Slough Borough Council Health Scrutiny Committee. 8th December 2011

NHS Berkshire Progress Update on Additional Engagement Work Undertaken Regarding the Future of East Berkshire Mental health Inpatient Services

1.0. Introduction

This paper brings together the results of the additional engagement work agreed by NHS Berkshire and Berkshire Healthcare NHS Foundation Trust (BHFT) in July. The Committee is requested to review this and note the work planned for completion prior to the NHS Board Meeting in January when it is hoped to make a decision regarding the preferred option.

2.0. Case for Change

An alternative means of providing mental health inpatient services for East Berkshire patients has been sought for a considerable time: there is a clear consensus that the existing arrangements on three separate sites, in accommodation which does not allow for single rooms, ensuite facilities and safe access to outside space is not an acceptable standard of provision for patients, and is likely to compromise clinical outcomes.

Numbers of people requiring mental health inpatient services have continued to decline, and with the benefit of additional community services, and improvements in quality and productivity, it is likely that this trend will continue.

This trend leads to the increasing perception of mental health inpatient services as a specialist provision, rather than the dominant feature of mental health services which was the case in previous years. The proportion of people receiving mental health services who require inpatient services is growing smaller, but there is a corresponding growth in acuity and the level of risk presented. This adds further weight to the requirement for a specialist environment to ensure patients' needs are met effectively.

The additional engagement work undertaken has confirmed a good level of understanding of the case for change among stakeholders. However, it was also clear that in some cases there was a limited understanding of the nature of mental health inpatient services, the numbers of patients involved and the needs of individuals and families. For some stakeholders, concerns remained about the distance of Prospect Park Hospital for patients and their families, the nature of any transport support available and planned community service development. There has been additional debate about the impact of investment in inpatient services which would result in a reduction in community service availability- and this factor has been decisive for some stakeholders supporting option 1, the consolidation of all inpatient beds on the Prospect Park Hospital site.

Given the lack of consensus about the future model of service provision, work was undertaken to agree criteria on which the decision could be based, and a Commissioning Statement for Mental Health Inpatient Service was developed and approved by the East Berkshire Mental Health Local Implementation Team. This group includes commissioner and provider representatives of NHS and Local Authorities, as well as clinicians and the local advocacy service provider.

Detail of the community service development and transport support proposed, should option 1 be approved, is included at appendix 1 and appendix 2, criteria for decision making at appendix 3 and the work undertaken to explore the clinical evidence base is provided at appendix 4.

3.0. Clinical and Stakeholder Engagement

At the request of the East Berkshire Clinical Executive Committee (the PCTs primary decision making group, comprising Clinical Commissioning Group Leads and members of the Cluster Executive),

additional information was requested on the detail of the community service provision and transport support offer planned by BHFT in association with option 1, the consolidation of all inpatient services on Prospect Park Hospital site.

In addition, Slough CCG requested that additional work be undertaken to ensure all East Berkshire options had been fully explored, and that service user experience was strongly informing decision making. The East Berkshire Mental health Lead GPs have been involved in this additional work throughout. A summary of the results of the additional work requested is provided below in section 4.

A number of meetings have been held with Health Scrutiny Committees, with Lead Council Members for Health and Social Care, with LINk representatives etc, to listen to concerns, to provide information about options and to inform the next steps. This has enabled a greater understanding of the clinical case for change and evidence supporting different options, resulting in a higher level of support for option 1 from some groups than previously identified. However, concern remains about the potential impact on service users and their families, and further work is planned in terms of stakeholder discussions to ensure that all concerns expressed are properly addressed – in particular the viability and costs of refurbishment of East Berkshire sites to provide an East Berkshire inpatient facility, and mitigation of adverse impacts of option1, should this be selected.

4.0. Community Service Development

4.1. Older Adults

Dementia Plans have been approved by all three East Berkshire Clinical Commissioning Groups and a Dementia Local Implementation Team is in place in each of the three Council areas. Service development currently in progress represents £347k additional investment in East Berkshire.

