London Clinical Senate

# Advice on proposals for mental health services in Camden and Islington

**June 2018**

# Independent advice on proposals for mental health services in Camden and Islington

**Prepared for:** Tony Hoolaghan, Chief Operating Officer, Islington CCG, on behalf of Islington CCG, Camden CCG and Camden and Islington NHS Foundation Trust.

**Approved by:** Dr Mike Gill, London Clinical Senate Chair

**Date:** 14 June 2018

**AIMS OF THE REPORT:** To provide the following advice:

1. The clinical case for change and proposed model of care are underpinned by a clear evidence base and:
    a. Will enable improvements in clinical care and quality benefits for patients
    b. Are informed by best practice
    c. Align with national policy and are supported by STP plans and commissioning intentions
2. Whether the proposals for developing community services will enable delivery of more care in the least restrictive setting
3. Whether the approach of meeting the need for future inpatient demand by further development of community mental health services is robust.

The review team also considered that:

1. There is evidence that the options considered will be deliverable and sustainable
2. Outcomes and measures of success are identified and clear.

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# 1. Executive Summary

The London Clinical Senate has been asked to provide independent advice on proposals to improve mental health services in Camden and Islington provided by Camden and Islington NHS Foundation Trust.

The clinical review team found that the **overall direction for developing mental health services in Camden and Islington is generally clear and consistent with national policy and local strategic priorities**.

It heard a **strong and consistent commitment amongst health and care partners** to deliver improvements in mental health services and care for the local borough populations.

Documentation provided **evidence of a significant amount of engagement**. Service users met by the review team were clear about the need and opportunities to improve services; however, **the majority did not feel they were very informed about the specific proposals**.

## Case for change and proposed model of care

The review team agreed there is a **strong case for the modernisation of inpatient mental health wards and the surrounding environment** because of the risks to safety.

However, it believes the **case for change in community services is the more critical in delivering the strategy and ambitions**, including ensuring that **future inpatient beds would be sufficient**.

**The proposals for community services are not well described and lack development**. There **needs to be a much better narrative** so that stakeholders are able to get a much clearer view of what this would look like and how it would differ from the current model of care and services.

Benchmarking data showed opportunities exist to improve current inpatient bed usage. There needs to be **greater transparency in the way that the modelling of future bed numbers is presented**.

The review team heard about **several initiatives that the Trust has implemented which are reported to be having an impact**, though there were some **differences in the perceived impact** that different people described.

The **timelines and connections are not clear around the reviews of services and pathways that are relevant to the proposals and capacity plans**.

Proposals are described as consolidating services in hubs and co-locating teams to improve efficiencies e.g. reducing duplication, communicating easier and faster, better working practices which would release staff time to do more – it is **not sufficiently clear what would be different in practice.**

The **way in which hubs would interface with other health and community** needs to be clearer, especially how hubs would interlink with local authority and community organisations.

**The workforce implications of the proposals need to be better described** - there does not appear to be an overall workforce development plan.

It is **difficult to see how the ambition for expansion of community services would be achieved without investment**. Clarity is needed into how the clinical capacity required would be provided to give people confidence that the proposals would be delivered.

## Programme planning, leadership and risk

A **clear overview of the programme is needed to show how the different initiatives interface and the relevant timing of any changes and expected impact**. Any implications of this in terms of equity of access should also be considered.

A **programme plan with key milestones** should be developed and critically reviewed to ensure the right capacity and leadership would be available when required to deliver the proposals, subject to the outcome of consultation.

The proposals and their deliverability should be subject to a **comprehensive risk assessment.** Actions to mitigate identified risk to an acceptable level should be agreed.

## 2. Summary of advice and recommendations

The London Clinical Senate was asked to provide advice on the three specific issues relating to these proposals, which are shown in the boxes below. Our advice is summarised underneath each, followed by recommendations.

**Whether the proposals for changes to inpatient and community mental health services:**

**a. Will enable improvements in clinical care and quality benefits for patients**
**b. Are informed by best practice**
**c. Align with national policy and are supported by STP plans and commissioning intentions**

1. The strategic direction and overarching aims for developing and improving mental health services for people in Camden and Islington are clear, with a focus on supporting recovery, resilience and independence through development and delivery of practice-based treatment and support and specialist treatment and supporting pathways. The approach emphasises co-production with service users and carers and collaborative working with physical health, local authority and voluntary sector services.
2. The clinical strategy is shaped by the reality that most mental health problems are managed in general practice and by community based teams. It centres on increasing early and effective intervention, supporting more people at home and in community settings, reducing hospital admission, and delivering services in a more integrated and holistic way, all built around the local population's needs.
3. The strategy is consistent with national policy and local priorities and reflects the ambitions for mental health set out in the NHS Five Year Forward View[1]. We heard a strong and consistent commitment from health and care partners to improving mental health services, care, support and outcomes for the local population. We believe there is a shared vision and a determination to achieve this and that all partners accept they have a responsibility. This is reflected in the North London Partners' sustainability and transformation plan (STP). As well as the overarching mental health programme, the STP describes related workstreams that will enable delivery. These include workforce development, identified as critical.
4. The case for change underpinning the proposals highlights characteristics in Camden and Islington's populations and factors that impact on mental health and wellbeing. Both boroughs have relatively young, diverse and transient populations, with the largest numbers in the 20-40 years' age group, and a high prevalence of serious mental illness. Both are densely populated with high levels of deprivation alongside high levels of wealth. Camden has many homeless people. Populations are projected to increase by 11-17% over the next 12 years.
5. The case for change identifies opportunities to enhance delivery and quality of care and experience for service users and carers, and also the experience for staff and a commitment to ongoing improvement. Current inpatient wards at St Pancras Hospital are outdated, despite efforts to maintain a clean, safe environment. The last two Care Quality Commission (CQC) inspections reports (2016 and 2018) reinforce this. There is a clear case for modernising inpatient wards and

[1] NHS Five Year Forward View (2014)

facilities so they are fit for purpose and for improving the outdoor space. Benchmarking data also indicates potential for inpatient capacity to be used more efficiently.

6. The case for change in community services highlights that services and teams are spread out across the boroughs in multiple locations, determined by space available rather than where the services are most needed. Consequently, teams and services are fragmented, impacting on joined-up working and co-ordinated care. Benchmarking data shows that community teams in Camden and Islington have the lowest overall caseload compared to other London trusts, which suggests more people could be supported in the community if services were available. The case for change is clear that the quality, design and capacity of premises needs to improve to enable this.
7. Several initiatives and new workstreams have been established across the trust's services as part of the overall clinical strategy implementation, overseen by a Clinical Strategy Programme Board. We saw evidence that these have been informed by change and innovation successfully implemented elsewhere, both in London and further afield. Metrics have been identified to measure benefits and impact. Two evidence-based examples of community models were shared, the Integrated Practice Unit for Psychosis and practice-based mental health teams. Both are reported to be having an impact, improving physical health and reducing referrals to specialist services and admissions, though there were differences in the impact described by people we met. The trust's commitment to research and to translate this into practice, engaging staff and benefiting services users, was also evident.
8. Current initiatives include reviews of services and pathways that have a bearing on the proposals we considered and on capacity planning. These include reviews of the rehabilitation, crisis and older people's pathways that extend into 2019/20. The review team requested and received further information on the rehabilitation pathway review completed during 2017/18 that indicates some impact in the last year, with further work planned to act on recommendations over the coming year. Although part of an overarching programme we did not feel the connections and interdependencies between these workstreams, including delivery timelines and expected capacity impact, were sufficiently clear.
9. There is evidence that the process to discuss and develop the case and proposals for change has involved significant engagement with services users, carers and staff. Although, this seems to have focused more on inpatient than community services. Information provided and our discussions indicated broad clinical support for the proposals.
10. The service users we met were clear about the need and opportunities to improve services however most did not feel very informed about the specific proposals we were discussing. Notwithstanding this, the review team had a helpful conversation with two groups of services users who explained what is important to them. Three main themes emerged:
    a. Concerns about difficulties that some service users, carers and families would face in accessing the proposed location for current St Pancras wards, particularly for those with limited mobility. Some service users also felt the local neighbourhood would offer less opportunity for short escorted or unescorted leave.
    b. Lack of information on the proposals for community services, which meant service users felt they could not comment on them in an informed way.
    c. Service users felt they had experienced a dilution of services over time. Perceived gaps in meeting needs of people in the 40-60 year age group and in the support for education, training and employment were highlighted.

11. Documentation shared, and especially the trust's clinical strategy, showed strong commitment to co-production. In these proposals, we saw most reference to co-production in the case for change to inpatient services. Service users want to be involved in co-designing facilities proposed, both in inpatient and in community settings, and shared examples of involvement in previous schemes. Some felt that not all of the commitments made in previous schemes had been implemented (gym facilities were given as a specific example.)
12. The STP highlights the importance of developing and supporting the health and social care workforce to deliver the vision, plans and proposals described. Building capacity in the workforce is noted as a key enabler alongside estates, technology, delivery and commissioning models and the interdependency between the workforce workstream and initiatives within the mental health programme is acknowledged as crucial. The proposals include many references to workforce development and provide examples of specific initiatives on recruitment and retention, development and use of new roles and upskilling of current staff. The review team felt however that, as presented, workforce issues are considered in a general way and an assessment of workforce implications, development needs and opportunities relating to the specific proposals that we have been asked to consider, and a plan to address these, is missing. This is a significant gap in understanding how the proposals would be delivered.
13. The NHS and local authority stakeholders we met were clear that the estate strategy is an enabler to delivering high quality care and redesign of pathways and not an end in itself. The case for change emphasises modernisation of inpatient mental health wards and the surrounding environment. The review team agrees there is a clear case for this and agrees that benefits in care delivery and quality would accrue. However, members were unanimous that the case for change and proposals for community services are the more critical in delivering the strategy and ambitions described, including ensuring that inpatient capacity would be sufficient as the population and need grows over the coming years. Consequently, we were concerned about the lack of detail about community services in the proposals and felt that they lacked overall coherence.
14. The proposals refer to the benefits of co-location in improving quality and outcomes of care, for example, co-locating mental health inpatient wards near to an acute hospital and co-locating different community services and teams. In both instances, co-location alone would not deliver closer, more integrated working between physical and mental health, social care and voluntary sector services or break down barriers in the communities that prevent people engaging with services. Changes in ways of working, ethos and culture would also need to be taken into account. It would be helpful to acknowledge this more explicitly. Learning can be drawn from successful changes already achieved, of which we saw several examples.
15. Consolidating services and teams may bring benefits through co-location though may also raise issues of access. The equalities impact assessment identifies positive impacts overall, however, whilst the proposals would improve disability access to buildings it also identifies there could be a negative impact for some people with disabilities travelling further to reach the new location.

## Recommendations

16. The case for change should be further developed with greater emphasis on community services, a more detailed description of current challenges, and how the proposals would address these should be provided. This should be presented in a way that helps people understand what would be different and clearly articulate how the proposed model would deliver intended benefits and quality improvements. Use of service user stories could assist this.
17. Many benefits and improvements described relate to services or care processes. It would be helpful to be more specific about the population outcomes the proposals would contribute to and key indicators that could measure this and over what timeline.

18. Modelling capacity required to meet future projected need should cover community as well as inpatient services and include the predicted impact of changes. This would help people understand how the proposed changes in the model of care and specific initiatives to improve efficiency or effectiveness of pathways would impact individually and collectively. As well as aiding understanding, this would make the proposals and capacity planning more coherent.
19. An overarching programme plan is needed which sets out all activities that form part of, or have a bearing on, the proposals relating to the delivery models, workforce, estate and change management, and the timing and sequencing of activities and changes to show how they interface. It should demonstrate how community services would be expanded and scaled up over coming years, how and when the expected efficiencies in the use of inpatient beds would be achieved and how these align with changes in demand due to demographic growth to ensure that the right capacity would be available in the right place at the right time. This would help both to test, and convey, overall coherence of the proposals and how they would be delivered. It should enable critical interdependencies and risks to be determined.
20. A workforce development plan should be established that clearly sets out all of the workforce implications of these proposals and how they would be addressed. Key activities and milestones should align with the overarching plan mentioned above to ensure the right skills, capabilities and capacity would be available as and when required.
21. The programme should consider how changes could be implemented more consistently across the two boroughs e.g. notwithstanding the value of a proof of concept approach, development of practice-based mental health services is being rolled out a year later in Camden than in Islington. Any implications in terms of equity of access should also be considered.
22. Service users and staff should be involved in co-designing proposed facilities, both in inpatient and community settings. We note the intention to do this. The experience and perceptions that people have sets the context in which proposals for change will be considered. Service users' concerns that there is a gap in support for the 40-60 year age group should be further explored and how the proposals would enhance support for education, training and employment should be better described.
23. Travel and transport implications of the proposals, the proposed relocation of inpatient beds and consolidation of services into community hubs, concern some service users. It is important that ways of addressing concerns are explored and that the process is transparent. This includes areas of negative impact identified though the equalities impact assessment.

