Phase 2: Adult and Older Peoples Mental Health Services Options Paper

1. Purpose

The purpose of this paper is to set out options for change in Rotherham Mental Health Services in order to receive views.

2. Phase 1

Phase 1 of the Adult and Older People's Mental Health programme was made up of six projects.

Project	Update
Mental Health Hospital Liaison Service	Launched April 2015 1 hour response time in A&E Evidence of reduced admission / length of stay Crisis team freed up to work in community
New dementia pathway	CCG discussing with GPs Training delivered
IAPT	Improvements not yet realised NHS England funding to reduce waiting times Increasing 1 to 1 and group activity Resource re-allocation Pilot of 'opt in' bookings reduced waiting times from 16 week in June to 8 in October
MH Social Prescribing	Positive patient feedback and impact on discharge Referral numbers increasing
Carer Resilience (not an RDaSH project)	*Rolled out to 23 GP practices* *134 referrals and 127 assessments to date.*

3. Phase 2

Six stakeholder events were held across the summer along with on-line feedback to consider how services can be improved whilst making the necessary efficiency savings (see plan on a page). A summary of feedback is set out at appendix 1. A number of options have been considered by the Mental Health QIPP group which are set out below for your consideration.

4. A Rotherham Hub

Commissioners have requested a single contact number through which to access mental health services, operating 24/7 for all ages (children upwards) for people in crisis and new referrals .

The model proposes a two tier approach: an initial response staffed by trained administrators, feeding through to a specialist triage service. Discussions have taken place as to whether the hub should cover:

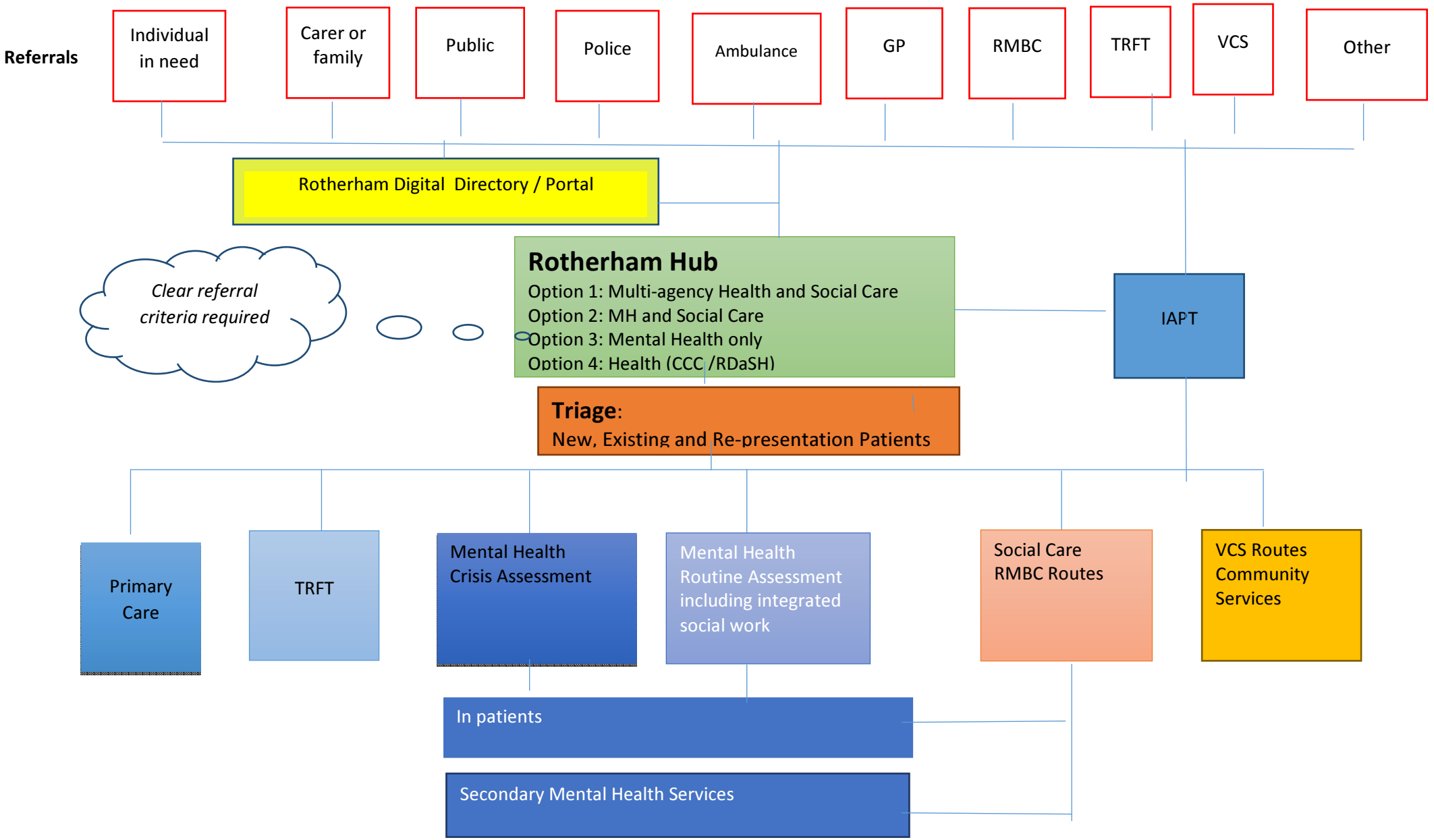
a. Mental health only
b. Mental health and physical health
c. Mental health and social care
d. Health and social care

