

# Recommendations for Transforming Rotherham Adult (18+) Mental Health Services

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# Executive Summary

## 1. Purpose

The purpose of this paper is to outline the recommendations for the reconfiguration of Rotherham Adult (18+) Mental Health Services to inform commissioner governance processes and the RDaSH Trust Board decision making process.

## 2. The Case For Change

The case for change has been set out in previous transformation documents. It is based on the national and local direction of travel and specific feedback from stakeholder events captured in the Trust's change principles.

The case for change is based on three pillars:

- i. **Good Practice** Clinical and research evidence in both mental health and social care increasingly supports a prevention, recovery and wellbeing approach, demonstrating the benefits to both patients and the wider system of supporting service users to live as full and independent lives as possible.
- ii. **Stakeholder views** At an operational level stakeholders have expressed a consistent need for:
  - a place based model where care is delivered closer to home
  - timely access to services with clear routes in
  - removal of artificial barriers such as age and narrow cluster based structures
  - a reduced number of assessments
  - named contacts
- iii. **Efficiency and Effectiveness** it is no longer possible to deliver effective services whilst achieving the required efficiency savings by piecemeal change

Taken together, these factors require a fundamental change in how we approach and deliver our services. The recommendations set out in this paper aim to move us from patient care based on service models to a patient needs led model to enable patients to live as full and independent life as possible.

We recognise that efficiency savings are required across the system and that if each part of the system takes out costs independently there could be a negative impact on patients, carers and other providers. These recommendations have therefore been developed following extensive engagement with primary care, social care and the third sector as well as patients and carers to ensure we work together constructively to achieve the best possible outcomes for all our service users without 'passing the buck'.

## 3. What does this mean in practice?

- 3.1 **Change of mindset** a needs led patient centred approach needs a different relationship with patients, carers and providers. We need to re-think how we work together within RDaSH and the wider health and social care system. These changes will require cultural change as well as changes in practice.
- 3.2 **More flexible allocation of resources** to enable care to wrap around the patient

**3.3 Improved flow** freeing up capacity to provide a more robust front end service to reduce the overall numbers entering secondary services /being admitted and the length of treatment/stay.

**3.4 Specialisms** ensuring professionals work within their professional training, maintaining and continuing to develop expertise to meet patient needs and deliver the new ways of working

#### **4. How will this be achieved?**

**4.1 Pathway Framework** A new pathway framework is proposed, informed by NICE guidelines, with three clinical streams:

- i. assessment and brief intervention at the front end to provide a rapid response and the capacity to offer a limited number of interventions for those in immediate need or who would benefit, reducing the numbers requiring secondary care
- ii. an MDT approach to complex care management for higher intensity, higher risk patients
- iii. a less medicalised model for longer term recovery and wellbeing for those with more enduring needs

**4.2 Multi-disciplinary working** across RDaSH specialisms and social care which can be extended to include physical care working closely with primary care

**4.3 Re-configuration of services** to include:

- i. First point of contact and triage service, hosted by an established provider such as the Care Co-ordination Centre for economies of scale
- ii. Crisis and rapid response
- iii. Two balanced locality based teams, aligned with social care
- iv. Borough wide teams, working and reporting into localities
- v. Integrated social care, initially for working age adults, across all pathways with the aim of extending to older people and learning disabilities.

#### **5. What will be different?**

**Patients** will be encouraged and supported to live more independent lives. They will receive the care they need according to their individual circumstances, delivered closer to home where possible.

**The system** Over time there will be an overall reduction in those entering service and length of time spent in service. The improved flow will reduce waiting times, inefficiencies and cost.

**Efficiency savings** Targets have been set across a number of areas. This paper addresses clinical savings. It is projected that the 2016-17 clinical savings will be met from the management re-structure and some targeted savings. 2017-18 clinical savings will require closer integration of services across the care group including a review of clinical and administrative roles and responsibilities once the care group has been established. There is currently a critical dependency between mental health and social care funding of roles.

#### **6. Transition**

Transition will require strong clinical and operational leadership and management. If funding were available the transition period can be facilitated and speeded up. However, given the required saving requirements transition will need to be managed over a period of time and it will take longer to realise the benefits. A trajectory will be developed.

