



**Southern Health**  
NHS Foundation Trust

Mental Health and Learning Disabilities

# **Statement of Strategic Direction**

March 2017



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# 1 Executive Summary

This document sets out the strategic direction for the Mental Health and Learning Disabilities services provided by Southern Health NHS Foundation Trust that will ensure that the care service users receive is consistent, of high quality, responsive, and delivers improved outcomes.






In developing this, our starting point has been the insight and views of the people who use services, their families and carers, our staff, and the wider system. This has enabled us to understand what is needed from services and where there is room for improvement. This has not always made for easy listening, but an open and honest assessment of our services was necessary if we are to move forward and improve.

We have also drawn on best practice and from advice from an Expert Reference Group (ERG) convened specifically to support the development of this work, to ensure that the improvements we are proposing will improve the quality of care that our service users receive. Finally we have been informed by the national policy directives including the Five Year Forward View for mental health, and Building the Right Support for people with a learning disability.

Further details on the approach adopted in developing our strategic direction can be found in Chapter 4 – “Approach”; whilst an assessment of our starting point and the reasons for needing to make improvements can be found in Chapter 5 – “The starting point for this strategic direction”.

## Our service principles

Our staff have developed a set of core principles against which all our services will be developed and delivered. Chapter 6 – “Future Service Design Principles” sets these out in more detail, but in summary, we will:

-  provide **high quality, safe, person-centred** and **holistic** services which improve the health, wellbeing and independence of the people we serve;
-  deliver **needs-led services**, which are **timely, proactive** and **easy to access by all, 24/7**;
-  have the **right people doing the right job**, taking ownership and pride in good communication;
-  adopt a **recovery-focused** approach, with a positive attitude to strengths, resilience and risk-taking, and which is adaptable to change; and
-  **fully participate in strong partnership working** to provide continuity across interfaces and transitions, supporting prevention and early intervention.

## Our priorities

We have therefore identified the following key priorities to improve the services we provide and to deliver on these principles (further details can be found in Chapter 7 – “What does this mean in practice”):

- **People who use our services, their families and their carers will be actively involved and included** in the in the delivery and design of services. Our service users are experts by experience, and by working together to collaboratively lead on the design and delivery of services we will improve the services that we provide.
- We will **fundamentally improve access to services** to ensure that we are able to respond to all requests for help and to avoid people being ‘bounced’ around the system – adopting the ethos that a request for help is an opportunity to help. We will develop a single point of access (from a service user’s point of view) that will be accessible to everyone (whether they are a service user, carer, GP, the police or a social worker) and regardless of the diagnosis, age or IQ of the service user.

- Linked to improving access, we will ensure that there is **robust and responsive support for people with urgent needs** by transforming the urgent care pathway, ensuring that resource is ring-fenced to provide robust alternatives to admission. Examples of this include ensuring that our hospital at home service has adequate resource to visit people at home multiple times per day, and exploring alternatives to provide support in the community, such as street triage.
- We will improve outcomes for those who use our services through the delivery of **needs-led, evidence based pathways** for functional mental illness, organic mental illness and learning disabilities. These pathways will provide purposeful, proactive support. They will link into local delivery systems of care. By mapping resource in this way we will also further develop specialist pathways that support some of our most vulnerable people.
- We will ensure that there is robust support to enable people to be cared for in the most appropriate setting, but where people require support in a hospital setting, we will deliver **consistent, purposeful inpatient care** around needs-led pathways. Our recovery ethos will be central to this – we will ensure that people only stay in hospital for as long as they need to by providing services such as in-reach from community teams.
- We will develop tertiary services to provide care across a complete pathway with pathways that are consistent across the trust. This will involve working with commissioners to develop new services such as low secure facilities for both adults and children, and resolving the physical environment issues within some of our adult forensic facilities.
- We will work with primary care and the local delivery systems to develop **primary care based mental health services** that keep people well, closer to home. We will continue to develop italk services (including italk for long term conditions and italk at work), and we will work with partners to identify any further opportunities to support people better in primary care.

### Realising our ambition

These priorities represent a transformation of the services we provide that will require a significant shift in our culture. If we are successful in ensuring that we are a service user, carer and family centric organisation, we will be successful in delivering this strategy. Delivering truly person centred care will require a change in emphasis to ensure that the patient is at the heart of everything, and meaningfully engaged and included in our services.

Developing the culture to support this transformation also relies on our leadership. Strong leadership and governance will be crucial to the delivery of our priorities. By ensuring that our staff are empowered and supported to deliver change and having strong clinical and operational leadership in place, we will ensure that change sticks. This will include an emphasis on clinical leadership including earned autonomy, accompanied by clear accountability.

Working in partnership with our Service Users, their Families, Carers and staff, along with our commissioners, social care and voluntary sector colleagues will be critical to realising the service principles and improving outcomes for the users of our services. In addition, the way in which services map onto and integrate with local delivery systems and primary care will be vital to their effectiveness.

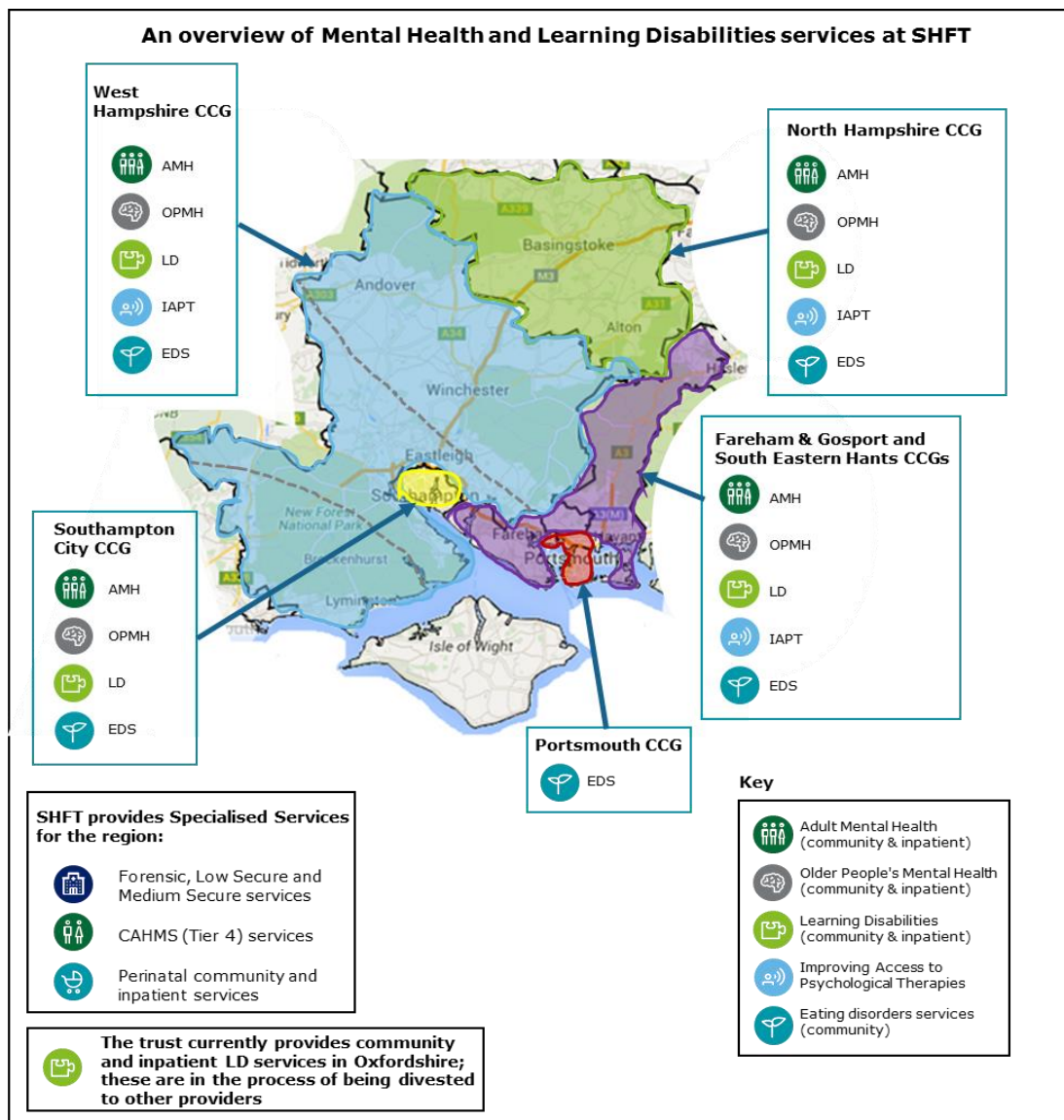
There are also a number of core enablers that we will put in place to ensure that the scale and pace of our ambition is realised which are outlined in further detail in Chapter 8 – “What do we need to deliver our strategy?” These include having a robust quality improvement methodology and resource in place to support change, ensuring that we have the right information and outcomes data available to drive positive improvement, and developing workforce, technology and estates strategies that will help us to realise our ambitions.

# 2 Introduction and context

## The services we provide

Southern Health NHS Foundation Trust formed in April 2011 following the acquisition of Hampshire Community Health Care (HCHC) by Hampshire Partnership NHS Foundation Trust and is currently one of the largest Mental Health and Community Services providers in the country. We employ circa 6,000 staff and see around 45,000 Mental Health and Learning Disability Health Service Users every year. We provide inpatient and community services in Adult Mental Health (AMH), Older People’s Mental Health (OPMH) and Learning Disabilities (LD) for people living in Hampshire and Southampton, along with Forensic services for children, adults, and people with Learning Disabilities, Perinatal services and Eating Disorders services. We also currently provide community and inpatient Learning Disabilities services in Oxfordshire, however these services are currently transferring to providers in Oxfordshire.

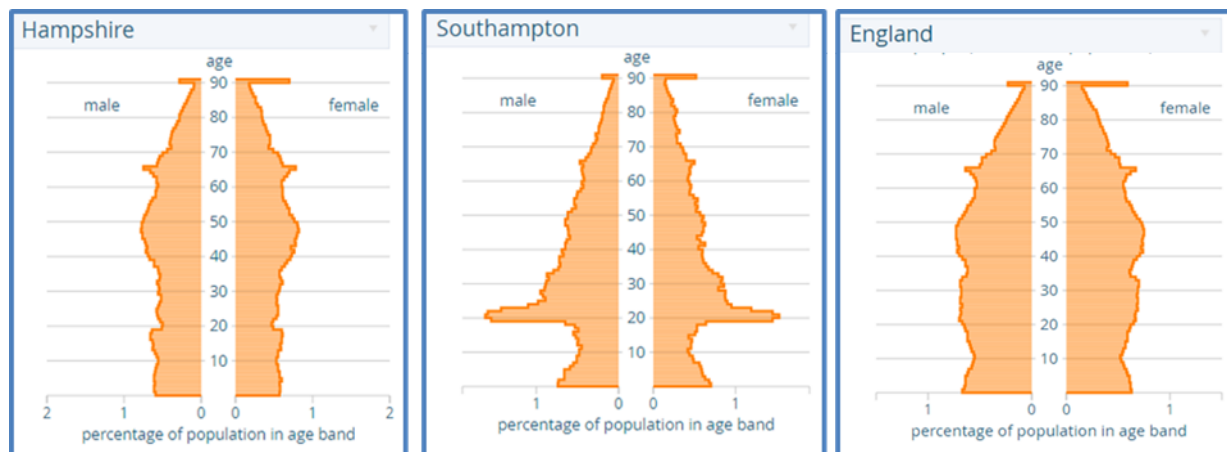
In addition to this, we provide community physical health services in Hampshire; a wide range of scheduled and acute physical health services at Lymington Hospital; children’s public health services and smoking cessation services across Hampshire.



## Population

We serve a population of c. 1.2 million people across parts of Hampshire and Southampton, and we also provide a range of specialist services to a wider population<sup>1</sup>. Our population is complex and heterogeneous, with an ageing population, particularly in Hampshire, contrasting with a younger demographic in Southampton.

### Population characteristics by age and gender<sup>2</sup>



#### Southampton

With a population of around 250,000, Southampton is more ethnically diverse than Hampshire and England overall and, in part due to its student cohort, has a high population turnover. Its population is also younger than that of Hampshire and the national average – 21% of the population are under 25 versus 12.5% nationally.

Deprivation is relatively high in Southampton and the proportion of people living in the most deprived areas in England is more than three times higher than the national average. Rates of childhood poverty are also high in Southampton, with a higher proportion of children in care than the national average. Southampton reports a significantly higher proportion of school children with social, emotional and mental health needs versus the England average, and the second highest rate of children with learning disabilities of all Local Authorities in the country. There are also higher rates of violent crime, drug use and admissions for alcohol issues in Southampton when compared with the rest of England.

Overall, the population of Southampton is younger, more diverse and more transitory in nature, than the rest of Hampshire. The rates of identified common mental illness, severe mental illness, depression and self-reported feelings of anxiety are subsequently significantly higher than the average in England. As a result, the rates of people in contact with specialist and functional Mental Health services is also above average.

#### Hampshire

The population of Hampshire is c. 1.3 million, of which we provide services that cover a population of c. 1 million.<sup>3</sup> The population is older compared with England as a whole – 18.5% of the population are aged over 65 (above the national average of 16.3%) and a significantly higher than average number of those people live alone. Hampshire is also less ethnically diverse than Southampton and England overall.

<sup>1</sup> SHFT serves a population of c.250,000 in Southampton, and 1m across Hampshire (excluding North East Hampshire).

<sup>2</sup> Population characteristics by age and gender, Office for National Statistics, Neighbourhood statistics <http://www.neighbourhood.statistics.gov.uk>

<sup>3</sup> SHFT provides mental health services for the majority of Hampshire excluding North East Hampshire

Hampshire is a relatively prosperous area, ranked the tenth least deprived local authority in England (out of 150) and has lower rates of homelessness and long-term unemployment in people of working age than the England average.

Although relatively lower rates of childhood poverty exist in Hampshire when compared with Southampton and the rest of England, more than one in ten children still live in low income households. The rates of admissions for self-harm amongst young people are higher than the UK average and that of Southampton.

Except for the populations served by South East Hampshire CCG & Fareham & Gosport CCG, the rates of identified common mental illness, severe mental illness, depression and self-reported feelings of anxiety in Hampshire are lower than the rates in Southampton and lower than the average in England. This theme is also reflected in the rates of people in contact with specialist Mental Health services. Overall, due to its higher ageing population there is a higher demand for services related to older people's services including the dementia care pathway.

## Partner organisations

### *System-wide working*

We are part of the Hampshire and Isle of Wight (HIOW) Sustainability and Transformation Plan (STP), to deliver the shared priorities for health and care across Hampshire and the Isle of Wight.

One of the key objectives of the HIOW STP is to improve the quality, capacity, and access to Mental Health services across the footprint. We are working with partners in a **Mental Health Alliance** that includes the three main Mental Health providers in the region, GPs, commissioners, Local Authorities, third sector and Service Users, Families and Carers that will work to standardise care. The Alliance has identified Mental Health crisis pathways, acute and community pathways, rehabilitation and out of area placements as priorities in the first instance and is in the process of developing a plan to achieve this.

The STP is developing six **Local Delivery Systems** (LDS), which bring the local commissioners and providers together to articulate the changes required at a local system level, and how and when they are going to be achieved. This will include taking forward the development of new care models which will include an integrated model of out of hospital care. Whilst this has a greater impact on the physical health services that we provide, the way in which Mental Health and Learning Disabilities services interact and integrate with the LDSs will be critical.

Learning Disability strategy in the region is driven by the **Southampton, Hampshire, Isle of Wight and Portsmouth Transforming Care Partnership** (SHIP TCP) in line with the strategy set out in the **Building the Right Support** Report. We are an active partner in the SHIP TCP which aims to transform services to ensure they build on a Child's, Young Person's or Adult's unique strengths and abilities, getting it right for the person first time by ensuring there is the right care in the right place at the right time, that is consistent across the SHIP TCP. This includes placing a greater focus on early intervention and prevention, developing community-based services in place of inpatient facilities where possible, and ensuring that good physical health is supported via upskilling general practice.

### *Commissioners*

We provide secondary care Mental Health and Learning Disabilities services on behalf of five Clinical Commissioning Groups (CCGs). The Hampshire CCGs jointly commission Mental Health and Learning Disabilities services whilst Southampton City CCG commissions Mental Health and Learning Disabilities services separately.

In Hampshire, the Joint Hampshire Adult Mental Health Commissioning strategy was published in 2012 and was developed by **Hampshire County Council** and NHS Hampshire (now the **Hampshire 5 CCGs**). The strategy was developed following a public consultation and aimed to commission: needs-led services; the roll-out of IAPT; physical health checks for those who are mental health inpatients; single points of access where possible; and mental health wellbeing centres. The strategy is due for renewal in 2017.

In partnership with Southampton City Council, the CCG launched the **Southampton 'Mental Health Matters' (MHM) strategy** as part of a review of Mental Health services in the city. Following a period of wide public consultation, a set of key focus areas were identified including ensuring a needs-based rather than age-based service in AMH and CAHMS; closer working with primary care to provide early intervention and prevention; launching a primary care pilot to aid the development of a primary care mental health model; increasing the IAPT access rate in line with the 5YFV aspirations; and developing services in the city around three integrated hubs (East, Central, and West). Work on some of these initiatives has commenced and a review of progress and further consultation is taking place at the moment.

#### *Specialised services (across the South of England)*

We also provide a number of tertiary services that are commissioned by NHS England. These include perinatal inpatient services and forensic services for adults, young people and people with learning disabilities, and a tier 4 CAMHS facility.

Specialised services commissioners have outlined a desire to commission further forensic services for the benefit of Service Users across the whole of the South of England. A key area of development is low secure CAMHS inpatients facilities. In addition, national pathway design and clinical decision making protocols are commencing and investments are being made in non-specialised care to enable parts of the pathway.

We are also part of a New Care Model in Tertiary Mental Health Services for secure Adult Mental Health services, which aims to incentivise clinicians and managers to ultimately eliminate inappropriate out of area placements. In order to do this we will work with partners to strengthen care pathways so that access to community support is improved, preventing avoidable admission and reducing length of inpatient stays through a clinically-led programme to develop services that meet the needs of the local population.

