KINGS FUND COLLEGE

EALING HAMMERSMITH & HOUNSLOW HEALTH AGENCY

MENTAL HEALTH REVIEW

April 1994

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CONTENTS

Appendices are contained within a separate volume.

PREFACE

This report has been produced from a range of consultations, submissions and written sources. There remain areas in which further data gathering is required. The submissions made by the Reference Group, who met on four occasions during this phase of the project, have been added as appendices or where relevant, have been incorporated into the text of the report. A separate volume contains the appendices so that the integrity of these pieces of work can be maintained.

The review was limited to psychiatric services for adults aged 19-65 years and excluded specialist Child and Adolescent, Drug, Alcohol, HIV and Psychotherapy services.

This report proposes that the next phase of work should include exploration of the role of primary health care, the impact of GP fundholders, and discussions with a range of key stakeholders in this service, users, carers and voluntary and private organisations and clinical staff within Trusts and provider units.

The EHH HA will take this report on the first phase of the Review forward by promoting a lively debate on the future of mental health services in Ealing, Hammersmith and Hounslow.

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April 1994

1. BACKGROUND TO THE REVIEW

1.1 This review of mental health services was commissioned by EHH HA who have the responsibility of commissioning services for the population of the greater part of West London.

1.2 The challenge to the commissioners has been to review current strategy and provision so as to enable a shared vision to emerge across the range of agencies and groups providing and using mental health services. This report records the progress in that process that has been achieved over the last six months.

1.3 For EHH HA to create and promote a shared vision for the future of mental health services requires the development of a coherent diagnostic picture which emerges from detailed consideration of the following elements:

- National Policy Guidance
- EHH Strategic Commissioning
- Provider/Trust Development
- Consultation With Stakeholders
- Primary Health Care, GPs and GP Fund-Holders
- Capacities of Sectors and Agencies Outside the NHS

Progress has been made on the first three of these elements during this phase of the review.

The Implementation of National Policy Guidance

1.4 The national policy guidance from "Better Services for the Mentally Ill" in 1975 through to the recent "Working with Patients", "Caring for People", and "The Health of the Nation" (1991), creates an impetus towards care in the community. The philosophy of caring for people entails:

- enabling people to live as normal a life as possible in their own homes or in a homely environment in the local community;
- providing the right amount of care and support to help people achieve maximum possible independence and, by acquiring or re-acquiring basic living skills, help them to achieve their full potential;
- giving people a greater individual say in how they live and the services needed to help them to do so;
- promoting choice and independence and allowing a range of options;
- providing help and support for carers;
- responding flexibly and sensitively to needs of individuals and their cares;
- providing services that intervene no more than is necessary to foster independence;
- providing services that concentrate on those with greatest needs.

1.5 Specific targets on hospital closure and reprovision have not been made, but the general objectives in the "Health of the Nation" include:

- To reduce ill-health and death caused by mental illness....(by providing):

  an appropriate balance of prevention, treatment and rehabilitation;

  the development of services and practice in both primary and secondary care;

  action outside the health and social services (1992).

1.6 The general improvement of mental health was also linked to a specific target on suicide:

- to improve significantly the health and social functioning of mentally ill people;
- to reduce the overall suicide rate by at least 15 per cent by the year 2000 (from 11.1 per 100,000 population in 1990 to no more than 9.4);
- to reduce the suicide rate of severely mentally ill people by at least 33 per cent by the year 2000 (from the estimate of 15 per cent in 1990 to no more than 10 per cent).

1.7 Commissioning agencies have also had to take account of a range of other central policy and practice guidance. The Reed Report set up proposals for significant diversion of mentally disordered persons from courts and prisons. The Care Programme Approach, the Assessments required under the NHS and Community Care Act 1991, together with the recent supervised discharge arrangements following on the Clunis Report, also requires investment of professionals time and monitoring.

1.8 The Mental Health Act Commission in its 1994 Biennial Report drew attention to the significant problems in London's acute psychiatric services. High levels of detained patients in such wards, high occupancy levels and blocked beds have been recorded as features of the acute services in London.

1.9 Certain aspects of the NHS Reforms are yet to be fully implemented in mental health. The development of Joint Commissioning with Local Authorities has yet to make a significant contribution. The impact of GP fund-holders in mental health has yet to emerge, and will pose questions about the relationship between primary and secondary psychiatric services.

1.10 The commissioning process and contracting culture is also emerging slowly in mental health. The full effect of capital charging, and attributing the costs of use of secure places has to be worked through. The development of contract currencies, (block contracts, finished consultant episodes, occupied bed nights, cost and volume contracts and spot purchase) has yet to impact fully on relationships between commissioners and providers.

1.11 The current policy guidance, whilst it contributes to a commissioning strategy, has to be seen in the light of other conditions that exist in inner London. To purchase mental health services on behalf of a population requires detailed knowledge of the needs of that population. It also requires investment to be calculated as far as is possible on the basis of measured needs.

1.12 There are a number of methods of estimating the mental health needs of a population. Firstly by on estimated comparison of local and national prevalence of disorders; second by a similar comparison of service utilisation; thirdly by taking into account deprivation and other indices and factors thought to determine mental health need; and fourthly by estimating expected levels of provision. The application of these techniques is not yet general across London, however it is clear that the weighted capitation formula applied to determine the budget allocation to EHH is insensitive to the estimated needs, and therefore to the need for investment in mental health services for the population of EHH.

1.13 There are further complex issues which effect the way in which commissioning agencies can implement national policy guidance. The first may seem rather obvious, but is a major factor in determining the pace of implementation. Existing services and resources are locked-in to historically determined styles of care and delivery systems. Reviewing, costing and un-locking these resources takes time, and this not only refers to the challenges of re-provision of long-stay hospital services. This historical factor also links with issues of Trust configuration, both between Mental Health Trusts and between Community Trusts and Mental Health Trusts. Commissioning agencies have to take account of the management capacity in provider units to achieve the significant shifts envisaged in national policy guidance, and necessarily included in the EHH strategic intent.

1.14 Both national policy and EHH strategic intent create expectations of new and emerging forms of care. This transition needs to take account of the different groups of patient/clients/users to be served by the services. There are a number of overlapping groups all of whom have claims to be 'priority' groups;

- those with needs for acute care, in particular those presenting at A&E Departments, and also those subject to the provisions of the Mental Health Act (MHAC 1994)
- those being diverted from police and court systems, often with acute needs (Reed Report)
- those requiring intensive care; those with treatment resistant conditions
- some 26 percent of the population, according to Goldberg (1991) who consult their doctors every year because of mental distress or mental illness, sometimes referred to as 'the new clientele' (Patmore and Weaver, 1991);
- the 'old long-stay population,' being resettled from hospital, many of whom are elderly (Leff, 1990; TAPS, 1990).

- the 'new long stay/term population,' with disabling mental health problems (O'Driscoll *et al.*, 1990; Thornicroft *et al.*, 1992), now likely to spend increasing periods 'in the community', where they may have access to alcohol and street drugs and where they may not be perceived as ill or disabled;

- people considered 'difficult to place', often with 'challenging behaviour' (Coid, 1991; Dass *et al*, 1991), including offenders with a mental disorder revolving in and out of the criminal justice and mental health systems (NACRO, 1992; Cm. 2088, 1992);

- homeless people and refugees with mental illness who would benefit from treatment and rehabilitation services as well as housing assistance (Fischer and Breakey, 1986);

- children and adolescents with severe emotional disturbances, including victims of neglect or abuse (Quinton and Rutter, 1984; Kutz, 1992; Williams and Skeldon, 1992);

- the large numbers of elderly people with mental health problems, including growing numbers who are over 85 (Audit Commission, 1986);

- people from black and other minorities amongst all the above groupings, for whom present services often miss the mark (Fernando, 1988).

[Adapted from Kings Fund Research Report 16].

1.15 The challenge faced by commissioning agencies within the configurations of services they 'inherit' is that of creating a "balance of care", and a "balanced service system" (O'Brien 1982) where primary, secondary and tertiary service boundaries are no longer rigidly applied and where resources can be allocated to delivery systems which fit both client need, expectations and patterns of service use This can only be achieved by close collaboration (a mature relationship) between commissioning and provider agencies in achieving provider development. This requires appropriate management capacity at both purchaser and provider levels.

1.16 A further challenge is faced by commissioning agencies in meeting the needs of diverse groups, within a mental health strategy, of defining the limits of "health care" in relation to "social care" and on the balance between "prevention" and "treatment" interventions.

1.17 The national policy and the EHH strategy entails significant shifts in the pattern of mental health services. Estimating the cost, usage and effectiveness of new services and the extent that they can replace and improve upon existing services, is bound to be part of a robust strategy.

1.18 This challenge also presents itself within existing services whereby expenditure against case-mix (types of patients) requires clarification, and comparison across trusts can not always be achieved because of the lack of equivalence in units ie in the designations used, such as 'intensive', 'locked', 'secure', 'forensic' against types of patients. The estimates of costs and usage of new services cannot be easily derived from an analysis of population need or current usage, and this makes a tight investment strategy difficult to achieve.

1.19 The policy, and to a certain extent public expectations, is running ahead of the technology of measurement and the change capacities of providers. The commissioning agency is central to meeting these challenges and achieving these changes.

1.20 A further environmental factor affecting the ability of commissioning agencies to implement policy is the level of investment in mental health from other sectors. Mergers of DHAs and FHSAs has created agencies responsible for significant budgets and populations. Local Authorities, who spend on average less than 4% of their budgets on mental health, yet have a lead on community care planning, may not be able to fulfil their partnership role in the major shifts envisaged by the policy. However maintaining mental health services in close proximity to the infra-structure in local communities and other mainstream services, such as education and housing, will be vital if a balanced and 'seamless' service is to be created and maintained. The Association of Metropolitan Authorities has recently reported (Nov 1993) on mental health services in local authorities.

1.21 The above factors also contribute to the lack of development in both joint commissioning and locality purchasing.

1.22 There are a number of initiatives currently underway which seek to explore and explain the problems of policy implementation. The London Implementation Group (Mental Health Reference Group) has met regularly since September 1993. The Task Force is currently undertaking a series of inner London consultations at ministers request. The Health Advisory Service (HAS) is currently reviewing purchasers plans for mental health in the LIG area. EHH HA has and will contribute significantly to these reviews.

1.23 EHH HA are therefore developing a robust strategy to meet these challenges and to take forward to implementation of national policy.

Progress Made in the Review

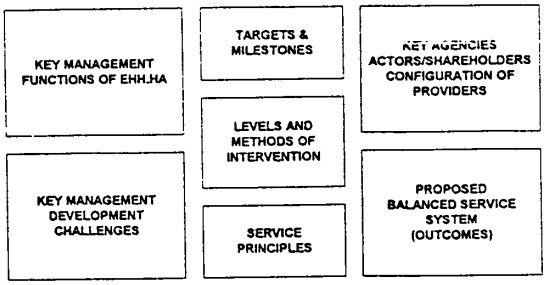
1.24 Progress so far in this review (to April 1994) includes initial findings in the following areas:

- population needs assessment
- the shape of current adult services
- mapping contacts
- comparing EHH and Trust strategies
- comparison of 'needs' and existing services
- options for further service development
- consultations with clinicians
- quality standards and monitoring
- research and development opportunities

1.25 However there is considerable further work to be undertaken in these areas and in two critical fields. Firstly the role of primary health care, and the impact of fund-holding GPs requires full exploration. Secondly consultation and the development of partnerships with other stakeholders such as voluntary, private and user-led organisations is necessary. Proposals for these components of this review are being submitted to EHH HA.

1.26 A further strategic issue concerns the extent to which the current review is seen as part of an organisational development agenda linking national policy, through commissioning to the agenda of providers, the users and the public.

1.27 If a long term strategic and organisational development approach is taken by commissioners the following elements will be required to build a strategy:



These elements of a strategy are brought together in figure 2 (page 10).

1.28 However, in order to identify these management development challenges we first require a detailed 'model' of how the NHS Reforms and the "managed market" impact upon mental health services. Such a model has two key dimensions:

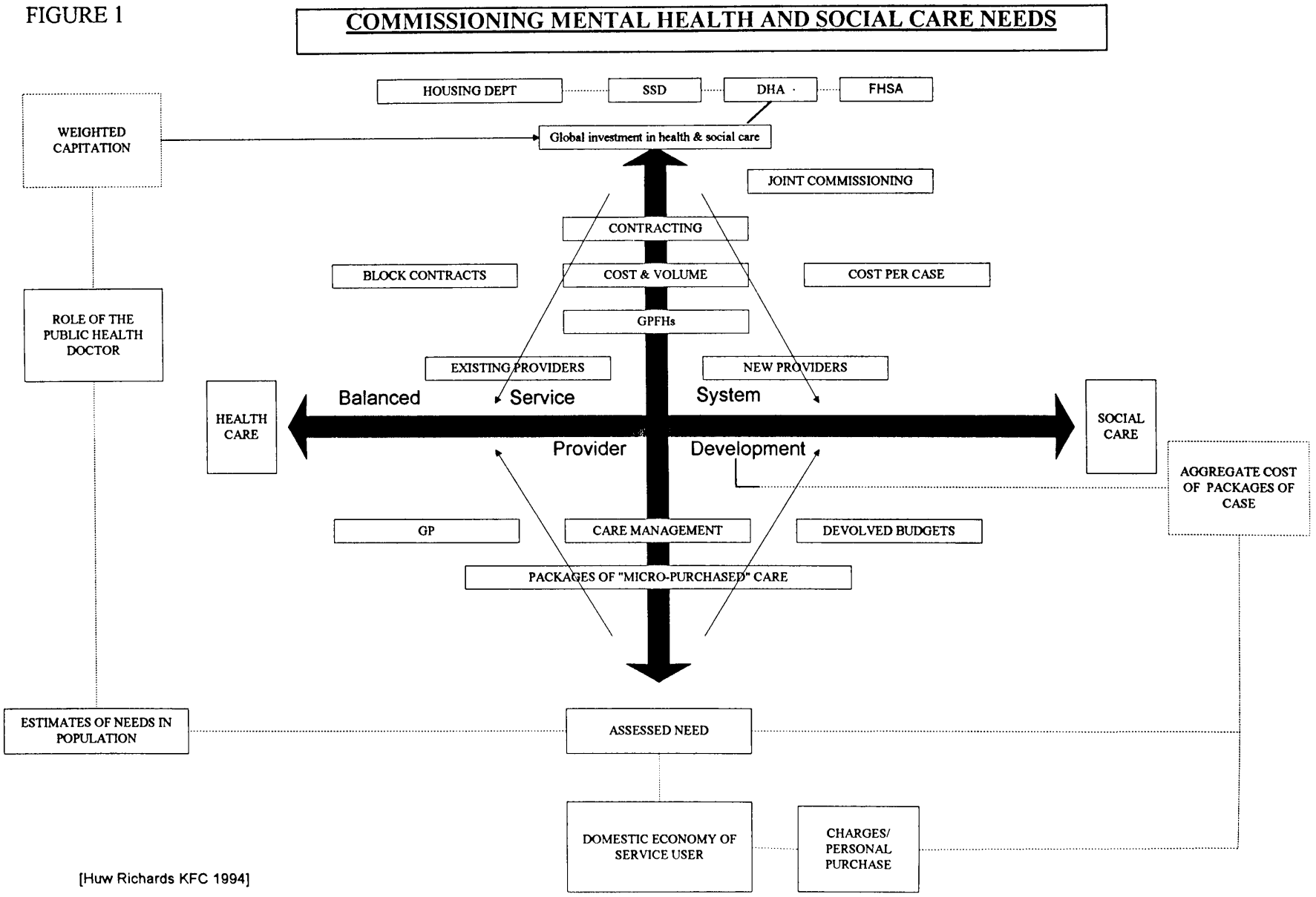
1. ***Vertical Integration*** between commissioning and provider intentions, that is, achieving a reconciliation between decisions made on the basis of assessing the needs of the population and decisions made of the basis of assessing the needs of individual patients.

2. ***Horizontal Integration*** between health and social care, that is, achieving the development of existing providers and the growth of new providers within a culture of inter-sectorial co-operation.

The model has to have two forms of "feedback" mechanisms to be fully reflexive. Firstly, the needs of the population should be reflected in the funding formula and, secondly, the tendency towards purchasing of packages of care for individuals requires an information system capable of aggregating such expenditure and comparing it against actual and possible investment. These two forms of feedback are primarily, respectively, for purchasers and providers.

