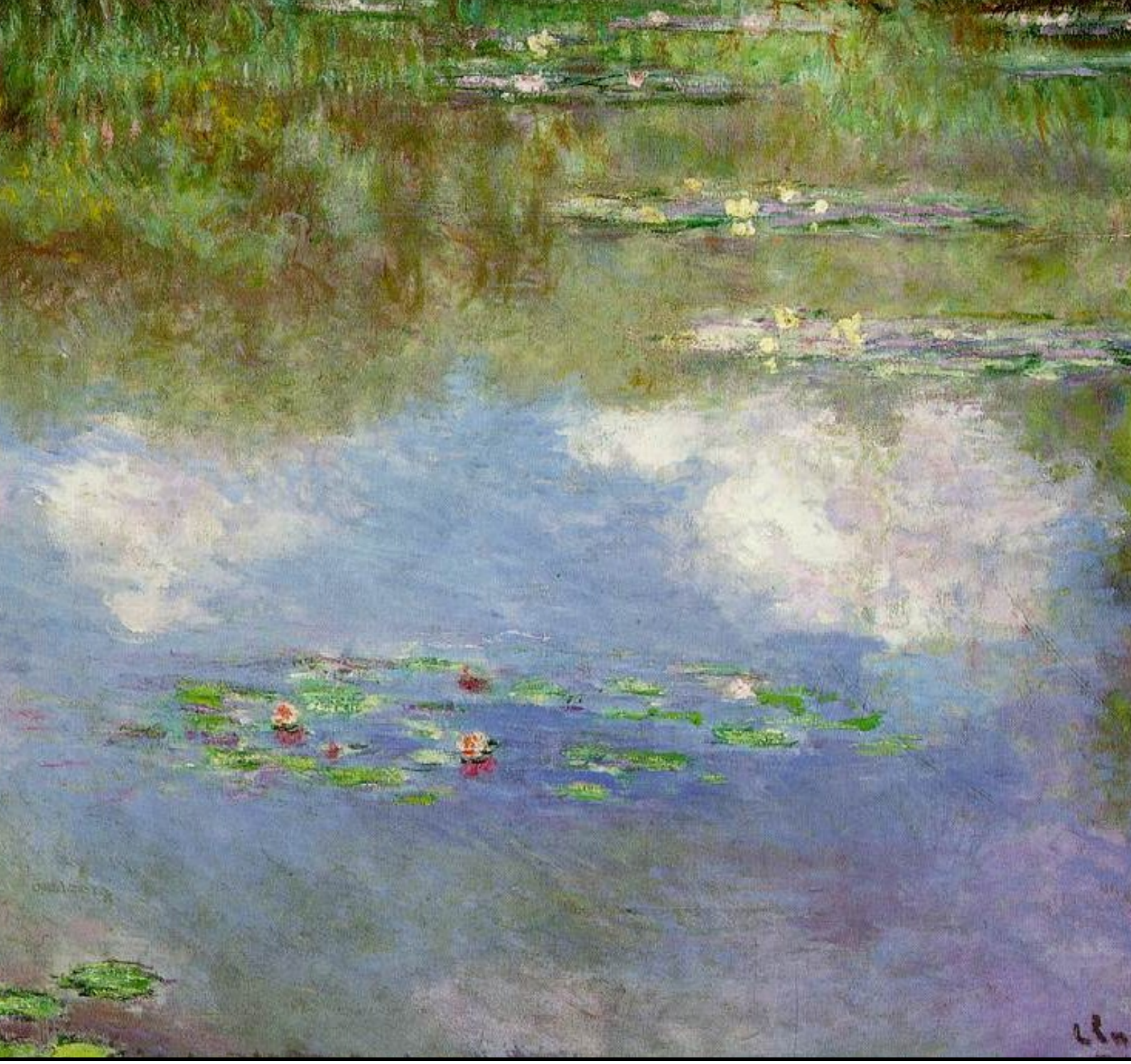

Adult Services & Health Policy & Scrutiny Committee

Consultation Response to Central and North West London NHS Foundation Trust's 'Building Better Mental Health Care'

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Westminster's consultation response to Central and North West London NHS Foundation Trust's '*Building Better Mental Health Care*' reconfiguration

Westminster's Adult Services and Health Policy & Scrutiny Committee at Westminster City Council would like to put on record our tentative support for Central and North West London Foundation Trust's plans outlined in their consultation document '*Building Better Mental Health Car*e.' Members of our Committee visited both of the facilities outlined in the consultation document and were satisfied with the rationale of the consultation; to revise the way that the Trust uses the beds, rather than simply removing bed capacity.

