Statutory Joint Scrutiny Committee

Thursday, 20 July 2006 4.00 p.m.
Town Hall, Runcorn

AGENDA

In accordance with the Health and Safety at Work Act the Council is required to notify those attending meetings of the fire evacuation procedures. A copy has previously been circulated to Members and instructions are located in all rooms within the Civic block.

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Agenda Item 1

St.Helens Council

HALTON BOROUGH COUNCIL

Warrington Borough Council

Town Hall, St. Helens, Merseyside, WA10 1HP
Telephone 01744 456110 (Tina Molyneux)

Agenda

STATUTORY JOINT SCRUTINY COMMITTEE 5 BOROUGHS PARTNERSHIP NHS TRUST

Proposals Relating to Improving Services for Adults with Mental Health Needs in Halton, St. Helens and Warrington

Date: Thursday, 20 July 2006 Time: 4.00 p.m. Venue: Runcorn Town Hall
Hall Heath Road
Runcorn, Cheshire WA7 5TN

Membership

Halton	**3**	**Councillors**	**Cargill, Inch and Loftus**
St. Helens	**3**	**Councillors**	**Bowden, McGuire and Stephanie Topping**
Warrington	**3**	**Councillors**	**Banner, Hoyle and Johnson**

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Meeting to Discuss Proposed Creation of

Statutory Joint Scrutiny Committee to Consider

5 Boroughs Partnership NHS Trust

Proposals Relating to Improving Services for Adults with Mental Health Needs

In Halton, St Helens & Warrington

Terms of Reference

1. To establish a statutory joint committee to scrutinise proposals from the 5 Boroughs Partnership NHS Trust to improve services for people with mental health needs in the boroughs of Halton, St Helens and Warrington.

2. To undertake the scrutiny of the proposals in accordance with the Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002, and the Directions to Local Authorities (Overview and Scrutiny Committees, Health Scrutiny Functions) July 2003.

3. To complete a report outlining the statutory committees views of the proposals and to make recommendations to the 5 Boroughs Partnership NHS Trust where relevant.

4. To monitor the Trust's responses to the report and agree mechanisms for the ongoing monitoring of future changes to mental health services.

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REPORT TO:	Executive Board
DATE:	20 July 2006
REPORTING OFFICER:	Strategic Director, Health & Community
SUBJECT:	5Boroughs Partnership NHS Trust Model of Care
WARDS:	Borough Wide

1.0 PURPOSE OF REPORT

1.1 To provide members with an assessment of the 5Boroughs Partnership Model of Care proposals, highlighting the key issues for the Council to consider.

2.0 RECOMMENDATIONS:

i) **It is recognized by the Council that the model proposed provides a sound platform to modernise mental health services and is proven elsewhere in the country. However, given the current lack of information and data provided by the 5 Borough Partnership NHS Trust and the uncertainty about the funding issues, there are at present significant doubts that this model can be delivered without a major impact upon the Council's services and resources. It is recommended therefore that the 5 Boroughs Partnership NHS Trust be invited to respond to the outstanding matters contained in the recommendations within the attached report in Appendix 2. If these matters are not addressed to the Council's satisfaction the Council reserves the right to refer this to the Secretary of State for Health.**

ii) **The report and the recommendations form the basis for the formal response of the Council to the proposed changes.**

iii) **Authority be delegated to the Deputy Chief Executive in consultation with the Deputy Leader to deal with any further information received after the Joint Scrutiny meeting up to the deadline of 24 August 2006.**

3.0 SUPPORTING INFORMATION

3.1 The Model of Care – the context

3.1.1 <u>The Model:</u>

3.1.2 In the Autumn of 2005 the 5BoroughsPartnership NHS Trust ("the Trust" for short) began the process of developing a new model of service delivery, now known as "Modernising Mental Health services: Improving Value through Transformation - Business Case for a New Model of Care" ("Model of Care" for short). This model is for adults of working age and some older people, and does not relate to people with learning disabilities or children and young people. The Model is now subject to formal public consultation until 24 August 2006 and was subject of a Special Health Halton Policy and Performance Board meeting on 10 July 2006. In addition, Warrington, St. Helens and Halton Council's have convened a Joint Scrutiny Board to scrutinise the proposals, recognising that they constitute a significant variation of NHS services. Their scrutiny programme will be completed by 14 August 2006.

3.1.3 The Model of Care proposes significant changes to the design and delivery of services across the four Boroughs of Halton, Warrington, St Helens and Knowsley.

3.1.4 It should be stressed that the Model of Care is developed in the context of a significant financial imbalance for the Trust, and it is acknowledged by the Trust that this is one of the key drivers for change. However they stress that the Model of Care has also been developed in order to modernise in accordance with national and local guidance and commissioning priorities.

3.1.5 The Model of Care, as presented by the 5Boroughs,is based largely on an approach developed in the Norfolk and Waveney Mental Health Trust in East Anglia. Contact has been made with staff from that Trust, who say that it works well – emergency psychiatric admissions have been reduced, lengths of stay as inpatients have reduced and staff say that they are very happy with the model. It should be noted however that all of this is anecdotal – the model has only been operational for less than a year and there has been no formal evaluation of its effectiveness.

3.1.6 The key features of the proposals are:

- A change in emphasis of service delivery from treatment and maintenance to recovery and social inclusion.
- The development of Resource and Recovery Centres in each locality, which combine inpatient services with the new Crisis Resolution/Home Treatment service. This more intensive approach is intended to be much more flexible and needs-led.
- Delivery of a reduced but more focused range of day therapies which provided directly alongside inpatient services.
- Provision of Access and Advice Teams which will act as gatekeepers to the new service. Tighter and more focused eligibility criteria will be developed which will determine the people who will be accepted by the service.

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3.1.7 Community Mental Health Teams (CMHTs), Assertive Outreach Teams and Early Intervention in Psychosis will continue to deliver services to the local community. Some of the current functions delivered by CMHTs - such as specific types of therapeutic interventions – will be transferred to therapists working in the Resource and Recovery Centres. The focus of CMHT work will be to support people with long-term conditions to maximise their well-being, recovery and choice about therapy.

3.1.8 In addition the Model of Care proposes establishing dual diagnosis workers – working with people who have both mental health problems and substance misuse issues. This is a national requirement and represents an enhanced service for this group of people.

3.1.9 The Model was initially developed in isolation from partners, although once formulated there has been discussion about local details. The effect of this appears to be that essentially only two options are being put forward for Halton by the Trust – acceptance of the model as presented or closure of the psychiatric wards in Halton. Although the Model of Care references consideration of other options this is not evidenced, and no evaluation of these options has been presented.

3.1.10 There are a number of other models and approaches, both locally and nationally, that could have been considered. As an example, in Older People's services in Halton an effective and cost-efficient Intermediate Care service has been developed, and this is an approach that could translate easily into mental health services – there is no suggestion however that this kind of approach has been considered or discussed with partners.

3.2 The Impact Assessment

3.2.1 <u>The Process:</u>

3.2.2 A joint impact assessment on the Model of Care was conducted by representatives of Halton Borough Council and Halton PCT. Senior staff from the Trust attended all the meetings to clarify issues as they arose. Meetings with the Portfolio Holder, Health and Social Care, Member of the Health PPB, Senior Council Officers, Halton PCT and the Trust have also met to explore the key issues. Impact assessments conducted by both St Helens and Knowsley were also used as source material. The full Impact Assessment and recommendations is therefore contained in Appendix 1.

3.2.3 As a model of service delivery, the consensus across health and social care services is that it will deliver positive outcomes for people who use services and is also likely to be both more efficient and more effective. There are three key issues which members will need to consider

- Financial implications arising from the Model of Care and potential for additional investment from the Council
- Care Pathways – comparing the way people who use services currently receive those services with the likely approach after the implementation of the Model of Care
- An assessment of the wider impact on the whole system of mental health services

4.0 POLICY IMPLICATIONS

4.1 The proposed model supports the general direction of national policy in mental health services, which aims for less use of inpatient services and greater inclusion of people with mental illnesses in their local communities.

4.2 The Trust states that the proposed Model meets the requirements of the Policy Implementation Guide (PIG), which sets out in detail the structures and operating policies of Community Mental Health Teams, Crisis Resolution/Home Treatment Teams, Early Intervention in Psychosis Services and Assertive Outreach Teams.

4.3 In addition, the National Service Framework for Older People requires that older and younger people with severe mental illnesses should not be treated together in the same environments, as this heightens the risks for Older People. The Trust says it can redesign one of the wards to take this into account and is prepared to commit capital expenditure to this; it has however not revealed how this will be done. In particular it is not clear how these groups of people will be kept separate in any day settings.

4.4 It is also clear that the Council will need to work closely with the Primary Care Trust to develop shared policies and protocols in a number of areas such as joint funding arrangements

5.0 FINANCIAL IMPLICATIONS

5.1 Appendix 1 outlines the financial considerations in some detail. It is clear from this that there may be a significant financial impact on a number of areas within the Borough Council through an increasing demand on community and mainstream services. These areas include:

- Infrastructure costs for housing and floating support services to support the model.
- Increased pressure on the Community Care Budget as more people require community based services than before
- Increased pressures on contracted services – particularly in residential and day care – to take people no longer catered for by the Trust.

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- Additional funding for front line staff to support the model.

5.2 It is not possible to specify how much additional resource would be required because of the vagueness of some of the information provided.