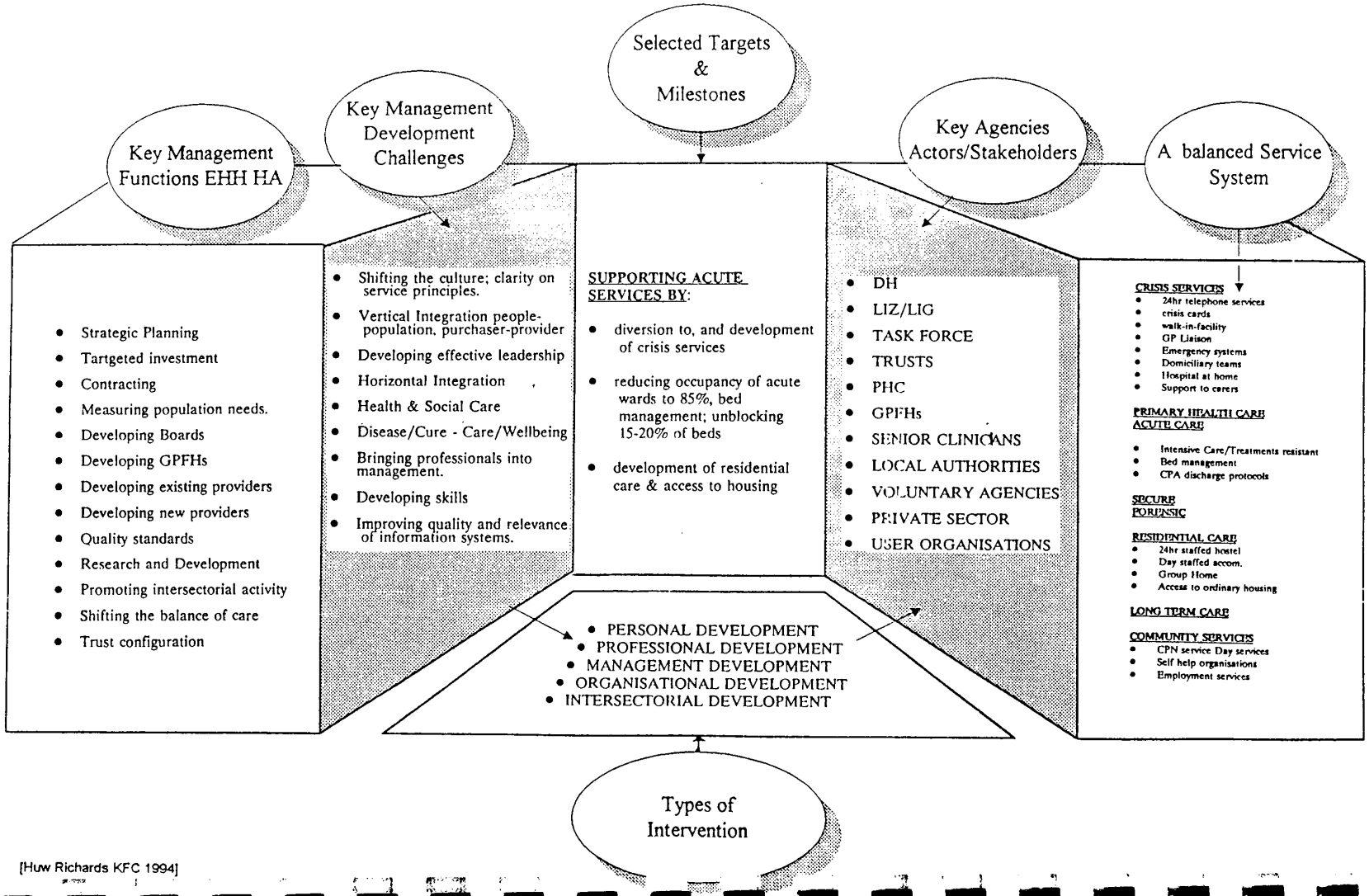
These elements of the NHS "managed" market and the organisational development challenge for EHH are shown in the following 2 figures.

FIGURE 1



[Huw Richards KFC 1994]

Figure 2 Elements of a robust commissioning strategy for EHH.HA



[Huw Richards KFC 1994]

Service Principles

1.29 Underpinning the EHH HA strategy and the service systems of providers must be a clear set of principles.

The UN Sub-Commission on Human Rights has set out a useful set of principles which cover the issues of confidentiality, representation and consent to treatment.

The Code of Practice for the 1983 Mental Health Act also sets out the practice implications of respecting patients and balancing their rights and needs, and the balance of care and control.

Medical Nursing and British Association of Social Workers Ethical codes provide also a firm foundation for principles of good practice which cover issues of

- respect for persons and equal respect
- confidentiality, truth-telling and promise-keeping
- beneficence, doing no harm
- creating conditions for autonomy and choice
- balancing care and control
- observation, safety and protection

These statements of principles are focused both on the conditions which surround the treatment of the individual and also attempt to clarify the duties and obligations professional staff have to patients in their care.

1.30 Some other formulations contain objectives that should inform service development and promote key characteristics in these services. These checklists are prescriptive and in most cases aspirations and goals. They are useful in reminding those planning and implementing service developments of some key precepts. The following formulation was offered by Thornicroft and Strathdee in working on this review and may be a useful set of perspectives for EHH to consider as it recasts its quality standards.

Services should be local and accessible and to the greatest extent possible delivered in the individual's usual environment.

Services should be comprehensive and address the diversity of needs of the individual.

Services should be flexible by being available whenever and for whatever duration. There should be a range of complementary models which provide individuals with choice.

Services should be consumer-orientated that is based on the needs of the user rather than those of providers.

Services should empower clients by using and adapting treatment techniques which enable clients to enhance their self-help skills and retain the fullest possible control over their own lives.

Services should be racially and culturally appropriate and include use of culturally appropriate needs assessment tools, representation on planning groups, cross-cultural training for staff, use of indigenous workers and bilingual staff, identification and provision of alternative basic facilities.

Services should focus on strengths, and should be built on the skills and strengths of clients and help them maintain a sense of identity, dignity and self-esteem. Patients should be discouraged from adopting the sick-role and the service from developing an environment organized around permanent illness with lowered expectations.

Services should be normalized and incorporate natural supports by being in the least restrictive, most natural setting possible. The usual work, education, leisure and support facilities in the community should be used in preference to specialised developments.

Services should meet special needs with particular attention being paid to those with physical disabilities, mental retardation, the homeless or imprisoned.

Services should be accountable to the consumers and carers and evaluated to ensure their continuing appropriateness, acceptability and effectiveness on agreed parameters.

The challenge for commissioning agencies is to be clear about what information they require from providers in order to assess the extent to which such objectives are being met.

Summary

1.31 A robust mental health strategy for EHH HA will be one that avoids over-specifying each component of a local balanced mental health service. It will focus on the enabling role of the commissioning agency in assisting providers to deliver within the strategic intent.

1.32 A robust strategy will pick targets and identify the elements which are directly related to achievement of the target in an appropriate time scale. A range of target developments might be pursued in different Trusts. An example of support to acute beds is given in this report, and proposals for working with GPs, and GPFHs and forensic and other sectors including user organisations will also be made.

1.33 A robust strategy is one which can respond to a changing environment and be self-regulating. The development of supporting sound information systems, quality appraisal, audit, research and development are essential to create a responsive strategy.

1.34 The time scale for implementation of a strategy that includes:

* support to acute and forensic and secure services
* achievement of a balanced service system
* consultation with stakeholders
* support to primary health care

will need to be realistic and will involve six aspects of an organisational development processes as well as the specific process of contracting, as set out in Figure 2.

1.35 The contracting "culture" created by EHH HA will have to take account of the management capacity of NHS Trusts, the currencies being used, the vertical and horizontal integration illustrated in Figure 2, and the ability to monitor contracts in relation to other sources of evaluation.

1.36 The achievement of the strategy will require EHH HA to work with agencies outside the NHS, in particular Local Authority Social Services Departments and housing providers. This may entail joint commissioning and purchasing elements of social care.

1.37 The experience of EHH HA in developing their strategy will contribute to current London-wide initiatives on commissioning in mental health.

2. THE BRIEF FOR THE REVIEW

The brief for the review was as follows:

2.1 The Mental Health of the EHH Population

To undertake a major review of service need relative to the resident population of West London with due regard to the transient nature of part of that population especially given the high numbers of homeless people.

2.2 A Balanced Service System

To recommend an appropriate and affordable model(s) of service delivery which are conducive to client needs, clinically appropriate, demonstrate good quality and are cost effective; these to take account of prevention and health promotion, specialist and forensic service provision.

2.3 To propose a preferred configuration of services which is community orientated balanced with acute and secure provision.

2.4 Activity Measures, Audit and Quality

To instigate units of measurement for activity, indicators and outcome measurements of quality (clinical and user orientated) to assess service utilisation and determine efficiency and effectiveness.

2.5 To undertake an options appraisal of existing service provision in the light of current proposals to increase the size and location of capital stock; this to inform imminent decisions on capital investment. **(Brief Deferred)**

2.6 Strategic Change and Investment

To propose a prioritised investment plan which relates need to the change management programme(s) necessary to deliver the strategic direction statement.

2.7 Research and Development

To identify and recommend projects for research and development which are considered important instruments to the promotion and delivery of the developing service.

3. THE CONDUCT OF THE REVIEW

3.1 The Kings Fund has worked with a number of agencies in the process of this review (CASPE Consulting; PRISM; Rho Delta). The King's Fund Team met with a Reference Group on four occasions. The Reference Group comprised people from a range of professions and agencies and included independent clinicians. A meeting was held with clinicians from the Trusts and a day meeting was held on Audit and Quality issues with the three Trusts represented. Membership of the Reference Group is set out in Appendix I.

3.2 The focus of the review included patients in the 19-65 age range and excluded specialist facilities such as the Cassel Hospital, drug and alcohol services, and Child and Adolescent Psychiatry Services.

3.3 The following elements were considered to be central to the data gathering and analysis phase of the project:

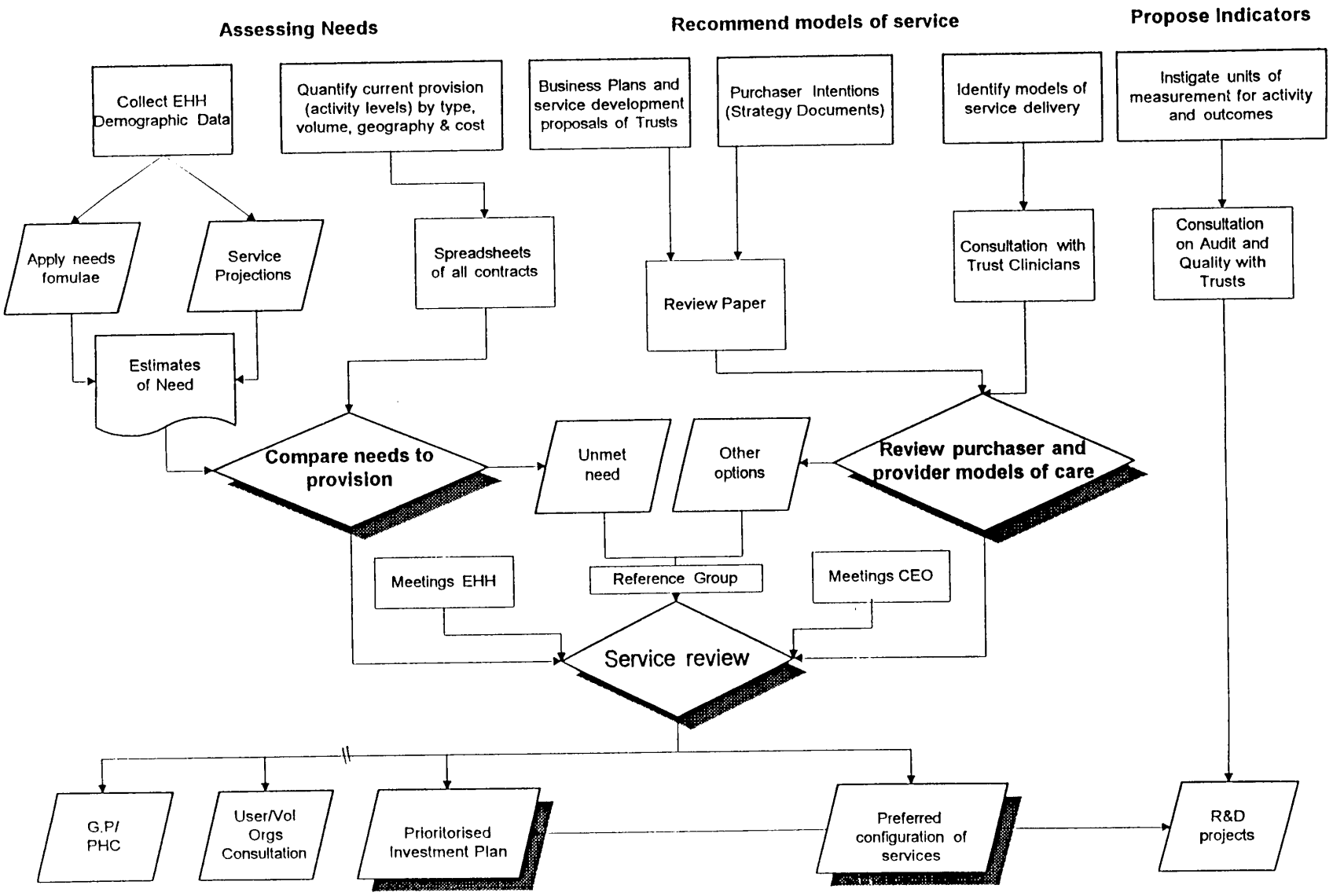
* an epidemiological needs assessment
* an outline of current adult provision
* a mapping of current contracts
* a description of EHH and Trust strategic intentions
* fit between estimated needs and current provisions
* options for service development
* purchaser audit and quality requirements
* options for research and development

3.4 The following outline project plan was used as a graphic guide to our work. Certain elements such as the clinicians consultation were added and the option appraisal of capital stock and capital investment was deferred. It should be noted that consultation with General Practitioners and users and user organisations was not part of this initial brief. It has been recognised by the Reference Group (where these interests are present, including Local Authority representation) that these links will be important as the findings from this review are taken forward in the coming months.

3.5 The papers submitted during the review are documented in Appendix II and documents produced for the Reference Group are listed in Appendix III.

3.6 The report of findings which follows will cross refer to the detailed data in the documents in the Appendices.

An Overview of the Project Plan



4. BRIEF 1: THE MENTAL HEALTH NEEDS OF THE EHH POPULATION

To undertake a major review of service need relative to the resident population of west london with due regard to the transient nature of that population especially given the high numbers of homeless people.

4.1 There are a number of complementary methods for assessing the needs of the population in EHH. The three boroughs have significantly different minority populations in terms of ethnicity and differ in their levels of social deprivation.

4.2 Ideally, if a case-register or other information system were available it would enable estimates to be made of numbers of people, the type of need, and the services to be designed and targeted on their needs. However, in the absence of such data bases, the best methods available include the use of indicators of what the range of needs may be and uses historically determined patterns of service as the basis for estimating what kinds of services people need.

4.3 There are obvious limitations in estimating mental ill health and likely service use by these methods. Such estimates of need when they attach to particular types of services are intrinsically conservative. In particular in a changing environment it is far from certain that applying the expected levels of a particular pattern of services will assist the process of exploring new models of service. A test can be applied however to assist this process, by considering new or substitute services which could meet properly estimated needs, in the light of the fact that these needs have been historically expressed as a need for a particular type of service.

4.4 For example, an estimated need for housing for those with mental disorder is expressed in part as the need for "unstaffed group homes". There are estimates for this type of provision because national data has been developed for it. However there are views that suggest that group homes are unpopular with patients, create problems of multi-occupation, and with 'voids' (unpaid rent) when a member of the group moves on. We at least know that there is a housing need to be met, but perhaps not in the way implied by the measures of estimated service need by type.

4.5 The methods available for assessing the needs of a population for mental health services are as follows:

- Estimates of needs based on epidemiological analysis. This estimates the national prevalence of mental disorders which may bring people into contact with psychiatric services

- National service utilization rates can be applied to local figures to suggest what services might be needed locally

- By taking account of economic and social characteristics of the population. It is known that some of these social characteristics are related to mental health problems and allow the capitation figures to be given a weight.

- Local provision may be compared with national levels. This gives a rough comparison but does not measure need

4.6 These methods also need to be complemented by other known factors which either effect the levels of mental disorder, determine its geographical location, or which effect the likely use of services. Therefore the generally accepted views that social class drift is part of long-term mental disorder; that homeless persons have much higher contact and greater duration of service that average residents; that certain gender and race issues in Asian and Afro-Caribbean populations create different patterns of service use and location; must all be added to the measurable figures from the methods in 4.5 above. These factors are particulary relevant in EHH and will significantly affect the overall picture gained from the standard methods.

4.7 Bearing these issues in mind, the mental health needs of the EHH population were estimated as follows:

4.8 The population of EHH is 639,700. The mid year 1992 OPCS survey gives the boroughs the following figures:

Ealing	280,000
Hammersmith & Fulham	152,000
Hounslow	208,200

Broad estimates suggest that 0.7% of the population suffers (prevalence) a psychotic disorder, this gives a figure of 3,514 for EHH.

4.9 The expected prevalence of disorders in EHH using Health of the Nation data is as follows:

Table 1: National and Expected EHH prevalence of Psychiatric Disorders

	Estimated Prevalence /500,000	Estimated for Ealing	Estimated for Hounslow	Estimated for Hammersmith	Estimated for EHH
Schizophrenia	1,000-2,500	550-1,400	420-1,050	300-760	1,280-3,200
Affective psychosis	500-2,500	275,1,400	220-1,050	150-760	640-3,200
Depression	10,000-25,000	5,500-14,000	4,200-10,500	3,000-7,600	12,800-32,000
Anxiety	8,000-30,000	4,480-16,800	3,360-12,600	2,400-9,000	10,240-38,400

Health of the Nation, 1993

The ranges here are relatively wide.