#### **National context**

Mental health problems are widespread and it is estimated that one in four adults in the country will experience a Mental Health problem in any given year. To this extent, it is estimated that mental Health problems are responsible for the largest burden of 'disease' in the UK - 28% of the total burden compared to 16% each for cancer and heart disease.<sup>4</sup> And yet, whilst mental Health problems are estimated to cost the economy £105 billion a year (similar to the cost of the entire NHS)<sup>5</sup>, only 13% of the NHS healthcare budget is spent on mental health problems.<sup>6</sup>

In recent years there has been increasing recognition of the need for a parity of esteem between Mental Health and Physical Health, as set out in the previous national strategy for mental health in England - **No Health without Mental Health**,<sup>7</sup> and a growing commitment in society to change how we think about Mental Health.

Although the national strategy has made tangible improvements, including changing public attitudes towards Mental Health through the 'Time to Change' campaign, there have been system wide challenges to implement this, with budget constraints and increasing demand putting services under strain. **The Five Year Forward View for Mental Health**, commissioned by NHS England, sets out a framework to guide local clinical strategy and service delivery over the next five years, based on the views of 20,000 people.

It sets out a number of priority actions for the NHS by 2020/21 around **improving access to care** (in particular crisis care, which is central to the Crisis Care Concordat), adopting an **integrated approach to Mental and Physical Health**, and **promoting good Mental Health** and **preventing poor Mental Health**, starting in childhood.

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<sup>4</sup> Fundamental Facts about Mental Health 2015. Mental Health Foundation

<sup>5</sup> Mental Health Taskforce, NHS England, February 2016

<sup>6</sup> Fundamental Facts about Mental Health 2015. Mental Health Foundation.

<sup>7</sup> No Health Without Mental Health: a cross-government mental health outcomes strategy for people of all ages. Department of Health, February 2011



This strategy encourages organisations in the public, private and voluntary sectors to work in partnership to identify the needs of their local population and opportunities for early intervention and prevention, designing services through co-production with Service Users and Carers to provide person-centred, recovery focussed care in the least restrictive environment.

For people with Learning Disabilities, the **Building the Right Support** Report,<sup>8</sup> outlines how to ensure the experience of care for people with Learning Disabilities is a positive one, with the creation of 48 locality-based Transforming Care Partnerships across England. Each Transforming Care Partnership is tasked to plan services that build local provisions, as noted earlier, and develop whole care pathways that enable people to be supported where, how and by whom they want, along the themes and priorities as outlined above.

The success of these national strategies relies on strong links with Local Authorities and Social Care providers, which operate under the statutory requirements of the **Care Act 2014**,<sup>9</sup> the aims of which are aligned to the overall goals of the Mental Health reforms.

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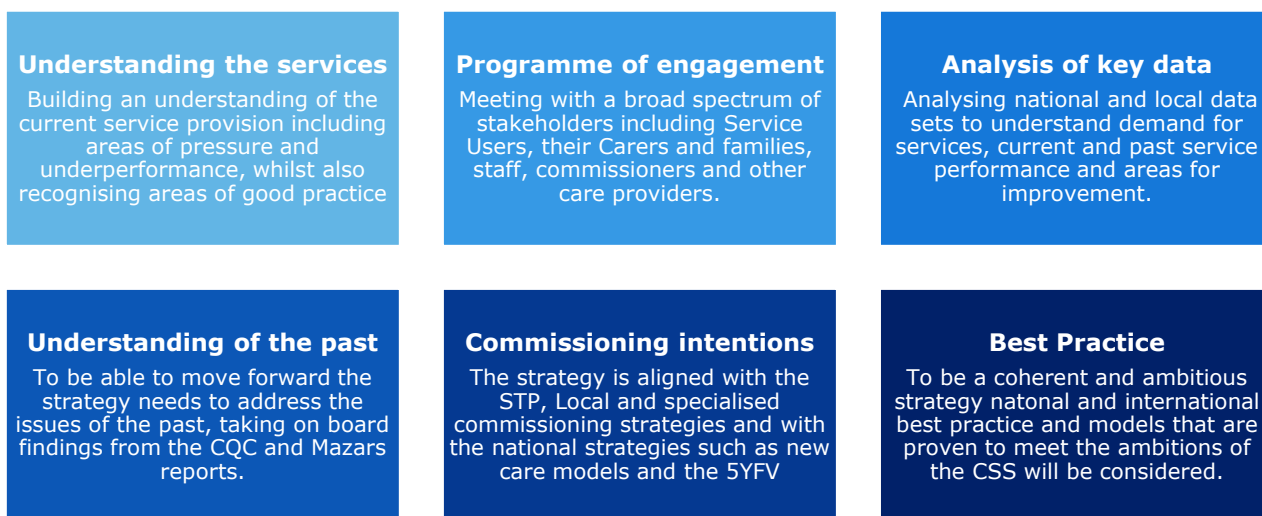
<sup>8</sup> Building the right support. NHS England, Local Government Association and Association of Directors of Adult Social Services, October 2015.

<sup>9</sup> Care Act 2014, c.23, Department of Health.

# 3 Approach

## Approach to developing the Clinical Services Strategy

In developing the strategy, we have gathered insights from a number of sources including extensive stakeholder engagement, and analysis of population, national, local and Trust data sets. We have taken a systematic approach to developing a strategy that is informed and shaped by our service users, carers, families and staff, which is summarised in the diagram below.



In developing this strategy we have undertaken an extensive programme of engagement with a broad spectrum of stakeholders, which is explored further below. In addition, detailed analysis of key data has been undertaken to help inform the stakeholder events, but also in understanding the current position, which can be found in Chapter 4. This has also included exploring some of the causes of the shortcomings of the past. In demonstrating an understanding of lessons learnt, the strategy looks to incorporate mechanisms to help avoid a repeat of these and to demonstrate improvement. An example of this, which is outlined in Chapter 7, suggests ways to improve active inclusion and engagement of Service Users, Carers and Families.

## Programme of engagement

Outlined below are some of the core components of our approach to engagement.



### *Service Users, Families and Carers*

The development of this strategy began with listening to Service Users, Families and Carers, who shared their opinions via an online questionnaire and a series of workshops. These took place with a number of groups across Hampshire and Southampton and focused on understanding what needs to improve, and

provoking positive, forward-thinking idea generation about the future of the services that they use (further details of the feedback received can be found in appendix 1).

In addition, Learning Disability Advocacy Services supported us by facilitating discussions and gathering information from those service users who may find accessing workshops or completing questionnaires online difficult.

### *Staff engagement*

Our staff are critical to the delivery of services and to the success of the transformation journey to come. By positively reflecting on the feedback gained from Service Users and Carers, and on their own experience and expertise around the services that they deliver, staff views have been pivotal in helping to shape the emerging strategy.

We have engaged with our staff via an anonymous online survey, and by visiting a range of services to speak to staff and managers to understand the challenges that they face, and asking what would improve the care that the organisation delivers.

In addition, a three day Clinical Strategy Design event with representatives from our organisation and partners was held, along with additional Medical and Psychology engagement sessions at which staff developed a set of core principles for the new service design and delivery. This was based on the feedback from Service Users; their Families and Carers; fellow colleagues; and key data.

### *Engagement with wider stakeholders and partner organisations*

In developing this strategy, we have also gained insight from the wider system including Commissioners, the voluntary sector, the STP and local providers, all of whom were invited to the clinical design workshop.

## **Commissioning intentions**

In addition to meeting with commissioners and their involvement in a number of the engagement events, commissioners also formed a large part of the membership of the Programme Steering Group that was set up to help oversee the development of this Strategy.

The membership includes members of our Executive Team, NHS England, NHS Improvement, the STP Senior Responsible Officer, and Chief Officer's from the Hampshire and Southampton CCGs. The Group is chaired by the Chair of SHFT and members of the Deloitte and Northumberland, Tyne and Wear (NTW) NHS Foundation Trust project team attend as required.

The role of the Steering Group has been to:

- Provide strategic oversight of the programme
- Resolve barriers to progress
- Ensure delivery against plan
- Resolve escalated risk including financial and clinical
- Provide support e.g. delivery, resourcing
- Ensuring coordination across the wider health economy

Commissioners have contributed not only to the above and to the debate more generally, but have also been asked explicitly to outline their commissioning intentions for mental health and learning disability services.

## **Best practice**

Finally, an Expert Reference Group (ERG) has been convened, chaired by Dr Geraldine Strathee (National Clinical Lead for the Mental Health Intelligence Network), and comprising national and international experts across the fields of Mental Health, Learning Disabilities, Integrated Community

Models and patient and service user experience. (For further information see appendix 2) to provide independent clinical expertise, and test and challenge the emerging themes that have arisen from this strategy.

The group was tasked with providing advice to the clinical services strategy programme to ensure that the models developed are consistent with wider system thinking, and reviewing and testing our emerging thinking and strategy, highlighting risks and issues requiring action.

# 4 The starting point for this strategic direction

## 4.1 Quality and safety issues highlighted by a number of external reviews

The development of this strategy has arisen in part as a response to significant quality and safety issues encountered by the Trust over the last three years. This includes concerns raised by a number of Families whose loved ones have been in the care of the Trust, the Care Quality Commission (CQC), and the Mazars report into the investigation of deaths in the Trust<sup>10</sup>.

### *Deaths and Serious and Untoward Incidents*

Over the past three years there have been significant concerns about the quality and safety of a number of services that we provide arising from a number of serious and untoward events. In December 2015 an independent report by the auditor Mazars, commissioned by NHS England following a death in one of our inpatient units, found a failure to properly investigate and learn from the deaths of people with Learning Disabilities and Mental Illness.<sup>10</sup> The report outlined a number of failings and was highly critical of the systems in place for investigation and learning from deaths, and the low number of investigations following deaths which involved Families.

In response to this report, we commissioned a review of how we involve families in investigations following a death, to learn first-hand from families who had been involved in the experience of a Trust investigation following the death of a loved one.<sup>11</sup> The review had contributions from 17 people from 12 different Families. The review highlighted the need for us to recognise the importance of involving Families in delivering effective services; and to improve the way in which we communicate and engage with Families when there is a death.

### *CQC assessment of services*

At the last full CQC inspection, in October 2014, the Trust was rated as “Requires Improvement” overall. While the CQC found many areas of good practice in our services including perinatal services, Eating Disorders services and Community Mental Health teams, it was found that there was a lack of consistency in the services provided. In addition, the inspection found that there were problems regarding access to crisis services and the availability of inpatient beds, along with inconsistent staffing and issues with the ability to provide a safe environment for care.

The inspection status of each service is shown overleaf.

Following the publication of the Mazars report, the Secretary of State asked the CQC to undertake a further inspection of our services in January 2016. The CQC issued the Trust with a warning notice to take immediate action to monitor and improve the safety of services and assess, monitor and mitigate risks to the health, safety and welfare of patients.

The CQC re-inspected our services in September 2016. The inspection concluded that we had taken sufficient action to meet the requirements set out in the warning notice.<sup>12</sup> However, the CQC acknowledged that there are areas which still require improvement including the environment at several sites; achieving and maintaining safe staffing levels, and embedding governance processes. The CQC continues to be in regular contact with us.

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<sup>10</sup> Independent review of deaths of people with a Learning Disability or Mental Health problem in contact with Southern Health NHS Foundation Trust April 2011 to March 2015. Mazars, December 2015.

<sup>11</sup> Statement on the publication of the report into how we involve families in investigations following a death. <http://www.southernhealth.nhs.uk/news-archive/2016/statement-on-the-Family-involvement-report/>

<sup>12</sup> Southern Health NHS Foundation Trust Quality Report. Care Quality Commission, November 2016

**Rating by service CQC October 2014:<sup>13</sup>**

Service	Overall rating	Safe	Effective	Caring	Responsive	Well led
Acute wards for adults of working age and psychiatric inpatient units	Requires Improvement	Requires Improvement	Requires Improvement	Good	Good	Good
Child and adolescent mental health wards	Requires Improvement	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement
Community-based mental health services for adults of working age	Good	Good	Good	Good	Good	Good
Community-based mental health services for older people	Good	Good	Good	Good	Good	Good
Forensic inpatient/secure wards	Requires Improvement	Inadequate	Good	Good	Good	Requires Improvement
Long stay/rehabilitation mental health wards for working age adults	Good	Good	Good	Good	Good	Good
Mental health crisis services and health based places of safety	Requires Improvement	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement
Perinatal services	Outstanding	Outstanding	Outstanding	Outstanding	Outstanding	Outstanding
Specialist eating disorder services	Good	Good	Good	Good	Good	Good
Wards for older people with mental health problems	Good	Requires Improvement	Good	Good	Good	Good
Wards for people with learning disabilities or autism	Requires Improvement	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement
Community mental health services for people with learning disabilities or autism	Good	Good	Good	Good	Good	Requires Improvement

	Outstanding
	Good
	Requires Improvement
	Inadequate

We remain in breach of a number of regulations of the Health and Social Care Act 2008 relating to risk assessments and quality of premises, and embedding systems and processes to ensure quality and safety of services.<sup>14</sup> Most recently, the CQC gave notice that it intends to prosecute the Trust over an alleged failure to provide safe care and treatment resulting in avoidable harm to a patient in December 2015, when a patient sustained serious injuries during a fall from a low roof at Melbury Lodge, Royal Hampshire County Hospital, Winchester.<sup>15</sup>

We are working hard to address the concerns raised over the past 3 years. This has involved putting in place a number of action plans to further strengthen governance including a CQC action plan and Serious Incident and Mortality improvement plan. NHS Improvement, NHS England, and our Commissioners are overseeing these developments and providing support via a Quality Oversight Committee. This mechanism is also being used as a way to provide external assurance on progress regarding the improvements and how these are being embedded in the organisation. We are also in the process of transferring our Learning Disabilities Services in Oxfordshire and Buckinghamshire to other providers, as well as all of our Social Care Services (TQ21), allowing the Trust to focus on a reduced set of services over a smaller area.

**4.2 Service User and Carer experience:**

Feedback from our Service Users, Carers and Families has formed the starting point for much of the approach to developing our Strategy. Engagement with Service Users, Families and Carers has revealed that whilst there are numerous examples of members of staff who deliver excellent care, there is a significant challenge for the Trust in listening to, and acting on feedback from Service Users and Carers.

The diagram below show the most frequently used words in the feedback from the workshops that were held with Service Users and Carers:

<sup>13</sup> Southern Health NHS Foundation Trust Inspection Reports. Care Quality Commission, February 2015

<sup>14</sup> Southern Health NHS Foundation Trust Quality Report. Care Quality Commission, November 2016

<sup>15</sup> <https://www.cqc.org.uk/content/southern-health-prosecution>



Service Users expressed significant concern around receiving help when they need it, sometimes struggling to speak to clinicians with the right skills, and having to “jump through hoops” to get support. They also described not feeling listened to and their opinions not taken into consideration, with limited help to resolve other issues such as social and physical health needs. Other themes around communication and experience included carers not feeling respected for the support they provide, and a sense of being too worried to ask for help in case their loved one is “taken away”. In addition, Service Users and Carers felt there are significant opportunities to do more to help people to lead meaningful lives, and reduce their dependency on services and joining up approaches with other health and social care agencies.

*Service User, Carer and Family inclusion*

A significant theme emerging from the feedback from our Service Users, Carers and their Families is one of feeling that they do not have a ‘voice’. On an individual level, in their own or their Family member’s care and treatment, Service Users cite issues in terms of being listened to, and communicated to clearly and transparently.

*“Carers need a fast track system to access services”*

*“Need to listen to families and carers and give them more support”*

Our Service Users, their Families and Carers recognise what needs to change, to make care better for the people, and express frustration at not being listened to in this respect. Reports such as those by Mazars have also highlighted shortcomings in how we have engaged Families in regard to investigations and complaints.

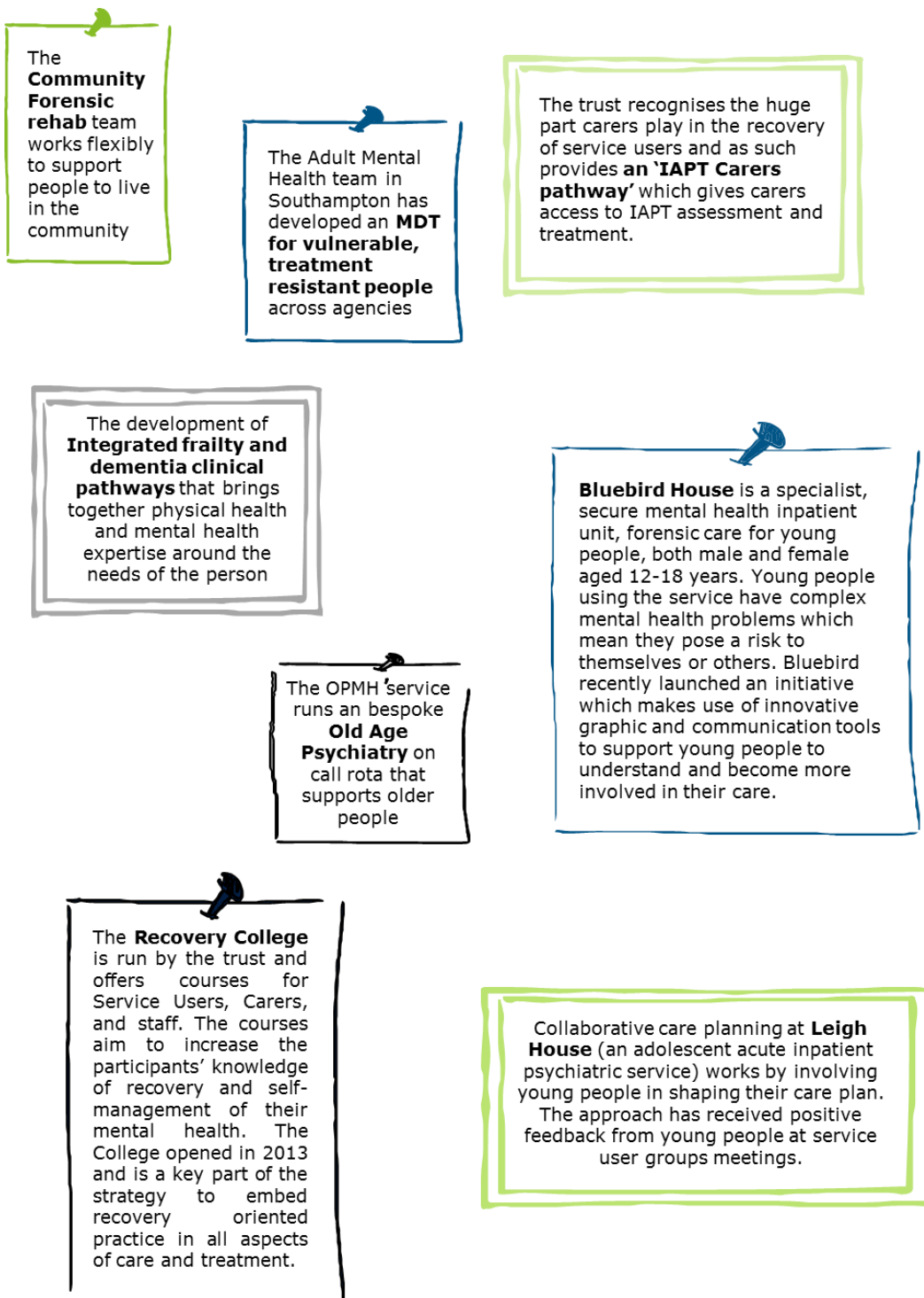
**Service User experience**

The proportion of people who are likely to recommend our services in the Friends and Family test has recently increased, from significantly below the national average for mental health of 88% - 67% in February 2016 - to 81% in November 2016. This demonstrates a vast improvement, and is closer to the national average for mental health services of 88%,<sup>16</sup> but shows that we still have work to do.