#### **7. Future Development**

Further development work is required with patients, carers, primary care and the voluntary sector to ensure there are clear, workable routes into service as well as robust routes back in for discharged patients who require specialist support.

The recommendations have been developed in parallel with and informed by the Integrated Locality pilot which RDaSH is a proactive part of. The approach outlined above could easily be built upon if the pilot is rolled out.

# Recommendations for Transforming Rotherham Adult (18+) Mental Health Services: A More Detailed View

## 1. Purpose

The purpose of this paper is to outline recommendations for the transformation of Rotherham adult mental health services in line with the Trust transformation principles. This paper is for consideration by the Trust and Stakeholder transformation groups in order to inform service configuration recommendations to the Trust Transformation Board in July 2016. The outcome from this phase will inform the management and operational structure. A formal consultation process will be held with the affected staff group in the autumn, according to the Trust's change policy.

The proposals have been developed through three rounds of engagement activity in Rotherham. This has included over 20 stakeholder events including patients, carers, commissioners, multi-professional RDaSH, RMBC and TRFT groups and the voluntary sector. RDaSH have carried out two rounds of conversations with GPs through locality meetings as well as on-line surveys. Discussions have also taken place across the wider Trust, the CCG's Systems Resilience Group, NHS England and RMBCs Scrutiny Committee. More detailed work is on-going, with further activity planned using Listening into Action methodology.

## 2. Scope

This paper relates to the Rotherham Working Age Adult (WAA) and Older Peoples (OP) Mental Health Services. Transformational change is in progress in Learning Disabilities and CAMHS with Drug and Alcohol Services coming up for re-commissioning. These various threads will be pulled together into a coherent approach under the new care group structure. All areas are represented within current governance arrangements to ensure proposed changes are aligned and join up where appropriate.

## 3. Aims and objectives

The Trust's transformation vision is to provide all age care (18+) which is delivered in an integrated way, ensuring patients receive care close to the community in which they live and empowering our staff to work innovatively to deliver quality services

The key themes that have consistently emerged from internal and whole system engagement events are:

- **Access to services:** clear routes in, with named contacts and services that are close to home
- **Assessment:** effective (including timely) assessment and signposting (utilising the whole system, i.e. the patient's own networks, health, social care and voluntary & community sector), reducing the number of assessment points
- **Removal of structural barriers:** patients are currently fitted into existing services rather than care being provided according to patient need. Services based on age and cluster re-enforce this
- **More effective use of resources** across the whole system, including developing opportunities to utilise professional specialisms through multi-disciplinary working and more effective partnerships with the primary sector, social care and voluntary and community assets

#### **4. Rationale for the Proposed Changes**

Currently both health and social care are largely based on the premise of what services can provide for service users, channelling the person down particular cluster based pathways, rather than formulating a response based on the needs of the person seeking help. There is clear evidence that patients are being brought into secondary services when more appropriate alternatives exist and that many are staying in service for long durations, creating dependency. As a result services have become log jammed. New people in need are not getting help in a timely way and long term service users are not being supported to live the best life they can. This is costly for both patients and commissioners.

The proposed changes therefore aim to:

1. work in partnership within the Trust and wider system to provide care which is patient focussed and needs led, to improve the patient experience and outcomes
2. deliver a prevention, recovery and well-being approach which enables service users to live as full and independent life as possible
3. provide a clear framework for pathways which wrap care around the patient supporting their needs, and enabling them to access the support they require as close to home as possible
4. improve access to services, with an integrated approach to assessment, reducing duplication
5. enable service users to move through services and into recovery/wellbeing without being blocked or delayed by structural boundaries
6. ensure our mental health provision is safe, effective and delivers the required efficiency savings

#### **5. Pathway Framework**

##### **5.1 Aims**

A new pathway framework is proposed to address the issues outlined above and improve flow through the system. The framework provides:

- i. a means to wrap care around the patient, utilising a prevention, recovery and wellbeing ethos
- ii. a formulation tool for use by all professional specialisms which facilitates patient ownership and follows the patient through their journey
- iii. an MDT approach, including social care, which removes age and cluster divisions, whilst defining specialist roles and responsibilities, knowledge and expertise