4.10 Applying the EHH population figures to national patterns of service use (Goldberg and Huxley 1980) the following picture emerges:

Table 2: National and EHH Expected Psychiatric Morbidity and Service Use

Measure	Annual prevalence (%) (national data)	Expected levels of EHHHA *
Number of adults suffering from mental illness / distress	25%	125,500
Number consulting primary care	23%	115,460
Number identified as having mental illness / distress	14%	70,280
Number referred to mental health services	1.7%	8,530
Number admitted to psychiatric hospital	0.6%	3,012

* assuming population 18 years and over is 501,700

(Thornicroft and Strathdee 1994)
(Based on Goldberg and Huxley 1992)

4.11 Service use figures from another source (Wing 1992) would suggest, in acute wards, 2803 admissions and the table above estimates a need of 3012. The actual number of acute beds for EHH between 214-230 (Thornicroft 1994) and the FCEs 2,198 with in general over 100% occupancy suggests both pressure on the acute sector and potentially unmet need in the population. It should be borne in mind also that the factors identified in paragraph 4.6 above will exacerbate this problem.

4.12 Calculations which take into account a range of factors, particulary deprivation have been used. The Jarman scores for each borough are as follows:

Table 3: EHH Population and Social Deprivation Scores

Local Authority	1991 Population	Jarman UPA 8 Score	Jarman rank (out of 403 Local Authorities)
Ealing	280,000	25.5	34
Hammersmith & Fulham	152,000	35.3	15
Hounslow	207,700	22.1	46
Total	**639,700**	**26.2***	

* weighted by population

This table shows that deprivation scores are high and a map in Appendix II to this report points to particulary high levels in some localities.

4.13 There are a number of other indicators which point to high levels of morbidity and the need for mental health services in EHH. These are:

- suicide rates
- ethnicity
- age structure
- unemployment
- homelessness

4.14 Suicide rates in EHH are higher than the national average.

Table 4: National and EHH Suicide Rates 1991/92

	Males	Females	Persons
EHH	19.3	7.4	13.2
Ealing	17.0	8.3	12.5
Hounslow	15.4	8.1	11.7
Hammersmith	29.2	6.3	17.2
England & Wales	**16.9**	**5.7**	**11.2**

4.15 The factor of ethnicity in EHH has to be taken into account. The variations across EHH make estimating its influence on mental health needs complex. This considerable variation across EHH suggests the need for local, accessible and culturally appropriate services.

4.16 In Ealing, Asians are the largest non-white group at 22% with the black population being about 7%. The mental health factors which have been reported concern a "markedly raised rate of suicide in young Indian women" (Thornicroft and Strathdee 1994) and that Asians are less likely than the white population to be referred to the psychiatric services, also low rates of consultation probably do not reflect low levels of psychological distress.

4.17 In Hammersmith and Fulham, 17.5% of the population is from black and ethnic communities (Community Care Plan 93/94). It has been reported that Afro-Caribbeans are more likely to be admitted to psychiatric hospital than their white neighbours. This finding is ambiguous in the sense that it may be a function of the service system, rather than a measure of morbidity. However it is the case that such groups have a greater change of being diagnosed as suffering from schizophrenia.

4.18 A linked problem exists between ethnicity and levels of homelessness in refugee populations. No measures are available but Reference Group members report increasing contact by the psychiatric services with refugees, particulary from Eastern Europe.

4.19 The age structure of the population also serves as a pointer for service needs. Over-representation in the 20-29 age range, will predict a higher rate of population at risk of developing psychotic disorders. The Health Service Indicators for 1991/2 (see Appendix III a(1)) suggest that there is a slight over-representation for males in the 25-44 age group compared with national figures, which may result in a slightly increased demand for psychiatric services.

4.20 Levels of unemployment are estimated at 14.9% in Hammersmith and Fulham, a total of over 18,000 people. Since high levels of suicide are related to levels of unemployment, and becoming unemployed has been associated with a general decline in mental health there exists a further indicator that there are significant mental health needs which are not fully captured in the measures commonly used.

4.21 The local authority community care plan notes that in Hammersmith and Fulham on indicators such as community charge rebates, social security take-up, unemployment (14.9%), free school meals (49%), homelessness (1,637 households in 1992), special housing needs for those with disabilities (575 people) and incoming refugees, that there are significant and complex social problems. These factors are likely to influence the need for mental health care. The community care plan notes that these problems are "compounded by the absence of support networks in the community". A further factor for which few estimates exist is the level of drug addiction. In some areas of EHH this may contribute to the needs for mental health services.

4.22 Homelessness can be defined in a variety of ways, and accurate estimates in certain categories are likely to be underestimates. This is particularly true of street homeless people. Homelessness can be defined as:

- statutory homelessness by local authorities
- occupation of bed & breakfast accommodation
- living in squats or hostels
- living with relatives in overcrowded conditions (hidden homelessness)
- "rooflessness", street homelessness
- travelling people

4.23 There is reported evidence that homeless persons are more likely to use psychiatric services and use them for longer than housed residents. Since this is the case, the volume of services consumed by homeless people and their demands on the psychiatric services, may be significantly underestimated.

4.24 Thornicroft and Strathdee (1994) note that:

> The homeless are another group whose specific needs for mental health care have received considerable attention in the USA in the past 10 years and who have now begun also to be the focus of research in the UK. Most of the studies have focused particularly on the homeless in hostels, but work has also begun on the evaluation of the psychiatric status of the street homeless. This body of research suggests that the homeless in hostels and night shelters and on the street probably have a rate of mental illness between 30 and 50%, and that functional psychoses predominate (Scott, 1993: Marshall and Reed, 1992; Timms and Fry, 1989; Marshall, 1989). Conventional

psychiatric services often fail to contact or engage consistently the homeless mentally ill, so that specific services for this group are needed. For example, clinics may be provided in places where the homeless tend to congregate or assertive outreach work carried out on the street. The extent of the local homeless population thus needs to be known in order to plan a comprehensive service for the long term mentally ill. The following information on numbers of homeless households in temporary accommodation in September 1993 was provided by the Director of Hammersmith and Fulham Housing Services Department, and derives from information collected by the Bed and Breakfast Information Exchange:

Table 5: Homeless Households in Temporary Accommodation September 1993

Accommodation type	Hammersmith & Fulham	Ealing	Hounslow
B&B/Hotels	240	0	36
Private sector/leasing	837	886	390
Other private sector	41	0	37
Hostels/refuges	87	167	161
Short life/short stay	92	9	4
Own accommodation	44	0	16
Total	**1,341**	**901**	**644**

The following figures were obtained from the 'Access to Health' organisation for the homeless in the three Boroughs. They relate to numbers of individuals rather than households. The difference between these figures and those above may partly be due to including those placed in accommodation within EHH who originate from other boroughs and excluding individuals from EHH placed outside the Borough. Also, the following figures, unlike those above, appear to include individuals not accepted by the Borough councils as qualifying for priority rehousing.

Table 6: The Homeless Population in Ealing, Hammersmith and Hounslow and Fulham

	Hammersmith	Ealing	Hounslow	Total
B&B	2,532	5,021	3,377	10,930
Squats	374	169	36	579
Hostel	39	0	0	39
Street homeless	11	7	0	18
Travellers	65	103	41	209
Total	**3,021**	**5,300**	**3,454**	**11,775**

4.25 **Summary**

- There are a variety of methods for estimating the mental health services needs of a population. They are proxy indicators and show in general a high estimated demand for mental health services in EHH.
- Other factors known to influence needs for mental health services, ethnicity, unemployment, drug addiction, age structure, homelessness and refugees are likely to significantly increase needs for mental health services in EHH.
- The suicide rate high relative to national standards high and this is a target of the Health of the Nation policy.
- The mental health needs of ethnic minorities are diverse and geographically concentrated and give rise to special needs some of which relate to the prevention of suicide target.
- Given the baseline estimates of mental health need from standard methods, the added local factors point in the direction of greater current need than the estimates suggest.

4.26 **Recommendations**

- Application of national estimated expected levels when expressed by service type requires comparison with equivalent existing services. More detailed descriptions of local services are needed to create exact equivalence.
- Data on refugees, homeless persons and their use of psychiatric services should be sought by survey techniques, possibly using the capital-recapture technique of Fisher et al 1994.
- The specific and varied needs of ethnic minority groups should be explored with a view to designing accessible and appropriate local services to meet their mental health needs.
- This comprehensive view of estimating population needs for mental health should be brought to the attention of appropriate central government agencies with a view to enabling the weighted capitation formula to be developed as more sensitive to mental health needs.

5. BRIEFS 2 & 3: THE COMPONENTS OF A BALANCED SERVICE SYSTEM

Brief 2: ***To recommend an appropriate and affordable model(s) of service delivery which are conducive to client needs, clinically appropriate, demonstrate good quality and are cost effective; these to take account of prevention and health promotion, specialist and forensic service provision***

Brief 3: ***To propose a preferred configuration of services which is community orientated balanced with acute and secure, to include forensic, provision.***

5.1 There are many formulations of what an ideal or model mental health service should contain. There have been valuable descriptions of such services such as:

- Dane County Wisconsin (Stein and Ganser 1983)
- New South Wales (Hoult 1986)
- Birmingham UK (Dean and Gadd 1989)
- Nottingham UK (Tyrer 1984)

However O'Donnell (1991) in a review of community care considered that although there is some evidence that "to be effective, care in the community should be comprehensive, assertive and continuous" more evaluation studies are needed. Wing (1979) summarised the essential characteristics of a mental health service for a community as that it should be "responsible, comprehensive, and integrated".

5.2 There is a natural tendency to see services as developments or "outreach" from current services. Another tendency is to take a "shopping list " approach from the literature, current services and experience and formulate an over inclusive set of service components.

5.3 There seems to be a case for thinking of mental health services as linked and integrated. However the characterisation of needs, including the approaches taken in the first section of this report may tend to be driven by the shape of existing services rather than drawing upon new developments in services.

5.4 Thornicroft and Strathdee propose a "seven step" approach to establishing community services which include:

- agreement on guiding principles
- setting sector boundaries
- estimating population needs

- creating an information infrastructure
- target priority groups
- assessment of needs of individual patients
- agreement on components for a comprehensive service

5.5 We have made progress on a number of these steps in this review, from service principles, through the various methods for estimating population needs. The later Brief 4 addresses issues of activity measures. We can begin by identifying the main components in a comprehensive system.

5.6 **A Balanced Service System**

Mental health services are located in primary, secondary and tertiary sectors of health agencies, but significant day and residential provision is often provided by local authorities, voluntary and private agencies. Most comprehensive service models include:

Table 7:

Community Based Services	Crisis intervention services; domiciliary contact by clinicians and short-term residential
	Information/phone-lines, walk-in access points
	Liaison with police, and criminal justice systems
	ASW links with Local Authorities
	Support to Primary Health Care
	Out patient clinics

Secondary In-Patient Services	Liaison Psychiatry	With a Range of Treatment Modalities
	Acute	
	Rehabilitation	
	Intensive Care	
	Forensic	
	Secure	
	Long Stay	

Tertiary Services	Access to tertiary and specialist services eg. drug and Alcohol/Child and Adolescent Psychiatry

Community based Services	Pre and post discharge planning and liaison
	Community Psychiatric Nursing Service
	A range of supported accommodation and residential based facilities
	Access to ordinary housing
	Day Services
	Vocational rehabilitation and employment opportunities
	Self-help groups

5.7 **Pressure on Acute Beds and Community Services**

There is no 'ideal' type of service but unless most of the above elements are present in sufficient quantity and quality, and are well co-ordinated a number of problems arise. Pressure on acute beds because of excess demand increases occupancy and creates both 'overheating' of the acute ward environment and also silting up' (blocking) of beds because discharges cannot be appropriately arranged. On the input

side the diversionary use of crisis teams and short-term facilities including 'hospital at home' schemes can both provide a normalised model of care and ensure more appropriate use of acute wards.

On the output side the range of community services should be available to allow timely discharge based on the Care Programme Approach. The existence of a range of support services

- CPN/Social work follow up
- Hostel
- Group House
- Supported Accommodation
- Access to ordinary housing
- Day Care
- Sheltered employment

does not imply that patients move through each part of the range. The problem of 'silting up' will occur within this system as in acute wards unless there is access to ordinary housing or/and a steady increase in supported accommodation.

5.8 The acute wards in the three Trusts are all showing signs of excess demand, high occupancy and trading up to, and beyond, the block contract figures. Further outside this part of the service on the crisis response side (III a p48 50/51) and on the level of community services (see III b/c on levels of local authority and voluntary community services) there are significant limitations in type and volume of services so that further pressure is placed back onto the secondary services.

Any comprehensive service model will recognise that a shortfall in provision in one area of service will have a knock-on effect on other areas. A balance of care can only be achieved by a balanced service system. This approach would therefore look critically at investment in only one part of the service if such an investment would not add value because of the absence of complimentary supporting services.

This is the case when investment in acute beds is considered. If community services are low and crisis services limited, extra acute beds may simply be used in the same way as they are currently. This has to be considered when we compare this existing levels of a range of services with the expected levels suggested by the analysis of the needs of the population, a crude investment in the global difference may not achieve a better balance of care.

5.10 Table 8: Expected Provision Compared to Actual Provision

Type of Provision	Expected places for Ealing Actual in bold	Expected places for Hammersmith and Fulham Actual in bold	Expected places for Hounslow Actual in bold	Expected places for EHH Actual in bold
24 hour staffed residences	156 **Actual: 95**	88 **Actual: 83-118 ***	115 **Actual: 16**	359 **Actual: 194-243 ***
Day staffed residences	124 **Actual:58-95**	70 **Actual: 18 ***	92 **Actual: 35**	286 **Actual: 111-148**
Acute psychiatric care	157 **Actual: 70-80**	88 **Actual: 70**	116 **Actual: 48-52**	361 **Actual: 188-202**
Unstaffed group homes	85 **Actual: 50**	47 **Actual: 34-113 ***	63 **Actual: 16**	195 **Actual: 100-179 ***
Adult placement schemes	15 **None known**	9 **None known**	11 **None known**	35 **None known**
Local secure places	11 **Actual: 13-14**	6 **Actual: 11.5**	8 **Actual: 1.5**	25 **Actual 26-27**
Respite facilities	5 **None known**	3 **None known**	4 **None known**	12 **None known**
Regional secure/SHA unit/ Special hospital	11 **Actual: 28**	6 **Actual: 13**	8 **Actual: 10**	25 **Actual: 51**

[Thornicroft and Strathdee]

(* = Figures amended by H. Richards (KFC) from material provided by Riverside Mental Health Trust)

Notes:

1. Thornicroft and Strathdee draw attention to the quality of the information on which their original table was based.
2. For the purposes of making some comparison between current and expected levels of services, Thornicroft and Strathdee included long stay and rehabilitation beds in hospital under 24 hour staffed residences. This does not imply that they believe the current distribution of such beds between hospital and community necessarily to be appropriate, or that the patient group served by them is necessarily the most appropriate one.

5.9 In applying the estimated need for historically determined patterns of service developed by Thornicroft and Strathdee we should note several caveats.

- local conditions may increase demand
- national policies may increase demand
- equivalence in definitions in national estimates e.g "local secure places" may not fit neatly with Trust definitions, and these may even differ between Trusts.

Having noted these caveats the overall picture attempts to include all known provision in EHH and project expected provision.

5.11 These tables (8 and 9) suggest relatively low current provision in most areas, apart from secure facilities. As previously, the shortfall between actual and expected appears greatest in Hounslow in both community and residential provision. As far as inpatient provision is concerned, Hammersmith and Fulham comes closest to the expected levels.

We do not have sufficient information on use of day care to allow us to make any comparison between actual levels and Wing's norms, as set out in Table 12 (Appendix III (a) p17). However, the number of patients on the 'primary' caseload at Ealing's mental health resource centres (364 in December 1993) approaches the number of patients Wing considers will require specialist day care (391, adjusting for deprivation). In Hammersmith and Hounslow, however, it seems very unlikely that the current range of day provision could accommodate the numbers Wing's work suggests (285 patients in specialist day care in Hounslow and 223 in Hammersmith).

5.12 Tables 8 and 9 show:

- significant underprovision in acute care
- significant underprovision in residential care
- a pattern of relatively high use of the most secure provision

5.13 The comparison of use of levels of secure provision suggests an inversion, with greater use of the more secure than the less secure facilities. (App III 48,50).

Forensic and Secure Provision

5.14 In the category of "local secure provision" a number of problems of equivalence arise. A range of appropriate facilities will have a number of "secure" elements. The configuration of the Trust's provision has a mixture of forensic, intensive care, behaviour modification and treatment resistant facilities with varying levels of security and close observation. There is also evidence that the case-mix in the acute wards has moved towards more detained patients who need intensive medical and nursing support. Furthermore the case-mix issue is highlighted in the role of the Henry Rollin unit which although considered a mixed forensic and intensive care facility has some overlap in case-mix terms with the Regional Secure Unit. These issues have been set out by Dr David James in his submission, reproduced in the Appendices to this report.

The national policy on discharges from special hospitals and the implications of the Reed Report for diversion and on medium secure places will create pressures for a variety of levels of security across a range of types of ward/unit environment. Dr Dolan's submission noted the need to relate "medium secure places" to the Reed Committee's proposals. Thornicroft and Strathdee note that these guidelines "would give higher levels of secure provision" that suggested in table 8.

5.15 The Trust's forensic and intensive beds are as follow:

> "Riverside and West London Healthcare Trust have locked specific intensive care facilities used for residents and for ECRs. Blair Ward in the John Connolly unit is a locked intensive care ward with patients admitted under the Mental Health Act. The cost and volume contract for Ealing services specific bed use on Blair Ward of OBNs equivalent to the use of 4 beds for EHH. Demand in 1993/1994 is apparently considerably exceeding this.

