



**NHS Next Stage Review
NHS Yorkshire and the Humber**

**Report of Mental Health
Clinical Pathway Group**

Nick Morris and Lyn Sowray

May 2008

THE MENTAL HEALTH CLINICAL PATHWAY GROUP

PREFACE

Approximately one in a hundred people will be in need of specialist mental health services at any one time and without proper support a significant majority of these people will end up with poor prospects of employment, discriminated against and isolated from family and community supports. One in ten of us will have a less traumatising mental health problem in the next year which will affect confidence, raise stress levels and result in reduced work efficiency and will also have profound impacts on family including emotional distress for children.

The difficulties that services face in dealing successfully with people with mental health problems stem from ignorance within the community, stigma and fear. Mental ill-health is one of the most misrepresented issues in the media causing misunderstandings in the public. Mental health service users are likely to have high levels of violence, abuse and discrimination directed at them compared with other groups within society and they are three times more likely to die prematurely from heart, stroke or respiratory disease than the average person on the street.

Mental health problems result in greater loss of economic potential to England than any other health condition with lost output and high benefits payments. Yet people suffering from mental health problems desire work, often retain the skills necessary to complete complex work tasks. When they do gain employment they are usually denied all but the most menial and poorly paid jobs. Their reduced economic status means they drift down the social ladder so that those with profound mental health problems end up representing disproportionately high numbers in poor neighbourhoods with reduced access to other forms of social and community support.

And yet things do not need to be so depressing. For example, approximately 78% of young people with schizophrenia will get better completely, or recover to a point that they can enjoy a full and fruitful life.

As a result of the above, the MH CPG looked at the promotion of mental health well being across the whole population and how services should respond when an individual identifies that they have a problem with their mental health. The Group identified that the key features for improving services for people relied in quicker and equitable access to services followed by integrated 'person centred care' that recognised them as 'whole people'. To deliver this there is a need for reduced stigma, increasing opportunities for general support to people at home, education and the workplace to encourage people to ask for and seek support when they need it. There should be integrated care across partnership for people who need to receive specialist care. The MH CPG recommends that mental health and mental well being needs to feature as a core element of all other forms of health care provision - there is no 'health' without mental health.

**NHS YORKSHIRE AND THE HUMBER
OUR NHS – OUR FUTURE
CLINICAL WORKING GROUP REPORT ON MENTAL HEALTH**

1. Introduction

This report is the result of work undertaken by the Mental Health Clinical Pathway Group, (MH CPG), (Appendix 1 for membership).

The group recognises that a prime consideration should be the mental well-being of the population. Mental Ill-Health represents a greater burden on society than any other health condition both in human and economic costs. Individuals need to feel supported by communities, families and workplaces that minimise contributing factors towards mental ill-health. National and local policy across all governmental departments should work to address the inequities that contribute to mental ill health. Whilst the issues are broader than Health and Social Care, the MH CPG recommend that Public Health take a lead to ensure that PCT's and local authority's contribute to/and prioritise the MH programmes of 'Choosing Health'. Commissioners should be required to recognise variation in need in communities and address issues of variable investment in services, and variations in resource distribution in order to tackle issues of inequality of access. The MH CPG would welcome a report commissioned by the Strategic Health Authority and Regional Government Office to act as a catalyst for Public Health.

This report will however focus on the coordination of mental health services required to meet the demands arising from local communities. It will not look at specific service elements or specific service user group in detail. Instead it provides a response to the issues raised by service users and the public about access, coordination of care and simplified care planning and delivery with the proposal to develop greater integration of services within a partnership framework, integration of primary and secondary care assessment and care-coordination and a continued integration of health and social care services.

2. Background and Context

National and local evidence suggests that the Yorkshire and the Humber population has a higher than average rate of both common mental health problems and severe mental illness. The vast majority of people will be responded to within the family, community of friends/colleagues or within primary care settings. However a significant number of people, approximately 1:100 at any one time, will be so disabled by mental health problems that they require the support of specialist mental health care services.

People with severe mental health problems usually suffer discrimination, lost work opportunities and a general reduction in social status leading to their decline through the social ladder. As a consequence people with severe mental health problems represent high proportions of the population in

deprived communities with little economic clout or potential. Physical health care is poorly serviced for people with MH problems in primary, acute or even specialist MH services. The Standardised Mortality Rate for death from coronary heart conditions, respiratory disorders or strokes is 3 x the general population level.

Within Yorkshire and the Humber, 38% of the people claiming incapacity or severe disability allowance have a mental health problem. The NHS will spend 13 % of its total budget on mental health equating to £150 per resident person. We have the second highest age standardised rates of hospital admission for self harm, the third highest age standardised rates of hospital admission for drug overdose and a 73.6 per 100,000 admission rate for depression compared to 69.0 per 100,000 for the England average.

Specialist mental health services have changed considerably over the past 20 years with a retraction from ‘asylum’ models, a gradual reduction in bed capacity and the growth of community care services. Services have responded to modernisation initiatives within the adult and older peoples NSF’s and the Valuing People White paper with a further development of community alternatives. This has resulted in a growth of rapid response services and implementation of ‘New Ways of working’ with reduced outpatient services and the development of multi-disciplinary specialist teams. Third sector providers are developing capacity but commissioned partnership networks are poorly developed in most places and third sector partners do not generally have the security of funding which would allow them to truly develop their role within a partnership framework.

Yorkshire and Humber currently have the following NHS providers of specialist MH services working in partnership with their local authority Social Services Departments.

Specialist MH Foundation Trust	- Rotherham, Doncaster & South Humber Healthcare NHS Trust - Leeds Partnership Trust
Specialist MH Care Trusts	- Sheffield Care Trust - Bradford District Care Trust
Specialist MH Trusts	- South West Yorkshire Mental Health Trust - Humber Mental Health Teaching NHS Trust - Tees, Esk and Wear Valleys NHS Trust [Scarborough and Ryedale]
Primary Care Trusts providing some specialist Mental Health Services	- North East Lincolnshire Care Trust Plus - Barnsley PCT - North Yorkshire and York PCT - North Lincolnshire PCT

There are a wide variety of not for profit and independent sector MH service providers. Whilst some localities are reasonably well served across the region, their number and the volume of services provided appears lower than national averages and their role in a partnership with statutory providers is not well developed.

It is important to note that whilst learning disability services have not been a feature of the national review of the NHS, the principles of the models described below are of relevance to people with a learning disability. The principles within 'Valuing People' of equal access to all services should form a template for integration with mainstream services.

3. The Case for Change

Joint Needs Assessment: Generally joint (Public health led Health and LA) needs assessment of population level demand is not meaningfully assessed, and therefore capacity/demand relationships are not understood. It is evident that spend and hence capacity is lower than national averages.

As a consequence, services and practitioners have developed complex and artificial barriers to referrals due to 'fears of overload' and mistrust of the referrer assessment.

Poor whole population needs assessment data has often led to ad-hoc commissioning and provider development of services which has resulted in services being organised into discreet 'building blocks' with artificial barriers between them that are not understood by service users and do not allow for easy flow through the care system. Referral routes are overly complex with an onus on the referrer, (often a generalist) to be experts in service identification and placement.