<sup>16</sup> Friends and Family Test Mental Health November 2016. NHS England.

### 4.3 Services overview

We provide a number of services across Hampshire and Southampton. There are numerous areas of good practice and innovation. A number of examples of these are outlined below (although this is not an exhaustive list).








The **Perinatal** (mother and baby) service at the trust is highly regarded nationally, and was the first in the country to receive an independent accreditation from the Royal College of Psychiatrists. The team has also won 'The Psychiatric Team of the Year' at the national 2013 Royal College of Psychiatrists Awards due to the excellent service provided by in the community and at the specialist unit.


The development of the **Care Navigator** role at the trust has been highlighted by the Crisp report as an example of good practice ('Old Problems, New Solutions: Improving Acute Psychiatric Care for Adults in England'). The Care Navigator supports the team with the safe transition of patients through the acute care pathway.

The Learning Disabilities service has developed **maps of interventions** developed along core pathways


**Willow Assessment and Treatment Unit** supports people with complex learning disabilities effectively embedding a team-wide approach to positive behavioural support.



The **Tableau** platform supplies services with up to date data in a usable visual format to allow real time access to data and information



**Consultancy And Support Team (CAST)** are a group of Service Users who have experienced complex mental health problems who help Service Users get the most from therapy programmes and treatment by sharing their personal experiences of recovery. CAST were involved in co-producing the EUPD pathway with clinicians



The **Southampton Primary Care Mental Health 'STAR' Project** was funded by the Prime Ministers Challenge Fund, and aimed to reach more of the population who may have mental health problems. This was done by providing structured needs and symptom assessment to people who were referred to the STAR team by GPs. This service was aimed at those not currently receiving care from a substance misuse team, IAPT, or a mental health team.

**Peer support workers** work in adult mental health inpatient facilities to provide credible, recovery-oriented care

Whilst there are numerous examples of good practice, there is often inconsistency in our services. This has been highlighted by Trust data, feedback from our staff working in services and from Service Users and Carers, along with the CQC in their 2014 inspection.

#### 4.3.1 Access to services including urgent response

Access to our services is a significant issue, as cited by Service Users, Families, Carer, staff and the wider system. Service Users fed back that getting into services is a significant challenge, and that they can end up feeling “fobbed off” due to a lack of ownership on the part of those services. At present, most of our services (excluding IAPT) do not accept self-referrals.

*"You have to jump through hoops to get what you need"*

*"You get fobbed off and turned away because you don't meet criteria"*

A number of our teams also describe issues with capacity, with CMHT clinicians raising issues in the Design Workshop around balancing the demands of urgent and routine Service User needs, which can limit the level of support that services are able to provide. Service Users and Carers gave numerous examples of asking for urgent help and either being turned away, or having to wait several days for support to be given.

The acceptance criteria of some services can mean that some of the most vulnerable people can fall through the gaps due to artificial thresholds. This is exacerbated by each service having its own processes and approaches to how referrals are handled and triaged. In addition, access to different services within the Trust can also be an issue, with referrals required between teams, and challenges with capacity in areas such as Psychology –which in some cases has had to stop any new referrals due to capacity.

#### 4.3.2 Urgent response/crisis services

Provision for urgent need is critical for the delivery of a high quality mental health service, as recognised by the 5YFV. The model for 24 hour crisis provision for working age adults is limited. There is currently no commissioned out of hours crisis provision for older people or people with Learning Disabilities, which means that when out of hours provision is required for specific patients, a solution has to be negotiated with the Working Age Adult Mental Health Teams who can then contact the on call psychiatrist for support.

In our Adult Mental Health services, there are differing models for how crisis care is provided, including the community mental health team (CMHT) ‘shared care’ approach in the daytime, and the AMHT (acute mental health team) providing support in the evenings. CMHTs are open Monday to Friday between 9am and 5pm and AMHTs are open 24/7 all year round. However, overnight the level of cover in an AMHT can be limited, which means that it is not possible to provide home visits, which can be required in order to prevent admission.

*"There's no support for people in crisis – it took 2 days to respond to me"*

*"Requests for help aren't taken seriously"*

The result of this, along with other factors (including in primary care access, changes in police practice and lack of social support), is that often, the only option for people in difficulty is to present at services which are not equipped to provide the care that they need. Local acute Trusts have raised that the pressure on A&E is a significant challenge, with high numbers of people attending A&E with mental health needs. Referrals to our services from A&E have increased by 44% versus the equivalent period a year ago, and attendances at A&E for a psychiatric disorder are significantly above average in Southampton.<sup>17</sup> The pressure on A&E means that our Liaison Psychiatry services in the local Acute Trusts (University Hospital of Southampton NHS FT, Hampshire Hospitals NHS FT and Portsmouth Hospital NHS Trust) becomes focused on people in A&E. Levels of cover vary in the Liaison Psychiatry services with no 24/7 service in place (cover tends to be limited or none after 6pm or 10pm depending on the area). The model often sees lone workers on duty, and is not resourced to provide crisis cover in the community.

The lack of crisis provision can also lead to Service Users or others calling the Police to deal with acute episodes of crisis. In the absence of other services, the Police can sometimes have to resort to using their

<sup>17</sup>Attendances at A&E for a psychiatric disorder, rates per 100,000. 2012/13, Public Health England - Public Health Profile ‘Fingertips’.

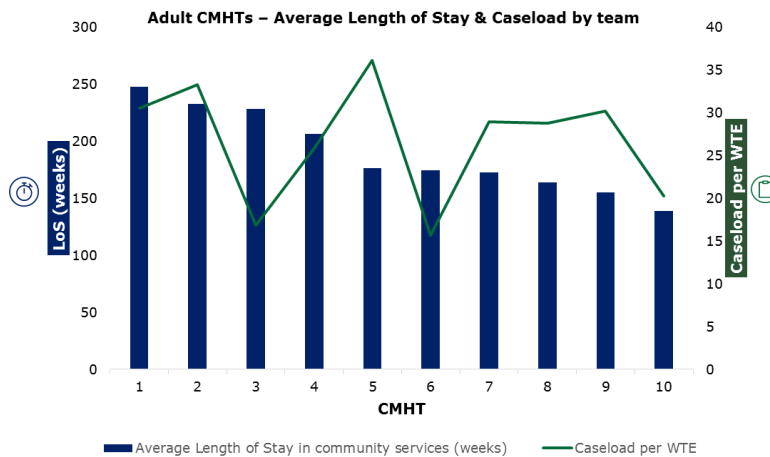
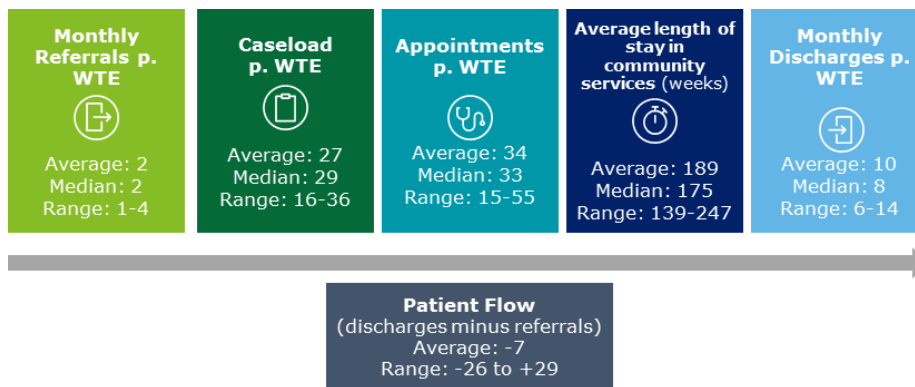
powers to detain people, which is distressing for Service Users and their Families. NHS Benchmarking shows that the number of section 136 assessments<sup>18</sup> for the population served by the Trust are significantly above average (fourth in the country), which may be related to the lack of crisis provision, whilst acute admissions under the Mental Health Act are below the national average (for further information, see appendix 4).<sup>19</sup> This may suggest that if there was the appropriate support available in the community in the first instance, a number of people could potentially have been managed at home.

### 4.3.3 The adult mental health pathway

Linked to the issue of provision of urgent response care is the overall adult pathway. There is not currently a consistently applied model of how care pathways are delivered for community teams and how their roles and responsibilities work and interact with each other.

#### Variation in delivery and variance from pathways

#### Performance metrics: Adult CMHTs<sup>20</sup>



The data above gives key metrics, weighted by whole time equivalent staffing resource, to enable some comparison across teams. This data shows that teams are working differently with significant variation in the caseload per team member, which has implications for how much capacity teams have to work with their caseload. In addition the average length of stay of Service Users in some teams is double that of other teams, which again suggests different practices for delivering care. Whilst variation in performance metrics between teams needs to be interpreted on the basis of variation in population need, and caseload

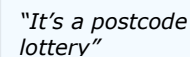
<sup>18</sup> Section 136 of the Mental Health Act 1983 allows a police officer to remove a person from a public place to a place of safety in the interest of that person or for the protection of others, if they think that person is mentally disordered and 'in immediate need of care or control.'

<sup>19</sup> NHS Benchmarking Network: Mental Health Inpatient and Community Benchmarking 2016.

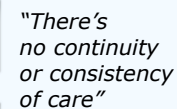
<sup>20</sup> SHFT Clinical Performance Dashboards, SHFT Tableau System.

weighting, in general terms the metrics should be more comparable. Our ambition is to configure all CMHTs to standardise service delivery at the highest quality.

Whilst we have developed a number of pathways, including Psychosis, Borderline Personality Disorder, and Affective Disorders, these have not been systematically implemented across teams. This is in part because in moving from policy to implementation, the resource and skills required to deliver these pathways have not been aligned to the requirements of these pathways. There is not currently a systematic approach to caseload weighting in the Trust, or access to the granularity of clinical data required to support a mapping of resource in this way.



"It's a postcode lottery"



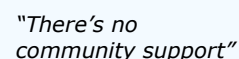
"There's no continuity or consistency of care"

In addition, some of the variation seen in CMHTs is due to the different ways in which teams deliver care to people with urgent needs - in the East our AMHTs receive direct referrals from GPs for all 'urgent' and 'new crisis' referrals; whilst the 'routine soon' and 'known urgent' referrals are sent to the CMHTs. In all other areas both of these functions are performed by the CMHT meaning the CMHT has to triage the crisis referrals and refer them to their area AMHT. These differences are due to the configuration of the Primary Care pathways across the different areas of the organisation. However, these factors mean that the CMHTs can be consumed by supporting people with urgent needs as best as they can between 9-5pm, which can limit their ability to provide proactive, planned care.

#### *Challenges in delivering alternatives to admission*

The impact of urgent demand also has an impact on the Acute Mental Health Teams (AMHTs) that are designed to deliver an alternative to admission by providing 'hospital at home' and facilitating early discharge from inpatient units. Our AMHTs are often unable to deliver a full crisis response due to a lack of capacity, which means that they cannot be as proactive in delivering care. This is evidenced by the fact that 67% of people under the care of the AMHT do not have a crisis plan in place.<sup>21</sup> Commissioners have acknowledged the gap in urgent response, and have signalled their intentions to develop this service in 2017/18.

The pathway components in the community - in terms of crisis provision, hospital at home and community care - can have an impact on who is admitted to a hospital bed. There are a number of factors that impact on admissions including the preventative service provision upstream (which is designed to keep people functioning well in the community), and once people are in hospital, the provision that exists in the community to support people post discharge (in terms of housing and social services). The lack of this infrastructure can sometimes mean that admissions are a result of no alternative, rather than necessarily being the best therapeutic option.



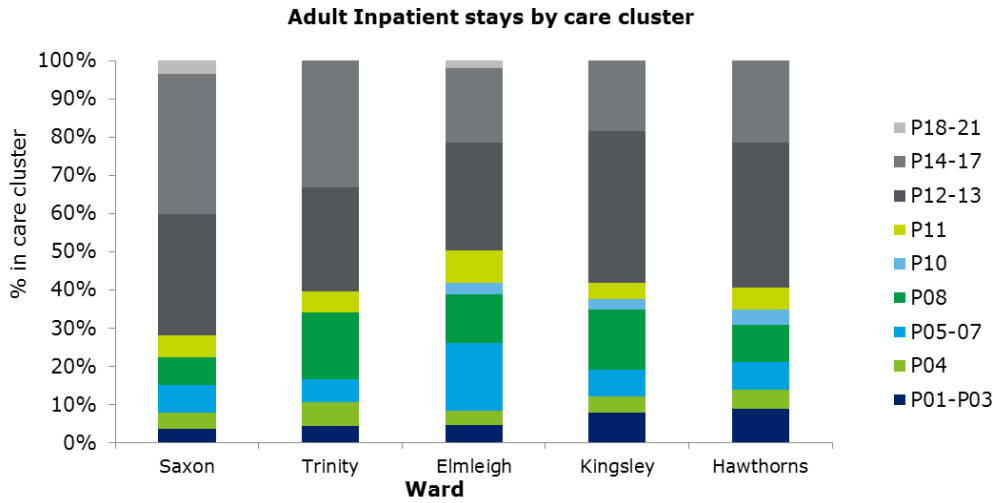
"There's no community support"

#### *Inpatient admissions*

NHS Benchmarking data shows that the number of adult beds per 100,000 population is largely in line with the national average (for details of this see appendix 4).<sup>22</sup> However the care cluster data of people on our wards that shows the needs and severity of Service Users (see appendix 3), suggests that some people may be in hospital due to the lack of an alternative. The chart below shows that 25% of episodes are for clusters which may not always require an inpatient bed: 6% of people on the wards are in care clusters 1-3 which are low to severe non-psychotic common mental health conditions; 13% of episodes are in cluster 8 which covers people with non-psychotic chaotic and challenging disorders where alternatives to admission may be preferable, and 6% are cluster 11, which represents people with psychosis who are stable. This suggests that there may be opportunities to support more people in the community.

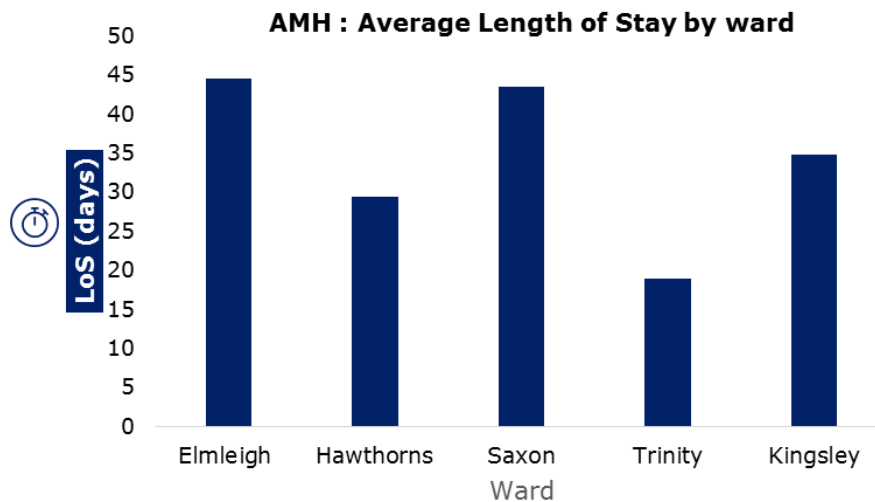
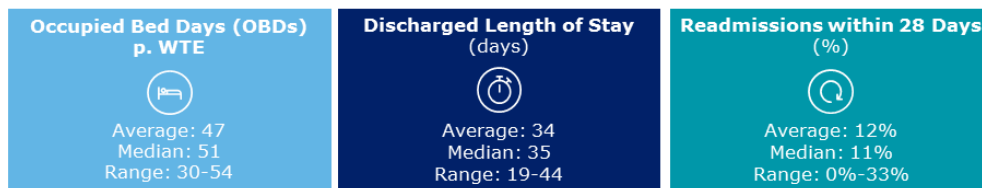
<sup>21</sup> SHFT Clinical Performance Dashboards, SHFT Tableau System.

<sup>22</sup> NHS Benchmarking Network: Inpatient and Community Mental Health Benchmarking 2016



Wards are managed locally, by each site and area management team, with local processes and procedures. Data suggests that there is variation in how people are managed and with what resource as shown below:

### Performance Metrics: Adult Mental Health – Acute Inpatient wards<sup>23</sup>

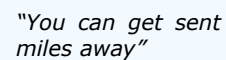


The data above shows that there is a significant difference in the length of stay between similar wards, with the average length of stay ranging from 19 to 44 days which suggests variation in clinical practice. In addition, the staffing models on the wards appears to be different, as evidenced by the difference in Occupied Bed Days (OBDs) per WTE between wards which varies from 18 in the North to 61 in Southampton. Whilst some of this variation may be due to differences in clinical remits of the wards, the difference in these metrics suggests that there is variation in approach in inpatient facilities.