5.16 Baron Ward in Ealing provides a facility which compliments the Regional Secure Unit and Blair Ward. Barron is a locked ward providing longer term rehabilitation for patients who are difficult to place" (Thornicroft and Strathdee 1994)."

5.17 Hammersmith and Fulham residents go principally to the Henry Rollin Unit at Horton Hospital in Epsom. There is no locked facility within the Riverside Trust area. Riverside Mental Health Trust had planned a 15 bed intensive care facility within London prior to the "reprovision" of the specialist services from Horton. The Trust's plans were for an Intensive Care Unit in London to complement a 72 bedded unit of Specialist Services reprovided on the Horton site.

5.18 This report rehearses the various propositions put forward for the reprovision of Horton below. However the key issue is that the reprovision of specialist services which includes

- Henry Rollin Unit (Addison and Derby wards)
- Behaviour Modification and Rehabilitation service (Glyn Ward)
- Treatment Resistant Schizophrenia Unit (Mott House)

and the development of intensive care facilities are seen as a priority by the Trust. The location is now likely to be a site north of the Thames.

5.19 The Henry Rollin unit has two levels of security, and the provision is a mix of forensic, intensive and interim secure provision. The flexibility of the interlocking elements within the Horton specialist services allows for "RSU" patients to be cared for and also for transfer to open wards (eg in Charing Cross).

Thornicroft and Strathdee (1994) note that "this innovative model of forensic care should be considered as potentially having general application".

5.20 **Table 10: Current Provision of Forensic/Intensive Care Beds**

Borough	Ealing	Hammersmith	Hounslow	EHH
No of intensive care beds	13 in contract for EHH 14 in use this year for Ealing[1]	11.5[2]	<1.5[3]	27[4]
Intensive care beds/250,000	11.5-12.5	19	<2	10.5
No of RSU residents	10	6	4	20
RSU residents/ 250,000	9	10	5	8
No of Special Hospital patients	18	7	6	31
Special hospital patients/250,000	16	11.5	7	12

1. Figures for Ealing include Barron Ward as an intensive care facility, as we understand from information about it sent to the Kings Fund that it is locked and highly staffed, and has a patient group which includes substantial numbers of patients with histories of significant violence. However, a strong case could also be made for classifying Barron as a specialist rehabilitation facility. Figures are based on West London Healthcare Trust activity data for use of beds in Blair and Barron wards by Ealing residents in the first quarter of 1993/4.

2. This figure for Hammersmith is an estimate based on activity data for the first half of 1993/4 for Henry Rollin Ward, and on West London Healthcare Trust activity data for the first quarter for 1993/4 for Barron Ward, where Hammersmith was using the equivalent of 0.8 bed. However, some inaccuracy has been introduced through the classification of Henry Rollin as a intensive care facility where it in fact functions as a mixed intensive care and medium secure services.

3. This is a figure for Hounslow and Spelthorne, based on activity data for the first quarter of 1993/4, and covers only use of Blair and Barron Ward. the '<' sign indicates that use for Hounslow residents alone is likely to be less than the figure given, which will include use of Barron ward by Spelthorne residents.

4. The EHH figure includes last year's level of use of the secure facility for young people at St. Andrews Northampton, which was 3 clients from EHH - we do not have information about which Borough.

5.21 **The Reprovision of Horton Units**

The Horton/Henry Rollin issue is not examined in depth in our report being essentially a provider issue for the Riverside Trust. However various propositions have been considered and are relevant to, an in fact test, the model of care which EHH proposes.

5.22 Reprovision proposals take different features as paramount and as their starting point, for example,

a) the value in a single site for West London e.g. at St Bernards Ealing.

b) the value of separating specialist services such as "forensic" from services which might be more locally provided, such as intensive care.

c) the value of maintaining the integrity of the Henry Rollin complex wherever it is sited since it functions well in the sum of its parts.

d) the value in seeking a 'local enough' inner London site such that access is improved (criteria c is satisfied) and Riverside maintains its range of services as it seeks new markets or Trust mergers.

e) the value in using private contractors for alternative provision.

5.23 On the basis of our consultations it would appear that (a) may be attractive in cost but does not create significantly better access and creates a significant concentration of mental health beds on a single site. We consider (b) to be both impractical and possibly undesirable on the grounds that a case-mix approach to purchasing would not press so finely distinctions in the apparent functions of 'wards'. Conversely we consider (c) to be a potentially strong case, but would wish to examine the current specialist review of the units by the Trust. We consider the cost-savings in (e) as likely to be marginal, but are not sufficiently clear as to whether EHH have alternative NHS Trust providers to compete for their use of the Horton facilities. We therefore consider (d) to be worthy of further exploration by EHH, and most consistent with the service principles set out in paragraph 5.3 following above.

5.24 A forensic service requires a number of interlocking elements

- court liaison services
- probation liaison
- community forensic nurses
- prison assessments
- special hospital assessments
- forensic out-patient clinics.

Table 9:

Borough	Ealing[1]	Hammersmith[2]	Hounslow[3]	EHH
Hospital hostel/24 hour staffed hostel	38[4]	30[5]-41[16]	0 (but one is planned 94/5)	68-79
High staffed hostel/250,000	34	49-65[16]	0	27
Day staffed hostel	58-95[6]	Approx 5-6 staffed houses-number of places not known 18[16] *	35[8]	111-148 *
Day staffed hostel/250,000	52-85	29[16] *	42	123-156 *
Group homes	50[9]	34 - 113[16] *	16[11]	100-179 *
Group homes/250,000	45	56-118[16] *	19	39-182 *
Supported flat	66-80[12]	25[16] *	none known	
Supported flats/250,000	59-71	40[16] *	0	
Total community residential	207-263[13]	85+[14]-197[16]	48-51[15]	340-511 *
Total/250,000	185-235	140+-252[16]	58-61	383-548 *

[Thornicroft and Strathdee 1994, and H. Richards, Kings Fund College 1994]

NOTES:

1. Information on Ealing services derived largely from the Borough Community Care Plan, Document D, current MIND national directory, MIND and Community Health council local information sheets. Ranges given where sources are not consistent.

2. Information on Hammersmith and Fulham largely from the Borough Community Care Plan, Document D, the MIND national directory, the MIND local directory of mental health services and some telephone discussions with workers at local voluntary bodies. Ranges given where sources not consistent.

3. Information on Hounslow largely from the Borough Community Care Plan, Hounslow and Spelthorne Community Mental Health Trust document summarising local mental health services, current MIND national directory, some telephone discussions with workers at local voluntary bodies. Ranges given where sources are not consistent.

4. Based on current bed use at two west London Healthcare hospital hostels (Lyndhurst and Oak Lodge) and two 24 hour staffed hostels run by St Mungo's. We have assumed hostels have day staff only unless documents state they have 24 hour staffing.

5. This refers to accommodation at Wood Lane and at Harwood Road and to two MIND houses with sleep in staff. Riverside plans to open an intensively staffed house with 10 to 12 places, to be completed by mid 1995.

6. Local Authority hostels at Bowman's Close and community Road, Richmond fellowship hostel, (? also West London Housing trust Hostel and Ealing Housing Association residential care (mentioned in Document D, not elsewhere) and MIND Rainbow Lodge (function now known to us).

7. London Cyrenians St Mungo's Trust, the Forward Project and the Broadway Project have staffed accommodation serving people from the Borough, but we do not know the numbers of places provided in these projects.

8. Chiswick Mental Health Aftercare Hostel, residential mental aftercare hostel at 97 London Road, Brentford.

9. Units owned by London Borough of Ealing and by Housing Associations.

10. Refers to five MIND group homes with places for 34.

11. Refers to St Mungo's group home with 6 places and 10 places and in Local Authority group homes.

12. Refers to housing department projects at Soan House, Newburgh and Telfer, Darwin Drive, Villiers Road and Goldsmith Avenue, Fielding Terrace and the Leamington Project, which are managed by Housing Associations, and Somerset Road Project, which is supported by MIND. However, we are not certain whether all this accommodation is occupied by people with mental health problems, or whether some of it may also be used by other groups of vulnerable clients.

13. Inter-Authority Comparisons and Consultancy give a figure of 81 in the 1991/2 indicators, but this figure appears now to be too low.

14. The only overall estimate we have is the figure of 85 given by Inter-Authority comparisons and Consultancy. in view of the number of organisations providing supported houses in the Borough, this may well be too low now.

15. 48 is the figure in the Inter-Authority Comparisons and Consultancy data, 51 the figure our information suggests.

These elements require multi-disciplinary staffing and require investment to achieve the best use of the in-patient beds.

5.25 The category of "local secure places" Requires further examination. A series of definitions has been proposed by Reference Group members and are as follow:

5.26 <u>Regional Service Facilities</u>

Medium to long term accommodation for up to 2 years in full security. Patients are offenders who may have committed serious crimes but who are relatively stable.

<u>Forensic Services</u>

In-patient secure facilities for patients who have offended and are on remand, have been placed on a hospital order by a court, or transferred form prison. Patients are often acutely ill, sometimes very violent and unstable.

<u>Intensive Care Unit (ICU)</u>

In-patient locked wards. Patients may have been transferred from a forensic unit, or have a history of severe mental illness and behaviour disturbance requiring careful management.

<u>Behaviour Modification/Rehabilitation Treatment Resistant Services</u>

In-patient non-secure but highly staffed services for patients with chronic and continuing severe mental illnesses. Usually not violent but can be frightening. Require long term support and treatment. Often "revolving door" patients.

<u>Adult Acute Admission</u>

Open wards, varying staffing levels depending on casemix. In Hammersmith usually over 70% of patients on section - i.e severely ill but not obviously a significant to others. May be a danger to self (e.g. self harm, mutilation, suicide).

5.27 It is now clear that in the existing patterns of Trust services there is some overlap between case-mix in acute through to the Regional Secure Unit and which is not adequately defined by the single term "local secure places". These are therefore reasons for being cautious of the projected EHH estimates from national levels, activity levels may already be higher than the EHH estimates from national data. The points arising from this initial review of forensic and secure services are:

5.28
- The support systems to in-patient beds (para 5.24) require better definition and are currently seen (and costed) as part of the global "places".
- The Trust services show overlap of the category of "local secure places" with acute on the one hand and RSU on the other, and show a greater variety of provision within the category.
- The national trends in both diversion and discharge from special Hospitals will create increased pressure on these services.
- A reduction in forensic services may compromise the strategy, proposed in this report of support to acute beds.

ACUTE WARDS

5.29 **Bed Management**

The pressures on acute beds may be significantly relieved and greater efficiency and effectiveness achieved by a bed management strategy which focuses on those who could be accommodated elsewhere, admitted elsewhere, and by a reduction in those patients 'blocking' beds estimated at between 15-20% of patients; we include a case example of bed management in Appendix XI. The focus on the Care Programme Approach in discharge planning will be most successful if community receiving facilities are strengthened.

5.30 **Re-Distribution or Positive Discrimination Amongst Providers**

The configuration of services between Trusts may require further investment and re-distribution towards Hounslow where investment is at £28 per head, even allowing that deprivation is significantly lower than the other Trusts where per capita levels of £58 and £61 are to be found in Ealing and Riverside respectively.

If such a form of redistribution investment is planned as noted above, the type of services to be purchased requires further description. The approach taken in Hounslow is set out in the annex to Brief 6.

5.31 We have thus far noted the reasonable interpretations of the data presented in tables 8 and 9 on the expected levels of services. In a balanced service system the beds/places will be utilised most efficiently and effectively if supporting provision before admission and after discharge is at appropriate levels.

5.32 It is clear that for the acute beds, where there is an underprovision by expected national levels, these support systems are also relatively weak with low levels of community services. The additional beds 66 for Hounslow and Spelthorne, 75 for Ealing and 18 for Riverside may not be best distributed in that way. More local consideration will be important and the investment in the needs of the population for acute care may not be best pursued by increasing solely the number of acute beds. We consider a number of strategies below.

5.33 Arguments for the 18 Riverside beds being an underestimate have been put forward: these include a number of reasons for the recent increases in demand for acute are. They are:

* closure programmes in other hospitals have created admissions of those who would have become "new long stay"
* the recession and unemployment levels.

5.34 The academic work at Charing Cross is thought to affect length of stay beyond that covered by the SIFTR.

5.35 If the "balance of care " approach used in relation to acute beds is taken to forensic and secure provision (under the category "local secure places") the need for liaison systems, for example diversion on the "input" side, and the Henry Rollin system of discharges to less secure provision on the "output" side create both balance and through-put.

5.36 There are other elements in a balanced and comprehensive service which are outside the scope of this review but nevertheless need to be included in a strategy which attempts to

- rectify the low level of community services
- support in-patient beds (acute, forensic and secure)

These elements are:

- preventive activity
- crisis intervention
- support to primary health care
- maximising community participation and voluntary activity.

5.37 Before expanding further on these elements, a summary of findings arising from an interpretation of the expected and actual levels of service in EHH can be made.

- All components estimated for EHH, with the exception of RSU places shows an underprovision.
- The low levels of community services place greater pressure on acute beds - occupancy rates are high, case-mix is increasingly dependant and blocking of beds is common.
- Proposals for future distribution of acute beds should take account of local variables, deprivation, ethnicity, and also academic functions.
- Bed management, lowering occupancy rates and unblocking beds by appropriate discharge should be examined before increasing actual acute bed numbers.
- The national estimates for forensic and secure provision do not reflect current activity and increased demand. Current over performance can not be sustained without increased investment.
- The variety of Trust forensic and secure services are broader than the category of "local secure places" in the national estimates, and local activity may already be greater than these.
- The specialist services (at Horton) function as a flexible model with links to RSU and open wards.
- The reprovision of Riverside Specialist Services will be north of the Thames but will maintain its flexible characteristics.
- The bed elements of a forensic service required (by analogy with the acute beds) the development of support services such as liaison and diversion systems.

5.38 The EHH HA will wish to develop a strategy which addresses the forensic, secure, acute and community services in order to achieve a balance between them - this will require collaboration with other providers apart from the NHS Trusts.The Local Authorities in their Social Service and Housing functions are key players in any comprehensive service. The extent to which EHH purchases "social care" may become an issue. Riverside Mental Health Trust, as noted earlier, has bid for the social care contract in part of their catchment area.

5.39 The elements noted in para 5.37 above must receive emphasis within an EHH strategy.

5.40 **Primary Health Care**

The role of primary health care in mental health services needs further exploration in EHH. The general practitioner is clearly central to a PHC "team" but the number and type of other members of a "team" may differ depending on the size of practice and its links with secondary and tertiary psychiatric services.

Tantam and Goldberg (1991) suggest that there are 5 groups of "mental health" patients presenting at primary care

- those requiring specific medical treatments
- those benefitting from specific psychological treatments
- those requiring supportive therapy and social intervention
- those requiring only recognition and discussion of problems
- those requiring no action from the doctor or his staff.

5.41 The treatments that mirror these needs are

- drug treatments
- behaviour therapy and cognitive therapy
- social work
- contact with community psychiatric nurses and nurse therapists.

5.42 The role of the psychiatrist in primary health care and in training GPs is stressed, as is the need for better communications between primary and secondary care. However in a cautionary note Tantam and Goldberg comment,

> "there is little evidence for the efficacy of collaboration in terms of patient care or cost effectiveness (Mitchell 1985), nor is there any consensus about the form collaboration should take".

5.43 The ability of GPs to diagnose and treat mental disorder and to refer appropriately to their team, if it exists, to other community agencies, and to secondary and tertiary services, are skills that will need training and support to GPs. This is a better starting point than scanning existing psychiatric services and attempting to feed them into the primary health care setting. Relocating tertiary psychotherapy in primary health care, or providing secondary service psychiatry at primary health care level will have their effects on the services provided to more intractable cases and to the longer term mentally ill patients maintained in the community. There is an argument for increasing the capacity of GPs and primary health care teams to address mental health issues and to liaise closely with existing psychiatric services, rather than to relocate secondary services.

Goldberg elsewhere (1991) has also cautioned against assuming that admission rates will be radically affected by attachments of psychiatrists to primary health care, although there is some evidence in that direction.

The need for a co-ordinated strategy by EHH towards primary health care is supported by the potential consequences of "the decision to move into primary care (being) made by each profession alone, without reference to the others" and the tendency of such developments to lead to the use of scarce resources by less mentally unwell patients. Goldberg concluded

> "only a co-ordinated, multidisciplinary team, which can refer patients to its members for specialised advice or intervention, and which has a manager who is responsible for ensuring that there is a proper distribution of resources among the various competing needs of the population at risk, can achieve these ends. The problems that prevent such a state of affairs from coming about are by no means insurmountable, but they show little sign of being surmounted. We are up against competing claims for professional hegemony, and we are not helped by a philosophy which encourages each profession to sell itself on the market."

EHH HA is in a position to "manage" the market within the NHS reforms (as set out in the figure in section 1 of this report) in order to create an effective and appropriate role for GPs and in particular for GP fund-holders.

5.44 Two further factors, the availability of other non-medical mental health workers and research on the efficacy of treatments, are likely to be important in determining a policy for EHH.

