South Staffordshire and Shropshire Healthcare
NHS Foundation Trust

South Staffordshire Mental Health Services

"No Delays" Service Improvement Project

A Discussion Document on Redesign Proposals for Service Improvement

going the extra mile

Table of Contents

Executive Summary

This document presents the results of work conducted over the last 12 months on "No Delays"– the Mental Health Service Improvement Project for the South Staffordshire Division of the South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSSHFT). The document reflects how, in conjunction with our stakeholders, we have reviewed our services, explored the options for improvement across seven pathways and shaped the proposals for future re-design.

The proposals herein reflect what we sincerely believe are the most appropriate options for evidence-based, incremental stepped-changes to our services that can benefit not only service users and carers, but ultimately all of our stakeholders.

Based on the fundamental principles of a non-ageist, stepped-care approach to service delivery, we are now able to share our recommendations and begin a period of wider engagement and collaboration. It is envisaged that, if agreed, the models developed will deliver a high-quality experience for our service users and carers within a system that is flexible, efficient and best able to meet the demands of the future.

We hope to demonstrate how our proposals will lead to recovery-focussed service provision that will be outcome driven and that will demonstrate its efficacy through a number of transparent improvements in service provision.

These tangible improvements will include:-

- ***Needs* rather than age led services with a recovery ethos so that there is no upper age limit preventing access to the full range of services for individuals presenting with complex mental health needs and no lower age limit for adults presenting with dementia.**
- **Locality teams that better mirror local authority and practice based commissioning boundaries.**
- **Shared understanding and deployment of the "stepped-care" model to ensure interventions are delivered in the right place and at the right time.**
- **A revised single point of access for local services that improves the timeliness of access by being more responsive and adaptable to local need.**
- **Re-designed services that ensure that there is a timely and appropriate face-to-face assessment of all referrals made to the Community Mental Health and Crisis teams and no signposting without assessment by a member of the team.**
- **Extended availability with Community teams being accessible from 8am to 8pm, 7 days per week.**
- **Development of capable Home Treatment teams providing intensive interventions that will offer adult and older adults presenting with functional disorders an alternative to hospital admission.**

- **Enhancement of Early Intervention services for younger adults to include a multi-disciplinary approach to the detection and treatment of psychosis and other complex mental health problems in their early stages.**
- **Improving the experience of carers through the facilitation of early assessment of need and ensuring timely access to appropriate information, assessment and support.**
- **Modern Day Opportunities that are equitable across South Staffordshire, recovery focussed, supportive of service users in crisis and that enable social inclusion.**
- **A transformative and needs-led Dementia Service that will deliver the recommendations of the National Dementia Strategy in full.**
- **A multi-disciplinary "care package" approach to psychological therapies that will ensure timely access to a range of evidence-based interventions.**
- **Offering alternatives to hospital admission.**
- **Reducing the length of hospital stays.**
- **Improving and minimising transitions for service users, thus ensuring an improvement in the service user experience through a smooth, high-quality journey through services and across services.**
- **Enhanced collaboration between Community teams and primary care providers including development of locality forums.**

We hope that you will find this document both informative and stimulating and we hope that you will share with us your comments, compliments and positive criticisms so that your voice is heard and your opinions incorporated.

1. Introduction

1.1 "No Delays" is the name given to the Service Improvement Project for Mental Health Services in the South Staffordshire Division of the South Staffordshire & Shropshire Healthcare NHS Foundation Trust (SSSFT).

1.2 Commencing in April 2008, "No Delays" was born of a commitment to work together with commissioners to bring about measurable improvements in key areas of our services, with the detail of these proposed changes being shaped through engagement with different stakeholders.

1.3 The impetus for change was driven from a number of areas. National drivers set the scene for changes in the NHS and Social Care landscape, including a move towards a "personalised" service driven by service user needs. In addition, care closer to home and local factors including feedback from GP colleagues, service users and carers served to highlight the need for a reshaped service that is able to fully deliver more responsive, timely and appropriate interventions for service users in an appropriate setting.

1.4 Over the last 12 months, seven "workstreams" working across seven pathways…

- **Acute Care & Crisis Care**
- **Dementia**
- **Primary Care Mental Health**
- **Day Opportunities**
- **Carers**
- **Psychological Therapies**
- **Transitions**

…have been working in partnership with service users, clinicians and colleagues from primary care, the local authority and the third and voluntary sectors to develop the proposals outlined in the following pages. We believe these proposals form a portfolio of incremental changes to our services that will benefit not only service users and carers, but ultimately all of our stakeholders.

2. The Purpose of the Document

2.1 This document outlines the favoured proposed model for the future of services from each workstream and across each pathway.

2.2. These proposals are simply options for your consideration. The detail outlined in this document is not "set in stone" and we do not offer these suggestions to you as a *fait accompli*. Instead, this document provides just one crucial part of a wider package of engagement and information sharing in the weeks and months to come.

2.3 Whilst every care has been taken to include as much engagement and as many voices as possible in the development of our proposals, we know that no process of consultation is perfect and that there will always be individuals and organisations that feel they have not been adequately empowered to express their opinion. It is with this in mind that we draw your attention to the latter sections of this document wherein we highlight the next steps in our engagement process and the mechanisms by which your opinions can be expressed and incorporated into our shared final plans.

3. A Note on the Proposals

3.1 What follows is a list of recommendations. It would be disingenuous for us to say that we do not have a vested interest in these recommendations. We believe that the options in this document represent the best available methods for enhancing the delivery of our services such that they best meet the needs of our service users and carers, both now and in the future.

3.2 We do not make this claim lightly. Rather, these proposals have been formed over the last year (and in some cases, longer) and that there are compelling reasons why they have emerged as the preferred option(s): -

Stakeholder Engagement

3.2.1 Where possible, each workstream has brought together the "key players" who have a role within the delivery of that specific part of our service. The development of each workstream has therefore not occurred in isolation but in conjunction with those with a vested interest in seeing the development of robust, efficient and high-quality services.

Pragmatism

3.2.2 Each workstream has developed a realistic proposal. We know that the NHS is a system with finite resources and unlimited demand and our services are no exception to this rule. The changes we propose must be delivered within existing resource and each workstream has been mindful of these parameters when developing their proposals.

Evidence Based

3.2.3 Each workstream has built their proposal according to existing best practice. Where appropriate, guidance from the National Institute for Health & Clinical Excellence (NICE) has been incorporated alongside evidence-based practice and current practice-based evidence. Each workstream has also considered patterns of current clinical activity and the demographics of each locality.

Option Appraised

3.2.4 Furthermore, each proposal presented in this document represents the culmination of a process wherein multiple avenues have been exhaustively explored and a variety of options have been held up to scrutiny to identify the most appropriate model.

Consistency of Vision

3.2.5 Each proposal has been shared and appraised within the "No Delays" process and a consistency in approach has been agreed. We believe that the options outlined below are consistent, not only with each other, but also with other services delivered by the Trust, the local authority and the third sector.

4. Project "Givens"

4.1 Finally, before outlining the proposals themselves, we need to share the "givens" of the project. These are the elements of "No Delays" that underpin our work to date. It is essential that we have a shared understanding of these founding principles so that we can all best understand how the workstreams have reached their proposed new service models. These founding principles are:-

- The provision of non – ageist services
- Changes to locality structures
- Understanding of and deployment of the "Stepped – Care" model

A Non-Ageist Service

4.1.1 Historically, mental health services have been divided into two categories - "working age" services and services for those individuals aged 65yrs and over. "Working age" services are traditionally delivered to those individuals who have left formal schooling and up to age 65. For those aged 65 and over, services are delivered by separate "services for older people".

4.1.2 "No Delays" has adopted a transformative agenda. We firmly believe that the provision of mental health services should be ***needs*** led rather than ***age*** led. Provision of services based solely on the age of the service user institutionalises arbitrary and discriminatory age-distinctions and disadvantages a significant proportion of our older service users.

4.1.3 This new approach is not without contention. There are careful considerations to be made about how best to maintain and incorporate the skills of clinicians to meet the needs of those service users whose distress is characterised by difficulties in adjusting to later life. Furthermore, competencies in differentiating organic disorders such as dementia from other functional illnesses will need to be addressed. That this process is difficult is not in doubt, but we have determined that this should not be a barrier to the delivery of a non-ageist service in itself.