It is anticipated that the Hub will be based in Rotherham. However further economies of scale could be realised if a wider geographic area is covered (for example as done by 111). Stakeholder feedback indicated that if the hub offered excellent local knowledge of Rotherham the geographic location was not important. Though it was felt it should be local to Yorkshire to benefit the regional economy.

5. Developing a Rotherham Digital Directory or Web Based Portal

There has been extensive feedback indicating that service users, carers, clinicians and providers do not have a full understanding of the Rotherham offer. This makes accessing and signposting to the correct services difficult. Along with the potential for a Rotherham Hub there is potential to work with partners to develop a Rotherham digital directory for health, social care and voluntary sector provision. Over time this could become a personalised portal which pushes information to individuals according to their profile. Digital services can promote self-help and networking opportunities, enabling service users /carers to access alternative sources of support. It can also facilitate access to services which users may not be able to physically travel to. Although digital activity is not appropriate for all, the exponential growth of on line activity demonstrates the demand and benefits.

The Rotherham Hub: Access to Support



6. New Mental Health Service Models

6.1 A Rotherham Service

RDaSH are seeking feedback on moving from internal business divisions to a borough based to better address local needs and reduce management costs. This offers opportunities to:

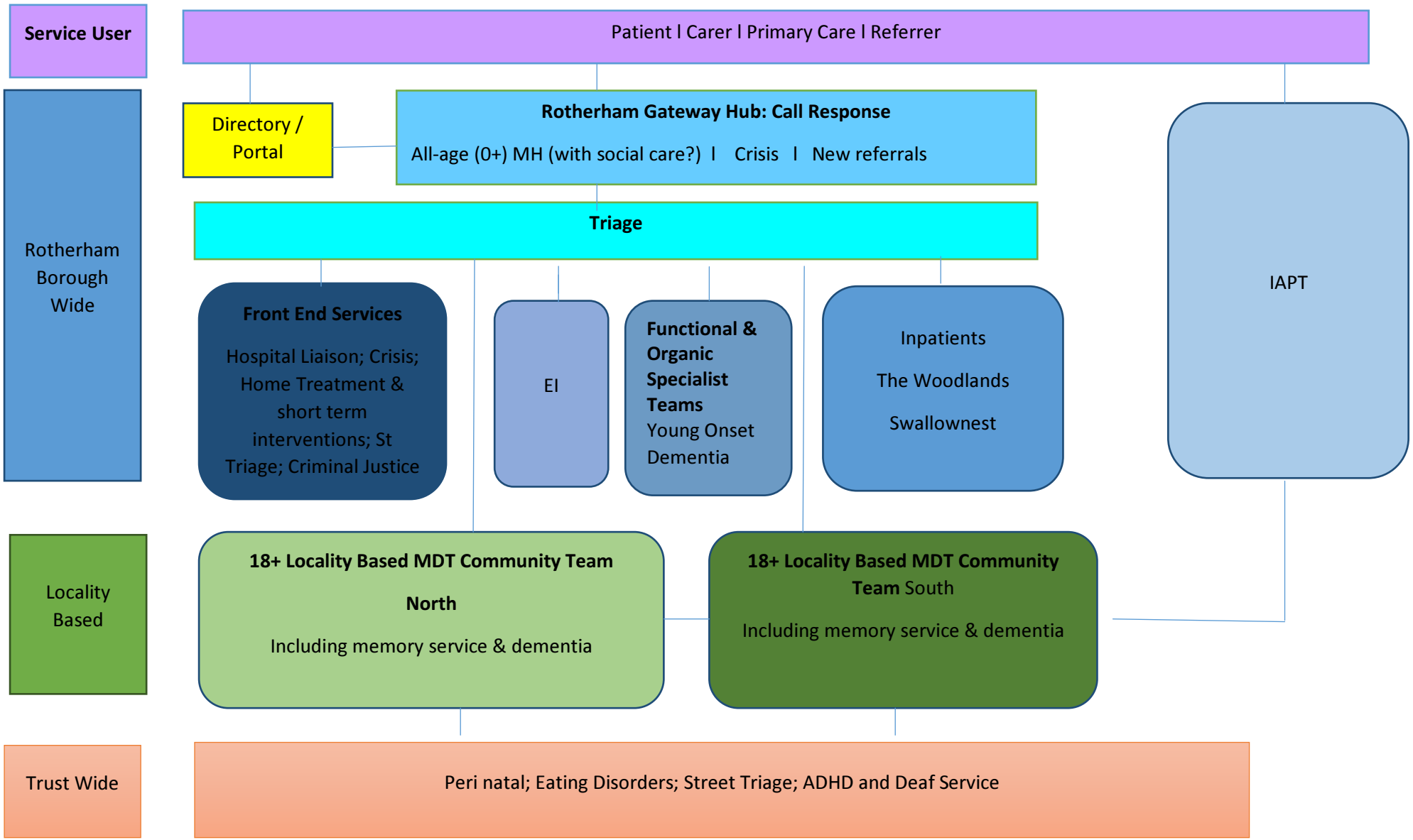
i. Develop local partnership working, a 'team Rotherham' approach
ii. Move from silo based age specialisms to multi-disciplinary teams which are better able to respond to patient need, rather than age
iii. Develop cross borough working where this is more effective and efficient

6.2 Rotherham Service Model Options

Option 1: A CMHT ageless (18+) locality based model

Pros	Cons
Adult / OP age barriers are removed to provide a smoother pathway for patients in relation to age	This does not meet the Royal College criteria as the generic approach does not take account of individual need
Mixed caseloads can protect against burn out (but concern re dilution of specialisms)	Reactive service responding to risk / high demand patients rather than need, less assertive patients may get less care
A larger pool of staff, providing greater flexibility / cover	Large teams requires strong leadership & management – clarity of purpose, transparency, productive and performance
Knowledge and skill sharing	Specialisms may become diluted, impacting on quality of service and retention and recruitment
Potential for savings and economies of scale	Roles and responsibilities are less clear than in option 3
Increased productivity through reduced travelling time, will reduce waiting times	Loss of productivity due to working with multiple medics
Opportunity to standardise practice will raise standards, taking best practice from each of the services	

Option 1: CMHT ageless (18+) locality based teams with borough wide front end and specialist services

