TOWER HAMLETS

HEALTH SCRUTINY PANEL

Tuesday, 16 September 2014 at 7.00 p.m.

Committee Room 1, 1st Floor, Town Hall, Mulberry Place, 5 Clove Crescent, London, E14 2BG

SUPPLEMENTAL AGENDA

This meeting is open to the public to attend.

Contact for further enquiries:
Antonella Burgio, Democratic Services
1st Floor, Town Hall, Mulberry Place, 5 Clove Crescent, E14 2BG
Tel: 020 7364 4881
E-mail: Antonella.Burgio@towerhamlets.gov.uk
Web: http://www.towerhamlets.gov.uk/committee

Scan this code for an electronic agenda:

PAGE NUMBER(S)

2. **MINUTES OF THE PREVIOUS MEETING(S)** **1 - 6**

Minutes attached

4 .3 **Modernising In-patient Assessment Services for Older Adults with a Functional Mental Health Problem in Tower Hamlets, City of London & Hackney** **7 - 48**

To receive a report from East London NHS Foundation Trust.

LONDON BOROUGH OF TOWER HAMLETS

MINUTES OF THE HEALTH SCRUTINY PANEL

HELD AT 6.30 P.M. ON TUESDAY, 15 JULY 2014

COMMITTEE ROOM 1, 1ST FLOOR, TOWN HALL, MULBERRY PLACE, 5 CLOVE CRESCENT, LONDON, E14 2BG

Members Present:

Councillor Asma Begum (Chair)

Councillor Danny Hassell
Councillor David Edgar
Councillor Suluk Ahmed
Councillor Mahbub Alam

Co-opted Members Present:

avid Burbridge – (Healthwatch Tower Hamlets Representative)
Dr Sharmin Shajahan (PhD) – Healthwatch Tower Hamlets

Guests Present:
Dianne Barham – (Director of Healthwatch Tower Hamlets)
John Wilkins – Deputy Chief Executive, East London NHS Foundation Trust
Councillor Andrew Wood –
Josh Potter – Deputy Director Of Commissioning And Transformation, NHS Tower Hamlets Clinical Commissioning Group

Officers Present:

Tahir Alam – (Strategy Policy & Performance Officer, Chief Executive's)
Deborah Cohen – (Service Head, Commissioning and Health, Education, Social Care & Wellbeing)
Frances Jones – (Service Manager One Tower Hamlets, Corporate Strategy and Equality Service, Law Probity & Governance)
Karen Sugars – (Programme Manager Health & Care Reforms, Education Social Care and Wellbeing)

Antonella Burgio – (Democratic Services)
Antoinette Duhaney – (Interim Senior Committee Officer)

Apologies:

Councillor Denise Jones and Councillor Md. Maium Miah

1. APPOINTMENT OF VICE-CHAIR

RESOLVED

That Councillor David Edgar be appointed as Vice Chair of the Health Scrutiny Panel

2. DECLARATIONS OF DISCLOSABLE PECUNIARY INTERESTS

Councillor Wood declared an interest in Agenda Item 5.2 on the grounds that he was Chair of the Patient Panel.

3. MINUTES OF THE PREVIOUS MEETING(S)

RESOLVED

That the minutes of the Health Scrutiny Panel held on 11 March 2014 be approved as a correct record of proceedings.

4. REPORTS FOR CONSIDERATION

4.1 Health Scrutiny Panel Terms of Reference, Quorum, Membership and Dates of Meetings

RESOLVED

1. That the terms of reference, quorum, membership and dates of meetings of the Health Scrutiny Panel be noted.
2. That future Health Scrutiny Panel meetings commence at 7pm on a trial basis and be reviewed in 3 months time.

4.2 Co-options to Health Scrutiny Panel

RESOLVED

That the appointment of David Burbage and Sharmin Shajahan as co-optees to the Health Scrutiny Panel be noted

4.3 The Care Act 2014

Karen Sugars gave a presentation on the Care Act 2014 and the impact of the new legislation on Tower Hamlets. The Panel was advised that the Act received royal ascent in May 2014 and would take effect from April 2015. It

was a major change pulling together more than 40 separate pieces of legislation and the main aim of these changes was to put people's needs and aspirations at the forefront of healthcare. The key components of the Act were:

- New legal framework for adult social carer
- Reformed quality and safety regulations for healthcare providers
- Creation of Health Education England and Health Research Authority

The Act also imposed certain duties such as better integration of health and social care services statutory adult safeguarding boards. An Ofsted style rating system for hospitals and care home providers would be introduced and there would be a universal eligibility threshold. The Act would facilitate joint working on assessments, planning and delivery. However some likely challenges included:

- Increased number of assessments and requests for support at a time of severe financial constraint
- Challenging timescales to achieve priorities
- Shortfall in funding to implement reforms

RESOLVED

That the presentation be noted.

5. ANY OTHER BUSINESS WHICH THE CHAIR CONSIDERS TO BE URGENT

5.1 CCG - Health Landscape

Following a short video, Josh Potter gave a presentation to the Health Scrutiny Panel on the role of the CCG which had responsibility for planning, buying and monitoring local health services. The CCG was comprised of 36 GP practices arranged into 8 networks each with 4-5 practices. The CCG worked closely with a wide range of health providers to commission health services. The key visions of the CCG were:

- High quality health & social care services
- A vibrant and stable health & social care system
- Integrated services to cater for individual needs

NHS Tower Hamlets CCG was responsible for a number of services including planned hospital care, maternity services, cancer services, fertility services, urgent & emergency care, children's services and treatment of infectious diseases. The CCG managed a budget of approximately £340million which included £164m for hospital care and £51m for community health services. The key priorities included:

- Safe and convenient maternity services
- Improved health outcomes for children and young people
- Integrated care for patients with multiple health conditions
- Timely high quality urgent and emergency care

- Commissioning of integrated mental health services
- Innovative use of technology

In response to questions and comments from Members, Mr Potter stated that:

- the commissioning of primary care was relatively new.
- NHS England did not have the local knowledge of the CCG.
- CCGs would not be the sole purchaser of GP services but would be accountable to NHS England and the Secretary of State for Health.
- Co-commissioning would reduce a lot of duplication and also save money.

RESOLVED

That the presentation be noted.

5.2 Healthwatch Tower Hamlets

Dianne Barham gave a presentation to the Health Scrutiny Panel on Healthwatch Tower Hamlets. Healthwatch Tower Hamlets was a charitable company with a Board of Directors to manage business and monitor performance alongside an Advisory Group representing the interests of residents.

The main role of Healthwatch was:

- Encourage and support local people to engage in the commissioning, provision and monitoring of local health and social care services
- Make recommendations for service improvements based on the experiences of health and social care service users
- Signposting about services available
- Highlighting concerns to Healthwatch England and the Care Quality Commission so that they can review or investigate these concerns

The priorities for 2014/15 included a public event arranged for 14 August 2014, patient feedback on integrated care, assessing the impact of NHS payment legislation on child migrants and stronger links with faith groups.

RESOLVED

That the presentation be noted.

5.3 Work Planning

Tahir Alam, Senior Strategy Policy and Performance Officer, Corporate Strategy and Equality Service tabled a document and Panel considered the topics and priorities that they wished to pursue.

RESOLVED

That an update on the proposed workprogramme with suggested timings be presented at the next Panel meeting.

The meeting ended at 8.00 p.m.

Chair, Councillor Asma Begum
Health Scrutiny Panel

This page is intentionally left blank

East London NHS
NHS Foundation Trust

PROPOSAL TO MODERNISE FUNCTIONAL IN-PATIENT SERVICES FOR OLDER ADULTS IN TOWER HAMLETS AND CITY & HACKNEY

Full Business Case

14 April 2014
Version 19.0

Contents

	Executive Summary	3
1.0	Introduction	3
2.0	Background	3
3.0	Strategic Context and National Policy Guidance	4
4.0	Current Inpatient Provision and Performance	4
5.0	The Case for Change	5
6.0	Options for Change	5
7.0	Reasons for selecting Mile End as the preferred site	5
8.0	Recommendation	6
	Proposal to Modernise Functional In-Patient Services for Older Adults	7
1.0	Introduction	7
2.0	Background	7
3.0	Functional Mental Health Problems	8
4.0	The National Strategic Context	9
5.0	The Local Strategic Context	10
6.0	National Policy Guidance	14
7.0	Current Inpatient Provision and Performance	15
8.0	Snapshot Survey Carried Out 17 June 2013	16
9.0	Clinical Evidence from Elsewhere in England	17
10.0	Remodelled Community Services	18
11.0	Improved Care Pathway Management – Estimating Capacity	22
12.0	Maintaining Close Partnership Working	24
13.0	Market Analysis and Population Growth	27
14.0	Site Options Appraisal	27
15.0	Travel Considerations for Carers	31
16.0	Options for Change	34
17.0	Non Financial Evaluation	36
18.0	Financial Evaluation	38
19.0	Recommendations	40
20.0	Appendices	41

A	Mental Health Benchmarking Club Report (June 2011)
B	Care Pathway Management Protocol
C	Site Options Appraisal
D	Travel Impact Report
E	ELFT Carer Transport Protocol
F	Draft Consultation Strategy
G	Equality Impact Analysis
H	Mobilisation Plan
I	Quality Impact Assessment
J	Older Adult Strategy Programme Board, Project Plan
K	Joint improvement Partnership (London) Prevention of Admission to Residential Care Project.
L	Mile End Site Map

PROPOSAL TO MODERNISE FUNCTIONAL IN-PATIENT SERVICES FOR OLDER ADULTS

Executive Summary

1.0 Introduction

1.1 Traditionally, older people with mental health problems have been identified into one of two groups, depending on diagnosis:

- those who have an ‘organic’ brain disorder such as dementia; and,
- older people with so-called ‘functional’ disorders, the most common of which is depressive illness, but also including people with schizophrenia and other psychoses.

1.2 This paper proposes the modernisation of East London NHS Foundation Trust (ELFT) services for older people with functional mental illness in Tower Hamlets and City & Hackney through two inter-related components:

- consolidation of inpatient services to create a new more centralised inpatient unit;
- continued improvement of care pathway management processes and systems both in the community and in hospital.

1.3 The proposals have been developed to meet local commissioning priorities; the Trust has worked closely with CCGs in exploring the options to deliver the key aims of improved integration and enhancement of community service provision. Initially proposals included centralising services provided to older people in Newham; local commissioners have decided not to pursue this option for the present.

1.4 The proposal is designed to deliver comprehensive functional mental health services and in so doing improve service quality for older people in City & Hackney and Tower Hamlets. That is, the reduction in beds enables improvement across the care pathway.

1.5 The Business Case allows the Trust to meet its current contract to provide Functional Older Adult inpatient services to City & Hackney and Tower Hamlets, as well as at present to Newham. Implementation of the proposals will sit alongside improved clinical processes and redirected clinical resources, for example, consultant job plans will be restructured so that senior clinical leaders move from a traditional consultative support model to the ward to an active clinical leadership role. Clinical pathways in both boroughs will be focused on minimising stay in hospital and reducing delayed transfers of care.

2.0 Background

2.1 In January 2008, ELFT began a review of mental health services for older people in partnership with service commissioners and other key local stakeholders. A Strategy Board was established, chaired by the Trust’s Chief Executive, with membership that included a carer’s representative and two Foundation Trust Governors. The Board co-ordinated the work of various project groups as they developed modernisation proposals. The review concluded that the Trust should provide a wider range of

rehabilitative community based services with the aim of supporting people more fully at home, whilst at the same time reducing surplus inpatient capacity.

