Response to NHS Chief Executive’s Open Call for Evidence and Ideas

Respondent ID: 154

Organisation name: Berkshire Healthcare NHS Foundation Trust

Type of response: Online and case studies
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<tr>
<td>Rex Haigh</td>
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<td><a href="mailto:rexhaigh@nhs.net">rexhaigh@nhs.net</a></td>
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Please choose the description below that best fits your organisation’s main role:

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**What can the NHS and NHS Commissioning Board learn from national and international best practice to accelerate the pace and scale of adoption of innovations throughout the NHS?**

Organisational culture is too neglected in the NHS - large quantities of altruism are being lost in the cynicism of marketisation.

This culture is grown through the nature and quality of interpersonal relationships, sometimes known as 'emotional intelligence', and is rarely given sufficient thought by senior managers in the NHS.

**What specific actions do you think national NHS bodies, such as the NHS National Commissioning Board, need to take to encourage and stimulate the successful and rapid adoption and spread of innovations throughout the NHS?**

Cross-departmental frameworks for 'complex biopsychosocial disorders' - so that budget wars between different agencies do not prevent good working models being used more widely.

Realisation that complex disorders need complex treatments which need complex research. This does not comply to a dose/response model of drug action, and gold standard RCT research is not suitable or indeed possible for most of it.

1) campaigning by patient groups for more sophisticated public (and political) understanding of personality disorder
2) sponsorship by relevant industry (eg telecoms for patients' peer support networks)
3) academics accepting different forms of research (eg

Do you have any further comments about accelerating the adoption and spread of innovation in healthcare?

Managed innovation networks in specific clinical/service areas - including new fields where little robust research evidence exists, and less than ideal 'evidence-based treatments' are being 'shoe-horned' onto insufficiently informed patient groups.
In mental health, this should particularly include PERSONALITY DISORDERS.

Nottingham’s Institute of Mental Health has a template for such innovation networks (although only local ones so far)

**We would like to be able to follow up interesting comments and case studies. Can we contact you for this purpose?**

Yes

**Do you want to be kept in touch with the next steps in this process?**

Yes

**Do you want to be included in a wider community of interest?**

Yes

**What specific actions do you think local NHS bodies, such as providers and Clinical Commissioning Groups, need to take to encourage and stimulate the successful and rapid adoption and spread of innovations throughout the NHS?**

Training of senior managers (commissioning and providing) to achieve:

1) Open-mindedness about the social fringes of mental disorder: they can no more be medicalised into ‘brain malfunction’ than they can be excluded from psychiatric territory.

2) Understanding how pooled budgets and joint working will not only reduce morbidity and mortality, but also reduce long-term care costs in various sectors.
## QIPP Questionnaire: August 2011

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<th>1</th>
<th>Number of referrals into the service for financial year 2010-2011?</th>
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<td>2</td>
<td>Is this typical of previous years?</td>
<td>Yes – previous year 25 referrals</td>
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| 3 | Is there a trend? | 19 females  
8 males  
18 Camden clients  
9 Islington clients |
| 4 | Number of people accepted into the service for financial year 2010-2011? | 21 started with the service. All those who attended for assessment were accepted. 4 people did not attend assessment and 2 attended the assessment but did not start with the service. |
| 5 | Is this typical of previous years? | Yes – similar stats |
| 6 | Is there a trend? | Nothing significant. |
| 7 | Number of people who completed treatment in the service for financial year 2010-2011? | 18 completed the 2 years |
| 8 | Is this typical of previous years? | This has increased as prior to 2009 there was no set time limit to the service so clients could stay with the service long term. There is now an active move of programme within the service. |
| 9 | Is there a trend? | Nothing significant |