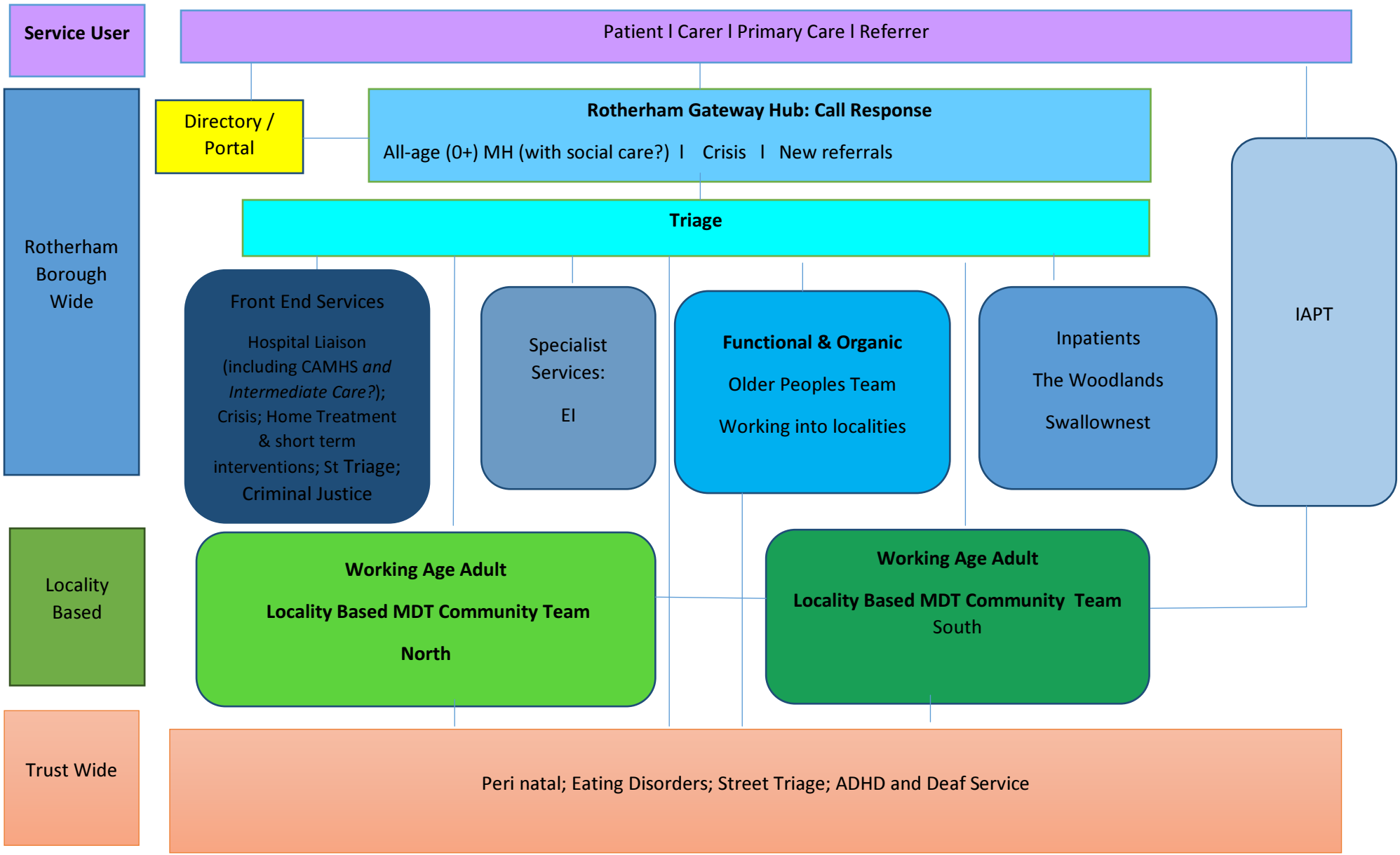


Option 2: Working Age Adult Locality Model with Centrally Based OP Team

In this option adult teams would be locality based, with the OP team centrally based working into localities. It would provide a smoother transition for patients and staff, managing risk. It could provide a phased approach to option 3, enabling more time to develop the model and facilitate cultural change. However this is a more expensive model than option 3.

Pros	**Cons**
Meets the Royal College Criteria, with older peoples team remaining separate from working age adults	Continued separation of OP and working adults makes the benefits of all-age working together harder to address: i. Meeting patient's needs which don't fall into age categories ii. Cross fertilisation of best practice
Addresses cluster based adult issues, stakeholder feedback re locality bases	As with the current model, the OP team would continue to need to travel across localities, productivity could be increased through agile working
Safeguards against dilution of specialist knowledge and resources	Knowledge and skill sharing to be achieved through management rather than co-location
Less challenging culturally, could be used as a stepping stone to model 3	Maintenance of status quo for OP team. Cultural change: team Rotherham harder to achieve
	Less efficiency savings than options 1 and 3

Option 2: Working Age Adult Locality Model with Centrally Based OP Team Working into Localities



Option 3: Needs Led Community Based All-Age Pathway Model

In this option two locality teams would support 18+ all age services including:

Psychosis (other than first episode)

Bipolar

Personality Disorder (DBT)

