Proposal to Restructure Mental Health Acute Care Services -
Increasing capacity of home treatment teams and reducing over reliance on in-patient beds

Background

The National Service Framework for Mental Health has shaped the design and delivery of mental health services over the past nine years.

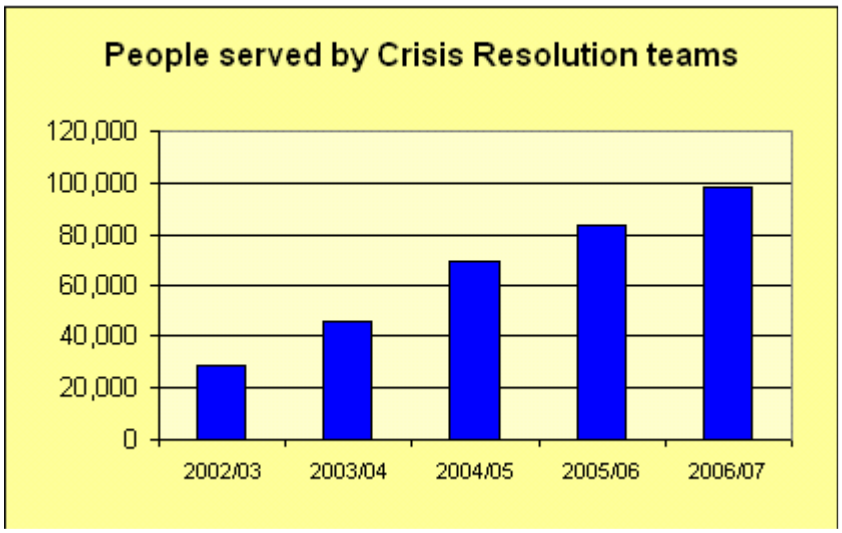
The NSF set national standards and defined service models for promoting mental health and treating mental illness

A number of requirements, expectations, outcomes and targets were set, spelling out how services should be developed, delivered and what they should achieve.

One of the many expectations of the NSF was for services to be delivered as close as possible to home so that family and community links could be sustained. A major programme of the NSF was to deliver Home Treatment as a standard intervention and alternative to hospital admission.

This was in recognition that people had improved recovery outcomes if they could be maintained in their own environment and also that most people, and particularly people from black and minority ethnic backgrounds, found this form of treatment to be far more acceptable than hospital admission.

Seen as a great success there are now some 343 home treatment teams operating nationally. Almost 100,000 people used these services last year and as a result, admissions to hospital are falling.



Current Situation in Haringey

Home Treatment

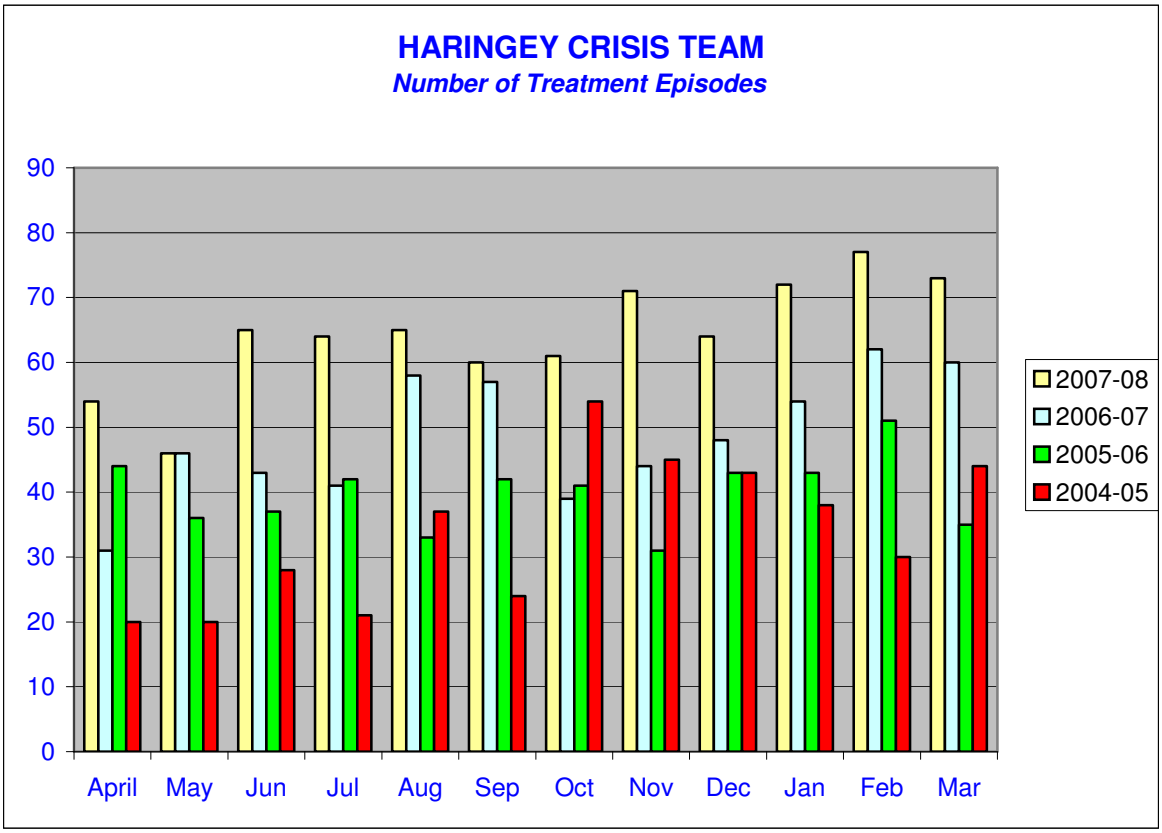
In Haringey, Crisis Resolution Home Treatment Teams (CRHTT) were established in 2004. The East Team was set up in February followed by the West Team in October.

