HEALTH OVERVIEW AND SCRUTINY COMMITTEE PAPER – 22nd May 2012

Distribution: **Hampshire Overview and Scrutiny Committee (HOSC)**

Submitted by: **Adult Mental Health Division, Southern Health NHS Foundation Trust (SHFT)**

Date: **11th May 2012**

Purpose: This paper responds directly to the points raised by the HOSC Working Group on 23rd April 2012.

a. Details of the outcomes that the Trust will use to measure the performance of the new model for adult mental health services.

We monitor our performance centrally through a Divisional Performance Group and Divisional Service Board.

Some of the things that we will be recording and considering, to enable us to monitor if our model is realising the redesign benefits and that our systems are working properly are:

- The number of people referred/coming into the service and the number of people currently in the service, compared to the amount of staff available in certain parts of the service to meet this demand.

- The caseload that a team and/or a member of staff may have at any one time, compared to the number of service users in the system.

- The length of stay for a service user in different parts of the service alongside the number of discharges that take place.

- Auditing care plans and clinical pathways to ensure we are delivering the right care in the right place, at the right time for our service users.

- Measuring specific metrics that our commissioners and regulators want us to measure our work against, such as occupied bed days, rates of admissions, gate-keeping of admissions and follow ups.

- Checking that staff have the right tools and support to enable them to deliver their roles by reviewing staff training and development needs as well as sickness and vacancy rates.

- Reviewing quality outcomes against NICE guidelines, as well as learning from incidents and complaints, by peer-group inspections. Investigating every incident and actively learning lessons and implementing best practice through transparent, open dialogue across our services and with our service users.

- Rolling out of the INSPIRE tool which is designed to assess service users experience of the support they receive from mental health works in line with their recovery.

a.3. **Information is attached as requested:**

- Acute bed occupancy, including key milestones
- Separate bed data graphs for male, female and 'swing' beds
- Percentages of voluntary vs. detained inpatients
- Average length of stay for inpatients

In summary, acute bed occupancy data demonstrates that since the closure of the Meadows at the end of March 2012 we have continued to make steady progress in creating capacity in our acute care wards, with between 12 and 22 beds available every day in April.

The male and female bed availability charts demonstrate that there are fluctuations in demand for these beds, as we expect, with particular pressure in March on male beds. However, in April the availability of beds has been evenly distributed between men and women.

Our length of stay has fallen since October 2011. It is also noteworthy that in April, following the closure of the Meadows and reduction of acute beds by 10 in Southampton, the proportion of detained patients in our acute inpatient units has not increased. This is because the work to support people in community settings and reduce people's length of stay has been effective for voluntary service users and those who may be subject to the Mental Health Act.

b. The process that the Trust follows to establish the right capacity to be built into the system for the population of Hampshire is 107 beds

As HOSC members will be aware, in addition to consulting with our staff, services users and stakeholders we carefully examined our internal data. We also considered information from the Audit Commission, and Consilium Strategy Consulting as well as local and national sources to help us make a decision on how many beds were required in the future redesign model. Some of the tools we used in addition to establish the number of beds appropriate for the population of Hampshire included:

- Modelling the length of stay profile for each Adult Mental Health unit, as well as for the service as a whole;

- Our admission rates, length of stay profiles and occupancy rates, and external benchmarking of other leading mental health trusts in England.

- Analysis of the population trends and demand over the next five years.

- The mental health needs index (MINI) published by the Centre for Mental Health, to provide a relevant 'weighted population' calculation. (MINI takes the 'raw' 15-64 year olds population and weights the total by a series of factors linked to the incidence of severe mental illness such as poverty, unemployment and social isolation).

c. How will the Trust measure and monitor the impact of the new model of care, including the reduction in inpatient beds, on other social care and mental health providers in Hampshire

We regularly formally feed into the Partnership Operations Group, where we regularly share information with our social care colleagues as part of our Section 75 contract monitoring arrangements.

In addition to the measures and monitoring forums detailed in section (a) of this paper the Division will also be monitoring over time the following care outcomes:

- Care Quality Commission (CQC) inspection reports;
- Patient survey results;
- Measures of service user recovery, for example occupation, employment, living conditions, accommodation via Health of the Nation Outcomes Scales (HoNOS) - measured where appropriate at admission or Care Programme Approach (CPA) reviews;
- Closer working relationship with other care providers, measured by structured feedback from other service providers in the local community e.g. social services, children social services, criminal justice services, housing departments, third sector organisations;
- Evidence of service user involvement in our processes e.g. clinical and business meetings and development sessions via the Mental Health Foundation instruments;
- Data from qualitative interviews with service users, carers, staff, referrers and commissioners.

d. The executive summary or conclusions of the 'Consilium Strategy Consulting' report on inpatient capacity.

Please find attached the Consilium Strategy Consulting report.

As you are aware the document was one of a number of data sources, some of which have been outlined in section (b) of this paper, that have informed what has been a complex and detailed analysis of a variety of data sets, reports and national guidance and benchmarking to draw conclusions about the service redesign.