<sup>23</sup> SHFT Clinical Performance Dashboards, SHFT Tableau System.

### *Out of area beds*

The use of out of area beds by AMH has been highlighted as a concern by Service Users, Carers, staff, and in Trust-wide performance reporting. Sending people out of area can be distressing, and can also lead to longer length of stay. We currently have to use out of area beds on a regular basis, including a block purchase of beds. The need to use out of area beds is in part due to short term issues (due to the temporary closure of Hamtun ward Psychiatric Intensive Care Unit and Kingsley ward inpatient unit at Melbury Lodge). However, factors such as delayed transfers of care due to issues with community and social care agencies can also play a part in the need to send people elsewhere due to lack of bed capacity. In recognition of this problem we have developed a Care Navigator role which aims to support managing the admission and discharge of patients on wards.



"You can get sent miles away"

### **4.3.4 Older People's Mental Health Services**

#### *Age-led service model*

Our OPMH services currently provide care for functional and organic mental illness, focused primarily but not exclusively for people over the age of 65. Memory assessment services are provided for individuals of any age, and provide care for those younger people (under 65) with a diagnosis of early onset dementia. Services and their staffing resource are not currently organised along needs-led formalised pathway functions, but do deliver treatment focused on the individual, holistic, needs of each Service User.

As with AMH services, a key issue for this service is the lack of a commissioned out of hours crisis response for older age adults. Whilst there is an on call rota for older age psychiatrists, (when out of hours crisis monitoring is required for known patients), consultants must negotiate on a named individual-basis with services such as the AMHTs and/or Liaison workers to provide an urgent response to support people out of hours. This is not a full crisis service, which means that the level of intervention can only be at an arms' length. As in AMH, a robust approach to crisis would greatly improve the experience of Service Users and their Families.

People with functional illness are accepted into OPMH services from the age of 65, creating a transition point from AMH services to OPMH services. The transition and how this is managed varies according to Consultant, and is dependent on the capacity of 'receiving' teams as the pathway is not managed in a continuous flow.

The pathways for functional mental illness are not consistent across older people and working age adults. The size of the OPMH service means that it does not have the scale to provide access to the same breadth of resource as the adult mental health pathway. For example, there are only three psychologists in the whole service and as a result access to psychological therapies is limited.

#### *Organisational integration with physical health*

OPMH Services currently sit within the Trust's Integrated Service Division. The service merged with community physical health services in 2015, with a view to delivering more integrated, joined up care across mental and physical health. The OPMH service is distributed across multi-disciplinary teams which include old age psychiatry, CPNs and community physical health nursing. The integration of physical and mental health teams has happened to varying degrees – in some teams "integration" refers to the merging of operational management only, whilst in other teams, mental and physical health teams have clinically integrated, to greater or lesser degrees depending on locality. In one area, CPNs report monitoring physical health conditions such as pressure sores.

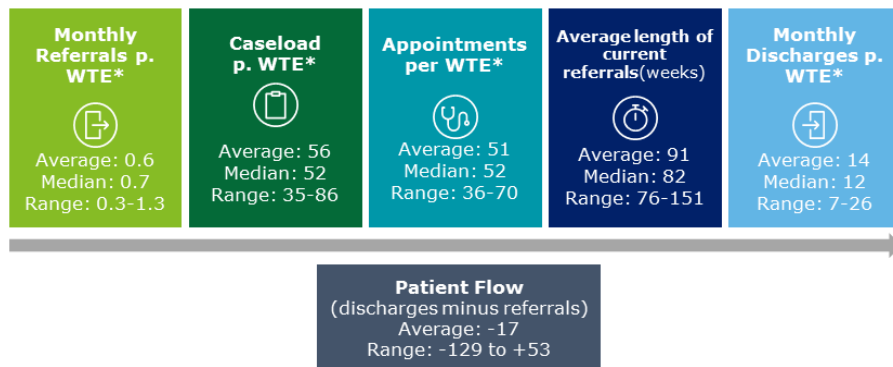
While positive benefits to Service Users have been noted from this approach, the result has been a small service spread thinly across a number of teams, leading to concerns about a loss of professional identity

amongst doctors in particular. This may be reflected in the vacancy rates which are higher than most parts of the Trust in OPMH at 16.5%, and 37% vacancy rates amongst medical staff.<sup>24</sup>

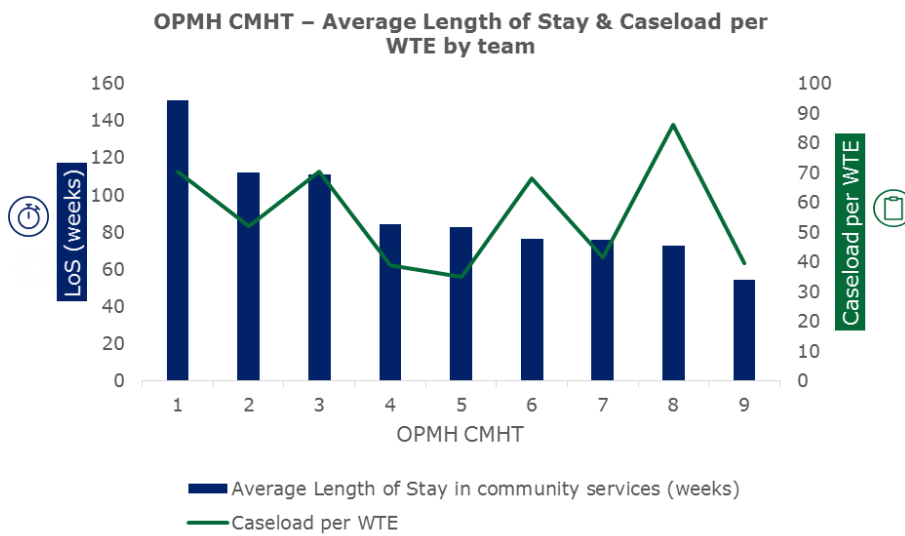
*Variation in service delivery*

As a result of both the integration with physical health and historical arrangements, there is no single consistent model of service delivery across OPMH teams, or defined pathways that services are working towards. Trust data suggests that there is variation between community teams and how they are assessing and treating patients.

**Performance metrics: Older People’s CMHTs<sup>25</sup>**



\*calculated based on adjusted WTE (where Funded WTEs for the specific OPMH CMHTs (Andover, Eastleigh and New Forest East) are adjusted for over recruitment of 50%, 28%, 35% respectively to those teams)



The data above shows that the caseload per WTE in teams is nearly three times higher in one team than another, which suggests that the time staff have to support people is very different. In addition, the length of stay in the community teams varies from 75 weeks to 151 weeks, which also indicates a difference in practice.

*Inpatient admissions*

<sup>24</sup> Staff Vacancy Report, Southern Health NHS Foundation Trust Tableau System & Information received from Southern Health NHS Foundation Trust Human Resources Information team

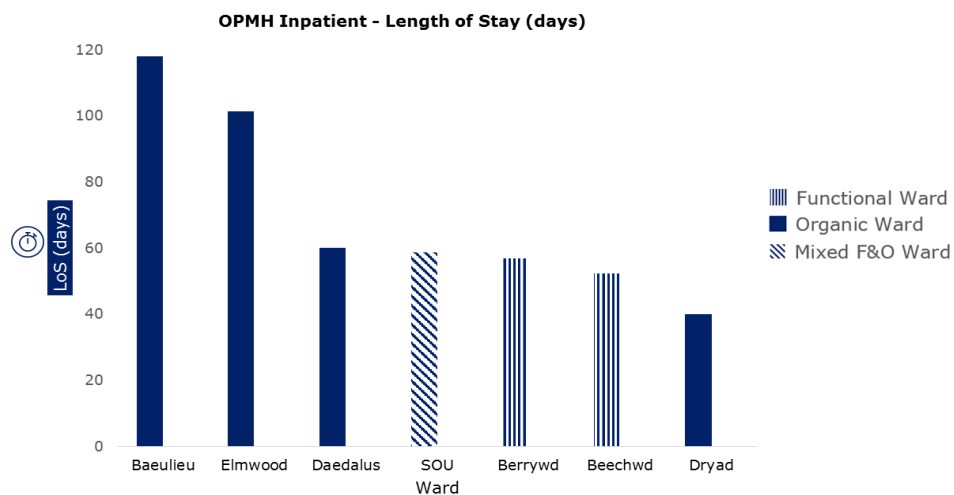
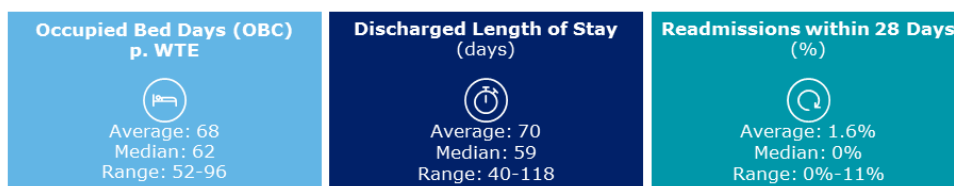
<sup>25</sup> SHFT Clinical Performance Dashboards, SHFT Tableau System.

NHS Benchmarking data shows that we have a higher reliance on inpatient stays in older people’s services than average (see appendix 4). There are significantly more beds for older age adults than national average (49 per 100,000 population versus 32 average), along with a higher rate of admissions versus the national average (c. 160 per 100,000 weighted population compared with national average of 142 per 100,000).<sup>26</sup> In addition, the average length of stay is also above average – our average length of stay is 111 days length of stay vs. the national average of 81 days. This could be influenced by the fact that the Hospital at Home service is for working age adults only, which limits the alternatives to admission for older people who require an intensive level of support.

Inpatient areas are generally diagnosis-led, although the service has considered taking a more flexible approach to admission so that people are offered admission to an environment which matches their need. For example, it is not suitable for a robust 68 year old man experiencing a manic relapse of his bipolar disorder, to be placed with frail Service Users with a similar diagnosis.

There is variation between inpatient wards. Data indicates that wards with similar specialisms show a threefold difference in length of stay, and staffing figures suggesting a difference in staffing models, both of which suggest a difference in approach to care delivery. However, there are other factors to consider, such as the differences in Social Services arrangements and availability of suitable placements across the localities.

**Performance metrics: Older People’s Mental Health – Inpatient wards**



Proactive support to Care Homes and similar providers can enhance the care that Service Users with dementia receive, and deescalate acuity before crisis occurs. This is currently delivered by individual nurses on an adhoc basis, with work by the service to build pathways models ongoing. The CPNs usually organise a rota to cover the Care homes between themselves.

<sup>26</sup> Mental Health Inpatient and Community Benchmarking 2016, NHS Benchmarking Network.



### 4.3.5 Learning disabilities

Our Learning Disabilities services include community and inpatient facilities for adults with Learning Disabilities in Hampshire and Oxfordshire. There has been significant criticism of some of our services in Oxfordshire over the past 3 years, and reports have focussed on the urgent need for change. At the time of writing we are in the process of transferring our community and inpatient facilities in Oxfordshire to another provider, which will allow us to focus on services on a smaller geography.

We will continue to provide services in Hampshire. Our services in Hampshire include Community Treatment Teams, Intensive Support Teams (focusing on individuals displaying behaviours which challenge), an Assessment and Treatment Inpatient Unit, Liaison Nurses in Acute hospitals, and an Autism Assessment Service for adults with a learning disability in Hampshire.

#### *Transforming Care Partnership*

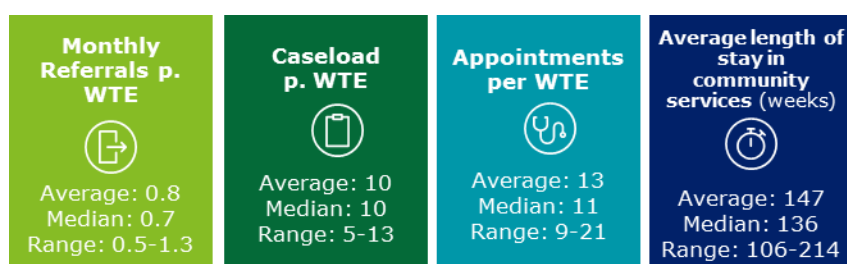
We are a key partner within the Southampton, Hampshire, Isle of Wight and Portsmouth Transforming Care Partnership (TCP), the remit of which is to deliver pathways across primary, secondary and community care including social services, and to reduce the reliance on inpatient beds. Following the direction from 'Transforming Care for People with Learning Disabilities' in 2015, 'Building the Right Support'<sup>27</sup> outlines the national service model and associated principles, which all Trusts are required to deliver by March 2019.

Our strategy is to prioritise community-based provision, and reduce the need for inpatient admission to only those cases where acuity means the issues cannot be managed safely in the community. We are committed to working with organisations and sectors to prevent the 'revolving door syndrome' of admissions and discharges, improve planning and delivery of care placements where needed, and reduce the likelihood and impact of placement breakdown.

#### *Community services*

A review of the Learning Disability pathways is underway in the region, under the leadership of the TCP. Our services have undertaken a significant programme of work to develop a series of needs-led, evidence-based clinical pathways which focus on the primary need of the individual. These pathways are flexible around primary need, and are visualised as "maps" of interventions around epilepsy, mental health, dementia, autism, complex needs, challenging behaviour and forensic needs. Services strive to be proactive and empowering in their approach, instead of paternalistic and life-long.

#### **Performance metrics: Learning Disabilities Community Teams<sup>28</sup>**



Data suggests that there is variation in how our community teams deliver care, with the average length of stay in community team ranging from 106 weeks to 214 weeks, and a threefold difference in the average caseload per WTE, which suggest difference in practice. Whilst some of this variation may be due to differences in the nature of the caseloads in the teams, the difference in these metrics suggests that there is variation in the delivery of care. Resource is not currently mapped to the pathways that have been developed, this will be the next step to ensure their effective implementation.

<sup>27</sup> Building the right support. NHS England, Local Government Association and Association of Directors of Adult Social Services, October 2015.

<sup>28</sup> SHFT Clinical Performance Dashboards, SHFT Tableau System.

### Access and urgent need

Currently there is no built-in 'urgent response' for people with Learning Disabilities. This includes people with learning disabilities who have mental health issues, as mainstream mental health services currently distinguish based on IQ. Intensive Support Teams (ISTs) operate flexibly to support known individuals outside of Mon-Fri, 9am-5pm using a positive behavioural support approach. However, this is only open to people who are known to the IST.

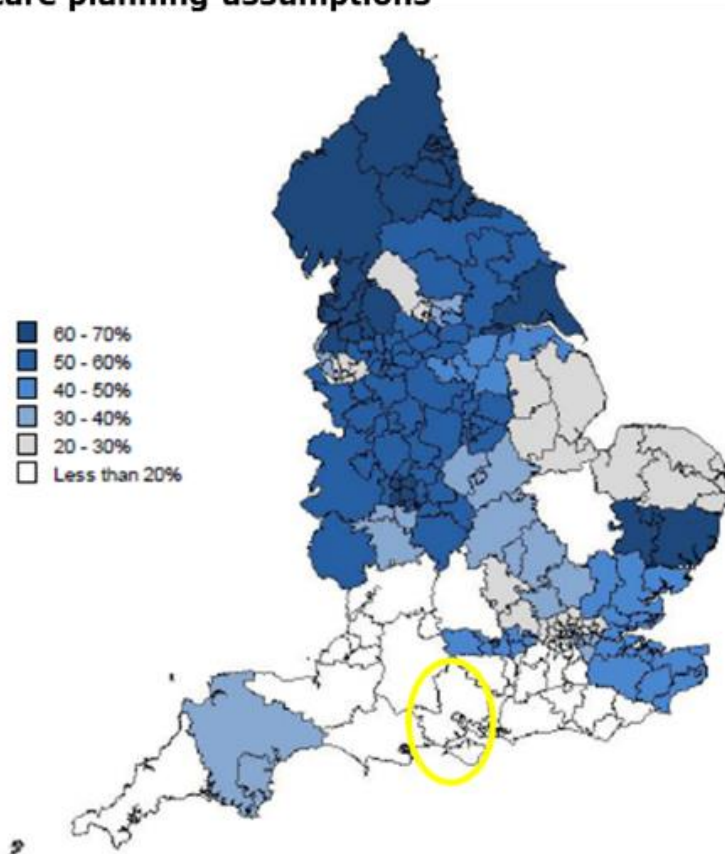
"There is no consistency in the first point of contact"

### Inpatients

The Trust provides inpatient care in Willow Assessment and Treatment Unit. This is spot purchased by commissioners both within and outside the county, the team follows the 'Blue Light Toolkit' which supports decision making to prevent people being admitted unnecessarily to inpatient facilities.<sup>29</sup>

The service has a comparatively low bed footprint versus other areas of the country, as illustrated below:

**Reduction in LD bed usage, implied by national care planning assumptions**



Reviewing inpatients under the framework of 'Care and Treatment Reviews' is an additional national directive, and links with the recommendations of the Lenehan Review on the need to review those adolescents who may soon require transfer to adult Learning Disabilities wards, in both cases providers are tasked with proactively working on community-based solutions. This is currently in progress as part of the Transforming Care work.

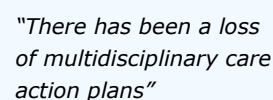
<sup>29</sup> <https://www.england.nhs.uk/wp-content/uploads/2015/10/ld-blue-light-protocol.pdf>

### *Transitions and interfaces*

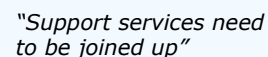
Services for children with Learning Disabilities are currently provided by other organisations. The number of children with Learning Disabilities known to schools in the region is significantly higher than average – there are 44.8 children known to schools with Learning Disabilities per 100,000 children in Hampshire and the figure is 69.1 in Southampton versus an average of 33.7.<sup>30</sup> Children with Learning Disabilities currently receive a mixture of services depending on where they live, varying from only having GP and occasional Paediatric support (described as a medical-only model), to CAMHS services which in some areas include Learning Disabilities as a function.