##### **5.2 All-age in Practice**

Whilst there is a commitment to removing artificial age barriers it is important to recognise specific needs of older people. The Faculty of Old Age Psychiatry developed guidance in 2014 for old age psychiatry services for the Royal College of Psychiatry. Noting that 'Restricting access to a service by age alone is not logical and now probably unlawful in the UK' they developed the following needs based criteria:

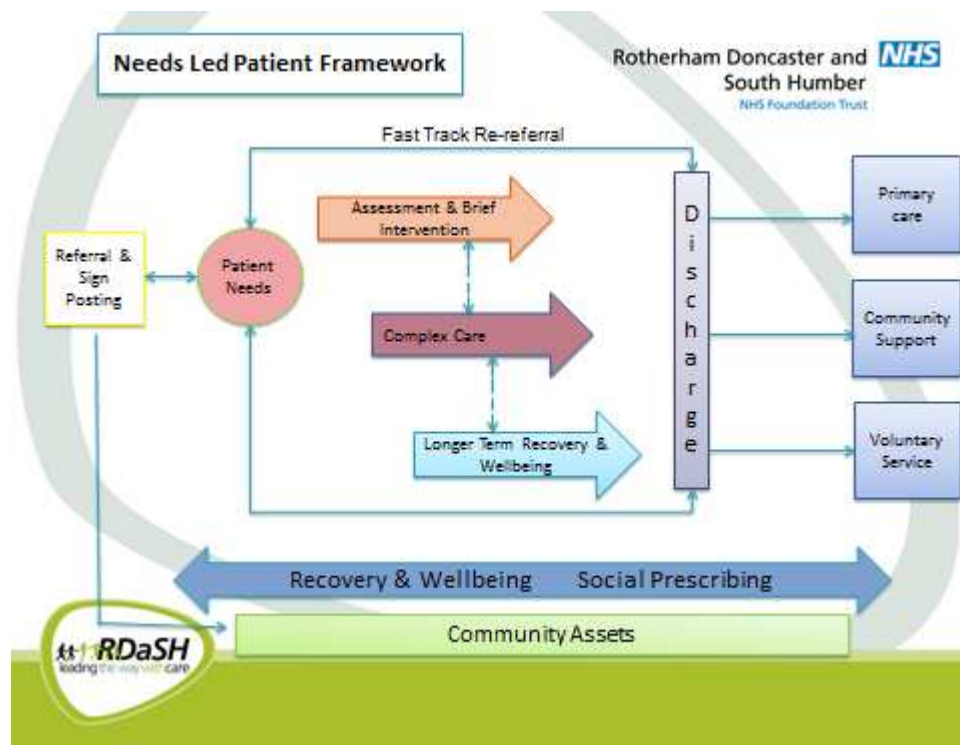
- i. People of any age with a primary dementia
- ii. People with mental disorder and physical illness or frailty which contribute(s) to, or complicate(s) the management of their mental illness. This may include people under 65
- iii. People with psychological or social difficulties related to the ageing process, or end of life issues, or who feel their needs may be best met by a service for older people. This would normally include people over the age of 70.

They noted that:

- In all cases the patient's choice should be considered when deciding the most appropriate service. Patients should generally be transferred between different psychiatric services when stable. Patients should only move services in a crisis in exceptional circumstances due to patient safety.
- For those patients with severe co-morbidity, conjoint management should be explored. The principles of conjoint management are that one team takes responsibility for the overall care and treatment of the patient, but draws upon support in addition to consultation from other services.

These principles are a useful guide for developing an-all age framework whilst recognising age related need.

There are three clinical streams within the proposed framework:



1. **Assessment and Brief Intervention:** providing rapid intervention where either the patient requires some short term, specific support to enable them to return to independent living (ie supporting them through a 'blip' or specific targeted activity to address a particular need) or an intervention to prevent further deterioration which could escalate to a crisis / hospitalisation. The interventions may be social, practical or psychological.
2. **Complex Care:** for patients who have multiple needs, are higher risk, require high intensity support or may have frequent relapses. Established treatment pathways, for example

depression, will continue to operate within the framework, providing a clear overview of what will be provided, where appropriate for the patient.