- Please reply to Lisa: lisa.wilson12@btinternet.com (NPD Evaluations, 36 Riviera Drive, Southend-on-Sea, Essex SS1 2QT if you want to send it by post) by **FRIDAY 2 SEPTEMBER**
- If you can get the numbers directly off computer systems, so much the better
• If you only have time to do estimates, please send us a note about the assumptions you have made to come to those estimates.
• ‘Completed treatment’ probably means ‘planned leaving’ or ‘good outcome’; please let us know if you are using different criteria.
• If you service has different ‘branches’ (ie entirely different treatment options which are not part of a planned sequence), and you have separate figures, please send them for each ‘branch’.
• We’ll use a good range of the vignettes (overleaf) as pen-picture ‘illustration’ boxes alongside the text.
Please give a short description of a typical user of your service, and typical outcome (anonymised AND with written permission that you keep in your records, please). Maximum ONE PARAGRAPH.
3) Growing Better Lives
– proposals for a local cross-agency ‘joined-up’ service for mentally disordered and socially excluded people in Slough

Slough is the most deprived part of the Thames Valley, and the last to be provided with its own community personality disorder service. Before this, service users had to travel to Reading or Aylesbury, often difficult journeys away for people. However, the fact Slough is last to have such a service means that it can be planned in the light of learning from the other recent work in the field, and especially in Thames Valley. Its unique demography can also be accommodated more thoughtfully.

With ex-service users, and as a spin-off from the DH-funded and NHS-managed Thames Valley Initiative, we set up a social firm: ‘Exclusion Link CIC’. Its purpose is “to work with groups of people marginalised from mainstream society by reason of emotional and behavioural difficulties, to help them conquer their problems and reintegrate into society. The company provides courses and therapeutic programmes based on the land, in close contact with the natural world, using the principles of greencare. The client group includes those with antisocial behaviour, persistent petty offending, drug and alcohol problems, homelessness, and long term unemployment.”

The organisation’s current project is funded (£59K over 18 months) by the National Lottery and Mind through their ‘EcoMinds’ programme. The project is in the first third of its period of operation, sited in the council’s garden centre, and is generating local interest and participation. It is also being seen as ‘an adjunct’ to the service users in the local community PD programme, so they can meet and undertake shared activities there in the time the programme is not operating. This has been considerably hampered by the mental health trust’s action to forbid any meaningful partnership between the NHS programme and the Growing Better Lives project. A striking observation has been how the newly commercialised mental health services, particularly in the local NHS Foundation Trusts, are now less flexible and willing to work with third sector partners – or to build the sort of informal ‘user-friendly’ psychosocial culture that most small third sector organisations enjoy. That quality of culture is a *sine qua non* of successful PD treatment programmes.

Notwithstanding, the ultimate aim is to set up ‘A city farm in Slough, in an attractive and accessible public place, to meet local needs for specialist mental health and well-being services’, and to run it ‘in a close and trusting partnership between health, social services, the third sector and others – as a nationally recognised innovation centre’. In practical terms, this will ideally be a ‘one-stop shop’ being cross-agency funded for its operating service revenue – by health (mental disorders, dysfunctional families, addictions, and other social services), MoJ (NOMS, probation), CLG (housing, homelessness), DWP (long-term unemployment and over-reliance on benefits) and possibly education (school-excluded adolescents, young carers). It is likely that such a complex revenue arrangement would take some years, with accumulating evidence of success, to achieve.

To raise capital for the service infrastructure is likely to be more straightforward: initial discussions with Slough Borough Council have identified some suitable sites, and appreciation of the likely social benefit; this would require the use of social investment bonds. Other possibilities include DEFRA ‘multifunction agriculture’ grants, charitable funding, or philanthropic local landowners. However, the detailed work of finding writing suitable business plans has only just begun.