This has 3 main components for older people with mental health problems:

- Home Treatment. To be available 7 days a week for people with either dementia or functional mental illness. This service will be available for a period of 2 – 12 weeks, depending on need, with visits up to 3 times a day.
- Memory Service. Including early diagnosis and nurse prescribing.
- Day Hospital redesign. In line with the approach taken in West Berkshire, this will release resources to fund the first 2 components of the plan, and be replaced by a programme of evidence-based, time limited interventions. This will include understanding dementia courses for carers and cognitive stimulation for service users.

Staff will be recruited to enable Monday –Friday service provision by the end of December. Extended hours services will be available in all three Council areas. A specification for a Dementia Liaison Service is currently being developed, to reduce length of stay in acute hospital wards, and signpost patients and families to sources of help.

4.2. Adults of Working Age

The Next Generation Care Programme includes a number of components to improve productivity and efficiency, including a common point of entry and a focus on improvements to urgent care.

BHFT has also provided detail of a potential investment of £207k for the establishment of a community service for people with a personality disorder in Slough, should option 1 be selected.

The rationale for this is the large number of people with a personality disorder accessing Ward 10 at Wexham Park Hospital, and their length of stay: Approximately 30% of the total BHFT in-patient

population have a personality disorder/Borderline Personality Disorder as part of their psychiatric formulation. NICE guidance suggests that in-patient admissions should be very short; however some of this client group are amongst the longest stays. In BHFT mean length of stay in an acute ward is 33 days. Patients with a personality disorder often remain longer because of risk. This can be 50 days or more. Last year there were 1040 admissions to BHFT acute wards, of which it is estimated 340 involved people with a personality disorder/BPD.

Ward 10 at Wexham Park Hospital has 20 beds used by approximately 168 patients in the last year. The current consultant psychiatrist for the ward estimates 40% of patients in ward 10 have personality disorder / BPD. This would mean approximately 67 patients with this diagnosis per year. The current mean length of stay for these clients is 56 days. This is 23 days over the Trust average.

Anticipated benefits of the service are detailed as follows:

- It is anticipated that the new service would provide both an early intervention and a basis for longer term recovery work that would result in fewer admissions and a reduced length of stay for this client group. This will be achieved by a service that would have the skills and capacity to meet the needs of people with personality disorder to a much greater extent than currently.

- People will experience a preferred method of service delivery much more capable of meeting their needs.

- The children of people who use the services are likely to experience a happier and more secure upbringing. Therefore, there is a reduced likelihood of local authority care and a decrease in the probability that they will themselves experience future problems.

- There will reduced use of GP, ambulance and A&E time because of less medication, distress and self harming.

- Reducing substance misuse as the service directly works with the reasons why this form of self-medication was used.

- Increased opportunity for individuals to find pathways into work and other positive ways to contribute to their town and society.

Illustrations of the way this service would work in practice are provided at appendix 1.

4.3. Transport Support

A Transport Solution Group was established by BHFT to address the high levels of concern regarding transport difficulties which could be experienced by patients, relatives and friends, should option 1 be selected. The group identified that solutions must:

- Be easily accessible including at weekends and during unexpected admissions.
- Be affordable for both relatives and carers (including those on a low income) and for the Trust
- Support relatives and carers by not adding any unnecessary stress or anxiety
- Be sustainable

Proposed solutions are as follows:

- Identification of a £100k, recurrent budget to provide transport support.

- Contracting with community transport providers who would provide transport for visitors to Prospect Park Hospital. Potential providers have been approached and agreement in principle to the viability of this proposal secured.

- Providing bespoke, individualised solutions for people who are unable to access the community transport services, which would include fuel subsidy if required.

  Illustrations of the way this service would work in practice are provided at appendix 2.

5.0. Additional Options Exploration

Work was commissioned from BSS by the PCT to identify potential alternative sites for provision of acute inpatient services in Slough, in partnership with GPs. In summary these are as follows:

