North Central London Sector Joint Health Overview and Scrutiny Committee
Meeting of Barnet, Enfield and Haringey Members
Tuesday 15th July 2014

Present:

Councillors	**Borough**
Gideon Bull (Chair)	LB Haringey
Alev Cazimoglu	LB Enfield
Pippa Connor	LB Haringey
Alison Cornelius	LB Barnet
Graham Old	LB Barnet
Anne-Marie Pearce	LB Enfield

Also present: Councillor Barry Rawlings (LB Barnet)

1. APOLOGIES FOR ABSENCE

None.

2. DECLARATIONS OF INTEREST

Cllr Cornelius declared a personal interest as an assistant chaplain at Barnet Hospital.

3. BARNET, ENFIELD AND HARINGEY MENTAL HEALTH SERVICES: FINANCIAL REVIEW – FINAL REPORT

Maria Kane, Andrew Wright, Mary Sexton and Dr Jonathan Bindman attended the meeting from Barnet, Enfield and Haringey Mental Health Trust. Ms Kane reported that, since the last discussion of the issue at the JHOSC, both enforcement notices that had been served on the Trust by the Care Quality Commission (CQC) following inspections had been lifted. There had also been a small surplus of £500,000 in the Trust's accounts for the previous financial year. However, a deficit of £4.7 million was forecast for the current year. There had nevertheless been small increases in funding from local CCGs.

As recommended in the financial review report, a Mental Health Transformation Board had now been established and the Trust and the Clinical Commissioning Groups (CCGs) were working together on whole system solutions. The local authorities had also been invited to be represented on the Board. The Trust had continued to extend its provision of specialist mental health services and recently won two additional contracts. The Trust's specialist services were highly regarded and this had been helped by the fact that they were fully funded by commissioners.

Around £60 million had been taken out of mental health services delivered by the Trust in the last five years. The levels of efficiency savings of 6% that had been required were above the 4% average that had been the norm elsewhere within the NHS. There was now limited scope for making further savings. Such savings could only come from reductions in staffing, which made up 60-70% of costs and would be difficult to achieve without impacting on quality and safety. Quality expectations remained high with the

new CQC inspection regime being extremely rigorous. The level of activity had increased by 11% in the last three years, despite the reductions in funding in real terms. A high percentage of patients – 70% - were detained under the Mental Health Act or "sectioned".

The Trust was now focussed on developing an enablement model of care. This would focus on promoting independence and self-help for patients. The aim was to keep people well and help patients manage their condition independently of services. The new model would require staff with different skills and a re-profiling of the work force.

Work was being undertaken with local CCGs and the Trust Development Authority (TDA) to develop a high level long term financial viability plan. Without additional funding, the services currently provided by the Trust were not sustainable. The Trust was also not financially viable in the long term.

It was noted that the Trust had 156 acute adult mental health beds. If forensic and other services were included as well, the number was 550. It was currently not possible to provide places for patients in Recovery Houses due to the Trust being unable to move patients out despite them being ready to go home. The average level of delayed transfers of care (DTOC) across Barnet, Enfield and Haringey was 11%, which was equivalent to a ward and a half. The issue was most acute in Haringey. There were working groups in all three boroughs that were addressing the issue. The Trust could not throw patients out onto the street but it was also not funded to provide accommodation. It had been forced to place patients in bed and breakfast accommodation although this was also not an ideal option. It was now placing patients in private sector mental health accommodation, which was costing the Trust an average of £20,000 per night. This was not sustainable and represented a large percentage of the Trust's projected deficit.

Ms Kane reported that the Trust was in active dialogue with each local authority over DTOCs. It was arguable that local authorities had a specific duty to assist under the Care Act. However, the Trust was mindful of the need to work in partnership. There was a sub-group of the Transformation Board that was looking at DTOCs and how they could be addressed. She recognised that all three CCGs could also benefit from more funding, particularly as they were currently receiving amounts that were slightly below their capitation levels. It was hoped that work on the development of the enablement model would be completed by the end of September. The CCGs had been involved in the development process and, in particular, in discussions regarding how CCGs could assist in the transition. The Trust wished to have clarity regarding the kind of services that that CCGs wished to commission in the future. It would be important to determine what level of service could be provided for the funding that was available.

Members expressed concern at the suggestion that local authorities might not be fully meeting their obligations to accommodate vulnerable people. They noted that the Trust had been in direct contact with Haringey Council but not Homes for Haringey. The enablement model was based on early intervention to support people at home and help them to stay in work. The transition to this model would require some double running of services whilst it was being brought in.

It was also noted that each recommendation of the report was being addressed by a particular sub-group of the Transformation Board. A number of productivity issues were being addressed and the use of information technology was a key part of this. There was a review of sites within the community taking place as it was felt that they were not all needed. However, the sale of any surplus sites would only provide a one-off capital receipt and would not impact much on the long term financial viability of the trust. The Trust also still wished to keep services local wherever possible.

In answer to a question, it was noted that there were 18 beds in the recovery houses in Barnet and Enfield and 7 in Haringey. Consideration was being given to providing another recovery house in Haringey and suitable premises were currently being sought.