5.3 There are also potential financial risks to the St. Helens and Halton PCT. These risks include:

- A potential increase in the use of out of area placements (at greater cost) arising from a shortage of local bedspace
- Removal of an alcohol detoxification bed (which had never been previously funded by the PCT)
- Transfer of the management of a substantial number of people to primary care from the Trust.
- Transfer of responsibility for the management of higher cost treatments (known as "atypical medication") to primary care services.

6.0 OTHER IMPLICATIONS

6.1 It is likely that the eligibility criteria for community mental health services provided within the Trust will need to tighten. This will mean a greater impact on staff within existing community services to absorb the shortfall.

6.2 In addition, it is unlikely that the Model will be fully implemented in the timescales put forward by the Trust and it is not clear how the project management of the changes will be affected by this, or what transition arrangements would be put in place. To be successful, there will need to be significant changes in local community services which will take time, and which will need robust partnership work and project management between the Council and the PCT.

6.3 Further detailed work would need to be undertaken on the impact on post 16 children who require mental health services.

7.0 RISK ANALYSIS

7.1 There is a risk to the Council that the closure of beds, the changes in eligibility for community services and the significant reduction in day services will place increased demands on community services within the Borough. It is recognised that Halton has a low base of such services and would need to work closely with the Primary Care Trust to strengthen this base over a period of time.

7.2 The rapid decrease in beds, if not managed through close working together will increase the numbers of patients placed out of borough. Current arrangements between the PCT and the Council are not sufficiently robust to manage an increase in such numbers. The

Council's Community Care budget for mental health services is already fully committed for this year.

7.3 There is a lack of appropriate in borough accommodation to support mental health service users, for example through crisis beds, supported accommodation and floating support. An increase in such resources will require additional funding.

7.4 The proposals set out that the numbers of residents currently receiving a service from the Community Mental Health Teams will decrease significantly. However, it is likely that these same people will still require a service from mainstream council services such as housing or benefits advice. Currently the council does not have the capacity to meet these additional needs.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 "Change for the Better" intends that services should be delivered equally to all groups. However, there will for a time at least be a different response to groups of older people, depending on their diagnosis. This goes against the national guidance from the National Service Framework for Older People. All Halton residents will continue to need to receive appropriate and safe mental health services delivered locally

9.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

Document	Place of Inspection	Contact Officer
Halton Joint Commissioning Strategy for Adults of Working Age with Mental Health Problems	Municipal Building Widnes	Dwayne Johnson Strategic Director Health & Community
4 Boroughs Commissioning Strategy for Adults of Working Age	Municipal Building Widnes	Dwayne Johnson Strategic Director Health & Community
4 Boroughs Commissioning Strategy – Securing Better Mental Health for Older People	Municipal Building Widnes	Dwayne Johnson Strategic Director Health & Community

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Appendix 1

5BOROUGHS PARTNERSHIP MODEL OF CARE

1.0 Financial and Service Impact Assessment

1.1 The reduction in the investment by the Trust in mental health services in Halton is substantial, and is significantly more than the other areas within the Trust's catchment. For Halton, the Trust states that, under the Model of Care, they would invest £1,899,123 less than their stated current position now. For Knowsley there would be a reduction of £1,788,767, for Warrington there would be £1,330,001 less investment, whilst in St Helens there would be an increase in investment of £404,862.

1.2 Similarly, the impact of the proposed changes arising form the Model of Care on service delivery in Halton is substantial and should not be underestimated. In terms of reductions in beds, two wards – one in Older People's Services, the other for Adults of Working Age – will shut.

1.3 This will leave 38 beds for adults of working age and older people, a reduction of 31 from the current total of 69. By comparison, Knowsley will see a reduction of 3 beds (from 36), St Helens will lose 11 (from 44) and Warrington will lose 14 (from 46). It should also be noted that current bed occupancy in the Halton area runs at 110%, with a number of people additionally having to be funded for placements out of area.

1.4 The rationale for this comes from:

- An annual submission by the Halton Mental Health Local Implementation Team to the Strategic Health Authority on the total expenditure by PCT and Borough Council on mental health services. This is done by all localities and had always previously shown that Halton performs badly in terms of investment in mental health services, when compared with similar areas. However, with little change in actual investment, the submission this year now suggests that Halton is in a very different position, particularly when compared with other Boroughs within the Trust's catchment. This is disputed locally as there has been no significant additional investment in mental health services and other areas have not disinvested. Nevertheless this is being used by the Trust as the basis to suggest that Halton invests disproportionately and can therefore "afford" to lose more.
- An estimate of the weighted population of the Borough, based on actual population and published deprivation figures, leading to a figure on bed reduction across adults of working age services and older people's services. However this weighted population does

not take into account older people even though older people's beds are reduced.

1.5 From the calculations done by the Trust, Halton should have a reduction in bed space of around 30%. The actual reduction is 42.5%.

1.6 It has proved very difficult to obtain detailed information on the financial situation from the Trust. The Trust states that the services that they currently provide for Halton cost around £2million more than they are actually given by the service commissioners, although recently information has been made available on the costs and subsequent impact of providing services to residents from Helsby and Frodsham.

1.7 The lack of detailed and appropriate financial transparency has made it impossible to verify this, or indeed to form a clear view as to whether the financial assumptions that underpin the proposals are sound. Borough Commissioners should be able to map the flows of investment in current service configurations against the proposals in the Model of Care.

1.8 It is also the case that the financial information that has been presented by the Trust is global and does not differentiate clearly between investment in Older People's and Adults services.

2.0 Impact on budgets:

2.1 Community Care Budget: the Trust have suggested that they have, for some time, dealt with a significant number of people who have not got severe and enduring mental illnesses which require their support, but who they have nevertheless supported because of lack of other services. Under the Model of Care this will not be able to continue as the eligibility criteria for the service will be much tighter.

2.2 It is inevitable that a proportion of these people – who will not currently be getting a social care service – will be eligible for an assessment of need under the NHS and Community Care Act and may well be entitled to services. Unfortunately the Trust have not provided a clear indication of the extent to which Local Authority community services will bear this additional work, and so it has not been possible to develop a clear picture of the financial risk to the Authority.

2.3 Similarly, many of the people who have been supported – through existing day hospital services for example – will in the future be the sole responsibility of Primary Care services. It is well established that current Primary Care mental health services are overstretched and there are significant waiting lists for some types of service. It is likely that there will be a greater demand for Primary Care services than before.

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2.4 It should also be noted that Halton PCT has already committed an additional £450,000 to the Trust, but it is not clear from the financial information provided by the Trust whether this has been taken into account in the service model.

2.5 Transitional funding: across the Boroughs affected by the Model of Care, the proposed change programme will require transitional funding, estimated by the Trust to be £925,000. The Trust expects to provide £250,000 of this, with the residue of £675,000 provided by the PCTs. It is not clear from the Model of Care, or the consultation, how this will be apportioned.

3.0 Impact Assessment: Care Pathways

3.1 General comment:

3.1.1 In terms of the care pathways for people who receive services provided under the Model of Care, it is clear that these services would be more intensive, more designed to promote social inclusion and recovery, and hence more responsive to individual need. There will also be a wider range of therapeutic interventions for some people

4.0 Older People:

4.1 People with a mental illness who are over 65 will also receive the approach described in the Model of Care and this will be an enhancement of the current approach for this group. However it is clear that people over 65 with dementias will not receive the approach proposed in the Model of Care and this will mean a differential response to the needs of this group.

4.2 People with less severe conditions

4.2.1 It is also clear that the Model of Care will require the rigorous application of eligibility criteria for people who will access the service. We have been informed that these criteria are currently being developed although we are not aware that there has been any attempt to develop these alongside partner organisations.

4.2.2 The clear implication from this is that people who have previously been dealt with by the Trust will no longer receive this service if they do not meet the new eligibility criteria. Whilst this may be right and proper, in terms of focusing the service on those with the greatest need and risk, it is unclear what care pathway will apply to this groups of people. As shown in 3.2.2, it may well be that the impact of support for this group falls more on the Local Authority than before.

5.0 Impact Assessment: Whole System Issues

5.1 Older People's Services:

5.1.1 In the most recent version of the Model of Care it has become apparent that Older People with a functional mental illness (as opposed to those who have a dementia) are also included in the service redesign. In Halton, the implications for this are that one of the Older People's psychiatric wards – with 14 beds – will close, and any older people with mental illnesses will be accommodated in the same wards as younger people.

5.1.2 This approach contradicts national guidance about minimising risks to older people by separating them from younger adults whose behaviour may be dangerous and volatile. The Trust insist that they can effectively redesign the remaining inpatient services to ensure segregation and safety, but evidence of this has not been produced.

5.1.3 The inclusion of older people with mental illnesses in the Models of Care will have an organisational impact on social care services. Caseloads will need to be moved across teams and there will need to be an analysis of caseload activity to ensure that this is equitable across services. Performance and financial data are currently collected on a basis determined by age and systems and procedures will need to be amended to take account of this.

5.1.4 It is also clear that men and women will be staying within the same ward-based setting, which is also contrary to national guidance. As with older people, the Trust states that it can maintain segregation by redesign of existing ward facilities but this has not been evidenced.

5.2 Social care input into the Model:

5.2.1 Concern has been expressed about the lack of social care input in key parts of the Model of Care – and in particular the Resource and Recovery Centre, which is entirely staffed by non-social care employees.

5.2.2 This suggests a model of care that is still dominated by a healthcare approach to treatment, rather than a more common approach which recognises the interplay of health and social care factors in mental health. This in itself poses risks to the service, in that key linkages into the community have less chance of being maintained without social care input – this in itself means that more intensive support (at greater cost) may be required on discharge.