We note the report that the pilots (trial closures) have not shown any demonstrable and significant negative impact. We note that there is a need to **monitor out of borough admissions**, given that in Kensington and Chelsea, there was some increase in out of area admissions during the course of their own pilot closures.

We do retain residual concerns over the **continuing success of providing more care in the community for patients with mental health conditions**. On the 5th July 2012, the Committee noted that when developing proposals for community settings, **the local community and population need to be engaged throughout and taken into account, in addition to service users**. We acknowledged the importance of effective communication, and for consideration to be given to patient and community safety, ethnic communities and homeless people. We also would like to be assured that **patient experience should not suffer as a result of the changes, given that satisfaction with care did seem to be lower post-changes in Kensington and Chelsea**.

Context

Nationally, mental ill-health accounts for the greatest burden of years of life with a disability. Whilst it only accounts for 5% of years of life lost before the age of 75, it is responsible for over 40% of all years of life spent with a disability. Mental ill-health has been shown to have a strong inter-relationship with other chronic diseases. For example, there is a three times higher likelihood of depression among those with diabetes.

Westminster

Locally, inpatient admission for chronic disease is 15-30% more common among those on GP depression registers, compared to those who are not. Westminster also has the largest number of rough sleepers of any local authority. Many rough sleepers have mental health or substance misuse problems. There are approximately 3,155 patients in the borough on a GP register for severe and enduring mental illness (e.g. schizophrenia), the 5th highest in the country in 2010/11. These patients are focused in the south of the borough, reflecting GP registrations for the homeless population. It is important that Central and North West London Foundation Trust acknowledge that in reconfiguring service inpatient acute and male psychiatric intensive care provision in Westminster, there may be exceptional factors which impact upon demand.

Member Visit to the Gordon Hospital – 12th November 2012

Staff took representatives to the Male PICU facility (**Psychiatric Intensive Care Unit**) – the Belgrave Ward at the Gordon Hospital. Officers of the Trust reported that the service was seen as very cheap to run but did not necessarily provide a good patient environment; however, GPs had been wedded to refer to the Unit. Westminster referrals were high because of the prevalence of mental health issues associated with rough sleepers and a number of foreign nationals. Foreign nationals were particularly difficult to deal with, administratively, as the hospital had to liaise with Embassies and complete an inordinate amount of paperwork to secure placements in home countries. It was reported that the block contract ensured 90% of the PCT funding went to Westminster patients, with 10% reserved for non-Westminster referrals. However it was reported to be hard to recover costs from patients who were foreign nationals. However, it was stated that mental health was moving to PBR (payment-by-results) and there was now a shadow PBR system in place to ease the transition.

Westminster's Mental Health Profile

Westminster was reported to have a similar profile to Hillingdon because of the number of foreign nationals that had been referred to the unit (i.e. Heathrow in Hillingdon). However, in terms of Westminster's local profile, the City of Westminster was similar to Camden and Lambeth in terms of higher-than-average (compared to national) incidences of psychosis and substance misuse. In Westminster there are also a number of 136 referrals (Section 136 enables a police officer to remove someone from a public place and take them to a place of safety.) In Belgrave PICU, it was reported that the average length of stay had been about two months.

It was reported that the rooms were '*ligature proof'.* However the PICU beds at St Charles had ensuite facilities (unlike the Belgrave Ward). Rather than remove toilet seats as some hospitals would do, the Trust reported that engagement with patients and spending time with patients was a better preventative measure. The Trust reported that the closure of beds at St Charles would be a slow process, due to 'stepping down' the provision in a measured way. However they reported that they were fairly confident in reducing the acute provision by 15 at St Charles.