4.1.4 Proposals have thus been developed on an "ageless" basis and services will be delivered to adults aged 18 (16 or above if a service user has left formal schooling) or above with no upper age limit.

Changes in Locality Structure

4.1.5 Currently, our services are delivered through ten working-age adult community mental health teams and six older-adult community teams, aligned to old Primary Care Trust boundaries.

4.1.6 Changes in the commissioning landscape however have led to the establishment of Practice Based Commissioners (PbC) and there is a desire to broadly align our services with these new localities: -

I. **Stafford (including Rural & Penkridge)**
II. **Seisdon**
III. **Cannock Chase**
IV. **South East Staffordshire (including Burntwood & Lichfield)**
V. **Tamworth**
VI. **East Staffordshire (including Burton & Uttoxeter)**

4.1.7 In making these locality changes, we will not only be addressing the desires of commissioners and our colleagues in primary care but also our services will be delivered in

locality teams that are largely representative of district and borough council boundaries. The richness of data this transformation will bring will better allow us to consider issues of equity and division of labour in addition to building on natural geographical populations that mirror how service users and carers access services.

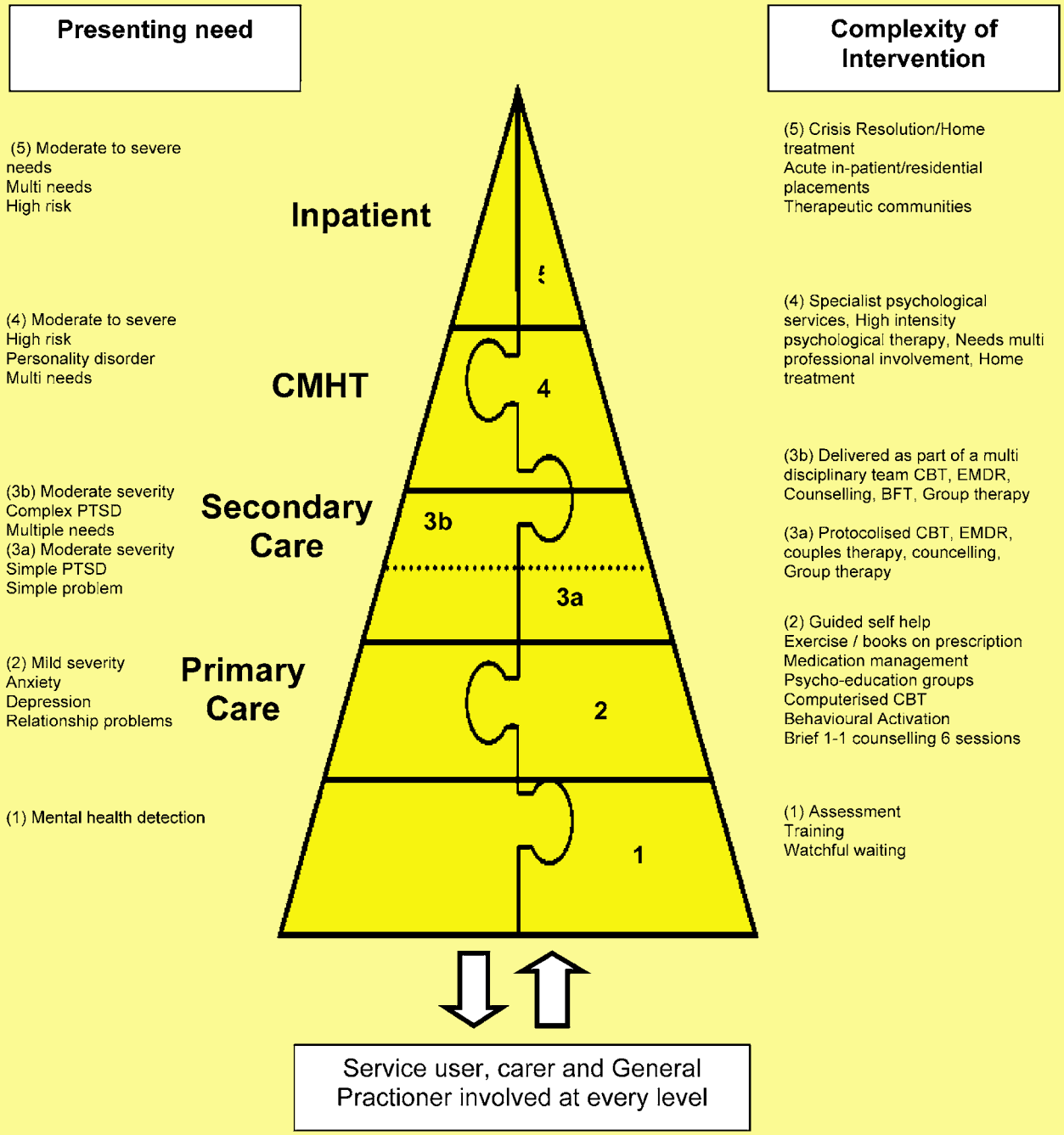
"Stepped-Care"

4.1.8 The final assumption on which proposals are based is that we have a shared understanding and deployment of "stepped care" with our colleagues in primary care.

4.1.9 The majority of service users with mental health needs initially present themselves and are subsequently treated within a primary care setting. Historically there has often been poorly defined or absent access criteria to reflect where, when and what type of service can best meet the needs of the service user and this lack of clarity has led to frustration in the experience of using, referring to and providing services and often causes further delays and disruption.

4.1.10 Using the "Stepped Care" approach, the threshold for access to specialist services and admission to hospital will be made explicit. The diagram below represents the stepped-care model and demonstrates where timely and appropriate services for service users with differing levels of need will be delivered.

The Stepped-Care Model



"Step 0"
Mental health promotion
Mental Health prevention
Anti stigma campaigning

"All Steps"
Advocacy
Carer Support
Day Opportunities

5. Proposed Model for Acute Care & Crisis Services

5.1 Introduction

5.1.1 Our vision is to enable service users to stay in their home, remain out of hospital and continue to be socially included. The focus of this pathway is therefore to ensure that – through re-design and the provision of enhanced services - we can bring about this vision for the highest number of our service users.

5.1.2 Currently, our acute and crisis services are delivered via in-patient facilities at St George's Hospital, Stafford, George Bryan Centre, Tamworth and Margaret Stanhope Centre, Burton and via Crisis teams covering the east and west of the patch. Psychiatric Liaison provides a service to the acute hospitals at Mid Stafford General and Queens Hospital, Burton. Alternatives to psychiatric hospital admission such as the provision of Home Treatment are currently significantly limited and current service provision is not fully inclusive of this critical service.

5.1.3 Despite best intentions and despite the availability of new and robust community services there are occasions when psychiatric hospital admission is wholly appropriate. When admission to hospital is indicated we will ensure that this transition occurs as smoothly as possible and will provide an in-patient stay that is recovery focussed, delivered by a multi-disciplinary team of professionals and that addresses issues of client choice.

5.1.4 Our enhanced service brings together all of these issues by highlighting critical changes in several aspects of our care provision: -

5.2 The Service User Group

5.2.1 It is the aim of our Acute Care and Crisis Services to meet the needs of those service users who meet the criteria of level 3 or above on the stepped-care model for mental health provision. This includes: -

- **Service users with psychosis.**
- **Service users with clinical depression or a debilitating anxiety disorder.**
- **Service users at risk of self-harm, suicidal ideation, a history of self-neglect or service users who pose a risk to others.**
- **Service users with dual diagnosis including those with complex mental health needs (as above) and also alcohol or substance misuse problems or a learning disability.**
- **Service users with a personality disorder.**

5.3 "Portals" – Access to Acute Services

5.3.1 There are occasions where service users are perceived to be in such significant distress that they potentially pose a risk to themselves (or occasionally to others). At these times, urgent assessment with a view to offering intensive treatment is required.