3.0 Strategic Context & National Policy Guidance

3.1 The proposed changes reflect national policy which consistently emphasises the importance of delivering effective care to older people with mental health problems. ***No Health Without Mental Health, a cross government mental health outcomes strategy for people of all ages***, sets national priorities for increasing value for money in the context of £20bn of efficiency savings required from the NHS by 2014 by:

- improving the quality and efficiency of current services;
- changing radically the way that current services are delivered so as to improve quality and reduce costs;
- shifting the focus of services towards promotion of mental health, prevention of mental illness and early identification and intervention as soon as mental illness arises; and,
- broadening the approach taken to tackle the wider social determinants and consequences of mental health problems.

3.2 These are consistent with social care policy directives such as ***A vision for adult social care: capable communities and active citizens,*** (2010), which recommended the redesign of services with the inclusion of:

- better joint working with the NHS;
- helping people to stay independent for longer, with a focus on reablement services, and more crisis or rapid response services;
- more streamlined assessment.

3.3 In its 2011 report, ***In-patient care for older people within mental health services***, the Faculty of the Psychiatry of Old Age of the Royal College of Psychiatrists advises:

'Hospital admission is needed for people with psychiatric and behavioural problems that cannot be managed in any other setting, with close links to physical healthcare services – with admissions limited by effective community services.'

4.0 Current Inpatient Provision and Performance

4.1 The current service structure for inpatient and community functional services is as follows:

	Ward Name	Beds	En-suite Rooms	Intermediate Care Team
City & Hackney	Larch	15	0	Yes (6 WTE)
Tower Hamlets	Leadenhall	19	14	No
Total		**34**	**14**	

4.2 Average Length of Stay [ALOS] has fallen from 104 days in 2009/10 to 78 days in 2013 with occupancy level across the two boroughs at around 73%.

5.0 The Case for Change

5.1 Changing older people's inpatient services will:

- achieve significant quality improvements in care pathway management and the delivery of community services based on lessons learned from elsewhere in England;
- achieve closer service integration and meet higher standards of physical health care through the consolidation of existing medical, therapy and nursing input;
- improve quality and efficiency by avoiding extended hospitalisation for older people unless absolutely necessary (in line with national policy guidance);
- locate mental health services near other general medical older people's services located on the Mile End site (in line with national policy guidance);
- tackle the inefficiencies resulting from current excess bed capacity with occupancy levels at 75% or less;
- adhere to outcomes of commissioned studies into site options and transport.

6.0 Options for Change

6.1 4 options are considered and evaluated:

Option 1: 34 beds

- No Change

Option 2: 28 beds

- Create two separate 14-bed fully en-suite wards at the Bancroft Unit on the Mile End Hospital Site, Bancroft Road;

- This option would result in a net bed reduction of 3 beds per CCG.

Options 3a and 3b - 19 and 26 beds respectively

- Retain Leadenhall Ward (on the Mile End Hospital site) and enhance staffing to deliver a high care function to meet the needs of patients with very challenging behaviours. This applies to both versions of Option 3. Option 3a simply utilises beds on Leadenhall and results in a net bed reduction of 7.5 beds per CCG

- Option 3b increases bed capacity by the use of Columbia ward annex as a 7-bedded (5 en-suite), female functional facility. This option would result in a net bed reduction of 4 beds per CCG. This additional space offers flexibility for further reductions if bed usage is such that numbers can be reduced further.

Neither of the option 3 variables would prevent Newham commissioners revising their view about co-location at a later date.

7.0 Reasons for Selecting Mile End as a Preferred Site

7.1 The Full Business Case examines the details of site selection and includes recommendations from the Royal College of Psychiatrists [RCP] and the outcome of a commissioned study by the independent health research organisation, Dr Foster (Sections 14 & 15 and Appendices C & D).

7.2 In summary, Mile End was selected in preference to the alternative existing site in Hackney for the following reasons:

- It offers the capacity to locate highly expert clinicians (in dementia and mental illness) in a centralised location thereby enhancing the delivery of integrated multi-disciplinary care and so improving the quality of service delivered to patients. At present specialised therapy staff are spread across three existing ward sites and this proposal would allow this resource to be concentrated in two locations; (i.e. Newham and Mile End).
- This option allows the Trust to consolidate and refine the delivery of physical health services to this group of inpatients. Maintaining all the SLAs and sub contracts associated with operating on multiple sites is challenging. Since the opening of Columbia Ward huge progress has been made in developing robust and comprehensive arrangements with colleagues in Community Health Newham and Bart's Health for MHCOP patients on the Mile End site. This improvement can be built upon and extended to include new MHCOP wards on that site, meaning clinical staff can improve and monitor physical healthcare arrangements much more reliably.
- It is the only available site with sufficient space to provide most rooms with en-suite accommodation, high quality day and therapy areas and to meet spikes in demand for beds.
- The Trust already provides centralised inpatient dementia care on the site and reducing the number of sites occupied by the service will facilitate the development of a centre of excellence.
- The outcome of the travel study was that the impact of relocation was less disruptive if services were located at Mile End rather than in Hackney. The Trust recognises the importance of travel considerations for older people and their carers, and additional assistance will be provided to support patient and carer transport.

7.3 Ivory Ward at the Newham Centre for Mental Health is the current 15-bed ward for older adults with mental illness. Commissioners in Newham have decided that this ward should continue to be used to provide facilities for functional illness, subject to a further review in 4 to 6 months. This ward would in any case, be too small to accommodate a consolidated service for all three East London boroughs.

7.4 The Lodge in Hackney was also considered but does not provide sufficient accommodation, or en-suite accommodation, nor is it located on the Homerton site where specialist physical healthcare is available and transport links, overall, are more challenging than at Mile End.

8.0 Recommendation

8.1 It is recommended that **initially Option 3b is adopted with the aim of moving to Option 3a after six months**. Linking these options delivers the key strategic aim of improving quality of care. It also contains costs and maximises the release of savings without compromising patient well-being and safety. As dementia assessment beds are already located on the site, there is potential to create a new centre for the care of older people with mental health problems by bringing together staff with expertise, and by working closely with colleagues in nearby physical health care services. An integral part of this recommendation is the proposed provision of significant additional ongoing assistance with travel for patients and carers who require this.

PROPOSAL TO MODERNISE FUNCTIONAL IN-PATIENT SERVICES FOR OLDER ADULTS IN CITY & HACKNEY AND TOWER HAMLETS

1.0 Introduction

1.1 This report proposes the modernisation of services provided for older people with functional mental health problems in City & Hackney and Tower Hamlets. These are specialist services caring for small numbers of people. In recent years bed occupancy has been reducing and now stands at around 73% of current capacity. The proposal's two inter-related components are a new centralised inpatient unit and the continued improvement of care pathway management processes and systems in both community and inpatient services. These aims should not be viewed separately but seen as essential components of a health system.

1.2 The proposals have been developed within the context of local priorities and the strategic direction of travel set by the CCGs who have collaborated closely with the Trust as it has examined options to deliver the key aims of improved integration and enhancement of community service provision.

1.3 These proposals have been developed by the Trust's Older Adult Programme Strategy Board and involve bringing together and centralising the specialist skills and experience required to care for this group of older people. They also involve the removal of surplus inpatient capacity and greater use of modern approaches to care pathway management and community service delivery.

1.4 Central to the proposals are the twin aims of improving service quality for older people, and the continued delivery of full and comprehensive functional mental health services for the people of City & Hackney and Tower Hamlets. If implemented the effect will be the enhancement both to locally based community services and an initial net bed reduction of surplus bed capacity equivalent to 4 beds later rising to 7.5 beds per Clinical Commissioning Group.

1.5 The preferred option will therefore provide 26 dedicated specialist functional beds in the first instance. This number will reduce after 6 months to 19 beds. A new consolidated unit provides higher staff to patient ratios with currently dispersed expertise being brought together to deliver better outcomes. This will offer improved capacity to commence rehabilitation and reablement processes within inpatient care to support the return home of patients as soon as possible; and avoid the loss of skills and confidence that can lead to onward referral to residential and nursing care.

2.0 Background

2.1 In January 2008, ELFT began a review of mental health services for older people in partnership with service commissioners and other key local stakeholders. A Strategy Board was established, chaired by the Trust's Chief Executive, with membership that included a carer's representative and two Foundation Trust Governors. The Board co-ordinated the work of various project groups as they developed modernisation proposals. The review concluded that the Trust should provide a wider range of

rehabilitative community based services with the aim of supporting people more fully at home, whilst at the same time reducing surplus inpatient capacity.

2.2 A phased approach has been taken to implementing these recommendations, with dementia assessment inpatient services being given first priority. The proposals contained in this report relate to the next phase of the programme which includes modernisation arrangements for functional beds.

2.3 In keeping with national policy guidance the Trust is fully committed to utilising new healthcare technologies to improve the quality and efficiency of its services. The Trust delivers functional mental health services to both borough populations under contractual arrangements and the application of these new technologies may alter the way in which these services are delivered.

2.4 Like all NHS organisations, the Trust is required to make significant efficiency savings every year. This proposal is dependent on commissioners in both boroughs working collaboratively with the Trust to remove excess bed capacity to create a new enhanced service for older people. The original thinking was that all three boroughs would participate in this change and that if one borough did not support the proposal, it would be critically undermined as the required £1m savings would not be achievable. Any balance would need to be found from other areas, which could include community services. The decision taken by Newham CCG not to centralise their beds has affected efficiency and this can be seen in the financial evaluation (paragraph 18).

3.0 Functional Mental Health Problems

3.1 Traditionally, older people with mental health problems have been identified into one of two groups, depending on diagnosis:

- those who have an ‘organic’ brain disorder such as dementia; and,
- older people with so-called ‘functional’ disorders, the most common of which is depressive illness, but also including people with schizophrenia and other psychoses.

While this categorisation has its limitations, it provides a proxy for the different needs that patients may have.

3.2 The provision of separate in-patient beds for these two groups has been consistently regarded as good practice by the Audit Commission and the Royal College of Psychiatrists. People with severe depression, for example, may find that sharing their living space with others with behavioural problems can make them feel worse. The effect on those with dementia of sharing a ward with people with severe depression may also be unhelpful. The type of care and treatment needed for the two groups is often quite different with both requiring specialist skills. All the proposals identified adhere fully to the principle of separation

3.3 Close adherence to these best practice principles has been central to all of ELFT’s planning for the development and improvement of older people's mental health services in East London.

4.0 The National Strategic Context

4.1 The proposals reflect national policy which consistently emphasises the importance of delivering effective care to older people with mental health problems. ***No Health Without Mental Health, a cross government mental health outcomes strategy for people of all ages***, sets national priorities for increasing value for money in the context of £20bn of efficiency savings required from the NHS by 2014 by:

- improving the quality and efficiency of current services;
- changing radically the way that current services are delivered so as to improve quality and reduce costs;
- shifting the focus of services towards promotion of mental health, prevention of mental illness and early identification and intervention as soon as mental illness arises; and,
- broadening the approach taken to tackle the wider social determinants and consequences of mental health problems.

4.2 These are consistent with social care policy directives such as ***A vision for adult social care: capable communities and active citizens,*** (2010), which recommended the redesign of services with the inclusion of:

- better joint working with the NHS;
- helping people to stay independent for longer, with a focus on reablement services, and more crisis or rapid response services;
- more streamlined assessment.