5.45 The distribution of GPs in EHH was described by Thornicroft and Strathdee (1994) as follows:

Distribution of GPs in relation to the population. Nationally the average general practice list size is 2010. The FHSA document shows the distribution of GPs as a rate per 1,000 population; firstly by their registered population and also by the population resident in that locality. In all cases with the exception of North Ealing, the rate per registered population (approx 0.5 GP per 1000) is smaller than that for the resident population (0.6 per 1000). List inflation may be responsible. There are some variations between localities in that Southall seems to have the lowest rate (0.4) per 1,000 registered patients and Northolt/Perivale has the highest (0.71) rate.

Number of GP practices by locality in EHH and the proportion of GPs by sex. In all but one locality male GPs out number their female colleagues, except in North Ealing where the situation is reversed. Feltham as a locality has the smallest number and proportion of female GPs at 6 and 23% respectively.

Size and Organisation of practices. EHH has a high proportion of single handed practices. Feltham locality has the highest proportion of single handers at 63% of practices, followed by Chiswick with 62%. Greenford has the highest proportion of two partner practices at 39% and Fulham the lowest at 12%. There remain only a very small proportion of larger practices. Only 12% of practices in EHH have 4 partners or more. This can be compared to a figure for England and Wales of 32.5% (Statistical Bulletin, Department of Health, October 1993).

5.46 The current primary care infrastructure is considered as "relatively unpromising for the development of mental health services closely linked to primary care".

- In less than five instances was a special interest in mental health noted by the GPs and in almost all cases this was in the 3 partner or more practices.
- The availability of a practice counsellor was cited in a tiny minority (approx 5) practices. In the specified practices there was at least two and more usually three or more partners. This is clearly well below the national norms if accurate.
- The structure or primary care services in EHH was the large number of single handed and small practices make it less likely that the area has or will be able to facilitate a model of attached mental health professionals to primary care. Nationally it is the larger, purpose built and health centre premises which facilitate such developments.

For further consideration of the degree to which a model of attached mental health professionals in primary care may be developed, the following information needs to be obtained:

- Numbers of practices with counsellors, clinical psychology sessions, attached CPNs, psychiatric outpatient clinics.
- Numbers of the severely mentally ill registered with each practice.
- Number of practices with available space to house attached mental health sessions.

- Number of fund-holders and their plans to buy mental health services.

Co-terminosity of primary care boundaries with local mental health and social services sector boundaries. The FHSA material suggests that a relatively high proportion of residents of the three Boroughs are registered with General Practitioners outside the localities in which they live, which is likely to make the development of sector teams which are highly integrated with primary care teams more difficult.

5.47 It is clear that considerable data collection is required to obtain a clear picture of the "mental health" capacities of primary health care in EHH. The developmental tasks which emerge from such work are likely to be significant. The role of fund-holding GPs or groups of GPs will be an important component in such development work if GPFHs are going to have an influence on the care and treatment purchased for patients. In this sense the relatively low capacity of EHH primary health care in mental health deprives EHH HA of a critical factor in shaping a balanced service system.

5.48 <u>Prevention and Crisis Services</u>

The Reference Group expressed the view that EHH HA should develop a strategy on prevention in as much detail as that for acute and forensic services. There is a role in prevention for primary health care but the most significant issue within a preventive strategy for EHH consistent with the pressures on other parts of the service (eg acute beds) is the provision of crisis intervention services.

5.49 A broad based preventive mental health strategy might be considered by EHH and taken forward under the public health remit. Newton and Craig (1991) give a framework for developing such a strategy, components of which might include:

- developing a clear aetioglogical theory for prevention in mental health
- avoiding over reliance on a "primary","secondary" and "tertiary" prevention model
- considering interventions and services which:

  * enhance coping skills
  * provide protective social support
  * improve parent-child relationships
  * support people at critical points/life-events
  * prevent recurring morbidity, relapse.

5.50 Some of these interventions are linked to primary health care, and some to secondary care. There is therefore, a clear basis for linking the development of a preventive strategy to support and development of primary health care. In particular EHH may draw on current work being undertaken by the Community Care Directorate in looking at psychological and psychotherapeutic interventions, and considering these in the light of recent guidance produced jointly by the British Psychological Society and the Royal College of Psychiatrists.

5.51 An approach to primary health care development in the context of preventive strategy should also draw upon NWTRHA Research and Development funding which place emphasis on primary health care; the full list of priorities is set out in Section 8 of this report.

5.52 An important component in the balanced service system is the provision of crisis services. Some reference to such services is required here because their development is critical to the emerging strategy of support to and diversion from pressurised acute beds, and because such services clearly link to a preventive strategy which involves primary health care, local authorities, and voluntary and user organisations.

5.53 Psychiatric emergency and crisis intervention services were recently reviewed by Katschnig and Gooper (1991). They note that there are key choices in planning such services:

- the extent to which the closely related concepts of crisis intervention and emergency psychiatric treatment should be separated
- the extent to which special crisis intervention wards can prevent becoming "silted up".

These issues are summarised as follows:

- A choice between developing a specialised psychiatric emergency and crisis intervention service, and not developing one at all. To choose the latter implies that the conventional medical and social services are regarded as appropriate to cope with both urgent and non-urgent types of work.
- If the choice is for specialised arrangement, then it may be developed as a separate service, or as a special component which is integral with or grafted-on to an existing service.
- If the choice is for an integrated or grafted-on component, the psychiatric emergency and crisis intervention service may be developed as part of (i) the social services, (ii) the general medical services, or (iii) the specialised psychiatric services.

5.54 The components of a crisis intervention service have included the following:

- Telephone hotlines (no face to face contact)
- Walk-in facilities
- Mobile outreach teams
- Crisis Intervention Wards
- All arrangements under Mental Health Legislation (1983)
- Contact with existing component of health services where identification and referral to (or services from) immediate psychiatric services is possible (eg PHC, A & E, etc)

5.55 During this review we have noted that "within Riverside there is a hospital based emergency clinic, a crisis intervention team working during office hours, and a crisis house with qualified staff available. There are no day centre or day hospital based emergency services or community mental health centre based service. (Thornicroft and Strathdee 1994).

5.56 In Ealing it is thought possible to extend the day time community mental health centres for crisis work, and consider the development of home based treatment based on assessments by community mental health centre teams.

5.57 In Hounslow and Spelthorne all emergency psychiatric services are hospital based with no other setting providing such services.

5.58 The EHH picture therefore provides considerable scope for development of crisis services. A strategy for their development would need to take account of the issues raised by Katsching and Cooper, and also ensure that they functioned as a direct support and diversion from the acute wards. This would suggest a 'filter' approach which prevents response psychiatric resources becoming heavily involved in crises which even if in this mental health domain would not have impacted on acute wards.

5.59 A first step would be to undertake a retrospective and prospective study of admissions to the acute wards to look for patterns, routes, locations, incidents which might inform the design of crisis services.

5.60 A second step would be to maximise the capacities of any agencies linked to acute admissions in crisis and consider ways in which they might be assisted by liaison psychiatry for example.

5.61 The links between primary health care development and crisis services has been noted. Where such comprehensive services exist and where the psychiatric service has an effective emergency (outreach) team, the need for specific services such as crisis intervention wards might be avoided.

5.62 **Recommendations**

EHH HA should consider the following proposals -

1. The creation of a balanced comprehensive mental health service system (as set out in above) by targeted investment in key components.

2. The development of a strategy to support acute beds, including bed management techniques and development of preventive and crisis intervention services.

3. Promotion of General Practitioner training in mental health.

4. Promotion of Fundholding and purchasing skills of GPFHs in mental health.

5. Liaison with local Authorities on community services, particularly in crisis and post-discharge areas.

6. Liaison with housing providers to develop at least 40 new places across EHH.

7. To support the forensic in-patients services by development of a range of liaison services.

8. To support the speedy reprovision of the specialist services currently at Horton and to develop the flexible linkages which that service illustrates, with RSUs and acute wards, across EHH.

9. To develop clear definitions of "forensic", "intensive" and "secure" across the Trusts for comparative purposes.

10. To consider realistically the "over performance" of acute and forensic provision and monitor the progress towards lower pressure on these beds by the strategy implicit in these recommendations.

11. To institute feasibility studies for the development of crisis services, development of psychiatric and psychological services at primary health care; development of residential units and access to mainstream, and ordinary housing. To apply to the NWTRHA Research and Development Committee for funds to undertake some of this work.

6. BRIEF 4: ACTIVITY MEASURES, AUDIT AND QUALITY

To instigate units of measurement for activity, indicators and outcome measurements of quality (clinical or user orientated) to assess service utilisation and determine efficiency and effectiveness

6.1 Information Systems

Current activity data appears somewhat sketchy, especially where it applies to community services. The following aspects of the current information infra-structure need to be assessed:

- A summary is needed of the information systems/databases in use throughout EHH, and any systems which might usefully be generally applied through the health authority need to be identified. This is touched upon in our proposals for audit sampling of such databases.
- The accuracy and capture rate of activity collected by such systems will need to be established.
- A caseload/casemix analysis of the activity of key clinical groups such as out patients, CPNs and clinical psychologists (the Audit Commission is currently using such an analysis method) is needed.
- The availability and current use of computers and age/sex registers within the local primary care settings needs to be known to service planners.
- The current availability to mental health service clinicians of modern computer equipment and databases and of training in their use needs to be assessed.
- The degree to which the current information structure allows regular activity and outcome reports to be made available to clinicians should be assessed, as should the level of incorporation of these data in clinicians' audit/response activities.

6.2 The information strategy developed between EHH and the Trusts will need to relate contracting (currencies and monitoring) data, clinical outcome data, and audit/quality indicators to day to day information systems.

6.3 **Purchasing Currencies**

There is a direct relationship between the methods of purchasing and contracting and the type of activity data which can be obtained and used to evaluate services. There is currently a mix of FCE, OBN and block contracts. In order to 'map' all contracts by provider, nature of the service and activity/contact measures, a spread sheet of all EHH contracts was developed. It shows the relationship between the cost/volume of the activity and its method of purchase. This shows the basic activity data available for measurement.

6.4 **Quality Standards**

The EHH have a set of standards which are reproduced in Appendix VI. These contain 44 items.

6.5 An Audit and Quality consultation day with representatives from the 3 Trusts was held. Each has a quality strategy with clinical and medical audit components.

6.6 The EHH set of standards was divided into by those which are procedural, (1.1, 1.2, 1.3, 2 and 2.10), these are standards which require Trusts to have certain systems in place, to endorse certain statutory requirements (e.g. data protection legislation), and to promote certain policy guidance (e.g. the Patient's Charter). From a purchaser perspective it would be useful to group these requirements together.

6.7 The procedural standards in the EHH standards document can be distinguished from substantive requirements that bear on actual services, and these are grouped in the EHH document under the following headings:

- access
- environment
- consumer issues
- waiting times
- individual care planning.

6.8 In discussion with Trusts, it became apparent that whilst all of the Trusts comply in some way with the procedural standards, it was not clear that systems exist in all cases to obtain information on the substantive standards. The information on many of these items is embedded in various systems, some obtained from time to time in clinical audit, some in the PSYMON system (Ealing), some in medical records and other data systems.

6.9 The purchaser has a number of ways of considering issues of quality.

Sets of Standards	Contract Monitoring	Development of the Public Health Clinicians role in examining outcomes

These functions are all compatible and give complementary ways into matters of quality.

6.10 A further method open to purchasers is to identify, in provider systems, information which they can regularly sample which would be agreed as giving an indication of quality and performance. This may encounter non-uniform data systems amongst providers. Therefore there may be a case for the purchasers specifying and agreeing with providers what data should be collected, on what areas, in what form, and which selected indicators should be sampled. This process will initially begin with what is routinely collected, i.e. be somewhat provider driven. The advantage of this starting point is that it avoids imposing a set of unobtainable or unmeasurable standards on providers which may require them to collect data only in such a way as to meet the purchasers requirements.

6.11 The EHH Standards require clarification in terms of their type, data sources, and usage in general quality monitoring, for example by visits by EHH officers, or in more specific analysis of audit exercises and clinical outcomes. Proposals for such developments have been received and are reproduced as Appendices VII and VIII.

6.12 The approach purchasers take to quality should entail a range of tasks

a) ensure that providers have systems to monitor quality,

b) to sample certain agreed data at certain times,

c) to promote and receive specific audit reports,

d) to promote and receive clinical outcome data.

The more general EHH standards, other than the procedural (eg, statutory requirements) should either be given much clearer operational specifically and agreed, for the purposes of data collection, with the Trusts, or they should be brought together in a more general document relating services principles to practice.

6.13 Contract monitoring requires standard forms which is not the case at present across

6.13 Contract monitoring requires standard forms which is not the case at present across the Trusts.

6.14 If item (b) para 6.12 is pursued it will require agreement between the purchaser (EHH) and the three Trusts on the items selected for analysis and a common form of collection and presentation. These are a range of possible targets for data collection relating to quality, for example information on:

- Meeting the Patients Charter
- Health of the Nation Targets
- Communications with GPs
- Treatment responses to special groups
- Clinical/Service outcomes
- Consumer Satisfaction and Quality of Life Measures

6.15 Liaison with Trust quality systems should be examined. Such arrangements may have to differ between Trusts, but the main items noted above should be covered. For example, Riverside Mental Health Trust has established a Quality Strategy Group which services the member level Quality Council which is chaired by a non-executive director. The council co-ordinates a range of quality initiatives including:

- Patient Management Protocols
- Human Resource Issues
- Medical, Clinical and Contextual audit
- Clinical outcomes
- Consumer satisfaction
- Health of the Nation targets, eg suicide

6.16 Trusts also have procedures for both internal and external enquiries into untoward incidents and unexpected deaths. These enquiries raise issues which are taken forward into policy and procedural guidance within the Trusts.

6.17 The trend is towards identification of a small number of indicators which purchasers can obtain which give a broad picture of the quality standards of providers. These are grouped in an example provided in Appendix IX into six areas:

- clinical audit
- services for black and ethnic minorities
- consumer involvement
- health of the nation; health promotion
- communication with GPs
- clinical standards/outcome measures

6.18 The findings of this section are, in summary, that action should be considered in the following areas:

a) Contract currencies should be related to activity performance measures and recognise how these create incentives or disincentives in quality terms.

b) Contract monitoring/quality visits have ceased but may be the basis for negotiating purchasers requirements for information related to quality,

c) Contract monitoring forms are not uniform between Trusts.

d) The EHH 44 items in the standards document requires review, but the procedural standards are sound.

e) A sampling exercise of Trust data along the lines set out in paras 6.17 and SELHA document Appendix IX, should be considered.

f) The development of the public health role in purchasers view of quality and clinical and R & D outcome material should be considered, and is discussed in Appendix VIII.

7. BRIEF 6: STRATEGIC CHANGE AND INVESTMENT

To propose a prioritised investment plan which relates need to the change management programme(s) necessary to deliver the strategic direction statement

7.1 A prioritised investment plan depends upon the adoption of a clear strategic intent. The proposed strategy in this report rests upon the following assumptions:

- the strategy set out by EHH in its draft Commissioning Strategy 94/95 - 98/99 [DOC72KF] remains the basis for current policy;
- that a balanced service system is required;
- that there is currently a shortfall in all components;
- that the starting point of acute provision requires simultaneous investment in other components which relieve pressure in the acute wards. A target occupancy level of 90% or less is desirable;
- that the forensic service as represented by the Henry Rollin unit will be reprovided;
- that the balance between different levels of secure provision and its use will be examined;
- that collaboration with Local Authorities (SSDs) and all providers is closely linked to the Health Agency ability to deliver a balanced service system.

7.2 We have established that there is little disagreement between the EHH strategic direction and the Trusts intentions (see Appendix X submission to Reference Group meeting I).

7.3 We therefore set out here an overview of current purchasing; how purchasing takes place; the relation of service definitions to case mix and proceed to a purchasing scenario which addresses the strategic direction on the assumptions in paragraph 7.1 above.

Overview of Current Purchasing

7.4 The mental health services of EHH are purchased from a range of providers. These comprise the three major providers in the shape of NHS Trusts complemented by a number of private and other NHS providers contributing both breadth and volume to the overall purchasing pattern.

7.5 Hounslow & Spelthorne Community & Mental Health Trust provides acute inpatient & outpatient services, community services - Community Psychiatric Nurses (CPNs) - and a day hospital, all based within the London Borough of Hounslow.

The contracts governing these services total some £2.9 million in 1993/1994, out of EHH's total adult mental health budget of some £32 million.

7.6 Riverside Mental Health Trust provides a wider range of general services comprising acute inpatients and outpatients, rehabilitation, long stay, and CPNs plus a number of specialist services; the Eating Disorder Unit (EDU), the treatment resistant schizophrenia unit (Mott House), the Behaviour Modification & Rehabilitation Unit (BM&R) and the Henry Rollin Unit providing a locked intensive care service to patients with a wide range of mental health problems. In 1993/1994 the total contract sum paid for these services was £10.3 million. Most general services are centred on the London Borough of Hammersmith & Fulham whilst the Henry Rollin, BM&R and Mott are located in Horton, Surrey.

The £10.3 million includes the contract costs of the Cassel Hospital, Child and Adolescent Services, services for people with learning disabilities, mental health of the elderly and substance misuse. These services fall outside the scope of this review. The contract cost of adult services will therefore be lower than the £10.3m figure.