**Whether the proposals for developing community services will enable delivery of more care in the least restrictive setting.**

24. As already noted, benchmarking data indicates opportunities exist to increase the capacity and capability of the trust's community services and therefore enable more care to be delivered in a community setting. We do not feel, however, that the proposals are sufficiently well developed or described to appreciate the scale of change they could achieve. Service users we met have also requested further information. The review team heard different levels of detail about the vision and approach to developing community services from different stakeholders. This suggested that aspects of the proposals might be better developed than were presented to the review team.

25. Mental health services are currently provided from numerous sites across Camden and Islington. The proposals describe consolidating services in hubs and co-locating teams to improve efficiencies, such as reducing duplication, facilitating easier and timelier communication, delivering more joined-up care, as well as more effective working practices to release specialist staff and give them more time to care. However, the lack of detail makes it difficult to understand what would be different, including opening hours, for example whether services would be provided every day of the week including weekends or for extended hours.
26. By their nature, community hubs would not operate in isolation but the way in which they would interface with or connect to other services is not well described. Some stakeholders discussed place-based approaches such as neighbourhood networks, which bring NHS, local authority and voluntary sector services together in a co-ordinated way. Explaining how this would work using language that people would understand begins to provide the better narrative we are suggesting.
27. The proposals assume that community services, including social care, would be sufficiently resourced and of sufficient capacity and quality to deliver the changes and benefits described including enabling better use of inpatient capacity. The review team recognised, as did people we met, that investment in community services would be required to deliver the ambition for expansion proposed, especially during the transition period.

### Recommendations

28. There needs to be a better narrative around the proposals so service users, and other stakeholders, get a clearer view of proposed future arrangements and how these would differ from the model of care and services available now, and what it would mean for the way people would access and experience care. This should describe how the community hubs would function, how they would enable integration with other health, ambulance, local authority, voluntary sector services, and support groups to provide joined up pathways and coordinated care and enable access to the range of support that people may need.
29. How the community capacity would be provided, and any underpinning assumptions, should be set out to give people confidence that proposals could be delivered. Whether the aim is to increase capacity by using existing staff and facilities differently, including moving capacity from inpatient to community settings, and/or by increasing investment should be transparent. Risks around this should be reflected in the risk register (see point 38) with mitigating action.
30. The workforce implications of delivering the proposals and the increased community capacity required need to be better described (as for the recommendation in point 19).

**Whether the approach of meeting the need for future inpatient demand by further development of community mental health services is robust.**

31. Data shows the trust currently has 235 inpatient beds encompassing men's psychiatric intensive care, women's psychiatric intensive care, acute, older adult and rehabilitation services. Modelling demographic growth indicates an additional 19 beds required to meet population need by 2025 assuming no change to the clinical model or pathway efficiencies. The trust has concluded from analysis that reducing average length of inpatient stay to the London average would release 45 beds i.e. 26 more than assessed to be required to meet future need. The proposal does not seek to reduce current inpatient bed numbers.

32. Benchmarking data shows that the number of acute adult beds per 100,000 weighted population is higher than the London average. Acute admissions are below the London average. Average length of stay in acute wards, including Psychiatric Intensive Care Unit (PICU) wards, is well above the London average. A similar pattern for admissions and length of stay is seen in older adult services. Length of stay for rehabilitation wards is also reported to be comparatively high. Information provided notes that some local factors in part account for the higher propensity to admit and the higher length of stays e.g. the higher prevalence of psychosis, high levels of homelessness, and of funded overseas visitors.

33. We heard about initiatives implemented or planned to improve bed usage including reconfiguring beds to open a female PICU ward and actions to reduce length of stay and improve flow, for example more systematic assessment and clinical review, increased social care presence to facilitate discharge, the Red2Green approach.

34. The assumption that more efficient care processes and pathways would lead to improvements in the use of current beds is reasonable. Reducing length of stay and increasing capacity would in turn reduce the time people spend in hospital and waiting times for admission and the need for people to be placed out of area. Safeguards to mitigate the risk of people feeling pressure to leave before they felt ready, a concern raised by service users, were described.

35. Data provided indicates that initiatives are having an impact or have the potential to do so. However, the way information was provided to the review team made it difficult to assimilate. For example, progress was not presented alongside a baseline or goal, interdependencies between developments in community services was ambiguous, and how inpatient beds would be used efficiently was not clear. Additionally, the modelling of the community capacity that would be needed to reduce demand on inpatient beds was not obvious, as was the impact of demographic growth on future capacity. Where specific goals were set, improvements were made but not to the level planned e.g. 97% occupancy in acute wards by March 2018 against a plan of 95%. The scale of change required to achieve the goal of 85% occupancy has not been modelled as far as the review team could see.

### Recommendation

36. There needs to be greater transparency in the way modelling of future bed numbers and community capacity is presented, including the impact of initiatives to improve efficiencies or reduce demand and current or planned reviews of the rehabilitation, crisis care and older people's pathways. Presenting this in a more straightforward way would aid understanding. Given the characteristics of the local populations, modelling should reaffirm how demographic changes assessed to impact on demand for different types of care e.g. acute, rehabilitation and be clearer on assumptions made e.g. future prevalence of psychosis, homelessness. To be robust, proposals need to be clearer about what the impact is expected to be and by when.

## Further advice: programme planning, leadership and risk

37. A programme plan with key milestones should be developed and critically reviewed to ensure the right programme capacity and leadership would be available when required to deliver the proposals and transition to the model of care agreed. This should show when benefits would be realised, aligned to the range of activities that the programme encompasses. Subject to the outcome of consultation, the proposed community hubs would open by June 2022 and a new, modern inpatient facility would open by November 2022. Service users, carers and staff should be involved in identifying the benefits that changes should deliver and in agreeing the key measures

that should be used to understand progress and impact. They should also be involved in arrangements for ongoing monitoring.

38. The clinical proposals and their deliverability should be subject to a comprehensive risk assessment, including considering unintended consequences. This should consider issues around capacity planning, interdependencies, delivery timeline, workforce development and equalities of access. Active monitoring would be needed to evidence that equality of access would not deteriorate because of changes proposed. Impact monitoring should start now to establish baseline. The risk register should set out agreed actions to mitigate identified risks and be owned by all partners.

### 2.1. Conclusion

The review team concluded that the **case for change** for the modernisation of inpatient mental health wards in Camden and Islington and improvements to the surrounding environment **is clear.** The model of care and underpinning clinical assumptions are based on clinical evidence.

The review team **was assured of the strong and consistent commitment** from health and care partners to improving mental health services, care, support and outcomes for the local population.

The review team concluded that **more detailed consideration of the narrative** around the implementation of the two community hubs, and the timing of the proposed new inpatient bed premises and the community hubs coming on stream, **would be helpful** before going out to consultation, but felt that **these do not need to hold up progress**.

The review team welcomes the commitment to evaluating the impact of changes implemented, and would like to invite commissioners to provide the Senate Council with an update on the programme's progress so that findings and learning can be widely shared.

## 3. Formulation of advice

### 3.1. Terms of reference

Terms of reference setting out the scope, approach and timescale for the review were developed and agreed with Islington CCG on behalf of Islington CCG, Camden CCG and Camden and Islington NHS Foundation Trust, and approved by the Chair of the London Clinical Senate Council. (Appendix F).

### 3.2. Review process

Planning, assuring and delivering service change for patients (NHS England, November 2018) requires NHS England to be assured that any proposal for major service change or reconfiguration satisfies four tests set by the Government in 2010:

1. Strong public and patient engagement
2. Consistency with current and prospective need for patient choice
3. Clear, clinical evidence base
4. Support for proposals from commissioners.

The Clinical Senate's advice focuses on the third test.

NHS England introduced a new test applicable from 1 April 2017. This requires that in any proposal including plans to reduce significantly hospital bed numbers NHS England will expect commissioners to be able to evidence that they could meet one of the following three conditions:

i. Demonstrate that sufficient alternative provision, such as increased GP or community services, is being put in place alongside or ahead of bed closures, and that the new workforce will be there to deliver it; and/or
ii. Show that specific new treatments or therapies, such as new anti-coagulation drugs used to treat strokes, will reduce specific categories of admissions; or
iii. Where a hospital has been using beds less efficiently than the national average, that it has a credible plan to improve performance without affecting patient care (for example in line with the Getting it Right First Time programme).

Although the proposals relating to this review do not include bed closures, the spirit of the test in ensuring sufficient bed capacity is relevant in that an objective of the proposals is to mitigate the need to increase mental health inpatient beds in line with predicted population growth.

This advice requested relates to the proposed changes to inpatient mental health services and the proposed development of two community hubs (Appendix A). It does not involve other services on the St Pancras site. Funding issues are also beyond scope. These are described in order to understand the dependencies underpinning the proposals. Advice in relation to option evaluation valuation is also outside the scope of this review.

The chair of the Clinical Senate Council invited Dr Ian Abbs, Chief Medical Officer of Guy's and St Thomas' NHS Foundation Trust and Anushta Sivananthan, Medical Director at Cheshire and Wirral Partnership NHS Foundation Trust and senior clinician with relevant mental health expertise, to co-chair the review. This co-chair arrangement ensured the review team had an external co-chair with mental health expertise since those Senate Council members with mental health expertise declared conflicts of interest (Appendix E).

Overall membership of the review team (Appendix D) included clinicians with expertise in mental health and two service users/carers (one member of the Clinical Senate patient and public voice group and a representative from a service user advocacy organisation). Clinical membership was multi-professional, including medical, nursing and allied health professional expertise. Membership also included external expertise, independent of London, as well as expertise from areas within London unrelated to the changes proposed.

To ensure independence, the review team did not include anyone who has been involved in the development of the proposals being considered or associated with the bodies. All members were asked formally to declare interests and no conflicts were identified.

The central part of the review process involved the review team having the opportunity to discuss the case for change and proposed model of care directly with a range of stakeholders in north central London who have been involved in developing the proposals and/or who could be affected by them. The review team was provided with informative materials (Appendix B) and asked to meet with service user and carer representatives involved in the process as well as with specific groups of clinicians involved in delivering the mental health services with which they interface.

A review team teleconference took place to review the documentation provided and agree key issues for discussion during the one-day review team session. Discussions took place over one day (Appendix C). A whole day session took place on 15 May 2018, which involved the review team meeting representatives and service users. (We note that a second service user participated in the early teleconference and reviewed documentations and material, but was unable to take part in the full one-day session).

This report presents the review team's findings, conclusions and advice drawing from the overall process. The advice provided is the unanimous view of all members.

### 3.3. Limitations

In formulating advice, the review team reviewed documentation that has both informed and been developed by commissioners and the Trust. The CCGs and Trust made relevant documentation available to the review team together with an overarching overview of key content to guide review team members through the programme's history and the significance of documentation provided. The review team formulated its advice based on consideration and triangulation of the documentation provided, discussion with key stakeholders and team members' knowledge and experience.

### 3.4. Meetings and hearing session

The review team came together three times during the course of the review.

- 8 May – Members shared preliminary views on the proposals from the desk-top review of documentation, agreed a framework to formulate the advice requested and key issues to explore at a full day meeting with stakeholders in north central London (Appendix C)
- 15 May – The review team held a 'hearing session' to discuss identified issues with stakeholders involved in the development of the proposals. At the end of this session the review team agreed provisional findings and advice (the service user advocate was unable to attend)
- 4 June – A teleconference was held to discuss and finalise the review team's findings and advice.

## 4. Detailed findings

Meeting the needs of, and improving the mental health and wellbeing of people in Camden and Islington is clearly a priority for the commissioners, the Trust, local partners and for service users and carers.

Central to this priority is providing the calibre of mental health care that residents deserve and expect. This includes early and effective treatment and care; helping people to live as well as possible; and ensuring world-class academic research is translated into tailored treatment for every individual.

The review team agreed that the strategic direction and overarching aims for developing and improving mental health services for people in Camden and Islington are clear with a focus on recovery, resilience and independence delivered through practice-based treatment and support and specialist treatment and supporting pathways. There is a strong emphasis on co-production and co-design with service users and carers both in inpatient and in community settings, and collaborative working with physical health, local authority and voluntary sector services.

The review team saw documentation to support the proposals:

- The Trust's clinical strategy 2016-21[2] which has strong ambitions to:
    - Strengthen and further develop mental health and substance misuse services provided within primary care and community settings
    - Maintain specialist care-pathways based on clinical need
    - Strengthen the focus on recovery, resilience and independence.