4.3 In its 2011 report, ***In-patient care for older people within mental health services***, the Faculty of the Psychiatry of Old Age of the Royal College of Psychiatrists advises:

'Hospital admission is needed for people with psychiatric and behavioural problems that cannot be managed in any other setting, with close links to physical healthcare services – with admissions limited by effective community services.'

4.4 The report emphasises the importance of the Department of Health's Quality Innovation Productivity and Prevention programme [QIPP] and the priority of *'avoiding hospital admissions through effective joined-up community care and ensuring that hospital inpatient care itself is effective and that unnecessarily long stays are avoided (for example, by action to tackle delayed discharges)'*

4.5 Since 2012, the provision and redesign of services has been required to take account of the **Equality Act 2010**. The Royal College of Psychiatrists issued guidance for achieving compliance with the Act in December 2011 in the form of a joint paper from the Faculties of Old Age and General and Community Psychiatry. The guidance opens with the following statement:

'From April 2012, unjustifiable age discrimination will be banned in the UK and health and social care services will be legally required to promote age equality in their adult mental health services. Of all health and social care services, older people's mental healthcare has been highlighted as one of the worst examples of discrimination. This has been described in a number of high-level national reports.'

4.6 The Act created a legal duty on public sector bodies to have regard to the need to eliminate both direct and indirect age discrimination. The guiding principle is not that

older people should necessarily be given exactly the same services as younger adults, but that they should not be disadvantaged in accessing or using services that are appropriate to their needs.

4.7 The National Commissioning Board's Mandate for 2013/14 also highlights the need for commissioners and providers to develop out of hospital and integrated care pathways and to improve the quality of care for people with long-term conditions, including older people. Furthermore, this approach is echoed in the new plans for integrated care in each CCG.

5.0 The Local Strategic Context

5.1 Services for older people in East London are delivered within the context of a broader framework of partnerships between CCGs, local authorities and other key stakeholders. The Trust recognises the benefits of developing local integrated care pathways for service users and carers within the context of the local Joint Strategic Needs Assessments [JSNAs] and local commissioning strategies.

5.2 Tower Hamlets - Strategy

5.3 The Tower Hamlets JSNA identifies a number of demographic and socioeconomic factors that affect current and future health and social care need, including:

- The expected population increase from 250,000 in 2011 to 270,000 by 2016;
- A relatively young population with 37% aged 25-39 compared to 27% across London;
- High population churn - 19% move in or out of the borough per year;
- Ethnicity - 50% White, 34% Bangladeshi, 7% Black, 3% Chinese, 2% Indian, 4% other;
- Trends in migration – current national, EU, non EU trends remain to be quantified;
- High socioeconomic deprivation - 33% of households live on an income of less than £20k compared to 22% in London and 12% are unemployed compared to 9% in London;
- 16 of 17 Tower Hamlets wards are in the 20% most deprived in the country (12 in lowest 5%);
- Economic downturn – particularly linked to mental health and problem drinking;
- Changes to welfare system – particularly impacts on income, employment, housing.

5.4 The Tower Hamlets Community Plan is fundamental to improving the health and wellbeing of people through its objectives to improve educational standards and the socioeconomic circumstances of those in greatest need. This is clearly set out in the One Tower Hamlets vision to reduce 'the inequalities and poverty that we see all around us, strengthening cohesion and making sure our communities live well together'

5.5 The Improving Health and Wellbeing Strategy 2006-2016 (a sub strategy of the Community Plan) sets out a vision of integrated, evidence based, high quality, prevention orientated and person centred health and social care services. The foundational principle of the strategy is that in an area with amongst the highest health need in the country, Tower Hamlets residents should receive the best quality health and social care services.

5.6 The local authority and the CCG have together identified the delivery of the Community Plan's priorities as fundamental to addressing the wider determinants impacting on the health and wellbeing of older people such as income, housing, fuel poverty, crime and community cohesion. The Older People's Housing Strategy aims to meet the challenges of providing good quality housing to older people and this will therefore have a significant impact on health and wellbeing. Older people account for a high proportion of use of health and social care resources.

5.7 In 2013, the Tower Hamlets Clinical Commissioning Group, Health and Well-Being Board and the Local Authority consulted on the Tower Hamlets Mental Health Strategy. This sets out a three-year vision for improving the quality of life for people with mental health problems through self-management and improved access to high quality expert care and support, and by challenging the stigma and discrimination associated with mental ill-health. It takes a life course approach and a makes a commitment to improving outcomes for people at all stages of their lives. The strategy acknowledges the gains made in services in recent years and recognises the quality of community dementia services but seeks further improvement through choice and control for services users and their carers, better access to talking therapies, more person-centred planning and increased integration of health and social care systems.

5.8 As the Strategy says, there have been very significant improvements in outcomes for people with dementia following the implementation of its strategy developed in partnership with the local authority and ELFT. This works on the creation of new integrated teams and dedicated community services for people with dementia and for older people experiencing functional mental health problems. Continuing throughout 2013 this work is likely to lead to further modernisation of services in partnership with the local authority and ELFT and the development of new Rapid Assessment Interface and Discharge [RAID] services.

5.9 Within its recently published prospectus Tower Hamlets CCG committed to work with partner CCGs to consider improvements to community and inpatient pathways for older adults with functional mental health problems, including consideration of the cost and quality improvement that may be realised through a redesign of inpatient functional older adult mental health assessment services, and continuing care for people with dementia.

5.10 **City & Hackney - Strategy**

5.11 The City & Hackney JSNA describes a densely populated inner London borough with a remarkably diverse population. Over twenty thousand people come to live in Hackney every year and a similar number leave with one third of the population born outside the UK. Although deprived, the borough has enormous assets in both its physical and community resources. The City of London is unique as, although little more than one-mile square, it is densely developed and is home to 11,700 residents.

5.12 The 2010 Index of Multiple Deprivation placed Hackney as the second most deprived borough in England and the City of London was ranked 262 out of 326. There is however considerable variation between wards.

5.13 City & Hackney CCG has identified the following strategic aims:

- Improve equality of health care for Hackney and City of London residents;

- Ensure our health care system is affordable and of high quality and improves patient experience;
- Work with partner commissioners and our Health and Wellbeing Boards to reduce health inequalities and improve outcomes for local people;
- Develop integrated out of hospital services to mitigate the increasing cost of hospital based unscheduled care;
- Reduce early death rates from cardiovascular and respiratory diseases.

5.14 Within its specific plans for mental health (CCG prospectus May 2013) the CCG has committed to working closely with partner organisations to ensure good mental health support in the community leading to a reduction in bed capacity.

5.15 Trust Strategy

5.16 In January 2008 the Trust began a review of mental health services for older people with the aim of ensuring full compliance with emerging national strategy, the latest evidence base and congruence with local strategic plans. The principal organisational drivers stemmed from a concern that the Trust's older adult service strategy had not been updated for some years. A number of work stream groups were initiated to develop plans for modernisation for the various aspects of the service, including services for people with functional mental illness (see Appendix K, Older Adult Strategy Programme Board, Project Plan).

5.17 In keeping with national guidance, the broad principles underpinning the review included a desire, in collaboration with partners, to:

- Develop a range of early identification, assessment and support services;
- Invest in a broader range of community services thereby offering intensive home-based support as an alternative to hospital admission;
- Offer choice in treatment and care options to users and carers;
- Embed a reablement approach to treatment and care throughout the service;
- Reposition continuing care within a continuum of rehabilitation services rather than an end-point in a patient's journey with the Trust;
- Review overall inpatient capacity across East London in line with good clinical practice and service demand;
- Ensure an optimal balance of resources with the aim of increased investment in community services;
- Consider the condition of current accommodation standards and future requirements, in particular where this is not fit for purpose, in order to determine future investment in estate.

5.18 Broadly the review concluded that the Trust should provide a wider range of rehabilitative community based services with the aim of supporting people more fully at home, while at the same time reducing surplus inpatient capacity.

5.19 The proposals were accepted by the Trust Board, which in recognition of the significant organisational effort that would be required to achieve its ambition, proposed the establishment of an Older Adult Directorate to provide the impetus and focus for the implementation of this vision.

5.20 In 2010/11 the new Older People's Mental Health Directorate undertook a wide ranging review of service provision in collaboration with commissioners, third sector organisations and users and carers.

5.21 The review supported a redesign that included the establishment of a new range of community services and a linked reduction across dementia and functional inpatient services. A phased approach was taken to the implementation of these recommendations:

- **Phase 1** - The establishment of new community services in all three boroughs;
- **Phase 2** - The redesign of dementia in patient provision, which was completed in 2012;
- **Phase 3** - The redesign of functional bed provision; the final stage of the service redesign was scheduled, following consultation with all parties, at that point to take place over 2013/14.

5.22 The full suite of documentation supporting Phase 2 was developed in collaboration with commissioning partners and the public consultation exercise was commissioner led. Following this a comprehensive review document was produced by commissioners summarising the main themes and including a forward plan that has been used for the implementation of Phase 3.

5.23 Phase 2 of the service redesign programme was successfully implemented and has delivered the anticipated outcomes. For example bed demand has fallen, length of stay has been reduced and increasing numbers of people are being supported to live independently. The outcomes for the redesign of MHCOP functional inpatient services are similar to those for the dementia service and similar high levels of success are anticipated.

5.24 The Trust's Forward Plan Strategy for 2011/12 identified the continuing redesign of older adult services to improve quality and delivery as a key priority for the improvement of service user satisfaction.

Extract from ELFT Forward Plan Strategy 2011/12

Key Priorities & Timescales	How this Priority underpins the strategy	Key milestones (2011-12)	Key milestones (2012-13)	Key milestones (2013-14)
Improving service user satisfaction				
Older Adults Services - Redesign	Provide high quality, safe and cost-effective services that address local need and maintain public and commissioner confidence.	Reconfigure existing inpatient services and develop East London wide services, where appropriate, to improve the quality and delivery of services and make best use of available resources.	Post project evaluation of service reconfiguration Work with commissioners to further review Older Adults services	Implement any service changes following review

5.25 In keeping with national policy guidance, the Trust is fully committed to utilising new healthcare technologies to improve the quality and efficiency of the services it delivers. Functional mental health services are delivered to the two borough populations under

contractual arrangements and the application of these new technologies may alter the way in which these services are delivered.

6.0 National Policy Guidance

6.1 Although significant policy guidance has been issued for dementia services in recent years, including a National Dementia Strategy, comparatively little has been written specifically in relation to services for older people experiencing functional mental illness. This lack of guidance may reflect ongoing variations in practice in England and Wales amongst NHS providers, with some Trusts continuing to operate combined dementia/functional inpatient wards.

6.2 In its 2011 report, ***In-patient care for older people within mental health services***, the Faculty of the Psychiatry of Old Age of the Royal College of Psychiatrists [RCP] acknowledged the ongoing division of opinion about this. While the report clearly identified separation as best practice, it also sought to summarise the relative benefits and limitations of both approaches.

6.3 The RCP report used an Audit Commission definition of hospital admission from 2002 and sought to update and expand upon the principles inherent within it:

'Hospital admission is needed for people with psychiatric and behavioural problems that cannot be managed in any other setting, with close links to physical healthcare services – with admissions limited by effective community services. This statement highlights three key principles:

1) *In-patient care provides specialist expertise, with intensive levels of assessment, monitoring and treatment, unable to be provided elsewhere*
2) *It is imperative that there is good access to physical healthcare, with robust arrangements for geriatric medical liaison*
3) *Community services must be developed to allow proper alternatives to inpatient care to avoid unnecessary admission'*

6.4 The RCP report stresses the importance of placing inpatient care in the context of modern community services:

'Community services must be developed to allow proper alternatives to in-patient care to avoid unnecessary admission. Services such as crisis intervention and home treatment are all too often exclusive to adult mental health services, but arrangements should be made within trusts to provide equally relevant services for older people. This is an area which is clearly age discriminating and contravenes the Age Discrimination Act that will be enforceable by 2012.'