Originally these teams were designed to accept all and any referrals for assessment as well as offer treatment to people as an alternative to hospital admission. With this broad remit it was very difficult for the teams to reach their targeted number of home treatment episodes.

With the reconfiguration of community services last year this initial assessment function moved to the START team freeing up more time for the CRHTTs to focus on providing treatment at home and also to help more people to return home earlier in their recovery.

This has enabled Haringey's Home Treatment Teams to not only reach their nationally set target of 727 episodes for the first time but to achieve a final total of 772 in 07/08. The experience of the staff working in those teams is that with further investment an even greater number of individuals would be able to benefit from being treated at home and particular focus could be given to those able to return home with additional support.

With a clear demand for home treatment beyond the set target and with the teams delivering more treatments than they are resourced to provide there is now an obvious requirement for the Trust and its partners to review the current resource allocation and assess whether this needs to be adjusted to allow the further development and modernisation of services.



HARINGEY CRISIS TEAM

Number of Treatment Episodes

HARINGEY	April	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total	increases on the previous year
2007-08	54	46	65	64	65	60	61	71	64	72	77	73	772	+32%
2006-07	31	46	43	41	58	57	39	44	48	54	62	60	583	+22%
2005-06	44	36	37	42	33	42	41	31	43	43	51	35	478	+18%
2004-05	20	20	28	21	37	24	54	45	43	38	30	44	404	

In-patient Beds

With the introduction of home treatment teams nationally there has been an expectation that the number hospital admissions would fall and the need for inpatient beds would reduce allowing re-investment into more modern ways of providing interventions.

Some areas have been more successful in this than others.