5.3 Community services:

5.3.1 The Model of Care assumes robust community services which can initially prevent people from being referred in the first place or can

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receive them back into the community quickly and effectively. Without these services Resource and Recovery Centres – with their limited bed resource – will quickly fill up and people will have to be found alternative placements outside the Borough.

5.3.2 As examples of this:

- Many areas have community based crisis houses, where people who are in a mental health crisis can go instead of being admitted to hospital. National evaluations of such schemes have demonstrated very positive outcomes
- The provision of supported accommodation for people with mental health problems is a key element of community-based services. As part of the Supporting People programme the Office of the Deputy Prime Minister estimated that Halton needs between 45 and 130 supported places. It currently has 26, although this is itself a substantial increase from the previous total of 15, following the commitment to local mental health services of the Supporting People programme.

5.4 Children's Services:

5.4.1 The 5BoroughsPartnership Child and Adolescent Mental Health Services (CAMHS) are working closely with Halton PCT to deliver a comprehensive service that meets national proxy targets and address local need. This should result in enhanced provision for the CAMHS service which also includes people aged 16 – 16, so the reduction of beds proposed by the Model of Care – which only applies to Adults of Working Age - is considered to have few implications for children's mental health services. The CAMHS Partnership Board will continue to monitor this situation, however.

5.4.2 In addition work is going on to establish care pathways and transition processes for people known to CAMHS services who move to Adults Services as they get older. This work will not be affected by the Model of Care.

6.0 Other issues

6.1 Pace of change:

6.1.1 Halton area has been identified by the Trust as the first to implement the new Model of Care – it has been stated within the proposals that Halton will be the first of the areas to change and that the anticipated implementation date is 1st October 2006.

6.2 Frodsham and Helsby:

6.2.1 Currently, a proportion of local services in the Trust in Halton are provided to residents of Frodsham and Helsby. The money they

receive from this – believed to be £130,000 from Wirral and West Cheshire PCT – nowhere near reflects the activity provided by the Trust – indeed it now seems that patients from Frodsham and Helsby absorb around £1.3 million from the Trust each year in terms of activity and service use. From the perspective of local mental health services, this means that this amount of service has not been available for Halton residents. In addition, this is money that could otherwise have been invested to develop a stronger local community infrastructure in mental health services. This situation has apparently arisen from a loose agreement between the two PCTs, and will need to be resolved by the PCT.

6.2.2 The Trust has indicated that they will only provide a service commensurate with the income received. However they have also said that they will not act unilaterally and withdraw services until alternatives have been put in place.

6.2.3 The Trust has given no clear steer on how they intend to deal with this situation. It is understood that there have been no discussions between the Trust and either Wirral and West Cheshire PCT or Cheshire County Council about the potential impact of the Model of Care on their residents.

6.3 Workforce:

6.3.1 Successful implementation of the Model of Care depends upon a capable and competent workforce. It will require a significant cultural change in the way services are delivered – in terms of the pace of change (paragraph 6.1.1) Norfolk and Waveney stressed that it took them at least eighteen months to achieve the desired cultural shift.

6.3.2 The Trust has struggled in the past to recruit key professional staff – reflecting a national workforce picture. Some progress has been made in the recruitment of nurses in particular, but psychiatrists, psychologists, occupational therapists and pharmacists remain at a premium. In terms of workforce development, a new and modern management structure is still unfolding within the Trust, and there are no linkages to local workforce strategies.

6.3.3 It should also be noted that the Model of Care has not considered the capabilities and competencies required from the voluntary and independent sectors. Whilst they may argue that this is not their business, the successful implementation of the Model of Care will depend on the local community's capacity to deliver additional services.

7. CONCLUSIONS AND RECOMMENDATIONS:

7.1 General:

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7.1.1 The Model of Care is an approach to the delivery of mental health services that:

- Promotes recovery rather than maintenance of a mental health state
- Are responsive to individual need
- Are stated to meet national policy requirements
- Meet the requirement for the Trust of achieving financial stability

7.1.2 The Model is based on an approach used elsewhere in the country and is a variation on a number of similar approaches elsewhere, many of which have produced positive outcomes for service users. As a model, it is therefore one which can be supported.

7.1.3 **It is RECOMMENDED that the basic model of service being proposed is deemed to be acceptable to the Local Authority.**

7.2 Financial and Service Implications:

7.2.1 There is a significant reduction in the financial resources available to Halton residents as a result of this Model. The figure for this is unclear and has varied according to different presentations of the Model. For Adults of Working Age, it appears that there is a reduction of around £1.8 million, but this does not apparently include any figures for Older People's Services. It is therefore difficult to gain a full picture of the overall impact on services.

7.2.2 **It is RECOMMENDED that the 5BoroughsPartnership should be asked to provide full details of the financial impact on Halton, including the impact on Older People's Services.**

7.2.3 It seems clear that the residents of Frodsham and Helsby have been receiving a service disproportionate to the funding that has been given to the Trust. This has reduced the opportunities for the development of Halton-based community services. When this matter is resolved, there is a case to be made that any advantages to the Trust should be reinvested in local community services.

7.2.4 There are real concerns about the capacity of the local primary care and community mental health services outside the Trust to both absorb the transfer of case responsibility that the Model will require and provide the range of discharge services that will prevent the new services from becoming oversubscribed and unable to deliver their aims. It has long been recognised that local services have remained under-developed, when compared with regional and national data.

7.2.5 It is understood that funding is to be made available by the Primary Care Trust to support aspects of the transition from one service model to another, and particularly project management of the

changes. It is not known whether this is purely intended as a resource for the Trust or whether this could be used to enhance local community services in readiness for the changes. There is an additional case to be made for this.

7.2.6 **It is RECOMMENDED that the 5BoroughsPartnership be urged to take all possible steps to resolve the issue of the funding of the service to residents of Frodsham and Helsby as soon as possible.**

7.2.7 **It is RECOMMENDED that, when this matter is resolved, the 5BoroughsPartnership be urged to consider this adjustment in financial circumstances as a potential windfall which should be reinvested – either partly or in total – in local community mental health services. This would allow the development of an infrastructure which would better support the delivery of the Model of Care.**

7.2.8 **It is RECOMMENDED that the Primary Care Trust should be urged to consider a level of investment in transition funding for local community-based services, to support the full implementation of the Model of Care.**

7.3 Older People's Services:

7.3.1 Under the proposed model, Older People with mental illnesses will be treated, as with younger people, in the Resource and Recovery Centres. It is however a requirement of the National Service Framework for Older People, and of supporting guidance, that both groups should be kept separate, to reduce risks to the most vulnerable people. The Trust has committed to a level of capital expenditure to adapt existing premises in the Brooker Unit to meet this target, but has not explained how this will be done.

7.3.2 **It is RECOMMENDED that the Trust be encouraged to demonstrate at an early stage how this requirement will be met.**

7.4 Timescales:

7.4.1 If approved, Halton mental health services will be the first to change to the new Model. It has been stated by the Trust that these changes will need to be implemented by 1st October 2006. The changes required, however, are not just in terms of the mechanics of service but in the whole culture of service delivery, and this is likely to take some time to deliver. It is not considered that it is reasonable or realistic to develop effective service change by 1st October 2006, and that there needs to be a robust project management process in place to ensure effective delivery.

7.4.2 **It is RECOMMENDED that the Trust be asked to reconsider the**

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date for implementation of the new Model in Halton.

7.4.3 **It is RECOMMENDED that the Trust be asked to develop robust project management plans – agreed with local partners – for the delivery of the Model of Care in Halton.**

7.5 Social Care input:

7.5.1 National service models require an combined approach between health and social care services in the delivery of mental health services, and this is supported by substantial good practice evidence. To this end a formal partnership arrangement between the Trust and the Borough Council has been developed. Although social care services have been included in parts of the Model it remains dominated by an approach which is led by the health services, and it is unclear what role social care staff will play within the new model of service delivery. There is no direct representation of social care at the highest levels – including at Board level – within the Trust.

7.5.2 **It is RECOMMENDED that the Trust be urged to fully clarify the position of social care services in the Halton Model of Care.**

7.5.3 **It is RECOMMENDED that the Trust be urged to consider its position with regard to the representation of social care on the Trust Board, with a view to strengthening the partnership arrangements across the Trust catchment area.**

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St. Helens Council

Adult Social Care and Health

REPORT TO : ST. HELENS BOROUGH COUNCIL / ST. HELENS PRIMARY CARE TRUST

SUBJECT :

IMPACT ASSESSMENT – MODERNISING MENTAL HEALTH SERVICES, IMPROVING VALUE THROUGH TRANSFORMATION ; BUSINESS CASE FOR A NEW MODEL OF CARE (FINAL VERSION 12B - APRIL 2006)

1. PURPOSE

1.1. This report builds upon initial Impact Assessment undertaken in relation to VERSION 9 (March 2006) and subsequent agreement reached with 5BPT to progress.

- Financial Analysis of Current Investments compared to Business Case Financial Profiles.
- Care Pathways as currently experienced and how these will change.
- Whole Systems Impact.

1.2. This Report will focus upon the WHOLE SYSTEMS IMPACT and will reflect the OBJECTIVES identified within the Business Case to measure impacts. The Business Case as proposed will seek to essentially reconfigure IN-PATIENT SERVICES and delivery a RESOURCE and RECOVERY CENTRE for each Borough.