Resources spent on gate-keeping could be utilised better on care provision if services had greater trust in the referral made and capacity matched service demand. Additionally, robust care coordination supported by care navigation systems, (see below) would improve this for all service users.

Epidemiology: Localised epidemiological data is generally poorly developed. Until commissioners have developed robust needs assessment, the following data derived from national prevalence rates gives a scale of the need.

Approximately 1:100 people at any time will need care from specialist care providers. 1:10 of the population will have a need for some form MH support in any one year, with 90% of these people receiving support from non-specialist care services. The rates of self reported stress, depression and anxiety are amongst the highest in the country.

Yorkshire and Humber has a higher than average suicide rate, 9.5 per 100,000 population compared to 8.4 nationally. The national rate is reducing but the rate for this region has been rising since 2003. Whilst more research is required into the impact on suicide of generalised hopelessness, poverty and societal factors which are not necessarily a product of mental illness and hence not necessarily open to influence by MH care provision, the health and social care community has a responsibility to work with other organisation to influence economic and societal improvements and reduce inequalities of opportunity.

Self assessment of the national service framework implementation teams has illustrated considerable variation in the services provided in localities and the speed with which services have been modernised. This is illustrated by the following:-

Poorly developed and ill-defined roles for **Community Mental Health Teams** in many areas since the introduction of Specialist Teams. CMHT's should be the building block of services for most people needing specialist care but staff numbers and capacity do not reflect the need in communities and resources do not reflect variation in demand.

Primary Care MH Teams are often poorly developed. Few localities have planned and delivered services which are integrated with specialist services.

Psychological therapies: In early 2007 only two areas measured and had strategies in place to ensure waiting times for psychological therapies were reduced, although most areas accept that this was a priority area for development. Psychological therapy/talking therapy remain un-available in some areas to people with severe mental health problems. People with long term conditions, carers and older people with MH problems do not have easy access to psychological interventions despite evidence to suggest that this would be beneficial. It is estimated that 50% of 'unexplained' medical conditions could be resolved by psychological interventions.

Crisis Resolution and Home Treatment, (CR/HTT): The region spends the fourth lowest amount on CR/HTT according to the National Audit Office. Only two PCT areas are achieving targets for home treatment episodes and few teams appear to be funded to provide full out of hours home treatment support. Examination of poor performance suggests that teams are focusing on assessment of people experiencing early stages of a mental health crisis that could be dealt with by more responsive primary and community services. This impacts on the teams capacity to deliver home treatment. Teams are often inappropriately expected to be open access to primary referral points. Teams do not always play the central role in gate-keeping access to beds that evidence indicates is necessary.

Early Intervention in Psychoses, (EIP): The establishment of EIP teams across the region has been slow, due to lack of investment and only two PCT areas are treating their expected number of new cases. This is an area of concern as evidence clearly demonstrates that early intervention offers the best outcomes for a young person with realistic opportunities for a full recovery from a first episode of psychoses.

CAMHS: There are many examples of valued CAMHS services but little evidence of strategic development across the region and hence (as with other MH services) little understanding of relative performance of the services.

The transition from children's mental health services to adult services is poorly developed. Variation in age transition exists between health and social

services. CAMHS on-call systems are variable leading to some inappropriate care on adult units and poor levels of 'Tier 4 provision'.

Older People: The implementation of integrated health and social care teams is not yet complete across the region. There is variation in provision of memory assessment services.

Demand will grow with increasing old age populations yet capacity in community older peoples MH services does not appear to be led by commissioned demand forecasts. Older peoples CMHT's are smaller than their adult MH equivalents - relative to size of demand.

The government have commissioned the development of a national strategy for dementia care which will be available summer 2008. The CPG endorse the emerging themes but recognise that variation in implementation will occur without coordinated strategic leadership.

Service User Outcome based Commissioning: The CPG identify that quality control, outcome measures, standards and poorly developed 'benchmark' data sets are an area for urgent development. Commissioning should focus on service user outcomes rather than just targets.

Assessments: CPA and equivalent person centred care planning systems appear to be IT driven processes and hence not seen as core to clinical and practitioner working or culture. The role of these systems in assisting staff to coordinate care, resource deployment and planning is poorly developed and poorly understood by many practitioners. Risk assessment is poorly researched, (Appleby) and poorly applied in practice with evidence that risk ratings are not leading to changes in care coordination responses. People who use the service and their carers report having many assessments which are repetitive.

At an individual care level, the regional service user and carer focus group acknowledged that services had improved in particular the quality of care environments. **However they still believe care is not service user focused and that information enabling them to have informed choices about the care available is poor. Whilst most staff work very hard in difficult circumstances, attitudes and 'respect' for service users remains a significant concern.**

Services need to provide integrated 'holistic' care to individuals. For example: people with MH problems find work difficult to attain yet there is no doubt of its health promotion benefits as regards recovery from mental health problems. Planning and commissioning must be undertaken in partnership with the wider health community, social services, education, housing, employment, criminal justice system, voluntary and community organisations.

Services need to be integrated across the 'Tiers' of provision. For example, Offenders have significant mental health problems. Home Office surveys report that up to 90% of the prison population have profound MH problems

often associated with dual diagnosis drug problems. Follow-up from release from custody is variable in quality.

Mental health services benefit from a plethora of NICE and good practice guidelines which the MH CPG group wish to endorse and see integrated into the generic care pathway outlined below. We would expect that each locality would ensure implementation of evidence based models of care.

4. What the public want from mental health services

People who use services and their carers want help as soon as they identify they have a problem and they want information. The 'Staying Healthy' CPG public focus group sited mental well being as an important component of being healthy. They want better information on their condition, medication, its side effects and other therapies available to them. They want information/advice to help them navigate the care system. Communication with people who use mental health services and their carers was inconsistent although it was said to be improving.

They perceive inconsistency in all aspects of mental health services. At times they did not experience being treated as people and with dignity and respect. Lack of continuity in treatment and personnel was identified as an area for improvement with consistency of care-coordination over the span of their care.

There is an over reliance on medication rather than other therapeutic approaches.

'Discharge and then re-referral' is a feature of services, even for people with long standing conditions.

There are too many steps in accessing care and too many re-assessments. This is very unhelpful.

Carers were not assessed for their own needs.

Inpatient care is still an area of concern for service users with services being described as chaotic, lacking supervision with some staff appearing to be uncaring. Newer inpatient facilities compare favourably with the old but are not yet available in all areas.

Access to recreational activities, study and employment is not widely available for people who use mental health services and they want their care plans to focus on what they can do rather than on what they cannot do.