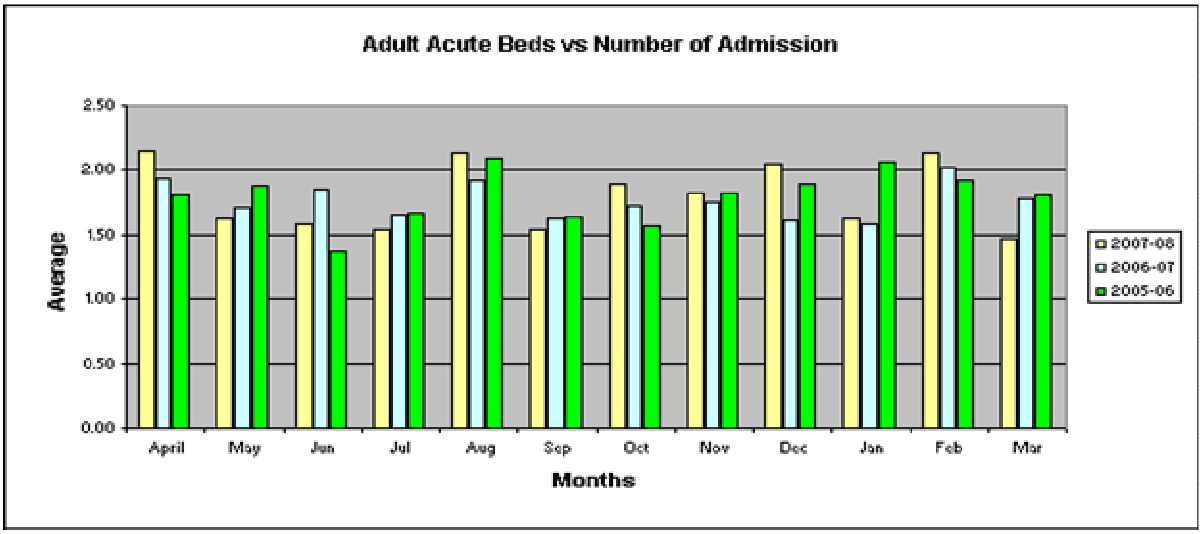
Comparing the use of inpatient beds in Haringey with other providers, the findings can be quite striking. In a recent benchmarking exercise it was found that Haringey uses up to four times as many beds per 100,000 weighted population than the lowest bed users nationally; almost twice as many as neighbouring boroughs and almost 20 more than one of its closest bed number comparators. Even after a further ward reduction, Haringey would have a higher number of beds than most other London providers.

Looking at these two factors; the high number of beds and the obvious demand for home treatment, there is evidence to suggest that limited provision at one point in the system is causing pressure and maintaining demand in another.

Haringey Adult Acute Beds

Acute Beds vs Number of Admission

HARINGEY	April	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	**Ave**
2007-08	2.15	1.63	1.58	1.54	2.13	1.54	1.89	1.83	2.05	1.62	2.13	1.47	1.80
2006-07	1.93	1.71	1.85	1.66	1.93	1.62	1.73	1.75	1.62	1.59	2.02	1.78	1.76
2005-06	1.81	1.88	1.38	1.66	2.09	1.64	1.57	1.82	1.89	2.06	1.92	1.80	1.79