3. **Longer Term Recovery and Wellbeing:** Lower intensity patients who are more stable but have enduring needs or need a longer/slower recovery period. This stream will require less medical intervention and will include social care.

A menu of NICE based treatment pathways will sit within the framework.

Targeted activity will be developed to improve the flow through services including:

- i. reviewing referral criteria with GPs for greater transparency
- ii. strengthening the knowledge of front line mental health services to ensure patients are signposted to the right place first time
- iii. increasing the level of resource at the front end for rapid, brief interventions
- iv. working with staff to strengthen the prevention, recovery and wellbeing approach for more patient centred care and discharge, using professional based formulations, co-produced with patients
- v. developing alternatives to long term secondary care treatment interventions, where patients are no longer benefitting, including models such as the successful mental health social prescribing pilot delivered by the voluntary sector
- vi. ensuring that there are rapid routes back into specialist support for discharged patients who may relapse

A more detailed summary of the framework is set out at appendix 1. An example patient journey is set out at Appendix 2 illustrating how the patient may move within the framework according to their need and how the framework provides flexible options to enable this.

## **6. Implications for Service Design**

The pathway framework and service design work together to enable a more flexible, personalised approach to care. The framework determines what is needed for the individual and who will provide it. The service design is about how we organise ourselves to deliver care in an efficient and effective way. Appendix 3 overlays the proposed service configuration on the pathway framework. There are three elements:

- i. Initial point of contact and triage
- ii. Crisis and Rapid Response
- iii. Locality Teams (which will have some borough wide services working into them)

It is proposed to move more resources into front end to provide short term interventions to those in crisis or for those who could benefit from this approach, without the need for longer term treatment. However, treatment teams may also adopt this approach.

Set out below is a summary of what this means in practice.

### **6.1 Initial Point of Contact and Triage**

**Purpose:** A 24/7, 365 day service for crisis and new referrals to assess need and signpost the individual to the appropriate place. Discussions are taking place with the Care Co-ordination Centre to host this service providing an initial point of contact for both physical and mental health and a single all age (including Children's) contact number for the Mental Health Hospital Liaison Service. This is seen as an initial stepping stone to developing a wider Rotherham Hub including social care.



Role	Profession
<b>Initial point of contact</b> <ul style="list-style-type: none"> <li>capture and record core patient information (building on data already known)</li> <li>initial screening and signposting where appropriate</li> <li>initial prioritisation</li> </ul>	Administrative
<b>Triage</b> <ul style="list-style-type: none"> <li>assess need</li> <li>signpost service users (patients, carers and professionals) to the most appropriate place for their need (which may be the wider system rather than RDaSH services)</li> </ul>	Clinical
<b>Scope:</b> Phase 1: Mental Health (and LD tbd) adult new and crisis referrals in core hours. Out of hours MH, LD, Drug and Alcohol and children 16 and over Phase 2: may include Drug and Alcohol and Children's Services Phase 3: to develop into wider Rotherham Hub including social care	

### Anticipated Benefits

Benefit	By	Measure
Patient Care	Directing the person in need to the right place, first time Fast tracking re-referrals	Service user satisfaction Reduction in number of referrals / re-referrals <sup>1</sup>  Reduction in inappropriate numbers coming into service
Efficiency/ effectiveness	To join 4 MH and LD entry points into a combined physical and mental health service to: <ol style="list-style-type: none"> <li>provide a specialist gateway into services</li> <li>with a bigger critical mass of staff for 24/7 coverage</li> <li>Streamline processes and systems</li> <li>Make more effective use of infrastructure costs (eg telephony)</li> </ol>	Reduction in entry points Reduction in staffing Streamlining: Single process / systems solution interfacing with external systems to avoid duplicate data entry Improved management information for service delivery

### Note:

- Discussion are taking place with the CCC, an alternative option may be to work with the Doncaster SPA, whilst this would be a simpler solution in the short term, it would not provide the same stepping stone to a Rotherham hub
- Access to IAPT and Drug and Alcohol Services will remain separate in phase one

### 6.2 Crisis and Rapid Response

**Purpose:** To provide a rapid response to those in Crisis or in need of a rapid response, with provision for brief interventions to support specific short term needs for all adults. This service will

<sup>1</sup> This will require working with primary care and social care around referral criteria

incorporate functions such as assessment, crisis, hospital liaison and home treatment. There will be an integrated approach with social care (see below).