6.5 ELFT remains fully compliant with equality legislation, as the Crisis and Home Treatment services have been available to older people for a number of years. In City & Hackney, these services are further augmented by an older adult Intermediate Care Team which was modernised during 2012/13 and offers a seven day/week service

6.6 Further improvements to community service provision are anticipated with the commissioned introduction of RAID Services.

7.0 Current Inpatient Provision and Performance

7.1 The Trust currently has 49 designated older adult functional beds located across three boroughs; 34 of these beds are in City & Hackney and Tower Hamlets. All current ward environments have limitations, for example, Larch ward provides no en-suite rooms.

7.2 The current service structure for inpatient and intermediate care services in City & Hackney and Tower Hamlets is shown in the table below:

Summary of current service provision

Directorate	Ward Name	Bed Number	No. Ensuite Rooms	Intermediate Care Team
City & Hackney	Larch	15	0	Yes (6 w.t.e.)
Tower Hamlets	Leadenhall	19	14	No
Totals		**34**	**14**	

7.3 As this table shows, lower bed numbers in City & Hackney are augmented by an Intermediate Care Team that targets service users in the community who have higher care needs, that is people who are the most likely to require admission. This team was formed after the closure of day hospital services and retained its historic working pattern of 9.00am – 5.00pm, Monday to Friday until the recent modernisation (see 6.5 above). Currently there are 173 cases being care co-ordinated in City & Hackney

7.4 Four-year analysis of occupancy & ALOS

Year	Ward Name	Bed Number	Available Bed Days	OBD (excl. Leave)	Occpcy.	Admsns.	Dischs.	ALOS
2009/10	CH Larch	15	5475	4212	76.9%	61	55	66
2009/10	TH Leadenhall	19	6935	5110	73.7%	53	49	147
2009/10		**34**	**12410**	**9322**	**75.1%**	**114**	**104**	**104**
2010/11	CH Larch	15	5475	4050	74.0%	49	59	109
2010/11	TH Leadenhall	19	6935	5407	78.0%	71	63	106
2010/11		**34**	**12410**	**9457**	**76.2%**	**120**	**122**	**108**
2011/12	CH Larch	15	5490	3993	72.7%	48	48	109
2011/12	TH Leadenhall	19	6954	5270	73.0%	69	61	93
2011/12		**34**	**12444**	**9263**	**74.4%**	**117**	**109**	**100**
2012/13	CH Larch	15	5475	4224	77.1	35	48	91
2012/13	TH Leadenhall	19	6935	4878	70.3	77	77	70
2012/13		**34**	**12410**	**9102**	**73.3%**	**110**	**125**	**78**

The table above shows occupancy, admissions and Average Length of Stay [ALOS] for the four years up to and including 2012/13. Occupancy has been gradually reducing and now stands at 73%, significantly below the upper recommended level of 90%. Likewise, ALOS has dropped from 104 days in 2009/1The table above shows occupancy and Average Length of Stay (ALOS) for the last four years. Occupancy now

stands at 73.3% and ALOS has fallen from 104 to 78 days in 2012/13. However, it should be noted that there are significantly more admissions in Tower Hamlets although ALOS in the borough is much lower than in City & Hackney. Centralisation will support the consistent implementation of unified clinical management approaches.

7.5 The table below shows occupied bed days expressed as equivalent bed usage on Larch and Leadenhall from April 2013 to January 2014 inclusive. The average number of beds used on both wards during the first quarter was 24.7 and during the last three months 20.3 but this average benefits from notably low usage in November. If November is excluded and October included the average use was 21.7 beds. November was the only month when the number of beds used fell below the bed complement on Leadenhall, i.e., 19 beds. So, whilst it is fair to say that bed usage is reducing, the reduction is as yet insufficient to safely rely on Leadenhall as the sole admission facility for functional patients.

2013/14	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	
Larch Beds	13	13	13	11	10	11	10	9	11	11	ALOS = 86 days
L'hall beds	14	10	11	13	10	10	10	7	12	11	ALOS = 66 days
Total	27	23	24	24	20	21	20	16	23	22	
Larch Adm	3	4	3	2	6	6	1	7	4	5	= 41
L'hall Adm	11	3	6	10	3	5	4	9	11	1	= 63

7.6 The bottom two rows of the table chart the monthly admissions to each ward. This reflects the pattern identified in paragraph 7.4 above where the number of admissions is significantly higher in Tower Hamlets notably in April, July and December, whilst ALOS is lower. An enhanced community service is available in Hackney to support people in the community and help to prevent admission. Successful pathway management will mean that the number of admissions reduces particularly in Tower Hamlets and ALOS reduces particularly in City and Hackney.

7.7 An analysis of admissions to functional wards over a 3-year period shows there were twice as many female admissions as male as, i.e. female admissions were 64%. Over the same period the most common diagnoses, as a % of all recorded diagnoses recorded on Rio for patients admitted were, in rank order:

1. Depression / anxiety disorders 33%
2. Schizophrenia / psychosis 23%
3. Bipolar disorders 13%
4. Dementia (including alcohol related) 10%
5. Personality disorders 3%
6. Substance misuse 3%
7. Other 15%

8.0 Snapshot Survey – February 2014

8.1 The original three-borough business case included, at the request of commissioners, a snapshot survey of patients in the functional wards. This was repeated in early February on Leadenhall and Larch. The survey identified 18 patients in hospital across the two wards and a further 5 on leave as shown below:

	No. Beds	No. Patients in Hospital	No. Patients on leave
CH Larch	15	6	4
TH Leadenhall	19	12	1
Total	**34**	**18**	**5**

8.2 The recorded diagnoses for those in hospital were as follows:

Diagnosis	No. Patients	% in hospital
Schizophrenia	10	56
Depression (with psychotic features)	3	16.5
Schizo-Affective Disorder	1	5.5
Bi-polar Affective Disorder	3	16.5
Persistent delusional disorder		
Personality Disorder		
Alcohol misuse		
Dementia	1	5.5
Schizophrenia and Dementia		
Diagnosis not yet fixed		

8.3 Length of stay for those in hospital were:

	Less than 1 month	1-3 months	3-6 months	6 months +	1 year +
TH	3	5	3	1	0
C & H	2	1	0	0	3

9.0 Clinical Evidence from elsewhere in England

9.1 Information from other locations in England, suitable for direct comparison, is limited. Some services continue to operate integrated older people's acute admission beds which bring together patients with organic and functional mental health problems in the same ward environment. This practice distorts comparisons with ELFT's services which operate separate inpatient services for these groups.

9.2 The Audit Commission's Mental Health Benchmarking Club looked at NHS mental health trusts' older adult beds in their entirety, with published comparators reflecting the combined performance of dementia and functional inpatient services. The last comparison report was issued in June 2011 based on data submitted by 47 Trusts in April 2011 (see Appendix A). This snapshot was taken just prior to commencement of the Trust's modernisation programme and centralisation of inpatient dementia services and so provides a fair comparison. In general terms it highlighted the initial scope for the modernisation of inpatient services for older adults as the Trust benchmarked in the upper quartile for:

- Available beds per 100,000 population
- Admissions per 100,000 population
- Occupied bed days per 100,000 population
- Delayed transfers of care
- Mean & Median ALOS.

9.3 For Trusts elsewhere in England, the current operating environment appears to be giving rise to a renewed focus on LOS and bed numbers. Tees, Esk and Wear Valleys NHS Foundation Trust [TEW] also operates separate functional beds. It has recently published the outcome of service improvement work that has seen functional inpatient ALOS fall to 47 days. TEW aims to reduce length of stay further in both functional and organic wards by:

- Providing services seven days a week;
- Doubling acute and care home liaison services;
- Supporting inpatient units to discharge patients as early as possible;
- Sustaining memory assessment treatment services in line with the dementia pathway;
- Providing specialist assessment and treatment services for organic and functional patients in separate units.

9.4 South London and Maudsley NHS Mental Health Trust [SLAM] reduced its combined LOS significantly for all older people's wards from 91 days to 69 days, simply through closer monitoring of discharge planning arrangements. SLAM is now developing business cases for the introduction of 7-day, 9am–9pm older people's Home Treatment Teams to impact further on admission numbers and LOS.

10.0 Remodelled Community Services

10.1 The Community Mental Health Teams (CMHTs) are clinically led by Consultant Psychiatrists. Senior clinical leadership makes a key contribution to service modernisation and it would be ELFT's aim to refocus clinical time. The option recommended in this report has the potential to liberate significant senior clinical resources for the enhancement of community services. This is directly relevant to work being led by the CCGs to achieve greater integration of local services and to enhance community care pathways. The Trust can envisage the potential for delivering an enhanced service to GPs and other members of the extended primary care and social care network.

Current community services – staffing establishments

	Tower Hamlets CMHT	Hackney ICT	Hackney CMHT
Manager / Band 8a/PO7	1		1
Senior Practitioner Band 7	1	1	2
Community Nurse Band 6	5	2	8
Social Worker /AMHP	2	0	5
Occupational Therapist	1	0	1
Psychologist	1	0	1
Support workers /OTA	2	3	1
Total WTE	**13**	**6**	**19**

In line with Phases 1 and 2 of the Trust's modernisation programme, community services for older people with functional mental health problems have been remodelled since 2010. Following the implementation of the Dementia Strategy the focus of all teams has been redirected to working specifically with people with functional illnesses

which, in turn has led to increased and focused working with the inpatient services. Staffing establishments are shown in the table above.

10.2 The Community Mental Health Teams (CMHTs) are clinically led by Consultant Psychiatrists. Senior clinical leadership makes a key contribution to service modernisation. Revised consultant job plans will direct consultant time so it is balanced across hospital and community. Pathway management activity will mirror arrangements on the wards, notably the adoption of “zoning” reviews. These are RAG rated daily assessments of each individual on the caseload identifying what needs to be achieved that day and who will do it. A version of this exists in TEW and has proven to be an effective problem-solving approach. The option recommended in this report has the potential to liberate significant senior clinical resources for the enhancement of community services. This is directly relevant to work being led by the CCGs to achieve greater integration of local services and to enhance community care pathways. The Trust can envisage the potential for delivering an enhanced service to GPs and other members of the extended primary care and social care network.

10.3 The change model envisages that clinical resources will be differently focused including redeploying resources currently used on the wards, into the community but also using existing resources differently in order to assure robust management of the clinical pathway. The Trust estimates the following resources will be affected:

Post	**w.t.e.**
Consultant	0.75
Junior Doctor	1.50
Psychologist	0.40
Pharmacist	0.20

- The explicit expectation that Consultants will function as Clinical Team Leaders is described elsewhere in this document and will be reflected in a revised job plan, diving their time equally between ward and community and scheduling daily caseload reviews.

- This additional time is associated with two grades of staff – in old parlance the SHO and Senior registrar. Both will be working under the direction of the consultant to support people at home, often undertaking joint reviews with other MDT members and enhancing medical oversight outside hospital. The Senior Registrar will also deputise for the consultant where necessary (eg leave cover with senior clinical supervision from another consultant) to ensure that daily reviews continue.

- The psychologist will offer additional case management of complex cases, team consultation and training to the MDT. This is especially important in services for people with functional illness as rehabilitation outcomes are better with additional psychological capacity.