7.7 West London Healthcare Trust provides a similarly wide range of services all located in the London Borough of Ealing for a total contract sum of approximately £9.8 million. These services comprise acute inpatients and outpatients, rehabilitation, long stay and community (at four mental health resource centres). West London Healthcare Trust also provides secure services in the shape of locked intensive care (Blair Ward) and Barron Ward for difficult to place patients, a specialist brain injury rehabilitation service, as well as housing the Regional Secure Unit (RSU) at Three Bridges Hospital.

7.8 Other services are obtained from the Special Hospital Service Authority [SHSA] (providing long term secure places in Rampton, Broadmoor and Ashworth hospitals for dangerously ill patients), and Norwich Mental Health Trust which currently has 1 EHH patient in its RSU (Norvic).

Overflow services are provided by Wexham Park (NHS) hospital in Sussex as well as a number of private facilities namely; Royal Masonic Hospital (Stafford Wing and Bowden House), John Clare Unit, Priory Hospital, Cardinal Clinic and Charter Clinic.

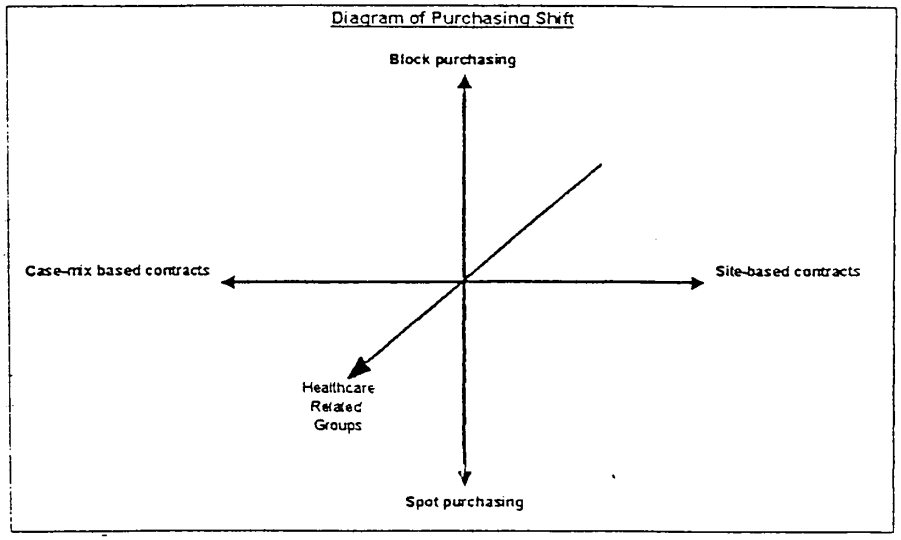
7.9 Finally there are services provided to EHH residents who become ill while away form home. By their nature, the provision of these services will depend on individual circumstances.

A full schedule of purchasing is provided at the end of this section and as Appendix V, giving details of service by provider, nature and type, location, total service available, volume of service purchased by EHH, contract type, unit costs, total service prices and projected activity. All data is based upon financial year 1993/1994 and is as complete as possible at the date of writing.

Forms of Contracts

7.10 The forms of the contracts under which EHH purchases the above services are almost as varied as the services themselves. There is a wish to move away from block purchasing on the site or ward basis toward spot purchasing on a case-mix basis. That is to say, historically, contracts have been based around particular geographically located services eg. a ward or clinic and have specified that the service should be provided in return for a fixed contract sum. Contract sums in block contract do not (usually) vary with different activity levels. Such contracts have shortfalls for purchasers in that there is not an incentive for the provider to treat more patients. For this reason purchasing on a "spot" or "micro" basis has advantages in that the purchaser only pays for services actually provided to individual patients. Under such arrangements a package of care may be purchased according to the needs of the particular patient rather than according to the supposed function of the service unit. This may be represented by the following diagram (Table 11).

7.11 **Table 11**



7.12 EHH is currently at the stage of desegregating its block contracts into a larger number of cost and volume and potentially cost per case contracts. This process has progressed to different degrees with the three main providers but most aspects of the block contract will have disappeared in the 1994/1995 contracting round.

7.13 The difficulty of moving contracting in this direction is one of quantification and definition. Block contracts were easy to quantify, for example in terms of a number of beds on an acute ward. The alternative measures of volume are less straightforward. The main contenders in the case of inpatient services, for example, are Finished Consultant Episodes (FCEs) and Occupied Bed Nights (OBNs).

7.14 An FCE occurs when a patient's episode of care is deemed to have been completed and they are discharged or transferred and so FCEs are a measure of quantity of care and of outcomes. FCEs, however, give little or no information as to the amount of work done by the provider since they may last anything from a few days to several years. OBNs, on the other hand, are to some extent a measure of work done since they record the number of nights during which beds are occupied. But what they do not do is measure numbers of patients treated.

7.15 Furthermore, OBNs and FCEs act in opposite directions in terms of contractual incentives. A contract measured in OBNs may encourage a high bed occupancy level but will give no reward for greater throughput of patients. FCEs do reward increased throughput (but possibly at the risk of lower quality of care) and could discourage providers from admitting more "difficult" cases which take longer to treat. In most cases where EHH contracts have so far been desegregated contracts have been determined in terms of both FCEs and OBNs, with implicit assumptions about lengths of stay. Clearly any purchaser needs to be assured that its contracting terms do not contain incentives which act contrary to its objectives and so combined FCEs and OBNs would appear to be the best solution to the problem.

Contract Monitoring

7.16 Additional to the problems of setting "currencies" for contracts are the difficulties of measuring performance. Each provider prepares quarterly contract monitoring data for EHH detailing volumes of work under the different constituent parts of their respective contracts. There is evidence from within the Reference Group to suggest that providers' own activity data is subject to high degrees of inaccuracy. This situation is not uncommon amongst health providers.

Major reasons for inaccuracy of data are often found to be:

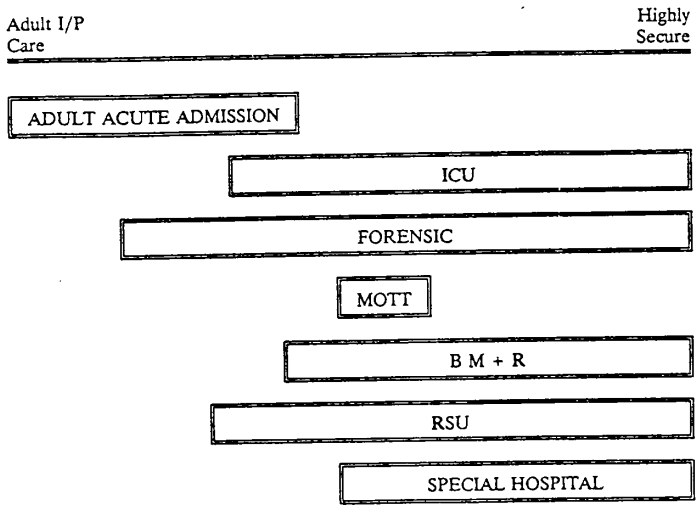
* poor training of clerical/administrative staff both in systems to be followed and in their recognition of the importance of accuracy
* unwieldy data collections systems encouraging staff to take shortcuts
* coding of data by non-clinically trained staff

7.17 Notwithstanding the problems of data collection, in order for contract monitoring information to be of use to the purchaser, its structure and units of measurement need to reflect the terms of the contract. For example, if a contract is specified in FCEs then contract monitoring information should be in FCEs and there should be a common definition of FCE used by both purchaser and provider. Additionally the grouping of contract monitoring data must match he constituent parts of the contract so that, for example, adult data is separated from, for example, elderly patient data.

Defining the Service

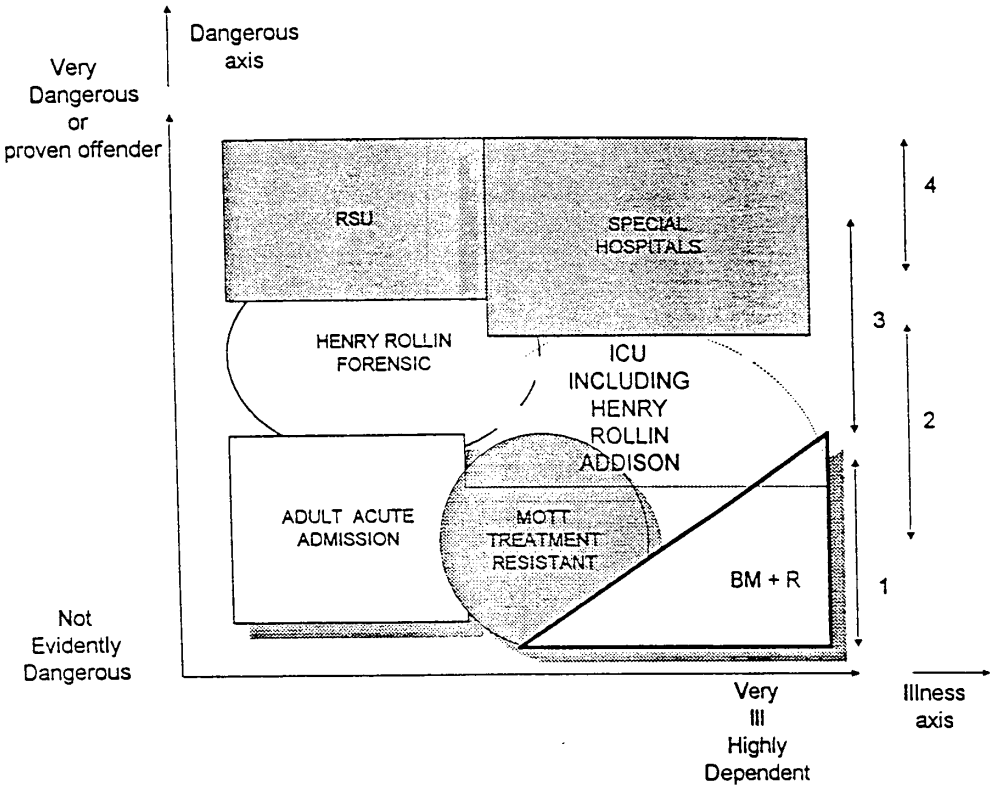
7.18 A further problem facing the purchaser is that of definition of service type. It is accepted that simple terms such as "acute", "intensive care" and "rehabilitation" are gross simplifications of the ranges of services provided by individual provider units. Furthermore, such terminology implies that these service are discreet and mutually exclusive which, of course, they are not. Purchasing according to Healthcare Related Groups may therefore be aided by a different model of service definitions as represented by the following diagrams (table 12a and 12b) submitted by the Riverside Mental Health Trust and capable of application in the other Trusts.

7.19 **Table 12a: Example of Case-Mix by Ward Type, Riverside Mental Health Trust**



[C.Heginbotham, Riverside Mental Health Trust]

Table 12b: Example of case-mix by ward type illness and 'dangerousness' from Riverside Mental Health Trust



ILL REQUIRING
IN PATIENT
ADMISSION,
SOME DEPENDENCY

KEY
1. USUALLY NOT LOCKED
2. LOCKED
3. SECURE
4. HIGHLY SECURE

ALL BOUNDARIES ARE FLEXIBLE

[C.Heginbotham, Riverside Mental Health Trust]

7.20 This diagram attempts to represent services in terms of the case-mix of patients catered for.

7.21 The vertical axis represents the "dangerousness" of the patient and, therefore, the likely requirement for security and supervision in the service.

7.22 The horizontal axis represents degree of illness which gives an indication of the amount of treatment the patient may require.

7.23 Both axis of the diagram also represent the fact that patients' conditions change as they respond to treatment. So, for example, behaviourial modification and rehabilitation services such as the BM&R cover a wide spectrum along the well/unwell axis. Finally, this model of services is useful in that it indicates the degree of overlap of services.

7.24 There are limitations of this model, however. Most notable is the difficulty in progressing it from a theoretical concept to a purchasing tool. Its usefulness as such a tool will be considerably limited until there are objective measures of dangerous and of degree of illness in order that scales may be applied to the two axis. If this were possible it may then become possible to overlay a map of service costs. This challenge is essentially the same as that faced by micro-purchasing in a community context. There are two problems associated with a purchasing strategy seeking to move to "cost per care type" and "cost per package of care".

7.25 Firstly, the ability (and costs involved) to cost individual use of service "packages". Secondly, the impact of this kind of purchase which depends on the level at which it takes place. Spot/micro-purchasing of services <u>within</u> Trusts is a provider issue concerned with devolution of responsibility and budgets. The key data for both the trusts and the commissioning agency is whether this 'needs led' purchase can meet need at current costs or whether it points to the need for further investment.

7.26 In short, there is little to be gained by having a more complex person-centred form of purchasing within a fixed budget which does not allow for shifts of investment from one service to another as usage changes. The 'market force' created by spot purchasing is nullified if the fixed global budget is locked into the existing provider configuration.

7.27 A further consequence of such budgetary and provider rigidity is that the assessments for care packages will be conservative (driven by historical knowledge of existing services) and 'supply side' driven (in the knowledge that the package must not cost more than the amount spent at that time).

7.28 In short the intention of moving from block contract to more case-based purchase has potentially, radical consequences. Commissioners will seek a "trade off" between the potential extra demands on investment from the aggregate individual purchases and the pressures on the providers to respond to the care packages and by being flexible, free up some resources at that level. A final feature of such a model is that the dynamics between investment (by EHH) and purchase (by Trusts) may shift the balance towards more purchase of social care. In that sense, the provision of both health and social care by Trusts would create more flexibility. It is noteworthy that one Trust is currently considering bidding for the social case contracts in certain areas (outside EHH).

7.29 This approach, moving towards case based purchasing, is also consistent with the epidemiological starting point of this review and its relationship to the way in which EHH receives its own funds for its commissioning investment (weighted capitation). We propose in this report that all these elements need further examination to assess the balance between the components of the 'managed market', and in particular the population based needs assessment required to underpin locality purchasing. The factors of GP fundholders and the developments of price bands for secondary mental health services will also have a major impact on the way in which treatment and care is purchased.

7.30 The challenge which EHH faces now is to develop, with providers, a comprehensive, local service in which a balance of care is possible in terms of some key areas.

* crisis and emergencies
* acute care
* discharge planning
* community care
* (primary health care)

7.31 If the current service configuration is taken, as set out in terms of its measurable/costed components (see table 1 above) and the shortfall costed the under-investment is calculated as £16 million. This is set out in table 13.

Table 13: Costing of Services Required to Match Levels Indicated by Epidemiological Study

Type of provision	Total expected places for EHH	Actual Places			Additional requirement	Unit costs (£)	Gross cost (£)
		Lower	Upper	Mean			
24 hour staffed residences	359	194	218	206	153	33,710	5,157,603
Day staffed residences	286	98	136	117	169	20,000	3,380,000
Acute beds	361	188	202	195	166	41,128	6,827,273
Unstaffed group homes	195	100	100	100	95	4,500	427,500
Adult placement schemes	35	0	0	0	35	6,000	210,000
Local secure places	25	26	27	27	0	n/a	0
Respite facilities	12	0	0	0	12	1,290	15,485
RSU/SHSA places	25	51	51	51	0	n/a	0
Total cost							16,017,860

7.32 This crude calculation is based on a supposition that buying more of the same, in the same way is likely to deliver the strategy. It accepts a 56% underfunding of the service. This is not only an unrealistic target, but may be undesirable in any event since it assumes purchasing the same types of services as have been provided in the past, allowing little scope for new types of service delivery.

7.33 If the acute bed element is targeted then the underfunding (required investment) stands at nearly £7 million.

7.34 Neither of these scenarios takes account of the dynamics intended by the NHS reforms (the responsive and managed market; provider development) or proceeds from the attempt to achieve a better balance of care.

7.35 We propose that EHH explore a scenario which accepts the diagnostic view in this report, begins with support to acute facilities and takes a systems approach to investing for an interdependent balanced care system.

7.36 This scenario runs an investment strategy with the following assumptions:

a That supporting acute services is the starting point, and that investment should be made so that occupancy rates of existing acute wards should reduce to 90% occupancy (OBNs) and eventually to an optimum 85%. We have used a current 100% occupancy in the calculations, although this is an underestimate since some wards are at higher levels.

b That bed-management techniques are coupled with targeted investment in diversionary crisis services, in pre and post discharge arrangements (CPA), and in end-point continued access to ordinary and supported housing.

c That provider development and further exploration of unit costs of new services is undertaken.

d That the global investment by EHH in mental health is supported by a revised weighted capitation system which is based on epidemiological needs assessment (Jarman 8/10 Tounsend/Wing etc).

e That this model requires a view of a comprehensive mental health service, but does not at this stage deal with the redistribution between Trusts. Item (a) may be slightly different in the Hounslow case in actually creating some acute beds.

7.37 The following table 14 outlines the components before, during and after acute care with a view to identifying how the elements might be able to support each other and ensure that patients are placed in the appropriate facility for, and at the appropriate time.

7.38 **Table 14**

Elements of a comprehensive mental health service	Existing services unit costs (recurrent revenue)	Provider development	Investment strategy of c.£4 million *
PREVENTIVE/DIVERSIONARY/CRISIS SERVICES			
24 hour telephone crisis services			1
Crisis cards			2
Walk in facility			3
Fast-track GP liaison			4
Emergency systems (Police/ASW) A&E			5
Residential staffed crisis unit			6
Domiciliary teams			7
Hospital at home			8
	Increase in bed numbers to reduce occupancy by 15%		
ACUTE CARE	41,128	30	1,233,844
Bed management			9
CPA/Discharge protocols			10
	Provision to relieve estimated current bed blocking of 20% (40 places)		
COMMUNITY SERVICES			
24hr staffed "hostel"	33,710	20	1,011,295
Day staffed accommodation	20,000	10	600,000
Unstaffed accommodation	4,500	10	135,000
Access to ordinary housing			11
Support to primary healthcare			12
CPN/SW liaison			13

* £4 million represents approx. 12.5% of current EHH mental health investment. The total cost of implementing the Needs Assessment Target derived from the 'gap' between existing and expected services (see table 13), items 1-13 require costing would be approx. 56%.