- A stand alone acute inpatient unit in Slough, which was confirmed as not viable because of risks associated with its isolation: a limited staff group would not be able to provide the full range of therapeutic interventions to promote recovery, management of risk to patients and others would be compromised because of the small staff group who would be likely to be difficult to recruit and retained. This option was not supported by the clinicians with experience in acute inpatient care.
- In addition, the potential for a Slough/Windsor and Maidenhead only option has been explored, potentially on the Heatherwood site, but not supported by BHFT clinicians or Windsor and Maidenhead GPs.
- BHFT has also considered what could be provided in Slough with a residential component in order to answer the concerns raised by local GPs. The potential for commissioning of local independent sector provision has been considered by BHFT and also local GPs, but not supported as a viable alternative on either grounds of cost or clinical evidence. However, further discussions are taking place to identify the extent to which Nursing Home provision could support the care and treatment of people with dementia, to minimise the need for hospital admission.
- Options of refurbishment of accommodation at Wexham Park, Upton Hospital or Heatherwood have been further queried by stakeholders. To date this has not been identified as financially viable, and a formal report will be provided to the CCGs and Cluster Board by Berkshire Shared Services to outline the factors which have informed this position. Discussions will also be held between BSS representatives and Slough LINk to ensure sharing of this information with the wider stakeholder group.

6.0. Service User Experience

Public Consultation identified no strong preference for any of 3 options consulted on. Responses were strongly linked with where people lived. 41% of respondents to the consultation survey were service users or carers. The patient survey conducted by BHFT strongly supported provision of single rooms and outside space.

Lack of privacy and dignity associated with shared rooms were emphasised by patients and carers.

The ability of family and friends to be able to visit easily was acknowledged as important, as well as the need to provide a quality environment with good treatment outcomes.

Service users requiring transfer to intensive care would need to be transported to Prospect Park Hospital from any East Berkshire Acute inpatient Unit if required – this is a challenging and potentially very distressing experience for patients and families.

Approximately 20- 25% of Slough residents requiring inpatient services already go to Prospect Park Hospital – and the PCT has not received any complaint from any of these people or their families about their experience. However, further work is being undertaken to identify the actual numbers of people involved and some detail about their experience, and what support may help them with the distance from their homes.

7.0. Financial issues

The cost of a new build facility on the Upton site was previously estimated at approximately £21m, which would require borrowing above the level of reserves held by BHFT. This would have a revenue impact of approximately £2m per annum.

A new build on Wexham Park site also has approximately the same cost – which has an annual impact of approximately £2m per annum because of the cost of borrowing required sums.

Exploration of possible conversion of Wexham Park Hospital accommodation is not in line with the Trusts own plans for use of its accommodation, but the cost of achieving this, were it to be possible, is estimated in excess of £10m, with corresponding revenue impact. The cost of equivalent refurbishment on Heatherwood or St Marks sites is estimated as a similar figure.

Cost of changes required to Prospect Park Hospital would be approx £5 - 6m. This funding is already available within BHFT budget, having been built up over a number of years, as a one-off sum to support anticipated necessary changes to inpatient services.

Consideration of all options needs to be in the context of the savings plan that BHFT is already embarking on, in order to meet demand and continue to provide effectives services. This requires achievement of a savings target of £12m over 3 years. A recurrent savings assumption of £1.9m resulting from consolidation of beds at Prospect Park Hospital has been included in this plan.

Any additional investment required, or loss of currently identified savings would not necessarily impact on community service provision. Should this be the case, agreement would be required regarding the apportionment of savings, both geographically and in terms of service functions, taking into account the relative merits of investment in community and inpatient services.

8.0. Decision making process and next steps

During the additional engagement work undertaken this summer and autumn, a Gateway Review was undertaken. One of the recommendations of the review being that a commissioning statement was completed for mental health inpatient services (referred to in section 2 above). This has now been completed, and approved by the Mental Health lead GPs and the East Berkshire LIT. The vision for mental health inpatient services is as follows:

To offer time-limited safety, support and therapy to people who are too unwell, and present too high a level of risk to themselves or others to be cared for outside hospital. To achieve this by providing a range of therapeutic and other activities in a good quality environment, with the aim of supporting recovery and return to the community as soon as possible

The criteria for potential changes to mental health inpatient services are included in this commissioning statement and attached at appendix 4. This document will also be used to inform the Cluster Board decision making process.

Since commencing the additional engagement work, there has been an increased mutual understanding of stakeholder concerns and the clinical evidence and financial considerations underpinning the various options. The following actions will be completed prior to the January Cluster Board discussion:

- Publication of the results of the engagement work undertaken – which will include: a fact sheet about mental health inpatient services, information about community service and transport support should option1 be selected, and an overall summary of the engagement work – issues identified and the response to them.