You will note that the data in respect to Woodhaven was not included in the Cons Ilium Report. This was noted by the Trust and Adult Mental Health Management team. Additional information was reviewed to validate the original Consilium conclusion (see below).

	Weighted Population	Admissions rates per 100,000	Average Length of Stay (days)
	16-59/64 (age)		
Woodhaven	77,040	389	40

The additional information for Woodhaven demonstrates that the conclusions of the original 2011 external benchmarking exercise remained unaffected (i.e. Southern Health could reduce AMH acute and PICU beds from a total of 190 to between 108 and 131). The total number in the redesigned service will be 133 (including PICU beds).

In fact the inclusion of the Woodhaven data illustrated a potential to reduce acute and PICU beds beyond the proposed AMH plans.

In response to your questions (e) to (h) regarding the therapeutic environment at Woodhaven:

We believe that all patients, regardless of their legal status, should expect and receive a high quality therapeutic environment. All of the remaining inpatient units, as part of the redesign, are of a standard that we are clinically satisfied will provide an environment to help recovery and service users return back into the community as soon as possible.

In terms of the physical environment within our hospitals, we participate in the Patient Environment Action Team (PEAT) programme (Health and Social Care Information Centre 2011), which considers the physical environment, food and privacy and dignity. Our units are consistently rated as 'good' or 'excellent' on these assessments.

However, a therapeutic environment is not created by the physical environment alone. A large part of the environment that aids recovery is created by the staff and therapies that a service user receives. Our wards are staffed by multidisciplinary teams including doctors (as part of the service redesign we now have dedicated acute care consultants in every unit), nursing staff, psychologists, occupational therapists, pharmacists and health care support workers. Development of our staff is a priority, and is occurring through our training programmes, strengthening of practice development in teams, and the delivery of a leadership development programme for our senior ward staff and other leaders across the service.

Melbury Lodge benefits from other advantages to Woodhaven. The inclusion of a Mother and Baby unit and an Older People's Mental Health ward at the site encourages staff to support each other and share best practice. The advantages of being on the Royal Hampshire Hospital site at Winchester, is that public transport links are good. It also means that if someone needs acute care they can receive it quickly and safely as working relationships with acute care services are very good.

All our inpatient wards are implementing the Productive Mental Health Ward programme, a national programme which aims to improve the efficiency of wards, with a focus on releasing time to care.

Our units also actively seek feedback from service users, and use the feedback to improve services. We have robust arrangements in the West for involving service users in any decisions affecting Adult Mental Health Services. The Service User Involvement Project, commissioned through Andover Mind, facilitates community meetings and is well established within the area's management structures. If we were to undertake any major works at any our of adult mental health sites, we would use our stakeholder groups to gather feedback into our plans.

i. A plan setting out the actions that are being taken by the Trust and its partners to improve access to out of hours mental health assessments.

There are two types of mental health assessments:

1) A Mental Health assessment is carried out to determine someone's mental state and to inform the development of a care package, if it's needed. In our new model, in most cases new service users would have these types of assessments done by our Access and Assessment Teams.

2) Mental Health Act assessment is a statutory process which is carried out by a team of multi disciplinary professionals in the event of someone refusing admission to hospital when an assessment of their mental state indicates a high level of risk to someone's health, safety or protection of others.

One of the key goals of the service redesign was to improve access to Adult Mental Health Services out of hours. We are now rolling out a 24 hour single point of access in each area to which GPs can refer new service users. For those service users already known to our service, they will now experience a smoother journey to the most appropriate team or service provider that best meets their needs. It is early days for these services, which launched in April 2012, but we have already had positive feedback from GPs as to the benefits of the single point of access.

In March 2011, alongside our own service redesign, we also began to work with key partners to improve out of hours service access to Mental Health Act (MHA) Assessments. We are currently taking part in a three month trial in East Hampshire alongside our colleagues in social services to improve the Approved Mental Health Professionals (AMHP – these people are employed by social services and can complete MHA assessments) provision.

In addition to this, a joint-working group has been set up and aims to:

- Ensure the equitable quality of AMHP Service delivery at all times of the 24 hour day across all seven days;
- Deliver a service which minimises the disruption to the service user and his or her family taking into account the 'service user experience';
- Provide a service which is accessible and limits the potential variation in practice promoting local governance and leadership;
- Deliver efficiency in the provision of a sufficient number of AMHPs to meet recorded demand.

Whilst working with our AMHP colleagues we are also mindful of the various other agencies which play an interdependent role in providing out of hour services to our client groups. With our partner agencies we have developed a comprehensive work plan for in- hours and out-of-hours services, which is being monitored by a multi-agency Section136 Group. This work plan is derived from National Guidance and provides a broad focus including waiting times, staffing, training, associated with for example ambulance services and arrests under Section 136, and many others change programmes.

Clarify whether night discharging occurred within the acute inpatient mental health units.

The Division does not undertake planned discharge of service users during the night.