1.3. The Business Case has identified the following OBJECTIVES to be addressed through the proposed service reconfigurations.

- In-patient environment not fit for purpose.
- In-patient environments lacking therapeutic services and interventions.
- Length of in-patient stays in excess of national NORMS i.e. 45 days compared to 18 to 24 days.
- In-patient environments characterised by delayed discharges.
- Occupancy levels representative of 30 to 40% of patients not needing to be in hospital.

- Overtrading by 5BPT allied to current activity and significant cost pressures.

- A need for 5BPT to achieve financial balance by financial year end 2006 / 2007 and financial balances by financial year end 2007 / 2008.

1.4. This Report will analysis the above OBJECTIVES in relation to the proposed NEW MODELS OF CARE and changes in future service activities allied to service users and carers.

2. HEADLINE FINANCIAL PROFILE

2.1. 'Work undertaken with the 5BPT together with financial mapping contained within the 4 BOROUGHS ADULT MENTAL HEALTH STRATEGY has identified the following cost profiles.

2.1.1. TOTAL CONTRACT VALUE PCT's and 5BPT

	TOTAL	ADULT MENTAL HEALTH	BUSINESS CASE
ST. HELENS	14,268,214	5,065,112	5,469,974
HALTON	11,632,000	5,711,958	3,812,835
WARRINGTON	18,478,000	6,767,045	5,437,044
KNOWSLEY	13,601,074	6,848,990	5,060,223
TOTALS	57,979,288	24,393,105	19,780,076

2.1.2 As can be seen from the TOTAL Contract Value, the Business Case seeks to reduce spending specifically in relation to Adult Mental Health Services, plus reducing "back office" costs by £1M. As a result the spending in relation to Adult Mental Health Services across the 4 Boroughs will fall from 42.07% to 34.11% of overall investment.

2.1.3. Given that 5BPT's CORE BUSINESS remains Adult Mental Health Services, further explanation is required allied to the 57.93% of investment (recognising back-office savings) excluded from the overall approach to FINANCIAL RECOVERY.

BUSINESS CASE COSTINGS – PER BOROUGH

	CURRENT SPEND	PROPOSED SPEND	DIFFERENCE	%
ST. HELENS	5,065,112	5,469,974	+ 404,862	+ 7.9%
HALTON	5,711,958	3,812,835	- 1,899,123	- 33.25%
KNOWSLEY	6.848,990	5,060,223	- 7,388,767	- 26%
WARRINGTON	6,767,045	5,438,044	- 1,330,001	- 19.75%

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2.1.4. 5BPT have confirmed that financial balance will be achieved through the above service reconfiguration costings, borough specific details are (to be provided by DARREN McCANN). As presented, the ONLY Borough with increased investment is St. Helens.

3. IMPACTS ACROSS WHOLE SYSTEM

3.1. This report will seek to consider potential impacts arising from the proposed reconfiguration of specialist mental health services located within the 5 Boroughs Partnership NHS Trust. The cost analysis provided captures investment provided by St. Helens PCT, however, community services are integrated across health and social care, budgetary responsibility for Local Authority Social Care Services remaining with St. Helens Council

3.2. The following description of services complementary to those provided by the 5BPT i.e. funded by St. Helens PCT, are shown by application of the TIERED MODEL contained within the 4 Boroughs Strategic Document. Impacts will be illustrated by drawing upon the recent experience of the closure of Peasley Cross Court (PXC). The decommissioning of PXC, challenged the existing service infrastructure capacities, resulting in a significant element of purchased activity by both Local Authority and PCT i.e. purchasing domiciliary, residential and nursing home support additional to services either directly provided or provided by Service Level Agreements.

3.3. The existing complementary service infrastructure would include :

TIER ONE : COMMUNITY SUPPORT AND SELF-HELP

SERVICE PROVIDER	FUNCTIONS
ST. HELENS MIND	Information, Advice and Advocacy (SLA St. Helens PCT)
CITIZENS ADVICE BUREAU	Specialist Money Advice (SLA St. Helens PCT)
COALITION FOR DISABLED PEOPLE	Service User Involvement, Information, Advice and Advocacy. (SLA St. Helens Council)
ST. HELENS MENTAL HEALTH FORUM	Service User Engagement, Information, Advice and Advocacy (SLA St. Helens PCT)

CARERS : REFERENCE GROUP	Carer Engagement, Information, Advice and Advocacy (SLA St. Helens PCT)

TIER TWO : PRIMARY CARE MENTAL HEALTH SERVICES

SERVICE PROVIDER	FUNCTIONS
PRIMARY CARE MENTAL HEALTH SERVICE	Information, Brief Interventions Talking, Therapies, Self-help Strategies (St. Helens PCT provided and funded)
TOGETHER	Family Support to assist Carers to care (St. Helens Council SLA) Housing Related Floated Support Scheme (Supporting People Programme)
MAKING SPACE	Vocational and Employment Opportunities (8 individuals at one time) St. Helens Council / St. Helens PCT SLA Housing Related Support. (accommodation and floating support – 28 units) Supporting People Programme.
RESIDENTIAL NURSING HOME PROVIDERS	
- **AVONDALE** Block Purchase SLA St. Helens PCT, LA Sport Purchased Places	25 places (50% over 65 years)
- **SHERDLEY COURT** St.Helens PCT SLA	25 places (20 over 65 years)
- **GREENGATE HOUSE** St. Helens PCT SLA	12 places (4 to focus over time upon recovery)

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TIER THREE : SPECIALIST MENTAL HEALTH SERVICES

SERVICE PROVIDER	FUNCTIONS
HEALTH PARK LODGE	
St. Helens Council funded, 5BPT providing.	Vocational and Employment Opportunities / Community Outreach Service.
COMMUNITY SUPPORT SERVICE	
St.Helens Council / Supporting People Programme Funded 5BPT Providing	Housing Related Support / Social Care Domiciliary Support Services (former floating support scheme)
ABBEY HOUSE	
St. Helens Council / Supporting People Programme Funded 5BPT Providing.	Housing Related Support / Social Care Support for 15 individual tenancies.
GERARD HOUSE	
St. Helens Council / St. Helens PCT funding 5BPT Providing.	Residential / Nursing Support to 2 individuals relocated from PXC to promote recovery.
BIRCH DAY UNIT	
St. Helens PCT funded, 5BPT Providing.	Day Opportunities (This service will be decommissioned, a body of people will access Heath Park Lodge and a new service will be commissioned within Voluntary Sector.

3.4. The above service map is complementary to those services provided by 5BPT and contained within the SLA with St. Helens PCT. As can be seen a spectrum of services across TIERS ONE to THREE exist, however, all of the above are currently operating to optimum capacities. Equally statutory mental health services have been subject to review and a programme of modernisation as evidenced by – changes in relation to vocational and work opportunities (HEATH PARK LODGE, COMMUNITY OUTREACH SERVICES and WORKSPACE); planned decommissioning of BIRCH

DAY UNIT and part re-provision; evolving Value for Money (VFM) Reviews allied to Housing Related Support Schemes, co-ordination allied to Housing and Accommodation Schemes and the closure of PXC.

3.5. The closure of PXC demonstrated the challenges to the above services and is actual evidence of impact, given the inter-relationship of in-patient / community mental health services infrastructures. This evidence will be replicated with the Business Case proposals planned to reconfigure in-patient services.

3.6. PXC closure demonstrated that current service capacities, external to 5BPT were constrained. Resettlement was only progressed through additional local Authority and PCT purchasing to secure appropriate domiciliary and residential / nursing home support. Such activity was over and above the existing 5BPT SLA, apart from 4 wte members of staff following two individuals into GERARD HOUSE for a time limited period.

3.7. The scale of activity allied to PXC was in relation to a relatively small number of people when compared to the implications associated with the Business Case. This Report will reflect this by, as indicated, analysis of the Key Objectives identified. Consequently the ramifications for the above complementary tiered infrastructure is significant in terms of service user / patient flows.

4. ELIGIBILITY

4.1. The Business Case will revise and refocus the functions of the Community Mental Health Team infrastructure to support the Resource and Recovery Centre for St. Helens. This is to ensure that service users with severe and enduring mental health are supported to maximise their well-being, recovery and choice about therapy. CMHT's will not provide TIER ONE and TWO interventions. In essence 5BPT will only provide a Serious Mental Illness Service, with caseloads set at 35 per individual practitioner and in relation to Enhanced Care Programme Approach.

4.2. Such focusing down will inevitably reduce access and lead to a movement of service users, currently supported by CMHT's who do not meet the revised criteria. This will IMPACT upon the Primary Care Mental Health Service infrastructure currently existing.

4.3. There is already evidence that referrals into CMHT's are falling, with a corresponding growth of referrals to the Primary Care Mental Health Service provided by St. Helens PCT. It is the case that the Primary Care Mental Health Service has limited resources and will incremental grow over time as further resources become available. Capacity does not exist to accommodate movements allied to existing users known to specialist mental health services or rapid growth in demand. The service is predicated upon brief interventions and throughput.

4.4. Equally it should also be recognised that Primary Care currently maintains significant numbers of people with serious Mental Health Needs.

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4.5. The Business Case will establish Access and Advice Centres (AAC) within each borough as the single gateway to specialist mental health services for the majority of referrals. The forerunner to AAC's is the Access and Screening Service operating within a number of the Boroughs. 5BPT had implemented Access and Screening across NORTH and SOUTH ST. HELENS. As indicated a consequence has been a fall of referrals to CMHT's with a corresponding rise in referrals to Primary Care Mental Health Service. The Access and Screening Service introduced a "hardening" towards eligibility and a movement of service users away from specialist services. 5BPT have now disbanded the Access and Screening Service.