- Provision of further information about the costs of refurbishment options on various sites to the Slough CCG and the stakeholder group pulled together by the Slough LINk.
- Further discussion about the community service offer and how this can be developed to minimise the need for admission as far as possible.
- Collation of the formal position of each of the CCGs, the Clinical Executive Committee and Health Scrutiny Committees prior to the Cluster Board meeting in January.

Bev Searle. Director of Joint Commissioning, NHS Berkshire.

Appendix 1.

Proposed Community Service for People with Personality Disorder – case illustrations

24 year old Ms T has very low self-esteem, having been emotionally and sexually abused as a child. She has been unable to develop healthy long term relationships with other people. Her inability to maintain relationships has resulted in her not working, being cut off from her wider family and a number of short term sexual contacts. She has a 3 year old child and lives on a local estate in Slough. She self-harms through cutting as a daily occurrence and has a history of overdose when encountering emotional problems. She has been admitted to psychiatric hospitals on 4 occasions in the last three years. On the last occasion she spent 50 days as an in-patient as the risk was deemed too great for her to be discharged. When in hospital her self-harming escalates and her sense of hope and future is diminished.

Following discharge she had previously had been followed up through routine psychiatric outpatient appointments and a nurse who as care co-ordinator monitored her mental state, risk and provided support at times of stress. In the past this hasn't been sufficient to prevent admissions or help her improve her quality of life. Concerns about her ability to care for her daughter are ever present and she fears losing her.

Ms T was helped by the **new proposed service** that provided her with the following opportunities:

- A care co-ordinator experienced in working with people with personality disorder who was able to help Ms T manage her emotions, self harm and unhelpful behaviours through the use of dialectical behaviour therapy (DBT). Working together to produce a Wellness Recovery Action Plan (WRAP) which highlighted what she wanted from life, a relapse prevention plan, a plan for crisis and an advance directive should she require admission to hospital.
- Putting her in touch with 'Growing Better Lives' a local horticultural and animal care project wanting to work in partnership with statutory services. This gave her a more secure sense of attachment to a place she could regularly go to with people who were sympathetic to her 'story'.
- It became apparent that she needed to do more in-depth therapy work, about her long history of trauma and abuse, to truly recover from it. She joined and successfully completed the intensive treatment programme facilitated by a clinical psychologist whilst keeping involved with her friends from 'Growing Better Lives' throughout.
- A crèche facility was supported by local authority personalised budget funding when Ms T was at the project, when she had appointments or when she felt or predicted a period of stress.

After the therapy, the work looking after animals gave her a real sense of fulfilment. Her confidence increased, she enrolled on an animal husbandry courses and intended to pursue a career on a farm.

Ex-service man Mr A has spent the last 3 months in hospital following a failed attempt to kill himself through drowning. He remains adamant that he will kill himself. He does not participate in ward activity and refuses medication on a regular basis. He suffers from emotions associated with his experiences of being in the Army; however, he does not suffer from PTSD. When he is at home he avoids social contact. He describes people as irritating him and he is worried about losing his temper. He self-medicates with his use of alcohol.

Mr A was helped by the **new proposed service** that provided him with the following opportunities:

- Supported by the Trust positive risk panel a care plan with the new service design was formulated.

- Along with a care co-ordinator a support, time recovery worker (STR) engaged with Mr A and discussed his interests and hobbies. Mr A is a fisherman and football supporter. The STR worker had enjoyed a similar rapport and wasn't long before Mr A had joined the Slough All Stars football and cricket teams.
- Mr A was put in touch with Mr B who also uses our services but had volunteered to help other people with emotional problems. Mr B had previously been in the forces as well. They both acknowledged with one another that it took another serviceman to understand their experiences.
- 6 months later he asked his care co-ordinator if he could see a therapist as he wanted help to understand why he was experiencing problems and to explore how he could move on.

Appendix 2.

Illustrations of proposed transport support

1. Mrs B (aged 75) lives in Langley with her son, who is a long standing user of mental health services and has had several previous admissions to hospital. He is admitted to hospital as part of a planned admission. Mrs B does not drive and but wishes to visit him whilst he is there.