- The pharmacist will act in a consultative capacity to deliver better assurance of medication plans and titration especially for patients on long term medications being maintained at home. This can also include the opportunity to meet service users and their carers and help them to improve their medication self-management.

It is essential that all community staff can effectively triage and signpost or can identify the issues requiring referral to health and social care services provided outside the team. It is therefore planned that community staff will participate in a skills enhancement programme to support improved holistic assessment, taking account of physical co-morbidities and areas of risk such as falls. Once in place, this will facilitate immediate interventions for lower level conditions and will support staff to identify where specialist input for complex conditions is necessary such as speech and language, swallowing assessments, IAPT services. Staff will be able to discuss these issues with service users and carers describing the options for care and support and how this will enable people to manage their symptoms better. This is in line with the life course approach embedded in both the City & Hackney and Tower Hamlets mental health strategies.

10.3 Services for older people with functional mental health problems are delivered by an integrated network of NHS, local authority and third sector provision. Carers also inevitably make a significant contribution to maintaining quality of life for individual patients. Within the Trust, care is delivered through an integrated commissioned network of teams and individual patients and carers will frequently receive support from more than one of these teams within the context of an integrated care plan:

- Community mental health teams
- Intermediate care teams
- Functional older adult inpatient beds
- Home Treatment Teams
- Liaison services
- Specialist psychological therapies
- Substance misuse services.

10.4 Both localities currently provide community based mental health services to older people (over 65) with functional mental illnesses residing within their borough. The teams have a specific focus on supporting people with long term mental health needs and associated co-morbidities. They provide the full range of health and social care interventions including assessment and provision of social care services under the NHS and Community Care Act, psychological, occupational and arts therapies. The teams deliver both short-term time limited interventions and longer term case management under the Care Programme Approach.

10.5 The service standard will be daily review meetings rather than twice weekly management rounds in conjunction with the inpatient services to ensure timely discharge. In addition the Tower Hamlets service provides a weekly rehabilitation and reablement group for both community and hospital patients to maximise social inclusion. It is anticipated that this approach will be developed further with centralisation to ensure local community links are maintained during the admission process.

10.6 City & Hackney have commissioned an Intermediate Care Team [ICT] where the Consultant Psychiatrist provides clinical leadership. The team has recently been remodelled to provide weekend cover and now has the capability to provide intensive support 7 days per week. The ICT works closely with liaison services and attends A&E when required. Further development and pathway integration is planned with the introduction of RAID services.

10.7 The table below is from the ELFT Performance Report (22 July 2013). Open referrals include all patients currently under the care of the team and those who are reviewed in Outpatient Clinics or are in receipt of a less complex or time limited intervention not warranting care co-ordination under the Care Programme Approach (CPA).

Team	Open Referrals*	On CPA
CH CMHT	300	164
CH ICT	12	7
TH CMHT	306	103

* The number of open referrals also includes those on CPA

10.8 ICT capacity is supported at weekends and out of hours by Home Treatment services which provide crisis intervention and monitoring until the older service resumes. The numbers of people aged 65+ supported are as follows:

Patients 65+ supported by HTT

Borough/Year	Combined No. Patients Supported by HTTs & ICTs
City & Hackney	
2010	77
2011	87
2012	88
Tower Hamlets*	
2010	25
2011	25
2012	16
Grand Total	**318**

10.9 Community services for older people with functional mental health problems have been substantially modernised since 2010. The opportunity afforded by releasing resources from wards to is to increase community capacity. The Trust is undertaking a comprehensive assessment of its older adult caseload. This will enable people to be linked to the most appropriate rehabilitative community service to meet their needs; high intensity services designed to facilitate discharge and prevent admission, longer term services designed to maximise individual capability and support people in the least institutionalised way, i.e. at home where possible and a group of people who can be discharged back to primary care or whose continuing life at home can be maintained with periodic outpatient support. Based on early data, it is thought that about 10 percent of people will fall into the final group, a further quarter into the hi-intensity group and the remainder into the long term group. Therefore the Trust looks to realign existing resources to support this aim. This work will be undertaken in close collaboration with the CCGs who are themselves leading commissioning processes aimed at delivering closer integration between local services.

10.10 The option recommended in this report will achieve the consolidation of medical and therapies personnel and will facilitate increased professional availability on the wards whilst potentially releasing additional resource for inputting into the work of the community teams.

11.0 Improved Care Pathway Management - Estimating Capacity

11.1 In 2012 the Trust looked for national leaders in the delivery of functional mental health services. Senior clinicians and managers from ELFT established close links with Tees, Esk and Wear Valleys NHS Foundation Trust [TEW] and visited a number of services to learn how TEW achieved both improved quality and performance. Since then, TEW has moved away from traditional pathway management and instigated a series of daily meetings. This has happened alongside a refocusing of senior psychiatric input and enhancements to clinical capacity on wards and in the community services.

11.2 The traditional model whereby consultant psychiatrists literally consulted to wards and spent the majority of their ward-based time in a ward round is judged to contribute to longer lengths of stay. The traditional consultative model is one where the consultant visits the ward for key clinical activities, notably the ward round and functions as the senior doctor but does not as the clinical leader ensuring that the caseload being is clinically managed across all the disciplines. The new model establishes daily reviews looking at need, actions to be taken, actions taken, sticking points. The consultant is the senior clinician leading these events and, notwithstanding individual clinical accountability, is responsible for assuring the quality of the clinical management process and of being the final arbiter in the management of admissions, all of which must be discussed and agreed with the consultant before they happen. Instead of ward rounds a daily meeting will be established which reviews each individual on the ward identifying what needs to be achieved that day and who will do it. Importantly the meeting – which is brief – also includes community staff. Geographical and logistical challenges mean that the best way of ensuring consistent community input will be to use teleconferencing between the ward and City & Hackney teams, though Tower Hamlets CMHT is based on the same site so has good access. Revised consultant job plans will direct consultant time so it is balanced across hospital and community and will mean the consultant can lead the daily review in situ on the ward. In addition, inpatient senior nurses at TEW hold what is known as a “huddle” which swiftly identifies any bed issues in Older Adult wards.

11.3 Pathway management activity in the community will mirror arrangements at Mile End, notably the adoption of “zoning” reviews. These are RAG rated daily assessments of each individual on the community caseload identifying their needs, what must be achieved that day and who will do it. As indicated above a version of this exists in TEW and has proven to be an effective problem-solving vehicle. So, although resources and circumstances in TEW are markedly different to East London, the principles apply equally well.

11.4 ELFT has already introduced a new care pathway management protocol to improve care quality and to remove care planning obstacles from the discharge process (see Appendix B). The protocol is built on the premise that it is not in patients’ best interests to stay in hospital longer than is therapeutically necessary, with a commitment to avoiding prolonged stays which can lead to the loss of skills and independence for individuals. Achieving a successful discharge for a person with ongoing mental health, and often physical, healthcare needs can be a complex task requiring input from a range of professionals and agencies. This new protocol clearly allocates tasks and accountability within a coordinated time frame.

11.5 The efficiencies derived from improved care pathway management are primarily focussed on reducing length of stay although it is recognised that the same processes

can avoid admission altogether for some patients and their carers. The Trust has made the conservative estimate of being able to avoid 10 - 15% of future admissions. Minimising the length of stay in hospital for older people to that which is strictly is aligned with social care reablement principles focussing on maintenance and regaining skills and confidence. These are important preventative factors in helping people to return to home and in avoiding expensive residential or nursing care.

11.6 At the time of the original service and site review, centralisation of inpatient services on the Mile End Hospital site offered the additional care pathway benefits associated with co-location with general services and the opportunity for close partnership working with geriatricians. Bart's health has reconfigured services in the meantime so that proximities are altered. Nonetheless ELFT has well established service level agreements on the Mile End site. Therefore on admission, in addition to a full mental health assessment, the standard for all patients is a full physical health work-up. This assessment follows an agreed Trust template and includes such things as routine bloods, ECG, falls assessment and a full skin assessment care. If anything abnormal is detected, of if the patient has a long term condition, the individual is referred to specialist services.

- The diabetes service is provided by Newham Community Health (NCH). All patients are seen on referral. The visiting nurse delivers training to ward staff and provides advice directly to patients. The diabetes nurse will attend the ward weekly when a patient with diabetes has been admitted.

- A Speech and Language Therapy service is provided by NCH through which patients are assessed on referral. The service includes weekly visits to the ward by a therapist who also delivers training to the ward staff.

- A dietician service is delivered via an SLA with the Homerton hospital and in addition to patient assessment on referral, includes staff training.

- Physiotherapy services are provided on a referral basis with the therapist providing an assessment, plan of care and on-going monitoring and review during the in-patient stay.

- Foot health services are provided from within the Mile End hospital on request

- Dental services are provided via Tower Hamlets CCG on request.

An enhanced presence will afford the opportunity to develop improved referral arrangements for specialist physical healthcare parallel to those that are available to inpatients of the Barts' geriatricians. The Trust proposes to offer the same referral arrangements for physical therapies etc for all functionally ill inpatients as are currently available for Tower Hamlets patients on the Mile End site. This will encompass speech and language therapy, physiotherapy, specialist diabetes, tissue viability, physiotherapy, chiropody, dental and in-house GP service. Typically these comprise an electronic referral as well as support and specialist advice, and education sessions.

11.7 A particular advantage of co-location is improved out-of-hours medical cover through which the relocated wards will have out-of-hours access to the duty doctors and duty senior nurses based on the Mile End site.

11.8 The recommended option also brings the major benefit of liberating significant senior clinical resources for the enhancement of community services. Thus clinical time that would otherwise have been focused on in-patient services can be redirected elsewhere to support rapid assessment and treatment thereby delivering the anticipated reduction in length of stay. This resource is essential to the success of the model which depends on the availability of skilled clinicians. This is within the context of work being led by the CCGs to achieve greater integration of local services and to enhance community care pathways. The Trust can envisage the potential for delivering an enhanced service to GPs and other members of the extended primary care and social care network.

11.9 Taking into account this background of achievable improvements to care pathway management, ELFT aims to reduce admissions and emulate the ALOS performance currently achieved by TEW – 47 days. A reduction in admissions of 10-15% with no further reduction in ALOS would further reduce bed utilisation from the existing average 21/2 beds to 18/20 beds. Reductions to ALOS would suggest strongly that the service could be provided from a single ward such as Leadenhall which would provide sufficient beds once average bed utilisation reached17 beds.

11.10 The new model involves a daily clinical review meeting of both community and ward patients. This is the front-line management process. The purpose of daily review is to ensure timely interventions, clear prioritisation of caseload and to quickly identify problems and issues that could delay discharge or suitable community intervention of a kind that would prevent admission. Significant issues will be reported to the Clinical and Service Directors. The Clinical and Service Directors will have identified a trajectory for admissions/discharges/ALOS and agree this with the front-line services. Each month, the two Directors will review these KPIs directly involving the relevant consultants as necessary. The purpose will be to ensure the change process is safely managed and remains on track, and to identify and seek solutions to any issues that are not locally resolved. In turn, their work will link to the monthly Directorate Quality and Performance meeting with Executive Directors where key service change is one of the standing agenda items.

11.11 Retention of the existing ward configuration would mean that redundant bed capacity and resources were not available to release savings or invest in alternative modernised care arrangements. In all the above scenarios, provision has been made to maintain occupancy levels at 90% in line with Royal College recommendations and local agreements with commissioners. This also offers sufficient headroom for the service to cope at periods of exceptional peak demand.