4.6. The fundamental reason for this decision is the principle of where within a service users care pathway, decision-making allied to specialist services should sit. St. Helens Commissioners have indicated that Access and Advice Services should act as "gateways" to specialist services but from within primary care. Primary Care or TIER 2 services should act as the determinants of specialist need, acknowledging TIER 3 services capacity to respond.

4.7. A further focusing down on eligibility and Access and Advice Centres located within Specialist Mental Health Services would lead to impacts on wider access and advice services operating within the Borough. The capability and capacity of existing TIER 1 and TIER 2 services are already constrained and again it is questionable whether such services, either mental health specific or generic in nature could absorb the inevitable movement of people away from and out of specialist mental health services.

4.8. The proposal to change eligibility implicit within the Business Case will require further analysis, with 5BPT colleagues, to scope the potential movement of individuals and appropriate support to meet needs. This is not a criticism of the Business Case but the importance of establishing appropriate and meaningful service user and carer pathways to services. In essence the Business Case should operate within a whole system, understanding both foreseen and where possible potential for hidden consequences.

5. IN-PATIENT SERVICES

5.1 The Business Case is primarily seeking to re-provide in-patient services and develop for each borough Resource and Recovery Centres (RRC). The dysfunctional nature of current in-patient services reflects the lack of community alternatives and supports to aid and promote effective recovery. Such a position equally applies to RRC development and 5BPT are proposing a range of services, which include :

- Intensive day programmes allied to RRC, new in nature.
- Crisis Resolution / Home Treatment, integral to RRC to both prevent inappropriate admissions and aid discharge and recovery, new in nature.
- CMHT's refocused, as already highlighted.
- Early Intervention and Assertive Outreach Services.
- Access and Advice Centres as the gateway to specialist services.

5.2. The Business Case seeks to provide the above infrastructure with capability and capacity to facilitate in-patient bed reductions. However, this approach demonstrates no evidence of complementary analysis allied to services that promote and enhance recovery i.e. social care, housing related and mainstream services. In that we know that positive mental health requires appropriate and sensitive services that support housing and accommodation, vocational and employment opportunities, income maximisation and social and community participation.

5.3. Understandably 5BPT are proposing changes to those services that they provide. However, the risks to this would be the lack of appraisal to consider the range of service provision, standing outside of 5BPT provision. No evidence exists that this has been undertaken to inform the 4 Boroughs Commissioning Strategy and where enhancements are required to promote and sustain recovery or prevent breakdown.

5.4. The Business Care is targeting In-patient Services for the following reasons :

- In-patient Services represent the highest cost aspect of overall service provision.
- In-patient Services are provided in facilities deemed not fit for purpose.
- Within St. Helens, Sherdley Unit operates at over capacity i.e. T4 94% and average length of stay 44 days, T5 114% and average length of stay 33 days, compared to national norms of average stays 18 – 24 days.
- In-patient environments characterised by 30 to 40% of in-patients inappropriately admitted compared to similar mental health trusts.
- National Policy perspective seeking to reduce in-patient admissions by 30% allied to CRT / HT.

5.5. 5BPT have also identified that despite the disproportionate spend allied to In-patient Services, such services are characterised as indicated, not only by over-occupancy but delayed discharges. For St. Helens 5BPT identified between April to December 2005, 6 Adults and 11 Older People whose discharges were delayed.

5.6. The Business Care has not provided intelligence to explain the reasons for such delays, apart from a general statement that a lack of "alternative provision" existed. 5BPT have quantified the delays in terms of lost bed days and for St. Helens this equated to 2696 for Adults and 884 for Older People with Mental Health Needs. 5BPT also indicate that a consequence of this position was placements, at cost to St. Helens PCT, into the private sector, due to no local in-patient bed availability.

5.7. It is therefore difficult to evaluate how the proposed RRC will improve such a situation, if as cited, alternative resources, is responsible for delayed discharges. A consequence could be that RRC will compound the current position, by seeking to accelerate discharges, against a backdrop of no corresponding development of community infrastructures, that explain the current reasons for delay in relation to discharge.

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5.8. Delayed discharges occur primarily for two key factors :

- A failure of effective care co-ordination to prioritise and progress the needs and care plans of people within in-patient environments.

- Community resources to provide appropriate discharge pathways. This is in relation to step-down specialist mental health services and other community support services i.e. appropriate residential / nursing home facilities to continue recovery and rehabilitation; accommodation and housing with support to promote and maintain independence; meaningful vocational, educational and employment opportunities and wider community services to build self-esteem and confidence.

  The absence of the above is currently a factor, at levels of sufficiency to progress individual needs, as identified by 5BPT in a timely and appropriate manner.

5.9. Consequently the prevention and avoidance of delayed discharges requires a complementary whole-system development to not only respond to the "here and now" but the changes flowing from the Business Case. However the Business Case will exist in isolation, without a corresponding and complementary review of wider service deficits. The Business Case will expose the constraints confronting all services other than those that 5BPT are seeking to re-provide.

5.10. The Business Case will further address the national requirement to reduce in-patient bed numbers by 30%. (a Crisis Resolution / Home Treatment Service target) and the practice of 30 to 40% of current in-patients inappropriately admitted compared to similar Mental Health Trust providers. The 5BPT are proposing the following RRC for Adults and Older People with Mental Health Needs.

ST.HELENS	Weighted Adult Population (No figures given for both Adults and Older People)	Royal College of Psychiatry Recommended in-patient bed numbers Lower / Upper		Existing Acute In-patient Beds	Proposed Bed Position	% Breakdown
	130,872	33	43	44	33	25%

5.11 The proposed bed reduction is set against an existing two fold in-patient reduction process. In that St. Helens PCT Service Level Agreement funds an original in-patient facility at Sherdley Unit i.e. T4 and T5 Wards of 50 beds in total, which has been reduced, in line with Crisis Resolution / Home Treatment targets, to enable enhancement of in-patient treatment. Equally the closure of PXC has led to the loss of 12 in-patient beds, which afforded a recovery pathway from in-patient wards within the Sherdley Unit.

5.12 As indicated within the Business Case, the consequence of these changes has been occupancy levels maintained at an average of 109%, delayed discharges reporting a total of 3580 lost bed days and a continuation of inappropriate admissions.

5.13 Equally in fixing the proposed number of in-patient beds for the St. Helens RRC, the 5BPT have used weighted population figures for ADULTS only. Yet the proposed RRC will continue to provide for Older People with Mental Health Needs. The Business Case has undertaken no modelling allied to Older People and the service consequences that will arise. This remains a significant deficit within the Business Case e.g. more Older People experienced delayed discharges, the Health Care Commission identified separate in-patient environments and the 4 Boroughs Older Peoples Mental Health Strategy has identified a raft of service enhancements.

5.14 The proposed reduction by 25% of in-patient beds for St. Helens will impact in the following areas (as evidenced by the closure of PXC).

- A greater expectation will arise allied to effective Care Co-ordination. In that capacity is required to respond in a timely way to both prevent inappropriate admissions, ensure care planning is proactive following admission and assure co-ordination to facilitate discharge.

- Critically that a comprehensive and complementary infrastructure exists to see in-patient treatment and care as an "episode" of an overall care pathway. This assumes that alternatives to aid recovery exist i.e..

  - Therapeutic programmes (This will be provided as part of the Business Case).

  - Capacity within Primary Care to enable step-down management and requiring on-going monitoring and review (this currently does not exist at an appropriate level of capability and capacity).

  - Residential / nursing home provision for those not able to move back into ordinary housing following in-patient care. (Currently the amount of nursing / residential care in borough is constrained, especially for Older People with Mental Health Needs.)

  - Accommodation / housing with Support (again housing related support is insufficient to absorb a significant growth).

  - Vocational and employment opportunities are being reconfigured but again no additional capacity has been developed.

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- Wider advice and information services are not geared to provide advice and support to enable alternative sustainment of individuals currently accessing mental health services.

- Substance misuse services, will be dealt with as a separate section, but the implications for those with co-existing needs is significant.

5.15. Whilst recognising the above impacts, this is not to question the desirability of a RRC model of care as opposed to provision as presently configured. The impacts illustrate and reinforce the importance of a whole system change programme that seeks to enhance services to enable changes, in this case to inpatient services. At issue is the potential risk to the sustainability of the proposed model because service enhancements are not planned in those impact areas identified.

6. PURCHASED ACTIVITIES – LOCAL AUTHORITY AND PCT.

6.1 There is little or no evidence within the Business Case that the Models of Care as proposed, will limit or reduce the need for commissioners to purchase, additional to existing Service Level Agreements, services over and above those provided by 5BPT. The experience in relation to PXC would suggest activity to the contrary, In that St. Helens Council and St. Helens PCT were required to purchase nursing and residential care home places and additional domiciliary care support hours to enable individuals to move on, appropriately, from PXC. What the decommissioning of PXC exposed was the level of capacities currently prevailing within complementary services.

6.2. The Business Case is in essence seeking to provide services differently, as opposed to creating additionality . 5BPT will seek to deploy resources with greater efficiency and effectiveness and use savings to offset budgetary pressures. This is distinct to efficiencies that unlock resources to build capability and capacity and so afford the additionality that is required, as evidenced by the closure of PXC. The Council and the PCT therefore run the risk that 5BPT will work differently but this will passport cost pressures to other parts of the system i.e. out of area / borough purchases / increased community support purchased costs.