2. Mr C (aged 83) lives in Maidenhead and has been admitted to hospital for further investigations as he becoming increasingly confused. Mrs C is understandably worried and wants to visit daily. The admission has happened late on a Friday evening. Usually her daughter (who lives nearby and drives) visits her parents at weekends but this weekend she is away.

The proposed transport solution:

Mrs B is already registered with the Community Transport Scheme. She calls the booking centre on Thursday and arranges to be picked up to visit her son on Saturday and then every other day. She wants to be there for the afternoon.

The booking centre confirms that the mini bus will pick her up between 12.30 and 1 o'clock. She agrees with the centre that she wants to be home about 7.30 p.m. and so arranges for transport back home between 6 and 6.30 from the hospital.

Mr C has not been admitted before. When the CPN who arranged the admission visited he explained to Mrs C about the community transport scheme and gave her a contact card with the out of hours number so that she could arrange to be picked up the next day. (She has also been given all the ward contact details so she is able to keep in contact with the ward and her husband in the meantime.)

Mrs C calls the out of hour's service, who on checking the schedule, confirm that there is a mini bus already making that journey the next day. The contact centre confirm with Mrs C that she will be picked up between 1 and 1.30 p.m. They also ask her whether she wants to arrange transport for Sunday and Monday as it is the weekend and this is done.

The mini bus that is scheduled to pick up Mrs B then calls to pick up Mrs C on the way to PPH.

3. Ms H from Slough is a mother with 2 children of school age. She lives with her partner. The family are on a low income and receive benefits. Her partner Mr J drives but the additional cost of petrol would make the journey unsustainable.

The proposed transport solution:

The family receives income support and housing benefit therefore Mrs H's partner is eligible to take advantage of the community transport scheme. However, because there needs to be a certain amount of flexibility in the dial a ride service times he could not guarantee being back in time to care for the 2 children.

The CPN provides the information leaflet on the Community Transport Scheme which also has details for the Reimbursement Scheme for which he is eligible if the Community Transport Scheme is not an option. Mr J is then able to claim a mileage allowance for the additional mileage.

4. Mr K lives in Slough and generally works full time. His long term partner works in London. Both people drive. Mr K requires a short admission. The family are not in receipt of any benefits.

In this vignette neither Mr K nor his partner would be eligible for the community transport scheme. Although, through their relationship with Mr K's Care Coordinator, any specific concerns or issues could be discussed, with the aim of supporting communication and contact during Mr K's admission.

Appendix 4.

Mental Health Inpatient Services: Commissioning Statement. October 2011.

Criteria for Decision Making on Proposed Service Changes

1. Clinical Evidence Base

This should be clearly demonstrated, and be supported by the majority of clinicians involved.

Service change proposals should represent provision of safe, effective services, where the physical environment promotes good outcomes for patients.

Proposals for change should effectively balance an understanding of current need with demographic change and analysis of the impact of continued development of community based services.

Proposals for change should enable the care pathway to be enhanced, fostering close and collaborative working between inpatient and community services.

Proposals should facilitate compliance with statutory requirements of the Mental Health Act (including arrangements for APOS and Intensive Care provision)

National guidance should be used to inform local proposals, which should describe the extent to which specified standards and criteria will be met.

Proposals should support the achievement of performance and quality targets.

2. Support of Clinical Commissioners

Developments should be supported by the majority of the 7 Clinical Commissioning Groups in Berkshire, including their non-GP Members, at the relevant level of federation.

3. Promotion of choice for patients and improved patient experience.

Services should be locally accessible wherever possible and centralised where necessary.

Choice of provider for mental health inpatient care is not at present a NHS policy aim due to the benefits of integration with social care and the operation of the Mental Health Act. However, proposals for service change should outline the interaction between the proposed service environment and treatment and care provided.

Proposals should also demonstrate how service user and carer experience will be enhanced, as well as mitigation of any adverse impacts. This should include understanding diversity and mitigation of inequalities.

4. Engagement of public, patients and local authorities

Proposals for major change should include required engagement and consultation, the findings of which should inform their development and plans for implementation.