5. General Principles agreed by the MH CPG

The group discussed the views of the regional service user focus group together with the views of people in their own localities. The following key principles were agreed by the group:

- The system must be person centred
- Service users involved at all levels, (self care through to service planning)
- With the right care at the right time delivered by the right person in the most appropriate place
- Needs driven not age defined
- Modular assessment that adds value to the person using the service
- Service is safe and does not cause further harm to the person
- Evidence based wherever possible
- Good collaboration/communication with carers

Design features of a world class patient journey

- Early access/intervention – single point of access
- No waits and no queues
- Self access facilitated to assessment of need with ‘care navigation’ systems of information and advice to enable self choice
- Minimum duplication/waste of patient time with reduced barriers and smooth journey across any necessary interfaces
- Care Navigators to support person in receipt of care coordination
- Good collaboration/communication across services – active partnership
- Variety of evidence based interventions offered
- Outcome oriented performance monitoring
- Staff training and development to be a design feature of the service

The group received several examples of good practice in service delivery from across the region and this evidence has been used in formulating the generic mental health pathways and recommendations. However it appears that many good practice services do not fit within a whole system approach to care development. A glossary of good practice submitted will be made available separate from the main report.

6. The key features of a Mental Health ‘generic’ Care Pathway

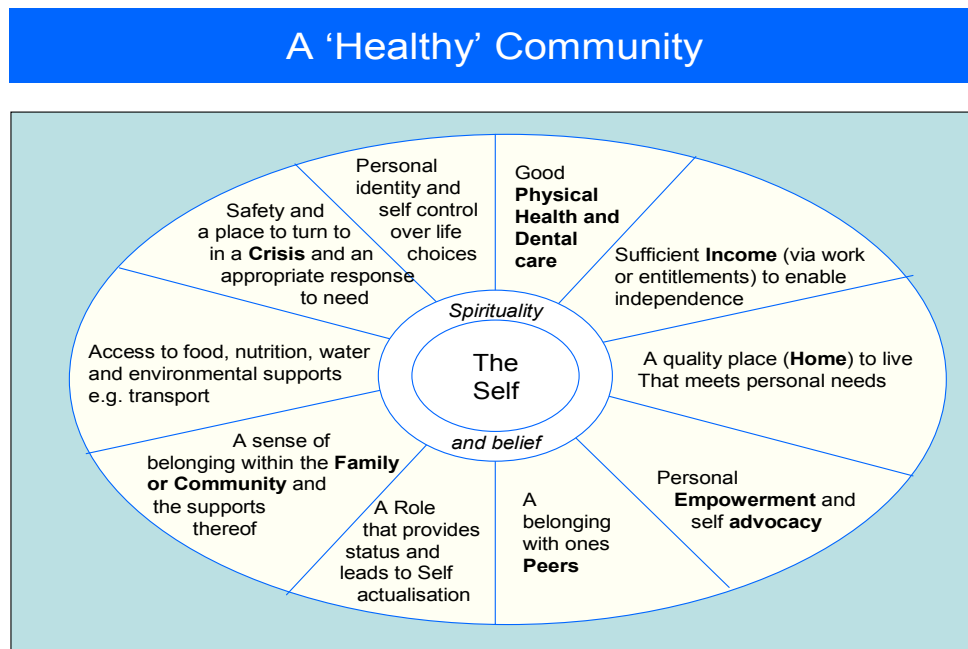
The following sections and diagrams aim to highlight the key features of the generic care pathway that the MH CPG believe would meet the aspirations of the public and mental health service users. The first section sets the context for commissioning, partnership work and the care planning process.

6.1) Mental Health Promotion and Mental ‘Well Being’

Diagram 1 below is derived from a model of Comprehensive Mental Health Services, which the MH CPG believe provides a useful starting point for describing a ‘mentally well community’ within which a persons mental well being can be supported. There are other, perhaps more sophisticated models derived from public health, Local Authority work, etc. but the MH CPG believe this is a simple and very useful model for the purposes of this report.

The model represents the key ‘domains’ required for a ‘healthy life’. Local communities and family structures should allow for an individual to be supported in each of the domains. The wording represents aspects of a person’s life that enable healthy fit within a community or family. If any domain is missing it would likely lead to difficulties and reduced life potential.

Diagram 1



The MH CPG does not pretend that this is a definitive model but believe it provides the basis for the following;

- A significant level of mental health distress arises from a failure to provide safety and security and a sense of belonging within the family, community or through work. Well-being also requires exercise of choice over everyday

life and a respect for diversity. Hence Local Authorities working through their Directors of Social Services and the Director of Public Health in PCTs; should aim to provide a 'healthy community'. The Joint Strategic Needs Assessment for a locality would ideally include all the above components in assessing the health and social care needs of its resident population. Local Area Agreements could use this assessment as a basis for joint commissioning services.

- All organisations should aim to provide a healthy workplace consistent with existing policy following the principles of the above model.

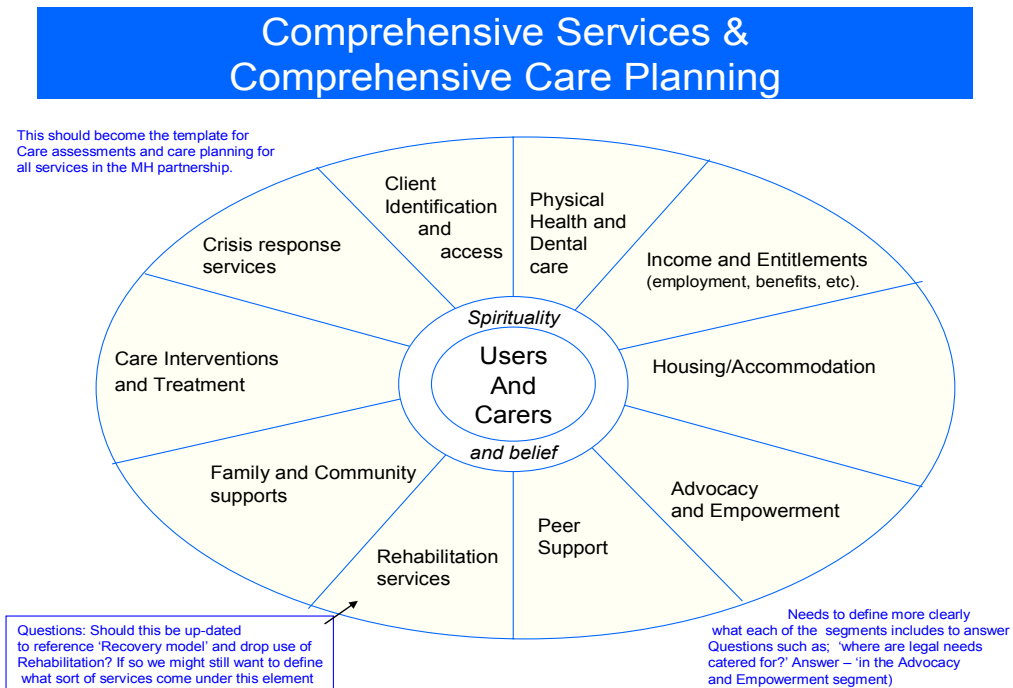
As such, MH promotion will be delivered which should reduce the overall burden of mental health distress and encourage individuals to thrive. Through the observance of, and support to individuals in crisis/need within the above model it is likely that most people will receive the timely care required to prevent the need to access more specialist support.