[2] Clinical Strategy 2016–2021 A vision for the transformation of mental health services, Camden and Islington NHS Foundation Trust (2016)

It recognises that mental health problems for most people are managed in general practice and by community based teams. It centres on increasing early and effective intervention, supporting more people at home and in community settings, reducing the need for hospital admission, and delivering services in a more integrated and holistic way, built around needs of local people.

- The North London Partners in Care STP which outlines a shared commitment amongst health and care partners to deliver improvements in mental health services and care for the local population by proposing a 'stepped' model of care supporting people with mental ill-health to live well, enabling them to receive care in the least restrictive setting for their needs. The aim is to reduce demand on the acute sector and mitigate the need for additional mental health inpatient beds. The mental health STP plan includes the following initiatives:
    - Improving community resilience by developing employment schemes, mental health first and other health awareness campaigns to support self-management and early intervention in mental health
    - Increasing access to primary care mental health services: ensuring more accessible mental health support is delivered locally within primary care services. This includes expanding practice-based mental health (PBMH) and improving access to psychological therapies (IAPT) services
    - Improving the acute mental health pathway: by developing alternatives to admission by strengthening crisis and home treatment teams
    - Developing a women's PICU: to ensure local provision of inpatient services to female service users requiring psychiatric intensive care, where currently there is none
    - Investing in mental health liaison services: scaling up 24/7 all-age comprehensive liaison to more wards and emergency departments
    - New model of care for child and adolescent mental health services (CAMHS) and perinatal services
    - Investing in a dementia friendly north central London (NCL): looking at prevention and early intervention, supporting people to remain at home longer and supporting carers to ensure that we meet national standards around dementia.
- The Five Year Forward View has encouraged efforts to deliver more healthcare out of acute hospitals and closer to home, with the aim of providing better care for patients, cutting the number of unplanned bed days in hospitals and reducing net costs. The review team heard there is a clear desire in Camden and Islington to support this national policy and shift care from being delivered in an acute setting to being delivered in integrated community settings to improve mental and physical health and delivery of social care.

    The review team notes the Trust's vision for transforming care to deliver the best possible health outcomes for the residents of Camden and Islington, and acknowledge that initiatives, reviews and programmes are being put in place to support that vision, such as increasing access to primary care mental health services and investing mental health services delivered in A&E.

    However, the review team considers that there is clearly a challenge for commissioners and the Trust to develop a fit for purpose and cost-effective mental health service of high quality and accessible for the residents of Camden and Islington.

The review team heard that there had been **significant progress made in Camden and Islington to**:

**Improve community resilience**

- Camden and Islington CCGs have implemented new employment schemes based on Integrated Personal Support, an-evidence based type of employment support to help those with mental health conditions back into work. These initiatives are specifically supported by NHS England and have been shown to reduce activity, and cost, to health services as people gain employment. However, the review team heard from service users about the lack of perceived support given to service users to help them back into work, such as interview training, help with CVs and coaching; although some were positive about the Recovery College
- Mental Health First aid is widely rolled out to Camden and Islington Council and voluntary sector services. This initiative is aimed at non-specialist front line services helping them identify mental health concerns and support people to access mental health services. Similarly, suicide prevention training is also being commissioned to support early identification and intervention with people who may be at risk of suicide but not in contact with mental health services.

**Increase access to primary care mental health services**

- The review team heard that primary care mental health services are being rolled out (investment of £1.5 million this year by the Trust) and the CCGs are on target to increase access to increased access to psychological therapies (IAPT) services to 25% by 2021
- Islington CCG has also invested in 'integrated IAPT' which specifically targets people with long-term physical health conditions who may otherwise not recognise and come forward for help with depression and anxiety associated with their conditions, but which nevertheless make their condition more difficult to live with. Initially this is targeted at those with diabetes and chronic pulmonary respiratory disorder.

**Improve the acute mental health pathway**

- Camden and Islington both have crisis home recovery teams that respond to individuals in the community who feel in crisis and who, without immediate support, would attend an emergency department
- A 24-hour crisis telephone line that the public and professionals can call to get advice and support
- Crisis houses are also available across the boroughs to help avoid in-patient admissions where possible.

These teams will be reviewed in 2018/19 to ensure that they are being efficiently used and working to ensure that they are working to fully support people in the community, able to respond in a timely way, working closely with voluntary sector and social care; in order to support people's needs in the least restrictive setting.

The review team believes there needs to be greater transparency in the impact of initiatives to improve efficiencies or reduce demand though such pathway reviews. The review team heard service users say that more money should be invested in crisis teams as more people are accessing those services, but the staff do not have enough time to support them as they used to. Additionally, consideration should be given to providing clear referral pathways that can be accessed by paramedics.

**Serenity integrated mentoring**

- Islington and Camden CCGs are early implementers of the serenity integrated mentoring (SIM) programme, which brings together police and care co-ordinators around a specific cohort of patients who are repeatedly admitted to health-based paces of safety under s136 of the Mental Health Act. In pilots elsewhere, this has resulted in a 50% decline in attendance at health-based places of safety and impacted on subsequent admissions.

**Women's psychiatric intensive care unit**

- Last November, the Trust launched an 11-bed women's PICU as a shared resource for the NCL STP; however, the majority of admissions would be from Camden and Islington due to the higher acuity of need in these boroughs. The review team heard that the service is demonstrating significant improvement to patient care – not only are patients now able to be provided with services in the NHS and within their local area enabling visits from relatives and better joined-up care, but length of stay has also reduced to an average of 27 days from previous average in the private sector of 45 days.

**Investment in mental health liaison services**

- The Trust provides mental health liaison services in University College London Hospital (UCLH), Royal Free London and Whittington Health hospitals, which are the main emergency departments, attended by Camden and Islington residents. The services operate 24/7 and provide in-reach to the wards to support training of staff, early discharge and reduced re-admission. They can be described as meeting many of the Core 24 requirements.
- The review team heard that the CQC had identified significant problems with the interface between the Whittington and the Trust around the emergency care pathway and that it was in need of significant improvement. Islington CCG was charged with addressing the issue with some urgency. With capital funding from NHS England, a new mental health suite is being implemented at Whittington Hospital, which will provide a safe and therapeutic environment for patients who have attended emergency departments to be assessed and cared for prior to admission or discharge. It is expected that the mental health suite would provide a calming environment and would support more people to be able to access services at Crisis Houses, or in the community with support from community teams and thereby reduce admissions to acute in-patient mental health settings. Some service users expressed concerns that these community teams were working at full capacity and did not have as much time as they used to, to support them.

**New model of care for CAMHS and perinatal services**

- The Trust does not provide CAMHS services and therefore these inpatient and community proposals would not impact on CAMHS services. However, in 2016, the Trust launched a new community speciality perinatal service, which is an NCL-wide resource and builds upon the small services that were already operating in Camden, Haringey and Islington. The new service works across maternity units and in the community to support the needs of pregnant women and those with babies under one year old. This multi-disciplinary specialist service ensures that the top 3-5% of women with severe mental health needs are provided with specialist care and support. There were some concerns that these were not as joined-up as they perhaps could be.

**Investment in a dementia friendly NCL**

- Dementia is a growing challenge. In England, it is estimated that around 676,000 people have dementia, and Camden and Islington have high rates of dementia diagnosis. NHS England has committed to ensuring that two-thirds of all those estimated to have dementia have received a diagnosis. As of March 2017, Camden's diagnosis rate was 75.4% and Islington's 96.8%, which means that people in Camden and Islington could access support and services early in their diagnosis thus reducing crisis and in-patient care and supporting more people in their homes.

## 4.1. Case for change

**Borough characteristics**

The review team heard that the case for change highlights characteristics within Camden and Islington's populations and factors that impact on mental health and well-being.

The review team heard that the current Joint Strategic Needs Assessments (JSNAs) for Camden and Islington outline a clear requirement for sustainable and high quality mental health service in the area. Both Camden and Islington have significantly higher rates of mental health diagnosis than other London boroughs. Islington has the highest proportion of its population diagnosed with a psychotic disorder, with Camden third highest nationally.

Both Camden and Islington are densely populated with high levels of deprivation as well as great wealth, and there is a prevalence of serious mental illness that places them in the top three boroughs in London. Additionally, Camden has the third highest number of homeless people in England.

Between them, they serve a population of some 471,000, which is expected to grow by between 11% and 17% by 2030. Within this, there is a large population of 20-40 year olds, with relatively fewer children and young people and older people than other London boroughs. The Trust has contact with over 44,000 services users a year, of which 10% are overseas visitors, reflecting the diverse and transient nature of the population of the boroughs.

**Camden and Islington NHS Foundation Trust**

The Trust provides mental health services for people in the area. Islington CCG commissions almost 98% of services in its role as lead commissioner, with Camden CCG as an associate commissioner.

The review team heard that the Trust provides mental health services for people with psychoses, complex psychological conditions such as personality disorder, substance misuse, acute and crisis care, common mental health disorders and dementia care. In addition, it has specialist programmes such as mental health care for veterans living in London. The Trust serves people living primarily in Camden and Islington as well as Kingston-upon-Thames. It also provides statutory social work and social care services on behalf of the London boroughs of Camden and Islington.

Services are provided for adults of working age, adults with learning difficulties and older people in the London area, in either a community or inpatient setting. The Trust does not provide child and adolescent mental health services (provided by the Tavistock and Portman in Camden and Whittington Health in Islington).

The Trust has 30 sites across Camden and Islington and Kingston-upon-Thames, as follows:

- 235 inpatient beds are accommodated at St Pancras Hospital in Camden and at Highgate Mental health Centre in Islington
- 78 community beds (residential) are provided across several sites
- Community clinical services are available from a number of buildings, spread across Camden and Islington.

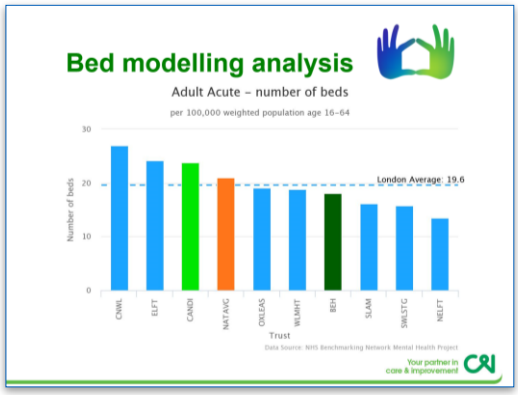
The Trust's headquarters is St Pancras Hospital, located in Camden and occupies the site of the former St Pancras Workhouse and Infirmary. This comprises 17 separate buildings and structures. The site is located north of King's Cross and St Pancras stations and west of the mainline railway tracks. The Grand Union canal is located just to the north and east of the site. St Pancras Gardens forms the southern boundary to the site.

In recent years, there has been significant development of the area and a number of large-scale housing developments now overlook the site.

Additionally, current inpatient wards at St Pancras Hospital are of poor design, poor condition, and poor environment. The CQC's report highlighted that they do not meet current standards and present risks to patients' safety; e.g. availability of ligature point.

**Inpatient beds**

The Trust described how they have more inpatient beds per 100,000 weighted population than the London average and indicated they were aware that beds could be used more efficiently.



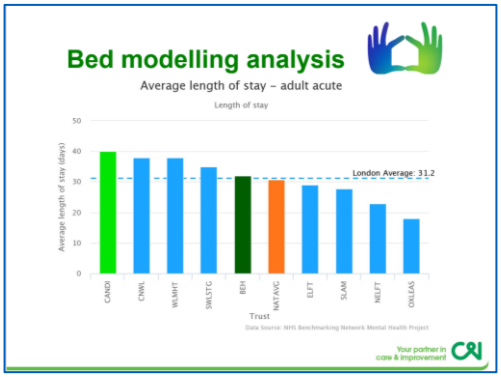

In 2017, bed occupancy was at 97-98% for acute and 99% for older adults, and the Trust's ambition was to achieve 95% by March 2018.

The review team also heard that some local factors in part account for the higher propensity to admit and the higher length of stays e.g. the higher prevalence of psychosis, relatively high levels of homelessness, and of funded overseas visitors.

Benchmarking data also shows that community teams had the lowest overall caseload when compared to other London trusts, indicating that more service users could be supported in the community if services were available.

**Length of stay**

The Trust acknowledged that it was an outlier compared to other trusts for length of stay (LoS), which contributed to high bed occupancy levels and meant that they often had to use private beds to accommodate needs; this included a length of stay for older adults of 135 days.




The Trust said that they would be putting in place more efficient care processes and pathways which would in turn lead to improved bed usage; however the review team was not clear of the interdependencies between developments in community services and more efficient beds.