The transition from children's to adult services is a crucial period that currently relies on relationships across different organisations. Staff highlighted that the transition can be difficult and requires clinicians in adult Learning Disabilities services to 'start again'. 'Building the Right Support' requires agencies to create all age solutions, with continuity of high quality care between providers where necessary.

The breakdown of the integrated LD teams between health and social care in Hampshire has created a risk of artificial transitions for Service Users. It is vital that teams in health and social care work closely together for the benefit of the Service User, despite the disaggregation of teams.



*"There has been a loss of multidisciplinary care action plans"*



*"Support services need to be joined up"*

### *Engagement with Service Users and Carers*

Engagement with Service Users and Carers has been previously noted as a significant issue for our Trust. Family Carers have described receiving very little support, often only suggested when crisis point has been reached, and then not available out of hours. Proactive service offers by health and social care are a key element of 'Building the Right Support', but little experience of this has been noted by individuals and their Carers.

Advocacy services who support those with significant Learning Disabilities have cited issues around information sharing with Service Users, Families and Carers, and in ensuring the professionals work as a team across agencies and specialisms, sharing knowledge and coordinating care.

### **4.3.6 Specialised services**

We run a number of tertiary services across Mental Health and Learning Disabilities services. These include perinatal services, which are rated Outstanding; a tier 4 CAMHS service, and various forensic services for adults, young people and people with Learning Disabilities.

#### *Forensic Services*

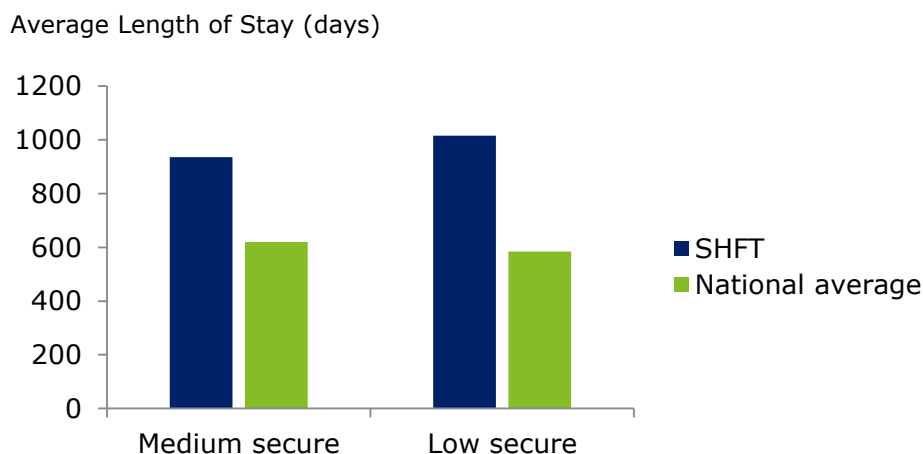
We provide 78 adult medium secure beds at Ravenswood, 23 low secure step down rehab beds and a small community forensic service, along with low and medium secure forensic services for people with Learning Disabilities.

The lack of provision of acute low secure beds for adults in Hampshire represents a gap in the pathway and can mean that people requiring this level of care either have to go out of area, or in some cases, are stepped up to the medium secure unit, neither of which are optimal for patient experience. The average length of stay in our units is longer than the national average for both medium secure units and low secure units. The variance to the national average in our low secure units is likely to be because we only deliver low secure rehab facilities, but may also be connected to the amount of community forensic capacity that is available. The longer than average length of stay in our medium secure wards may also be due to the other provision that is available, as there is not currently acute low secure provision.

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<sup>30</sup> Public Health England - Public Health Profile 'Fingertips.'

### NHS Benchmarking: Average Length of Stay versus national average<sup>31</sup>



The physical environment within Ravenswood presents a significant challenge to the delivery of the service. It is an old building that requires a great deal of maintenance and lacks clear lines of sight. Although recent refurbishment has resulted in marked improvements as noted by the CQC, there continue to be challenges, and the site has to mitigate those areas where it cannot meet current national standards. Whilst in the past, plans have been considered to develop a new medium secure facility which were not feasible due to the significant capital investment that they required, progress is now being made on an affordable solution with a business case being developed during 2017.

The service has established a community forensic team that supports people transitioning out of forensic services, for which mainstream CMHT support would not be appropriate. This small team works flexibly and resourcefully to support this cohort of patients in the community. The service is currently exploring how to increase and augment community provision to support people in the community.

#### *Children and Young people*

There are 21 beds in Bluebird ward which is a medium secure unit for people aged 18 years and under which specialises in treating emerging personality disorder. It is one of seven medium secure facilities in the country that support young people who have been detained under the Mental Health Act.

Whilst the Trust provides medium secure facilities, the overall pathway is incomplete locally, as there are no low secure beds within the South of England, and there is not clear gatekeeping process that coordinates and supports the forensic pathway. The lack of low secure provision means that people either have to go out of area, or often have to be rehabilitated in the medium secure ward, which adds complexity to the ward and is not the best setting for the patient. In addition, the absence of low secure provision presents a problem to non-forensic patients who are at high risk of causing harm to themselves.

There are also gaps within the CAMHS mainstream pathway. The absence of a Psychiatric Intensive Care Unit (PICU) means that there is a significant gap between tier 4 inpatient beds and the medium secure provision, and there is no means of managing acute periods of risk that do not meet forensic thresholds.

#### **4.3.7 Primary care based mental health services**

Evidence suggests that outcomes are better when people receive early identification of and treatment for mental health conditions. The majority of people with mental health difficulties present to primary care,<sup>32</sup> with GPs reporting that 1 in 3 consultations involve a mental health component.<sup>33</sup>

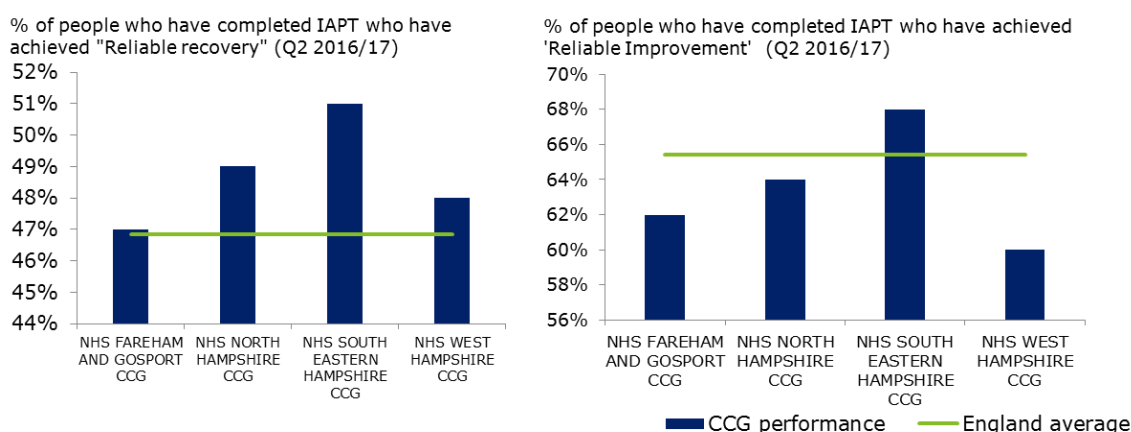
<sup>31</sup> NHS Benchmarking Network: Inpatient and Community Mental Health Benchmarking 2016

<sup>32</sup> Mental ill health in primary care. Rees et al. <http://www.birmingham.ac.uk/Documents/college-mds/haps/projects/HCNA/08HCNA3D31.pdf>

### Improving access to psychological therapies (IAPT)

We deliver italk – a step 2 and 3 psychological therapies service in partnership with Solent Mind. This service is for the population of Hampshire (North Hampshire, West Hampshire, South Eastern Hampshire and Fareham and Gosport CCGs) for people aged 16 and over who are not already in contact with other mental health services. People can either self-refer directly to the service or be referred by their GPs or any other healthcare practitioner.

Outcomes data shows that the percentage of people achieving reliable recovery is slightly above the national average, although the proportion achieving reliable improvement is below the national average in three of the four CCGs that commission our italk services.<sup>34</sup>



Access to italk is lower than average, with 2.9% of people with depression and/or anxiety disorders accessing services versus the national average of 3.8% and the national target for 2016/17 of 3.95%<sup>35</sup>. Improving access to these services requires a system wide effort with general practice to direct people to these services. The proportion of people being referred in the higher clusters is significant with over 50% of referrals in cluster 4, 5, 6, 7 and 8 which leads to waits at step 3, whereas the proportion of people with milder presentations is low.<sup>36</sup> There is an opportunity for milder cases to be seen by the service.

In addition to access, there are issues with capacity in the italk service. Although the waiting times for italk are generally ahead of target – on average 87% of people received an appointment within six weeks of referral versus the target of 75%<sup>37</sup> - the waiting times between the first and second treatment appointments suggest a secondary waiting list as 32% of people wait more than 28 days between their first and second appointments. Whilst part of this is due to an agreed 90 day treatment time for step 3 services, as access increases work will need to be done to ensure that there is the workforce available to support an increase in referrals.<sup>38</sup>

### Practice based mental health services

Mental ill health in primary care ranges from sub-syndromal symptoms, to clear cases of mental disorder which range significantly in severity and the disability they cause. The current lack of systematically commissioned practice based mental health services means there is limited opportunity to provide support for those who are in a situation where more support than that available from GP practices is needed, but the full services of community mental health teams are not required.

"GPs should have more information on which Mental Health services are available to offer to people"

<sup>33</sup> A commissioner's guide to primary care mental health: Strengthening mental health commissioning in primary care: Learning from experience. London Mental Health Strategic Clinical Network for Mental Health, 2014.

<sup>34</sup> NHS RightCare CCG data packs, NHS England.

<sup>35</sup> Mental Health Five Year Forward View Dashboard - Q2 2016/17, NHS England.

<sup>36</sup> SHFT cluster data for open IAPT referrals 6<sup>th</sup> March 2017

<sup>37</sup> SHFT Clinical Performance Dashboards, SHFT Tableau System.

<sup>38</sup> August 2016 to October 2016 data for SHFT, NHS Digital IAPT Reports.

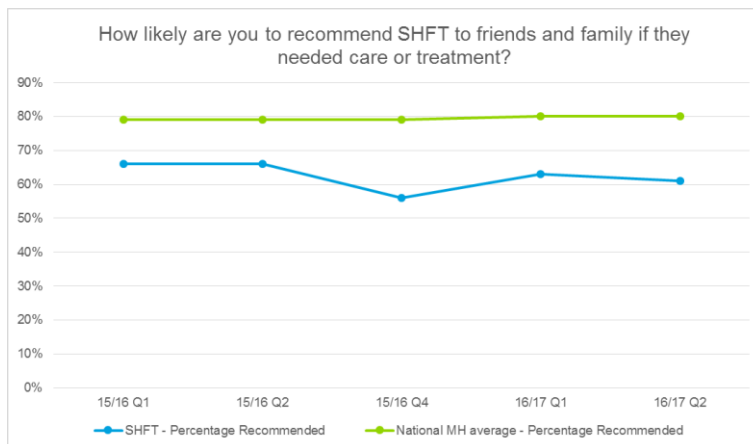
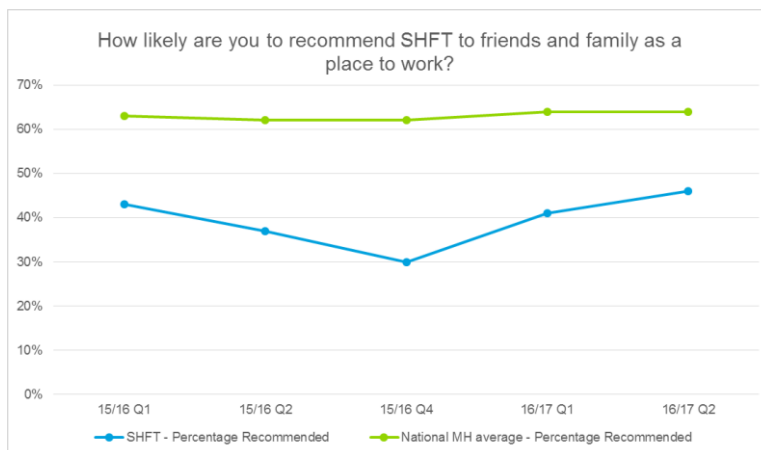
There have been a number of pilots, however there is not at present a commissioned model. An example of this is the Southampton ‘STAR’ project which has been developed around primary care hubs in Southampton to support emotional needs of people providing structured needs, symptom assessment, problem-solving, activation & connecting people to community resources. Another example is the italk community model with Psychological Wellbeing Practitioners embedded in GP practices in Gosport, with a direct booking facility.

There is an opportunity to work with local delivery systems to identify the need in primary care and work together to develop a solution that addresses this. The newly commissioned italk model with italk core, italk health and italk@work goes some way to support this.

#### 4.4 Staff experience

##### Staff survey results

The results of our Friends and Family test echoes that there is a need for change in the Trust, both in terms our services and as a place to work. Only 61% of our staff would recommend SHFT to their friends and Family for care and treatment, which is significantly below the national average of 80%.<sup>39</sup> In addition, only 46% of our employees would recommend the trust as a good place to work, which is significantly below the national average of 64%.<sup>40</sup> It is of note that the completion rate of the survey at SHFT which is 5%, is below the national average of 12%.



##### Staff feedback

<sup>39</sup> Staff Friends and Family data, Q2 2016/17. NHS England.

<sup>40</sup> Southern Health NHSFT, Board paper, October 2016

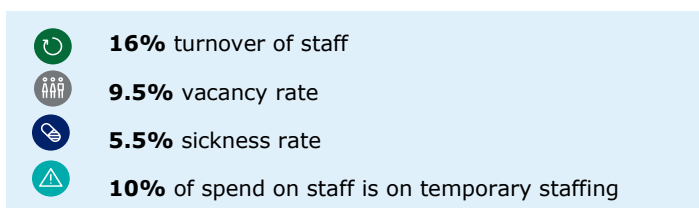
In developing the strategy our staff have been engaged in a variety of ways, via one to one interviews, service visits, online anonymous surveys and workshops. Whilst there was a lot of praise for the dedication, commitment and resilience of their colleagues, the culture of the organisation was a significant theme that emerged, which echoed the views of our Service Users, families and Carers.

The issues raised by staff centred on a perceived lack of expert clinical leadership, lack of autonomy given to staff to deliver quick wins, and the lack of support that staff felt they received from the organisation, particularly during difficult times. Staff felt that there is room for improvement by the Trust leadership, for example giving frontline staff who have greater understanding of their business, leadership roles to develop services and improve patient pathways.

The impact of the scrutiny that the Trust has been subject to in the national press has undoubtedly had an adverse impact on staff experience, with some quoted as “fearful of ending up on the 10 o’clock news” and worried about taking measured positive risks to improve Service User care. In addition to this, staff recognised that this pressure has been a significant distraction for the organisation, and in some cases has impacted upon local service delivery, with staff noting they feel “under a microscope” and exposed, which presents risks to the sustainability of the workforce.

#### 4.5 Workforce sustainability

Workforce challenges present a significant issue for the Trust. Issues such as the lack of availability of band 5 nurses are a nationwide problem, however this is coupled with reputational challenges the Trust has as a result of the events of the past three years.



The impact of the reputational issues on the ability of the Trust to retain staff is seen in staff turnover, which is significantly higher than the national average for mental health trusts of 12% (16% in AMH and 15% in OPMH<sup>41</sup>), and in a number of inpatient facilities and community teams it is as high as over 20%.<sup>42</sup> The vacancy rate in the mental health division is 9.5% (versus a national average of 12%) with a number of teams experiencing significant issues with high vacancy rates.<sup>43</sup> Whilst sickness and absence rates are currently below the national average for mental health (7%) in AMH (5.5%), they are considerably higher in OPMH, where sickness levels are 8.9%.<sup>44</sup>

Workforce challenges pose a risk to the delivery of services. For example, Hamtun Ward, the Psychiatric Intensive Care Unit in Southampton, was closed between July 2016 and March 2017 due to chronic staff shortages, and services such as Hawthorns Psychiatric Intensive Care Unit, and the Ashford Unit, have a vacancy rate over 20%.<sup>45</sup>

As is the case throughout the NHS, workforce shortages pose a significant risk to the Trust and as outlined above, shortages have impacted on the Trust’s ability to deliver services. Vacancies and absence can also lead to plugging gaps with bank and agency, which impacts on quality, safety and finances.<sup>46</sup> In the Mental Health and Learning Disabilities division, temporary staffing accounts for 10.7% of staffing costs, with particular issues on certain teams – especially a number of inpatient facilities,

<sup>41</sup> Southern Health NHSFT Workforce data - turnover is calculated as the number of WTE leavers over the rolling 12 month period divided by the average monthly staff in post over the 12 month period

<sup>42</sup> NHS Benchmarking Network: Inpatient and Community Mental Health Benchmarking 2016

<sup>43</sup> Trust Tableau System, NHS Benchmarking. Whilst this appears better than average it will be impacted by the fact that the trust has had to temporarily close facilities whilst it undertakes refurbishment/due to vacancies.

<sup>44</sup> Southern Health NHSFT Workforce data – sickness % Dec 16, NHS Benchmarking Network: Inpatient and Community Mental Health Benchmarking 2016.

<sup>45</sup> SHFT Clinical Performance Dashboards, SHFT Tableau System.

<sup>46</sup> Workforce planning in the NHS. The King’s Fund, April 2015.

where the spend on temporary staffing exceeds 30% (such as Willow Assessment and Treatment Unit, Hawthorns PICU and three older people’s mental health ward).<sup>47</sup>

#### 4.6 The future of mental health services

##### Rising demand due to population changes

The current challenges that we face are also set against a context of a growing and an ageing population. The need for health services is set to increase as the populations of Hampshire and Southampton are projected to increase by c. 73,000 people between 2014 and 2021<sup>48</sup>, which will mean there are more people with mental illness. In addition, the population is ageing. Between 2014 and 2021, the number of people aged over 65 is projected to increase by 15.5% in Hampshire and 8.8% in Southampton. An ageing population brings with it increasing demand on services as older people are vulnerable to mental illness, including organic illness, depression and anxiety.