5.3.2 The initial indication that a person is in need of mental health care can take place in a variety of settings, e.g. within a GP practice, police station, A&E department, social service area office, voluntary organisation, education service, work place, etc. We propose a system in which there is a "single step" from these key points of access into a "one stop shop". Here, assessment will be made and on-going care coordination and navigation will be put in place using the CPA (Care Programme Approach) process. It is, therefore, proposed that:-

- **Referrals will be made to a single point of access (SPA) based within a local community team that is available between the hours of 8am and 8pm,**

7 days per week. Once technology is available, a single telephone number covering all localities will be introduced.

- **Referrals between 8pm and 8am will be addressed by a local, dedicated Out-of-Hours Crisis Service.**
- **Referrals will be accepted from a variety of community services (including self and carer referrals).**
- **A "duty system" will perform initial information-gathering duties, risk assessment and referral processing.**
- **The service will provide a rapid response (currently the response time is within 4 hours of referral and, through service change, this response time will reduce to within 2 hours when a local, urgent response is required).**
- **The response will be delivered in the most appropriate location (e.g. the home of the service user, a police station, at the community base or at a psychiatric emergency room).**
- **Both the SPA and the response will be multi-disciplinary in composition (with "on call" arrangements).**
- **Links to other specialist services and the third sector will be enhanced.**

5.3.3 In addition, **it is proposed that liaison psychiatry will also act as a "portal" to our service** and will be able to refer service users to the SPA if required. Again, this service will work from **8am to 8pm, 7 days per week** and will hand over to our Crisis/Home Treatment service (see below) overnight.

5.3.4 It is proposed that the focus of SPA is on inclusion. That is, there will be no work and no referral that is not immediately accepted into the service. Only where the referral is found, after assessment, to not meet the criteria for secondary services will the referral be signposted out. At no point in this process will the referrer be expected to re-refer the service user to another agency.

5.4 How We Assess Referrals

5.4.1 An assessment of the needs of the referred service user will be made. Where a referral is established to be non-urgent, the needs of this service user, alongside relevant information, will be outlined and addressed within 21 days. This may be done through allocation to the community mental health team or through signposting to other services. The service will ensure that each case is held until another service has "picked up" the service user.

5.4.2 As mentioned, **it is proposed that *urgent* referrals will be seen within two hours.** This will include "appropriate adult" and other urgent assessments (e.g. Mental Health Assessments). **Following this initial, urgent assessment, the service user will be assigned to the Home Treatment team or back to the Community Mental Health team for ongoing work.**

5.5 The Community Mental Health Teams (CMHTs)

5.5.1 These teams are locally based and it is proposed that the teams will operate from **8am to 8pm, 7 days per week**. There are three essential functions carried out by the CMHTs: -

- Assessment of referrals via SPA / Duty.
- Therapeutic navigation of the service user via CPA.

- Preventing breakdown of care and delivering recovery-focused interventions.

5.5.2 Individual packages of care will be drawn-up with service users and carers and will be delivered in community settings. **Routine Outpatient appointments will not be necessary as all care plans will be based on and delivered to individual needs.**

5.5.3 In terms of the composition of the CMHTs, **it is proposed that there is an emphasis on generic workers with a set of core competences**. For example, psychological therapies will be delivered by a skilled workforce under supervision rather than a designated clinical psychologist per se. In addition, STaR (Support Time and Recovery) workers will employ a range of skills, either directly or with other colleagues, to help move service users towards recovery using a bio-psycho-social approach to care.

5.5.4 There will be an emphasis within the CMHTs of an inclusive approach to care with a proposed shift in emphasis from the strict medical model to a socially inclusive recovery-focussed model.

5.5.5 Pivotal to the function of the CMHTs will be **the proposed introduction of liaison workers (e.g. dual diagnosis, personality disorder and forensic) who will provide caseload support, risk management strategies and supervision to the teams.**

5.6 Assertive Outreach and Early Intervention Services (AOT / EIS)

5.6.1 These teams are currently operating across South Staffordshire and provide nurse-led packages of care to a discreet group of service users. **It is proposed that, in line with policy implementation guidance, these services will be enhanced to provide a multi-disciplinary approach and for transition to and from these services to be via CMHT single point of access**. All service users within AOT and EIS will be cared for within the Care Programme Approach (CPA) process and a range of skills will be employed to assist in moving the service user towards recovery. In addition, the EIS will have a substantial role in the early detection of psychosis or other major mental health problems.

5.7 Home Treatment Teams (HTT) & Out-of-Hours Crisis Services

5.7.1 It is proposed that HTT will be developed to provide a multi-disciplinary alternative to psychiatric in-patient admission by engaging with service users for packages of intensive home-based care lasting up to four weeks. In addition, the service will provide the "crisis response" service for service users outside the times operated by standard crisis service (i.e. after 8pm until 8am).

5.7.2 It is proposed that the HTT will operate as two teams, serving the east and west regions of our area separately. **The HTT will be delivered within the homes of service users and the multi-disciplinary teams will deploy a range of skills and functions including: -**

- **Prescribing and medication management.**
- **Psychological interventions.**
- **Referring to and drawing upon acute day treatment within modernised "day opportunities".**
- **Operating within a multi-disciplinary framework with dedicated medico-nursing, social care and occupational therapy staff.**
- **Performing an assessment role within A&E or other emergency settings**

(including Section 136 - Place of Safety and Mental Health Act assessments).

- **Linking with and supporting third sector "crisis homes" across the region.**
- **Developing out-of-hours arrangements with other specialist services (Child & Adolescent Services - CAMHS, Learning Disabilities, Forensic Services etc.).**

5.8 In-patient Provision

5.8.1 Proposals with regards to the current deployment of and availability of in-patient bed resource are currently pending and will focus on the provision of high dependency bed resource in the east, re-provision of in-patient function via home treatment beds, reduction in length of stay and alternatives to hospital admission via acute day treatment, day resources and work with the third sector regarding the development and support of "crisis house" services in the community.

5.8.2 It is proposed that where an in-patient stay is considered appropriate (either informal or formal), this will be facilitated and managed through the HTT, with each locality having a (flexible) allocated number of beds available to them. In-patient provision will thus be considered a "resource" attached to localities and will sit alongside "crisis houses" provided by the third sector.

5.8.3 It is proposed that psychiatric in-patient provision will be overseen by a clinical lead (from any profession) that will have recognised competencies for delivering safe, evidence-based care within such settings.

Certain elements of the following principles are currently deployed across in-patient services and it is proposed that these are enhanced and robustly applied: -

- **Clear and recognised purpose of admission based on measured criteria with clinical outcomes being agreed prior to admission with the service user and the clinical teams.**
- **Reduced length of stay – the aim being a maximum duration of 14 days (for informal admissions).**
- **Robust deployment of transition pathways.**
- **Harm minimisation will be at the core of the service.**
- **Therapeutic interventions will be delivered as part of a care plan agreed and executed by in-patient staff supported by the CMHTs.**
- **There will be a focus on recovery with close working with STaR workers.**
- **A gender-sensitive approach to care.**

5.8.4 The following milestones are currently deployed across in-patient services to some extent and robust and equitable deployment is proposed: -

- **Purpose of admission with a clear package of initial care and identified outcomes will be agreed prior to admission taking place in the majority of cases.**
- **Risk and needs assessment will commence prior to admission and be continued from the day of admission.**
- **Physical examination will occur on the day of admission with reasons for any deviance from this clearly evidenced and documented.**
- **Orientation to the ward and the staff will occur within 24-hours of admission.**
- **At 72-hours after admission, a further assessment (including full physical and detailed risk assessments) occurs.**

- **Within five days, a package of intervention will be implemented, pre-discharge CPA and a carer assessment will occur.**
- **Treatment reviews will occur daily and physical, social, spiritual and psychological outcomes will be measured.**
- **Discharge planning will occur in conjunction with the CMHT (or other appropriate team).**
- **Engagement with the CMHT (and primary care) is ongoing throughout admission.**

5.8.5 It is further proposed that care planning during admission will be via clinical pathways and influenced by NICE guidance. The skills and clinicians within the CMHTs, HTT and wards will be fluid. Dedicated supervision, training and development will be in place and an ethos of "progressive" in-patient care will be fostered.