The review team heard of a number of initiatives that have been implemented, or are planned, to improve bed usage so that inpatient capacity will be sufficient as the population and needs grow over the coming years:

- Free up 12 beds across the system by 31 July 2017 to enable the opening of a Women's PICU by 1 November 2017
- Fully utilise new community resource to step down some long staying rehabilitation patients by September 2017
- Reduce the number of people staying beyond the agreed median length of stay by 50% by the end of 2017
- Convert four older people's continuing care beds to acute beds by 31 March 2018.

The review team heard that this was achieved in a range of ways including the recent opening of the women's PICU bed, more systematic clinical assessment and clinical review, closer links with Islington's Crisis House to better use this voluntary sector service, and working more closely with social care to facilitate discharge.

It is clear that the Trust has sought out examples of change, good practice and innovation implemented in other areas, such as the Red2Green initiative in the West London NHS Mental Health Trust. This has helped them learn from others' experiences and inform how they shape their future proposed services.

In particular, the Trust has made progress through the reduction in continuing health care beds by four as planned, but increases to the acute bed base to support demand. Utilisation of all types of beds has reduced in the last year. Utilisation of acute beds has reduced from 99% to 96% in the last year, a reduction of 3% (although not hitting the target of 95%).

The Trust has also been putting effort into reducing waiting times for admission and the need for people to be placed out of area; this has resulted in occupied bed days for private sector placement acute and PICU placements falling from a high of 2,065 in quarter three of 2017/18 to 330 in the following quarter. With more referrals into the home treatment teams, new admissions have reduced from 591 to 474 between 15/16 and 17/18 representing a 20% reduction.

The drive to reduce length of stay for older people and for rehabilitation is beginning to have an impact, but the review team heard concerns from service users about making sure there were enough safeguards in place to mitigate the risk of people feeling under pressure to be discharged before they felt ready.

Modelling of demographic growth indicates that an additional 19 beds would be required to meet population need by 2025 assuming no change to the clinical model or pathway efficiencies. The Trust has concluded from analysis carried out that reducing average length of inpatient stay to the London average would release 45 beds i.e. 26 more than assessed to be required to meet future need. The proposal does not seek to reduce current inpatient bed numbers.

| Type of Bed | Current Location | No of Beds (Feb 16) | No of Beds Predicted by STP due to demograhic growth and no service developments (Feb 21) McKinsey | No of Beds Predicted in STP with demographic growth and Service Developments (Feb 21) McKinsey Mitigation | Current No of beds (Feb 18) | No of Beds Predicted in OBC due to 8% demographic growth and no community developments (Feb 25 ) | No of Beds Predicted in OBC due to demographic growth with Clinical Strategy implemented community developments (Feb 25) |
|---|---|---|---|---|---|---|---|
| **Service Developments Assumed / Delivered** | | **(15/16) full year data available to McKinsey** | **Assumptions are 13.3% demographic growth from 15/16 - 20/21 (5 years) steady length of stay and occupancy** | **As detailed in the STP** Increased CRHT Teams / Perinatal/Primary Care | **Service Developments from Feb 17 include**: Women's PICU | **N/A** | **As detailed in the Clinical Strategy** |
| **Mens PICU** | **Total** | **12** | **13** | **13** | **12** | **13** | **12** |
| Length of stay MPICU | | **55** | | | **89** | | |
| **Women PICU** | **Total** | **0** | **0** | **10** | **11** | **12** | **11** |
| Length of stay WPICU | | | | | **36** | | |
| **Acute** | **Total** | **152** | **173** | **140** | **140** | **151** | **130** |
| Length of stay Acute | | **49** | | **38** | **67** | | |
| **Older Adult** | **Total** | **28** | **32** | **27** | **28** | **30** | **30** |
| Length of stay Older Adult | | **135** | | **37** | **118** | | |
| **Rehabilitation** | **Total** | **44** | **51** | **66** | **44** | **48** | **52** |
| Length of stay Rehab | | **1103** | | | **721** | | |
| | **Total number of beds** | **236** | **269** | **246** | **235** | **254** | **235** |

The review team was unanimous in the view that the **case for change and proposals for community services are the more critical** in delivering the strategy and ambitions described, **including ensuring that inpatient capacity will be sufficient as the population and need grows** over the coming years. Consequently, it felt that **more detailed consideration around the detail of the development of community services within the proposals would be helpful**.

The review team heard the case that more service users could be supported in the community if services were available and that the quality, design and capacity of premises needs to improve to enable the development of community-based care.

However, it also heard that services and teams are spread out across the two boroughs, which does not make it easy for joined-up working and coordinated care. Premises were being used because of historical reasons, not modern clinical reasons.

The proposals describe consolidating services in community hubs and co-locating teams to improve efficiencies, for example, reducing duplication such as repeated assessments; facilitating easier and timelier communication, delivering more joined up care and more effective working practices that would release staff time-to-time care.

However, the review team felt that there was a lack of detail which makes it hard to understand what would be different in practice, including opening hours, for example whether services would be provided every day of the week including weekends or for extended hours. Service users raised this as concern.

To meet these challenges, the Trust has included in its estates strategy proposals for the redevelopment of the site to:

- Provide modern, therapeutic mental health facilities across Camden and Islington
- Move more services into the community
- Build high quality, up-to-date, warm and welcoming inpatient facilities
- Create world-class research facilities to help us deliver the very best care.

These proposals are in line with the Trust's 2016-2021 clinical strategy whose focus is to promote recovery, resilience and independence via easy to access community-based services and specialist care-pathways, based on:

- Expanding capacity by integrating more staff into primary care and community settings
- Integrating physical and mental health
- Reducing the physical and psychological barriers to entry (through more local provision, better access for those with disabilities and more generally through greater awareness in the community)
- Improving lives and wellbeing through wider integration of social and mental health support.

The review team heard details of the proposals to deliver:

**A new build inpatient facility** – located at Whittington Hospital. The inpatient facility will be a three-storey new build surrounded by landscaped gardens with car parking available at our neighbouring Highgate Mental Health Centre

- The new facility would have 84 single bed rooms, supported by 606m$^2$ of support space, an external courtyard or garden space and consulting rooms for each ward
- The new facility would be fully accessible, and present an attractive, therapeutic and welcoming environment for staff and service users
- The facility would be designed to be future proof allowing reconfiguration in use as requirements change over the next decades.

**Three community hubs** that would provide service users and carers with a familiar, non-stigmatising, easily accessible place where they could access a variety of services that promote holistic care. They would include spaces for service users and carers, which are co-designed by them. This would be delivered by co-locating Trust teams to encourage and support joint working, encouraging holistic care and eliminating duplicate assessments. There is great potential to scale up holistic care by co-locating, local authority and voluntary sector services, providing a whole-system approach.

- A four-storey community hub at the Trust's existing site in Greenland Road, in the London Borough of Camden
- A four-storey community hub at the Trust's existing site at Lowther Road in the London Borough of Islington, replacing the existing building
- A community hub at the St Pancras Hospital site, with consulting rooms, meeting rooms, training facilities and the Recovery College. The Recovery College includes space for both clinical delivery and support facilities for the clinical teams

The **St Pancras site would be redeveloped** to provide a total of 2,187m$^2$ of accommodation for the Trust, the community hub as above, and host a new Institute of Mental Health with our University College London partners which would take up approximately the same space

**Improved patient pathways** through practice based mental health teams and specialist care pathways.

This means that for some residents, some services would move from their current locations and the final details of this are yet to be fully determined.

The range of stakeholders met by the review team from clinicians, local authorities, commissioners, and service users were on the whole clear that the estates strategy is an enabler to the provision of high-quality care for the residents of Camden and Islington.

## 4.2. Clear case for modernising facilities

The review team agrees there is a **clear case for modernising these facilities and improving the environment** for service users and their carers. However, it **strongly believes the case for change and proposals for improvements in community services are the more critical** to delivering the strategy and ambitions described.

The review team heard the Trust's vision to reduce stigma and stress by providing a familiar, easily accessible community setting, away from hospital where some service users may previously have been inpatients. It heard where these plans could meet the need for more spaces in the community and more community appointments outside hospital by co-locating teams across the boroughs, breaking down barriers between teams, encouraging holistic care and eliminating duplicate assessments.

Documentation seen by the review team stated that by co-locating the new purpose built facility alongside the Whittington Health hospital, service users would be able to receive specialist mental health treatment from the same site as users of the acute physical health care service, which would help reduce the stigma attached to mental health facilities.

Service users were quite concerned that this was a cost-cutting exercise and cited previous initiatives, such as an independent living centre, where they felt that not all of the commitments made had been implemented (gym facilities were given as a specific example). It was also clear that some service users perceived there has been a dilution of community services over time. They would like reassurances that services would be co-located and easily accessible.

The review team heard that community hubs would not operate in isolation, and heard from several sources that there would be links with primary care teams, local community agencies and voluntary sector groups within these hubs. However, it was not clear how this would happen in practice, for example how mutual support groups in the community would be facilitated and needs to be better described and signposted. Service users who use a variety of services from health, social care and community groups raised this as a concern.

The review team heard that mental health consultants (practice-based mental health teams) are helping to develop specialist skills in primary care, skilling-up primary care staff that in turn reduces referrals to inpatient services and builds capacity in the system, reduces duplication and multiple hand-offs. The team heard that the development of practice-based mental health in Islington is expected to reduce secondary care referrals by at least 30%.

As community hubs mature what would develop would be the richness from the multi-disciplinary teams and different social care and voluntary and community agencies coming together, providing a different offer to service users to what is in place at the moment; a more holistic care offer.

While these benefits have already been seen in part in Islington, the review team is concerned that this has not yet been implemented in Camden and would like to see how such programmes could implemented more consistently across the two boroughs.

The review team heard a number of initiatives to increase community support for mental health services, for example looking at how the system could be used on a neighbourhood basis, joining up the local authority, the voluntary sector, GPs, other health professionals, and the ambulance services, in a neighbourhood way, to build networks which become much more resilient and able to tackle challenges on a local basis effectively.

The review team felt that it had heard many initiatives and programmes but that they were not really described in a simple language, such that service users in particular would find easier to understand. Service users met by the review team have also requested further information. Different stakeholders we met provided different levels of detail about the vision and approach to developing community services, which suggested that aspects of the proposals might be better, developed than presented.

The review team was concerned about the lack of detail on community services within the proposals developed so far, particularly around capacity and timing.

However, towards the end of its review meeting on 15 May, it heard that there was a Clinical Strategy Programme Board that oversees and monitors all the programmes and projects that have been established to support the delivery of the clinical strategy. The Board has driven delivery of various projects and identified many new projects.

It saw evidence that these have been informed by change and innovation successfully implemented elsewhere, both in London and further afield. It has an agreed a set of metrics which are used to monitor the achievement of the overall transformation and understand whether the programmes realise their expected benefits.

An example of the impact that specific developments were having was presented; the integrated practice unit for psychosis which has been operating for two years, working in collaboration with GPs and other healthcare providers, as well as the third sector. Its 2017 patient reported outcomes measures (PROM) results showed 81% satisfaction with medication, 79% agreement that our services treated people with dignity and respect, 75% satisfaction with speed of access to care and 72% for support for carers.

The Trust is now expanding its programme to tackle other physical health problems in this group, such as diabetes and chronic obstructive pulmonary disease (COPD), alongside reducing suicide levels. In addition, five physical health and wellbeing clinics have been opened. Staff have also been issued with physical health skills passports, for monitoring and logging additional physical health assessment training. A specially designed physical health screening tool has led to assessments and further help or treatment for more than 2000 service users.

## 4.3. Equity of access

Service users also cited equity of access, with concerns that people from the south of Camden would have to travel further than they do now, and that the new facility would be on a steep hill (Waterlow Park is a steep climb if you want to get some air) with poor transport links (buses stop at the bottom of the hill) and this is clearly not suitable for everyone. They also cited that they currently have closer access to shops and cafes. The review team heard that equity of access would be added to the programme risk register.

Documentation seen by the review team states that the majority of vulnerable or protected groups identified as part of the equality impact assessment have been judged as achieving greater equality, improved outcomes or increased accessibility through the proposal. For example, both inpatient and community developments would provide improved disabled access for service users, staff and visitors. For many other groups, the purpose built facilities offer an improvement in therapeutic environment, access to outdoor space and care delivered closer to home. However, some service users said that there was greater access to outdoor space at St Pancras and that access to green space is more than just a wander in a landscaped garden, and should actively involve service users, carers and staff.

## 4.4. Co-production

Documentation shared, and especially the Trust's clinical strategy, showed a very strong commitment to co-production. In these proposals, we saw most reference to co-production in relation to the case for change to inpatient services and service users have asked for more involvement in the development of inpatient services, community hubs. They are particularly keen to be involved in the co-design of proposals, sharing shared examples of involvement in previous schemes.