The increase in demand with limited resource requires us to develop different ways of working with Service Users, Carers, General Practice, the voluntary sector and Local Authority to ensure that the needs of our population are met, and that best practice approaches are taken.

##### Realising national ambitions for Mental Health

The Five Year Forward View for Mental Health, commissioned by NHS England, sets out an ambitious framework to guide local clinical strategy and service delivery over the next five years. Delivering this vision will require mental health organisations and wider systems of health and care to work together to expand the provision and delivery of care to people suffering with mental health issues.

The table below summarises the metrics that apply to SHFT, and our progress against them:

Ambition for 2020/21		SHFT progress against 16/17	
Perinatal mental health	30,000 more women each year nationally can access evidence-based specialist perinatal mental health care		Award-winning perinatal MH team recently extended to Portsmouth, IOW and NE Hampshire & Farnham
Adult mental health: common MH problems	At least 25% of people with common MH conditions can access psychological therapy each year (2016/17 target: 15.8%)		All 4 CCGs where IAPT is provided by SHFT has not met this year's target so far
Adult mental health: community, acute and crisis care	60% people experiencing a first episode of psychosis will access NICE concordant care within 2 weeks		Target met. SHFT has achieved 86% in the past 12 months.
	Specialist EIP provision are in line with NICE recommendations		Audits against NICE standards were completed in Sept 2016 (at time of writing only known for Southampton)
	People with severe mental illness receiving a full annual physical health check to increase to 280,000 nationally by 2020/21		Below England average in all 5 CCGs
	All areas will provide best practice, 24/7 crisis resolution and home treatment as alternative to admission by 2020/21		Hospital at home teams are 24/7 but not full scale provision
Secure care pathways	Acute adult mental health care out of area placements will be eliminated by 2020/21		The trust is using out of area placements but there is a plan to reduce.
	All acute hospitals to have all-age mental health liaison services with at least 50% meeting the 'Core 24' service standard by 2020/21		Provides liaison psychiatry in all acute trusts but is not 24/7 and is consumed with A&E
	NHSE to address existing fragmented pathways in secure care, increase provision of community-based services and trial new co-commissioning funding and service models		Working with Oxford Health in the NHSE vanguard to ensure the secure pathways are seamless
Suicide prevention	By 2020/21, the number of people taking their own lives will be reduced by 10% nationally compared to 2016/17 levels		Suicide levels are below average in Hampshire and above average in Southampton. Hampshire County Council has a multi-agency suicide prevention strategy that links with the Crisis Care Concordat
Commitment to mental health funding	NHSE 5YFV MH Dashboard: Mental health 2016/17 planned spend as a proportion of overall CCG funding allocation		Below England average of 13.1% for all CCGs except Southampton which is in line with national average
	Parity of Esteem achieved in 2016/17 planned period		Achieved for all areas except Southampton CCG

	On track
	In progress
	Significant gap

##### Progress against 5YFV metrics:<sup>49</sup>

<sup>47</sup> Bank and Agency Report, Southern Health NHSFT Tableau System

<sup>48</sup> UK Population Projection Estimates, Office for National Statistics.

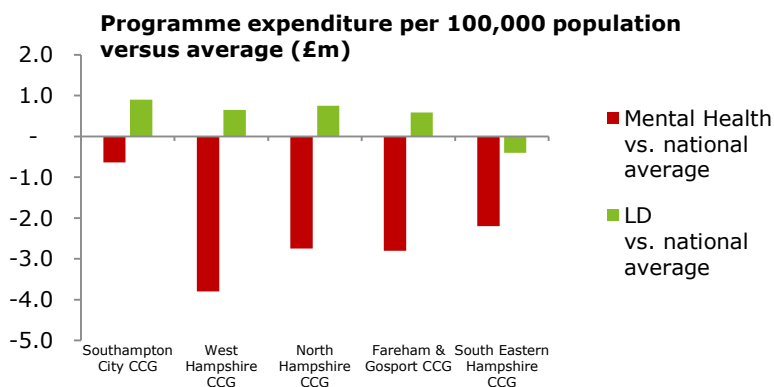
<sup>49</sup> Implementing the Five Year Forward View for Mental Health, NHS England July 2016. Mental Health Five Year Forward View Dashboard - Q2 2016/17, NHS England. Categories such as children’s where SHFT does not provide services have been excluded. RAG rating is based on SHFT data in relation to the metrics.



Whilst the Trust is making progress on some of the more specialised metrics, the key areas where there is work to do are:

1. Delivering access to crisis care and liaison services;
2. Increasing access to psychological therapies; and
3. Increase physical health checks for people with serious mental illness.

In addition to this, it is of important context that benchmarking suggests that expenditure on mental health per 100,000 population is below average versus both the national average and the peer group average for all our CCGs in Mental Health. Conversely the expenditure on Learning Disabilities by all CCGs, with the exception of North Hampshire CCG is above average as outlined in the chart below:<sup>50</sup>



Across all CCGs, this equates to spend of c. £30-38m below average on mental health services, and c. £7-7.5m above average on Learning Disabilities services.<sup>51</sup>

#### 4.7 Summary



**Service users, families and carers** are not sufficiently prominent and included in our organisation



Service users, carers, families and professionals **struggle to access services**, due to thresholds and strict criteria that are not needs led



There is not a sufficiently robust **24/7 crisis response service**, with sufficient alternatives to admission, which means that community teams pick up the slack



There is **variation** in community services that are not always needs-led, and resource is not configured around embedded pathways, and instead often consumed by urgent needs



Inpatient care is sometimes a result of a lack of an alternative. As with community services there is variation in provision



The absence of embedded care pathways means that **specialist pathways are not always consistent** with mainstream pathways, and there are gaps in provision which mean that people can end up out of area



There are opportunities to further develop practice based services and improve access and capacity, in italk

These challenges are set against increasing demand due to population growth and the ambitions for parity of esteem, and increasing concerns about the sustainability of the workforce

<sup>50</sup> NHS England 2015/16 Programme Budget

<sup>51</sup> This relates to total spend on Mental health and Learning Disabilities services and not just Southern's share. It has been calculated by extrapolating spend per 100,000 population to the population level of each CCG.

#### **4.8 Time to act and transform services**

Although we are making progress in addressing the concerns of the CQC around governance and safety, and we have already taken steps to focus services on a core footprint, it is acknowledged that there needs to be a concerted focus on redesigning Mental Health and Learning Disabilities Services, in order to deliver consistently high quality services to our population.

The scale of change required is significant, and will only be achieved if we work in partnership with commissioners and the wider health and care system, Service Users, Families and Carers, to co-design services that deliver high quality care for the people that use them. This will require a significant shift in culture.

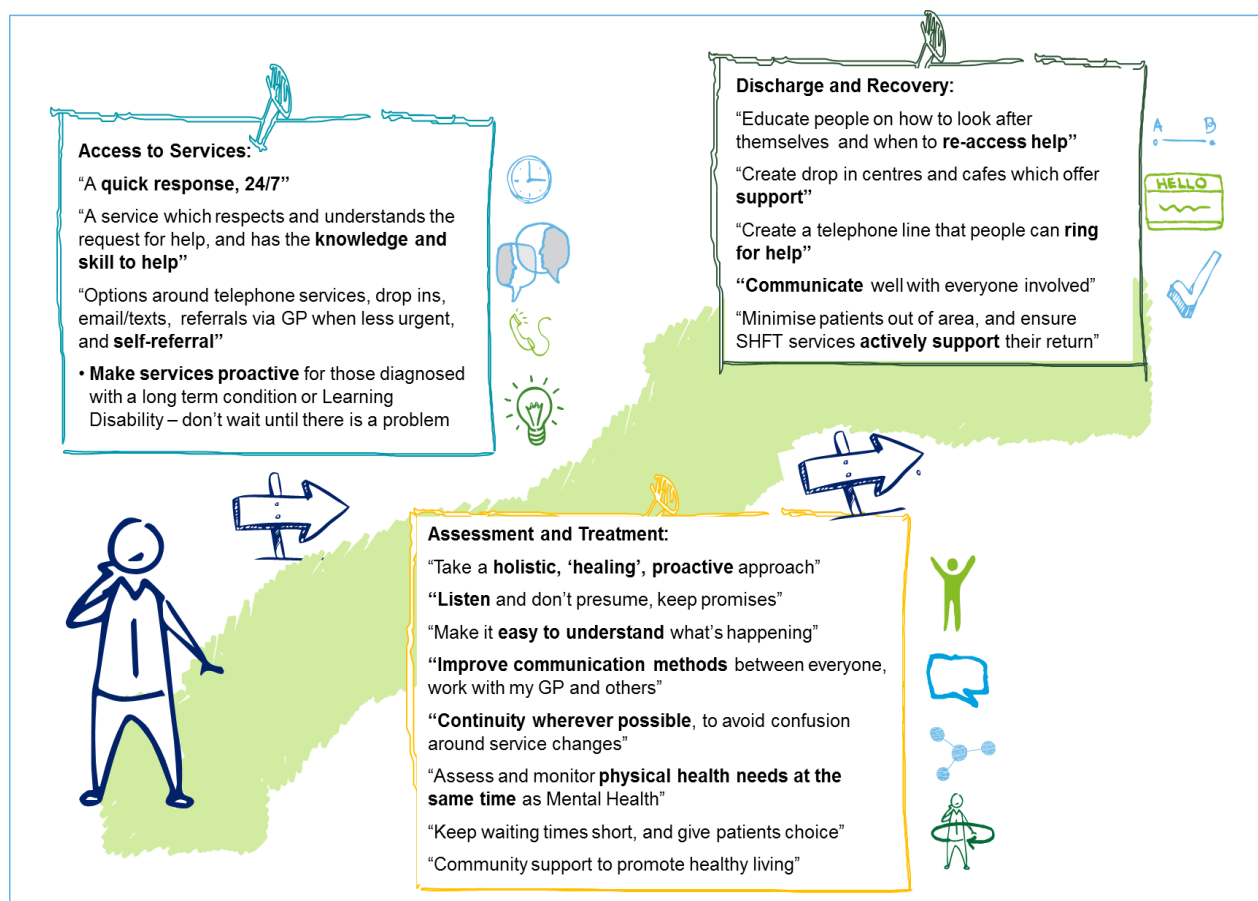
# 5 Future Service Design Principles

Our approach to developing this strategy has involved working with a wide group of stakeholders including Service Users, Families and Carers who experience our services first-hand; our staff; and national and international experts. Their feedback has informed the development of the strategic service design principles which underpin our services.

## What does good look like for our Service Users and Carers?

Understanding the needs and requirements of our Service Users, Families and Carers has been the starting point of this work. We have engaged with our Service Users, Families and Carers via workshops, conversations and a questionnaire to understand what 'good' care would look like. Further information can be found in appendix 1.

Below is a graphical representation of a 'good' service user journey based on the feedback from our service users and carers, which has informed this strategy.

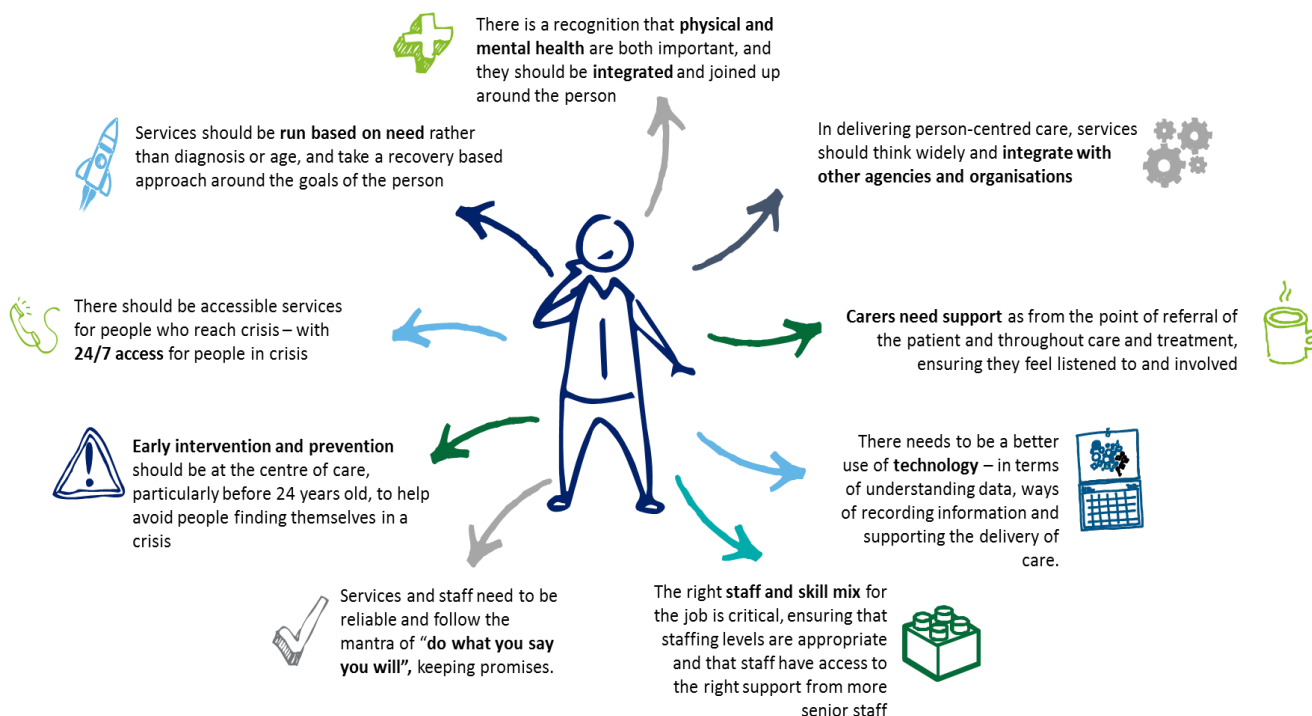


This work is the beginning of an ongoing conversation and collaboration with our Service Users, their Families and Carers to improve services and include them in decisions that affect the services they use.

## What does good look like to our staff?






Our staff are the core of our organisation, and have a unique insight into how our services work. Our staff shared a number of clear and inspiring ideas about opportunities to improve the services they deliver. An overwhelming message from our staff was that personalised care and treatment based around the needs of the person is essential.

Our staff provided the following clear messages about how our services can be improved:



## Overarching Strategic Principles for the delivery of Clinical Services

Our staff have developed a set of core principles in a 3 day clinical design workshop, where over 80 staff members of all professions and grades came together with partners to hear the feedback from our Service Users, Families, Carers and their colleagues. They then incorporated this into a future way forwards by designing a set of service principles which are a starting point to base our service design on. Our services principles are:

-  To provide **high quality, safe, person-centred** and **holistic** services which improve the health, wellbeing and independence of the people we serve
-  To deliver **needs-led services**, which are **timely, proactive** and **easy to access by all, 24/7**
-  To have the **right people doing the right job**, taking ownership and pride in good communication
-  To adopt a **recovery-focused** approach, with a positive attitude to strengths, resilience and risk-taking, and which is adaptable to change
-  To participate in **strong partnership working** to provide continuity across interfaces and transitions, supporting prevention and early intervention.

Below is further detail on each of the principles, how we will deliver on these principles and the benefits of these principles for Service Users, their families and Carers.

## **High quality, safe, person-centred care delivered around the holistic needs of the person**

Delivering person-centred care means that care is delivered based on the needs and strengths of service users, rather than around how services happen to be configured and operated in that area. This means working in equal partnership with the individual, their family and carers, and partner organisations in the planning and delivery of their care. People using services should feel confident that they have ownership of, and clarity around, the care they are receiving, and be actively involved in shared decision-making. Service Users are treated as a whole person, creating a plan about their Mental Health diagnosis that considers their physical, emotional, spiritual and social needs. The 'bio-psycho-social' clinical approach delivers this as it encompasses the biological (physical health), psychological and social needs of the person.

*How:*

- We will actively involve and include Service Users, Families and Carers in the development of our services
- We will strengthen links with other agencies, including the Local Authority, Social Services, General Practice and the Voluntary Sector
- We will work with our staff to develop our skills in co-production, Service User and Carer experience and care planning
- We will listen, and understand how Service Users wish to access their care records, to promote the concept of having a shared understanding and person-centred plan
- We will commit to supporting Service Users and Carers to get to the right service via 'warm transfers'

### **Outcomes for service users and carers:**



- Service users will have a better experience of care, as care is coordinated around their needs
- Service users will have better physical health outcomes as care is more joined up

## **Needs-led services, which are timely, proactive and easy to access, 24/7**

Needs-led services are designed around the individual need of the person, rather than applying thresholds which result from categorising the person according to age, ability or other parameters. This requires a more flexible approach to accessing the right services by pulling clinical skills across all pathways, in a multi-disciplinary approach. It means that the service adapts to the individual, rather than the individual adapting to the service. This includes providing care 24/7 for people with urgent needs.

*How:*

- We will develop urgent care services that provide delivery of assessment and treatment 24/7 for all Service Users
- We will redesign our services around needs-led pathways. For example the psychosis pathway will be consistent for Service Users whatever their age or ability. As complexity and severity increase we will draw on more specialised skill sets for example in LD or older people's services.
- We will develop a holistic assessment and formulation processes which includes assessment of physical health status and any social needs.
- We will seek further opportunities to work proactively with local delivery systems of care and Primary Care.

### **Outcomes for service users and carers:**



- Service users, their carers and families will have an improved experience of care as services are available and accessible
- Outcomes will improve for our service users as they are cared for in the right setting, with the right level of support for their needs, without the need to resort to other services such as A&E.

## **Having the right people doing the right job, taking ownership and taking pride in good communication**

Getting it right first time is critical in delivering high quality services, and our staff are vital to delivering this. Continuing to foster a culture where staff are compassionate, caring and listen to Service Users and Carers, while being honest and transparent about what is and is not possible, is key. This will require a solid understanding of the skills and capabilities required in the workforce, where there are gaps, and how the appropriate deployment of these skills and resources can be managed. Ensuring effective, respectful communication between all parties prevents unnecessary repetition of Service User and Carer stories and supports the delivery of a seamless package of care.