Numerous stakeholder benefits are expected, particularly for service users and for the local ‘mental health ecology’:

**Service users:**
- Self-referral without needing psychiatric assessment
- Pathways in from all relevant agencies
- Comprehensive user-led support systems
- Effective psychosocial self-help groups, before and after therapy
- Facilitative power relationships
- Access to wider (regional and national) expertise in service user involvement
• Paths out into employment or education

**Mainstream mental health services:**
• Reduced long-term hospital admissions for borderline PD
• Improved service user experience and satisfaction
• Less crisis management needed
• Reduced medication use
• Improved mental health of service users’ children

**Other areas of NHS provision:**
• Less frequent GP attendance (commonly called ‘heartsink’)
• Less medically unexplained symptoms and expenditure on unhelpful investigation and referral
• Reduced calls to 999 services, and self-harm, and A&E attendance
• Less complaints about unhelpful care

**Other public sector providers are also likely to benefit:**
• Improved parenting prevents children being taken into local authority care
• Treating mental disorder in minor offenders, especially women, will prevent unhelpful imprisonment
• Self-medication with street drugs and alcohol is likely to be less with definitive treatment of underlying causes
• Service users successfully completing treatment programmes are more likely to find work, training or education - and rely less on state benefits.

**‘World Class Commissioning’:**
• Local leadership from commissioners
• Partnerships with shared vision and encouragement of innovation
• Continuous engagement with service users, clinicians and public
• Planning priorities to meet unmet public mental health needs
• Strategies for areas of high morbidity and poor provider choice
• Continuous quality improvement mechanisms
• Robust and sustainable business AND clinical models

This example has been included in the ‘innovation’ submission mainly because it demonstrates the difficulties of trying to implement ideas to run NHS services in new ways. Despite having a team of about eight extremely committed individuals all working pro-bono (including senior clinicians, ex-service users, business advisors, statutory sector managers), and working up the plans over nearly five years, there is little tangible benefit yet. The potential impact on deprived and excluded individuals, and on the culture of the local care system, could be substantial - but the current structures seem to be blocking rather than facilitating it all.

*Rex Haigh*
*31 August 2011*
1) The National PD Development Programme 2003-2011
   – a policy initiative in community mental health

(several research papers have been published and the second draft of a detailed final report for DH publication is in preparation, since the programme closed in April 2011)
2) The Thames Valley Initiative and ‘Mini Therapeutic Communities’
– a user-friendly and cost-efficient clinical model for previously untreatable disorders

Personality Disorder is a common condition with high morbidity and mortality, which was considered largely untreatable by mainstream mental health services until the publication of ‘No Longer a Diagnosis of Exclusion’ in 2003. However, a small number of specialist units had been running residential treatment programmes for decades – the ‘therapeutic communities’ or TCs. In the public mental health sector, the Henderson and the Cassel Hospitals were the best known – but there has also been a long history of their use in residential children’s care, prisons, learning difficulties and addictions. In many countries, but not the UK, ‘residential rehab’ is synonymous with therapeutic community.

As well as their almost universal use of different formats of group therapy, they all share some features which are often seen as ‘modern’ or ‘innovations’ in contemporary mental health thinking, such as:

- Close partnership with service users (‘communalism’ as described in the 1960s)
- Defined pathways and progression (often with closely defined goals and expectations)
- Staff induction, training, support, supervision (and close attention to team dynamics)
- Self-help and mutual support (within an overall ‘containing framework’)
- Focus on relationships not symptoms (in line with modern ‘recovery’ ideas)
- Expectation of individuals taking responsibility for their own actions (‘reality confrontation’)
- Accredited service standards (currently administered through RCPsych)
- Cross-sector working (staff movements, and referral between services)
- Open communications (eg ‘culture of enquiry’)
- Personal development of emotional intelligence (required of staff AND service users)

With cost pressures and reduction of inpatient provision since the 1980s, residential communities gradually closed and several changed to non-residential format, using the same therapeutic principles. The core service from one of these ‘day-TCs’, Winterbourne House in Reading, was used as one tier of a more inclusive and extensive model that formed the clinical backbone of the successful pilot bid for the ‘Thames Valley Initiative’. The client group for these services are mostly those diagnosable with moderate or severe borderline personality disorder (BPD), and who have not been helped by simpler treatments (such as outpatient psychiatric or psychological treatment, or programmes such as IAPT).