11.12 It is anticipated that achievement of current TEW performance would comfortably allow the use of a single ward including maintaining occupancy at a maximum 90%.

12.0 Maintaining Close Partnership Working

12.1 The Trust has well developed partnership working arrangements in place with the local authorities in each borough. All of the Trust's plans are predicated on maintaining these arrangements and the development of more efficient care pathway management will assist social care staff.

12.2 As bed reductions will significantly be offset by the under-utilisation of the existing bed complement, the Trust does not anticipate any negative impact on social care budgets or the voluntary sector from the proposed development. The proposed model may

even have a positive effect as principles of reablement and supporting carers and patients in the community are central to service delivery.

12.3 As can be seen from the table overleaf, functional patients do not make high demands on residential care when discharged from hospital and this has been the pattern for some time. This is consistent with the key findings of a study undertaken in 2011 by the Joint improvement Partnership (London) *Prevention of Admission to Residential Care Project* (see Appendix L) which sponsored a review of data and practice in four outer London Boroughs to understand the variations in use of residential care. The study included three boroughs which appeared to have higher than average use and one which was slightly lower.

12.4 Amongst the key findings of the report were:

- *Avoiding crisis is key - Individuals placed in residential care following a crisis caused by carer breakdown or other event rarely return to the community;*
- *The predominant demand for residential care arises from dementia clients, whose needs are not always met by currently commissioned placements or community services.*

12.5 The proposed model enhances the Trust's collaborative approach to working with carers, the voluntary sector and local authorities who remain key partners in sustaining individuals in a process of recovery. The proposals set out in this report will have an overall positive effect on the demand for social care services (i.e. that demand for social care support will, in the long term, either reduce or not increase) as they support the principles of reablement and supporting patients and their carers in the community. Local and national evidence indicates that early and focused interventions deliver improved and more cost effective support. Thus by enhancing the ability of mental health professionals to offer specialist interventions at key stages during a patients illness, particularly at times of vulnerability such as at a point of crisis or hospital discharge, the draw on local authority resources will be minimised and, it is anticipated will be for shorter periods.

Table: Discharge destination from functional ward over 3-year period

Ward/Year	Deaths	Local Authority Foster Care (not Part 3)	Local Authority Part 3 Residential Home	NHS Hospital - Medium Secure	NHS provider for Ment ill/Hcap	NHS Run Care Home	Non-NHS Residential Care	Other NHS provider	Temporary place of residence	Usual place of residence	Grand Total
2010	**1**		**1**	**1**	**3**	**0**		**6**	**2**	**101**	**115**
CH Orchard	1				1			6		49	57
TH Leadenhall Ward			1	1	2				2	52	58
2011	**2**	**1**	**2**			**2**	**0**	**11**	**7**	**81**	**106**
CH Orchard						1		11		38	50
TH Leadenhall Ward	2	1	2			1			7	43	56
2012					**1**		**7**	**4**	**0**	**92**	**104**
CH Orchard										23	23
TH Leadenhall Ward					1		7	4		69	81
Grand Total	**3**	**1**	**3**	**1**	**4**	**2**	**7**	**21**	**9**	**274**	**325**

13.0 Market Analysis and Population Growth

13.1 From the GLA benchmark population data available for 2011, the 65+ population is forecast to rise as follows:

Older Adult (65+) predicted population growth in City & Hackney and Tower Hamlets

Year	City of London	Hackney	Tower Hamlets	Total	% increase by 2021 comp to 2011
2011	1051	17424	15607	**34082**	
2016	1280	19257	16355	**36892**	
2021	1471	21366	18404	**41242**	**21%**

13.2 Whilst current performance is sufficient to ensure the service will be able to work within the capacity of the proposed consolidated service, further reductions in ALOS towards the 47 days achieved by TEW, will ensure the service is future-proofed for the predicted growth in the over 65 population, within the capacity afforded by the preferred option.

13.3 The Trust has not yet faced significant competition in the provision of inpatient services for older people. However, the introduction of the new CCGs, the passing of the recent Health Bill and the introduction of Payment by Results, could all potentially introduce new competitive pressures into the local mental health care market.

13.4 Against this background, ELFT will be required to continue to pursue the twin aims of improving care quality and increasing efficiency, whilst working in close partnership with primary care and the local authorities.

14.0 Site Options Appraisal

14.1 The Trust views stand-alone acute admission wards for older people as non-viable on the grounds of safety, quality and cost. The Trust therefore developed a long-list of site options based on current service provision in all three boroughs, and approved by the Older Adult Programme Board as follows:

Option 1 Redevelopment of the Lodge in Hackney, where Larch ward is located

Option 2 Use of Ivory Ward at the Newham Centre for Mental Health, or alternatively, East Ham Care Centre

Option 3 Redevelopment of Leadenhall Ward and use of the Columbia Ward Annexe at Mile End Hospital to give capacity to manage peak demand up to 32* beds.

14.2 A formal site options appraisal was commissioned (see Appendix C) to assess the suitability of the sites and notional functional content and operating assumptions were agreed. This provided for 25 beds, all with ensuite facilities and associated support within a departmental footprint of 1,100m².

**At this point an assumption was made that functional beds for all three boroughs would be centralised. Subsequently commissioners in Newham decided not to centralise beds from that borough so this business case focuses solely on a centralised model for City & Hackney and Tower Hamlets.*

14.3 An outline specification for the service was developed as follows:

- 25 inpatient beds (15 female, 10 male) all with ensuite facilities
- Assisted bathroom and shower
- Day and dining space
- Assessment and treatment rooms
- Support accommodation
- Staff facilities
- A departmental area of approximately 1,100m²
- Single entrance to the unit preferred
- Shared communal spaces but to include separate quiet/female day space
- Separate sleeping accommodation for men and women but to incorporate 'swing rooms' which can be used flexibly for either sex to meet shifts in demand
- Sufficient assessment space to enable efficient multi-disciplinary team working
- Support based on a single unit (will increase if accommodation needs to be split, even on same site).

14.4 An outline comparison was undertaken on how well each site could accommodate the specified requirement and the advantages and disadvantages of each site/building.

The key drivers were identified as:

- Improved quality and efficiency
- Changes to service delivery to shift more towards prevention, early detection and intervention, and delivery of care close to home
- Better integration of health and social care
- Increasing independence with a focus on reablement
- More streamlined assessment
- Provision of a continuum of care within rehabilitation services
- Ensuring the condition of accommodation is fit for purpose for the new and developing models of care
- Ensuring inpatient care, with intensive assessment, monitoring and treatment, is available when required
- Providing the most effective service configuration for effectiveness and efficiency within available resources
- Ensuring that older people are not disadvantaged due to their age.

14.5 These ten key drivers were in turn used to develop and rank a concise set of six criteria for use in a facilitated option appraisal exercise as set out below:

1. Reduces local health inequalities
2. Improves and future proofs access to local, personalised health services
3. Provides improved quality of clinical services in priority areas, and facilitates quality training

4. Provides healthcare in a good quality environment, with fit for purpose estate, greater energy efficiency and better space utilisation
5. Is aligned with local, regional and national policy and the NHS vision for the future
6. Is achievable.

14.6 A further major consideration was co-location with general older people services, not fully achieved by the current model. The important interrelationship between mental and physical health in older people with functional mental health problems has been observed and recorded the many years:

‘In people growing old with established mental illness, increased cardiovascular and respiratory disease and lifestyle issues (smoking, obesity, poor diet and lack of exercise) contribute to poor physical health. Those factors also influence the mental illness process and medication effects. This group also has a lower life expectancy in comparison with the general population.’

Harris, E. C. & Barraclough, B. (1998) Excess mortality of mental disorder. British Journal of Psychiatry, 173, 11–53

14.7 Within this context, the co-location of the functional service with general and other adult inpatient services has important implications in terms of patient safety, patient experience and clinical effectiveness.

14.8 Option 3 in the business case proposes the co-location of services on the Mile End site. The proposed redesign supports closer working across the MHCOP inpatient dementia, acute mental health and other general medical services and those delivered from elsewhere a contractual basis.

14.9 There is an established and robust mental health infrastructure at the Mile End site which includes a full range of mental health professionals, including older people's CMHTs and a dementia team, rapid response services and buildings and facilities to support the safe and effective running of a modern acute mental health service. This infrastructure has been of benefit to the patients on Columbia ward and has supported an efficient and coordinated response to patient and carer need in a broad range of contexts, for example, in delivering comprehensive physical health assessments and care, collaborative working with colleagues in adult acute care and supporting good end of life care planning.

14.10 Additionally, based on the experience of running a centralised dementia inpatient service, the Trust has a comprehensive range of support services in place to enhance the delivery of general health and welfare services to patients. These are contractually arranged and include tissue viability, speech and language therapy, diabetes services, etc. The likely demand arising from the cohort of newly admitted patients with a functional condition is known and the contractual arrangements with providers can be made in advance of any service consolidation to respond to any change in demand.

14.11 Furthermore, the clinical benefits to be derived from the co-location of dementia and functional acute inpatient services are numerous and include the consolidation of older adult expertise on one site, enhanced efficiency of resource allocation across services and the ability to offer patients a more bespoke clinical response if their condition changes with treatment. For example some patients have a mixed clinical

presentation and presently do not have a realistic option of transferring to a clinical environment that is better able to respond to their treatment needs if these change. The consolidation of older adult acute services on one site will support such a plan.

14.12 The outcomes of the site option appraisal were as follows:

Option 1 **Redevelopment of the Lodge (Hackney)**
This option was scored down because it was not on a general hospital site which runs counter to the recommendations of the Royal College of Psychiatrists, and there are likely to be higher costs of refurbishment.

Option 2 **Use of Ivory Ward (Newham Centre for Mental Health) or alternatively, East Ham Care Centre**
This option was marked down because it was identified that additional space was unlikely to be available and therefore the limited floor area would make the single unit unachievable. There are the higher costs of refurbishment in a PFI building and the site does not offer co-location with other inpatient physical healthcare services for older people. East Ham Care Centre was ruled out on clinical grounds as well as having insufficient space. This option has not been considered in this business case as Newham functional services are not included in the proposal.

Option 3 **Redevelopment of Leadenhall Ward and use of the Columbia Ward Annexe to give capacity to manage peak demand up to 32 beds (Bancroft Road, Tower Hamlets)**
This option was preferred due to being in the most accessible location of the three single site options and for its location on a site that includes general hospital services. It was also viewed as being the most achievable.

14.13 In summary, Mile End was selected in preference to the alternative existing site services in Newham and Hackney for a number of reasons:

- It is the only available site where sufficient space is available to provide ensuite accommodation, high quality day and therapy areas and to meet spikes in demand for beds by utilising spare bed capacity within a self-contained area of Columbia within the same building; The Trust already successfully provides centralised inpatient dementia care on the Mile End Hospital site and bringing together specialist doctors, nurses and therapists together within one campus has the potential to improve patient care and rehabilitation through the creation of a centre of excellence for the care of older people with mental health problems;
- It is the only site to meet the Royal College of Psychiatrists' recommendation for locating inpatient care on a hospital site delivering physical inpatient healthcare to older people;
- The outcome of the travel study in terms of the relative impact on the population served (NB. The Trust recognises the importance considerations in the context of older people and their carers and additional assistance will be provided to support patient and carer transport).

14.14 It should be noted that for older people with mental illness, admission to hospital is typically unplanned and at a point of crisis where urgent medical intervention may also be required. Patients who are severely mentally ill may require assessment and

treatment under the Mental Health Act and these formal assessment and treatment orders legally require this care to take place in a hospital setting.