5.8.6 There is also a proposal to move towards the delivery of "psychiatric emergency rooms" as an alternative place of assessment to A&E rooms for service users presenting between 8pm and 8am.

5.9 Intensive Care / High Dependency (ICU / HDU)

5.9.1 Access to HDU / ICU will be maintained via parent wards. These units will predominantly cater for service users, whose needs are greater, require closer observation and/or who require more acute therapeutic interventions, with the aim of repatriating service users to the least restrictive environment at the earliest opportunity. **It is proposed that, in addition to these services, "vulnerable adult" beds will also be available within localities.**

5.10 Proposed Outcomes

5.10.1 The changes outlined above will yield a number of generic and specific improvements in the service user experience than can be evidenced using the following outcomes: -

- **Increased community participation.**
- **Increased social networks and employment opportunities.**
- **Increased uptake of education and training.**
- **Improved physical health.**
- **Improved mental health wellbeing and reducing distress.**
- **Increased independent living.**
- **Improved choice.**
- **Increased service user and carer satisfaction.**
- **Increased access.**
- **100% face-to-face assessment of referrals.**
- **The provision of alternatives to hospital admission via HTT and acute day treatment via modernised day services.**
- **Reduced length of in-patient stay.**

6. Proposed Model for Psychological Therapies

6.1 Introduction

6.1.1 The provision of psychological therapy sits at the heart of mental health services. There has been increased interest in the delivery of timely, appropriate, evidence-based therapeutic interventions for service users in recent years stemming from both national and local policies and guidance (e.g. New Ways of Working, Improving Access to Psychological Therapies etc.).

6.1.2 As psychological therapy has such a pivotal role within our services, **the following proposal is based on a model that embeds psychological therapy within each and every service that we deliver rather than maintaining therapy as a separate and distinct entity. In establishing provision of psychological therapy at the core of our business, the proposal allows for the development of a model based on "packages" of care that can be combined and personalised to meet the needs of each service user. The type of care package provided is thus dependent on the complexity of the presenting problem, formulation and intervention.**

6.2 Access to Care

6.2.1 **In line with the proposed stepped-care model of service provision outlined earlier, packages of psychological care will be delivered to steps "3b" and above**. The proposed model will allow us to address some significant aspects of psychological therapy delivery. For example, the provision of an equitable and consistent service across all localities will be achieved by introducing a single set of referral acceptance criteria with shared intended outcomes and availability of the same range of evidence-based interventions across all geographical areas in South Staffordshire. In line with the broader principals of "No Delays", this transparent new service will be needs led and will be inclusive for all service users regardless of age, ethnicity, disability, sexuality, language or spirituality.

6.2.2 Furthermore, the proposed model of care packages will allow us to: -

- Minimise referral-to-treatment time for psychological therapy (to within 18 weeks).
- Open access to more than one NICE approved psychological therapy per presenting need.
- Provide clear and detailed information about our services including outcome data that includes: -
  - Statistically and clinically significant reductions in symptoms as measured on clinical assessment measures (e.g. The Beck Depression Inventory).
  - Statistically and clinically significant improvement in well-being (e.g. The Satisfaction with Life Scale).
  - Statistically and clinically significant improvement in occupational functioning.
  - High levels of service user satisfaction as assessed through feedback and audit mechanisms.

6.3 Delivery of Care

6.3.1 To deliver these objectives, **we propose a model in which care packages are commenced with an indicative limit of 25-hours input per service user and where additional input is authorised by a clinical supervisor.** For each service user, a package of care will be judged complete when: -

- Either significant improvement is achieved….
- Or the service user, supported by the clinician, requests an alternative care package of psychological therapy…
- Or insufficient progress leads to alternative care packages at the same step on the stepped-care model (or negotiated "step up" or "step down").

6.3.2 The model introduces a new approach to disengagement from services with the stepped-care model allowing service users to make transitions up and down the levels of stepped care as their needs change. The value of this model is that ongoing support can easily be transferred both to and from provision in a primary care setting to our secondary care services.

6.3.3 **We propose that packages of psychological therapy will be delivered by a diverse selection of practitioners, all trained to a minimum level of competency**. Those clinicians with higher levels of competence and training will form therapy sub-teams to provide governance, drive service efficiency and effectiveness. In this model, those service users with the greatest need will be aligned with those clinicians with the most competent clinicians.

6.4 Further Considerations

6.4.1 In order to help establish the model of "embedded" packages of psychological care being delivered across all services, a revised "single point of access" (SPA) for referrals into the mental health service is required. Considerations of this revised SPA have been made by other workstreams within the "No Delays" project. Whilst some proposed changes to SPA (see the "Acute Care" section) might be implemented in the short term, **we propose wider consideration be made of a long-term solution, delivering SPA across all statutory and non-statutory mental health, substance misuse, and learning disability services.**

6.5 Proposed Outcomes

- **Wider access to psychological therapies.**
- **Timely access to psychological therapy thus improving the service-user experience and reducing the length of treatment.**
- **A range of therapeutic interventions consistent with the choice agenda.**

7. Proposed Model for Dementia Services

7.1 Introduction

7.1.1 There are currently some 560,000 people in England living with dementia and around 476,000 people provide unpaid care for someone with dementia. Over the next fifteen years it is anticipated that the number of people with dementia will increase by nearly 40%.

7.1.2 There are currently some 7,200 people with dementia in South Staffordshire and projected figures suggest that this number will increase by around 34% by 2017. However, we predict a disproportionate rise in dementia cases in rural areas (up to 55%) as many older people migrate from the city in later life. The majority of people living with dementia will have other long term conditions such as coronary heart disease, diabetes or respiratory disease and are likely to experience difficulties in accessing timely, appropriate care and treatment in the right setting. Many will be living alone. It is crucial therefore to develop early access to diagnosis and home based support in order to avert the medical crisis that so often leads to long term hospital or residential care.

7.1.3 Furthermore, the specific needs associated with young onset dementia; including alcohol related brain damage and learning disability require additional attention because these people often fall into a gap in current service provision.

7.1.4 We propose the provision of a new, specialist Dementia Service across four domains. The service will deliver on the recommendations of the National Dementia Strategy and will be a need rather than an age defined service that is consistent with the plan for Dementia Services proposed by the Joint Commissioning Unit for South Staffordshire: -

7.2 Memory Assessment Services

7.2.1 **Memory Assessment Services (MAS) will accommodate a range of points of "first contact" for those people with memory and/or other cognitive complaints** (e.g. through contact with a GP, health visitor, other statutory or third sector organisations or through contact with general acute hospital services).

7.2.2 Whatever the avenue for accessing MAS, **service users will be offered a timely referral to a specialist practitioner or general hospital liaison team for screening of their cognitive functioning alongside an assessment of their immediate social care needs (and fast-track referral for social care support where appropriate).**

7.2.3 **For those service users with identified problems, a referral to a specialist assessment service will be made.** We envisage that this service will be physically seated within the homes of our service users and/or at clinics within traditional primary care settings. In doing so, we aim to maximise timely assessment within easily accessible locales. **Service users will receive pre-diagnostic counselling prior to an assessment of their physical health, mental health and neuropsychological performance.** This process will be completed by post-diagnostic counselling following assessment.

7.2.4 For those service users who receive a diagnosis of dementia, MAS will offer information regarding impairment and dysfunction, an assessment of immediate need and offer pharmacological treatment

where appropriate. Service users care will be handed over to a designated Dementia Care Manager and the service user (and their carers) will make a seamless transition to the "Looking to the Future" service.

7.2.5 Strengths of Proposed Model

- **The service is no longer age-defined.**
- **The service is compatible with the National Dementia Strategy.**
- **Enables a multi-professional assessment within an easily accessible environment.**
- **Reduces the stigma of dementia being associated with mental illness.**
- **The service specifically addresses the needs of service users (and their carers) with dementia rather than aiming to provide a service within the confines of a generic service for "older people".**

7.3 "Looking to the Future" Services

7.3.1 **Post-diagnosis, service users and their carers will join the "Looking to the Future" (LttF) service. There is no discharge anticipated from this care provision, instead service users and their carers will be routinely assessed throughout their journey living with dementia.** The service aims to provide adaptive provision of care as the needs of the service user and carer change over time. For example: -

7.3.2 **Befriending Role** - The LttF care manager offers an advocacy role alongside information about how best to maximise social inclusion, access to benefits, support, self-help and information about such issues as lasting power of attorney and advance directives. The objective is for the person to live well in the present.