Additionally, the review team felt that **service users, carers and staff should be involved** in identifying the benefits that changes should aim to deliver and in agreeing the key measures that should be used to understand progress and impact. They should also be involved in arrangements for ongoing monitoring.

## 4.5. Workforce

The review team heard that the proposals are currently described as consolidating services in hubs and co-locating teams to improve efficiencies e.g. reducing duplication (such as assessments), communicating more easily and quickly, more effective working practices which would release staff time to do more.

But it felt that the **workforce implications of the proposals need to be better described**.

The STP highlights the importance of developing and supporting the health and social care workforce to deliver the vision, plans and proposals described, and building capacity in the workforce is noted as a key enabler alongside estates, technology, delivery and commissioning models and the interdependency between the workforce workstream and initiatives within the mental health programme.

The proposals include many references to workforce development and provide examples of specific initiatives on recruitment and retention, development and use of new roles and upskilling of current staff. And the review team heard of initiatives, such as working with the voluntary sector to aid recruitment as it is easier to recruit in the voluntary sector than the health sector; using and investing in that resource for prevention/intervention and coproduction; a whole system approach.

The review team felt however that, as presented, workforce issues are considered in a general way and an assessment of workforce implications, development needs and opportunities relating to the specific proposals that we have been asked to consider, and a plan to address these, is missing. This is a significant gap in understanding how the proposals would be delivered.

## 4.6. Investment

The review team heard **mixed messages about how the ambition for expansion of community services would be achieved without investment**, and asked specifically about whether there would be a cost-neutral future or a revenue shift to achieve the investment. It heard evidence of the possibility of short-term funding, and the investment of £1.5m in practice-based mental health services by the Trust.

The review team heard that there is a commitment to invest in community services and to remove money from the system where it does not deliver better outcomes for service users or using buildings that aren't needed or being used well, and reinvest it in services that benefit service users, carers, staff and the whole health and care system.

The CCGs stated that they are committed to looking in-depth at where they can invest in mental health services, that money has been received in Islington from NHS England to support improvements to capacity in their IAPT services, which they can't do without investment.

The CCGs are working with the trust to review the crisis recovery teams and rehabilitation pathways, looking to invest in 2019/20.

From July 2017 to February 2018, a trust-initiated rehabilitation pathway review was undertaken which made a number of recommendations and achieved the following:

1. Creating more consistent care delivery across community rehabilitation services, which includes a clinical peer support model to help identify solutions to enable discharge from hospital care. 14 complex care patients were reviewed which lead to eight discharges to the community
2. The service continues to review expected discharge dates on a weekly basis. Those identified for discharge to supported housing or residential care are reviewed on a fortnightly basis to ensure the processes required are completed in a timely manner to prevent delays
3. Implementation of the preferred clinical model. A small task and finish group was established to present the preferred staffing model to support current clinical model in practice across community rehabilitation units.

These initiatives have supported the reduce length of stay reported in the PCBC for rehabilitation and greater movement through the patient pathway. The number of outliers and/or length of stay for the outliers, as well as average length of stay has also fallen. This has also improved patient flow across the acute to rehab pathway.

Additionally, the review team heard that the trust and CCGs have agreed to convene a task and finish group to oversee actions and key recommendations stemming from the review of these rehabilitation services, reviewing provision across the whole of the two borough rehabilitation pathway, not just the services provided by the trust. The review is expected to:

- Ensure that provision is efficient and outcome focused
- Support the principles of least restrictive practice and settings
- Support patient flow and movement through the system
- Ensure the right capacity is available across all levels of care and that the approach is suitably tailored, supporting timely step-up and step down
- Ensure that provision meets and exceeds national standards, and is aspirational and strength based in approach.

Although part of an overarching programme, the review team did not feel the connections and interdependencies between these workstreams, including delivery timelines and expected capacity impact, were sufficiently clear.

## 4.7. Programme planning, leadership and risk

Although not asked to do so, and because the review team spent some time in discussion, programme planning, leadership and risk were also raised as areas that need further development.

The review team heard evidence from a number of sources that the new community hubs were planned to be in place by June 2022 in time for the new inpatient services to be ready for December 2022. However, **it is not convinced that the connections and interdependence between the two proposals were clear**, and that capacity would be in the right place and at the right time.

It was suggested that a **programme plan with key milestones should be developed** and critically reviewed to ensure the right capacity and leadership would be available when required to deliver the proposals, subject to the outcome of consultation. The proposals and their deliverability should also be subject to a **comprehensive risk assessment, and actions to mitigate identified risk to an acceptable level should be agreed**.

The risk register received for the programme shared with the review team focuses on risks associated estate proposals. However, there seemed to be no risk register for developments in community services. The review team suggest that the clinical proposals and their deliverability should be subject to a comprehensive risk assessment, including consideration of unintended consequences. This should consider issues relating to capacity planning, interdependencies, the delivery timeline, workforce development and equalities of access. The resultant risk register should set out the actions agreed to mitigate identified risks to an acceptable level and be owned by all partners.

## Appendix A. Scope of proposals

Mental health inpatient services provided by Camden and Islington NHS Foundation Trust are provided at both St Pancras Hospital in Camden and the Highgate Centre for Mental Health in Islington.

Facilities at the St Pancras Hospital site are very old: wards are accommodated in Victorian buildings that fail to meet modern standards for inpatient mental healthcare and do not provide an effective therapeutic environment.

The CQC report published in June 2016 highlighted that the Trust's wards require significant improvement. A further CQC inspection took place in December 2017, and its report[3], published in 2018, noted some action had been taken.

The St Pancras Hospital site is situated on a busy central London street with limited outdoor space. The vicinity around St Pancras has also changed considerably over the years and tall buildings now overlook the site. With building work set to continue, inpatient privacy and dignity is likely to be further compromised. Commissioners and the Trust are acting to address these issues as they are expected to become increasingly problematic in years to come.

Commissioners and the Trust state that maintaining and upgrading current premises to meet modern standards would require significant investment. Due to the basic structure of some buildings, the Trust would still be unable to satisfy the standards prescribed by the Department of Health best practice guidance as well as many important elements of its clinical strategy[4] e.g. the St Pancras Hospital site does not comply with the standards for inpatient mental health services[5] (Royal College of Psychiatry 2017). In particular, it struggles with the following standards:

- Clear lines of sight to enable staff members to view patients (type 1 required standard) - additional mitigations have been put in place following the CQC inspection in June 2016 (noted in the December 2017 inspection report published in March 2018)
- Every patient has an en-suite bathroom (type 3 desirable standard).

In addition, the St Pancras Hospital site is limited with regard to:

- Meeting the needs of disabled people due to poor layout and facilities
- Providing unescorted access to outdoor space for patients which limits accessibility
- Providing a comfortable environment, as the buildings are often too hot and poorly ventilated.

The Trust and commissioners have put together proposals to develop 84 mental health inpatient beds at a new purpose-built site on land purchased next to the Whittington Hospital and another Camden and Islington NHS Foundation Trust site with inpatient facilities, the Highgate Centre for Mental Health.

They propose closing and transferring the current 83 inpatient beds at St Pancras to this site:

- Three acute care wards (44 beds)
- One women's psychiatric intensive care unit (11 beds)
- Two rehabilitation wards (28 beds).

[3] CQC report into Camden and Islington NHS Foundation Trust (CQC - March 2018)
[4] Clinical Strategy 2016-2021: a vision for the transformation of mental health services (Camden and Islington NHS Foundation Trust 2016)
[5] Standards for inpatient mental health services (Royal College of Psychiatry 2017)

Commissioners and the Trust say that the proposed new development would be able to meet the Royal College of Psychiatry standards for inpatient mental health services and provide a spacious comfortable environment conducive to high quality standards of care. The proposal does not include any change to the overall number of inpatient beds.

However, the St Pancras Hospital site is located in the London Borough of Camden and predominantly used by Camden residents, though residents from other boroughs, including Islington, also access these inpatient facilities.

Additionally, the Trust's two women's wards are located on the St Pancras Hospital site and both of these, the only exclusive women's wards, would be included in the move. The new site is located in the London Borough of Islington and some patients, and their families and friends, may therefore have a greater distance to travel.

The Trust's plans also include further development of the estate for community services, specifically provision of two community hubs (one in Camden and one in Islington). These would improve access with more care provided closer to where people live and allow more care to be provided in the least restrictive setting.

These proposals form part of the North Central London[6] Sustainability and Transformation Plan (NCL STP). This sets out three significant gaps in mental health provision locally:

- The health and wellbeing gap – not everyone estimated to be in need of care is accessing it, e.g. the need to increase access rates for increased access to psychological treatment (IAPT) provision
- Care and quality gap – more should be done to meet people's needs out of hospital; benchmarking data shows that Camden and Islington NHS Foundation Trust admits more people under the mental health act than the London or national average
- Financial gap – without changes to the mental health system locally, the demand for inpatient beds will outstrip available resources.

The NCL STP vision is to shift care from being delivered in an acute setting to being delivered in integrated community settings to improve mental and physical health and delivery of social care. The Trust's Clinical Strategy 2016-21 similarly has strong ambitions to deliver clinical care within primary care and community settings where possible and to strengthen the focus on recovery, resilience and independence.

The STP states:

*"We plan to develop a 'stepped' model of care supporting people with mental ill health to live well, enabling them to receive care in the least restrictive setting for their needs. The provision of appropriate social care is a key success factor for people with long-standing mental ill health and this will be central to the success of the stepped model.*

*"We aim to reduce demand on the acute sector and mitigate the need for additional mental health inpatient beds. We want to improve overall mental health outcomes across North London and reduce inequalities for those with mental ill health, enable more people to live well and receive services closer to home and ensure that we are treating both physical and mental ill health equally."*

Since the development of the STP and the Clinical Strategy, key areas have been developed to move this journey forward:

[6] North Central London includes the London boroughs of Barnet, Camden, Enfield, Haringey and Islington

- Development of practice-based mental health in Islington which provides multidisciplinary assessment and advice as the first point of contact with secondary care, based in the community in a non-stigmatising environment. It is expected to reduce secondary care referrals by at least 30 per cent. The Trust and Camden CCG are working on similar plans for Camden residents which complement other community mental health services in the borough
- A small (1 bed) reduction in acute inpatient beds to develop a women's psychiatric intensive care unit for patients in north central London; avoiding out of area placements
- A number of initiatives to reduce emergency department (ED) attendance and inpatient admissions have also begun, or are in development and expected to begin in the next few months. These include a police and Trust liaison model, a mental health suite and mental health nurse triage in ED
- There has been some reconfiguration of inpatient beds and work on reducing length of stay which is contributing to the evidence that there is no requirement to increase the current number of inpatient beds to meet future demand.

The STP, the Trust clinical strategy and the developments underway or in development form the basis of local partners' decision not to increase inpatient beds and to develop larger community hub locations so that expansion of community services could be accommodated. Primary care estate is limited and current Trust community estate is fragmented over many sites.

If the plans do not go ahead, the Trust and commissioners believe there is a significant risk that the inpatient services on the St Pancras Hospital site will not be fit for purpose and would jeopardise the clinical care of patients.

Considerable informal engagement has already taken place with the local community, service users, and staff as well as with MPs and overview and scrutiny committees. Discussions have been informed by explaining and discussion three options:

**Option 1:** To do nothing. Maintain all existing buildings to a minimum, but safe, standard; do not move the inpatient beds, nor build any new community facilities.

**Option 2:** Move the inpatient accommodation from the St Pancras Hospital site to a newly built facility next to the Whittington Hospital, opposite Highgate Mental Health Centre, and invest significantly in building new mental health community hubs in Camden and Islington.

**Option 3:** Move the inpatient accommodation from the St Pancras Hospital site to a newly-built facility next to St Ann's in Tottenham (London Borough of Haringey) and invest significantly in building new community mental health hubs in Camden and Islington.

The majority of service users and staff **favoured option 2**. Overall feedback indicated that stakeholders are mainly supportive of the proposals although some have expressed concerns. These relate to:

- Access - the move of inpatient services out of Camden, though the 'trade-off' of needing to relocate facilities to a more affordable location to deliver benefits versus benefits that would accrue was felt to be acknowledged
- The sale of NHS assets - needed to fund the proposal.

