief Officer stated this was complex with many competing pressures, but to increase spending currently would require a reduction in spending elsewhere.

Members questioned the reasons for the disparity in health and adult social care mental health spending. The Trust responded that if was difficult to find reasons behind these. This year Barnet CCG spent 6.5% of its annual allocation on mental health services, Enfield 9% and Haringey 10%.
When asked if levels of care in the boroughs were the same, it was stated that all quality indicators are the same, but there may be differences in services provided (e.g. talking therapies provided by the Whittington in LB Haringey).

Members concurred that prevention was important and stated that public heath funding had increased ten times on mental health services in Haringey. The Trust confirmed they were working with council's Public Health teams and agreed the importance of working across organisations on prevention in all pathways, including mental health and the integration of physical with mental health.

A Member welcomed the joint working on Mental Health strategy and primary care initiatives. Local authorities, however, should also be held to account.

5 BEH-MHT DISCUSSION AND QUESTIONS ON CQC REPORTS

Stephen Cook, Interim Deputy Director of Nursing at BEH-MHT attended to discuss three recent CQC reports and update members on the improvement plans.

A member complimented the Trust on its CQC inspection report of 20th August 2013 regarding Forensic Services at Camlet Lodge in Enfield.

The CQC report of the inspection at Haringey Ward at St Ann's Hospital in Haringey, an assessment ward, and the Section 136 suite at St Ann's Hospital on 22nd November 2013 was discussed. This followed an earlier inspection on 19th June. Protracted periods of time patients spent in seclusion room, stemming from bed pressures, led to the issue of an enforcement notice being issued by the CQC on 13th December 2013 with a compliance date of 31st March 2014.

The Chair considered that the redevelopment of St Ann's needed to be progressed in order to improve the physical environment at the hospital which would assist with patient recovery.

A Member suggested that engaging with patients on wards could have more impact than an overnight stay in a seclusion room. The Trust stated that resources were needed and an adherence to protected engagement time. Meaningful engagement meant different things to different patients which could be a chat over a cup of tea or a board game. The Trust was ensuring protected engagement time was happening and that there was protected interaction between patients and clinicians too.

The BEH-MHT Medical Director described patients in the Haringey assessment ward as extremely disturbed. Consequently it was harder to have meaningful engagement and activity. These patients needed to be transferred into other inpatient wards as quickly as possible to aid recovery.

A Member noted that the recording of information was again mentioned by the inspection team. Staff need to record information for protection of patients. Patient involvement in their care package needs to be noted in the records for high quality continuity of care.

The Chair commended staff in mental health services who do a difficult job.

The Chief Executive of Enfield Healthwatch stated that an action plan should have begun earlier and questioned whether the CQC report was a surprise to the Trust since patients were saying the use of the seclusion room occurred regularly.
In response it was stated that the Board and service managers have a high profile on the wards, as well as the non-executive directors. They pick up on issues and raise them with the Board.

A representative from Healthwatch Barnet felt it would be valuable for the MHT to work with Barnet, Enfield and Haringey Healthwatch organisations with regard to patient experience and feedback. A Member raised the potential use of Healthwatch enter and view powers. Healthwatch Barnet stated they had used these powers to view mental health services.

Members discussed the CQC report of the inspection at Older Adults Wards at the Chase Farm Hospital site which took place on 25th and 26th September 2013, following an earlier inspection of these wards on 27th March 2013. The inspection covered The Oaks, Silver Birches, Cornwall Villas and Bay Tree House. Required actions included the care and welfare of people who use services, safety and suitability of premises, assessing and monitoring the quality of service provision, and records management.

A Member raised the number of references in the reports to records and care plans not being completed or adhered to and questioned why senior managers had not spotted this. The Trust stated it was now quality checking documents and care plans. Ward Managers were accountable for record keeping. All nurses have been written to individually and the Trust has developed a bespoke audit to monitor these aspects. A Member hoped that the new audit would not be just a tick box exercise.

A Member raised a concern about locked doors and pointed out that in Barnet, patients at the former Elysian House could go out or go to the library. Once they were moved to the Springwell Centre it was harder for them to go out when they wished. Few asked to go out but tended to sit and watched television instead. A member felt that an admission ward was different, but nevertheless engagement with patients did seem to be a wider issue. The Medical Director responded that he had visited The Oaks last week and found good activities taking place. Protected engagement time with patients was a priority.

ACTION: A member suggested how to raise engagement with patients as a future agenda item.

6 UPDATE ON NORTHGATE/NEW BEGINNINGS

Shaun Collins (Assistant Director, Child and Adolescent Mental Health Services at BEH-MHT) gave an overview of the development of the specialist pathway for adolescents with severe and enduring mental illness in Barnet Enfield and Haringey, as outlined in his paper.

A decision was taken in late 2011 by Barnet, Enfield and Haringey PCTs to decommission Northgate and increase capacity at the New Beginnings unit and in community assertive outreach teams. This had been intended to minimise hospital admissions. Many patients were previously sent to private providers a long distance from home. Following inpatient admission it was more challenging to re-integrate in the community.

A new single pathway has been established comprising increased capacity in a 17 bedded in-patient unit (with five additional beds) following a £1.6m refurbishment scheme of the New Beginnings Unit (now renamed the Beacon Centre) and expanded community teams. The Beacon Centre had been opened in June 2013. In-patient services include high dependency care, acute care in crisis and medium to long term treatments. A variety of psychological therapies are provided in inpatient and community settings.

A public consultation was held on the proposed new pathway. The pathway was launched in 2012. However, following April 2013, the CCGs no longer commissioned in-patient care. NHS England now commissioned this nationally with

the result that the CAMHS service is obliged to admit adolescents from out of area. Where Barnet, Enfield or Haringey children were placed out of area, they were repatriated as soon as possible.

Service users were very involved in the development of the service. Weekly meetings took place at the Beacon Centre where they could feed back experience of the service and propose ideas for improvement. The CAMHS service would be setting up formal meetings, including service users, to evaluate the new services. Joint Health Overview and Scrutiny Members were welcome to visit and attend a meeting. ACTION: Committee Secretary.

BEH- MHT was in the process of setting up an independent advocacy service for young people using Barnardos.

Increased demand had been experienced in both patient numbers and the complexity of illnesses. The incidence of violence and aggression on the ward has also increased. There had been good movement from the in-patient ward into community.

A Member pointed out a previous proposal for the Chair and herself to attend a service user meeting at Northgate had never materialised. In response, Shaun Collins stated that the new meetings with service users are more inclusive, since they also include community service users. Joint Health Overview and Scrutiny Members were welcome to attend.

A Member questioned whether demand was likely to increase in the foreseeable future. In their years of experience as a Councillor three residents had recently approached them on this subject, whereas there had been none in previous years.

A number of factors were involved including adolescent s with severe problems now presenting at a younger age. Additionally, adolescents previously may have gone down the criminal justice route, but were now coming under the CAMHS.

The Chair thanked BEH-MHT and Enfield CCG.