Agenda Item 5

NHS
East London
NHS Foundation Trust

From: Mason Fitzgerald, Director of Corporate Affairs

To: Council of Governors

Date: 23 November 2017

Subject: Strategic Planning Update

1.0 Purpose of the Report

1.1 To provide the Council with an update on strategic planning activity in the Trust.

1.2 This paper will be supported by a presentation about the Big Conversation, and the Council will be asked to do an exercise to provide feedback on the Trust's mission.

2.0 Role of governors in relation to this item, and key points

2.1 The Trust Board has the legal power to approve the Trust's strategic plans. In developing the plans, the Board must have regard to the view of the Council of Governors.

2.2 The role of Governors is therefore to engage with the membership and provide feedback to the Trust on the development of the Trust's strategic plans.

3.0 Managing demand upon secondary care mental health services

3.1 Attached at Appendix 1 is a brief discussion paper on the management of demand upon Secondary Mental Health Services. This paper summarises a review of evidence of interventions that can help in managing demand. It was requested at a previous Council meeting for information.

4.0 Update on Sustainability and Transformation Partnerships (STPs)

4.1 East London Health & Care Partnership (North East London STP)

4.1.1 The seven north east London CCG Boards have recruited a single Accountable Officer. Jane Milligan (currently Tower Hamlets CCG Chief Officer) will take up the role from December 2017, and will continue as the executive lead for the East London Health & Care Partnership (ELHCP).

4.1.2 City & Hackney: partners are continuing to develop a shadow accountable care system, with integrated commissioning arrangements in place, a commissioner and provider partnership board, and four strategic workstreams: unplanned care, planned care, children & young people, and prevention. City & Hackney partners are developing a "Neighbourhood Care Team" model, with eight

neighbourhoods identified around general practice, covering populations of 22,000 – 50,000. The trust will be an essential partner to the developing model.

4.1.3 Newham: Newham provider partners, including the trust, Newham Health Collaborative, Barts Health, and the London Borough of Newham are in the process of developing a partnership and a Memorandum of Understanding to underpin collaborative working. Newham Health Collaborative and Newham CCG have agreed to work with the National Association of Primary Care to take forward the Primary Care Home model in Newham, which the Trust will be an essential partner to this development.

4.1.4 Tower Hamlets: Tower Hamlets Together is currently reviewing its governance arrangements to reflect some of the emergent principles of accountable care, with the ambition that a revised approach will be in place from early 2018. Tower Hamlets Together has featured in the media over the past month, including an article in the Guardian newspaper on the Rapid Response/Discharge to Assess service provided by the trust at the Royal London Hospital.

4.2 Bedford, Luton and Milton Keynes STP (BLMK)

4.2.1 The BLMK Chief Officers Group has approved a number of Transformation Fund bids, for a wide range of projects. A mental health bid (focussing on crisis cafes as part of the crisis pathway) is due to be considered in November 2017.

4.2.2 Bedfordshire: The Trust has been awarded the contract for Community Health Services in Bedfordshire. This outcome will support further development of hospital services across the CCG area.

4.2.3 Luton: Luton provider partners, including the trust, the 4 Luton GP clusters, Cambridgeshire Community Services, Luton & Dunstable Foundation Trust and Luton Council are in the process of developing a partnership and a Memorandum of Understanding to underpin collaborative working. It is likely that an initial area of focus for joint working will be the BLMK STP priority of reducing emergency admissions from care homes, along with developing primary care home pilots.

5.0 Operational Plan 2018-19

5.1 The Trust has received commissioning intentions from Clinical Commissioning Groups for 2018-19. The Trust is currently engaging in contract negotiation meetings with commissioners in order to agree areas for investment, savings plans and other service changes.

5.2 The Trust is also developing its Cash Releasing Efficiency Savings plans for 2018-19.

5.3 An update will be brought to the next Council meeting.

6.0 The "Big Conversation"

6.1 Feedback received from the 'Big Conversation' exercise has been collated and analysed. The exercise involved 20 sessions and over 700 staff.

6.2 The analysis has been discussed at a Trust workshop on 12 October, and shared with all staff and patient/carer groups in order to develop the mission statement and areas of focus.

6.3 At the meeting there will be a presentation about the Big Conversation, and the Council will be asked to do an exercise to provide feedback on the Trust's mission.

7.0 Action being requested

7.1 The Council of Governors is asked to **RECEIVE** and **NOTE** the report.

Managing Demand upon Secondary Mental Health Services
A Brief Discussion Paper

1 Managing inpatient demand through crisis resolution and responsive community care

1.1 Much of the pressure on inpatient beds can be attributed to insufficient support in the community and a lack of alternatives to hospital[1] such as crisis resolution and home treatment (CRHT) teams which play a particularly important role in providing intensive community support to people in crisis both to prevent admission and to facilitate prompt discharge. Crisis houses and similar services such as host families can provide alternative residential settings, and liaison psychiatry services provide specialist services to those who present at accident and emergency (A&E).

1.2 Most people in receipt of secondary mental health services do not require admission to hospital and are supported by community mental health services to manage their mental health conditions. Any problems with community service provision can create significant pressures on acute mental health services. Delayed discharges from hospital are often associated with the absence of good-quality, well-resourced community teams[2].