Long term conditions (clusters 7 and 11)

Anxiety and depression (stepped up from IAPT)

Frail and Physical Disability (18+)

Care Home Liaison – to be expanded to include working age adult remit and specialism

Expand YOS to include adult specialists and Korsacoffs

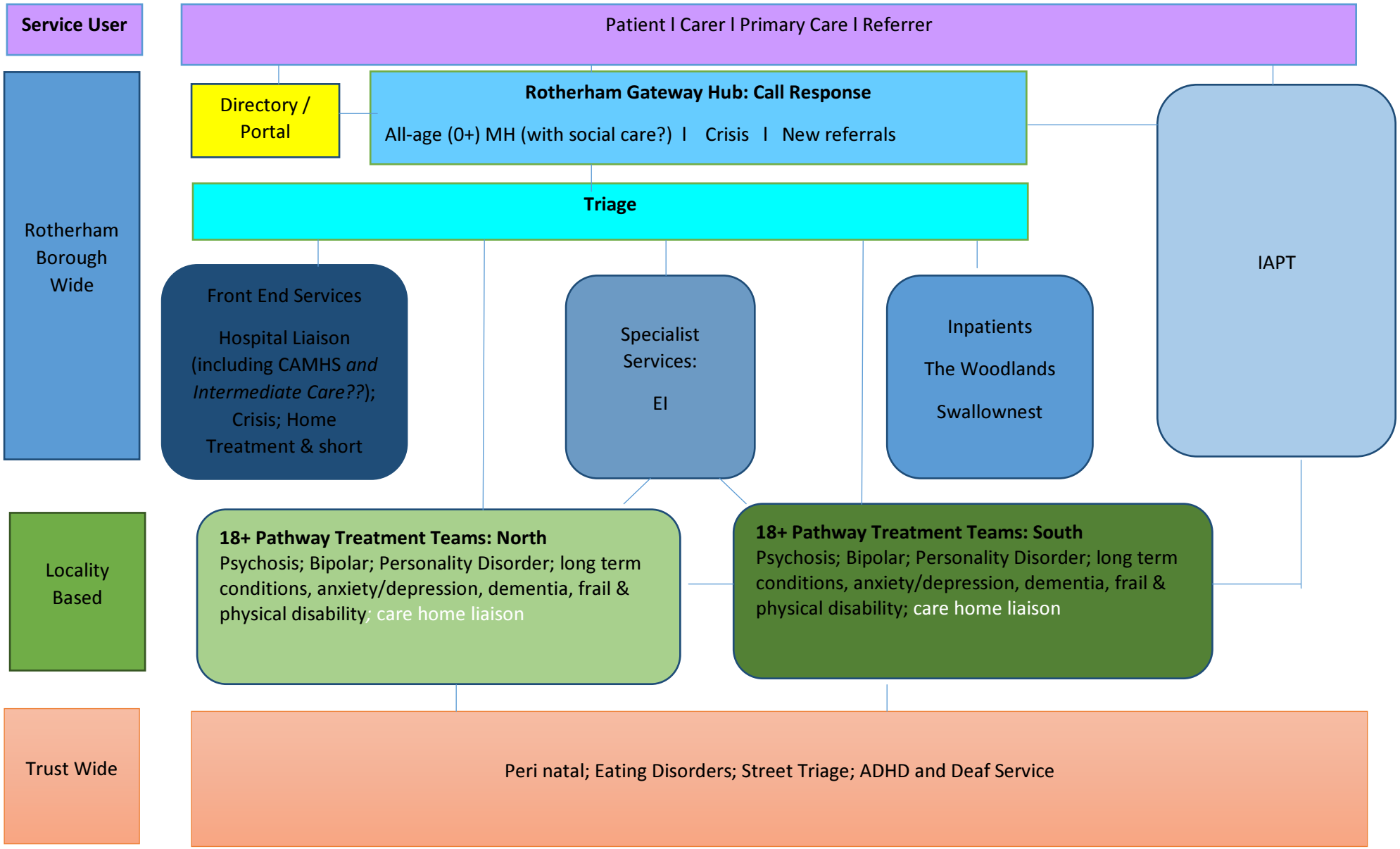
Dementia services would be embedded in the localities. Consideration will be given to where activities such as CST and OTAGO run to facilitate access whilst providing best value for money and how patients on the new pathway will be referred in by GPs.