The PCT asked CNWLFT to close PICU because of the provision available in Kensington and Chelsea (St Charles Hospital). The Belgrave PICU at the Gordon was thus closed for a trial period on August 10th 2012.

Belgrave PICU – the increasing severity of mental health conditions

The staff at the hospital referred to the **increasing severity of mental health issues** in patients admitted to the Hospital. Staff showed representatives into the 'seclusion room' which had been used as a way to segregate patients with severe mental health difficulties.

Triage Wards

We welcome the new development at the Trust of *mental health triage wards*, with 1 FTE consultant at each site (at the 3 acute mental health sites). It was reported that this was best practice and the Trust had visited Essex (Southend) and Lambeth to see how others had followed this path. There are three of these models in place at the three CNWLFT sites and the Trust was obtaining an evaluation of how it had been working. The Trust was also soliciting service-user and staff feedback on the model. The triage model was 'gatekept' by the 'Home Treatment Team.' On arrival at the Triage unit, 50% of the patients are triaged for acceptance into the unit and 50% are dealt with by the Home Treatment Team.

The closures of the Male PICU at the Gordon and the closures of beds at St Charles would create £500,000 and £400,000 would be reinvested into community services.

The triage ward did not have ensuite facilities for patients. There was a 'group room' for activities and there was a redecoration scheduled to take place to improve the look and feel of the central areas. There would be input from service-users and the Trust would consult good practice models on decoration. Smoking was reported to be an issue, in relation to the need for staff accompaniment to the roof terrace, but NHS Stop Smoking cessation staff did visit and ward managers were pragmatic about the problem.

The Consultation on Bed Closures – Staffing at the Gordon

In reference to the proposed changes to the Belgrave PICU and St Charles, the Trust reported that they were in a fortunate situation, as there were vacancies in the Trust, and this meant that staff could easily be redeployed. In these situations, staff were redeployed to units nearer to where they lived (and 4 / 5 staff had already done this). The triage model of acute mental healthcare was also broadening staff member experience and allowed the sharing of staff skill sets. As PICU staff had advanced skills in dealing with very disturbed patients (which would be a 'niche' skill), the case mix of a triage ward was quite rewarding for transferred staff. There was a buddy & mentor system in place for staff to share experience and knowledge.

Visit to St Charles' Hospital – 16th November

Members asked about whether the changes were a cost-driven exercise rather than for the purpose of improving care. The Trust responded that since they had taken over acute services, the issue was the improvement of quality of care for patients. A lot of work was undertaken to benchmark the inpatient bed provision internally between boroughs and externally with other trusts. The bed provision per 100,000 for Westminster (and Kensington & Chelsea) was much higher than elsewhere and the length of stay was comparatively high. In order to improve the care for patients by reducing the length of stay - the service implemented 'triage wards' (as highlighted above.)

Members also asked about the reduction in PICU provision, as reports show that 24 in 1000 people suffer from psychosis. It was reported that CNWLFT had a dedicated Early Intervention Service (EIS), which worked with the Trust to look to provide care for patients with psychosis in the community. The team had a target caseload of 34-40 new cases per year. These were people who were not known to current mental health services. The age group seen spanned from 14-35 and the team worked closely with the Home Treatment Team and community recovery services. It was hoped that better integration between these teams would stop re-admission / admission into PICU wards. A step change was needed within the community teams but this was reported to be already happening.

Members asked whether the reduction of beds would have an adverse effect on GP's referring into the service. The Trust reported that they worked with the GP's to educate them around the referral criteria and they would always provide an inpatient bed to a patient that needed admission. If someone presented needing an inpatient admission, the Trust would look to house the patient in his or her borough in the first instance and 9 times out of 10, the Trust could do this. Otherwise the Trust would look across the other inpatient units; trying to ensure the patient stays within the service. If not, then a bed would be purchased for admission. **At no stage would the patient not be admitted to an acute ward.** During the test closure, the Trust has not had to purchase any beds from the private sector. **Members of the Committee are naturally cautious around the flexibility of the Trust to cope with extra demand and hope that the Trust continues to monitor the situation.**

ENDS