However, when such access to specialist support is needed it should be delivered in accordance with the generic model described below.

6.2) Commissioning and Partnership

Diagram 2, represents a holistic model of Mental Health services derived from stakeholder (J. Turner-Crowson, NIMH (USA) in the early 90's.)

Diagram 2



It was developed to assist commissioners in understanding the key elements of a service necessary for provision of good quality mental health care to a

local population. Commissioners should develop the local market or environment under this commissioning framework, led by the local strategic partnership board to ensure provision of all elements of the model. A range of organisations need to come together to provide the overall partnership of services necessary to meet need. The NHS and Social Services clearly have a significant role to play in providing services however they are not best placed to provide advocacy, housing, community and family support, jobs etc. which would need to be provided by other organisations working to stimulate a healthy local community. An organisation may find they have the skills and experience to occupy a small number of niche role in such a model. However no organisation can (or should) provide services to meet all the needs of an individual/group, hence partnership provision is required to allow individuals to access elements of care from a range of providers to meet all their needs. Commissioner contracts should be developed with each organisation within the partnership over sufficient time periods, (10 years minimum) to allow for service development within effective partnerships. This would mean a shift away from the annualised 're-commissioning/tendering process' that so besets the third sector organisations. This model would therefore provide security of funding and role within the partnership structures for all providers, ensuring an equal playing field for third sector providers.

Commissioning needs to be built upon a population need based model of planning, which would ensure the commissioning of a capacity and demand model rather than the current activity model which leads to significant un-met need. Public health based epidemiological models have been used for many years to produce indication of prevalence, (G. Glover (MINI); Wing et al), for severe mental health problems. A high quality first class mental health service can only meet the principles set-out above if service capacity is sufficient to meet this need. Additionally this capacity has to be focused on where it is needed, (for example: matching localised needs assessment using GP practice MH registers and estimated MINI data down to practice level), to ensure resources are deployed to address variation in need/demand. This would allow services to be developed with appropriate case loads as defined by MH policy implementation guidance. This should be the case for all age mental health services. Additionally staff must work with the right service users relative to their skills and experience with the most qualified and experienced staff retained to work with those most in need;

- Psychiatrists and Psychologists should work to consultancy models with low case loads allowing them to support the team colleagues.
- CMHT staff, (Psychiatry, CPN's, SW's, OT's, Psychologists, etc) focus work with people needing care coordination, (subject to CPA, SAP, Person Centred Care)
- Psychologists and therapists integrated into MH teams to provide team support and case management support to difficult and complex cases
- Counsellors and other psychological therapy staff being available to all people who would benefit from psychological interventions within Tier 2 care, and as part of a care package within Tier 3 services.

These approaches are consistent with 'New Ways of Working' in Mental Health - Department of Health and the CPG believe this approach can be delivered in the generic care management model described in section 5.

6.3) Care Coordination

At an individual level the above model is helpful in describing a comprehensive care planning framework. Assessment tools such as HoNOS based tools, or the Camberwell Assessment of Need (CAN), all map well against this model. The main objective of this approach is that all care assessors should be competent enough to undertake an assessment that starts to map need against each of the domains.

Each organisation in the partnership should be encouraged to use this as a basis for a 'single assessment framework' and hence contributing to a streamlined joint assessment. Service users rightly demand a simplified and where possible single assessment of their needs. This above approach would mean that a **single core assessment** can be completed for each individual using the skills of well trained and competent assessors. Working within a multi-disciplinary framework the initial **Core Assessment** can be added to with **modular inputs** from specialists/other organisations seeking to identify their unique contribution to the overall care of the individual.

6.4) Care navigation and Care Co-ordination

a) A Personal Advisory Service and Navigation

Most people will be able to identify that they need help and they will have the personal resources, (strength/empowerment and self control over life choices) that will enable them to access support. What they need though is good quality information and advice which is easy to access. The CPG recommend development of robust Personal Advisory Services in each locality that are open access in order to facilitate self navigation through the care options. For most people this system will be characterised by libraries of information held in many places, web-based information and assessment material, and guided self help material. The Personal Advisory Service will include staff known as 'Navigators' who can help and advise necessary. **This system of advice and information should help many people to self access primary services, third sector and self help services, occupational health systems, etc. that will meet their needs. The CPG recommends that the Personal Advisory Service is commissioned from an independent (Not-for-profit) organisation.**

Some people (approximately 1:100 at present) will be unable to exercise full control over their life choices due to their MH problems. These people will require the input of specialist practitioners acting as care co-ordinators. Navigation for these people may be characterised by a personal advisor available to help them to make choices and advocate for them. The person may choose personal friends or family to act in this capacity, (informal carers),

but they should be assisted by the Personal Advisory Services which will act as a focus for information and advice and be readily available to them. **All people receiving care-coordination should however be offered the services of 'Navigators' employed by the Personal Advisory service to 'advocate' and support the person until they can exercise control once again over their lives.**

b) Care Co-ordination

Care co-ordination is the process of assessment and identification of need that occurs via the negotiation between the assessor and the service user. Working together they will aim to match need to the services and interventions available to support them. Working from the service users perspective, the objective is to empower the service user to make choices from a wide variety of options available to meet their care needs – 'guided' by advice from the practitioner. (On very rare occasions legislative frameworks, (MH Act), may be required if the perceived needs and choices made by service users are deemed to put the service user and or others at risk).

Navigation at this time is the processes of helping the person articulate their views and choices to the care co-ordinator so that they are empowered to exercise informed choice. As stated above, most people will feel capable, (informed and empowered) of negotiating their own needs on an equal footing with the practitioner. However appropriate information is required about the problems they are experiencing and the supports and interventions available. **All organisations have an obligation to make good quality information available and practitioners are duty bound to ensure the person using the service is as informed as possible about the issues and the choices they can make. This must be addressed as a matter of priority by all organisations.**