Restricted resources and expectation of providing a community PD service to a population of 2.1m required further innovation. Hub services are all 3 days per week (the previous main model was 5 days) and these now exist in Oxford, Aylesbury, Milton Keynes and Slough as well as the original unit in Reading. The three day programmes free staff for other work on the two days the therapy groups are not meeting, and it frees the service users (sometimes somewhat reluctantly) to engage in more activities just with each other and with their own communities.

In addition to the hubs, the population needs could not be addressed unless services were also provided in towns that were geographically remote from the hubs: these are called the ‘spokes’. In different forms, but using the same therapeutic principles, these use clinical staff based in the hubs to run smaller programmes which now exist in Wallingford, Witney, Banbury, High Wycombe, Amersham, Newbury, Wokingham, Bracknell and Maidenhead.

Several of them use a model described as a ‘mini-TC’ for up to 16 service users having, total staff contact time of less than 8 hours per week. In the ‘hub’ services the provision is now for up to 40+ people with up to 15 hours contact per week (the previous 5 days per week services would have 20-40 people for 25+
hours per week). Similar group therapy / mini-TC programmes have been set up entirely independently elsewhere in the country, for example 'Diverse Pathways' is part of the Leeds Managed Clinical Network.

Figures published for the Wallingford programme in demonstrate considerable cost benefits. The group was researched in its early stages (2005-2007), with seven participants who had therapy groups including staff for 5 hours each week. Comparison of pre-treatment and post-treatment service use showed:

- GP attendance reduced by 70%
- CMHT attendance decreased by 98%
- 97% reduction in psychiatric admissions
- 100% reduction in suicide attempts
- 88% reduction in self-harm events.

On psychometric tests, CORE scores showed a large reduction, particularly in the risk-to-self section.

The authors of the Wallingford research calculated the costs of the programme, and costs of the treatment avoided had service use not changed. The savings made were estimated to be £70,000 over one year. The cost offset extrapolation of these figures for a mini-TC for fourteen service users would be an annual saving of £109K. Now the group has grown to a sustainable size of 14, the savings are likely to exceed this by a considerable margin.

Other innovations in the Thames Valley Initiative (TVI) include:

- Inpatient inreach
- Assertive engagement (with 3rd sector)
- Step-down and next-steps programmes (with 3rd sector)
- Programmes for parents of children in care (with forensic services)
- Psychoeducation and support for carers (with 3rd sector)
- Psychoeducation and support for young carers (with 3rd sector and CAMHS)
- User-led diagnosis groups
- Facilitated independent self-help groups
- Medication planning seminars (with pharmacy staff)
- Programmes for elderly adults
- Ex-service users as staff trainers
- Ex-service users as co-therapists
- Cross-sector theoretical, experiential and clinical teaching
Female - age 33

Attended therapeutic support services – Dartmouth Park and current under Psychologist at CMHT (continuous)

Use of crisis houses – Drayton Park over last 2 years has needed support twice. This has decreased since using SDS

Diagnosis of BPD and dis–associative disorder previous diagnosis include PTSD.

Customer has stated that they find their depressive and anxiety symptoms have made social interaction very difficult which in turn has affected their confidence. The support that this customer was seeking at the beginning of their engagement with the service was interview skills, self confidence, becoming less isolated and having a structure to their time and routine.

Some of the key areas that we have been able to support and have seen progress and outcomes achieved are

Social networks – there has been access to the emergence social programme And a more regular interaction with friends.

Physical health – there has been access to gym and health related activities and plans draw up supporting diet.

Vocational – this customer is highly functional and is continuous in researching positions and training and being offered voluntary activities to part take in. Some of these have included one day a week Art based positions/ children groups in galleries. This customer is also interested in Art Therapy.

Mental Health – having been able to access and commit to the psychologist which has now had a positive impact on the acceptance of their situation and management of presenting issues.

Living Skills – a more structure approach to the week and general care of self and now maintains housing issues

On the whole this customer represents a typical customer in regards to the willingness and desire to engage in activities, training and work towards returning to work. Overcoming the areas of difficulty confidence, anxiety, ways of seeing their situation as impossible, disclosure, acceptance of own diagnosis and motivation.