14.15 Although not selected as the preferred option for this scheme, the Trust envisages the continued future use of the vacated site in Hackney; the Newham site will continue to provide functional admission beds for Newham.

14.16 The Trust is working with commissioners on the overall Estates Strategy. The East London CCGs are leading this work and have agreed the CSU will provide project support. In recognition of this strategic work the Trust will be supporting the inclusion of the released estate within the Hackney for development and utilisation in line with the CCG strategy. The released estate will form part of the CCG vision for the operating plan framework for mental health in 2014/15. Any service developed for local residents in City & Hackney or Tower Hamlets related estates will be in consultation with the CCG.

15.0 Travel Considerations for Carers

15.1 Carers play a major role in the wellbeing and recovery of patients and the Trust welcomes carer involvement in planning patient care. The Trust encourages ward visiting by relatives and carers and, aside from protected meal times, has an open visiting policy from 10:00 hours to 20:00 hours. Outside these hours special visiting arrangements can be made where necessary. ELFT is fully committed to continuing to support carers in future and has sought to identify the likely impact of its proposals and the actions necessary to reduce any negative impact.

15.2 Dr Foster Intelligence was commissioned to investigate the implications on travel time for services users and carers in the case of the potential consolidation of functional assessment wards in the area (see Appendix D). Again, this work was commissioned to include Newham. The report has analysed the levels of access to both the nearest functional assessment unit and the proposed Mile End Hospital site. The key findings of the report in relation to residents of Tower Hamlets and City & Hackney were as follows:

- Currently, between 20% and 24% of residents living would be able to walk to their nearest functional assessment ward. Most people therefore face a significant walk currently, i.e. with no change.
- Currently the population weighted average cycling time to the nearest functional assessment ward is 10 - 11.3 minutes and over 90% of the population can cycle to their nearest unit within 20 minutes. . Following the restructure, this increases in Hackney so the average time is 18.3 minutes.
- Currently, the population weighted average journey time by public transport to the nearest functional assessment ward is 19.6 – 20.9 minutes with 92% of residents within 30 minutes by public transport. This increases for Hackney residents after the restructure to an average travel time of 33.2 minutes but only 39% of residents being within 30 minutes on public transport. There is also the potential for increases to travel costs by adding additional nodes into the journey, while only having a small impact on overall journey time.
- Currently, the population weighted average travel time to access the nearest functional assessment ward by driving is between 6.9 and 8.2 minutes with 89% or 73% of people within a 10 minute drive. This would increase to 13.1 minutes for

City and Hackney residents and fewer than 28% of them would be within a 10 minute drive.

15.3 Average travel times and travel time under 30 minutes is shown below:

Population weighted average travel times (public transport) to consolidated ward

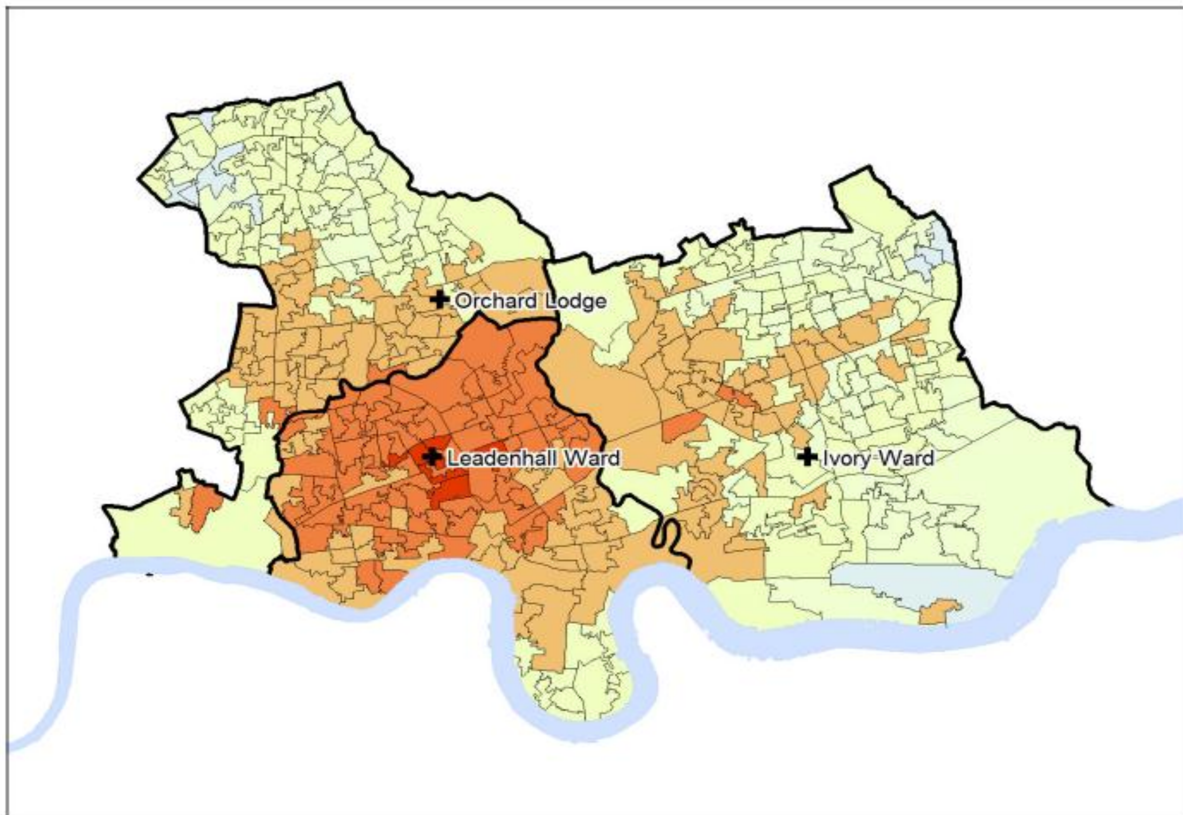
	City and Hackney PCT	Newham PCT	Tower Hamlets PCT	Overall
Average travel time (min)	33.2	34.2	19.8	29.1

Residents within 30 minute public transport travel time of the consolidated ward

PCT	Total residents	Residents within 30 min public transport	% of residents within 30 min public transport
Tower Hamlets PCT	237,896	217,715	92%
Newham PCT	240,124	92,727	39%
City and Hackney PCT	230,905	90,685	39%

15.4 The map below shows transport times in each borough.

Map showing the public transport times in all three boroughs following the proposed restructure



Key
Travel time (min)
- 60+
- 50 to 60
- 40 to 50
- 30 to 40
- 20 to 30
- 10 to 20
- 0 to 10

15.5 The Trust recognises that some carers may have a more complex journey to the new unit and wishes to take positive action to offset any difficulties that may lessen carer contact while a patient is in hospital. Therefore the Trust will extend the Carer Transport Policy already in place for the adjacent Columbia dementia assessment ward and under which, 94 carer journeys have been made since its introduction in 2012. This policy (see Appendix E) commits to:

- Undertake an assessment of individual travel arrangements for all carers to determine if individual journeys to the new proposed ward are more difficult than would have been to the previous borough ward;
- Work in collaboration with carers to resolve any transport issues which may include the provision of bespoke transport arrangements.

15.6 The policy considers a carer is an individual who is a close family member (such as a spouse or child) and who lives with the patient or has a significant caring role. At the time of admission the care co-ordinator will, in collaboration with the carer, determine if

the journey to the Mile End Hospital site is significantly more complex than the journey would have been to the borough based ward. This determination will take into account:

- mobility issues;
- journey time;
- number of transport changes needed to complete the journey;
- physical, sensory or mental health problems that make travelling by public transport difficult;
- personal safety considerations, including travelling after dark.

15.7 In situations where a journey is agreed as significantly more complex the care co-coordinator will determine how the Trust might support visiting arrangements. This might include the provision of a taxi, payment towards parking costs or provision of hospital transport. Arrangements will be reviewed weekly by the ward team and the carer throughout the patient's stay.

15.8 The Trust recognises that a formal transport survey is likely to have limitations and may not fully reflect realities on the ground for older people. The transport implications of the proposals set out in this report will be subject to further consultation and continued monitoring if implemented.

16.0 Options for Change

16.1 Four options are presented here for consideration and have been designed to maintain a full and comprehensive functional mental health service for both of the CCGs. The change options have been selected for their potential to:

- ✓ Co-locate older adult inpatient services on a single centrally located site to improve quality via enhanced care pathway management and therapies input in which previously very limited therapy resources, spread across numerous ward sites, are consolidated on one ward with fewer patients thereby improving the therapist: patient ratio.
- ✓ Provide good access to hospital acute services;
- ✓ Achieve better care for acutely ill mobile patients and those who are frail and vulnerable.

16.2 The options are as follows:

- **Option 1 (34 beds)**
  No Change

This option would see the continued delivery of functional inpatient services from the two current inpatient wards in City & Hackney and Tower Hamlets.

16.3 This option is likely to see further reductions in combined occupancy from the current 73% to under 50% as care pathway management continues to improve to levels currently achieved by 'best-in-class' NHS providers.

16.4 This reduction in occupancy is likely to impact upon the Trust's ability to maintain a critical mass of specialist functional assessment and therapy capability at each of the three sites and this should be weighed against the potential benefits of maintaining local inpatient services. An option of no change in this scenario would also mean that

resources which could be redirected to support the development of improved clinical pathways would not be available limiting the capacity to modernise and reduce length of stay.

- **Option 2 (28 beds)**
  Create two separate 14-bed fully en-suite wards at the Bancroft Unit (on the Mile End Hospital Site, Bancroft Road). This option would result in a net reduction in surplus inpatient capacity equivalent to 3 beds per CCG.

16.5 Option 2 is predicated on the acquisition of additional ward space on the Bancroft Unit and is dependent on further discussions with Barts' Health.

16.6 For Option 2 the preliminary estimates of likely capital costs for the refurbishment of Bancroft currently stand at £1.5m and this includes a sum of £100k for the fitting of additional windows to the wards. This option also provides a relatively high number of beds and, given the opportunities of reducing bed usage these beds are less flexible than an option with one larger and one smaller ward. This would mean that resources which could be used to enhance care pathways, would be tied up.

- **Options 3a and 3b (19 - 26 beds as required)**

  - Retain Leadenhall Ward on the Mile End Hospital site, and enhance staffing to deliver a high care function to meet the needs of patients with very challenging behaviours. This applies to both Option 3a and 3b. Option 3a simply utilises beds on Leadenhall and results in a net bed reduction 7.5 beds per CCG ;
  - Option 3b increases bed capacity through the utilisation of the recently refurbished Columbia ward annex, a 7-bedded (5 en-suite) female functional facility. Therapy and meeting room space would be shared with Columbia ward. This option would result in a net bed reduction of 4 beds per CCG;
  - Option 3b is sufficiently flexible to permit future reductions if required.
  - Options 3a and 3b facilitate the enhancement to clinical and medical services to support improvements to the clinical pathways.

  A site map of the Mile End site is attached in Appendix L.

