NCAT visit report

To:
Cambridge and Peterborough FT

Date:
2/9/11

Venue(s)
1. Cavell Centre, Edith Cavell Healthcare Campus, Bretton Gate, Peterborough PE3 9GZ
2. Acer Ward, Hinchingbrooke Hospital, Hinchingbrooke Park, Huntingdon, Cambridgeshire, PE29 6NT

NCAT visitors:
Dr Pete Sudbury (Medical Director, Barnet, Enfield and Haringey MHT)
Prof. Tom Craig (Professor of Social Psychiatry, KCL; Consultant rehabilitation psychiatrist, SLAM)

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Introduction:

1. The review was commissioned by NHS Cambridgeshire and NHS Peterborough via the East of England SHA, and our visit was at the end of an extensive pre-consultation process.
2. The 3-month public consultation is planned to commence in October
3. Due to time constraints, our visit was restricted to the North of the patch (Peterborough and Huntingdon), where the changes are perhaps more contentious, but we understand that the issues in Cambridge are similar, as is the degree of engagement of stakeholders. Follow-up visits to the South of the patch could be arranged should that prove necessary.

Background to review

Case for change.

This is a second stage of reconfiguration of MH services in the area. The first stage developed (i) an effective and valued model of older people's healthcare, including home treatment; and (ii) the strengthening of links into primary care, using primary care MH workers and link workers. The Trust is acting, with support from commissioners, to implement known best practice in the delivery of community-based and in-patient MH services, reducing a current excessive dependence on in-patient care.

Proposals

The proposals, which have been developed through extensive consultation with GPs, patients and other stakeholders, with consultancy assistance from UnitedHealth UK involve changes to the organisation and delivery of most aspects of services. The major headlines are:

1. A shift in emphasis, in line with national policy and best practice, towards prevention, early intervention, self-help and patient driven care.
2. Reconfiguration of community MH services into local hubs ("service centres" or "Advice and Support centres"), with a genuine single point of access for all services, with accurate, timely triage to the appropriate level of care.
3. Implementation of a number of lifespan pathways: eating disorders, early intervention in psychosis and Aspergers / ADHD. The Trust representatives also spoke of their intention to develop similar pathways for personality and affective disorders.
4. A more assertive and outward-focused model of rehabilitation, with patients moving out of long stay rehabilitation units into more appropriate accommodation, usually not in the health sector.
5. Streamlining in-patient care for adults, through process changes including short-term admissions under the control of the HTT, admission wards focusing on the first 3 weeks of admission, and accompanying changes in the functioning of the wards.
6. Resulting from this, some closures or relocations of beds, and a proposed development of replacement acute in-patient capacity in Peterborough.
7. closure of some older people's beds due to overcapacity following successful previous implementation of community models of care
8. Reduction in the number of in-patient sites to improve safety and appropriateness of the in-patient facilities

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Expected outcome

These changes can be expected to produce

1. significant further improvements in links with primary care,
2. much greater ease of referral, and in the rapidity and appropriateness of response to it
3. improved co-ordination of care around the patient
4. significant reductions in the need for in-patient care, and consequent reductions in the associated overhead costs.
5. improvements to in-patient patient safety, privacy and dignity
6. stronger, more effective community care
7. savings totalling £11.2m over 3 years (including £3.9m from ward reconfigurations; £6.7m from community reconfiguration)

There are transitional problems particularly around the management of Acer Ward and its associated HTT. On the basis of the evidence we have gathered, we are of the opinion that there is unacceptable clinical risk in the current arrangements, due to the ward and attached HTT having 14 vacancies from a complement of 33, which they have been unable to fill. Such recruitment and retention problems are not uncommon as details of proposed reconfigurations emerge. The associated clinical risk is particularly around the effective functioning of the HTT, and we are of the opinion that having both ward and HTT functioning suboptimally for a significant period of time is not acceptable. **We therefore strongly recommend that the move of Acer ward to the Cavel Centre, with associated strengthening of the HTT, should be implemented as rapidly as possible, this being the only feasible mitigation for that risk**.

Documents reviewed

CPFT service redesign consultation document 2011-12 v9
NHS Peterborough cluster leads CPFT contract and redesign briefing paper
Letter to GPs about consultation
Senate 15/3/11 mental health commissioning
MH consultation steering group terms of reference
CPFT inpatient redesign - comms and engagement plan June n2011
Project Risk Log
NHSC CPFT 11 12 Memo of understanding
JSNA 2010
MHD Consultant steering group terms of reference
CPFT consultation document v2 final
Pathways booklet Jan 2010 final
Final data C&P all
Final data C&P EoE
C+P presentation 26 Apr
Acute care pathway Cams and Peterborough
Redesign financial background
Commissioning strategy for older people
Locality structure

