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Update on the RDaSH Rotherham Care Group Transformation Plan

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RDaSH leading the way with care

1. Purpose

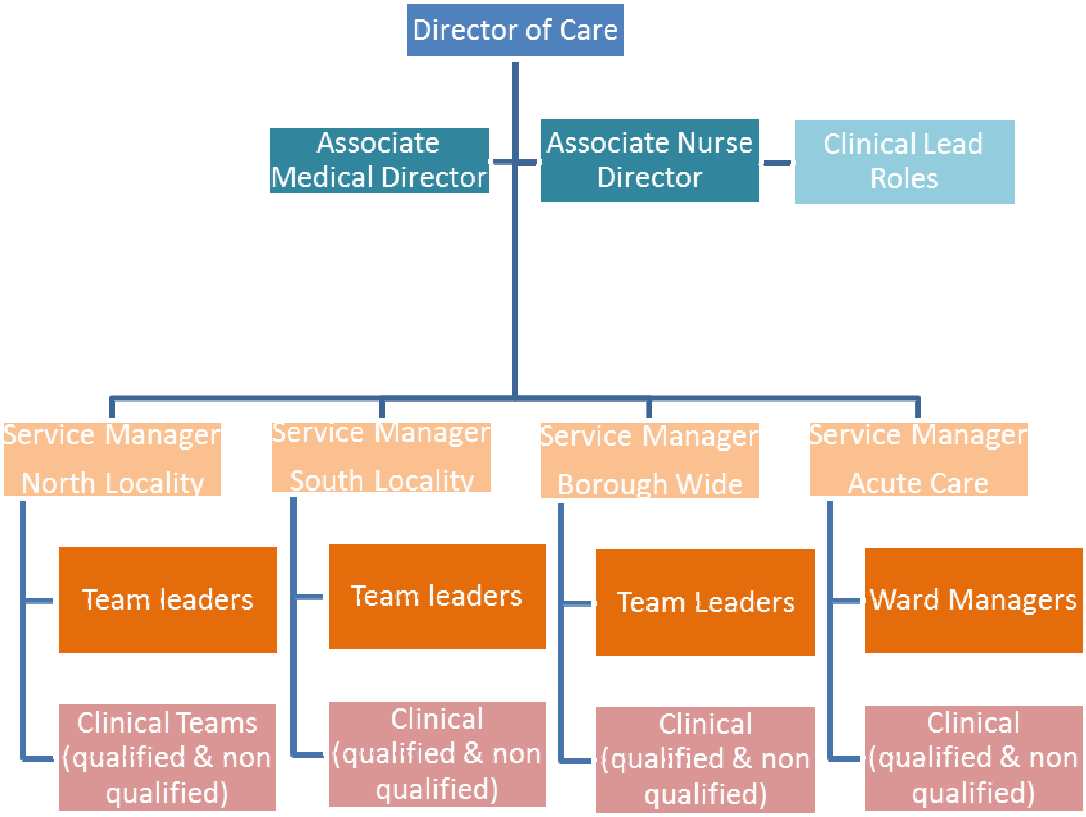
The purpose of this paper is to update the Commission on the RDaSH adult mental health transformation activity as outlined to the Commission in Summer 2016.

2. Group Formation

RDaSH have now moved from age related cross Trust business divisions to place a based locality Care Group. The management structure is in place. This is made up of three new Care Group senior management positions:

- Director of Care: Dianne Graham
- Associate Medical Director: Dr Graham Tosh
- Associate Nurse Director: Rachel Millard

The post of Rotherham Locality Manager was removed as part of the senior management re-structure. The service management structure set out below emerged from the pathway framework and service configuration work to support the delivery of a multi-disciplinary approach, where care wraps round the patient. The structure is based on a prevention and recovery model and has been developed in line with the Five Year Forward View, the Place Based Plan and in anticipation of the roll out of an integrated health and social care model. The new structure represents a reduction of 6.33 whole time equivalent band 8 service manager roles to 4.



3. Clinical Services Transformation

3.1 Care Co-ordination and Integrated Rapid Response

Currently there are multiple contact points for stakeholders (patients, carers and professionals) to access support. An integrated physical and mental health initial point of contact will be provided by Rotherham NHS Foundation Trust's (TRFT) Care Co-ordination Centre (CCC). Initially this will be for all-age adult mental health (excluding IAPT) and learning disabilities service users. This will include an all-age (including children's) single point of contact for mental health hospital liaison. Triage will be carried out in an extended Integrated Rapid Response Service. This will build on the current TRFT service and plans include the RMBC mental health social care services relating to Adult Mental Health Practitioners and RDaSH crisis and home treatment teams. The services will initially be co-located, leading to full integration. This phased approach is to ensure smooth transition and manage risk.