7.3.3 **Counsellor / Enabler Role** - The care manager helps to address the emotional, social and occupational needs of the service user and their carer. Needs assessments are provided to help prevent and resolve behaviours that may challenge others. Medication assessment and management (including cholinesterase inhibitors) are facilitated. Mental capacity assessments are addressed to assist in complex and emotionally fraught decisions - for example, driving and financial competence.

7.3.4 **Therapeutic Navigator Role** - The care manager will assist in addressing issues relating to medical care and home treatment (including medicine administration), assistive technology and provision of day opportunities. Where appropriate, the care manager will also guide the service user and their carers though transitions to nursing and/or residential care in addition to support around the end-of-life and grief counselling.

7.3.5 Alongside these three broad roles, the care manager will assist in ensuring that each specific case receives the appropriate clinical and social care involvement (e.g. functional rehabilitation, cognitive rehabilitation, therapy services, social work and/or pharmacological interventions).

7.3.6 Strengths of Proposed Model

- **Early interventions will be provided that are "fit for purpose".**
- **Continuity of (timely) support.**
- **Provides a service for family / carers who are in significant psychological distress.**
- **The dementia care managers will develop relationships with service users and carers and will engage in preventative interventions, thus minimise the onset of crises and the need for acute inpatient admissions.**

7.4 Care Home Education and Support Service

7.4.1 Currently the Care Home Liaison service provides interventions for older people referred to the CMHT from care homes. There is inequity in provision with the west of the patch (Cannock, Stafford and Seisdon) having a very small resource of only one CPN. It is proposed that this service is enhanced as the Care Home Education and Support Service (CHESS) to provide equity across South Staffordshire to improve the quality of care, avoid the breakdown of care home placements and prevent unnecessary hospital admissions by employing a dedicated, multi-professional support and intervention service.

7.4.2 Workforce development and resident support are crucial in delivering person-centred care within care homes. CHESS combines the provision of education for care home staff with practical support, assessments and interventions to mange or resolve challenging behaviours.

7.4.3 Delivering NICE compliant, non-pharmacological interventions for the management of challenging behaviours will require psychological approaches based on addressing unmet needs and/or addressing unsupportive environmental settings. **CHESS will therefore aim to deliver a wide variety of psychological interventions including behavioural analysis, functional analysis, functional displacement, low arousal management of aggression and simulated presence therapy.**

7.4.4 In this respect, **CHESS will aim to make a cultural shift towards delivery of a recovery model.** The recovery based approach focuses on the strengths of both the person and the care setting, defines dependency and challenge in terms of needs to be met, understands the function of the behaviour and implements time-limited supported learning interventions and programmes to achieve needs-led goals.

7.4.5 Strengths of Proposed Model

- **Prevention of crisis-driven hospital admissions that are a source of significant distress to service users and carers.**
- **Offers and evidence-based an NICE compliant approach.**

7.5 In-patient Provision

7.5.1 It is proposed that dedicated in-patient beds will be provided for people with dementia presenting with complex diagnostic, behavioural and/or co-morbidity needs that require hospital admission.

7.5.2 Depending on when on an individual's journey an admission to hospital is recommended, the gatekeeper for the service will either be the responsible clinician within MAS, the dementia care manager or the responsible keyworker within CHESS.

7.5.3 Strengths of Proposed Model

- **In-patient wards will be "fit for purpose" and geared to a specific role – providing expert in-patient care for people whose needs are too complex to be met within community services at this time.**
- **In-patient provision will be harmonious with all other arms of the overall Dementia Service to provide a new, holistic service.**
- **Skill mix and resources will be appropriate to the needs of dementia sufferers and will foster an ethos of person-centred care.**

- **Specific criteria for admissions will reduce capacity pressures and ensure timely, appropriate and specialist care for service users.**

7.6 Dementia Services – Anticipated Outcomes

- **Early diagnosis delivered within an appropriate setting in a timely manner.**
- **The provision of ongoing support from a service that is both flexible and adaptive.**
- **A referral to End of Life service that will improve the service user experience and ensure a more dignified end of life.**
- **A reduction in crises with a subsequent reduction in the need for in-patient admission.**
- **Enhanced capacity to meet the future demands of an ageing population.**
- **A need rather than age led service that reduces stigma.**

8. Carers

8.1 Introduction

8.1.1 This pathway focuses on the direct responsibility of health and social care services through the auspices of South Staffordshire and Shropshire NHS foundation Trust in improving the experience of carers who support individuals experiencing mental health difficulties. The caring role is acknowledged as an equally valuable role within the care team to ensure service users have every opportunity for recovery.

8.1.2 **This proposal is derived from 'Commitment to Carers', the Staffordshire multi-agency strategy 2008-2011 and is informed from various consultation events as part of the "No Delays" process.**

8.1.3 As part of the redesign of Mental Health Services, this pathway is expected to both inform and embed carers' issues in all aspect of service delivery and make clear what carers should expect by way of response from the Trust.

8.2 Background Legislation and Policies

8.2.1 **This proposal brings together several disparate pieces of national and local legislation and policies to inform the Trust's commitment to the carers of service users accessing mental health services: -**

- Commitment to Carers: Multi-Agency Strategy for Carers 2008-2011
- Carers Recognition and Services Act 1995
- Carers and Disabled Children Act 2000
- Carers Equal Opportunities Act 2004
- National Strategy for Carers 1999 and 2008
- Transforming Social Care 2007
- National Service Framework – Standard 6
- Carers Policy (SCH)
- Carers Direct Payment (SCH)
- National Indicators (NI 136)
- The "Next Stage" Review (The Darzi Report)
- Strategic Health Authority

8.3 Aims & Proposed Outcomes

8.3.1 'Commitment to Carers' has eight overarching aims and associated outcomes. Those most pertinent to the "No Delays" have been identified and are noted below: -

I. Implement a change programme to become carer focused:

- **Increased awareness of carer issues and organisational responsibilities to carers.**

II. Implement a multi-agency approach to carer information provision:

- **Good quality and timely information is available in an understandable and accessible format.**
- **Carers are more knowledgeable and informed about the services available to support them.**
- **Relevant agencies are aware of the procedures for signposting carers to the appropriate support and services.**

III. Carers are identified and recognised as individuals and receive an assessment of their needs as appropriate:

- **Carers receive fair and equitable access to services and clarity about eligibility.**
- **Carers are recognised as partners within the triangle of care- users/**

carers/professionals and are fully involved throughout.

- **Clear eligibility criteria.**
- **Clear access criteria.**
- **Unmet need is recorded and analysed.**

IV. Implement a framework for consultation, engagement and feedback so carers can be heard and actively involved in shaping services:

- **Quality assurance reviews with carers**
- **Carers are routinely involved in service planning events and opportunities are made which maximise their ability to attend**

V. Carers have more opportunities for time off from caring:

- **Flexible and age appropriate services to provide carers with a break and the cared for person with a positive experience.**
- **Carers are able to take regular breaks.**
- **Carers from previously under-represented groups able to access culturally specific or specialist services.**
- **Carers supported in their caring role and enabled to continue caring for longer.**

VI. Carers are not isolated and have access to a wide range of services for themselves:

- **Recognition of the emotional needs of all carers regardless of gender, race, age, disability, religious beliefs and sexual orientation.**

VII. Carers are supported to optimise their financial circumstances including access to work:

- **Carers needs and aspirations regarding work, leisure and lifelong learning opportunities are identified through assessment.**
- **Carers are supported in their caring role via individual budgets or direct payments.**

VIII. Carers health needs are met and they have easy access to good quality health services:

- **Identification of carers.**
- **Appropriate signposting and referral.**

8.4 Pathway Development

8.4.1 When the actual experiences of carers shared at our engagement event are considered in the context of these aims and objectives, it is clear that the pathway has a number of stages that need addressing and clarifying from the carer's perspective.