Role	Profession
To receive referrals from those in crisis / referring those in crisis,	Medics Nurses Social Workers AMHPs Admin
To assess referrals and provide time /session limited (tbd) short term interventions	
To provide home treatment to prevent hospital admissions or facilitate discharge	
Gatekeeping admissions to inpatients extended to all adults with intensive home support to facilitate discharge	

### Anticipated Benefits

Benefit	By	Measure
Patient Care	To provide more timely interventions to reduce the need for secondary service or prevent a downward spiral	Service user satisfaction Waiting times Average duration of treatment
Efficiency/ effectiveness	More timely interventions to improve flow and reduce the overall demand on secondary services and the wider system	Numbers entering secondary services Gatekeeping: reduced admissions/ length of stay

## 6.3 Locality Teams

### Purpose:

- i. To provide treatment for those requiring secondary services closer to home
- ii. To provide flexible care according to patient need
- iii. To strengthen relationships with primary and social care and third sector / community assets
- iv. Provide a named contact

Whilst it is recognised that Rotherham GPs have seven localities there is not enough resource within mental health or social care to mirror this. The mental health localities will therefore be divided into two: north and south to mirror social care provision and provide a simple and integrated model. Services will work into the localities, as is the practice with current older people's services and GPs will have named contacts within the locality for when specialist advice is needed. The locality boundaries are being set based on demand and demographics to provide balance across the two sectors and resource will be allocated accordingly. Discussions are taking place with the CCG and RMBC for co-located premises, although this is unlikely to be realised until 2017-18 at the earliest.

The mental health services will include Older Peoples Community mental health functions; memory services; community therapies, intensive community therapies, social inclusion and recovery.

Role	Profession
Designated assessments referred direct from triage	Medics

Brief, complex and longer term interventions, with treatment pathways informed by NICE guidelines	Nurses OTs Physios Psychologists Social Workers AMHPs Care Co-ordinators Admin
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**Anticipated Benefits:**

Benefit	By	Measure
Patient Care	To remove artificial age and structural boundaries to meet the needs of the individual	Patient satisfaction Patient Flow
Efficiency/ effectiveness	To reduce the length of time spent in secondary services by use of patient formulation, elective, time limited interventions and proactive discharge management and use of community resources	Average Length of treatment time Waiting times

**6.4 Specialist Borough Wide Services**

It is recommended that some services are borough wide either because of their specialist nature (Early Intervention and Assertive Outreach) or because they are too small to be viable if split across localities (Young Onset Dementia and Korsakoffs). The teams will work into the localities and will be line managed through the locality structure.

**6.5 Social Care**

**Purpose:** To provide integrated health and social care to support service users ensure statutory requirements are met and that staff work to their professional expertise.

**Principles:** Mental Health and Social Care staff will work together to:

- support a strengths based prevention, recovery and wellbeing approach which:
  - is needs led
  - develops the resilience of the individual through maximising personal resources, close support networks (family, friends etc) and community assets
  - meets the requirements of the Care Act 2014 and Mental Health Act
- support service user needs with roles and responsibilities based on professional expertise
- staff will be co-located sharing office space
- working to a profession based line management structure with social care staff reporting to an RMBC manager and mental health staff to an RDaSH manager
- professional supervision will be provided by RMBC and RDaSH for social care and mental health respectively, with an overarching mechanism to manage and review cases
- Processes and systems will be streamlined according to agreed protocols including Care Act Compliance and Safeguarding
- There will be a single point of access for mental health and related social care issues

- There will be a single assessment with one assessment form which meets the needs of health and social care wherever possible
- Staff will have shared access to information across IT systems within information governance protocols

Key social care activities have been identified as:

- Provision of services that are Care Act compliant
- 24 hour AMHP service: covering all aspect of work under MH act and any RMBC out of hours crisis issues.
- Assessment and short term centred intervention: including full needs assessment, working into the wards and re-referrals from treatment teams
- Social care activity in relation to safeguarding, BIA assessment, 117, management and review of residential care placements / direct payments and professional issues

**Scope** RMBC staff are currently embedded in mental health working age adult teams, but are separate for older peoples and learning disability services. The initial scope is therefore for working age adults, with the aim of extending this to older people and learning disabilities.