3.2 Locality Teams

The mental health locality services will map onto the new proposed locality model of North, South and Central. The mental health model will have two teams that work into the third locality as there isinsufficient resource to split three ways. Work is underway with the Council to identify opportunities to co-locate services and use community accommodation for group and therapy work. This needs aligning with the wider conversations around the role out of the Village Pilot.

It's anticipated that over 60 % of RDaSH staff will be based in locality teams. Staff within the locality will be attached to pathway teams, according to their skills and specialisms. A new pathway framework has been developed of brief interventions, complex care and longer term conditions. A skills audit and gap analysis has been carried out to identify current skills and shortfalls. Staff will predominantly work within a pathway stream, but may work across pathways according to patient need and their own specialism.

Staff from the memory service and older people's community team will form part of the complex care pathway. Roles will be reviewed to in the light of the primary care dementia pathway and in anticipation of growing demand over the next ten years. The role of the Care Home Liaison team will be reviewed alongside TRFTs team with a view to integration. It is proposed that IAPT services and Learning Disabilities and Drug and Alcohol community functions will be locality based to further develop links with primary care and improve integration with mental health services.

3.3 Adult Mental Health Hospital Liaison This successful early transformation project is now re-currently funded. Development funding has been secured from NHSEngland to enable the service to become compliant with the national Core 24 standard, which will enable the service to become 24/7.

3.4 Inpatients

We are developing all age services within our inpatient facilities in order to provide improved care based on need rather than age.

Woodlands
The Ferns ward has been open as a pilot since May 2017 aiming to provide cognitive rehabilitation for patients admitted initially to TRFT who are deemed to be medically stable. This is a joint pilot between RDASH and TRFT and it has been funded until the end of November 2017.

3.5 Social Care
Health and social care responsibilities have become blurred within working age adult teams. These have been reviewed with Council colleagues in the light of the Care Act and mental health guidance[1] A new model for integrated working is being developed to support the independent lives/recovery and wellbeing ethos and aligned with the pathway framework. RMBC Adult Mental Health Practitioner roles and social work roles will form part of an RMBC change process.

Social care for older people and learning disabilities are currently separate to RDaSH services which creates a disjoin for service users and is at odds with the stated place plan and the national 5 year forward requirement of integrated mental health and social care by 2020. It is hoped that the new integrated working age adult mental health model will be extended to an integrated all-age adult mental health and learning disability model.

3.6 The Wellbeing Hub
RDASH are currently piloting a centrally located well-being hub in partnership with Rotherham United Sports Trust (RUST). The aim is to address the needs of those members of the Rotherham community who struggle to sustain good mental and physical health as a result of challenging social circumstances, poor coping ability, lack of support network, and poor quality of life. Interventions are delivered via therapeutic and educational classes that are supported by a broader programme of sport based activity. Opportunities for peer support, voluntary work and preparation for employment are key objectives.

3.7 Social Prescribing
The Rotherham Social Prescribing Scheme is a nationally acclaimed, innovative project with a high profile within the NHS and voluntary sector. Social Prescribing involves funding social activity via the voluntary sector to support those needs that traditional health intervention cannot sustainably address such as social isolation and poverty. It sits alongside clinical interventions helping people live their lives in a way that feels like “living” rather than “coping” and “surviving”. It expands on Rotherham’s integrated response to patient care; it’s where the NHS ‘meets’ the community and its assets, shifting the focus from conditions or ages to localities and communities.

NHS Rotherham CCG has already used social prescribing to support people with long term physical health problems. Following on from the successful Long Term Conditions (LTC) social prescribing scheme, which found consistent reductions in the use of services, (a 6-11% reduction in non-elective in patient stays and a 13-17% reduction in the use of A+E services, more detailed analysis shows higher reductions in certain types of patients), this approach was extended in 2015 to mental health

patients within Rotherham for a one year pilot. The independent evaluation of the pilot scheme carried out by Sheffield Hallam University's Centre for Regional Economic and Social Research (CRESR), found that it helped increase the number of discharges from mental health services and improved social and emotional well-being of the service users. Within the first year 54% of the service users who had been referred to the service had been discharged from mental health services, some patients having been supported by secondary mental health services for between 5-20 years, with only 2 discharged service users being re-referred. The evaluation also showed that patients who had been through the mental health scheme have experienced wider social benefits.

4. Next Steps

The next steps include:

- Launch of the integrated CCC (phase one scheduled for October 2017) and IRR phase 1
- Completion of the clinical and administration review
- Roll out of the pathway framework (phased, brief interventions is currently being piloted)
- Roll out of locality teams, aligned to the roll out of Village Pilot model (from January 2018)

A more detailed update on the pathway framework will be provided to the Commission's November meeting.