People seen / interviewed

Commissioners: Claire Warner, John Ellis
Trust senior managers: Keith Spencer (Director), Mick Simpson (General maanger), Jill Hudson Senior manager quality and innovation),
Clinicians:
Dr Manaan Kar Ray (clinical director),
Dr Zahoor Syed, Dr Dell'Erba (consultant psychiatrists)
Rena Hughes, Elaine Young, Denise Hone (modern matrons).
Maxine Coppard (ward manager)
LINk and OSC Cambridgeshire:
Bernie Gold, Jane Belman, Cllrs Sails, Kenny, West, Reynolds.
OSC Peterborough:
Cllr Rush
GP MH lead:
Dr Caroline Lea-Cox (telephone conference)

Discussion & analysis

Quality check

Patient safety

These proposals, properly implemented, will have a positive impact on patient safety.

1. Barriers to (re)entry to specialist MH services will be reduced, and waiting times for triage and assessment minimised
2. Improved links with primary care, which result in "upskilling" up GPs, impact positively on the healthcare of the 90%+ of patients with MH problems who are dealt with entirely in primary care.
3. Recovery-focused models of care, concentrating on enablement of patients, improve safety in the long term, by improving self management.

Patient related / clin outcomes

Patient experience

1. The experience of in-patients will be very significantly improved by moving from substandard accommodation in Acer ward, which is isolated, to the excellent Cavell centre in Peterborough.
2. Closing long-stay rehabilitation units, and moving patients to appropriate accommodation, with appropriate assistance, in the community, will improve the life experience of those patients.
3. The improvement in HTTs in the north of the county will allow more patients to be better managed at home and in the community: home treatment is generally preferred by both patients and carers to in-patient admission.
4. The development of "lifespan" rather than age boundaried services improves continuity of care and seamless transition through age boundaries that are arbitrary and have no significance in the development or time-course of mental health conditions.
5. There are no clear plans for involvement of other providers in the delivery of services, even those such as rehabilitation and recovery, where non-statutory

organisations may well be better qualified to help patients develop their independence, although discussions have taken place. The Trust is highly successful in employing "experts by experience" to deliver care within teams, and the addition of such partnerships would further enhance the range of options available to patients (also meeting the Lansley "choice" criterion).

Wider issues

Trust management and planning

The Trust is well-led, open to change and has a good track record of change management. The proposed changes are significant in both scope and scale, but the evidence around the planning and engagement process so far, from the previous reconfiguration and from the detailed plans, suggests that they and their partners can confidently be expected successfully to deliver the proposed models of care.

Future state modelling:

The Trust and commissioners may need to revisit or make more widely known their capacity modelling in 2 areas: around community bases, and especially around in-patient bed numbers.

Community hubs:

The effective functioning of the community hubs underpins the clinical strategy, and the Trust and commissioners need to clarify and publicise the assumptions underlying the working of these, at a basic level for the consultation (where case vignettes, indicative numbers of expected referrals and their disposal should be sufficient), and in greater detail as the implementation process rolls forward.

In-patient bed numbers.

Current state: Over the last 3 years, the Trust has reduced out of area placements by 60 beds, and reduced adult in-patient beds by 25, a very significant and sustained trajectory of reduction in overall bed use. Benchmarking supplied to us puts the Trust in or on the upper quartile for admissions and occupied bed days per weighted head of adult population. Benchmarked against East of England, the best performer uses just over half the occupied bed days per weighted head of population compared to CPFT. CPFT shows high admissions and bed use particularly in affective, neurotic and somatoform disorders: reducing these to the lowest quartile would halve the bed usage associated with these disorders and reduce overall admissions by over a third. Even within the Trust area, there is wide variation in in-patient bed use, with areas further from hospitals, particularly Fenland, using fewer beds than expected considering their population and level of deprivation.

The current reconfiguration plan envisages implementing a number of measures with proven significant impact on bed usage, including

- use of "assertive inreach" by HTTs, and their access to short-term beds,
- implementation of admission wards,
- use of "lean" methodology in the running of in-patient areas,
- strengthening of HTTs
- more preemptive models of community care.

However, the current plan has acute beds remaining at 108 (including reprovision of 16 in a new-build facility), whilst the bed reduction is entirely in rehabilitation beds, where the Trust is also an outlier in terms of the number in use.
Clinicians and managers pointed to (i) current high levels of bed occupancy, (ii) concerns about knock-on effects of rehab bed closures on ability to discharge patients from acute care (iii) a larger in-patient catchment area (500k WAP, compared to 400k population of Cambridgeshire) as justification for their cautious approach to bed numbers.

(i) The first reflects a tendency for those working in clinical systems to be "constrained by the present" when envisaging future service use, and reflects an underlying (and understandable) unwillingness to anticipate the possibility of success of clinical innovations that have not yet been introduced. This lack of confidence is not justified either by the track record of the Trust or the clarity and ambition of its vision for service development.