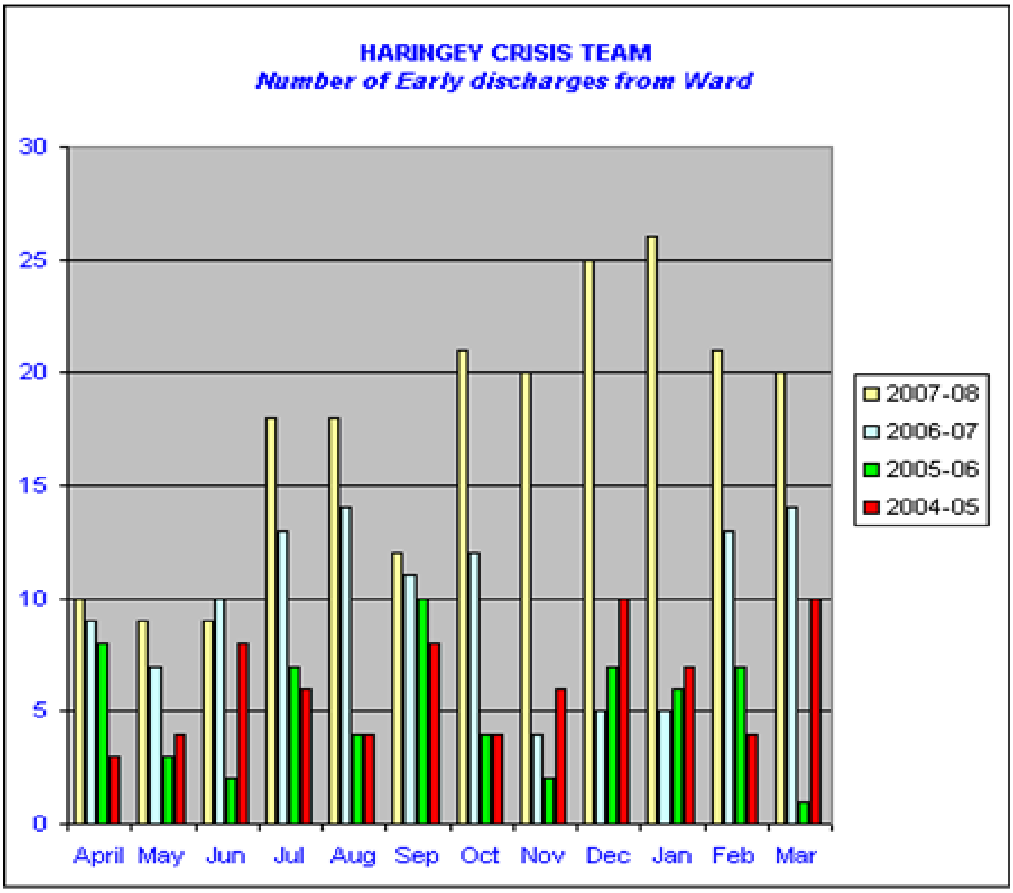


There is clearly an existing demand on beds but viewed alongside the capacity in the home treatment teams there is a suggestion that a shift of resource could enable more people to be treated at home and more could be supported to return home more quickly and safely following a stay in hospital. The fact that admission rates have stayed stable whilst bed numbers have reduced may support this.

Further evidence to support this suggestion is presented in the remainder of this document:

Number of Early Discharges from Ward		

HARINGEY	April	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2007-08	10	9	9	18	18	12	21	20	25	26	21	20	209
2006-07	9	7	10	13	14	11	12	4	5	5	13	14	117
2005-06	8	3	2	7	4	10	4	2	7	6	7	1	61
2004-05	3	4	8	6	4	8	4	6	10	7	4	10	74



CRHTT Staffing

CSIP recommends 14 wte Home Treatment staff per 100,000 weighted population. For Haringey this means there should be 38 wte staff working in the CRHTTs. Haringey currently operates with 23 wte.

Bed Usage

Current numbers of adult acute beds across Barnet Enfield and Haringey

Service	Barnet	Enfield	Haringey	Total
Adult acute	45	50	95 (excluding Lea ward (Edmonton))	190

The following identifies some targets for the suggested appropriate number of beds per population in a number of worldwide locations.

England – 16-20 adult acute beds per 100,000 (CSIP/NIMHE)

Canada – 18 adult acute beds per 100,000 (+12 rehab and EMI beds): 'Putting People First' 2003

Australia – 15-20 adult acute beds per 100,000 (National MH Report 2000 – Commonwealth Dept' of Health and Aged Care)

Oregon – 8 adult acute beds per 100,000 (Oregon Office of MH)

Vermont - 7 adult acute beds per 100,000

Applying targets of 16-20 beds per 100,000 weighted population suggests the following number of beds for Barnet, Enfield and Haringey.

16-20 Beds per 100,000

	Population	Local MINI score	Lower Range	Upper Range
Barnet	327,000	0.67	35	44
Enfield	283,000	0.93	42	53
Haringey	225,000	1.16	42	52

Using existing bed numbers in Barnet and Enfield as targets for Haringey also indicates a current high bed base in Haringey

Barnet & Enfield weighted for Haringey

Service model	Beds per 100,000 people	Local MINI score	Beds adjusted for Haringey MINI score	Total Haringey bed requirement
Barnet	14	0.67	24	54
Enfield	18	0.93	22	50
Current Haringey service	42	1.16	42	95

The following shows how this compares with some of the lower bed using areas nationally.

Northumberland, Tyne & Wear – 51 acute beds for 318,000 (16 per 100,000)

Norfolk & Waveney – 20 acute beds for 130,000 (15 per 100,000)
Service model based on an integrated team of staff working across in-patient and crisis/home treatment services