*How:*

- We will develop a clear understanding of the pathways and packages of care, and what skills and capabilities are required to deliver these
- We will develop an up to date workforce strategy which supports the delivery of this Strategic Statement
- We will consider front-loading clinical expertise, for the benefit of our Service Users, and of our staff, in providing support, leadership and opportunities for upskilling
- We will ensure that communication, clinical and non-clinical, is clear and transparent at all levels in the Trust

### **Outcome for service users and Carers:**



- Service users' experience of care will improve as we get it right first time.
- Service users will achieve their goals more effectively.
- Clinical outcomes will improve as service users feel supported to manage their condition by the right staff.
- Our staff will be supported and empowered to deliver high quality clinical care.

## **A recovery-oriented approach, with a positive attitude to strengths, resilience and risk-taking, and which is adaptable to change**

Recovery is a way of living a satisfying, hopeful and contributing life even with limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life. It also means understanding the limitations imposed by illness, but finding a way to live a fulfilling life despite this. Recovery and personalisation approaches see people who use services as 'whole people in their whole context' building on their strengths and abilities and supporting them when and where this is needed.<sup>52</sup> This means working to identify things that people are good at and recognising, valuing and building upon them; empowering the individual by supporting them to identify potential risks and develop coping strategies with the ability to cope with life's challenges.

*How:*

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<sup>52</sup> Brewis, R. & Fitzgerald, J. (2010) Citizenship in Health: Self-direction theory to practice. Wythall, West Midlands: In Control Partnerships.

- We will systematically and consistently work alongside Service Users to set their own goals, and continuously review these
- Our Service Users and Carers will be supported by staff in collaborative risk assessments and crisis planning, to develop greater resilience, which will require close links with other services, partner agencies and voluntary sector organisations
- We will develop an organisational approach to supporting staff with positive risk-taking
- We will build on existing good practice, further developing peer worker roles across the whole pathway and further utilising the Recovery College in Southampton
- Our services will identify appropriate outcome metrics and use these to drive improvements for and with Service Users

#### Outcomes:



- Service users will have a sense of meaning and purpose and hope and optimism.
- Clinical outcomes will improve as service users will feel empowered to take more responsibility for their own health and wellbeing

#### **Strong partnership working to provide continuity across interfaces and transitions, supporting prevention and early intervention**

Our services sit within a broader landscape of support for people who use services, including general practice, social care, support from the voluntary sector, and importantly, support from the community. Delivering high quality care requires close working with other agencies to develop joint strategies that maximise the available resource to deliver the best outcomes. This requires continuity across interfaces and transitions to ensure that there are not issues such as further waits for other service involvement. Interfaces can occur within pathways, across multiple departments and across different organisations and sectors.

#### How:

- We will work with the wider system to support people with mental illness and learning disabilities
- We will work collaboratively across specialisms and with other providers to plan how to deliver more joined up care including reviewing technology systems to provide better information flow, and consideration of how services can 'pull' one another's expertise without relying on lengthy referral processes
- We will enhance links with primary care and other providers to support prevention and early intervention agendas

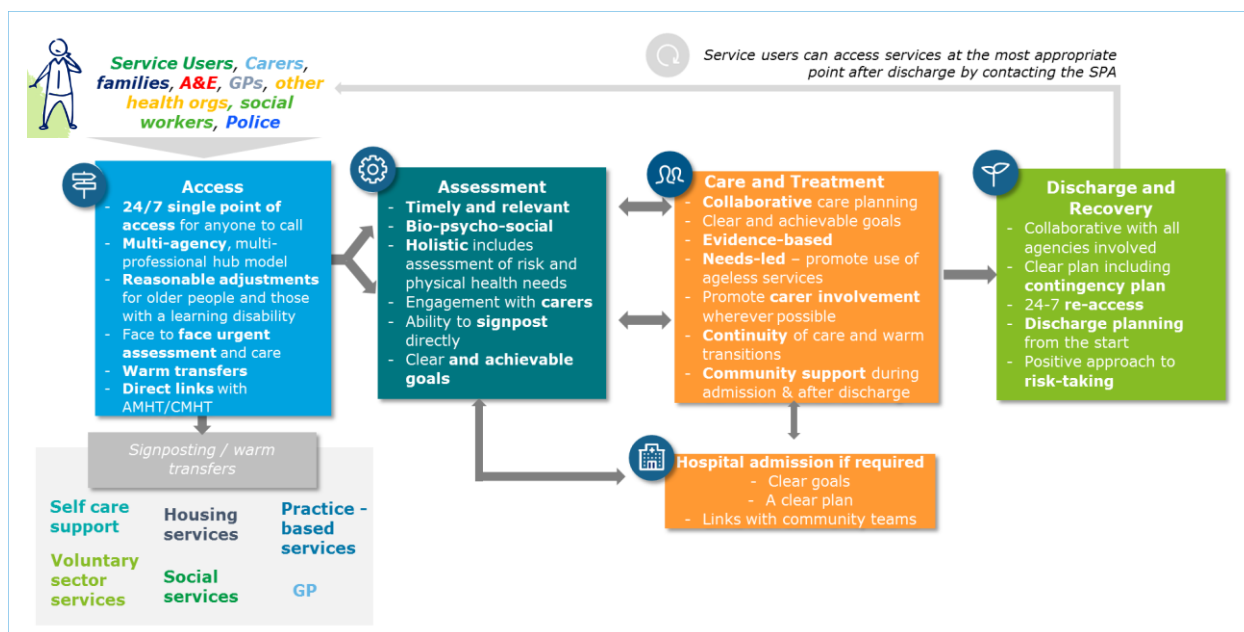
#### Outcomes for service users and carers:



- Experience of our services will improve as service users see that professionals are helping them manage their condition in a joined up way.
- Outcomes will improve as service users will be able to access the right support as quickly as possible.

#### High Level Stages of the Pathway:

Our staff have developed a set of core principles for each stage of the pathway, building on Service User and Carer feedback. These principles provide a framework against which our services will be delivered at each stage of the Service User journey. While there will be adaptations for the different services that we provide, the core principles outlined below will hold true for all Mental Health and Learning Disabilities services.



In developing our services according to these principles, we will ensure that services consistent and of high quality:

## Principles for access to services

There are significant opportunities to improve access into our services, and the speed of onward assessment, including where there is urgent need. We will ensure that our services deliver the following principles around access:

- **24/7 access point**, for the whole of Hampshire, accessible to Service Users from across all pathways, Carers, GPs, professionals and anyone else to call, particularly for access to urgent Mental Health services, and to gain advice, information and support
- To include **reasonable adjustments** for Older People, those with Learning Disabilities and anyone else with additional needs, to maximise the ability to access and benefit from services. Examples of this might include adapting the communication style, the amount of time spent with the person, or the environment or venue within which the person is seen
- To take telephone calls **without waiting** or use of answerphones, and to use other forms of technology such as text, web chat, apps and email
- A **multi-agency, multi-profession** Hub model, with sharing of information systems, to be staffed by qualified professionals, supported by non-clinical staff
- The 'spokes' of the access service to provide support close to home for Service Users, enabling rapid and frequent support to be delivered locally
- To have provision for **Face to Face urgent assessment** and care using a bio-psycho-social model that can be adapted to circumstance but is in its approach across all locality teams to provide support at home as an alternative to hospital admission when appropriate
- To have provision for inpatient **admission** to crisis beds when needed, as well as other options such as Crisis Cafés, Safe Havens or a Mental Health Bus
- To work in collaboration with GPs and other providers in the care of those with **long-term conditions**
- To provide **advice and support** to GPs and other partners, including Carers
- To **signpost** callers when necessary, with warm transfers wherever possible, using a service directory which is kept up to date and maintained on a frequent and regular basis by the Trust and its partners



- To **facilitate re-access** when needed, at the point in the pathway which is most appropriate for that individual at that time
- Direct links to locally-provided AMHT and CMHT teams from across the specialisms, who will support the triage clinicians in the access point by providing **additional expertise** and advice when needed

#### What this will mean for service users and Carers:



- Service users will have rapid access to skilled advice and support, 24/7
- No need to attend A&E unless physically unwell or injured
- Admissions only when necessary – cared for closer to home
- Improved clinical outcomes as a result

### Improvements to assessment processes

Delivering person-centred, recovery-focused care across interfaces starts with a holistic, consistent assessment process that takes into account the needs of the whole person and is co-produced, engaging Service Users and Carers. We will ensure that the assessment process for all services adopts the following key principles:

- **Timely and relevant, non-judgmental, validating of experience**
- **Bio-psycho-social** model which includes assessment of risk, and holistic including physical health, spiritual and cultural needs
- **Multi-agency and service** wherever possible, to also identify and support social and other needs
- **Engagement with Carers**, listening to their concerns and respecting their knowledge – taking a common-sense approach to confidentiality
- **Supporting clinicians** by allocating preparation time and admin support in producing notes, reports and onward referrals/follow up
- Ability to **signpost** directly to other services, not make Service Users wait again or repeat their story
- **Communication and processes** which are easy to understand, and add value for the Service User and Carer(s)
- Formulation of needs, sharing of expectations, with **clear and achievable goals**
- **Being honest** about what can and can't be done, be radical and genuine

#### What this will mean for our service users and Carers:



- All needs are considered at once
- Service users, their families and their carers feel listened to and involved, by skilled clinicians who have the time to engage
- Clear understanding of the process and the outcomes
- Able to contribute their expectations and plan towards clear goals
- Improved clinical outcomes as a result

### Principles for care and treatment

**Care and treatment** is usually the longest part of the intervention which encompasses many different services and pathways. The transformation of care and treatment will happen at a pathway level, underpinned by the following core principles:

- **Evidence-based, needs-led, and timely**
- Treatment planning which is **collaborative, with clear and achievable goals and is always recovery-focused** with agreed metrics for evaluating progress, helpfulness and wellbeing
- **Continuity of care and warm transitions**
- To promote the use of **needs led, mainstream Mental Health services** wherever possible, and to ensure those who need specialist support from Learning Disability, Older People's and Specialist Services clinicians can access that, in tandem or alone
- **Consistency of services** – removal of the postcode/commissioning lottery as far as possible and clarity about what limitations exist.
- **Use of senior staff** skills and experience, to upskill and support others
- To promote **Carer inclusion** wherever possible, listening even if sharing is not possible
- To facilitate the '**stepping up**' of care and treatment when needed, within community-delivered services
- To ensure **inpatient admission has clear goals and a plan**, with community support during the admission and after discharge
- Using the staff with the right skills at the right point, without waiting

#### What this will mean for service users and Carers



- All needs will be taken into account at the same time, in services that don't create barriers or transitions around age, diagnosis or other parameters
- Service users feel listened to and involved, by skilled clinicians who have the time to engage
- Additional support is available quickly when needed, to prevent crisis and reduce the need for admissions
- Able to work towards clear goals from the start
- Improved clinical outcomes as a result



#### Principles for Discharge and Recovery

Preparing Service Users for recovery and leaving services right from the start of their pathway is critical. It ensures that they, their Carers and the staff with whom they work, are focussed, well prepared and confident that they can move forward to life in the community, safe in the knowledge that support is available easily and quickly should they need it. As with care and treatment, the transformation of the approach to discharge and recovery will happen at a pathway level, and will be underpinned by the following principles:

- **Collaborative planning** from the start of agreeing the care and treatment plan, with Service User, Carer(s), and partners including GPs involved
- Clear plans, including **contingency plans**, and 24/7 re-access available if needed
- **Integrated** to include physical health, social, spiritual and cultural needs
- Clarity regarding the words 'discharge' and 'recovery' and what they mean in different pathways – consider alternatives to 'discharge' such as 'transfer of care'
- Positive approach to **risk-taking**

- Specific strategy for **long term, vulnerable people** who may be resistant to treatment – working collaboratively with GPs and other partners involved as needed for the individual

#### **What this will mean for service users and Carers:**









- Focus on leading a meaningful life, and only accessing care and support when needed
- Feel listened to and involved, by skilled clinicians who have the time to engage
- Additional support and advice available quickly when needed, to prevent crisis and reduce the need for admissions, and empower individuals to care for themselves
- Able to work towards clear goals from the start
- Improved clinical outcomes as a result

These principles relate to the design and delivery of Mental Health and Learning Disabilities pathways delivered by the Trust. There are a number of interdependencies both with the other services that we deliver, as well as with other agencies including primary care, social services and the voluntary sector. Collaboration with these other organisations will be crucial to the success of any service development.

There is also a need to focus on prevention and collaborative work in the community, in particular supporting emotional wellbeing in the Local Delivery Systems. Our Mental Health Pathways will not function without strong preventative initiatives in local areas, which will improve the health of the population in general, supporting those at the less severe end of the spectrum of services, and also supporting those who have required a more intensive intervention and are moving towards recovery. These services will be improved by confidence in a high quality Mental Health and Learning Disability service which is accessible and reaches out to work with others.

# 6 What does this mean in practice

We have identified a number of priorities that will improve the care that service users receive and deliver on our service principles to ensure that our Mental Health and Learning Disabilities services offer consistently high quality care. These are outlined below, and in more detail in this chapter:

Current provision:	Key priorities:
 <p><b>Service user and carer inclusion</b> is not sufficiently prominent enough in the trust</p>	 <p>We will <b>actively involve, engage and include</b> service users, families and carers in service delivery and design</p>
 <p>Service users, carers, families and professionals <b>struggle to access services</b>, due to thresholds and strict criteria that are not always needs-led</p>	 <p>We will improve access to services via a <b>single point of access</b> for all requests accompanied by a culture of supporting requests for help and providing needs led pathways</p>
 <p>There is not a sufficiently robust <b>24/7 crisis response service</b>, with sufficient alternatives to admission, which means that community teams pick up the slack</p>	 <p>We will transform the <b>urgent care pathway</b> to deliver responsive, reliable high quality care 24/7 including developing alternatives to admission</p>
 <p>There is <b>variation</b> in our services that are not always needs-led, resource is not configured around clear pathways, and instead often consumed by urgent needs</p>	 <p>We will improve outcomes for those who use our services through the delivery of <b>needs-led, evidence based pathways</b> that reduce variation whilst linking into local delivery systems of care</p>
 <p>Inpatient care is sometimes a result of a lack of an alternative with variation in provision</p>	 <p>We will deliver <b>consistent, purposeful, needs-led inpatient care</b> across the trust when it is needed</p>
 <p>The absence of embedded care pathways means that <b>specialist pathways are not always consistent</b> with mainstream pathways, and there are gaps in provision which mean that people can end up out of area</p>	 <p>We will develop our tertiary services to provide care across <b>a complete pathway</b> with pathways that are consistent across the trust</p>
 <p>There are challenges in managing people in general practice – there is scope to <b>increase access to italk</b></p>	 <p>We will increase access to italk and work with the system to explore <b>primary care based mental health services</b> to help keep people well</p>

 **We will actively involve and engage people who use our services, their families and carers, in service delivery and design**

## Our aims and vision

We will work with people who use services, their families and carers to engage meaningfully in the coproduction of delivery and design of the services that we provide. Service users are 'experts by experience', and by working together we will improve the quality, safety and effectiveness of our services. This will include ensuring that people who use services, families and carers are central to decision making about their care, and working in partnership to identify how we will work together to develop and improve the services that we provide.

### Benefits to service users and Carers



- Improved patient outcomes as services are tailored to the needs of people receiving care.
- Improved patient experience and satisfaction.
- Involvement can be a personally therapeutic experience.
- Families will be better supported to maintain their health and wellbeing.
- Our staff value working in collaboration with people who use services, and an enhanced staff experience will result in improved quality of care

### How we will deliver this:

Including people who use services, carers and families meaningfully is a journey which we must work together to navigate. We recognise that this will require a shift in thinking about how our staff and service users, families and carers work together.

In order to achieve this we will co-develop a strategy with people who use our services, their families and carers that will determine how we work together to improve our services both in terms of delivery and development of services. We will also involve advocacy services to support cases where individuals need support to express their views, to ensure that their opinions are heard.

#### *Collaborative involvement in assessment and treatment and discharge*

We will work in partnership to ensure that people who use services, their carers and families are always at the centre of decisions about care and treatment. This will include agreeing the purpose and goals of care collaboratively, and making sure that service users are given appropriate choice and control - for example over what kind of treatment they receive.

In addition to service users, we will include families and carers in decisions about care where appropriate. Families and carers usually have a good understanding of a person's strengths, weaknesses, symptoms, likes and dislikes, and can share these particularly when someone is unwell, in order to gain a clear picture of what is going on in the lives of their loved ones. We will consider how we engage carers to enable their full inclusion in care and support, decision making and service delivery, including adopting tools such as the Triangle of Care, which provides a framework to help services to improve their engagement with carers. We will also ensure that carers are provided the opportunity to have a Carers Assessment in relation to their caring role and their own mental and physical well-being.

### The Triangle of Care



The Triangle of Care is a self-assessment tool for mental health providers developed by the Carers' Trust in 2010. It is based on the principle that care is made better by making sure there are good working relationships between the service user, the mental health professional and the carer. It sets out a programme for service development with regard to supporting carers. It provides 6 Key Elements (Standards) required to achieve better collaboration:

1. Carers and the essential role they play are identified at first contact or as soon as possible thereafter
2. Staff are 'carer aware' and trained in carer engagement strategies
3. Policy and practice protocols re confidentiality and sharing information are in place
4. Defined post(s) responsible for carers are in place
5. A Carer introduction to the service and staff is available with a relevant range of information across the care pathway
6. A range of carer support services are available.

### *Involvement and inclusion in service delivery*

We will work with service users and carers to establish the best way of including them in the delivery of services, including the Recovery College and also expanding the use of peer workers throughout community and inpatient mental health services.

### *Involvement and inclusion in service level and strategic redesign of services*

In addition to putting people who use our services, their carers and families at the centre of decision making about their care, we will harness their invaluable insight and experience in the design and improvement of our services.

We will build on the work that we have started as part of this process to work in partnership with people who use our services, their families and carers to agree a shared purpose and goals, and to define what service user and carer leadership will look like. Through use of approaches such as experience-based co-design, we will ensure this collaborative way of working is embedded at all stages of service improvement.

Underpinning this, we will work to identify the support that we will require to meaningfully include service users, carers and their families. This is likely to include training for staff and service users, families and carers and looking for ways of engaging that ensures that involvement takes account of the needs of those taking part.