17.0 Non-Financial Evaluation

17.1 Table 5: Strengths Weaknesses Opportunities Threats [SWOT] Analysis

	Option 1: No Change	**Option 2:** Develop 2 x 14 Bed Wards in Bancroft & Develop New Tower Hamlets ICT	**Options 3a and b:** Retain Leadenhall ward as a stand-alone unit or in conjunction with the refurbished Columbia ward annex giving 19-26 beds & develop New Tower Hamlets ICT
STRENGTHS	• Steady state with known service configuration • Local inpatient services within Borough	• Achieves co-location of older people's inpatient services • Delivers enhanced community services and equity for service users in TH (with CCG agreement) • Small size of wards helpful in delivering personalised care • Delivers en-suite facilities for all inpatients • Opportunity for Centre of Excellence	• Achieves co-location of older people's inpatient services • Deliverable in the short term as the Trust owns all estate involved and no capital works required • Optimal efficient use of all current spare bed capacity giving potential for up to 26 beds • Offers opportunity to separate patients with challenging behaviour from frail elderly • Delivers female only clinical area • Most bedrooms have en-suite facilities (14/19 on Leadenhall and 5/7 on the Annex) • Delivers enhanced community services and equity for service users in TH (with CCG agreement) • Avoids the creation of small inefficient ward teams • Opportunity for Centre of Excellence
WEAKNESSES	• Wasted resources associated with current excess inpatient capacity • Fails to deliver enhanced community services • Fails to deliver full en-suite facilities for all inpatients • Lost opportunity to create a centre for excellence with all older adult inpatient services located on same site	• 14 beds at the lower limit of viability, critical mass and efficiency • Bancroft not currently owned by the Trust • Higher per bed day cost than single ward option and requires additional commissioner investment • Could necessitate new ways of working if multiple ward rounds are to be avoided • Provides more beds than are currently required and reductions could not be easily achieved • Even if available delay because of capital works requirement	• Split ward arrangement may present some management challenges. • Not all beds are en-suite
OPPORTS	• Few, as all resource tied up in current configuration	• Potential for improved therapeutic regime by bringing together therapist staff on a single site • Does not fully exploit opportunities of currently under-utilised beds • Centre of excellence	• Potential for improved therapeutic regime by bringing together therapist staff on a single site • If Option 3b (26 beds) chosen option 3a (19 beds) easily achieved once occupancy levels drop further. • Flexible care pathways for patients with both dementia and functional problems • Centre of excellence

	Option 1: No Change	**Option 2:** Develop 2 x 14 Bed Wards in Bancroft & Develop New Tower Hamlets ICT	**Option 3:** Retain Leadenhall ward as stand-alone unit or in conjunction with refurbished Columbia Annex 19 – 26 beds & develop New Tower Hamlets ICT
THREATS	• Inefficient use of resources liable to make the Trust less competitive in the medium term • Current model now beginning to look outmoded and inefficient when benchmarked against other services • Limits clinical quality improvement opportunities.	• Scale of the wards and lack of critical mass could ultimately lead to the services becoming uncompetitive on price • Potentially less flexible than single ward if bed demand reduces • Above threats could undermine any clinical quality improvements	• Annex arrangement with Colombia ward will require careful planning and coordinated operational management to maintain optimal efficiency

18.0 Financial Evaluation

Original Business Case for City and Hackney, Newham and Tower Hamlets

Original Business Case	*Direct Budget*	*Indirect Clinical + Support Costs*	*Estates & Facilities Costs*	*Total Cost*	
Option 1					
Orchard Lodge	*£912,986*	*£200,640*	*£258,181*	*£1,371,807*	
Ivory	*£758,211*	*£236,887*	*£309,882*	*£1,304,980*	
Leadenhall	*£790,251*	*£266,887*	*£245,715*	*£1,302,853*	
Intermediate Care Hackney	*£232,275*			*£232,275*	
Intermediate Care Newham	*£295,090*			*£295,090*	
Total Option 1	***£2,988,813***	***£704,414***	***£813,778***	***£4,507,005***	
Option 2					
14 Bed Bancroft	*£758,211*	*£352,207*	*£245,000*	*£1,355,418*	
9 Bed Bancroft + 5 bed annex	*£1,233,494*	*£352,207*	*£245,000*	*£1,830,701*	
Bancroft additional rental costs	*£300,000*			*£300,000*	
Intermediate Care Hackney	*£232,275*			*£232,275*	
Intermediate Care Newham	*£295,090*			*£295,090*	
Total Option 2	***£2,819,070***	***£704,414***	***£490,000***	***£4,013,484***	
Option 2 Savings	***£169,743***	***£0***	***£323,778***	***£493,521***	
		Less estates savings		*-£323,778*	*(1)*
		Net savings		***£169,743***	*(2)*
Option 3					
Leadenhall	*£850,485*	*£389,414*	*£245,000*	*£1,484,899*	
Columbia Ward Annex (female unit)	*£561,716*	*£315,000*	*£245,000*	*£1,121,716*	
Intermediate Care Hackney	*£232,275*			*£232,275*	
Intermediate Care Newham	*£295,090*			*£295,090*	
Total Option 3	***£1,939,566***	***£704,414***	***£490,000***	***£3,133,980***	
Option 3 Savings	***£1,049,247***	***£0***	***£323,778***	***£1,373,025***	
		Less estates savings		*-£323,778*	*(1)*
		Net savings		***£1,049,247***	*(2)*

(1) Estates savings to be retained by ELFT to support costs of vacated premises

(2) Net savings after return of £133k per CCG to be applied by the Trust against its 2013/14 and 2014/15 CRES Programme. For further information, refer to the Trust's recent CRES

Revised Two Borough Solution Business Case

	Updated version			
Revised Two Borough Solution	*Direct Budget*	*Indirect Clinical + Support Costs*	*Estates & Facilities Costs*	*Total Cost*
Option 1				
Orchard Lodge	*£912,986*	*£200,640*	*£258,181*	*£1,371,807*
Ivory	*£0*	*£0*	*£0*	*£0*
Leadenhall	*£790,251*	*£266,887*	*£245,715*	*£1,302,853*
Intermediate Care Hackney	*£232,275*			*£232,275*
Intermediate Care Newham	*£0*			*£0*
Total Option 1	***£1,935,512***	***£467,527***	***£503,896***	***£2,906,935***
Option 2				
14 Bed Bancroft	*£758,211*	*£316,471*	*£245,000*	*£1,319,682*
9 Bed Bancroft + 5 bed annex	*£1,233,494*	*£316,471*	*£245,000*	*£1,794,965*
Bancroft additional rental costs	*£300,000*			*£300,000*
Intermediate Care Hackney	*£232,275*			*£232,275*
Intermediate Care Newham	*£0*			*£0*
Total Option 2	***£2,523,980***	***£632,941***	***£490,000***	***£3,646,921***
Option 2 Additional Cost	***-£588,468***	***-£165,414***	***£13,896***	***-£739,986***
	Less increase in indirect costs			*£165,414*
	Net savings			***-£574,572***
Option 3a				
Leadenhall Only	*£850,485*	*£632,941*	*£245,000*	*£1,728,426*
Nil	*£0*	*£0*	*£0*	*£0*
Intermediate Care Hackney	*£232,275*			*£232,275*
Intermediate Care Newham	*£0*			*£0*
Total Option 3	***£1,082,760***	***£632,941***	***£245,000***	***£1,960,701***
Option 3 Savings	***£852,752***	***-£165,414***	***£258,896***	***£946,234***
	Less estates savings retained			*-£258,896*
	Less increase in indirect costs			*£165,414*
	Net savings			***£852,752***
Option 3b				
Leadenhall	*£850,485*	*£349,902*	*£245,000*	*£1,445,387*
Columbia Ward Annex	*£509,628*	*£283,039*	*£245,000*	*£1,037,667*
Intermediate Care Hackney	*£232,275*			*£232,275*
Intermediate Care Newham	*£0*			*£0*
Total Option 3	***£1,592,388***	***£632,941***	***£490,000***	***£2,715,329***
Option 3 Savings	***£343,124***	***-£165,414***	***£13,896***	***£191,606***
	Deduct: indirect cost increase			*£165,414*
	Net savings			***£357,020***

Estimated Capital Costs

	Option 1: No Change	Option 2: 2 x 14 bed wards in Bancroft Unit	Option 3: Retain Leadenhall ward (19 beds) refurbish the Columbia ward annexe
Construction Cost	-	1,667,000	-
Professional / local authority fees	-	334,000	-
Direct Order items	-	234,000	-
VAT	-	381,000	-
Contingency Risk	-	131,000	-
£ Totals	**-**	**2,747,000**	**0***

*Refurbishment of Leadenhall and Columbia Ward Annex has already been undertaken

19.0 Recommendations

19.1 It is recommended that, subject to consultation (see Appendix F), a solution is adopted that links **Option 3a and Option 3b.** That is, that the Tower Hamlets and City & Hackney functional services centralise on a single site, initially occupying Leadenhall and Columbia Annex but, after six months, vacating Columbia Annex so that services are provided from a one 19-bed ward, Leadenhall. This approach is considered to be clinically safe with the second stage bed reduction facilitated through full implementation of a modernised clinical pathway. This will deliver the key strategic aims shared by the Trust and the CCGs of improving care quality and maximising integration and efficiency across the City & Hackney and Tower Hamlets older adult bed base. With dementia assessment beds already located on the site, there is the potential to create a new centre of excellence by bringing together staff with expertise in the care of older people with mental health problems.

19.2 This option can be delivered from within the Trust's current estate assets for minimal capital investment and within the existing revenue envelope.

19.3 This approach delivers a high quality environment for patients and staff and ensures the maximum number of patients benefit from individual ensuite rooms. The facilities are air conditioned and provide garden access in addition to therapy rooms and high quality day areas.

19.4 It is anticipated that the proposed service redesign, with a focus on rehabilitation and supporting independence will, over time, see the development of an increasingly dynamic response to patient need. The new service proposal, which locates the inpatient service as a component in a broad care pathway rather than an end point in an episode of major illness, is more responsive to patient need and better able to offer a flexible and bespoke service than the existing model. Within the current service configuration, therapy staff are thinly dispersed across the three inpatient units. This option has the potential to improve the levels of therapeutic intervention by concentrating therapy resources within the context of a centre for excellence.

19.5 Additionally, the proposed redesign compliments the service arrangements of partner agencies and particularly major partners such as local authorities. It is anticipated that specialist and increasingly integrated care pathways will be developed that will support the delivery of targeted care where there is a focus on early identification, intervention and prevention. This has been the case with the dementia service redesign as evidenced in

closer working with social care, the Alzheimer's Society and users and carers. A similar positive effect is anticipated in this case.

19.6 It is also anticipated that over a three to five year period, continued improvements in community intervention and care pathway management will see lengths of stay and admissions continue to fall significantly to the 47 days ALOS currently achieved by Tees, Esk and Wear NHS Foundation Trust. Specialist mental health services provided by the Trust are working in an increasingly collaborative manner with local authority and other partners to deliver a greater range of community treatment options including psycho-education, carer support and early intervention. Evidence suggests that such approaches enhance patient and carer experience and deliver improved health and welfare outcomes.

20.0 Appendices:

- A: Audit Practice Mental Health Benchmarking Club Report (The Audit Commission, June 2011)
- B: Functional Inpatient Care Pathway Management Protocol, Actions Required For Discharge
- C: Site Options Appraisal in respect of Functional Assessment Inpatient Provision for Older Adults
- D: Travel Impact of Ward Consolidation
- E: Colombia and Leadenhall Ward Transport Policy
- F: Draft Consultation Strategy
- G: Equality Impact Analysis City and Hackney, Newham and Tower Hamlets
- H: Mobilisation / Transformation Plan
- I: East London NHS Foundation Trust: Quality Impact Assessment Tool
- J: Older Adult Strategy Programme Board, Project Plan
- K: Joint improvement Partnership (London) Prevention of Admission to Residential Care Project.
- L: Mile End Site map

This page is intentionally left blank