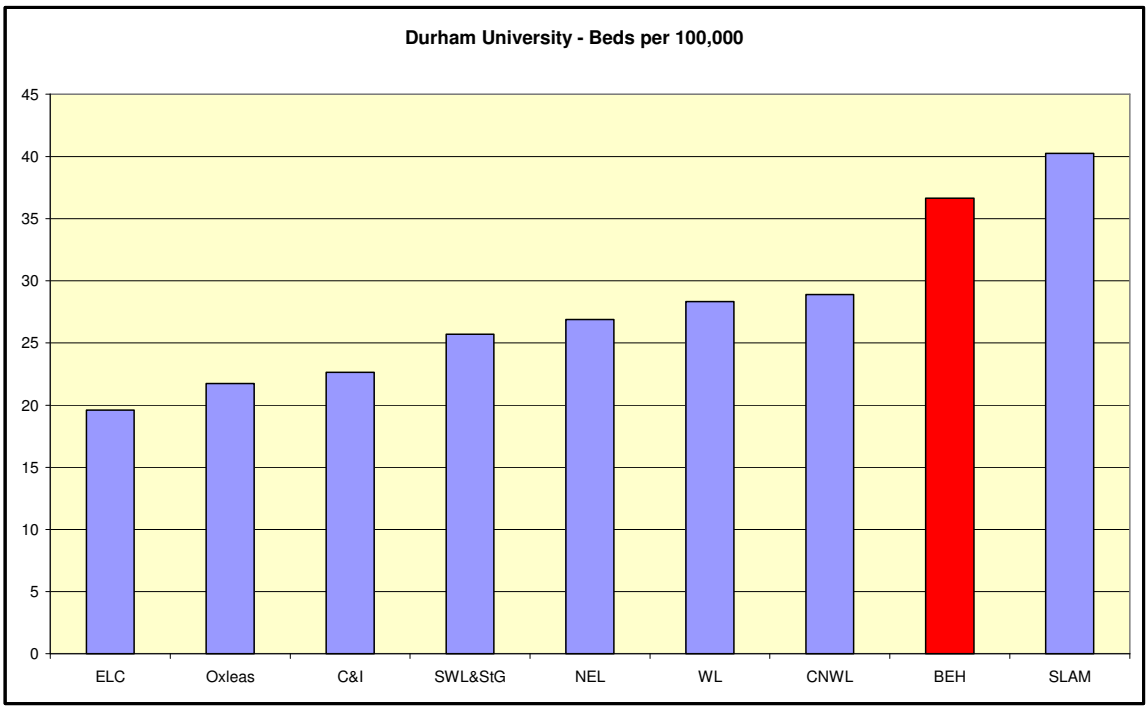
Tees, Esk & Wear - 20 acute beds for 152,000 (13 per 100,000)
Service model based on collocation of adult and OPMH wards and crisis/home treatment team.

Sussex (Worthing area) – 32 acute beds for 300,000 (11 per 100,000)
Service model based on collocation of 2 adult wards, 1 OPMH ward and crisis/home treatment team

Applying these best practice benchmarks to Haringey provides an even more marked illustration of bed usage to population.

Service model	Beds per 100,000 people	Local MINI score	Beds adjusted for Haringey MINI score	Total Haringey bed requirement
Northumberland,Tyne & Wear, Morpeth unit	16	1.09	17	38
Norfolk & Waveney, Lowestoft unit	15	1.14	15	34
Tees, Esk & Wear, Hartlepool unit	13	1.59	9	21
Sussex, Worthing unit	11	0.95`	13	30
Current Haringey service	42	1.16	42	95

It is also possible to benchmark the trust as a whole with other more local providers. Data collected by The Durham University as part of the annual mapping exercise demonstrates that BEH-MHT has significantly more beds, after adjusting for need, than all other London Trusts except the South London and Maudsley Foundation Trust.



The Trust has been able to obtain a borough breakdown of adult acute beds for the South London and Maudsley Foundation Trust (SLAM). It is interesting to note that SLAM's own figures show a total compliment of 329 adult acute beds, a figure that differs significantly from the numbers reported by Durham University (524).

BEH-MHT and SLAM's respective borough based bed provision is shown in the following table.