A. Precursors to pathway and self-identification

8.4.1.1 Many carers are supporting individuals who may or may not be receiving support in primary care. There appears to be a stage at which they often do not identify themselves as carers nor seek support, perhaps as their role is part of their understanding of family/friendship/civil responsibility. It is often the case that these "carers" develop concerns or the person they care for becomes more dependent.

B. "What information might help me now"? - Ensuring timely access to relevant information.

8.4.1.2 At the point of self-identification as a carer, the need for information is the next stage. There is a lot of information available

in a variety of formats and media but the key appears to be accessibility and relevance to the carer in their particular situation.

C. "Where do I go for help whilst I am still coping"? - Signposting

8.4.1.3 Many carers can be signposted to sources of information and services that will support their role with no further input and their caring role will continue. This will be dependent on the nature of the condition of the individual that they are caring for and the amount of care provided.

8.4.1.4 Most carers once identified however should be offered an assessment in their own right, as well as full involvement with the assessment and service provision for the cared for (dependent on the individual's agreement). The result of this assessment often includes signposting to services provided through the independent sector.

D. Carers Assessment

8.4.1.5 We propose that a carers assessment will be offered to all carers identified as part of the CPA assessment and care planning process for an individual with mental health needs (carers information packs are available, produced by Making Space), as well as for those who request an assessment through self referral. Referrals should go to the CMHTs Single Point of Access. Trained professionals should carry out assessments and there are two specialist Carers Assessment Workers available across South Staffordshire. If an individual self-refers but does not meet the eligibility for an assessment or subsequent to the assessment, a service, this needs to be documented and feedback provided to the individual.

E. Service Provision

8.4.1.6 If a carer is identified as providing regular and significant support to the individual they are caring for they will be provided with a support plan which identifies their needs and how these can best be met. This may be through signposting/referral to other agencies (e.g. carers network) or may include provision of direct payments. Services available include: -

- Carers direct payments
- Carers support plan
- Carers breaks
- Carers emergency respite service
- Individual budgets
- Personalisation (options available)
- (Previously Mentioned Groups and information are still available at this stage)

F. Review

8.4.1.7 Currently the only reviews routinely completed by the Carers Assessment Workers are for Direct Payments. The carer's wellbeing is informally reviewed however through the support given to the service user.

G. Crisis

8.4.1.8 For most cases, the above stages will happen one after the other but there are occasions when the carer is faced with a crisis in their caring role and special consideration needs to be given to this situation.

H. End of pathway

8.4.1.9 The desired outcome of the pathway would most often be a return to a stable and supported caring role. However there are

times when the carer's role ends and this must be handled sensitively. Carers may experience the death of the service user, or conversely the successful recovery of the service user to a point when they no longer require the support of the carer. There are also situations when the carer can no longer maintain any caring role and the support for the individual is provided entirely by paid professionals or by another family member/ friend.

I. Overcoming Dilemmas

8.4.1.10 Through consultation a number of issues have been raised which we must be mindful of when considering provision for carers: -

8.4.1.11 *Confidentiality and sharing of information* – Many practitioners have raised the issue of confidentiality of the service user, and their rights not to have the carer involved in their assessment and care planning process (including the sharing of this information). This is often frustrating for the carer and although best practice guidance would indicate that the service user should be advised and counselled on the benefits of sharing information and involving carers this ultimate right cannot be over ruled whilst the individual has capacity to make their decision.

8.4.1.12 *Safeguarding* – Through the assessment process with the service user it is possible that the carer is alleged to have abused the service user and vulnerable adult procedures are invoked. This can prove difficult for carers if the allegations are not proven. If proven, the carers' role often becomes untenable.

8.4.1.13 *Training* – Training for staff and carers is a critical issue in ensuring that the pathway is well understood and effective, and services are delivered appropriately. Carers who have high expectations that are not reflected in the pathway often feel let down and are liable to make representation.

8.4.11.14 Dignity & Respect – The "Dignity and Respect" programme should be equally applicable to carers as for service users.

9. Proposed Model for Day Opportunities

9.1 Introduction

9.1.1 The identification of a future model for provision of Day Opportunities for mental health service users in South Staffordshire is a three-stage process. Firstly, existing services must be identified and scrutinised to ensure that they are "fit for purpose". **That is, current Day Opportunities should be consistent with the stepped-care model of service delivery, should deliver significant improvements in designated outcomes for service users and should specifically address the needs of service users within mental health services.**

9.1.2 In addition to this review, there is a distinct and separate need to define a new model or framework that addresses the three core strands of a comprehensive package of Day Opportunities: -

- **Day Opportunities in acute mental health provision.**
- **Psychological Therapies embedded within Day Opportunities.**
- **Social Inclusion (e.g. vocational and employment opportunities).**

9.1.3 Finally, to address the specific needs of the populations of each geographical locality, it is proposed that provision of Day Opportunities remains the concern of local areas (whilst adhering to the principles of the larger framework for provision). In adopting this approach it is proposed that each locality can adapt their services to best reflect not only the needs of local service users, but existing interfaces with community, statutory, third sector and voluntary provision so long as the three core standards are met and there is evidence of equitable deployment across all localities.

9.2 Current Services

9.2.1 Current Day Opportunities provide a variety of therapeutic, social inclusion and support functions in the five localities. These services, underpinned to differing levels by the Care Programme Approach (CPA), are accessible predominantly by adults of working age and include three work preparation units in Burton, Lichfield and Stafford.

No locality currently provides for all three standards. Burton, for example, only caters for the vocational/employment aspect of the model and re-design of all day services across all localities will be required to ensure all localities are resourced to meet the acute, psychological and vocational/social inclusion needs of local service users.

9.2.2 A number of "blocks" within the current Day Opportunities system have been identified. For example: -

- There is significant variability across these services in terms of helping service users to move beyond Day Opportunity provision.
- Referral into day opportunities can be from a number of sources and through differing processes.
- There is evidence of repetition of information gathering on entry into Day Opportunities from the point of referral.
- Work Units are lacking clarity of purpose and role.
- Spring Meadow Unit and St David's Day Service cite difficulties with lack of social inclusion opportunities locally, so people remain on the mental health caseloads.
- The Work Placement trainer role covers only Burton, Lichfield and Tamworth.

9.2.3 Taking all of these issues into account and using the findings of previous reviews of Day Opportunity provision to underpin the proposal (e.g. The Review of Adult Mental Health Day and The South Staffordshire Strategy for Day Opportunities 2008), we propose a new model for the delivery of Day Opportunities.

9.3 The Proposed Model

9.3.1 The national drive for the modernisation of mental health day services was responded to in Staffordshire through a comprehensive review commissioned by the Mental Health Partnership Board that was completed in July 2007. This review elicited that the stepped-care model was imperative and also elicited that the purpose of day opportunities was to:

- Provide a means of supporting individuals develop or regain skills which promote recovery to good mental health or prevent poor mental health.
- Reduce the need for hospital admission in times of crisis.
- Rromote the social inclusion agenda.

The proposal outlined below fully reflects the essence of the findings of the review:-

9.3.2 Each defined geographical locality (i.e. Burton, Cannock, Lichfield, Stafford, Tamworth and Wombourne) has participated in the development of both an overarching proposal for the shape of future Day Opportunity provision and a proposal for how this larger framework might be employed at a local level.

9.3.3 The overall proposed service specification for Day Opportunities in South Staffordshire is: -

- **Day Opportunities should become part of Community Mental Health Team resources and all resources (staff, financial) should be operationally managed and developed within this framework across working age and (functional) older age.**
- **Access to services should be through a reconfigured Single Point of Access (see the Acute Care pathway for details).**
- **Day Opportunities delivered by the Trust should be consistent with the stepped-care model of provision outlined in the Day Service Strategy (July 2007).**
- **Service delivery should be needs led, throughout and should be driven by the Care Programme Approach (CPA) and should impose no upper age limits.**
- **Day Opportunities should deliver three essential aspects of care, based on the principles of hope, recovery and rehabilitation within clearly defined domains: -**
  - **Acute Day Provision - aims to provide "safe spaces", offer an alternative to hospital admission, offer crisis resolution and reduce the length of stay in acute in-patient facilities.**
  - **Psychological Therapies - evidence-based, time-limited, and outcome measured should be delivered by appropriately trained and supervised staff within the Day Opportunity setting.**
  - **Social Inclusion – offers vocational training, education, volunteering, paid training places, supported**

employment and/or competitive employment. A focus on community engagement, and skill acquisition or maintenance will deliver "hope, rehabilitation and recovery".