This option enables a needs led approach, protecting specialisms, whilst delivering the benefits of an all-age service. It offers best value for money, and is the most significant change.

Pros	**Cons**
Meets stakeholder / commissioner requirement re locality based services Older people have more access to functional services	Large teams, will require clear roles and responsibilities and sufficient leadership and management within the structure
Addresses Royal College criteria, enabling needs led care by underpinning with specialist pathways	Success is dependent on the development of new pathways
High performing and /or niche, specialist services are protected through the borough wide model	Patients may be in more than one pathway, which will require management (CPA thoroughly embedded and team philosophy of sharing care would need to be developed)
Enables advantages of all-age services: Greater flexibility, removing age barrier Reduces the number of instances where patient doesn't 'fit' the service. Sharing good practice, standardising where appropriate	
A healthier environment for staff, protect against burnout.	
Medics better aligned to pathways than in option one	
A larger pool of staff, providing greater flexibility / cover	
More potential for savings and economies of	

scale than option 2	
Work force planning: maintaining specialist knowledge / staff motivation whilst providing opportunity to extend skills. Benefits recruitment and retention	
Increased productivity	

Option3: Needs Led Community Based Pathway Model



Option 4: is do nothing. This would not address issues highlighted by commissioners and stakeholders or meet the required efficiency savings.

7. Next Steps

Action	Date
Further service discussion with patients, carers, GPs, staff and stakeholders	November – December 2015
Develop the approved models, pathways and service criteria	December 2015
Formal staff consultation	January – February 2016
Implementation	From April 2016

8. Feedback

You are asked to comment on the above options, making alternative suggestions where appropriate. We are interested in your views as to:

- The key issues for you and your patients and carers
- What would make the service better
- Given the shrinking resource envelope, what could not be done going forward

Additional feedback can be sent to Steph Watt, Programme Lead at steph.watt@rdash.nhs.uk
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Graeme Fagan, Assistant Director
Alison Lancaster, Locality Manager
Kerri Booker, Service Manager
Steph Watt, Programme Lead
November 2015

Appendix 1 Stakeholder Feedback

Theme	Feedback
Accessing Help	• I need help or I am acting on behalf of somebody who needs help. I don't necessarily know what help is needed and need an easy way to find out • I don't know what help exists and I don't know how to access it • It is difficult to distinguish between health and social care needs • When I do try to access help, the process can be slow (high risk and high stress when the person is in crisis) • Travelling to treatment is difficult (either because the service user is not mobile, or because it is not local and difficult to access by public transport)
Accessing Information	• I have to tell my story and provide the same information repeatedly • I cannot access the information I need about patients and carers, so I need to ask the service user / provider for it again. This raises their stress levels and wastes time
Waiting Times Patient Hand offs	• Waiting times are too long for IAPT, the memory clinic and adult secondary services psychology and specialist therapy, allocation of care coordinator specifically in ICT • Sometimes I was referred to one service only to be referred on to another, on occasion this happened more than once
Quality of Service	• Once I got into service the quality was good. • The consistency of care plans and discharge pathways require review
Barriers to services	• My needs / age don't fit your organisational structure (CAMHS transitions, frail working age adults and 65+ who are not 'old') • Your organisational structure does not sufficiently support the needs of Rotherham
Opportunities	• 'We are all doing the same thing ….. we need to join together' TRFT Director in a multi-agency meeting including the voluntary sector to: • Simplify and make transparent the offer for the people of Rotherham • Pool resources – effort and expenditure • Reduce waste / gaps • To work more effectively with the voluntary and community sector • Carers, support me / utilise my knowledge, to benefit the service user / service development • Understanding what is out there • Working in partnership to develop new ways of working (social prescribing being one example)
Threats	• An all-age service may address transition issues and provide efficiency savings but there is a risk that specialisms are lost resulting in : i. a negative impact on the patient experience, particularly for the frail and elderly as resources may be focussed on more complex /demanding cases ii. de-skilling staff - impacting on retention and recruitment • National guidance and evidence raises concerns regarding ageless services • Required savings may impact on front line services • The models may not go on to deliver the level of assumed future saving requirements • The estate may be a barrier to change • Agile working can be isolating