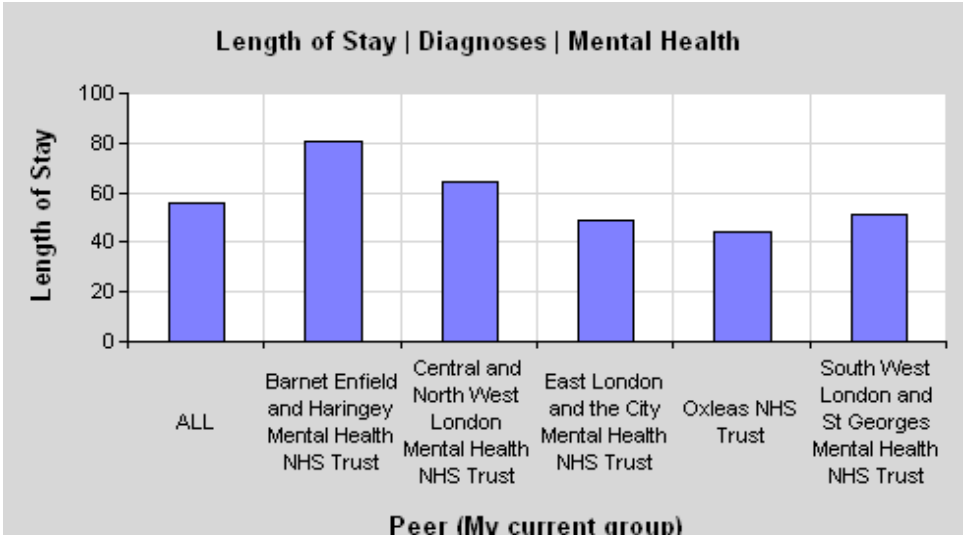
Service model	Beds per 100,000 people	Local MINI score	Beds adjusted for Haringey MINI score	Total Haringey bed requirement
Southwark	36	1..61	26	58
Lambeth	36	1.40	30	68
Lewisham	28	1.14	29	65
Croydon	23	0.76	35	78
Current Haringey service	42	1.16	42	95

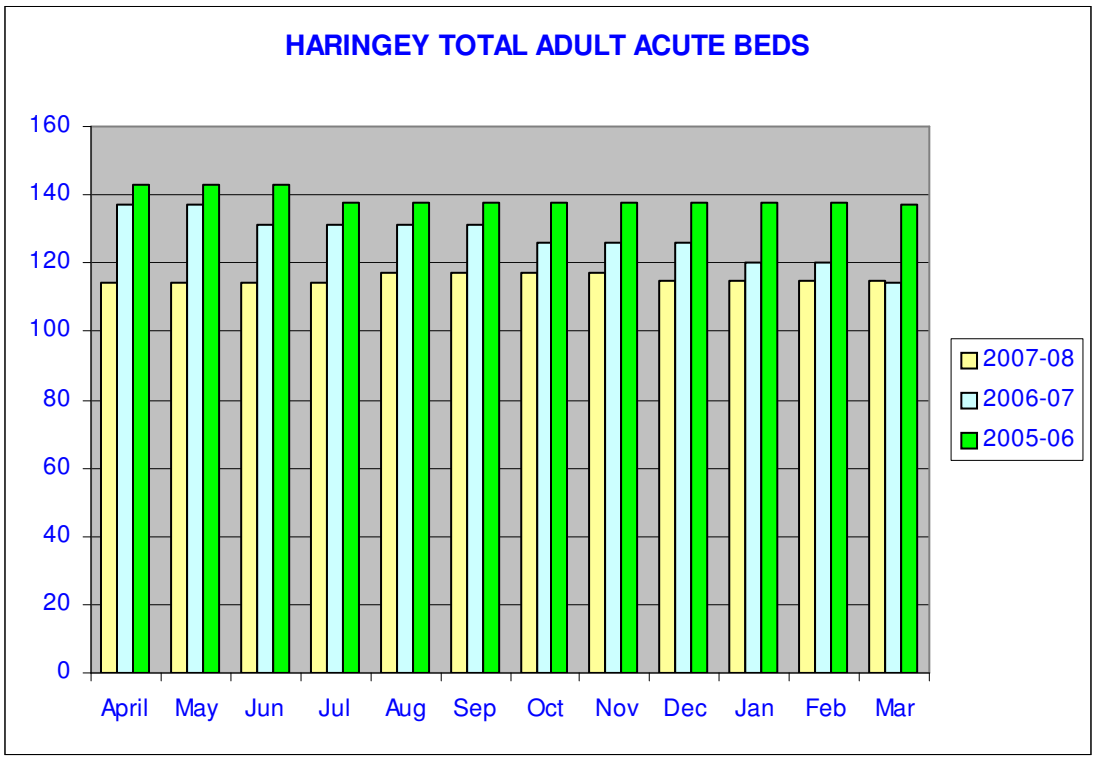
Length of Stay

Another factor which it is important to consider when comparing numbers of beds is the average length of time any individual stays in hospital during an admission.