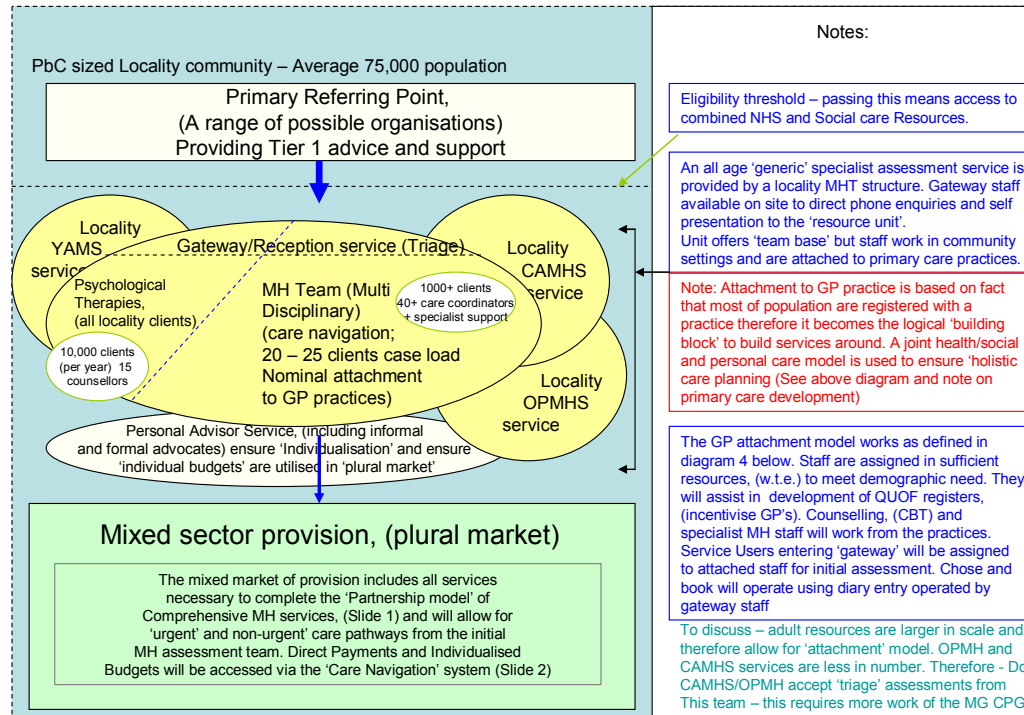
The output of the care coordination process is a comprehensive care plan that is available to all parties including the person using the service and their carers. A Carer assessment should also be completed on the 'significant person' caring on a day to day basis. The MHCPG would like to see the trial of the care plan being available on a 'data stick' so that they 'own' it and it can be used by service providers in 'real time'. We would want to see the development of an integrated electronic patient record across primary care and specialist providers, accessible to the service user and all providers as soon as possible.

The MH CPG believe that the general principles of the 'holistic' model of care provision and of the care coordination process are of relevance to all age groups and also to people with long term conditions and people with a learning disability that require specialist support. This area requires further work supported by commissioners and partnership boards to test this out.

7) The Generic Care Pathway

7.1) The Non-urgent Care Pathway

Diagram 3: The following diagram describes the key elements of a non-urgent mental health care pathway.



This diagram is drawn from the evidence submitted to the CPG process and from evidence emerging from service user and stakeholder processes. It is a simplified representation of a MH service model. As such readers please accept that there will be much detail that needs to fit behind the 'high level' elements of the model.

In the absence of robust, locally determined joint needs assessment of the population, the figures used above refer to the likely numbers of people in need of services from a locality of 75,000 people with average demographic picture based on national epidemiological information (approx 630,000 people in specialist care in England). The staff numbers are based on the numbers required to deliver the caseloads stated. Commissioners should conduct public health led needs assessment to determine local need.

Key features of the model are:

- Recognition that people who need mental health services are identified and seek access to help from a variety of points from GP practices, to schools, work places, police, and social services, etc. These areas need to provide basic 'Tier' 1 care to ensure they spot, assess and can deal with

those issues presented to them. They need the skills to identify those that need referral to non generic services, i.e. into Tier 2 and 3 special services. Such Tier 1 services could include:

- i. GP based health visiting and practice nurse services, (peri-natal tier 1 support – Edinburgh post natal depression inventory).
 - ii. A&E and Acute Hospital services. (A separate specialist A&E and ward based MH Liaison services needs to be commissioned to provide Tier 2/3 advice support to the high numbers of people in acute areas with MH problems)
 - Social Care area offices with generic assessment
 - Work place Occupational Health services
 - School/College based school nurse services
 - University based GP services and counselling services
- b) The ‘tier’ 1 access points are ‘all age’ therefore they need to be able to ‘sign-post’ into appropriate services and not be worried too much about bureaucratic multi-referral protocols or cumbersome paper systems.
- c) The integration of psychological therapy services and what are often referred to as primary care mental health services with the ‘traditional’ CMHT type staff into a local, integrated multi-disciplinary Locality MH resource team. The team would provide an all age service, (18– elderly service with specialist workers located within the team)
- d) The locality MH team could be based on a practice based commissioning consortium population or equivalent depending upon local circumstances

The key feature of the locality mental health team will be to:

- Accept and assess new clients, (Including self referrals) and take responsibility for ensuring they receive the care they need by identifying the skills and staff to best meet the needs. A suitable decision support /assessment tool; The Integrated Packages Approach to Care, (InPAC) is being developed across Yorkshire and Humber which could be used at this ‘Gateway’ point.
[This represents a major opportunity and simplification of the referral system for GP’s and other referrers. If they identify a person needs services they can refer into a ‘whole system’ mental health service. The mental health service will take responsibility for navigating the person to the best staff member to meet need. Referrers will not need to remember numerous referral protocols].
- act as a central point for enquiries and referrals (all age),
- provide a base for self referral access,
- act as a Clinical Assessment Service, (Choose and Book) booking people into slots available in CMHT/Counsellor and other workers diaries direct.
- ensure provision of rapid response to more urgent assessment using ‘Lean Thinking’ methodology of ‘do today’s work today’ serviced by an extended hours operation.

- ensure referral to specialist support and assistance, (e.g. Acute care services – Home Treatment and In-patient care)
- ensure referral for joint work to other providers such as third sector organisations and independent sector.
- The team will provide local psychological therapy services on a stepped care basis to Tier 2 clients but also to people with more complex MH problems who would benefit from increased access to ‘talking therapies’ as an alternative (or more likely addition) to other forms of treatment.
- The team will seek support from care navigators provided by the Personal Advisory Service to those people that require inputs from more than one agency/service and hence require on going care co-ordination under CPA, SAP etc.
- The team will provide an assessment services for adults (18 years old to elderly). Whilst referral networks currently exist for CAMHS, Youth Mental health services, older age local MH services and Learning Disability services, the Locality team could provide an all age point of contact with the community allowing the team to signpost self referrers or their family to appropriate services.
- They would refer into specialist district wide services such as early intervention teams and assertive outreach services but would ensure they continue to care coordinate the person for eventual return to local service networks.
- Identification of the team resources against primary care practices, (see Diagram 4) means primary care attachment of staff which will ensure good relationships and rapid consultancy support to the primary care teams.

Where they are currently not well developed, the CPG recommends the development of the following services to interface closely with the locality all age access service:

- a locality CAMHS service to work along side the locality MH service.
- Locality older peoples MH service to receive referrals for specialist older people’s care headed up integrated memory assessment services and evidence based cognitive impairment services.
- a young person’s, (16 – 25) mental health service as currently developed in early intervention teams to meet the mental health needs of all younger people not just those with psychosis.

The administrative size of the locality mental health team would depend on local assessed need; initially based on public health/epidemiological based predictors and would be built up from GP practice registered populations to practice based commissioning consortia to PCT/local authority populations (joint strategic needs assessment).

Depending on local population characteristics the team administrative structure could be broken down into smaller more manageable teams as long as they retain sufficient staff to provide critical mix of skills and professions to the multidisciplinary team.