7.39 The best available unit costs for all these options are added at the end of this section (table 13).

7.40 It is clear from the diagram that to reduce the occupancy levels of acute wards to 85% optimum level will require investment. In order for the acute wards to be most effective both preventive crisis services are required and longer-term residential facilities. Also clear protocols on acute care will be required to maintain the optimum levels.

7.41 We have not yet been able to obtain costings for all the elements in the model but some may be available soon from the research into the daily living programme being undertaken by Professor Knapp at the Institute of Psychiatry.

7.42 It is also the case that provider Trusts have some of these services in various forms and the degree of provider development in order that EHH can purchase these services will need to be explored.

7.43 Items 9/10 are closely related to the development of protocols and may be subsumed into the acute beds costs.

7.44 Access to ordinary housing (Item 11) may require collaboration with private capital and with a range of agencies.

7.45 Development of existing services or new services under items 1-8 will require further investment.

7.46 The costed elements provide a necessary revenue figure of at least £4 million annually. Unless investment is spread appropriatly across items 1-13 this initial investment will not provide added value in the long term and the occupancy of the acute beds will return to the 100%+ level.

7.47 In summary, this prioritised investment plan, to take forward the EHH strategic direction, requires also a change management programme in order to obtain the return in health gain from the investment. The costing of known items starting with the twin areas of reducing occupancy levels and freeing beds blocked gives a starting baseline of £4 million recurring revenue costs. Because of the inter-relationship of the constituent parts of a balanced system unless further investments are made in these areas (items 1-13) then the system will in time revert to its current state. Unit costs for these items are not yet available. The complete investment plan is small compared to a less targeted plan which attempts to bring all service elements up to the level proposed by our epidemiological needs assessment, or a plan which invests in more acute beds under current conditions.

7.48 Table 15

Unit cost calculations

24 hour staffed residences	Places	Total cost	Unit cost
Elliot ward	10	320,000	32,000
Lyndhurst hostel	4	127,000	31,750
WLHT long stay service	63	1,998,000	31,714
Oak Lodge	8	315,000	39,375
Mean unit cost			33,710

Day staffed residences	Unit cost
Estimate based on previous work (learning disability service)	20,000
Mean unit cost	20,000

Acute beds	Places	Total cost	Unit cost
John Connolly	79	3,863,000	48,899
West Middlesex Hospital	35	1,301,000	37,171
Ashford Hospital	18	653,000	37,314
Charing Cross Hospital	70	n/a	n/a
Mean unit cost	202		41,128

Unstaffed group homes	Unit cost
Assume no revenue cost other than cost of ca Annual cost of revenue @	50,000 9.0%
Mean unit cost	4,500

Adult placement schemes	Unit cost
Estimate based on previous work (learning disability service)	6,000
Mean unit cost	6,000

Respite facilities Places Total cost	Unit cost
Estimate based on previous work (learning disability services) Disability level 1 Disability level 2 Disability level 3 Disability level 4 Disability level 5	748 935 1,122 1,403 2,244
Mean unit cost	1,290

NOTE
The above costings are extremely approximate and should not be used for the basis of any significant decisions. All the above unit costs were based on the limited information to hand at the time of writing this report and whilst it is believed that they represent reasonable estimates, the author can accept no responsibility for their reliability. It is therefore recommended that further validation work be undertaken.

7.49 **"Redistribution" Between Providers Trusts**

If the inequalities between Trusts is seen to require either redistribution or extra investment in Hounslow and Spelthorne to bring them up to a similar per capital spend, then it will be of particular importance to EHH to be clear about the type and balance of care to be purchased. This annex to the investment plan is provided to give an example of the style of services and future areas of expenditure in the Hounslow and Spelthorne Trust. This is not to suggest that this exercise should not also be undertaken with other Trusts based on their priorities which the EHH strategic direction.

HOUNSLOW AND SPELTHORNE NHS TRUST

Overall Philosophy of Care

7.50 The trust identifies the provision of services to people suffering from severe mental illness as one of its main priorities.

7.51 This includes the provision of services to patients who present in emergency situations, but in more general terms is concerned with the provision of locally based services to the catchment area population. For this reason, adequate comprehensive and appropriate in-patient facilities are recognised as a focus for the trust mental health services.

7.52 The Trust, however, clearly recognises that the majority of people receiving mental health services will have little or no contact with in-patient services. For these people, the trust also wishes to provide appropriate and accessible services within the community for those most severely affected by emotional and psychiatric difficulties.

7.53 The Trust wishes to provide mental health services which are capable of early and appropriate intervention in response to identified needs for specialist help.

7.54 A cornerstone of good mental health service provision is the ability to respond flexibly and appropriately, and to be able to follow through initial interventions with co-ordinated and consistent follow-up. This may require the trust to remain in contact with individuals over many years of care.

7.55 The Trust recognises that the design and delivery of mental health services should include significant input from general practitioners, users and carers and voluntary organisations, as well as hospital and community based providers.

Issues Underpinning the Philosophy of Care

7.56 The balance and inter-dependence between hospital and community-based delivery of care as appropriate to individual needs.

7.57 A focus of care based on outreach from the hospital based services into the community, and in particular the planning and design of services to meet the specific needs of neighbourhoods within that community.

7.58 Responsibility for the patient's care throughout their movement across parts of the service (ie. whether in the community, local hospital or in specialist care) is paramount.

7.59 Early intervention as a key criteria of the service offered, with follow-through and continuing support undertaken as a joint venture between the hospital and community services.

7.60 Key stakeholders contributing to the design and delivery of services include general practitioners, users and carers from all backgrounds, voluntary organisations as well as those working within the hospital sector.

Examples of the Implementation of the Philosophy

7.61 The Trust considers the most appropriate way of providing a comprehensive and flexible mental health service to be through the development of locality based teams. Such teams can draw on multi-disciplinary based skills while developing an intimate knowledge of their own locality and an understanding of their clients' needs.

7.62 At the same time they can provide continuity of care across the different parts of the mental health services with which the patient may come in contact, and consistency over the period of time that the patient remains in contact with those services.

Specific Examples of the Trust's Overall Philosophy of Care are Given below:

7.63 **FELTHAM**

The neighbourhood has a population of 50,000 who are mainly Caucasian. The area has a high level of deprivation including a high percentage of unemployment, a high number of drug abusers and a significant incidence of child abuse. The area has a large amount of high-rise accommodation and is badly served by public transport networks.

7.64 The current project is intended to rationalise the existing community health centres and clinics, which will allow the creation of a base for those people who suffer from enduring mental health problems. The premises will offer a centre where packages of care can be developed for individuals. Consultants from the hospital will form part

of the team, as will general practitioners, CPNs, psychologists and occupational therapists. A centre manager will co-ordinate the activities. The clinic will offer a drop in facility as well as living skills and social skills groups.

7.65 The centre will form part of a two-fold outreach service: firstly from the hospital to the centre and secondly from the centre out into the wider community.

Criteria for evaluation of the centre might include:

7.66 Reduction of overall admissions among the severely mentally ill.

7.67 Increase in the number of severely mentally ill cared for in the community.

7.68 Shorter lengths of stay in hospital.

7.69 Decrease in the number of unplanned referrals.

7.70 Demonstrably better collaboration across agencies.

7.71 Reduction in the number of suicides known to GPs/unknown to psychiatric services.

7.72 (NB: The Hounslow suicide rate is lower than and Riverside despite the lower expenditure per capita on mental health services (£25 per head as against £58/£60 per head).

1991/1992 Suicide Rate

Hounslow	11.7 per 100,000 population
Ealing	12.5 per 100,000 population
Hammersmith and Fulham	17.2 per 100,000 population

7.73 Psychiatric Support and Aftercare Workshops (PSAW)

The pilot for this scheme was established in Spelthorne two years ago and a similar scheme has now been established in Brentford. The workshop offers a creative environment for up to six individuals at any one time. It is funded by charitable contributions as well as grants from social services and the Health Authority.

7.74 It is felt that those using this service would otherwise have returned to in-patient care within the health service. Available statistics from the Spelthorne PSAW demonstrate that the re-admission rate during

Proposed Additional Criteria for Measurement of Outcome:

7.75
- Use of day hospital facilities (and non-attenders to be followed up).
- Follow up of those who miss first assessment appointments.
- Audit of general practitioner involvement.
- Integrated care pathway (ICP) data to be used more extensively to monitor patient outcomes.
- Increased use of collaborative working to set goals for individual patients and better monitoring of achievement.

Summary

7.76 Hounslow and Spelthorne recognises that the key elements of an appropriate mental health service are the provision of an accessible, comprehensive and consistent service which targets the most severely affected sections of the population.

7.77 While the present services are perceived as operating at a basic level - due to the historically limited resources available - it is believed that a number of exciting developments have taken place, and are due to take place in the near future.

7.78 The Trust is developing a pattern of service based on mental health teams working in geographical localities, who are capable of producing packages of care drawn from the services provided by the trust. At the same time, they will be able to focus on the needs of the particular locality in which they work, and work towards the development of future services to meet those needs.

7.79 The following outline proposes a capital and revenue costing for future investment in the trust.

Investment Plan for Adult Psychiatry

7.80 In order to fully implement the Trust's philosophy of care and to build on the integrated community and mental health outreach approach, the following staged investment is required:

- Early Intervention - Primary Care Focus - Counselling - CPN/Consultant outreach.
- Psychiatric outpatients/Day Hospital.
- Intensive Community Support/24 hour support line/crisis prevention/refuge.

- Acute admission/access to secure and forensic services.
- Active Rehabilitation.
- Hospital hostel/group home/sheltered housing.
- New long stay.

7.81 **Early intervention**

- Primary care focus
- Consultant outreach - existing provision
- Qualified Counsellors linked professionally to psychological/psychotherapy services locally
  = 0.5 wte per neighbourhood
  2.0 wte x 15K = £30,000

7.82 **Psychiatric Outpatients/Day Hospital**

- Existing outpatients x 24 place Day Hospital
- Increase day places by 12 in Feltham Resource Centre
- Staffing
  - 2 nurses
  - 2 OTs
  - 1 clinical psychologist
  - 1 SW

  = £100,000 plus running costs

7.83 **Intensive Community Support/24 hour support/crisis intervention**

Establish five consultant outreach teams, one for each neighbourhood but two in Hounslow due to size of catchment population. Improve Primary Care training of Junior doctors.

Additional Consultant	1 wte	58,000
Junior doctors	4 wte	100,000
CPNs (additional)	12 wte	264,000
OTs (additional)	8 wte	160,000
Social Worker	4 wte	160,000
Psychologists	4 wte	150,000
		892,000
Add 20% for out of hours	=	1070,000

7.84 **Develop Night Service in Existing Day Hospital & Cardinal Road Clinic Use to Provide Night Refuge**

CPNs x 2	44,000
E Grade Nurse x 4	50,000
Social Worker x 2	40,000
OT x 2	40,000
Clinical Psychologist	60,000
	224,000

7.85 **Reprovision of Acute Admission Service**

Additional 16 beds to include 4 intensive care beds.

Staffing/running costs 70,000

7.86 **Active Rehabilitation**

Re designate Hospital hostel - "O" Block to be a 16 bedded active rehabilitation unit.

Additional revenue 120,000

7.87 **Hospital Hostel/Group Home/Sheltered Housing**

Develop an off site hospital hostel with 8-12 places

Capital £700,000
Revenue £400,000

Develop two group homes with the Housing Association for 6-8 clients each.

Both schemes Capital 1.5 million Revenue £450,000

Sheltered Housing provision with housing department.
Nil revenue for Health
Nil capital to find
Clients looked after by outreach community teams

7.88 **New Long Stay**

A 20 bedded new long stay unit to be developed on our near a hospital site.

New build Capital 1 million
Revenue £600,000

Cost of Schemes

7.89 Total 3.6 million revenue staff

Assume 80:20 staff/non staff costs	750,000
Assume 5% admin. costs	360,000
Assume 2% training	700,000

Grand total 5.4 million

7.90 **Capital Required**

Acute build reprovision	provided for
Acute rehab	provided for
Sheltered Housing	760,000
Group Home	1,500,000
Four Outreach Centres	3,000,000
Total	5,360,000

ANNEX 1

SCHEDULE OF MENTAL HEALTH SERVICES CURRENTLY PURCHASED

1	2	3	4
Service name	Provider	Nature of service	Type
Blair Ward (St. Bernard's)	West London Healthcare Trust	Locked intensive care	Secure
John Connolly Wing		Acute/Admission beds	Acute
Elliot Ward		Hospital hostel	Rehab.
Lyndhurst Hostel		Rehab.	Rehab.
Work Rehabilitation		Work Rehabilitation	O/P Rehab.
Behaviour Therapy		Behaviour Therapy	O/P Acute
Barron Ward		Difficult to place	Secure
Brain Injury (Denbigh Ward)		Brain Injury	Specialist Rehab.
Long Stay Service		Long stay & rehab.	L/stay & rehab.
Oak Lodge		Hospital Hostel	Long stay
Outpatient Psychotherapy		Outpatient Psychotherapy	O/P
Community Mental Hlth. Resource Centres		Mental Health Resource Centres	Community Acute
Three Bridges		RSU	Forensic
W.Middx. Hosp. Wards Q2 & Q3	Hounslow & Spelthorne Community & Mental Health Trust	Acute/Admission beds	Acute
Ashford Hospital Wards C9 & C10		Acute/Admission beds	Acute
Psychiatric Outpatients		Psychiatric outpatients	O/P
Clinical Psychology		Psychiatric outpatients	O/P
Psychotherapy		Psychotherapy	O/P
Community Psychiatric Nurses		CPNs	Community
W.Middx. & Ashford Day Hosps.		Adult day hospital	Community
Henry Rollin Unit (Derby Unit)	Riverside Mental Health Trust	Locked intensive care/forensic	Secure
Gordon/Chelsea & West. Hosps.		Adult Acute beds	Acute
Charing Cross Hospital		Adult Acute beds	Acute
Behaviour Mod. & Rehab. Unit (Glyn)		Rehabilitation	Rehab.
Treatment Resistant Unit (Mott Ho.)		Treat. resist. schizophrenics	Rehab.
Long stay (Horton)		Long stay	Long stay
Cassell adult		Psychotherapy	I/P
Eating Disorder Unit (Gordon Hosp.)		Eating disorders	I/P
Eating Disorder Unit (Gordon Hosp.)		Eating disorders	O/P
Charing Cross Hospital		Outpatients	O/P
Community Psychiatric Nurses		CPNs	Community
Ashworth (special hospital)	SHSA	Long term secure	Secure
Broadmoor (special hospital)	SHSA	Long term secure	Secure
Rampton (special hospital)	SHSA	Long term secure	Secure
Norvic RSU	NMHT	RSU	Forensic
Wexham Park	Other NHS	Overflow	Acute
Stamford Wing, RMH	Cygnet Hlthcare.	Overflow	Acute
Bowden House Clinic, RMH	Cygnet Hlthcare.	Overflow	Acute
St. Andrews - John Clare Unit	Other Private	Long term secure, young people	Secure
Priory Hospital	Other Private	Overflow	Acute
Cardinal Clinic	Other Private	Overflow	Acute
Charter Clinic	Other Private	Overflow	Acute
Mental Health ECRs	Various	Forensic inpatients	Forensic
Mental Health ECRs	Various	Acute beds	Acute
Mental Health ECRs	Various	Psychotherapy inpatients	I/P
Mental Health ECRs	Various	Outpatients	O/P
Total mental health care group	All		