## Appendix B. Supporting information

The following documentation informed the review

1. Local information, including a selection of maps showing the locations of St Pancras Hospital, the Whittington Hospital and the community hubs, as well as deprivation maps for Camden and Islington
2. North Central London sustainability and transformation plan (June 2017)
3. Camden and Islington NHS Foundation Trust clinical strategy (2016)
4. CQC inspection report from the most recent inspection, which took place between 4 and 7 December 2017. (6 March 2018)
5. St Pancras redevelopment case for change – relocation of mental health in-patient beds and development of community hubs (Camden and Islington CCGs) (March 2018)
6. Equality impact assessment (Islington CCG) (2013)
7. Quality impact assessment (Islington CCG) (2013)
8. Equality delivery system (EDS2) (Camden CCG) (2016)
9. Equality objectives and EDS report (Islington CCG) (2016)
10. Camden and Islington NHS Foundation Trust equality strategy and annual report v1 (2013)
11. Pre-consultation business case v 4.2 (April 2018)
12. St Pancras Programme risk register (June 2018)
13. Healthwatch Camden informal consultation with service users, staff and carers (March 2018)
14. Clinical Strategy Programme Board summary and programme plan (May 2018)
15. Rehabilitation review summary (May 2018)

# Appendix C. Review team enquiry session

London Clinical Senate

**Advice on proposals for mental health services in Camden and Islington**

**Review Team Teleconference**

**3.00-5.00pm, 8 May 2018**

To dial in: Call **0800 032 8069** then the participant code: **91621460#**

## AGENDA

1. **Introductions**
2. **Brief overview of the background and context**
3. **Review Team remit**
   - Key task / advice requested (terms of reference attached)
   - Timeline and key activities
   - Conflicts of interest declaration and confidentiality agreement
4. **Formulating advice - key issues to consider** (attached for discussion)
5. **Review of documentation about the case for change and proposals**
   - Share views on the case for change, proposals for change and overall reflections on the documentation provided
   - Discuss and agree key issues that should be explored at the all-day session on Tuesday 15 May 2018
   - Consider if there is further information/documentation that the Review Team needs at this point to prepare for the 15 May and provide the advice requested
6. **Arrangements for the all-day session on 15 May 2018** (final draft programme attached)
   - Agree how to structure the lines of enquiry
   - Discuss which members would like to lead on which issues
7. **Activities after the 15 May**
   - Feeding back highlights to commissioners
   - Timeline for producing the written report and advice
   - Follow-up teleconference/receiving review team members' feedback
8. **Any other issues**

Contact: Sue Dutch: sue.dutch@nhs.net; 0113 80 70443

London Clinical Senate

**Advice on proposals for mental health services in Camden and Islington**
**Discussions with stakeholders – 15 May 2018**

## PROGRAMME

**Venue: Conference Room, St Pancras Hospital, St Pancras Way, London NW1 0PE**

| Time | Activity | Purpose/notes |
|---|---|---|
| 8.45 - 9.430 | Review Team discussions | Preparatory session |
| 09.30 - 11.00 | Opening presentation, questions and discussion:<br>*Dr Vincent Kirchner, Medical Director, Camden and Islington NHS Foundation Trust*<br>*David Wilmott, Interim Director of Nursing, Camden and Islington NHS Foundation Trust*<br>*Deborah Wright, Head of Social Work and Social Care, Camden and Islington NHS Foundation Trust*<br>Dr Jeff Halperin, *Head of Psychology* and Psychotherapy Services, *Camden and Islington NHS Foundation Trust*<br>*Dr Rathini Ratnaval, Clinical Lead for Mental Health, Islington CCG*<br>*Dr Alex Warner, Clinical Lead for Mental Health, Camden CCG* | • The review team will receive a presentation on the local context, the case for change and proposed model of care, the benefits/ improvements in quality and outcomes they aim to bring and the underpinning evidence. This will include capacity planning and modelling of activity/flow across the pathway proposed implementation steps and sequence and key milestones, risks and mitigation.<br>• The review team will have the opportunity to explore the proposals with key stakeholders in the Trust and CCGs, focusing on key issues identified from the review of documentation submitted. Key areas that the review team would like to explore have been shared in advance. |
| 11.00 - 11.15 | Break – move to different rooms | • Discussions with service users will be held in different rooms |
| 11. 15- 12.15 | Discussion with service users<br>*In this session the review team will meet with two groups of service users (running simultaneously).*<br>*The Review Team will split into two groups. The discussions will be held in separate rooms and in informal style guided by the service users.* | • Opportunity to discuss the case for change and model of care across the whole pathway with service users who have been involved in developing the proposals and/or who may be affected by them.<br>• The session will explore how service users are involved; hear what is important to service users and how their opinions and experiences have informed proposals and listen to/discuss overall views. |
| 12.15 - 12.45 | Lunch break | |
| 12.45 - 13.30 | Discussion with representatives of the Local Authorities Social Services<br>*Sarah McClinton, Director of Adult Social Services, London Borough of Camden*<br>*Maggie Kufeldt, Director of Adult Social Services, London Borough of Islington* | • Opportunity to understand Local Authorities priorities for mental health care and services and views on the proposals – case for change, model of care, evidence base and improvement goals |

| Time | Activity | Purpose/notes |
|---|---|---|
| 13.30 - 14.00 | Discussion about the overall proposals from a strategic and operational perspective<br><br>*Angela McNab, Chief Executive Officer, Camden and Islington NHS Foundation Trust* | • Opportunity to explore the case for change, proposals and aims in the context of the Trust's overall strategy, STP alignment, as well as issues of capacity, delivery, key opportunities, risks and mitigation. |
| 14.00 - 14.45 | Discussion with the Clinical Directors of the Trust's divisions which encompass the services being considered<br><br>*Ian Griffith, Clinical Director for Acute Division and Chris Curtis, Clinical Director for Community Division, Camden and Islington, NHS Foundation Trust* | • Opportunity to explore current services, challenges, proposals for change, evidence, aims, capacity planning, overall coherence, risks and mitigation in more depth. |
| 14.45-15.00 | Break | |
| 15.00 – 15.30 | Discussion about proposals for mental health within the context of the Sustainability and Transformation Plan (STP)<br><br>*Paul Jenkins, Senior Responsible Officer for the North London Partners' STP mental health workstream* | • Opportunity to explore how the proposals align with overall plans for north central London, how the STP supports the proposals, key dependencies with other programmes/ pathways, risks and mitigation. |
| 15.30 - 16.00 | Discussion about the crisis care pathway and impact of the proposals<br><br>*Dr Josephine Sauvage, Chair Islington CCG, Emergency Care Clinical Lead and Co-Chair of the North London Partners' Clinical Executive* | • Opportunity to explore current arrangements for crisis care, how the proposals will address current challenges / improve the pathway and how the wider urgent and emergency care system and pathways will align and enable this. |
| 16.00– 16.45 | Final questions and discussion – commissioner perspective<br><br>*Tony Hoolaghan, Chief Operating Officer, Islington CCG*<br>*Jill Britton, Associate Director Joint Commissioning, Islington CCG*<br>*Sarah Mansuralli, Chief Operating Officer, Camden CCG*<br>*Debra Holt, Assistant Director Integrated Commissioning, Camden CCG*<br>*Richard Lewin* - Director of Integrated Commissioning Supporting People, London Borough of Camden<br><br>*Dr Vincent Kirchner will join the end of this session for final remarks* | • Opportunity to discuss the case for change, and proposals with the commissioners who have requested the Clinical Senate's advice, who would lead a public consultation on the proposals and enable change through commissioning. This may cover:<br>o Views on approach, goals, engagement, fit with wider system/other proposals, equalities impact, risks and mitigation, success measures<br>o Significant issues that have emerged from discussions so far<br><br>• An opportunity to revisit/clarify any issues with the Trust Medical Director. |
| 16.45 - 17.30 | Review Team discussion time | |
| 17.30 | Session ends | |

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## Appendix D. Review team members

**Chair: Dr Ian Abbs,** Member of the London Clinical Senate Council, chief medical officer, Guy's and St Thomas' NHS Foundation Trust. Ian Abbs became chief medical officer in January 2011. He joined the Trust as a consultant renal physician and honorary senior lecturer at King's College London in 1994 and has had a distinguished clinical and academic career, which has included a broad range of senior management positions. In addition to his clinical work, Ian has played a key role in the development of clinical academic groups, the management units of King's Health Partners, and was closely involved in work to integrate with Lambeth and Southwark community services.

**Co-chair: Dr Anushta (Nush) Sivananthan,** consultant psychiatrist and medical director, compliance, quality and assurance, Cheshire and Wirral Partnership NHS Foundation Trust, is an old age psychiatrist and medical director at Cheshire and Wirral Partnership NHS Foundation Trust (CWP). She took the position as medical director in 2010 having previously held positions as both the trustwide clinical director for adult services and clinical director for older people's services. She has also held the programme director role for old age psychiatry at Mersey Deanery and is the senior responsible officer for community and primary care integration in Cheshire East.

**Dr Elizabeth Barron**, Consultant psychiatrist, Rotherham Doncaster and South Humber NHS Foundation Trust. After combining psychiatry and GP practice, Dr Barron worked in research, sat on the national steering group for standards in rehabilitation psychiatry and worked in rehabilitation psychiatry in South Essex. She is now NHS consultant psychiatrist promoting multi-professional education in North Lincolnshire, part of Rotherham Doncaster and South Humber Foundation Trust.

**Aileen Buckton**, has been executive director of community services at Lewisham clinical commissioning group since June 2005, and has responsibility for adult social care and health, crime reduction, cultural and leisure services, community and neighbourhood development, adult learning and supported housing. She is currently chair of London's Association of Directors of Adult Social Services (ADASS), has worked in a number of local authorities across London, and has over 25 years' experience in local government management. In the past, she has also served on a number of voluntary organisation management committees and has worked teaching both social work and community development.

**Dr Jacqui Butler** is an Australian-trained emergency medicine consultant who has been working at King's College Hospital in London for the past nine years. King's College Hospital is a major teaching hospital in south east London whose emergency department has one of the highest attendances for mental health service users in London and has an embedded Mental Health Liaison team. Dr Butler is the clinical lead for the emergency department, and specifically the lead for mental health within the department. She finds working with this particular group of patients especially rewarding and has a keen understanding of the challenges involved in providing high quality service and care to them in the emergency care and crisis pathways.

**Marie Crofts** has been a mental health nurse for 34 years and has held a variety of posts within provider and commissioning organisations. She is currently director of nursing and quality in a mental health and learning disability trust within Gloucestershire and Herefordshire (2gether NHS Foundation Trust). She is passionate about improving mental health services through evidence based practice and transforming services through co-production and co-design, and has worked alongside service users and carers in a number of regional programmes and contributed to a book on commissioning CAMHS, as well using her experience to influence national programmes. She is a trustee of Papyrus, the national charity dedicated to the prevention of young suicide.

**Dr Annabel Crowe**, GP and a governing body member of Hounslow clinical commissioning group and clinical director for serious and long-term mental health needs in north west London. Dr Crowe is a GP and has worked in Hounslow for the past 24 years, initially as a partner and now as a sessional GP. She has been the GP clinical lead in mental health for Hounslow for eight years and is currently a governing body member of Hounslow clinical commissioning group. For the past year, she has been clinical director for serious and long-term mental health needs at north west London, and has been closely involved in developing primary care mental health services locally and GP training in mental health. She is currently working on improvement of the mental crisis care pathway across north west London.

**Dr Charlotte Harrison** has been a consultant psychiatrist at south west London and St Georges Mental Health NHS Trust since 2003 and was appointed as the deputy medical director in April 2017. She is the clinical lead for the Phoenix Unit and Wandsworth rehabilitation and recovery service, which provides care and treatment for people suffering from a severe and enduring mental illness in a variety of settings including a high dependency rehabilitation unit, a community rehabilitation unit, a complex needs community unit and supported accommodation settings. She has been a member of the rehabilitation faculty at the Royal College of Psychiatrists since 2009 and the academic secretary since 2013, where she has taken the lead role in designing and developing the annual residential conference programme. She was an author of the joint commissioning guidance for rehabilitation services as well as participating in working groups for relevant areas such as personal health budgets, capacity, mental health law and employment. She completed a masters of business administration (MBA) at Imperial College Business School in 2011 and was a trustee for 2Care, a mental health charity between 2009 and 2016.

**Eleanor Levy,** a patient and carer representative and member of the London Clinical Senate's patient and public voice group. Eleanor has been involved as a patient and carer representative at local, regional and national levels since 2013 and has trained as a patient leader and a qualified mental health first aider. She has experience as a manager in developing multi-disciplinary services in criminal justice, homelessness and community based mental and physical health services and leading client engagement and recovery approaches. Her personal experience in recovery and overcoming obstacles of disability and social exclusion supports her passion in upholding social values and championing diversity. She has sophisticated supervision and performance management skills that bring out the best in staff, with an equally strong commercial project management background, with leadership, communications and change management skills consistent with her chartered manager status, gained for a project supporting patient engagement and governance within the NHS.