(ii) The second, whilst a possibility in the short-term, is no justification for a planned capital investment, or for implicitly expecting the Trust to remain in the upper quartile for bed use for the foreseeable future, compared to other organisations that do not have rehabilitation beds in such numbers.

(iii) A 20% difference in catchment is not sufficient to explain the variation, nor does it explain the internal variation in admission rates

The Trust needs to rework its modelling along a range of assumptions, up to and including achievement of lower quartile (at minimum) or "best in class" bed use. This can be supported by examining variation between areas within the Trust catchment. This modelling should also cover bed provision for older people, where there is a larger national variation, but where the Trust should also anticipate its ability to perform in the bottom quartile, given that service changes introduced last year have already reduced bed use, and may be expected to continue to do so.
The combination of these may indicate a significant risk of the Trust being left with excess estate in the short to medium term (2-5 years), especially should the proposed new build go ahead. This remodelling does not need to be done in any detail for the consultation to proceed successfully, though it would be sensible to include within the current consultation the possibility of future (potentially large) bed reductions if current and further plans are successful in reducing the need for in-patient care.

Overlaps between physical and mental health

We are concerned at the weakness of liaison services in the general hospitals in Peterborough and Huntingdon, which is a potential source of uncontrolled and poorly-triaged mental health admissions to both acute and MH providers. The cost-effectiveness for acute providers of these services is beyond doubt, and it is surprising that neither acute hospital has sought to commission such services, which are clearly not within the core MH contract.
In addition, very large healthcare savings can be generated by effective treatment of comorbid MH problems in people with physical long-term conditions reducing healthcare costs for those individuals by up to 2/3. Commissioners can encourage such cross-silo working by integrated pathway commissioning for LTCs.

Contingencies

Clinical IT: The stated dependency for the community hub developments on the implementation of a clinical IT system may cause serious problems for the Trust if left unchallenged. The current timeframes may well not be sufficient to allow for

procurement, implementation and comprehensive roll-out of a full EPR. The Trust may need to develop contingency plans for use of paper and low-tech information transfer systems, such as fax or e-mail, in the eventuality that clinical IT does not materialise at the required rate.

Community placements and accommodation. There is a clear problem with the availability of suitable community accommodation for patients discharged from acute and rehabilitative care. This is particularly the case in Peterborough. The development of these and other community (non-health) recovery-oriented services will be important in ensuring the sustainability of this clinical model.

Stakeholder engagement and agreement

The evidence suggests a well-conducted, extensive and inclusive pre-consultation and engagement of important stakeholders in the pre-consultation. The pivotal and catalytic role played by emerging GP commissioners was acknowledged widely, and the positive and knowledgeable engagement of the LINk and OSCs was obvious and welcome.

Although we did not meet with patients, there is evidence of their significant input into the plans as they have been developed.

Impact on populations

Health inequalities

The OSC expressed concern around access to MH care, especially in Fenland. These plans in general improve access for patients seen in primary care or by other referral agencies, but the Trust and its partners may need to consider specifically how access is improved for those who are geographically and perhaps socially isolated, and who may not seek health advice at all.

Health of population

Interventions that have shown improvement in general population mental health are generally based in primary care, and this is a compelling supporting argument for the Trust strategy of developing close links with primary care clinicians and services.

Conclusions

1. These are an excellent set of clinical proposals, which reflect international best practice and undoubtedly meet the criterion for a sound clinical case for change.
2. There is every indication that the Trust management and leadership is of high quality, and is able successfully to deliver this well-planned project.
3. The degree of collaboration between Trust, commissioners and GPs, and active engagement of other stakeholders is exemplary.
4. The plans would benefit, and patient choice be increased, by inclusion of other, particularly non-statutory, providers within the pathways, particularly those appertaining to recovery and rehabilitation.
5. The general hospital liaison function of crisis teams should be developed and marketed by the MHT to the acute Trusts, with support from commissioners.
6. Following a review of modelling assumptions, the consultation should include the possibility of future reductions in the bed base, which are highly likely to result from successful implementation of this strategy.

7. The move towards lifespan rather than age-boundaried services is to be encouraged, as it is likely to improve early intervention, seamless and consistent care throughout the age range. This may require commissioners to work outside their traditional age-boundaried commissioning silos.

Recommendations

1. Subject to the above, this case is ready to go to full public consultation.
2. The closure of Acer ward, strengthening of the local HTT, and relocation of the beds to the Cavell Centre should be expedited on the grounds of clinical safety, and should not await the consultation.

Document history:

1st Draft: 2nd September
Factual accuracy comments from commissioners and provider: 5-8th September
Final version: 8th Sept

Pete Sudbury