Service	Length of Stay	Variance from Lowest
Barnet adult acute	52	N/A
Enfield adult acute	64	+ 23%
Haringey Adult Acute	76	+ 46%

Again, comparing the trust as a whole with other London Trusts the data suggests that individuals stay for longer in BEH-MHT.

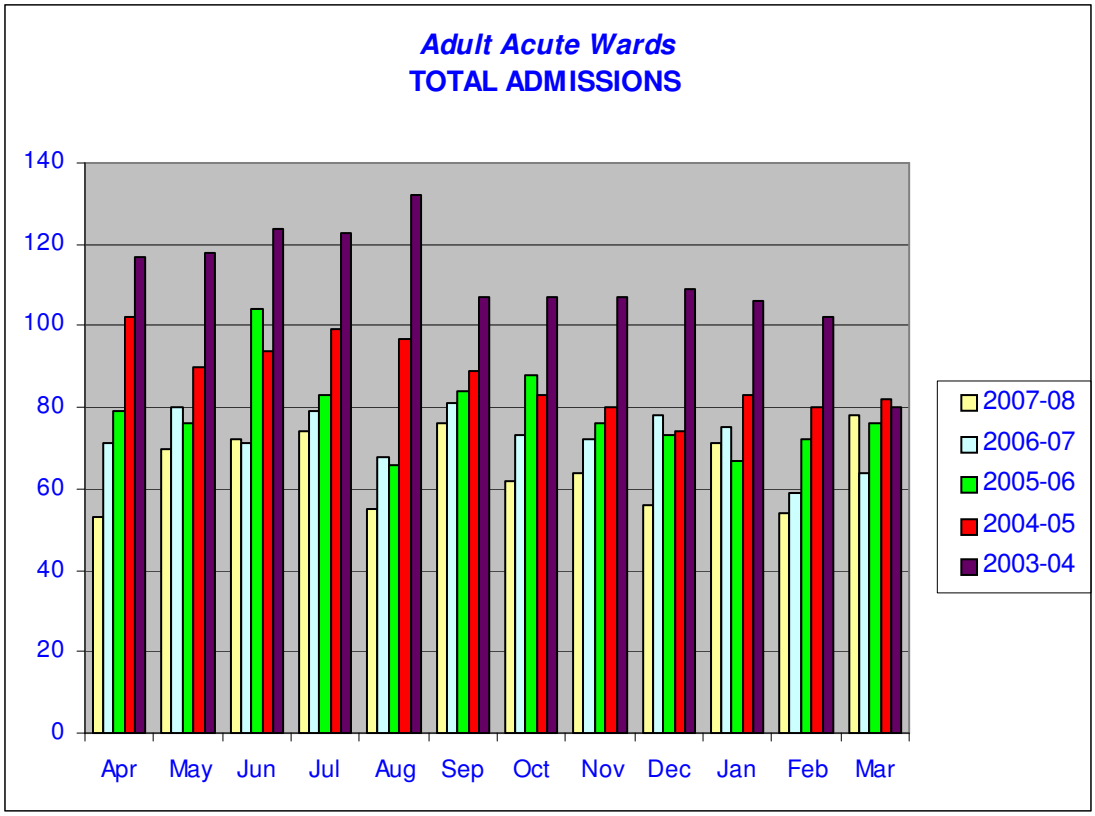




Note:

Theses figures do not include bed for PICU
Lea ward 20 beds is included although 5 of the 20 beds are for Haringey

			Changes in bed number		
2005/06	Beds	143-138	Wards were reorganised by sector		
		138-137	Lea ward reduced by 1 bed		
2006/07	Beds	137-131	Alexandra ward closed	-15	beds
	Beds		Lordship reduced beds by	-3	beds
	Beds		Finsbury.Northumberland/B. Castle increased +12		beds
	Beds	131-126	Lea & Downshill reduced beds	-5	beds
	Beds	126-120	Jan, Jubilee reduced beds	-6	beds
	Beds	120-114	March, Jubilee finally closed	-6	beds
2007/08	Beds	114-117	Aug, Increase beds due capacity issues	3	
		117-115	Dec, bed reduced	-2	



Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Year Total
2007-08	53	70	72	74	55	76	62	64	56	71	54	78	785
2006-07	71	80	71	79	68	81	73	72	78	75	59	64	871
2005-06	79	76	104	83	66	84	88	76	73	67	72	76	944
2004-05	102	90	94	99	97	89	83	80	74	83	80	82	1053
2003-04	117	118	124	123	132	107	107	107	109	106	102	80	1332

Much of this information indicates that whilst home treatment activity has increased and bed usage has reduced there remain areas of challenge, particularly around the further reduction of length of stays. The information also indicates that capacity has been managed throughout the successful transition to a new way of delivering services. It also suggests that a further transfer of resource could deliver similar outcomes bringing the service closer into line with comparators.

Mental Health Strategy 2005-2008

All of this suggests that now is the time to revisit The Haringey Joint Health and Social Care Mental Health Strategy 2005-2008 and shift the focus of the service yet further along the strategic pathway already set and agreed nationally and locally.

This document laid down a clear strategy ‘to reduce the reliance on hospital-based care in keeping with the strategic aim of developing community based services and to improve the quality of care provided within in-patient services.’

Even when written, it was identified that there was an ‘over-reliance on outdated institutional forms of care’ and a need to redirect resource from in-patient to community care.

What the proposed closure of an adult acute in-patient ward will do is allow these aims to be achieved.

Redirecting some of the resource to improve the availability of home treatment staff is almost guaranteed to reduce length of stay and reduce the over-reliance on hospital beds, bringing Haringey closer to its comparators in these areas.

What it could also achieve is an improvement to the therapeutic environment on the remaining wards for those people who do need to come into hospital. Just as the Home Treatment teams could benefit from additional staffing, increasing the establishment on the remaining wards would help to reduce the current over-reliance on temporary staffing and support initiatives such as Protected Engagement Time and the Star Wards II initiative.

Service Model

Through carrying out this benchmarking it has become apparent that in a number of those areas where bed use is at its lowest, a similar type of ‘functionalised’ service model has been introduced. This has involved consultant psychiatrists focussing on one part of the care pathway.

This exists to some extent now in Haringey where there are dedicated consultants for the Start Teams, Home Treatment, Host and Antenna Teams.

For the Support and Recovery Teams, however, consultant time and responsibility remains split across the work in the community and that which needs to be undertaken on the wards.

It is envisaged that to enable a re-allocation of resources in the way discussed in this paper that a similar model would need to be introduced to ensure the best and most effective outcomes.

Current Situation

Preliminary consultations have begun with a number of staff and stakeholders.

Key to enabling the successful implementation of the model is to have the support of clinicians. There is much ongoing consultation with consultant psychiatrists about 'New Ways of Working' which would support and promote less restrictive forms of treatment and engagement.

Staff on Finsbury Ward in particular have also been identified for early consultation. If the proposal to close a ward and re-invest does move ahead this will have beneficial effects on the overall plans to refurbish a number of wards at St Anns Hospital. Identification of this ward would support early enablement and decant processes.

Further discussion is ongoing with service user and carer groups, through, for example, the Consultation Subgroup of the mental health partnership board as well as individual meetings with a number of representatives from those groups.

Other partners are signed up to this strategic development through the Mental Health Strategy 2005-08 and are involved in detailed discussion through, for example the MH Exec, about benefits or disadvantages to the mental health system overall.

The Overview and Scrutiny Committee will be meeting with representatives from The Mental Health Trust, The PCT and the Local Authority to gain a more detailed understanding of these proposals and advise on further consultation requirements.

Risk Management

The aim of this proposed resource shift is to increase capacity in remaining teams and services, supporting the delivery of increased opportunities for being treated in the community and delivering greater quality of services in the in-patient areas.

As staff will continue to be employed in the organisation, there remains flexibility to provide capacity and resource where most needed.

During the transition from ward to home treatment it will be possible to flex staff resource between in-patient and home treatment teams. This also means that if the model is implemented or piloted but found not to work there is always the option to reverse the decision, shift resource back and re-open additional in-patient beds.

Because of this ability to reverse or flex the arrangements the strategy carries a very low risk if the expected outcomes are not achieved.