7. UNMET SERVICE USER NEEDS.

7.1. The following categories of service user needs can be identified as remaining challenges not addressed by the Business Case. As such the Business Case is reinforcing working differently but maintaining a level of "status quo" for the following service user categories.

- Older People with Mental Health Needs.

- People with a co-existence of needs across Mental Health and Substance Misuse. (Drugs and Alcohol).

- People requiring Psychiatric In-patient Care ie. PICU.

- People requiring step-down from forensic in-patient care.

- People with Personality Disorders to be brought within the remit of Mental Health Services.

As such the Business Case is a lost opportunity to start to address the above challenges which currently confront existing services. Each of the above will be dealt with, in brief, but in themselves require thorough consideration.

7.2. Older People with Mental Health Needs – this is the area of single greatest weakness within the Business Case. As presented, at best, Older People with functional mental health needs are said to be mainstream to assure access and maximise resources currently not available. However such a position is clearly divorced from the 4 Boroughs Older Peoples Mental Health Strategy and highly questionable. Equally the 5BPT proposal appears to contradict Health Care Commission recommendations that Adults and Older People should not be treated and cared for in the same in-patient environments.

7.3. Older People appear to be treated as an adjunct in relation to service reconfigurations. The Business Case gives little consideration to older peoples' mental health needs in total. It is further implied that older people will be able to access the range of adult services to be provided, but no scoping of demand for such services has been undertaken.

7.4. People presenting with a co-existence of needs across mental health and substance misuse is again minimally addressed and yet this cohort of individuals represent significant challenges for both services and communities. The Business Case promotes the deployment of Dual Diagnosis Workers, one per CMHT, as a response. Within St. Helens such a position currently exists but this capacity is not able to meet the challenges arising from such needs.

7.5. In that co-existing needs within this area involves a hierarchy, as with other matters. Dual Diagnosis as defined by the Mental Health Policy Implementation Guide refers to a small but complex group of people. Whereas the current challenge for mental health services is a significant body of people, who access services, but primacy of need is in relation to substance misuse. Such people do not readily "fit" with any current service considerations and the potential exists, that a tightening of criteria, will exclude with no immediate alternative services available.

7.6. A clear hidden consequence of restricted access to current mental health services, although potentially appropriate, could be.

- Greater demands upon primary care health services.
- Greater presentations at A & E Department, either seeking assistance or due to self-harming, accidental or anti-social behaviours.
- Contributions towards anti-social behaviours and community safety issues.
- Contributions towards increased domestic violence.
- Greater criminality to feed primary needs.
- Increased risks associated with parenting and child protection.

The above reflects the significance associated with substance misuse and mental health services. The deployment of three Dual Diagnosis Workers plus a Consultant Nurse Practitioner can only respond to a strict definition and scratch the surface. The Business Case will change the current landscape and lead to exclusions, especially

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where the primary need is deemed to be one of substance.

7.7 5BPT have recently lodged a parallel Business Case to develop Psychiatric Intensive Care facilities which should have been contained within the NEW MODEL OF CARE. PCT's are now faced with revenue consequences additional to the current SLA with 5BPT. Whilst the absence of such services has required additional purchasing, often at cost, the cost consequences for development are significantly greater. As such a single Business Case, inclusive of Psychiatric Intensive Care facilities would have assured a comprehensive mental health infrastructure.

7.8. The loss of PXC has created a service gap in relation to the recovery and rehabilitation pathway for people within forensic in-patient environments. It is difficult to judge how the RRC approach will respond and aid those currently within forensic situation. St. Helens currently has three individuals awaiting step-down from Chesterton Low Secure Facility. As configured the pathway for such individuals.remains challenging. Equally the proposed Models of Care will not provide opportunities for such individuals. A consequence could be PCT and Local Authority purchased activity to facilitate move on. This will be a recurrent theme, even with the New Models of Care.

7.9 Finally, but significantly will be the widening of mental health services to include people deemed to be personality disordered. As yet no recognition exists of how such needs will be met. The Business Case could have been used as an opportunity to plan for this cohort of individuals. As with Psychiatric Intensive Care facilities, the danger exists of "add on" for this challenging group of people.

8. CONCLUSION

8,1 The above is reflective of the complex and competing service matters confronting a comprehensive mental health system, of which 5BPT are the sole statutory provider, given the integrated nature of agreements within St. Helens.

8,2, It is the case that 5BPT have risen to the challenge of seeking to both enhance outcomes for people with mental health needs and meet the imperative of financial balance confronting health economies. As such the proposed Model of Care is supported in principle, at issue is partnership working and the level of detail available, within or to support the Business Case.

8.3 The impact assessment as a consequence is lengthy and seeks to respond to those objectives highlighted and the information as provided. The Business Case will tighten eligibility and access and seek to exclude a significant number of people currently using specialist mental health services. This may very well be appropriate, however, the one dimensional approach adopted, will lead to consequences elsewhere.

ROBERT VICKERS

ACTING ASSISTANT DIRECTOR VULNERABLE ADULTS

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St Helens NHS
Primary Care Trust

DRAFT

Report to: **St Helens Borough Council**

Subject: **Impact Assessment**
Modernising Mental Health Services
Improving Value Through Transformation: Business Case for a New Model of Care (Version 9 – March 2006)

1 Headline Comment (In Brief)

1.1 The Business Case is focused upon 4 of the 5 boroughs served by the 5 Boroughs Partnership NHS Trust. Ashton, Leigh and Wigan remain outside of the proposed model of care. This is significant, in that Wigan have the largest borough population and contribute proportionately the greatest investment into 5 Boroughs Partnership NHS Trust infrastructures. Ashton, Leigh and Wigan are working on a parallel process and the outcome and impact of this remains to be evaluated.

1.2 The Business Case lacks clarity in relation to the health Care Commission's recommendation that Adults and Older People should not be treated and cared for within the same inpatient environments. The new model of care appears to promote Resource and Recovery Centres that are ageless in terms of functional mental illness for older people.

1.3 The Business Case is predicated upon a robust and comprehensive community infrastructure to deliver inpatient bed provision located within resource and Recovery Centres.

1.4 The Business case is seeking to reconcile the key drivers of modernisation and financial balance. This is against a stated backdrop of historical under-investment and institutional patters of working. the challenge is to reconcile these competing positions to not only achieve a more efficient and effective use of existing resources but achieve real savings.

1.5 Key to the above is the implementation of clear Service Level Agreements/Service Specifications which enables and informs effective performance management. The current reality is of commissioners and the provider lacking sophistication in this area of activity. Therefore, this will require a significant cultural shift as underpinning practice to achieve Business Case objective.

1.6 Reference is made to capturing the views of service users and carers in forming the business Case. Given the confidential nature of the Business Case document, evidence of how service user/carer perspectives have informed development is important.

1.7 The change represented within the Business Case remains both radical and fundamental. Recognition exists that delivery will require both Leadership and a capable and competent workforce. The Business Case promotes enhanced establishments across all service areas but this is within a national context of health and social care workforce challenges. Interestingly, the Business Case contains no contingency planning allied to the key resource of specific professional groupings.

1.8 The Business Case appears not to address the significant need allied to Dual Diagnosis ie. Mental Health and Substance Misuse. At present current inpatient activity reflects a high correlation in relation to mental health and substance misuse and an acknowledged absence of community resource infrastructure. Movement towards a Resource and Recovery centre model will require a co-ordinated position allied to Dual Diagnosis.

1.9 The profile of Older People with functional mental health needs should be part of a comprehensive Older Peoples Mental Health Strategy. The presentation within the Business Case is at best simply "alluded to" rather than fully addressed. As such the new model of care fails to see older people with mental health needs "in the round" and within a context of mainstreaming.

2. Financial Context Specific to Mental Health

Whilst acknowledging the health under resourcing at a comparative national and regional level of mental health services, the following areas are raised, recognising that the "devil is in the detail".

2.1 Current and Anticipated Future Levels of Investment

- Information as currently presented is misleading, in that the current levels of investment places all acute inpatient costs within Knowsley for St Helens.

- Equally, the figures as currently presented are global and therefore it is not possible to understand investment in Adult and Older Peoples Mental Health Services.

- The investment profiles as presented would indicate a difference between now and the future of £3,687,254. As currently presented St Helens community would reconfigure and services would be enhanced to the cost of £404,862. However, as indicated this does not recognise the current costs associated with inpatient service provision. Therefore, it is not possible to confirm investment flows.

- As presented, the cost profile differentiates between Direct and Indirect costs. The 5 BPT have identified Indirect costs of £8.9M (includes overheads and capital charges), based upon 2006/07 prices, this represents 28% of total costs. 5 BPT would seek to save £1M against indirect costs. However, this figure is suggested but no details are provided. Equally borough specific contributions should include the totality of investment, irrespective of how 5 Boroughs Partnership NHS

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Trust subsequently apportion. It is also unclear as to whether the 28% of total cost are 4 Borough specific and excludes Ashton, Leigh and Wigan ie. have 5 BPT desegregated indirect costs and if so how has this been applied.

- The profiles as presented identifies with future, estimated drugs and other non pay costs (£1.4) but current levels of investment does not show, yet one would anticipate this could be demonstrated. Equally, reference is made to Senior House Officer within current investment but not future.