The Committee noted that the CCGs were receiving a total of approximately £15 million of activity additional to that which they were paying for. In particular, Barnet was receiving significantly more services than it was actually contracted to receive. However, services were not commissioned in the same way across the boroughs. The MHT had been found to be not particularly expensive. Its reference costs were the 2nd lowest in London. The key issue was that levels of investment from local CCGs were lower than elsewhere.

The contractual issues with CCGs were historical as the block contracts were rolled over from one year to the next. This was an issue common to all mental health providers. The move to payment by results (PbR) should help ease the financial pressures. However, there had been delays in implementing the change to a tariff based system and mental health was a very complex area. Prices charged to commissioners were likely to increase.

Ms Kane reported that the CCGs had accepted the findings of the report but it was nevertheless difficult for them to fully fund the Mental Health Trust's services. The money to fund services would nevertheless need to come from somewhere. All three CCGs were probably not funded to the level that they ought to be and desperately needed more money themselves. However, "parity of esteem" did not currently equate to parity of payment. The Trust aimed to do its best to maintain quality but the financial pressures were likely to have an impact on it at some stage. The pressures would be exacerbated by demographic changes.

The Panel noted the DTOCs were also impacting on A&E performance at acute hospitals in the area. It was agreed that the MHT would be requested to provide statistics on DTOCs and an analysis of trends and that, in the light of this, consideration be given to making representations to relevant boroughs and the Department of Health.

AGREED:

That BEH MHT be requested to provide Committee Members with a breakdown and trend analysis of delayed transfers of care.

4. CQC REPORT – TRUST HEADQUARTERS

Mary Sexton from BEH MHT reported on recent CQC inspections involving the Trust. There had been particular issues regarding the use of seclusion rooms to accommodate

patients. However, this had only been done as a last resort when there were no other beds available within a reasonable distance. The CQC had served an enforcement notice on the Trust due to this but this had now been rescinded. The CQC had commented positively on the improvements that had been made when they re-inspected recently. There had also been issues raised relating to care on the Silver Birch older people's ward. There were still three outstanding issues here and the Trust was currently waiting for the CQC to re-inspect.

Issues had been raised in respect of the Home Treatment Teams. These had concerned medicines management and staffing. The CQC had revisited in June and found the Trust to be now fully compliant. Medicines management was now subject to enhanced monitoring internally in order to ensure that improvements were sustained.

Ms Kane commented that the Trust had been disappointed to receive the enforcement notices from the CQC. The medicines management issues were not directly linked to financial pressures although enhanced training on this issue could be provided were additional funds available. The Trust nevertheless accepted that it had got things wrong. However, it was noted that there was a link between resources and the issues relating to the use of seclusion rooms. The Trust currently had bed occupation levels that were well above the national average of 85%. Demand would always fluctuate but the Trust did not currently have any slack to deal with increased demand. In addition, there was a national crisis in relation to the availability of mental health beds.

The Committee noted that there had been high levels of staff sickness in respect of Oaks Ward. Average levels for the Trust were 3% but a small number of staff on long term sick could distort figures. There were now very low figures in respect of Oaks Ward. One particular emerging issue was the age profile of staff. In particular, the Trust now had a large number of staff who were over the age of 50 and therefore carried a comparatively higher risk of developing long term illnesses. However, the Trust provided support to staff who were experiencing health issues. Ms Kane commented that intensive and pressurised nature of work on wards including the most acutely ill patients could impact on staff sickness levels.

In response to a question, the Committee noted that staff turnover amongst consultants was not high and the Trust strove to ensure that there was continuity in the treatment of patients. However, people who were being treated by Home Treatment Teams would be covered by different staff due to the nature of shift patterns.

5. BARNET, ENFIELD AND HARINGEY MENTAL HEALTH TRUST - QUALITY ACCOUNT 2013-14

The Committee noted that the Quality Account showed progress across a range of key indicators. There was a particular need for the Trust to address the issue of communication with GPs. However, progress had been made in other areas. Dr Bindman commented that letters to GPs were still produced in the traditional way and were difficult to turn around in 24 hours. It would always be challenging to achieve a high level of compliance with this indicator without the use of e-mail.

Ms Kane commented that mental health was a very small part of the training of GPs. Efforts were being made to promote a better understanding of mental health amongst

them through the provision of in-service training in the Trust's Primary Care Academy. GPs were incentivised to attend this. It was hoped that attendance could be encouraged through the appraisal system for GPs.

In answer to a question, Ms Kane commented that the Trust tended to categorise patient safety incidents at a higher level when recording them than some other Trusts. It was important that people were encouraged to report incidents and the relevant learning was captured and responded to. It was noted that the GP survey had only yielded a 44% return rate against a benchmark of 80%. The Trust stated that they would be running the survey again in due course and would report back on results in due course. In respect of assessment, review and discharge letters, efforts would be made to improve the percentage sent out within 24 hours but, without the use of e-mail or other electronic means of communication, this was a challenging target.

It was noted that the Trust would be meeting with the Trust Development Authority at the end of September to discuss its future development in respect of its overall financial viability in the long term.

The Chair thanked officers from the Trust for their attendance at the meeting.

Gideon Bull
Chair