How the service model might work:

Tier 1 - Identifying the person in need and Tier 1 provision:

The initial identification 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, Accident & Emergency department, social service area office, voluntary organisation, education service, work place, (Occupational Health service), etc. **hence a one stop shop approach to access is a flawed model.** The key is allowing access from these entry points into a reliable 'one stop shop and one step' system for Tier 2 and above assessment and on-going care coordination.

Tier 1 MH services, (promotion, advice and support) would need to be available in all the above settings to dealing with the initial identification of a problem/need and hopefully containing the vast majority of people with 'simple' problems capable of responding to advice, listening, pastoral/friendly care, etc.

Tier 2 – Single access and assessment

The model is based on a 'One Stop and One Step' approach where self access and Tier 1 referral to the MH service leads to the MH team taking responsibility for initial assessment and identification of the most appropriate staff to support the person. **This removes all the current ambiguities associated with the referral process and means that primary referrers, (all organisations who may chose to refer) don't need to be specialists in placement with knowledge of numerous 'referral protocols'. They only need to know one protocol – if you believe someone needs support above general Tier 1 care and promotion then refer to the all age MH assessment team.** It requires the locality MH team to 'trust the referral' and focus on assessment of what can be offered to help. This process of 'trust the referrer' should also be a feature of internal requests for support within the MH partnership structures. It is based on the principle that if someone thinks you can help – then they are probably right. It may require a cultural 'leap of faith' but will mean that costly gate-keeping systems can be dismantled in favour of 'do today's work today' – the 'Lean model' which is significantly more efficient.

The model suggests that Local MH team staff should be attached to primary care practices as a way to get staff close to the people and communities they need to serve and provide a close working relationship between this key referral source, (GP practice staff). However the route to care does not need to be through the GP. All Tier 1 referrers should be able to refer to MH staff via the locality MH service and 'gateway assessment' as described below.

The 'attached' staff would foster a genuine relationship approach to referral from this key referral point with referrals being made direct to the attached staff by Practice staff without the need for referral to the 'gateway' service. Day to day interactions between practice staff and locality MH staff would provide for reduced referral bureaucracy and streamlined access to rapid assessment, (No Queue) into Tier 2 services comprising psychological therapy services alongside specialist MH practitioners.

Gateway/Reception workers would help provide triage services to people who self refer or for people referred by other Tier 1 services. An appropriate decision support tool, (e.g. InPAC – see above) would guide the assessment enabling the identification of the best person in the team to meet the assessed need. The person could then be 'booked' into the psychological therapy service or the specialist care team for more detailed MH assessment as appropriate.

The local MH team would house skilled staff to meet the needs of the local population and could draw on specialists via district wide service network. Care co-ordination of people with longer term care needs, supported by care navigators, would provide onward referral to a mixed market of services.

Because most people are registered with a GP, (and those that are not should get access to homeless/outreach MH services) a nominal association can be made between all mental health service users in all parts of the system and the GP they relate to. This means that simple systems can be put in place to ensure all clients have a known care-coordinator based on the practice they come from, (with some choice managed within this system). For people referred from G.P systems the care-coordinator is obvious – one of the staff attached from the locality team. For emergency access and access of new people via other Tier 1 services, the care coordinator is also immediately identifiable and can therefore provide care coordination support immediately on access.

Using choose and book methodologies, (and IT) the Gateway person should be able to book a new referral into a 'slot' in the diary of the therapist/MH practitioner to allow rapid access, (No queue).

Other Considerations

The organisation provider for the locality MH team should be commissioned with clear 'walls' between itself and other services it may provide. The main locality team should be provided by the NHS/LA in partnership. The 'walls' are a definite requirement to ensure maximum use of 'individual purchased care' arrangements, e.g. Direct Payments, with referral into partnership services where appropriate rather than 'retaining the person' in the statutory sector. Care Navigators, (Personal Advisors provided by an independent organisation) will help ensure this at an individual care level and commissioners can monitor service user flows to ensure access is occurring across the range of providers in the partnership.

Current referral networks to CAMHS, and LD services would not be compromised although the locality team could act as a community focus for self access and advice meaning the team should house sufficient expertise to be able to co-ordinate delivery of expert advice and signposting of all ages of people coming into its contact. Commissioners should explore the views of service users about whether the locality team could be the first point of referral to old age clients in order to simplify relationships between primary referrers

and the MH services. The CPG does not anticipate that this would reduce the size of current specialist older peoples teams in any way, however need based services delivery should override criteria based on age.

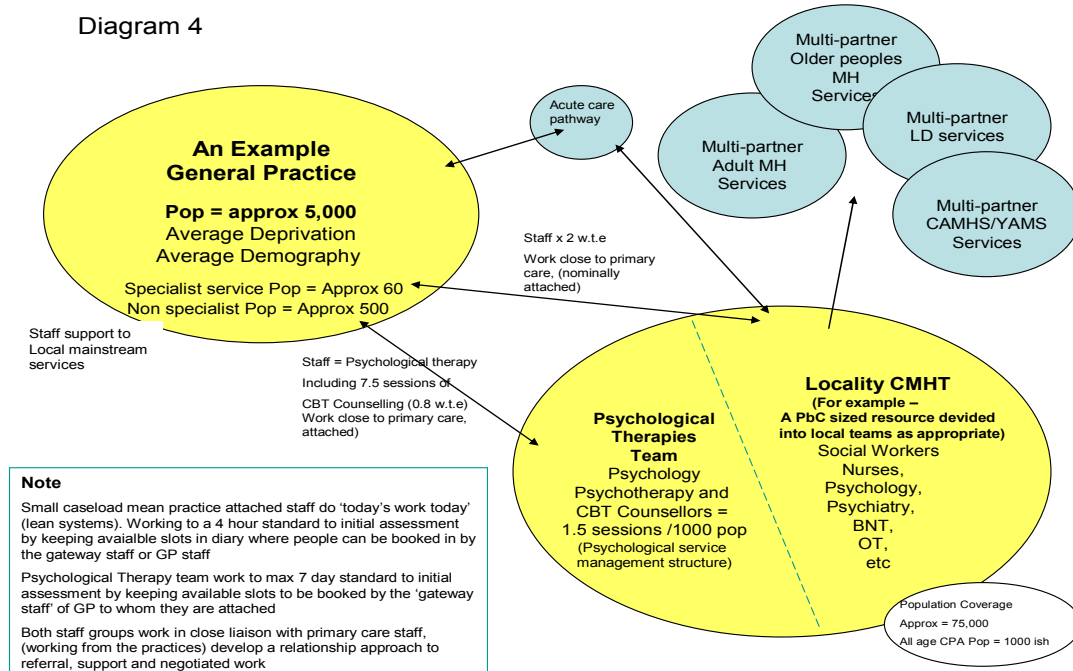
The workload for specialist staff would be people with significant problems and risk but they would act to support and advise primary care staff, the integrated psychological therapy staff and fellow mental health practitioners.

The MH staff would take responsibility for allocation of the client to the right member of staff for the needs as presented. There would be no ‘bounce backs’ to the GP or other Tier 1 service for any ‘inappropriate referrals’.