For major service change proposals, review by appropriately qualified external advisors should be undertaken, and recommendations used to refine proposals as required.

5. Value for Money

Financial impacts of proposals should be clearly demonstrated in project documentation or an Outline Business Case as appropriate.

Financial analyses should take into account any differential impacts between Clinical Commissioning Groups and/or be agreed at the appropriate level of "federation" with the Director of Finance for NHS Berkshire, before Board approval.

Appendix 5

Clinical Evidence Base

A review of the clinical evidence relating to Mental Health Inpatient Services was undertaken by the Public Health team at NHS Berkshire. The key points identified are as follows:

- Emphasis is on the provision of treatment in patient's own homes as far as possible, to achieve the best outcomes. This includes patients of all ages.

- Provision of single bedrooms with en-suite facilities is the optimum environment for inpatient services, ensuring patients are treated with respect and dignity.

- Consideration of travelling distance should be included in decision making about service provision.

- The physical environment is an important component of treatment and a poor environment can have a detrimental impact on patients.

Also, a brief review of development plans currently in progress in other parts of the country was undertaken, to identify issues in common and potential learning points:

- Future plans in Lancashire have identified the need for more personalised support, and a network of community and hospital based services. The "specialist" nature of inpatient care is highlighted and a reduced number of inpatient sites is planned to correspond with reduced demand, and increased provision of community services. Evidence and independent review supports improved outcomes for people receiving treatment in community settings. The impact of increased community service investment has resulted in reduction in the original estimate of inpatient service need.
- Manchester services have planned to consolidate onto 2 sites, following consultation in 2010. The objectives were to provide same sex accommodation, improved staff response as a result of the physical environment and improved user and carer experience.
- Central and North West London Foundation Trust has experienced reduced demand in need for inpatient services for older adults, with the development of community services. This has identified an inpatient service requirement 60% less than existing provision. The aim is to provide a single centre of excellence for older people on one site rather than the existing 2 sites.

In addition, a meeting was held with senior clinicians from BHFT (Consultants for both older adult and adults of working age services) and the three GP Mental Health Leads for Berkshire, along with senior managers of BHFT and PCT Commissioners. The BHFT Clinicians strongly supported consolidation of inpatient services on a single site in order to achieve the best clinical outcomes for patients. Their experience of the increased provision of community services is that requirement for inpatient services is reducing, in line with other areas of the country (see above). Clinicians recognise the need for locally accessible services – but see inpatient provision as a specialist function, for a small minority of patients (approximately 2% of adults of working age receiving support from Community Mental Health Teams, and the total number of patients of all ages requiring inpatient treatment at any one time equates to approximately 20 from each of the East Berkshire Council areas).

BHFT clinicians confirmed their view that better outcomes would be achieved for patients if they were treated in an environment which enabled access to outside space, provided single bedrooms, enabled flexible and sustainable staffing and provided access to therapeutic activity throughout the week.

Finally, the Director of Joint Commissioning visited Ward 10 at Wexham Park Hospital on 2 occasions – once with a member of the PCT Contracting Team, and once with the Mental Health Lead GP for Slough and a Governor of BHFT. The aim of this was to both gain a better understanding of the physical environment, and speak to service users and staff about their views.

The key points from this discussion were:

- The quality and safety issues resulting from the physical environment, which present a significant challenge. This includes the requirement for staff escorts for patients when they wish to access outside space, the shared bedroom accommodation (both male and female areas include areas where up to 4 people share a room), the reduced number of staff able to respond to calls for urgent assistance as a result of the ward being an isolated unit and the difficulties presented as a result of the distance to the Intensive Care Ward at prospect Park Hospital when the most unwell patients require transfer.
- The ability of family and friends to be able to visit easily was acknowledged as important, as well as the need to provide a quality environment with good treatment outcomes.
- The staff highlighted the work that had been done to improve the environment, but stressed that the building presented a number of problems which could not be overcome by further work – e.g. lines of sight were poor, thus making observation of patients difficult, some patients reported feeling unsafe on the ward because of the shared rooms, temperature control was difficult and work to remove ligature points reduced natural light in certain areas.
- The staff confirmed that they believed that nursing patients in purpose built environments with single rooms and ensuite facilities was the required quality standard for patients.