#### Anticipated Benefits

Benefit	By	Measure
Patient Care	To reduce the number of assessments and provide integrated support to address both mental health and social care needs in one place/process where possible	Service user experience Numbers entering service Number of assessments
Efficiency/ effectiveness	Utilise specialist expertise ensuring staff work to their professional training Streamline processes and systems Reduce duplication and cost	Efficiency savings

**IAPT services** currently work into localities and will continue to do so. They are part of the care group and will be more closely integrated with other services including more effective internal referrals. In the short term the IAPT service will continue to build on the gains made in reducing waiting times following non recurrent investment from NHS England to embed sustainable change.

#### Timescales

The proposed changes are transformational requiring changes in how we work with patients and carers, within RDaSH and with partners, as well as what we do and how we organise ourselves. This will also require cultural change as well as process and systems change. Due to the scale of change required a pragmatic, phased approach is being taken. RDaSH are developing the next phase of the programme plan which will also identify interdependencies with the Unity (patient record system) programme. Summarised below are the high level milestones of the next phase.

#### Phase 2

Governance Approval Process	
i. Service configuration	July 2016
ii. Confirmed clinical team design and	October 2016 (with formal HR consultation

management structure	process for affected staff, aligned with other care groups to manage redeployment opportunities)
Pathway design and development	On going
Admin review	November 2016
Phased transition (new referrals)	From December 2016
Implementation	By 1 April 2017*

\* Implementation will be phased, teams may initially be virtual as changes to estate will take longer to realise. Interdependencies with Unity and agile working will be realised in 2017-18.

### 8.QIPP Savings

It is anticipated that the service re-design will meet the required QIPP savings for this financial year through the senior and middle management re-structure and some targeted savings.

However, the 2017-18 target is more challenging and will require:

- i. A reduction in numbers in service (realisation of the benefits outlined above)
- ii. A review of clinical and administrative staffing
- iii. The outcome of discussions with RMBC regarding funding of social care roles

### 9. Risks

The main risks are that:

- i. There is a negative impact on patients during the transition period  
Mitigation: to work together across the system to manage this
- ii. Colleagues across the system do not work together to reduce the number of referrals and increase discharges so flow through the system is not improved. This will create blockages at the front end and increase waiting times  
Mitigation: To work together to communicate the benefits and develop and deliver a transition and training plan
- iii. Staff, colleagues and / or service users do not make the necessary cultural change to achieve new ways of working.  
Mitigation: clear, timely and consistent communication as to what, why, how and when changes will happen, with ongoing dialogue to monitor, respond and adapt to circumstances where required
- iv. There is a critical interdependency between mental health and social care funding of roles, this is to be reviewed by RMBC in 2017-18 and could have a negative impact on service provision and meeting the required savings  
Mitigation: to acknowledge the cost pressures on commissioners and providers and work together to find a pragmatic solution which supports the new shared principles and the needs of the whole system