Making it work

The above system will only work if there is sufficient staff to populate the attachment relationships with the primary care practices. Hence the need for robust needs assessment that can be drilled down to understanding of indicative need at practice level. An example of how this could be achieved is presented below. Commissioners should note that they can set the ‘bar’ for numbers entering the Tier 2 services but contracts with providers should reflect the desired ratio of staff with service users crossing the threshold.

An example of how staff would be attached to practices, (i.e. how the numbers of staff would be derived from local practice size population demand) is given in the following diagram (Diagram 4).



The practice attached staff could be all age generic assessors (all age service meeting non-age discriminatory requirements) but would probably be developed from existing adult community teams if only because staff numbers

currently make this more feasible without the need to denude less well populated older people's teams. However local Commissioners may agree a different arrangement at local level building on current referral networks however the key principle should still be to reduce the numbers of interfaces between Tier 2 services and Tier 1 referrers.

The presence of the locality team resource in a 'community' may (and should) encourage self access to advice and assistance from people/organisations not familiar with NHS/Social Care access pathways. The service may specifically be a benefit to carers seeking advice on someone close to them. Such access would clearly enable requests for help from all age groups and from people with concurrent MH problem and other related problem, e.g. Substance misuse Referral on to specialist older peoples MH teams LD services, CAMHS/YAMS teams and dual diagnosis specialist services would be facilitated by staff signposting necessary service users from the locality team to the specialist team. The advantage would be a referral that has at least been passed via a MH specialist rather than from a generic service offering some opportunity for diversion or lower level intervention for some.

Pre-existing interfaces with education systems would still be paramount for CAMHS and LD services operating within current configurations.

The MH CPG recognises that more work needs to be done on the interface with other MH care groups.

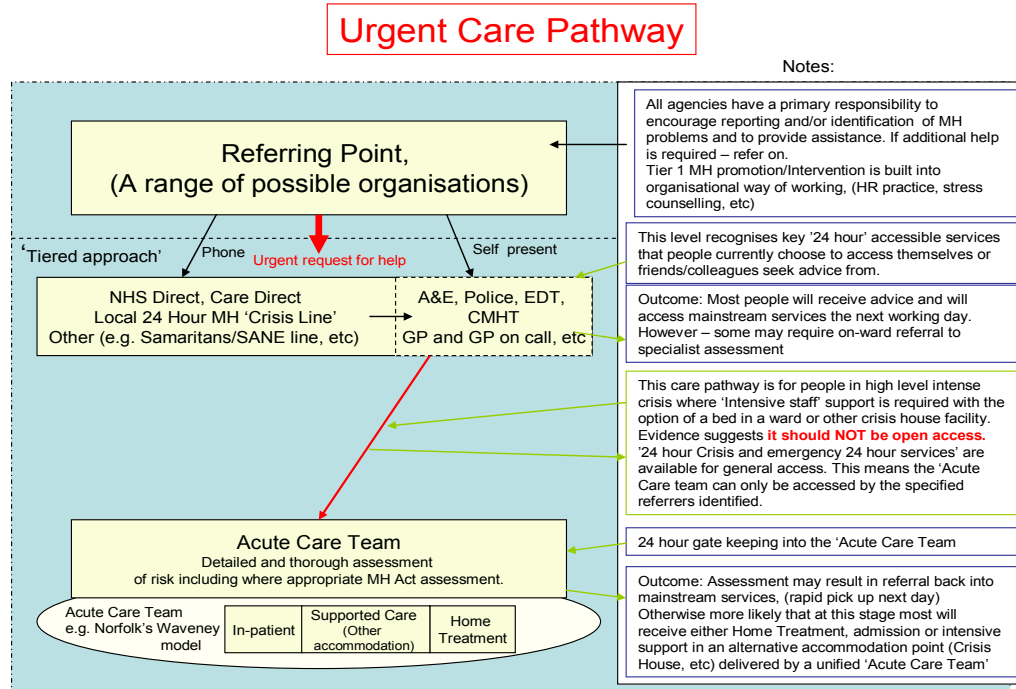
Notes:

1) The indicative figures (where presented) are based on average population deprivation/demography but the formula for obtaining the figures is easy to apply to non-normal populations.

2) Small GP practices, (single handed) could be served by 'core and cluster' models for staff allocation with shared resources.

b) The Urgent Care Pathway

There are occasions where services users are perceived to be in such risk of harm to themselves (or occasionally to others) that urgent assessment for intensive care is required.



The pathway to urgent 'acute care' is based on the principles of the MH Policy Guide for Crisis Resolution Teams, (DoH). **However, the MH CPG recommend that the term 'Crisis Resolution' is dropped completely as it causes significant confusion to referrers and commissioners alike.**

A model of 'Acute Care' is currently provided at Waveney Hospital – Norfolk. This model merges the Home Treatment team with the in-patient staff team to provide a more fluid and person responsive solution to care. The referral to this service represents very small numbers of the total population. In order for the team to be able to deliver highly intensive packages of care within non-hospital settings they must not be distracted by 'general crisis calls and assessments'. These can be covered by currently available 24 hour services, (A&E, Police, EDT, etc) and extended hours locality MH Teams. Commissioners should ensure the back-up of 24 hour 'crisis telephone lines' for people in mental distress/panic who can be assured of services available to respond the next day.

It would not be possible to provide 'choice' of provider at this service entry point. The nature of distress is comparable to acute A&E trauma and hence the service provided to the resident population should be used. This is important also to ensure on-going care once transferred from the Acute Care Team into community support.

8) Development Priorities

The MH CPG recommend that the following developments should be prioritised to deliver the generic care pathway identified above. Additionally there are some developments suggested that will meet the needs of specific care groups where the CPG assess demand significantly out-weighs current service capacity:

a) Developments supporting the care Pathway:

Urgent development by each commissioning partnership of a joint needs assessment and demand model for the local population based on public health data sets. This will underpin the indicative figures used in the above model and will be used to commission for provider capacity that will meet the local need.

Implementation of stepped care models of psychological therapies alongside local mental health services as described in the generic MH pathway. Use of the 'Layard' monies, (Operational Framework 2008/09) to facilitate care pathway development of psychological therapies as defined in the model such that access is available to all people in the health community. Meeting the gap in provision for older people and people with severe mental health problems.

Develop the capacity of the care-coordination teams for the 1:100 people at any one time needing care coordination through MH care services

Development of robust 'Care Navigation' systems including information and advice, web access tools, and self help guides, etc. Investment in care navigation staff, (personal advisors) to support people receiving co-ordinated care from specialist staff and facilitate use of individualised budgets.

Development of the referral access to Home Treatment, (Acute Care team) to shift away from open access and facilitate emergency support and delivery of the 'Crisis Resolution Team targets.

b) Developments to support current capacity gaps

Development of youth mental health services incorporating an early intervention in psychoses team to respond to all mental ill health in young people.

Urgent assessment of CAMHS Tier 4 need and evidence of best practice provision (nationally and internationally) in order to develop a commissioning strategy for its provision.