2.2 Transitional Funding

- The Business Case indicates that the proposed change programme will require transitional funding, anticipated implementation costs at £925K, presumed at 2006/07 prices. It is considered that the 5 BPT contribute to more than £250K, the balance of £675K from PCTs. Again clarity is required as to how this will be apportioned. Equally, how the 5 BPT will fund, through efficiencies £250K contribution towards implementation.

- Mental Health Strategies have suggested a phased implementation, with a maximum of two locations per annum. Taken together, future anticipated levels of funding and 5 BPT contribution towards implementation would generate net savings of £4,437,254 towards 5 BPT financial balance. As presented, essentially this will be set against indirect costs and switching investments from inpatient to community infrastructures.

2.3 Capital Consequences

- The Business Case confirms global revenue costs but provides no capital cost information.

- For St Helens it is proposed to develop Peasley Cross Court as the borough Resource and Recovery Centre. As currently configured Peasley Cross Court provides 24 beds, whereas the St Helens Resource and Recovery Centre proposes 33 inpatient beds. Equally, the Resource and Recovery Centre includes intensive day therapeutic services and integrated Crisis Resolution/Home Treatment Service.

- The current building will require development to meet the proposed Resource and Recovery Centre service specification. As yet the capital costs are not known or at least if know shared with partners and equally Capital Development Business Cases formulated and processed.

- Securement of capital funding will inevitably impact upon progression and service implementation timescales.

2.4 Investment Flows

- As indicated, whilst broad information exists allied to current and future anticipated borough investments, this information requires further detail to enable analysis.

- Borough commissioners should be able to map the flows of investment in terms of current service configurations to the proposed Model of Care. As indicated, this is difficult given inpatient costs for St Helens located within Knowsley Investment profile. Commissioners are therefore not able to determine switches of investments between and across services.

- Equally the £1M shown in relation to indirect cost savings will thus be apportioned equally to each borough ie. £250K each.

2.5 Contributions to Recovery

- Clarity is sought as to the contribution per borough towards overall recovery. This should be set within the context of historical and current investments within Mental Health Services as shown within the Report.

- Adult Investment weighted per head of population for St Helens is £111.50, the lowest of the 5 Boroughs served by 5 BPT. No comparative figure is given for Older Peoples Mental Health spend. Will contributions towards recovery lead to proportionate reductions to this figure, or will movements disproportionately effect individual boroughs.

2.6 Whole Systems Commissioning

- Whilst Local Authority Social Care establishments have been added into the document, Improving Value through Transformation remains a health economy position to achieve modernisation and financial balance.

- The approach at best assumes a whole systems process but contains no indication of impacts allied to:

  - step down services of sufficiency and appropriateness to meet needs over and above Resource and Recovery Centre profile.
  - complementary service infrastructures promoting primary care and social inclusion
  - a robust market approach to care and support covering Supporting People Programme, Voluntary and Independent Sector.
  - how the 4 Boroughs Commissioning Strategy will assist the development of comprehensive mental health services.

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2.7 Resource Deficits

- Improving Value through Transformation seeks to reconfigure existing service infrastructures, achieve financial balance and enhance service user and carer outcomes. However, this is against a continuing backdrop of:

  - forecast deficit and continuing cost pressures
  - a need for out of area treatments for a small but complex group of people
  - continuing delayed inpatient discharges across adults and older people with mental health needs.

- 5 BPT have not provided detail allied to either forecast deficit or where cost pressures are located. There is no indication of how 5 BPT will address cost pressures in the interim pending progression of Improving Value through Transformation.

- 5 BPT have identified and costed delayed discharge impacts per borough, yet there is no assurance that the new models of care will improve this position. Whilst Models of Care may promote better discharge, delayed discharges do require a wider whole systems commissioning approach.

- A risk to both Local Authorities and PCTs with the new Model of Care is that the adoption of revised entry eligibility will lead to service exclusions and a growth in out of area treatments. Positively enhanced community infrastructures should combat such a trend. Risk will be greatest during transition.

2.8 Income from Other Sources

- 5 BPT are showing income of £1M from other sources. Again, transparency allied to how such funds are utilised and risks associated with the proposed change programme is required.

3. New Model of Care

3.1 The Business Case sets out a new model of specialist mental health care. This is to be broadly supported given the proposed switch from inpatient focussed services to improved and enhanced community infrastructures.

3.2 The Business Case correlates to the tiered commissioning model within the 4 Borough Mental Health Commissioning strategy for Adults. However, the business case assumes that current service infrastructures will be reconfigured/refocused as identified.

3.3 This remains an assumption on the part of 5 BPT. In that Borough Commissioners may seek, as proposed within the 4 Borough Mental Health Commissioning Strategy, to either maintain or reconfigure services as defined within tiers one to three.

3.4 The impact of this would be to question Improving Value through Transformation to promote:

- Tier One and mental well being in the broadest sense.
- Tier Two, Primary Care and Access responding to those with mild to moderate mental health issues through mental health promotion, early identification and detection and appropriate interventions.
- Tier Three, Specialist Mental Health Services ie. functionality of community Mental Health Teams to promote recovery and social inclusion and act as a gateway into Secondary Mental Health Services ie. 5 BPT Resource and Recovery Centre model plus Crisis Resolution/Home Treatment, Assertive Outreach and Early Intervention Services (Tier Four).

3.5 The above represents further shifts in focus requiring a wider partnership to enhance service user and carer outcomes. Such an approach emphasises, mental well-being, the promotion of natural supports, mainstreaming and access to local community facilities and services, the importance of vocational and employment training, the need to maximise income and debt awareness and good housing and accommodation to promote recovery and well-being. All of which are implied rather than explicitly stated.

3.6 Specifically, St Helens would seek to work with 5 BPT to understand Access and Advice Centres and the proposed community infrastructure to support Resource and Recovery Centres. both of which presuppose reconfiguration of Community Mental Health Teams.

3.7 Unilateral progression, divorced from a Borough Commissioning framework will impact upon:

- Local Authority provided services seconded into 5 BPT ie. Abbey House, Community Support Team and Heath Park Lodge. These services are all critical to effective recovery.
- The current role played by voluntary and independent sectors allied to residential care placements, support to service users and carers and advice and support in relation to income and vocational and employment training.
- Primary Care, currently the Primary Care mental Health Service remains under resourced and therefore capability and capacity is constrained.

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- Specialist Substance Misuse Services, as indicated the Mental Health Service is challenged by those who present with a co-existence of needs. Whilst good relationships currently exist across service areas, Improving Value through Transformation provides little direction allied to how services will move forward to address Dual Diagnosis.

4. Workforce

4.1 The future Model of Care is predicated upon a capable and competent workforce able to meet the challenges associated with a major cultural and service transformation. 5 BPT are to be commended for seeking to implement such a radical and far reaching service change.

4.2 The clear risks to the above service transformation remains recruitment and retention of clinicians able to deliver. It is the case that 5 BPT have struggled to recruit key professionals, reflecting in part a national workforce picture.

4.3 The Resource and Recovery Centre model provides for:

- Dedicated psychiatrist and staff grade doctor.
- Development of nurse led services.
- Range of clinical psychology sessions led by a Consultant Clinical Psychologist
- Access to Occupational Therapy Services
- Dedicated pharmacy provision

4.4 The 5 PT have made some progress in relation to the above clinical groups but psychiatrists, psychologists, occupational therapists and pharmacists are at a premium. St Helens remains under represented in terms of substantive psychiatrists, psychologist and occupational therapists.

4.5 The 5 BPT remain limited in terms of workforce development. The impact of "Fit to Deliver", a new and modern management structure is still unfolding and outcomes are variable. Commissioners are unclear as to embedded workforce strategies to enable either:

- Existing staff to embrace different working practices or
- Recruitment strategies to respond to the changes allied to Improving Value through Transformation

4.6 As already indicate, whilst reference has been made to social work within the context of Resource and Recovery Centre, Improving value through Transformation has not considered the capability and competence required within either the Local Authority, Voluntary or Independent Sectors.

5. Leadership and Management

5.1 The nature and extent of the change programme is radical and fundamental. As such the transformation will require an organisational environment able to lead and manage the change programme. Whilst Improving Value through

Transformation proposes project management capacity, much of the change will fall to existing corporate and operational managers.

5.2 It is a judgement call as to whether 5 BPT do have the capability and capacity to manage such a significant change programme. Incremental progression will assist, but there is no evidence to date to support such an extensive change programme.

6. Underpinning Infrastructures

6.1 5 BPT appear to be seeking fundamental change within a context of less than robust systems, processes and infrastructures to support operational activity. This is evidenced by:

- Poor but improving information technology structures and processes
- Average business planning processes
- Satisfactory financial and performance management systems.
- As indicated, at best, average management information relating to workforce
- Variable positions operating in relation to LA/PCT partners to assure business development.

Robert Vickers
Joint Commissioning Manager

April 2006

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IMPACT ASSESSMENT OF PROPOSED "MODELS OF CARE" ON WARRINGTON

SUMMARY OF MEETING OF 22ND MAY 2006 BETWEEEN 5 BOROUGHS PARTNERSHIP TRUST (5BPT), WARRINGTON BOROUGH COUNCIL (WBC) AND WARRINGTON PCT

AGREED that:

1. As part of process of consultation that 5BPT would recognise the joint provision across health and social care in Warrington, not just that services were jointly commissioned by the PCT and WBC.

2. WBC would be allowed to participate fully with 5BPT in developing the proposals and within any implementation plan. This should include the need to work jointly on agreeing and implementing joint admission and discharge procedures for in-patients, including the monitoring delayed discharges of care in older peoples and adults mental health wards.