**Future development** In the short term, further work is required:

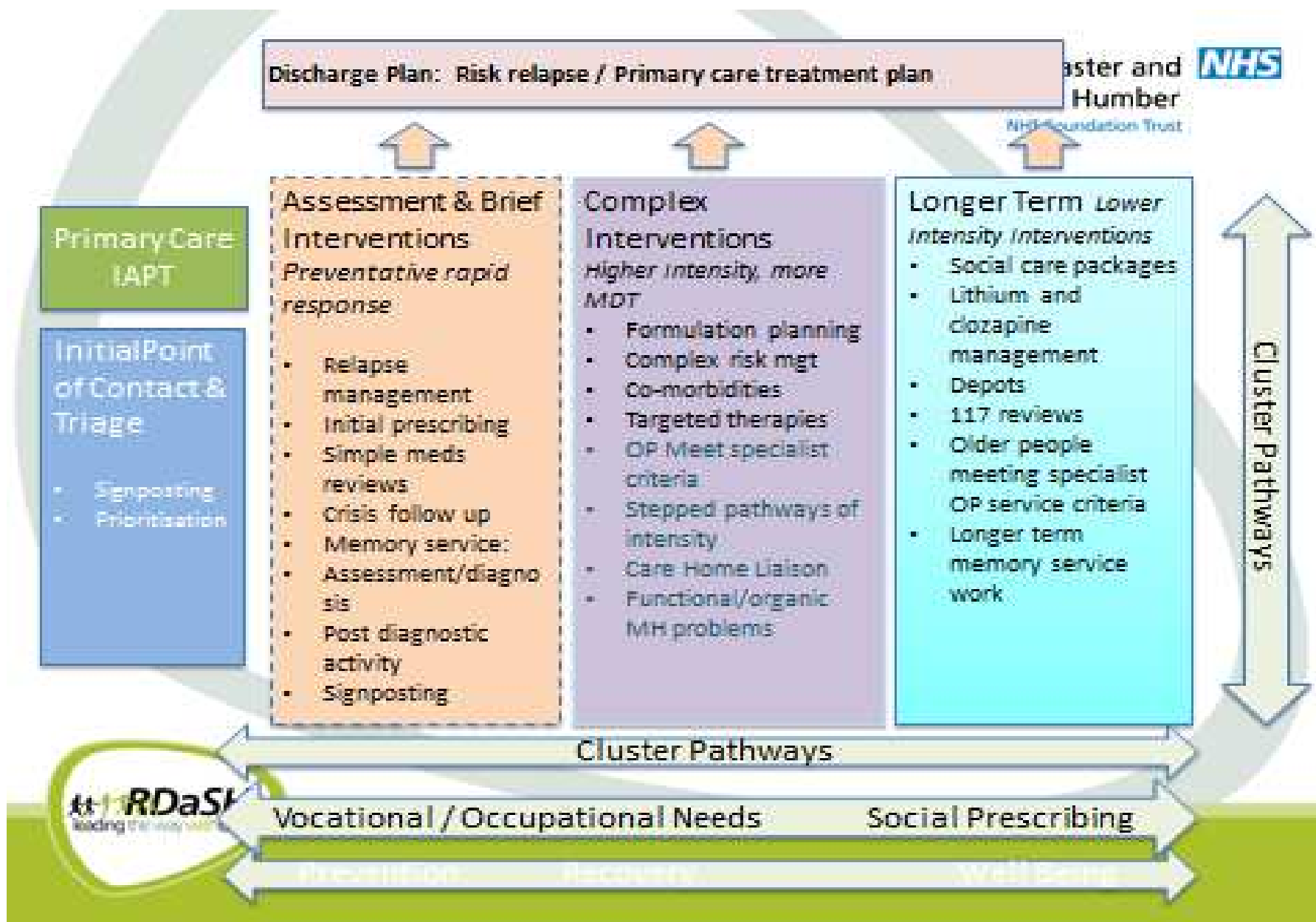
- To model services and trajectories to reduce numbers in service
- To work with primary care on referrals, discharge and re-referrals
- Develop alternative models with the voluntary sector in relation to bridging routes, such as social prescribing, to increase independent living and reduce isolation

For the longer term, these recommendations have been developed alongside the CCG's integrated locality pilot, which RDaSH is proud to be a member of. The recommendations can be further developed if the locality model is rolled out, extending the concept to whole system integration particularly in relation to a Rotherham wide health and social care first point of contact hub; physical health and mental health; all-age integration with social care and extended working with the voluntary sector.

## **10. Action**

Members are asked to comment on the proposals outlined above in relation to:

- i. Approach
- ii. Pathway framework
- iii. Service configuration
- iv. Partnership working with primary care and social care



## Pathway Framework: Patient Journey Options According to Patient Need

## Appendix 2