A Mental Health Liaison Team based in all acute hospital services. Working within A&E and medical assessment units, as well as providing mental health support in general medical and surgical units. The MH CPG considered this a

vast un-met need at this time across all age groups. The 'Mind the Gap' report identified a failure of the NHS to meet the needs of people with learning disabilities and serious mental health problem in acute care settings.

Dementia care services required to be modernised with early access to memory assessment services supported by rapid access home and community oriented services aimed at supporting people in their own homes. This model, currently available in some parts of the country allows people to be cared for in familiar environments maintaining their functioning for a longer time. It would also support nursing home/care home to care for people in later stage dementia services without recourse to 'hospital beds'

Reduction in 'dementia beds' would offset the costs of this community model.

Early intervention and treatment of alcohol dependency (as outlined in the 'being healthy group') for all clients to ensure better outcomes.

Employment schemes through **real** employment opportunities and large scale social enterprise initiatives which offer valued roles for people with mental health problems.

9. Key gaps in provision resolved with the provision of the model

Early and rapid access to non-urgent and urgent care with no queues

Open access to a range of services/interventions which would support people with common mental health problems. Self access with guided internet/self assessment material should be explored and facilitated where possible.

Effective liaison services to meet the vast MH need of the Acute hospital population.

Integration of in-patient and Home Treatment services into an acute team model with Home based Treatment delivered as a real alternative to in-patient care.

Integration with primary care. People who have mental health problems being able to access primary and secondary care mental health services in 'one step' and additionally increasing the likelihood of good physical health care. The MHCPG would like to explore further the overlaps with the Long Term Condition models of care.

Immediate access to psychological interventions to support people with long term physical or mental health problems and those with 'common' MH problems.

Staff who are trained to provide interventions which focus on the person receiving the service and don't cause further mental ill health.

On-going care co-ordination for services users with complex needs - much requested by such groups.

A demand/capacity commissioned model which recognises the need in the community and resources required to meet it which shifts away from a 'perverse' discharge oriented throughput activity model.

10. Barriers to Change – the lack of:-

- An electronic health record for people who use mental health services, which they 'own' and use to control their care.
- National standards for mental health services which can be used to benchmark services.
- Outcomes determined by people who use mental health services and their carers and which are used to commission/monitor services.
- Population based needs assessment used to allocate resources.
- A 'champion' for mental health in local strategic partnerships.

There is a significant Training and Development agenda focused on on-going training to staff to keep them 'customer focussed' in line with training funds available in the private sector services.

11. Recommendations to support implementation

- The group endorses the aspiration for mental health outcomes in the London report 'We expect all those people living in Yorkshire and the Humber to get the maximum out of life, free from discrimination, disability, and poverty – 'well being for all' is our outcome'. This aspiration should feature in local Strategic Partnerships and Local Area Agreements.

Action for Local Strategic Partnerships /Primary Care Trusts

- The group recommends implementing the generic mental health pathways described above. The 2008 – 2010 'Layard' monies will underpin the development of the psychological therapy capacity within the model.
- PCT's and Local Authorities should invest in CMHT's to provide care co-ordination capacity that matches needs assessment and the variations in demand arising from demographic factors.

The key features of the model are:-

- Integrated Primary/secondary and health and social care
- Care planning supported and challenged by care navigation systems and 'advocates'
- Single point of assessment to Tier 2 services and above

- Gateway assessment supported by a 'decision support tool', for example the 'Integrated Packages Approach to Care, (InPAC).
- Open access through the assessment service to a range of supportive interventions provided by a range of providers.
- NICE guidelines/good practice/evidence underpins the care packages.
- Care elements/packages allocated a cost so that individuals can have their own budget.
- A commissioned, independent 'Personal Advisor Service' incorporating care navigation – information/advice and guided self help material with Personal advisors or advocates are available to support people in accessing the appropriate support.

Action Primary Care Trusts

- National standards for services, based on outcome measures are agreed which enable benchmarking to take place.
- Immediate development of the informatics systems necessary to support the above models

Action Department of health

Nick Morris

Chair – MH CPG – for Yorkshire and Humber SHA

Mental Health Clinical Pathway Group Members

Appendix 1

Name	Title	Organisation
Nick Morris	Clinical Chair	Bradford District Care Trust
Lyn Wilkinson	SHA Facilitator	NHS Yorkshire and the Humber
Dr Chari	Psychiatrist	Barnsley PCT
Martine Standish	Associate Director, Public Health	Barnsley PCT
Dr Majid Azeb	GP & PEC Member	
Rupert Suckling	Public Health Consultant	Doncaster PCT
Peter Choules	Joint Commissioning Manager for Mental Health	East Riding of Yorkshire PCT
Dr Jane Wood	GP/Primary Care Mental Health Services Manager	Leeds PCT
Kevin Bond	Director of Mental Health	North East Lincs Teaching PCT
Dr David Geddes	Medical Director & GP	North Yorkshire & York PCT
Stephen Brooks	Manager	Selby & York Primary Care Mental Health Workers Team – North Yorkshire & York PCT

Dr Steve Burns	GP, Primary Care Mental Health Lead	Rotherham PCT
Dr Linda Harris	Clinical Director	Wakefield District PCT
Dr Steve Hopker	Consultant Psychiatrist	Bradford District Care Trust
Dr Mahmood Khan	Consultant	Bradford District Care Trust
Dr Douglas Gee	Medical Director	Humber Mental Health
Patrick Scott	Clinical Nurse Specialist	Humber Mental Health
Heather Raistrick	Unit General Manager, Hull	Humber Mental Health
Helen Wiseman	Head of Allied Health Professionals	Leeds Partnership NHS FT
Riadh Abed	Medical Director	Rotherham Doncaster & South Humber Mental Health NHS FT
Joe Cunnane	Clinical Director	Rotherham Doncaster & South Humber Mental Health NHS FT
Dr Tim Kendall	Medical Director	Sheffield Care Trust NHS Mental Health & Wellbeing
Julie Leeson	Director of Therapy Services/Allied Health Professional Rep	Sheffield Care Trust NHS Mental Health & Wellbeing
Roland Self	Associate Director of Psychology	South West Yorkshire Mental Health NHS Trust
Dr Nisreen Booya	Medical Director	South West Yorkshire Mental Health NHS Trust
John Wooller	Clinical Excellence Manager	Yorkshire Ambulance Service

Jonathan Phillips	Associate Director Adult Services	Calderdale MBC
Clare Hyde	Regional Mental Health Voluntary & Community Sector Partnership Development Lead.	CSIP
Rashna Hackett	Race Equality Lead	CSIP
Lilian Kershaw	CPG Facilitator	Barnsley PCT
Carl Wain	Supporting People Manager	Housing & Adult Social Services City of York Council
Ceri Wyborn	Information Speciality	Public Health Observatory, University of York
Karen Lynch	Programme Integration Lead	CSIP North East
Lynne Hall	Social Policy Integration Lead	CSIP North East
Ailsa Claire	Chief Executive	Barnsley PCT