3. The need to include personality disorder as a diagnosis which leads to admission and a significant proportion of the caseload for CMHT'S was recognised. Especially as the proposed revision of the Mental Health Act would redefine mental disorder to include this within the eligibility for mental health services.

4. The monthly joint provider meeting currently held between 5BPT and WBC be extended to include the development of the implementation plan and the project oversight in Warrington for Models of Care implementation once it is approved.

5. Regarding the proposed bed reductions totalled 66 down to 33 across adults and older people's beds. This would be a 50% reduction overall and the impact on Older People's Community Services had not been assessed. Agreed that the newly formed older people Mental Health Redesign Group in Warrington will look at this specific issue and recommend additional resources that would be needed either to develop older people's mental health services in the community to replace these bed reductions or to recommend discreet additional beds required.

6. Each borough's services would be discreet and available to that borough. This would be demonstrated by tracking the use of finances commissioned by each PCT for use within that borough.

7. 5BPT to provide the PCT with financial transition information over all services provided by 5 Boroughs over a three-year period to show use of changes of

finance during that time period. WBC to undertake a similar exercise for social care commissioned and provided so as to track the impact on respective services.

8. It was noted that up to £1 million was to be provided by PCT's for transitional costs over a two year period and that this needed to include social care costs where indicated and agreed.

9. 5 Boroughs agreed to revisit their financial modelling in terms of repaying brokerage and achieving financial balance, investing additional staffing into in-patients and identifying the surplus to be invested, by agreement with PCT and WBC, into additional community services across health and social care.

10. The specific impact on the Gatehouse Service of developing a Resource Centre at Hollins Park be carefully considered including retaining the Gatehouse for advice and information with part of the Crisis Resolution/Home Treatment Team based there as well. The success of the Gatehouse should be built on in relation to access and information into secondary care, a base for primary care mental health services as well as a focus for access into Crisis Resolution/Home Treatment Service. This would continue to avoid sucking people directly into in-patient services at Hollins Park.

11. Recognised that local authority involvement in an overall Models of Care project team across the 4 boroughs affected was essential. This, on the basis that local authorities were joint providers of services including supporting in-patient activity via assessment and operation of the Mental Health Act, as well as the main provider or purchaser of a range of specialist and generic community services.

12. Agreed by 5 BPT to consider Warrington BC as an equal provider of services who should participate at the start in any proposals, policies and procedures regarding service redesign – not merely as consultees amongst a range of other stakeholders whose views may or may not be taken into account

13. Warrington PCT and the BC stressed that unless Warrington resources were used for Warrington people and not used to subsidise other boroughs where investment is lower by PCT's then this would take resources away from Warrington people and this would be a key concern for the Scrutiny Committee. Assurances were given by 5 BPT that this would not be the case.

14. Agreed that the inclusion of Learning Disability provision in the tables and in Models of Care should be taken out.

15. Also agreed the impact on holding vacancies in many community teams by 5BPT was having detrimental effect on the ability of community staff to maintain

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existing caseloads. Agreed the importance of maintaining full support to CMHTs to ensure effective care co-ordination and the managing risk in the community.

16. Concern expressed by WBC about the capacity and ability of 5BPT to manage this overall project given the difficulties to date around sharing information and being open with regards to option appraisal, costings and policies and procedures. The heavily centralised structure of 5BPT was making local working difficult particularly in Warrington in terms of consistency. Agreed to ensure the monthly joint provider meetings between 5BPT and WBC are maintained and extended up to half a day per month to ensure that joint provision and development was working in practice. This includes adults and older people's mental health services.

17. Linked to the financial three year plan which it is agreed that the 5BPT would provide, it is essential from the local authority's point of view that existing investment by 5 Boroughs in Community Mental Health Teams (CMHTs) and other existing community services is at least maintained. Some concern that the numbers of staff and finance contained in earlier versions of Models of Care showed reductions in staffing in Warrington CMHT's to bring it within norm across the other Boroughs. WBC stressed that CMHT's need to be maintained, at least to the current level of staffing given the essential nature of what they do in providing ECC and essential support to approaching 1000 people with enhanced needs in the community.

8

Issues for Consideration by Statutory Joint Scrutiny Committee

Improving Services for Adults with Mental Health Needs

5 Boroughs Partnership NHS Trust

1. Purpose

The purpose of this report is to outline initial issues outlined identified with the 5 Boroughs NHS Trusts proposals relating to the development of services for adults with mental health needs.

2. Impact on Service Users and Carers

2.1 The reports referred to would seem to indicate a tightening of eligibility criteria across mental health services. This is likely to be as a result of the decrease in in-patient beds. The model is not clear about the impact that this will have for services users and carers in the Boroughs. The model is also unclear about any arrangements to ensure the safety and effective risk management of issues relating to individuals through the transition of services.

2.2 There are concerns about the possible impact on other aspects of 5 Boroughs work, notably the Child and Adolescent Mental Health Services, where there is no clarity in the proposals outlined.

2.3 The Committee is concerned that the proposals do not properly meet the needs of a number of specific groups including:-

- Older people with functional mental health needs
- People with duel diagnosis i.e. drug and/or alcohol and mental health problems
- People presently living in secure environments
- People with personality disorders
- Young people aged 16-17 years

2.4 The Committee also has concerns about the proposals to mixed inpatient settings for older people and younger adults. The Committee believes that this is contrary to acknowledged good practice. The Committee is also concerned that people under the age of 18 may be admitted to adult wards.

2.5 There are concerns about the impact on alcohol services, the proposals contain a reduction of allocated beds for alcohol detoxification.

3. Financial Information

3.1 The proposals in the plan are not supported by robust financial data. It is not possible to identify the financial impact on services in the 3 Boroughs and the

Committee believes that until this issue is addressed it will not be possible to complete the scrutiny exercise.

3.2 There are a number of concerns in relation to financial issues which are not clear in the proposals, including details of the impact of the £1m savings identified from back office functions and the £2.6m savings from cost releasing efficiency savings which are not clearly stated in the proposals.

3.3 The model of care seems heavily reliant on significant capital investments in the Resource and Recovery Centres (RRCs). There is no clarity about the likelihood of this funding or contingency plans should the funding not materialise.

3.4 There is no clarity in relation to transitional resources. A significant shift in the type of services provided is likely to lead to the need for transitional resources to be invested, which will facilitate shifts in services.

3.5 There are concerns about the workforce implications and, in particular, the impact on recruitment and the basis for decisions about filling posts.

3.6 The Committee is particularly concerned that Ashton, Leigh and Wigan do not appear to be properly factored in to the recovery plans. The Committee acknowledge a statement that they are not included in the process but feels that there is a lack of clarity about the financial impact of this.

3.7 The committee would like to know what the budget is for atypical drugs and a comparison of spend in each borough.

3.8 There are concerns about the impact on out of borough placements. What are the current arrangements for joint placement?

3.9 Project management, funding for this and process. Will partners have a place on the project board?

3.10 Future funding priorities given the pace of Government change we may have to look at a different model in the future. How can we resolve this?

4. <u>In-Patient Beds</u>

4.1 There is some confusion in the various documents about the number of in-patient beds. The Committee has concerns about the level of service for people who would have been utilising these in-patient beds, particularly in the light of the described over occupancy.

4.2 The Committee were concerned that the proposals relating to inpatient beds do not include psychiatric intensive care.

4.3 The impact on Council services, particularly the impact on the infrastructure currently in place and the type of accommodation required in each Local Authority given the planned bed reduction.

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5. Access to Services

5.1 The Committee is concerned about proposals to develop access and advice centres within each borough, as a single gateway to specialist mental health services. Based on the information provided, the Committee believes that further thought should be given to access to mental health services being from within Primary Care and other tier 2 services.

5.2 The Committee are disappointed that the RRC model seems mainly focussed on 9.00 a.m. to 5.00 p.m. services and the details of other out of office services are sparse. The Committee would welcome further information about staffing levels and implications for Council services out of hours.

5.3 The committee would like a comparison of Assertive Outreach Services – what currently exists and what will be required.

6. Impact on Council Services

6.1 The Model of Care refers to the impact on Council services including social care, however, the Committee were concerned that detailed information was not available.

6.2 The committee are unclear as to the future functioning of community mental health teams and how they will operate under the proposed model of care.

6.3 The committee are concerned about the impact on Council day services given the proposal to close day units.

7. Consultation Processes

7.1 The committee are concerned that there was some evidence that the consultation processes did not appear to be thorough and adequate. The Panel are concerned that service users, carers and staff working in the 5 Boroughs should be properly involved in the process and felt that the timescales of ending the consultation process on 24 August and implementing proposals by 1 October was unrealistic and unachievable.

8. General Points

8.1 The committee felt that some general points were worthy of further consideration. These include:-

- The lack of clear links with existing commissioning strategies for adults of a working age and older people.
- The proposed Model of Care does not cover all recommendations of the scrutiny exercise "scrutiny of hospital discharge services for St Helens residents with mental health problems".
- The focus on carers within the proposed Model of Care seems weak and carers issues do not appear to have been properly addressed.

8.2 Governance and accountability arrangements – how will this fit with current agreements?

8.3 Relationship with West Cheshire PCT - currently Halton (mainly 5 Boroughs Partnership NHS Trust) provides a service to residents in Helsby and Frodsham which impacts on the ability to provide services to Halton residents. How will this be resolved?

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