**Catherine Otim,** Occupational therapy service lead for Luton and Bedfordshire mental health and wellbeing services provided by East London NHS Foundation Trust. She has worked in various mental health settings, working within inpatient, community, forensic services and has led on the transformation of occupational therapy services in the psychiatric intensive care units within Tower Hamlets, East London NHS Foundation Trust. She currently has responsibility for the mental health occupational therapy service in Luton and Bedfordshire and over the last two years has led on the transformation of these services.

**Dr Ian Petch,** consultant clinical psychologist, south west London and St George's NHS Mental Health Trust, Trust head of psychology and psychotherapies has worked as a clinical psychologist since 1989 in a range of clinical settings, most recently improving access to psychological treatment (IAPT), post-traumatic stress service, CAMHS and early intervention in psychosis. He has worked in a range of professional and service development roles including the governance and development of psychological therapies in primary and secondary care. He has been the clinical lead for the modernisation of adult community mental health services and the clinical lead for the Health Foundation's co creating health self-management support.

## Appendix E. Declarations of interests

The London Clinical Senate provides independent and impartial advice. The review team did not include anyone who has been involved in the development of the proposals on which we are giving advice or who has been involved in, or is likely to be involved in, any part of NHS England's assurance process for these proposals. All review team members formally declared their interests and no conflicts exist.

The review process involved discussions with a range of stakeholders in north central London. The Senate Council includes members associated with north central London. These members have had no involvement in the review process.

## Appendix F. Review terms of reference

London Clinical Senate

### INDEPENDENT CLINICAL REVIEW: TERMS OF REFERENCE

**Title:** Advice on proposals for mental health services in Camden and Islington

**Sponsoring Organisations:** Islington Clinical Commissioning Group, Camden Clinical Commissioning Group and Camden and Islington NHS Foundation Trust

**Clinical Senate:** London

**NHS England regional or team:** NHS England (London)

**Terms of reference agreed by:**

Dr Mike Gill, Chair, Clinical Senate Council

**on behalf the London Clinical Senate and;**

Tony Hoolaghan, Chief Operating Officer, Islington CCG

**on behalf Islington CCG, Camden CCG and Camden and Islington NHS Foundation Trust.**

**Date:** 9 April 2018 (v1.0)

**Aims of the review and advice requested**

Islington CCG (as lead commissioner and on behalf of other bodies noted above) has asked the Clinical Senate to provide independent advice on proposals to improve mental health services in Camden and Islington. Services are provided by Camden and Islington NHS Foundation Trust.

The proposals centre on re-provision of the mental health inpatient accommodation currently provided at the Trust's St Pancras Hospital site in a new purpose built, modern facility that meets required standards and provides a more appropriate therapeutic environment which promotes recovery, respects privacy, dignity, comfort, safety and provides spaces for meaningful activities, including exercise. Constraints of the inpatient accommodation and the St Pancras site make the current facilities suboptimal.

In order to secure the funds required for the development much of the St Pancras site will be sold. This will also enable further development of community mental health services through investment in two community hubs (one in each borough) which would accommodate a range of community mental health services. The expansion and co-location of services that work closely together in modern, well designed facilities, will improve access and support for people with mental health problems.

Further detail on the background to this proposal is appended.

The Clinical Senate has been asked to provide advice on whether the proposals are underpinned by a clear evidence base, in particular:

1. Whether the proposals for changes to inpatient and community mental health services:
    a. will enable improvements in clinical care and quality benefits for patients
    b. are informed by best practice
    c. align with national policy and are supported by STP plans and commissioning intentions
2. Whether the proposals for developing community services will enable delivery of more care in the least restrictive setting
3. Whether the approach of meeting the need for future inpatient demand by further development of community mental health services is robust.

**Scope of the review**

Planning, assuring and delivering service change for patients (NHS England, November 2015) requires NHS England to be assured that any proposal for major service change or reconfiguration satisfies four tests set by the Government in 2010:

1. Strong public and patient engagement
2. Consistency with current and prospective need for patient choice
3. Clear, clinical evidence base
4. Support for proposals from commissioners

The Clinical Senate's advice focuses on the third test. In 2017, the NHS Chief Executive introduced a 5th new patient care test for hospital bed closures. Although mostly relevant to the acute hospital sector and although the proposals relating to this review do not include bed closures, the spirit of the test is relevant in that an objective of the proposals is to mitigate the need to increase mental health inpatient beds in line with predicted with population growth.

This advice requested relates to the proposed changes to inpatient mental health services and the proposed development of two community hubs. It does not involve other services on the St Pancras site. Funding issues are also beyond scope. These are described in order to understand the dependencies underpinning the proposals. Option evaluation is also outside the scope of this review.

The Clinical Senate Council has also agreed a set of principles which it believes are essential to improving quality of care and outcomes. The Council seeks evidence of, and promotes, these principles in the issues it considers and the advice that it provides. They are:

- Promoting **integrated working across health and across health and social care** and ensure a seamless patient journey
- Being **patient-centred and co-designed** (this includes patient experience, patient involvement in development and design of services)
- Reducing **inequalities** (this involves understanding and tackling inequalities in access, health outcomes and service experience – between people who share a protected characteristic and those who do not - and being responsive to the diversity within London's population) Demonstrating **parity of esteem between mental and physical health** for people of all ages Supporting **self-care** and **health and wellbeing**
- Improving **standards and outcomes** (these include use of evidence and research, application of national guidance, best practice and innovation)
- Ensuring **value** (this includes issue such as cost effectiveness and efficiency, long term sustainability, implications for the workforce, consideration of unintended consequences)

## Review Team

The Chair of the Clinical Senate Council will appoint an independent senior clinician with relevant mental health expertise to Co-Chair the Review with a member of the Clinical Senate Council. An external Co-Chair with mental health expertise as the Senate Council members with mental health expertise have declared conflicts of interest.

Overall membership of the Review Team will reflect a multi-professional panel with expertise in the services and pathways being considered. Subject to agreement with the chair on appointment the following perspectives will be included: consultant psychiatrists (general adult, older people and rehabilitation); a psychiatric nurse; a psychologist; two service users/carers (one member of the Clinical Senate Patient and Public Voice and a representative from a service user advocacy organisation); social care; a GP; emergency medicine. Membership will include external expertise, independent of London, as well as expertise from areas within London unrelated to the changes proposed. Advice on membership will be sought from the London Clinical Senate Council and Forum members with relevant expertise, and professional bodies as necessary.

The Review Team will seek advice from other independent experts on specific issues if indicated. The Review Team will not include anyone who has been involved in the development of the proposals being considered or associated with the bodies. All Review Team members will be required to formally declare any interests (which will be noted in the review report) and sign a confidentiality agreement.

## Method

In determining the review approach and formulating advice the Clinical Senate Council and Review Team will draw on the following, which includes guidance on testing an evidence base:

- Clinical Senate Review Process: Guidance Notes, NHS England, August 2014
- NHS England's Service Change Toolkit
- Planning, assuring and delivering service change for patients, NHS England, March 2018

Subject to appointment of the Chair it is expected to involve the following steps:

**Step 1**: **Establish the Review Team**

**Step 2**: **Brief the Review Team** and circulate key documentation for desk-top assessment (the proposed schedule of documentation is on page 4)

**Step 3**: Hold a **Review Team meeting/teleconference** to:

a. agree the overall methodology that will be applied to formulate the advice
b. share desk-top assessment findings
c. identify issues that need to be explored, clarified or validated to assist in formulating the advice
d. agree any further information/documentation that Review Team members agree to be required to inform the review

**Step 4:** Hold a **Review Team "enquiry session"** (1 day) within Camden and Islington to undertake the following:

a. Meet and discuss the proposals with stakeholders involved in their development to explore key lines of enquiry
b. Provide an opportunity for stakeholders impacted by the proposals to share views with the Review Team
c. Debate findings within the Review Team and finalise conclusions

d. Identify any outstanding issues and agree the process for following up (and further Review Team discussion as agreed necessary).

**Step 5:** **Prepare a report** setting out overall findings, conclusions, advice and any recommendations; circulate to the Review Team
Hold a meeting/teleconference with the Review Team to discuss the draft report content and agree any amendments

**Step 6:** Once agreed by the Review Team, **share the report with the Clinical Senate Council** which will:

- Ensure terms of reference have been met
- Comment on any specific issues where identified by the Review Team
- Agree that the report can be issued.

Subject to the schedule of Council meetings the Senate Council Chair may undertake this on the Council's behalf.

**Step 7:** **Issue the report and advice.**

## Documentation required

In formulating advice the Review Team will review documentation that has both informed and been developed by commissioners and the Trust. The CCGs and Trust will make relevant documentation available to the Review Team together with an overarching "navigator" paper to guide Review Team members through the programme's history and the significance of documentation provided. Relevant sections/pages of documents should be highlighted where the whole document does not apply to the proposals or context.

The documentation that will inform this review is anticipated as follows. Excluding those marked with an asterisk*, documents will be provided by Islington CCG. Further requirements may be confirmed following establishment of the Review Team.

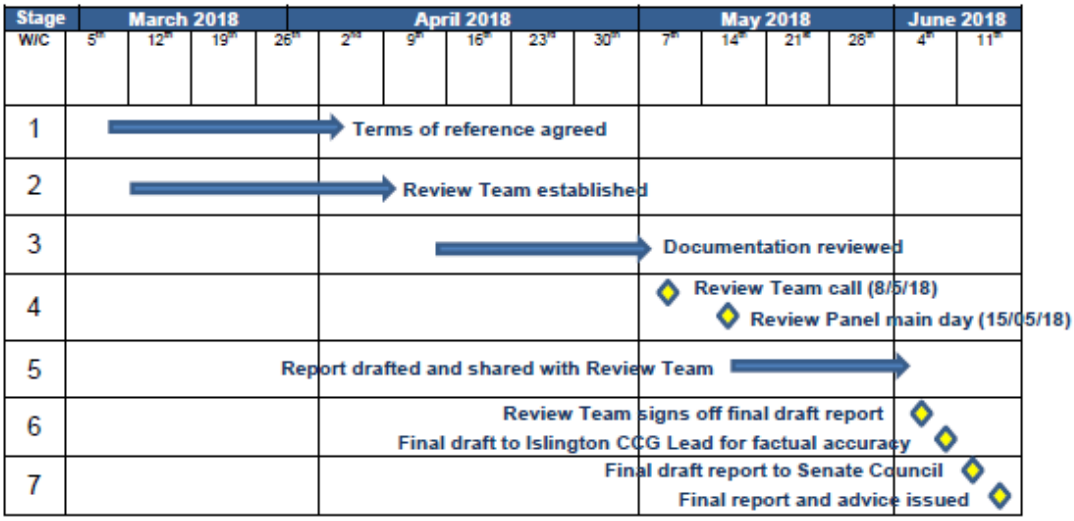
- The case for change (rationale for the proposed change and evidence base)
- Proposed clinical model (description, rationale and evidence base)
- Supporting activity and workforce data and modelling, patient flows and pathways, performance against key quality indicators benchmarking data/patient experience data – available information should be provided initially and any further specific requests will be discussed.
- CQC inspection reports* - to be accessed via www.cqc.org.uk
- Schedule of evidence and best practice that have informed the proposals
- Equality impact assessment
- Equality Delivery System (EDS2) report(s)
- North Central London STP*– to be accessed via http://www.northlondonpartners.org.uk/ourplan/
- Trust Clinical Strategy* - to be accessed via http://www.candi.nhs.uk/sites/default/files/Documents/C%26I_Clinical_Strategy_2016_design.pdf#
- Schedule of evidence and best practice that have informed the proposals
- Process used to develop the proposals including staff, service user and public involvement
- Programme risk log

The Review Team will formulate advice requested based on consideration and triangulation of documentation provided, discussion with key stakeholders and team members' knowledge and experience. The advice will be provided as a written report.

## Timeline

Islington CCG has requested that the advice is available by the end of April 2018 or as soon as possible thereafter. The initial advice request was received on 30 November 2017. This was further reviewed by commissioners and a final request was received on 12 February 2017.

The timeline below is largely based on the time required to recruit the Review Team.




## Risks

It is essential that the processes through which the Clinical Senate formulates advice are robust and the approach outlined is designed to do this. Recruiting the Chair and appropriately experienced Review Team members who are available on the key dates set for the review and ensuring adequate time to prepare for key activities are the most critical elements and pose the greatest risk. Every effort will be made to mitigate this risk.

## Reporting arrangements

The Review Team will report to the Clinical Senate Council which will agree the report and be accountable for the advice contained in the final report.

The Clinical Senate Council will submit the report to the sponsoring organisation and this advice will be considered as part of the NHS England assurance process for service change proposals.