1.3 More recently a number of providers have moved towards a locality-based model of service delivery, rationalising existing community teams and developing smaller numbers of community hubs. These aim to integrate care more closely with primary care and other local provision, including voluntary and community sector services.

2 Lack of workforce capacity to deliver and manage demand effectively

2.1 Nationally, work on the early intervention in psychosis referral pathways has identified issues in meeting the required staffing levels and skill-set. Insufficient staff numbers and limited skill-mix mean that no service currently has the capacity to deliver NICE-concordant services to more than 50 per cent of new first-episode cases by 2016[3].

2.2 Involving community staff in hospital discharge planning has been highlighted as a mechanism to support the reduction in readmissions to hospital.

3 Transformation Plans

3.1 Most transformation plans which have reduced the number of inpatient beds have focused predominately on community-based mental health services. Despite a rise of 5.1 per cent in the number of people in contact with secondary mental health services, the number of contacts that people have with mental health services is falling with a reduction of 4.3 per cent in 2012/13 compared to the previous year[4] and further reduction of 3.1 per cent in 2014/15[5]. They are also less likely to see a mental health professional, with only 52 per cent of service users surveyed in 2014 reporting having seen a mental health professional in the previous month, compared to 59 per cent in 2011[6]. A reduction in the proportion of people being supported under the Care Programme Approach indicates that they are also less likely to receive

[1] The Commission on Acute Adult Psychiatric Care (2015)
[2] The Commission on Acute Adult Psychiatric Care (2015)
[3] Khan and Brabham, 2015
[4] Health and Social Care Information Centre 2014
[5] Health and Social Care Information Centre 2015b
[6] Dormon, 2015

formalised support to plan and co-ordinate their care. Reductions in staffing and changes in skill mix have limited the ability to deliver timely and effective evidence-based care.

3.2 There is only limited evidence suggesting that case management is effective in reducing targeted admissions, for example admissions for heart failure of serious and enduring mental health[7]. Case management has been found to have other benefits, for example in reducing lengths of stay.

4 Investment

4.1 The highest return on investment in mental health is found with early identification and treatment of psychoses (within one year); then mental health promotion and wellbeing of children (within five years), followed by mental health promotion and wellbeing of older people (within five years)[8].

5 Mental health in primary care[9]

5.1 Mental health care in primary care has been defined as “the provision of basic preventive and curative mental health care at the first point of contact of entry into the health care system.” Given models of service structure and burden, primary care mental health services aim to achieve:

- Effectiveness - services should improve health and wellbeing
- Efficiency - limited resources should be distributed to maximise health gains to society
- Access - service provision should meet the need for services in the community

5.2 There is a recognised need to manage demand better upstream and the prevention possibilities of primary care as a provider to meet range of health needs. Locally, for example, this might be the ability to manage the whole pathway from primary care (Health E1) into secondary mental health services. We could carry out an analysis of patients currently on primary care lists and see what service offers can be made to them to pro-actively manage their physical health conditions.

6 Statutory and 3rd Sector Residential Support Services for Homeless People

6.1 There is potential for developing a new model of health care delivery for homeless patients, based on the highly successful service provided in Boston USA[10]. This model is of a fully integrated primary and secondary health care service including specialist primary care, out-reach services, intermediate care beds and in-reach services to acute beds.

6.2 The research has shown that homeless people attend A&E six times as often as the housed population, are admitted four times as often and stay three times as long – because they are three times as sick. This results in secondary care costs that are

[7] Purdy, 2010

[8] McDaid, David (2011) Making the long-term economic case for investing in mental health to contribute to sustainability. IMPACT, European Commission

[9] Managing common mental health disorders in primary care: conceptual models and evidence base BMJ 2005;330:839

[10] Morrison D S Homelessness as an independent risk factor for mortality: results from a retrospective cohort study. International Journal of Epidemiology 2009;38:877–883

eight times higher than average, largely consisting of unscheduled emergency admissions. The Nuffield Trust recently reported an overall increase of 11.8% in emergency admissions in England over the past five years at a cost of £330 million per year.

6.2 Many homeless people also have mental health problems and experience difficulty in accessing mental health services. Where there are significant numbers of homeless people specialist services may be necessary, in other areas enhanced access to mainstream services may suffice. In both situations services should be provided to these standards. It is crucial that mental health services are integrated with other health services and that there is good communication between them.

6.3 Hospital in-reach ward rounds/visits for homeless patients where necessary in the local Acute and Mental Health Trusts could be facilitated

6.4 Staff in primary and secondary care and third sector organisations could be enabled to formulate the interaction between mental health issues and the behaviours leading to homelessness using specific therapeutic frameworks, thereby increasing their understanding of the issues and increasing the range of responses available to them when dealing with challenging behaviours.

6.5 Homeless patients could be offered drop-in clinics with presenting problem addressed first, but offered health screening to include, physical health assessment, screening for dental/oral problems, BBV (Blood Borne Viruses), smoking, drug and alcohol problems, TB (Tuberculosis) screening, screening for mental health problems, diet and exercise.

6.6 Commissioners could require vertical integration such as care planning and continuity of care into secondary care and back into the community. A clear expectation of compassion, communication and continuity of care between secondary, primary and community care.