5	6	7	8
Location	Total Service Available	Contract details	Contrac Contract year
Ealing	14 beds / 5,110 OBNs	Cost per case 4 beds/equivalent OBNS	93/94
Ealing	79 beds / 28,835 OBNs	Cost & vol. 858 FCEs ± 5% & equiv. OBNS	93/94
Ealing	22 beds (10 for Hounslow)	Block	93/94
Ealing	4 beds	Cost per bed per annum	93/94
Ealing	See note	Block - to be developed	93/94
Ealing	33 FCEs p.a.	33 FCE outpatients	93/94
Ealing	17 beds / 6,205 OBNs	Cost per case 9 beds/equivalent OBNS	93/94
Ealing	8 beds	Cost per case	93/94
Ealing	73 beds	Cost per case	93/94
Ealing	8 beds	Cost per bed p.a.	93/94
Ealing	2,707 sessions p.a.	Block with indicative volumes	93/94
Ealing	4 Resource Centres	Block - to be developed	93/94
Ealing	48 beds (see note)	Funding topsliced by Region, no contract	93/94
Hounslow	35 beds / 12,775 OBNs	Block; indicative activity based on 92/93	93/94
Hounslow	35 beds / 12,775 OBNs	Block; indicative activity based on 92/93	93/94
Hounslow	n/a	Block; indicative activity based on 92/93	93/94
Hounslow	n/a	Block; indicative activity based on 92/93	93/94
Hounslow	n/a	Block; indicative activity based on 92/93	93/94
Hounslow	7 CPNs W.Middx.+6 Ashford+4 Hounslow	Block; indicative activity based on 92/93	93/94
Hounslow		Block; indicative activity based on 92/93	93/94
Horton Hospital, Surrey	40 beds / 14,600 OBNs	Block - see note	93/94
Westminster/Kensington	80 beds / 29,200 OBNs	Block - see note	93/94
Hammersmith	70 beds / 25,550 OBNs	Block - see note	93/94
Horton Hospital, Surrey	26 beds / 13,140 OBNs	Block - see note	93/94
Horton Hospital, Surrey	12 beds / 4,380 OBNs	Block - see note	93/94
Horton Hospital, Surrey	n/a as reducing for closure	Block - see note	93/94
Richmond	55 beds / 20,075 OBNs	Block - see note	93/94
Westminster	4 beds / 1,460 OBNs	Block - see note	93/94
Westminster	See note 35	Block - see note	93/94
Hammersmith	n/a	Block - see note	93/94
Hammersmith	10 CPNs	Block - see note	93/94
Liverpool		No contract, no charge	n/a
Surrey		No contract, no charge	n/a
Nottingham		No contract, no charge	n/a
Norwich		Cost per OBN	93/94
Slough		ECRs	n/a
Hammersmith	24 beds / 8,760 OBNs	ECRs	n/a
Hammersmith		ECRs	n/a
Northants.		Cost per OBN	n/a
Roehampton	66 beds / 24,090 OBNs	ECRs	n/a
Windsor	17 beds /6,205 OBNs	ECRs	n/a
Chelsea		ECRs	n/a
Various	n/a	ECRs	n/a
Various	n/a	ECRs	n/a
Various	n/a	ECRs	n/a
Various	n/a	ECRs	n/a

9	10	11	12	13	14	15	£16

ted Services

Target Activity Level (see note below)					Activity unit	Unit Cost	Total Contract Cost (000)
Ealing	Hammer-smith	Hounslow	Not specified	Total			
			1,460	1,460	OBNs	£172	£251
			858	858	FCEs	£4,502	£3,863
		10		10	Beds p.a.		£320
			4	4	Beds p.a.	£31,719	£127
			n/a	n/a	n/a		£172
			33	33	FCEs	£576	£19
			3,285	3,285	OBNs	£150	£493
			1,460	1,460	OBNs	£142	£208
			63	63	Beds p.a.	£31,719	£1,998
			8	8	Beds p.a.	£39,333	£315
			2,707	2,707	Sessions p.a.	£56	£152
			n/a	n/a	n/a	n/a	£1,923
			n/a	n/a	Patients	£0	£0
			317	317	FCEs	£4,105	£1,301
			159	159	FCEs	£4,105	£653
			4,505	4,505	Attendances	£43	£195
			870	870	Attendances	£162	£141
			360	360	Attendances	£147	£53
		8,844		8,844	Contacts	£40	£354
			3,585	3,585	Attendances	£68	£244
	3,800			3,800	OBNs		
	0			0	OBNs		
16	27,000	12		27,028	OBNs	£3,033	Total
	n/a			n/a	Beds		RMHT
	n/a			n/a	Beds		Contract
5	50	2		57	Clients	£34,239	Sum:
36	48	51		135	Bed months	£3,085	£10,344
	234			234	OBNs		-
	n/a			n/a	OBNs		see note 9
88	6,671	114		6,873	Attendances	£71	
	9,712			9,712	Contacts		
6	5	2		13	Clients	£0	£0
7	2	2		11	Clients	£0	£0
5	0	2		7	Clients	£0	£0
0	365	0		365	OBNs	£260	£95
			0	0	OBNs	£244	£0
			0	0	OBNs	£210	£0
			0	0	OBNs	£210	£0
			1,095	1,095	OBNs	£190	£208
			0	0	OBNs	£240	£0
			0	0	7 OBNs	£2,000	£0
			0	0	OBNs		£0
			0	0	?		
			0	0	?		£830
			0	0	?		
			0	0	?		
							£24,259

17	18	19
Projected 1993/94 Outturn Activity	Effect of Activity Variance on Cost (£)	Notes
8.67 beds / 3,177 OBNs	Pro rata	21,25
920 FCEs/29,751 OBNs	See note	24
3,184 OBNs	None	2,34
4 beds	See note	18,19
	None	20,22
8 FCEs	£10,000 refund 93/94	3
7.92 beds / 2,904 OBNs	Pro rata	26
4 beds / 1,467 OBNs	Pro rata	
	See note	18,19
	See note	18,19
2,628 sessions	Renegotiate over 100%	
	None	3
See note	None	4,23
317 FCEs	None	5
159 FCEs	None	6
4,505 attendances	None	
870 attendances	None	
360 attendances	None	
8844 contacts	None	
3,585 attendances	None	7
3,868 OBNs / 52 FCEs	None	8
602 OBNs / 44 FCEs	None	8,36
24,716 OBNs/628 FCEs	None	8
4,818 OBNs	None	8,35
560 OBNs	None	8,35
	None	8
	None	8
4 FCEs / 234 OBNs	None	8
103 Attendances	None	8
5,950 Attendances	None	8
9,496 Contacts	None	8,10
13 clients	None	
11 clients	None	
7 clients	None	
365 OBNs / 1 patient p.a.	Pro rata	
10 cases at 18/2/94	See note	12,31
60 cases at 18/2/94	See note	13,27
15 cases at 18/2/94	See note	14,28
882 OBNs	Pro rata	33
32 cases at 18/2/94	See note	15,32
7 cases @ 18/2/94	See note	16,29
3 cases @ 18/2/94	See note	17,30
	Pro rata	
	Pro rata	
	Pro rata	
	Pro rata	

ANNEX 2

NOTES TO SCHEDULE OF SERVICES

Notes

1 All costs are quoted exclusive of capital charges
2 Service for Hounslow residents
3 Entire service purchased by EHHHA
4 40 beds funded, additional 8 available for ECRs
5 About half of available beds are used by EHHHA
6 Actual usage = 50/50 Hounslow/Spelthorne residents
7 Unit of measurement to be resolved
8 This is a block contract in 93/94 but indicative activity is likely to form the basis of a cost & volume contract in 94/95.
9 The exact apportionment of costs to activity is under discussion and the results are unlikely to be available during the course of this work. Actual cost is in excess of contract sum according to RMHT.
10 Should be 12 CPNs
11 40 beds funded, additional 8 available for ECRs
12 Unit cost falls to £143/day after 28 days
13 Unit cost falls to £180 after 10 days & £170 after 20 days
14 Unit cost falls to £180 after 10 days & £170 after 20 days
15 Unit cost falls to £215 after 10 days & £200 after 20 days
16 Unit cost falls to £180 after 10 days & £170 after 20 days
17 Unit cost falls to £230 after 10 days, £205 after 20 days & £175 after 30 days
18 There is no effect on contract price for these services unless a total contract ceiling for the three services is exceeded In such circumstances it is likely that the contract would require renegotiation.
19 Regional payment rules apply. Payment ceases immediately on resettlement but continues to end of financial year in case of death.
20 The Work Rehab. service comprises a number of different elements, some on site, some via placements etc. A measure of total service is therefore meaningless but typical usage is 90-100 patients at any one time.
21 New contract to reflect actual activity i.e. 8 beds plus any additional activity.
22 Majority of service purchased by EHHHA
23 Over last 5 years, 31% of 48 beds have been used by EHH residents.
24 Activity above contracted level is charged at £1,948 for first 28 days or part thereof and £139 per day thereafter.
25 Blair Ward deals with acute patients who need intensive care for short periods because of the severity of their illness. They usually come from and return to acute wards.
26 Barron Ward deals with patients who have moderate to severe behaviour disorders and require intensive treatment, usually of a behavioural nature, and usually over long periods of time.
27 Cost of ECRs at 18/2/94: £218,510
28 Cost of ECRs at 18/2/94: £53,900
29 Cost of ECRs at 18/2/94: £31,790
30 Cost of ECRs at 18/2/94: £17,800
31 Cost of ECRs at 18/2/94: £55,657
32 Cost of ECRs at 18/2/94: £151,252
33 Cost of ECRs at 18/2/94: £128,649
34 This service will be transferred to Hounslow & Spelthorne in 94/95
35 Contract doesn't specify targets separately in 1993/94. Activity is included under other headings.
36 No target activity - effectively used for overflow only

Key to abbreviations
HSCMHT: Hounslow & Spelthorne Community and Mental Health Trust
WLHT: West London Healthcare Trust
RMHT: Riverside Mental Health Trust
NMHT: Norwich Mental Health Trust
FCE: Finished consultant episodes
RMH: Royal Masonic Hospital
RSU: Regional Secure Unit
SHSA: Special Hospital Service Authority

8. BRIEF 7: RESEARCH AND DEVELOPMENT

To identify and recommend projects for research and development which are considered important instruments to the promotion and delivery of the developing service

8.1 The research and development strategy for EHH will take account of both the national and regional priorities in mental health.

8.2 Yorkshire Region have the national lead in R&D in mental health and NWTRHA has produced its own internal guidelines for its funding of R&D projects.

8.3 The NWTRHA R&D budget for mental health is £1.5 million over the next 3 years.

8.4 The Regional group is concerned that the links between research and development should be clear in all cases.

8.5 The priorities identified in discussion at Regional level are understood to be as follows:

a. **Primary health care and community care:** models of service assessment and service provision in primary care; liaison and referral.

b. **Models of organisation of mental health services:** multi-agency approaches to service planning, needs assessment and service delivery

c. **Community care of the severely mentally ill:** teamwork in community settings: improving community support, aftercare and compliance.

d. **Development of models of service delivery for mentally disordered offenders:** factors that affect engagement with health services for this group; prevalence of offending behaviour in mentally disordered population.

e. **Development of models of service delivery for mentally disordered offenders:** factors that affect engagement with health services for this group; prevalence of offending behaviour in mentally disordered population.

f. **Child and adolescent mental health:** prevention of self harm; detection and management of eating disorders.

g. **Care and management of people with dementia:** the contribution of the primary health care team; carers; teamwork and continuity

h. **User involvement in commissioning mental health services:** including for multi-ethnic populations.

i. **Factors that effect the demand for intensive care, forensic and secure provision.**

j. **Mental health of people with learning disabilities:** including psychiatric learning disabilities interface.

8.6 It will be clear from this report that EHH has made progress on both b, and further applications for work in these areas will produce valuable results.

8.7 The undertaking and integration of research into clinical practice is fundamental to the development of quality in healthcare, and purchasers have an important role in supporting and promoting such activities. Difficulties do exist, however, in ensuring the timely integration of research findings and clinical practice it requires.

i) adequate dissemination and a critical review of up to date information.

ii) a system of internal review of care processes/clinical practice

iii) an organisational climate which supports change and innovation

8.8 Purchasers have a role, therefore, in supporting the assimilation of research by:

i) acting as a resource and developing a network of relationships with key individuals, groups and organisations undertaking research

ii) supporting the clinical audit process and in part setting the agenda with providers to review clinical practice in areas where substantial developments are reported in the literature or where policy change requires modification of clinical practice or service delivery

8.9 The importance of the development of clinical protocols and/or an outcome basis for Purchasing decisions lies in the need to demonstrate the impact of services on clients. Focusing in clinical outcomes requires services to describe, measure and evaluate the effect of a care process on clients for whom it cares. Historically it has been assumed that the training and motivation of health care staff was an adequate indicator of the quality of service being provided. This equated the "input" of the service with its "output". An outcome orientation requires the "output" to be made explicit and demonstrated. It is acknowledged, however, that mental health in particular is subject to the complex interaction of many variables and hence the development of meaningful outcome indices for mental health services is a difficult task.

8.10 The role of Purchasing in this context, therefore, is to work in conjunction with service Providers and individuals, agencies and research groups towards the development of meaningful outcome measures which adequately reflect the complex interaction between mental health, physical well being and personal

and social relationships, employment and many other aspects of functioning, with the goal of achieving an approach (or number of approaches) for demonstrating the effect of services on the clients being cared for.

8.11 Within the area of Mental Health services, Hammersmith and Hounslow Health Authority has taken a project approach to the introduction of outcomes orientation and a number of projects have been identified which will be the focus of work in the coming year, in particular:

a) Participation in the Royal College of Psychiatrists Research Unit study on the Health of the Nation Outcome Scales. Each of the Trusts have agreed to act as a pilot site for the field trials of these Outcome Scales.

b) Review of current procedures (clinical management and audit) for the management of suicide risk. A decrease in the level of suicides in the mentally ill is a key Target under the Health of the Nation initiative, and work on devising and implementing appropriate procedures is in hand.

c) A review of CPN services is underway in Hounslow and (Riverside MH Trust completed an audit of CPN activity in 1992). The purpose of the review is to identify the structures processes and outcomes associated with the CPN services. This includes identification of the clients with whom the services work and the goals/aim of the services.

d) A review of the clinical work undertaken by clinical psychologists, psychotherapists, CPNs and counsellors. This project is intended to identify the types of clients with whom these professional groups work, the nature and duration of interventions, the impact/clinical effectiveness of these interventions, and models of service delivery which maximise clinical benefit against cost.

e) The Riverside Trust is undertaking a programme of development of Patient Management Protocols. This programme is taking place in a range of sites both community (KCW), in-patient (Gordon Hospital) and specialist (Henry Rollin Unit, Horton). The objectives are to enhance decision-making skills at clinical level by 'mapping' the patient pathways, and identifying existing guidance at each stage. The protocols will provide a tool for planning, review, risk management and focus attention on key areas of transition for the patient.

8.12 It is proposed that EHH collaborate with the Regional R&D Group to identify a future joint approach.

8.13 Specific programme areas which should be taken forward and supported by EHH are as set out in paragraph 8.5 and in paragraph 8.11.

8.14 A consultation day with Trusts, similar to that held on Audit and Quality could be arranged with support from the Regional Group and R&D projects and sites identified.

8.15 Projects proposed for LIG/LIZ funding in Primary Health Care should be brought within an overall approach to R&D in mental health within EHH.

9. REFERENCES

1. Audit Commission (1986), *Making a Reality of Community Care,* HMSO, London.

2. Cmnd. 6233 (1975), *Better Services for the Mentally Ill,* HMSO, London.

3. Cm. 555 (1989), *Working for Patients,* HMSO, London.

4. Cm. 849 (1989), *Caring for People: Community Care in the Next Decade and Beyond,* HMSO, London.

5. CM. 1523 (1991), *The Health of the Nation: A Strategy for England,* HMSO, London.

6. CM. 2088 (1992), *Review of Health and Social Services for Mentally Disordered Offenders and Others Requiring Similar Services,* Final Summary Report, Department of Health/Home Office, HMSO, London.

7. Cm. 1986 (1992), *The Health of the Nation: A Strategy for England,* HMSO, London.

8. J. Coid (1991), 'Difficult to place psychiatric patients: the game of pass the parcel must stop', *British Medical Journal,* 302:3.

9. S. Dass et al. (1991), *Service Developments for People with Long-term Mental Ill Health: A National Survey,* Research and Development for Psychiatry, London.

10. S. Fernando (1988), *Race and Culture in Psychiatry,* Tavistock/Routledge, London.

11. P. Fischer and W. Breakey (1986), 'Homelessness and mental health: an overview', *International Journal of Mental Health,* 14:4-41.

12. D. Goldberg (1991), Filters to care - a model', in R. Jenkins and S. Griffiths (eds.), *Indicators for Mental Health in the Population,* HMSO, London.

13. Z. Kutz (ed.) (1992), *With Health in Mind: Mental Health Care for Children and Young People,* Action for Sick Children, London.

14. J. Leff (1990), 'Do long-stay patients benefit from Community placement?' Chapter 7, *Evaluation of Comprehensive Care of the Mentally Ill,* Royal College of Psychiatrists, Gaskell, London.

15. National Association for the Care and Resettlement of Offenders (NACRO) (1992), *Revolving Doors: Report of the Telethon Inquiry into the Relationship Between Mental Health, Homelessness and the Criminal Justice System,* NACRO Publications, London.

16. Office for Public Management (1992), *Assessment of the Housing Requirements of People with Special Needs over the Next Decade,* A report for the National Federation of Housing Associations, National Federation of Housing Associations and Office for Public Management, London.

17. C. O'Driscoll, J. Marshall and J.Reed (1990), 'Chronically ill psychiatric patients in a District General Hospital. A survey and two year follow-up in an inner London Health District', *British Journal of Psychiatry,* 157:694-702.

18. C. Patmore and T. Weaver (1991), 'Community mental health teams: lessons for planners and managers', *Good Practices in Mental Health,* London.

19. D. Quinton and M. Rutter (1984), 'Parents with children in care', *Psychology and Psychiatry,* 24:211-229.

20. TAPS (1990), *Better Out than In?,* Report from the 5th Annual Conference of the Team for the Assessment of Psychiatric Services, London.

21. G. Thornicroft (1991), 'The concept of case management for long-term mental illness', *International Review of Psychiatry,* (3): 125-132.

22. G. Thornicroft, C. Gooch and D.Dayson (1992), 'The TAPS project: readmission to hospital for long-term psychiatric patients after discharge to the community', *British Medical Journal,* 305:996-998.

23. R. Williams and I. Skeldon (1992), 'Mental health services for adolescents', Chapter 8 in J.Coleman and C.Warren-Adamson (eds.), *Youth Policy in the 1990s: The Way Forward,* Routledge, London.