- **Day Opportunity interventions should be evidence-based (or contribute to developing the evidence base if none exists), deliver best practise (NICE guidance, national guidance), should be outcome measured (benchmarking) and responsive to service user/carer feedback.**

9.4 Benefits of the Proposed Model

9.4.1 The proposed model ensures service users have equitable access to service delivery and local flexibility will allow for services to best meet the needs of their local populations.

9.4.2 Furthermore, the proposed model will ensure the assessment of service users' mental health needs is not unnecessarily duplicated when moving into or between services/interventions or when additional interventions are offered within the service.

9.4.3 In terms of the interventions themselves, service users will have choice and options around service delivery (including psychological and social inclusion approaches based on recovery and rehabilitation). It is proposed that time-limited interventions will reinforce discharge from services into mainstream community living and as a result, will increase social inclusion, self-esteem, health and wellbeing. Alongside these outcomes, the model allows scope for the development of coping strategies to empower service users to manage long-term mental health conditions.

9.5 Local Proposals

9.5.1 The first stage for any local implementation of the proposed model is the scrutinising (and where necessary, the transformation) of existing provision to ensure that services best meet the needs of mental health service users on the stepped-care model at the heart of the "No Delays" process.

9.5.2 Looking forward, each locality has proposed a system or implementing the larger model, adapted to the needs of local service users: -

9.5.2.1 Stafford

The Chartley Centre is a key pilot site for the development of psychological therapies and Day Opportunities within the overall "No Delays" model. The proposal is thus to consolidate and build upon the successes of this early implementation site: -

- Psychological therapies being delivered by a process of information sharing and election of preferred group.
- A rolling programme (40+ groups) of group interventions is available based on demand.
- Supervision structures are in place.
- Each group has established outcome measures
- Consideration is being made to using the therapy suites at St. George's as a base for acute Day Opportunities services.
- Links to bring about a fully inclusive service for adults of all ages are being forged.

- Social inclusion/vocational aspects of the service to be advised by and supported – through re-deployment of resources – by the current Quest model

9.5.2.2 Cannock

Several important developments within the locality are proposed to enhance services for both acutely unwell service users and for those with severe and enduring mental health issues: -

- Re-design of Spring Meadow to bring resources into line with CMHT and the provision of acute/crisis care and treatment.
- Development of in-patient "carousel groups" to equip service users with effective coping strategies.
- Development of a 24/7 "Home Treatment" service working alongside other disciplines, the Crisis service and carers.
- Development of a "Staying Well" group to address issues around relapse prevention.
- Developing further links with community groups and housing services and provision of employment/training to facilitate social inclusion with social inclusion/vocational aspects of the service to be advised by and supported – through re-deployment of resources – by the current Quest model.

These proposed developments will sit alongside recent changes in practice to provide a comprehensive set of Day Opportunities that are consistent with a recovery-focussed model of provision: -

- "Cognitive" therapeutic groups (e.g. our "cognitive writing" group).
- Evening "self-esteem" groups.
- Group in-patient sessions on Chebsey ward based around developing coping strategies.
- Health Promotion.

9.5.2.3 Lichfield

Following a service user focus group, the following needs have been identified: -

- A support group following discharge from service.
- Enhanced routes into employment and employment support.
- Enhanced training opportunities.

To facilitate the development of these services, it is proposed that there be development of the interface between our Day Opportunity provision and services offered by Job Centre Plus, Making Space, Connexions and Lichfield & Tamworth College.

Services delivered at The Friary facilitate early discharge from hospital or offer an alternative to admission. It is proposed that this service be enhanced to deliver services without age barriers and in line with enhanced CMHT working hours (see the Acute Care pathway for details): -

- Clozaril Clinics & Lithium monitoring.
- Daily attendance from one of the medical team.
- Service availability to be enhanced.

Links with the CMHT are being strengthened and this new working relationship has led to proposed changes in therapeutic provision with Day Opportunities: -

- Staff within the CMHT have been identified who would be willing to support group interventions.

- Trainers have been identified to ensure that groups are run on sound principles.
- Proposed services include relapse prevention, assertiveness training, anxiety and mood management.

Proposals with regards to Nuffield Centre are pending and will focus on re-provision and re-deployment of resources in tandem with Task Group in Burton and in partnership with Quest so as to ensure the stepped care model is applied. Significant transition work with other services will be critical.

9.5.2.4 Wombourne

It is proposed that the Day Opportunities in the Seisdon peninsula at the St David's therapeutic centre is further developed and a re-deployment of resources provided to ensure: -

- **The inclusion of senior clinical psychology input and clinical therapist posts to help deliver on psychological therapies alongside a community occupational therapist. The nature of this input will be locally driven.**
- **The development of acute care to support local crisis intervention.**
- **The further development of community groups to help deliver on the "bigger picture" of Day Opportunity within the locale including social inclusion/ vocational aspects of the service informed by the current Quest model.**

9.5.2.5 Burton

Day Opportunities within the Burton locality remain meagre. **We propose the development of a multi-disciplinary service offering high-levels of support to individuals who would otherwise require hospital admission, facilitated by strong links with the Home Treatment Team**. This resource could also offer daytime respite for carers of people receiving home treatment and also provide a walk-in mental health "A&E".

The development of a community service would also allow provision of services to enhance social inclusion through links with existing resources (e.g. Quest, Task Group and the third sector). These services, focussed on prevention, rehabilitation, employment and education would be open to all adults irrespective of age and be available seven days per week.

It is further proposed that enhanced psychological therapy options be established through training of existing staff and we aim to offer a broad range of therapeutic packages including CBT and solution-focussed therapy.

9.5.2.6 Tamworth

The amalgamation of Day Opportunities provided at the George Bryant Centre and Albert House is now completed. **It is proposed that this new service develop a "No Delays" compliant structure in line with the broader framework for Day Opportunities primarily focussing on acute day treatment and access to psychological therapies. In addition, the Quest model and Task Group in Burton should be extended for Tamworth service users.**

10. Transitions

10.1. Introduction

10.1.1 The Transitions pathway finds itself in a unique position. Only when the final proposals from the other areas of the "No Delays" have been agreed can the transitions within and between services be fully scrutinised to ensure that the experience of our service users is optimised.

10.1.2 Ahead of this, we have completed two audits to investigate the most significant and most frequent transitions that service users face during their time accessing our services.

10.2 Types of Transition

10.2.1 Six different transitions have been identified, each presenting a set of unique challenges to our system: -

1. Transfers within the Mental Health Division (e.g. from the community mental health team to crisis services or from locality to locality) – Although at first sight these arrangements should present little real problem, being covered by the Care Programme Approach process and our own admission / discharge processes, problems do still arise. On investigation, evidence suggests that is a failure to strictly adhere to these existing arrangements that is most likely to result in difficulties and a subsequent deterioration in the quality of the service user experience.
2. Transfer from/to another Directorate (e.g. from CAMHS to the community mental health team) – Evidence suggests that differences in referral criteria and the skill base of teams may lead to difficulties at this stage of the service user journey.
3. Transfer from/to a neighbouring Trust or Local Authority - These are especially significant if these transitions involve geographical boundary issues, specifically between regions that are not co-terminus.
4. Transitions from/to Primary Care – This is a particularly relevant issue. Adherence to a stepped-care model of service delivery will be reliant on smooth "steps up" and "steps own" the model. Provision of primary care mental health services remains sporadic and a barrier to transition.
5. Transitions between the Trust and Primary Care - It is also important to note the existence of shared-care arrangements relating to prescribing and associated responsibilities for specific medicines.
6. Transition between community and psychiatric in-patient services and vice versa.