## Report

A final draft report setting out the advice will be shared with the sponsoring organisation to provide an opportunity for checking factual accuracies prior to completion. Comments/correction must be received within 3 working days.

The final report will be submitted to the sponsoring organisation in the w/c 11 June 2018.

## Communication and media handling

Islington CCG (and partner bodies) will be responsible for publication and dissemination of the report. The expectation is that it will be made publicly available as soon as possible following completion. The Clinical Senate will post the report on its website at a time agreed with the sponsoring organisation.

Communication about the clinical review and all media enquiries will be dealt with by the sponsoring organisation.

If helpful, the Clinical Senate will support the sponsoring organisation in presenting the review's findings and explaining the rationale for the advice provided e.g. at a key stakeholder meeting subject to discussion and availability of Review Team members.

Disclosure under the Freedom of Information Act 2000

The London Clinical Senate is hosted by NHS England and operates under its policies, procedures and legislative framework as a public authority. All the written material held by the Clinical Senate, including any correspondence sent to us, may be considered for release following a request to us under the Freedom of Information Act 2000 unless the information is exempt.

## Resources

The Clinical Senate will recruit Review Team members and cover members' reasonable expenses. It will also provide management support to the Review Team, including coordinating all communication relating to the review, documentation sharing, meeting organisation and report production.

The sponsoring organisation will identify a named contact to coordinate the provision of documentation and any other information requested and to assist in coordinating stakeholders' participation in the review at a local level, including organising accommodation for meetings.

If during the course of the review the Review Team identifies any additional requirements to formulate the advice requested, the Review Chair or Clinical Senate Programme Lead will, if necessary, discuss these with the sponsoring organisation and may seek resources for this.

## Accountability and Governance

The Review Team is part of the London Clinical Senate accountability and governance structure.

The Clinical Senate is a non-statutory advisory body and will submit the review report and its advice on the proposals for mental health services to the sponsoring organisation. The sponsoring organisation remains accountable for decision making. The review report may draw attention to specific issues, including any risks, which the Clinical Senate believes the sponsoring organisation should consider or address.

If the Clinical Senate identifies any significant concerns through its work which indicate risk to patients it will raise these immediately with relevant senior staff in the organisation(s) involved. Please note that depending on the nature of the issues identified the Clinical Senate Council may be obliged to raise these with the relevant regulatory body(ies). Should this situation occur, the

Clinical Senate Council Chair will advise the Chief Executives, Clinical Leads and Chief Officers of the provider and commissioning organisations involved.

## Functions, responsibilities and roles

The **sponsoring organisation** will

i. provide the Review Team with the case for change, options appraisal and relevant background and current information, identifying relevant best practice and guidance and other documentation requested. Background information may include, among other things, relevant data and activity, internal and external reviews and audits, impact assessments, relevant workforce information and population projection, evidence of alignment with national, regional and local strategies and guidance (e.g., NHS Constitution and outcomes framework, Joint Strategic Needs Assessments, Sustainability and Transformation Plan, CCG delivery plans and commissioning intentions). Information requested for this Review is set-out on page 4. Additional requests may be made as the Review progresses.
ii. respond within the agreed timescale to the draft report on matters of factual inaccuracy.
iii. undertake not to attempt to unduly influence any members of the Review Team during the review.
iv. submit the final report to NHS England for inclusion in its formal service change assurance process.

**Clinical senate council and the sponsoring organisation** will

i. agree the terms of reference for the clinical review, including scope, timelines, methodology and reporting arrangements.

**Clinical Senate Council will**

ii. appoint a Review Team, this may be formed by members of the senate, external experts, and / or others with relevant expertise. It will appoint a chair or lead member.
iii. endorse the terms of reference, timetable and methodology for the review
iv. consider the review recommendations and report (and may wish to make further recommendations)
v. provide suitable support to the team and
vi. submit the final report to the sponsoring organisation

**Review Team** will

i. undertake its review in line with the methodology agreed in the terms of reference
ii. follow the report template and provide the sponsoring organisation with a draft report to check for factual inaccuracies.
iii. submit the draft report to the clinical senate council for comment, consider any such comments made and incorporate relevant amendments to the report. The team will subsequently submit a final draft of the report to the Clinical Senate Council.
iv. keep accurate notes of meetings.

**Review Team members** will undertake to

i. commit fully to the review and attend/join all briefings, meetings, interviews, panels etc. that are part of the review (as defined in the methodology).
ii. contribute fully to the process and review report
iii. ensure that the report accurately represents the consensus of opinion of the Review Team

iv. comply with a confidentiality agreement and not discuss the scope of the review nor the content of the draft or final report with anyone not immediately involved in it.
v. declare, to the chair and the clinical senate manager, any conflict of interest prior to the start of the review and /or any that materialise during the review.

**Contact details of key personnel coordinating the review process**

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Final version (with final timeline): 06.04.18

## Background

Mental health inpatient services provided by Camden and Islington Foundation Trust are currently provided on two sites; St Pancras in Camden and the Highgate centre for Mental Health in Islington. Facilities at the St Pancras site not fit for purpose. Wards are accommodated in Victorian buildings which fail to meet modern standards for inpatient mental health care and do not provide an effective therapeutic environment. The Care Quality Commission report published in June 2016, highlighted that the Trust's wards require significant improvement. A further CQC inspection took place in December 2017. The report (March 2018) noted some action had been taken.

The St Pancras site is situated on a busy central London street with limited outdoor space. The vicinity around St Pancras has also changed considerably over the years, with the site now overlooked by tall buildings and with building work set to continue, inpatient privacy and dignity will be compromised more and more. Commissioners and the Trust are acting now to address these issues as they are expected to become increasingly problematic in years to come.

Maintaining and upgrading current premises to meet modern standards will require significant investment. Due to the basic structure of some buildings the Trust would still be unable to satisfy the standards prescribed by the Department of Health best practice guidance as well as many important elements of the Clinical Strategy e.g. the St Pancras site does not comply with Standards for Acute Inpatient Facilities (Royal College of Psychiatry 2017). In particular, it struggles with the following standards:

- Clear lines of sight to enable staff members to view patients (type 1 required standard) - additional mitigations have been put in place following the CQC inspection in June 2016 (noted in the December 2017 inspection report published in March 2018).
- Every patient has an en-suite bathroom (type 3 desirable standard).

Similarly, the St Pancras site is limited with regard to:

- Meeting the needs of disabled people due to poor layout and facilities
- Providing unescorted access to outdoor space for patients which limits accessibility
- Providing a comfortable environment as the buildings are often too hot and poorly ventilated

The proposal therefore is to develop 84 mental health inpatient beds at a new purpose built site on land purchased adjacent to the Whittington Hospital (Whittington Health NHS Trust) and another Camden and Islington NHS Foundation Trust site with inpatient facilities, Highgate Centre for Mental Health transfer the current inpatient beds at St Pancras This will involve the transfer and closure of the following 83 inpatient beds currently located at Camden and Islington Foundation Trust's St Pancras Hospital Site.

- Three acute care wards (44 beds)
- One women's psychiatric intensive care unit (11 beds)
- Two rehabilitation wards (28 beds)

The proposed new development would be able to meet these standards and provide a spacious comfortable environment conducive to high quality standards of care. The proposal does not include any change to the overall number of inpatient beds. However, the St Pancras site is located in the London Borough of Camden and predominantly used by Camden residents, though residents from other boroughs, including Islington, also access these inpatient facilities.

The Trust's two women's specific wards are located on the site and both of these, the only exclusive women's wards, will be included in the move. The new site is located in the London Borough of Islington and some patients, and their families and friends, may therefore have a greater distance to travel.
The Trust's plans also include further development of the estate for community services, specifically provision of two community hubs (one in Camden and one in Islington). This would improve access with more care provided closer to where people live and allow more care to be provided in the least restrictive setting.

Projected population growth indicates that demand on mental health services will increase over the next 5-10 years. By expanding community services, commissioners and the Trust also aim to offset the need to increase the number of inpatient mental health beds in future.

The proposals form part of the North Central London Sustainability and Transformation Plan (NCL STP)[1]. This sets out three significant gaps in mental health provision locally:

- The Health and Well Being Gap – not everyone estimated to be in need of care are accessing it, e.g. the need to increase access rates for IAPT provision
- Care and Quality Gap – more should be done to meet people's needs out of hospital; benchmarking data shows that Camden and Islington NHS Foundation Trust admits more people under the MHA than the London or National average
- Financial Gap – without changes to the mental health system locally the demand for inpatient beds will outstrip available resources.

The NCL STP vision is to shift care from being delivered in an acute setting to being delivered in integrated community settings to improve mental and physical health and delivery of social care. The Trust's Clinical Strategy 2016-21 similarly has strong ambitions to deliver clinical care within primary care and community settings where possible and to strengthen the focus on recovery, resilience and independence.

The STP states:

*We plan to develop a 'stepped' model of care supporting people with mental ill health to live well, enabling them to receive care in the least restrictive setting for their needs. The provision of appropriate social care is a key success factor for people with long-standing mental ill health and this will be central to the success of the stepped model.*

*We aim to reduce demand on the acute sector and mitigate the need for additional mental health inpatient beds. We want to improve overall mental health outcomes across North London and reduce inequalities for those with mental ill health, enable more people to live well and receive services closer to home and ensure that we are treating both physical and mental ill health equally.*

Since the development of the STP and the Clinical Strategy key areas have been developed to move this journey forward:

- Development of Practice Based Mental Health in Islington which provides multidisciplinary assessment and advice as the first point of contact with secondary care, based in the community in a non-stigmatising environment. It is expecting to reduce secondary care referrals by at least 30%. The Trust and Camden CCG are working on similar plans for Camden residents, which compliment other community mental health services in the borough.
- A small (1 bed) reduction in acute inpatient beds to develop a Women's PICU for patients in NCL and to avoid out of area placements for these patients

[1] North Central London includes the London boroughs of Camden, Islington, Barnet, Enfield and Haringey

- A number of initiatives to reduce A&E attendance and in-patient admissions have also commenced or are in development and expected to commence in the next few months. These include police and Trust liaison model, mental health suite and mental health nurse triage at A&E.
- There has been some reconfiguration of inpatient beds and work on reducing length of stay which is contributing to the evidence that there is no requirement to increase the current number of inpatient beds to meet future demand.

The STP, Trust Clinical Strategy and the developments in track form the basis of local partners' decision not to increase inpatient beds and to develop larger Community Hub locations so that expansion of community services can be accommodated. Primary Care estate is limited and current Trust community estate is fragmented over many sites.

If the plans do not go ahead there is a significant risk that the inpatient services on the St Pancras Site will not be fit for purpose and will jeopardise the clinical care of patients.

Considerable informal engagement has already taken place with the local community, service users, and staff as well as with MPs and Overview and Scrutiny Committees. Discussions have been informed by explaining and discussion three options:

Option 1: To do nothing. Maintain all existing buildings to a minimum, but safe, standard; do not move the inpatient beds, nor build any new community facilities.

Option 2: Move the inpatient accommodation from the St Pancras site to a newly-built facility next to the Whittington Hospital, opposite Highgate Mental Health Centre, and invest significantly in building new mental health community hubs in Camden and Islington.

Option 3: Move the inpatient accommodation from the St Pancras site to a newly-built facility next to St Ann's in Tottenham (London Borough of Haringey) and invest significantly in building new community mental health hubs in Camden and Islington.

The majority of service users and staff favoured option 2. Overall feedback indicates that stakeholders are mainly supportive of the proposals though some have expressed concerns. These relate to access (the move of inpatient services out of Camden, though the "trade-off" of needing to relocate facilities to a more affordable location to deliver benefits v. benefits that would accrue was felt to be acknowledged) the sale of NHS assets (needed to fund the proposal).

# Glossary

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| ADASS | Association of Directors of Adult Social Services |
| CAMHS | Child and Adolescent Mental Health Services |
| CCG | Clinical Commissioning Group |
| COPD | Chronic Obstructive Pulmonary Disease |
| CQC | Care Quality Commission |
| ED | Emergency Department |
| FYFV | Five Year Forward View |
| IAPT | Improved Access to Psychological Treatment |
| JSNA | Joint Strategic Needs Analysis |
| LA | Local Authority |
| LoS | Length of Stay |
| MHA | Mental Health Act |
| NCL | North Central London |
| NHS | National Health Service |
| PICU | Psychiatric Intensive Care Unit |
| PBMH | Practice-Based Mental Health |
| PROM | Patient Reported Outcome Measures |
| SIM | Serenity Integrated Mentoring |
| STP | Sustainability and Transformation Plan |
| UCLH | University College London Hospitals NHS Foundation Trust |