10.3 Frequency of Transition

10.3.1 Our own audit data suggests that a number of transitions to/from the community mental health teams occur with high frequency: -

- Transition from the community team to Crisis.
- Transition from the community team to Day Opportunities.
- Transition from the community team to Assertive Outreach.
- High rates of re-referral of service users discharged from CAMHS to the adult community teams.

10.4 Proposed Model of Transitions

10.4.1 It is clear that even where transitional policies exist, the transition process still often remains a block to the delivery of high-quality care. **We therefore propose that transitions should be minimised where possible through a number of avenues.**

10.4.2 Delivery of care should be close to home and be made by capable, multi-disciplinary teams with adequate crisis-response services. This suggests that crisis services should be seated within each geographical locality and be a resource of the community teams themselves.

10.4.3 We also propose that "link worker" roles should be established to facilitate work across teams and Directorates (e.g. links with learning disabilities, CAMHS, substance misuse teams and any newly pioneered dementia service).

10.4.4 Local boundaries should be clarified and agreed upon by all teams and Directorates. This process should be expanded to include neighbouring authorities and our colleagues in primary care. Referral criteria should be agreed by all parties in line with national standards with a shared understanding that criteria must meet the needs of the individual, not the service.

10.4.5 Finally, we propose the development of a protocol that incorporates all the main principals from national and local policies.

11. Proposed Model with Primary Care

Introduction

11.1 The workstream has been informing a pathway within the context of increased commissioner interest and investment in the development of primary care mental health provision. There is a new impetus to deliver appropriate and timely therapeutic interventions in primary care settings.

11.2 To facilitate this process, the pathway, via the workstream has been working in partnership with colleagues from primary care to develop and formalise the stepped-care model outlined earlier in this document. This model is crucial to our shared understanding of where responsibility for different levels of mental health provision lies. In clarifying our position, **it is proposed that the delivery of timely, appropriate interventions in appropriate settings for service users will be enhanced.**

11.3 Alongside these developments, the primary care pathway has participated in the development of proposals for a revised single point of access into services, facilitating the process service user transitions "up and down" the stepped-care model of service provision and development of psychological care packages for implementation at all levels of our service(s).

11.4 In addition to this collaborative work, a proposed model of specific elements to facilitate the provision of mental health services in Primary Care settings has been developed.

Proposals

11.5 It is proposed that there will be agreement on and deployment of a stepped-care model that is shared by all partners and that covers all care pathways. Such a stepped-care model will clarify understanding of where specific mental health interventions are delivered and by whom.

11.6 It is proposed that specialist mental health services will be specifically accessible by those service users who needs would best be met by such a secondary service. That is, following assessment, service users who require an enhanced level of care coordination and whose needs are represented at stages "3b" and above on the stepped-care model will be accepted for treatment by secondary services. To meet the needs of service users accessing services at the primary care level, it is recommended that each locality, based on practiced based commissioning boundaries, commissions a primary care mental health service reflecting the successful services deployed in Stafford and Seisdon that is compliant with both the Improving Access to Psychological Therapies (IAPT) and also NICE guidance.

11.7 All service users referred to specialist mental health services will receive a routine assessment within four weeks of referral. In addition, all referrals for a locality will go to a multi-disciplinary single point of access and will be then triaged and forwarded to the most appropriate team. A "step down" of a referral to primary care mental health provision will only occur after a face-to-face assessment. It is proposed that the referral process itself should be streamlined by the introduction of a universal referral form.

11.8 Collaboration between community teams and primary care practices should be enhanced. Both healthcare providers should have a role in the annual review of Severe Mental Illness Registers. Furthermore, both services should

collaborate on the development of local databases of accessible services.

11.9 Locality Forums should be established where all stakeholders can meet to update on service changes and develop truly integrated partnerships that are based on mutual respect and understanding.

This collaboration will allow services to continuously develop and further enhance the experience of service users and carers.

11.10 Finally, we propose that Link Community Mental Health Practitioner roles should be standardised and accessible across the adult lifespan.

12. Summary

12.1 We have outlined in this document those proposed incremental, stepped-changes to our services that we feel will facilitate a service that is flexible, efficient and that can best meet the needs of our service users and carers.

12.2 These proposals have been carefully selected after appraisal of a wide variety of options. They are, where possible, evidence-based and guided by the principals of "No Delays" to deliver a non-ageist service based on a stepped-care model.

12.3 Each workstream within the project has produced practical suggestions for how to achieve service improvements through re-design and re-deployment of existing resources (but inclusive of successful Local Delivery Plan bids). If the principal recommendations are agreed and implemented, we anticipate the following outcomes as we gradually implement incremental change: -

- *Needs* rather than *age* led services.
- Locality teams that better mirror local authority and commissioner boundaries.
- A shared understanding of the "stepped-care" model to ensure interventions are delivered in the right place, at the right time and by the most appropriate service.
- A recovery-focussed ethos.
- A revised single point of access for services that is responsive and adaptable to local need.
- Face to face assessment of all referrals in a timely manner.
- Crisis services that are integrated into local community health teams.
- Community teams that are accessible from 8am to 8pm, 7 days per week.
- Development of capable Home Treatment Teams that will offer service users an alternative to hospital admission.
- Robust and effective multi-disciplinary Assertive Outreach and Early Intervention services .
- A commitment to move forwards on developing "psychiatric emergency facilities" as an alternative to A&E admission out-of-hours.
- Facilitating carers to identify needs and timely access to carer information, assessment and support.
- Day Opportunities that are modern and "fit for purpose", that meet the needs of our service users and that are equitable across the patch.
- Provision of acute Day Opportunities as an alternative to hospital admission.
- Day Opportunities that promote social inclusion and that are focussed on recovery with defined, measurable and clear anticipated outcomes.
- Day Opportunities that promote wider participation in psychological therapies.
- A transformative and needs-led Dementia Service, consistent with the JCU proposals that will promote and support the delivery on the recommendations of the National Dementia Strategy.
- Timely access to memory assessment services in appropriate locations.
- Support for dementia sufferers and their carers throughout their journey.
- Effective care home support and education within the community.
- A "care package" approach to psychological therapies that will ensure

timely access to a range of evidence-based interventions.

- Psychological therapies embedded in all aspects of service provision.
- Tightening and minimising of transitions for service users to ensure a smooth, high-quality journey through services.
- Enhanced collaboration between community teams and primary care providers including development of locality forums.
- A streamlined referral process to community teams is developed.
- Reduction in rates of psychiatric hospital admission and re-admission
- Reduced length of hospital stay
- Improved service user and carer experience

12.4 However, these proposals remain options for your consideration. As "No Delays" enters its next phase, it is our job to enter a period of wider engagement around our proposals, to listen to and incorporate your views and to take forward and implement these revised pathways. In doing so, we aim to deliver measurable improvements in the quality of the service user and carer experience alongside an efficient mental health service that is capable of meeting future demands.

13. Next Steps & Further Engagement

13.1 There are many ways in which your voice will be heard, your questions addressed and your criticisms and compliments incorporated.

13.2 Within this document you should find a questionnaire and stamped-addressed envelope with which you can provide feedback on the contents.

13.3 We will also establish and advertise a number of roadshows and focus groups to further canvass your opinions. We will advertise these events as widely as possible.

13.4 We would be grateful if you could share not only this document but also details of our plans for wider engagement with anyone else you feel would like to read of our plans and/or participate further.

14. Glossary of Terms

CAMHS	(Child & Adolescent Mental Health Services)
CMHT	(Community Mental Health Team)
CPA	(Care-Programme Approach)
CPN	(Community Psychiatric Nurse)
DD	(Dual Diagnosis)
EIS	(Early Intervention Service)
HTT	(Home Treatment Team)
IAPT	(Increasing Access to Psychological Therapies)
JCU	(Joint Commissioning Unit)
LD	(Learning Disability)
NICE	(National Institute for Clinical Excellence)
OT	(Occupational Therapy)
PbC	(Practice-based Commissioners)
PCT	(Primary Care Trust)
PD	(Personality Disorder)
SAP	(Single Assessment Process)
SPA	(Single Point of Access)
SSSFT	(South Staffordshire & Shropshire Healthcare NHS Foundation Trust)

Kall Kwik Business Centre t 01785 243303 f 01785 223334 e sales@kkstafford.co.uk