## **Examples of good practice**

### *Case study: Somerset Partnership NHS Foundation Trust*

The *Triangle of Care* model is mandatory as a Quality Improvement Plan for every service, and is integral to the governance of the Trust. The Triangle of Care Steering Group is part of the key management lines of accountability, and has Carer, Service User, Third Sector and staff representatives. The Trust's Lead for this initiative is also the operational manager of the Carers Assessment Service.

Staff buy-in is achieved through training, consultation, promotion by managers, policies and protocols. Every team has a Triangle of Care Champion who promotes Family and Carer-inclusive thinking.

### *Case study: Well London Health Champion Programme, Lambeth*

The Lambeth Living Well collaborative gives mental health Service Users an equal voice with providers and commissioners. The collaborative brings together mental health (NHS and social care) Service Users, Carers, practitioners and commissioners at monthly meetings. This provides participants with opportunities to share experience and design new systems based on what works for them.

**Outcomes:** The collaborative developed a support plan with Service Users stuck in hospital aimed at supporting them to achieve their ambitions and goals. The service was developed within existing resources and has so far worked with 210 people, discharging them into the community to live more independent, but supported lives at a considerable saving to the NHS.

Lambeth Cabinet member for wellbeing, Cllr Jim Dickson said: *'The Collaborative demonstrates that co-producing with mental health service users and Carers' produces excellent results and efficiencies.'*



**We will improve access to services via a single point of access for all requests for help accompanied by a culture of supporting all requests for help**

## Our aims and vision

We will improve access to our mental health and learning disabilities services, by ensuring that all those who need support can easily reach services (including via self-referral) and simplifying how people access our services, avoiding people being 'bounced' around the system. This is a priority for both urgent referrals and routine referrals. Our proposed design is to create a 24/7 single point of access, that is accessible to all regardless of their diagnosis, age or IQ, and will provide the entry point for our Mental Health and Learning Disabilities services.

### Benefits to service users and Carers:



- A clear way of accessing support, with the ability to self and Family /Carer-refer.
- Quick and reliable response to requests for help
- 24/7 urgent service delivery
- Access to advice and information for professionals, service users, Families, Carers and other services.

## How we will deliver this

Improving access to our services will require a major shift in culture to ensure that people are **supported to reach the right care**. We will respect the principle that mental health crisis is self-defined, accepting referrals from anyone (including self-referrals) and we will review the thresholds for our teams. The development of needs-led pathways will also support people to access the most appropriate service quickly. When a person's needs are better met by another organisation, we will facilitate warm transfers to support the person to get to the right place. This will require us to work with partners to develop an up to date service directory across health, social care and the voluntary sector.

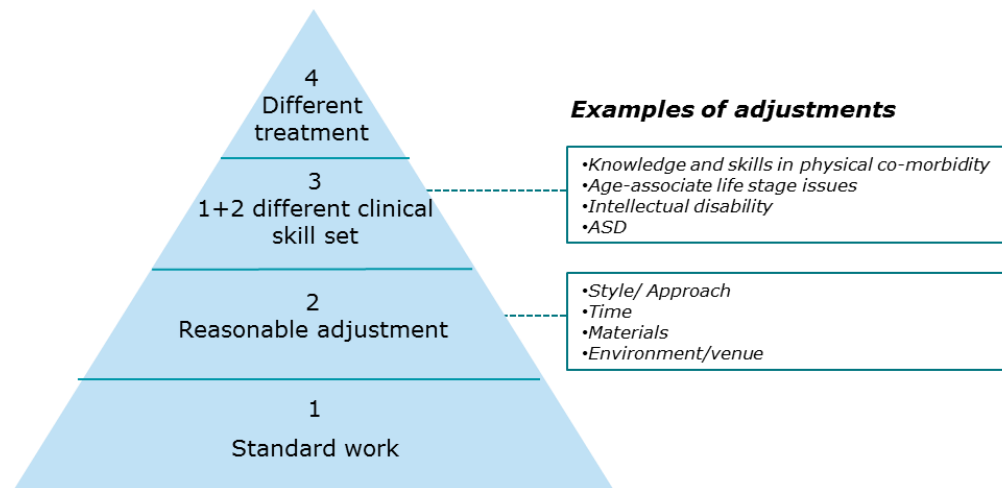
Our proposed solution to improve and simplify access is a **24/7, single point of access** which would be a multi-professional hub and spoke model, for urgent and routine referrals and requests for help. This will be accessible to everyone who uses our services, regardless of age or ability including those who use our Adult Mental Health services, Older People's Mental Health and Learning Disabilities services. The single point of access would include provision for a clinical advice line, for Service Users, Carers and partners to access. It should be noted that this may not be a single point of access from an organisational point of view, depending on the footprints at which it is planned, but it will be a single point of access from a service user's point of view.

Our single point of access will be the route for all referrals. It will triage referrals every day, as they are received and allocate them to the correct pathway using the expertise of specialist clinicians, and will include a **hub and spoke crisis model** which will provide Service Users and their Families with the care and support they need close to home. This will help to prevent the escalation of need both within our Mental Health and Learning Disabilities services, and reduce the need for people to resort to other services such as A&E.<sup>53</sup>

We will ensure that these responses have the correct level of capacity and resource to cope with urgent demand, and that all who need support are aware of our services, to ensure that people get to the right place, first time. We will work in partnership with 111, 999, social services and the Police to streamline urgent access and improve outcomes for the people who use our services.

<sup>53</sup> Based on experience of Bradford District Care Trust

The Single Point of Access will not discriminate based on age or IQ, and will take a reasonable adjustment approach, to meet the specific needs of people with Learning Disabilities or older people. The way in which we will adapt our approach for people with additional needs is reflected in the Reasonable Adjustments triangle, where clinicians from across specialisms support one another with additional expertise to support the service user:



The development of a single point of access will require **the alignment of commissioners and the broader system** to define the scope of services, and footprints over which it operates. It is our ambition to work with the system and the local delivery systems to develop a clinically and financially sustainable solution that is agreed on a system wide basis.

### Good practice examples

A number of trusts in the country have seen positive results from this model, including Bradford District Care NHSFT and Northumberland, Tyne and Wear NHS FT.

#### Case study: Initial Response Service (IRS) - Northumberland, Tyne and Wear NHS FT

**What is it?** The IRS provides a 24/7 response to telephone requests for both urgent and routine help, to provide practical advice and emotional support from qualified nursing staff and when appropriate, routing to the right service. This service does not discriminate and includes clinical expertise from learning disabilities and older adult services, meaning that all of those individuals can receive a 24/7 urgent response as well as better access to planned care.

Working alongside the crisis team, nurses provide clinical triage and lead the Rapid Response. In addition, through skill and experience sharing there are now interchangeable roles across the IRT and Crisis team.

**Outcome:** As a result, there has been an increase in number of service users with urgent mental health needs receiving an intervention from the service along with improved response times for home visits for face to face assessment (average 30 minutes from call to door). Avoidable harm has reduced, with no "bounced referrals" (these are now routed to the most appropriate service). Finally, less time is spent by the ambulance service in relation to service users with urgent mental health needs and there have been fewer breaches of 4hr A&E target relating to service users presenting with mental health problems.

#### Case study: Single Point of Access for crisis response - Bradford District Care NHS FT

In 2014, the Trust was spending £1.8m on out of area beds. The trust embarked on a journey of transformation, and has found that one of the biggest impacts in addressing these issues has been the Bradford First Response service. The Service gives a single phone number for all urgent care and provides crisis response by trained staff who identify the most appropriate action to take.



## Patient story

### **Daniel**

*Daniel is a 27 year old man who has recently separated from his girlfriend of 5 years. He has become withdrawn and isolated and his mood is very low. Daniel went to see his GP who gave him some advice and information about depression and explained that medication was not appropriate at this time. He suggested referring Daniel to mental health services for some support, but Daniel did not want to do this at this time. The GP respected his wishes and gave Daniel the contact number for the mental health single point of access (SPoA) should he need their help and support in the future.*

*Two weeks later, Daniel's mood had worsened and he had begun to have thoughts of ending his life. This was frightening Daniel and so he contacted the telephone number provided by his GP. Daniel was tearful on the phone and explained how he was feeling. He spoke to Sarah, a nurse, who told him that he would be seen at home by a clinician within the hour.*

*Daniel was seen by the Crisis Team at his home that day, and it was agreed that a full assessment would be carried out. A plan for a period of Home Based Treatment was agreed. Daniel was happy with this plan, and agreed he would contact the SPoA in between appointments if needed. Daniel was asked if he had any support at home or through friends and family, and he replied that he did not.*

*Daniel was seen daily by the Crisis Team for a period of 2 weeks and received treatment for his depression. It was agreed at the beginning of his treatment that he would benefit from further depression management from the Community Treatment Team and a referral was made. His ongoing care was allocated to a Community Psychiatric Nurse, David, and Daniel was seen jointly by the Community and Crisis Nurses before the Community team took over his care.*

*Daniel is now fully recovered and has been discharged from services. He has a Wellness and Recovery Action Plan for the future. He has the phone number of the SPoA should he need further help in the future.*



**We will transform the urgent care pathway to deliver responsive, reliable, appropriate, high quality care 24/7**

## Our aims and vision

A key priority within the 5YFV is to ensure that there is **consistent high quality, responsive crisis care**, to deliver the fastest resolution to people in need, helping to avoid escalation, or inappropriate treatment such as A&E or being unnecessarily detained by the police. In order to do this we will transform our urgent care pathway to ensure that there is robust and responsive care for people with urgent needs 24/7, regardless of age or IQ. This will mean that there is provision for urgent needs for all of our service users.

### **Benefits to service users and Carers:**



- Urgent treatment delivered closer to home – local delivery of services
- Less need to go to A&E or be taken to a place of safety – reduced use of Section 136
- Alternatives to admission which mean that people are more likely to receive support at home than require admission
- Improved patient satisfaction

## How we will deliver this

We will ensure that when urgent assessment is needed, it is delivered in a short timeframe, regardless of age or IQ and tailored to the needs of the person. In order to do this, we will develop **effective and capable triage**, underpinned by senior resource along with locally delivered rapid response functions, and a streamlined, safe, consistent and pragmatic approach to assessment that is proportionate to the needs presented, and includes, as standard, an evaluation of physical health. This has been successfully delivered as part of a full single point of access model in Northumberland, Tyne and Wear. Following

assessment, support will be agreed with the Service User (and with Families and Carer if appropriate) and implemented immediately either by the access team, the hospital at home team or if necessary via an admission.

In order to deliver this we will **redesign our current pathways and services** to ensure that there is the correct amount of ring-fenced resource to support people with urgent needs – including a 24/7 crisis response that can support all people with urgent needs. This will include support for older people and people with learning disabilities using the reasonable adjustments approach, and a robust hospital at home service that is equipped to provide intensive home-based treatment which will include multiple daily visits for those who require it.

Building on the current shared care model in the Trust, the **Hospital at Home service** will have a clear remit around intensive management of high risk patients in the community, with the capacity to visit or contact people multiple times per day, and to facilitate early supported discharge for people from inpatient units.

We will also explore additional alternatives to admission such as street triage, (building on the triage that has been trialled across parts of Hampshire in police control rooms), crisis cafes and crisis houses.

### **Good practice examples**

#### *Case study: Innovations and improvements in access to acute care in North East London*

North East London NHS Foundation Trust (NELFT) established the **Access Assessment & Brief Intervention Service**: This is a single point of access/referrals service to all mental health services for adults aged 18 years and over. The service provides biopsychosocial assessments with care planning focused on the psychological, physical, social and occupational needs of each individual. Only 2% of referrals are referred on to acute mental health services, and the majority of these patients are treated and discharged back to primary care (70%).

The Home Treatment Teams are an essential component of this integrated model. They act as gatekeepers to inpatient care and attend daily ward handovers to identify early discharges. This is important as it allows a single point of access to inpatient care and enables a reduction in the time spent as an inpatient. The HTT is also involved in all Mental Health Act assessments to ascertain if community care can be provided as an alternative to admission.

**Outcome:** NELFT now provides the highest ratio of acute home treatment to inpatient care and the lowest acute bed base across London.

#### *Case study: Operation Serenity –Isle of Wight*

Operation Serenity is a collaboration between the police, ambulance and NHS staff to develop innovative standards in the response, assessment, safeguarding and care of people with mental health problems. This involves a mental health practitioner and police offer responding to mental health crisis calls in a marked police car.

**Outcome:** As a result of the number of section 136 assessments were found to decrease by 50%; the use of police custody as a place of safety has been completely eliminated; and the accuracy of s136 has risen from 20% to around 75% (percentage of s136 detainees converted to an admission)

#### *Case study: Street Triage - improving access to care*

Street Triage is a service that comprises a mental health nurse, working alongside a dedicated police officer in mobile community units to improve access to Mental Health services and avoid preventable detentions by police when using section 136. Patients are taken to a place of safety where the Mental Health nurse supports the patient while waiting for formal assessment by the appropriate professionals.

**Outcome:** The annual rate of detentions under Section 136 reduced by **56%** in the first year.

## Patient story

### **Serena**

*Serena suffers from paranoid schizophrenia. She becomes very distressed and believes that her neighbours are spying on her and have been recording her telephone conversations. She begins to scream and bang on the walls, and a concerned neighbour calls the police.*

*On arriving, the officers believe that Serena is suffering from mental health problems and they contact the single point of access for support. On accessing Serena's records the clinician sees that Serena has recently been discharged from the service, and that one of her relapse indicators is that she believes she is being spied on.*

*The clinician agrees with the Police that a member of the Crisis Team will attend Serena's home to triage her mental health. The police agree to stay with Serena until the Crisis Team arrive.*

*The Crisis Team arrives 30 minutes later. As Serena had recently been discharged from services with a contingency plan, another assessment is not necessary. Serena is re-established on her medication regime and seen by the Crisis Team for 5 weeks for Intensive Home-based Treatment.*



**We will improve outcomes for those who use our services through the delivery of needs-led, evidence based pathways that are linked into local delivery systems of care**

## Our aims and vision

We will improve outcomes for service users by delivering needs-led, evidence based pathways to those who use our services regardless of their age or IQ. The community teams that deliver these services will be the engine-room of the delivery of care, assessing and treating people as well as helping people to stay well and avoiding escalation to crisis and admission. We will ensure that these services are able to be as proactive and preventative as possible, by engaging with primary care, ring-fencing resource for people with urgent needs, and focusing on well planned community-based, purposeful, NICE guidance compliant interventions delivered collaboratively with Service Users, their Carers and their Families. Linked to this, we will ensure that meaningful clinical, outcomes and operational metrics are collected and analysed to enable service improvements with an ability to compare with national parameters.

As well as driving improvements and consistency internally throughout our pathways, we will ensure that these pathways are mapped onto local delivery and link well with primary care, to wrap care around the needs of the person. We will adopt this approach in all of our services, including our current adult mental health, older people's mental health and learning disabilities pathways.

### **Benefits to service users and Carers:**



- Care will be proactive, evidence based and purposeful
- Outcomes will improve as interventions are targeted to the particular needs of the individual, by drawing additional expertise as required
- Patient experience will improve as care will be proactive and co-developed with the person.

## How we will do this

The needs led pathways that we will deliver are described below:

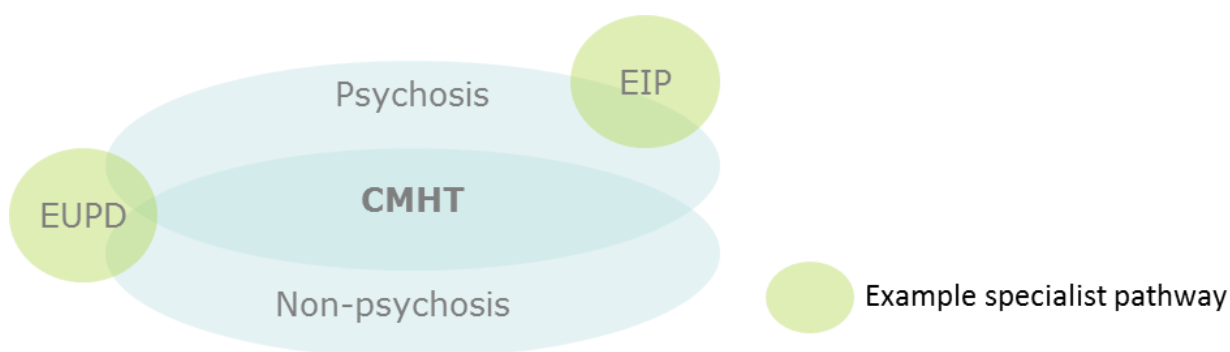
- Functional illness
- Dementia and functional illness in older people
- Learning Disabilities

### i) Functional illness

The **Community Mental Health Team is the engine-room** of the delivery of care to people with Mental Health needs. By ring-fencing urgent capacity we will ensure that the community team will be able to undertake planned work, as assessment and treatment clinics and home visits will not be disrupted by the need to respond to urgent requests for help. Care will be **person-centred, and recovery-oriented** – focusing on working collaboratively with service users to building strength and resilience. Teams will work with partner organisations including primary care, physical care, housing and social services around the needs of the person. The team will use the reasonable adjustments approach to working with individuals with learning disabilities, frailties and co-morbidities.

Whilst our services will be flexible according to a person's need, practice will be standardised by co-developing a set of **evidence-based interventions** for core needs. We will build on the pathways that we have developed around psychosis and affective disorders, ensuring that resource is mapped to the delivery of these interventions. This will in turn allow services to monitor gaps in intervention, skill set and capacity more easily, resulting in better patient outcomes.

The skills of our teams will be configured around the needs of these interventions/pathways. Wherever possible our teams will draw on support from all sources (such as CBT or Family intervention therapies). When a Service User needs to have additional input from these specialist services, this will be done according to need, as outlined in the reasonable adjustments diagram – ranging from the CMHT clinician receiving support to enhance their practice to, in a case of highly specialist need, having the care of the patient transferred to the specialist. We will also ensure that specialisms are preserved and developed to provide skills and expertise that will be drawn upon to provide the best quality care for our Service Users.



Examples of the specialist pathways that we will continue to develop include:

- **Emotionally Unstable Personality Disorder:** These are some of the most complex Service Users to engage and support who require specialised skills and the establishment of a clear and consistent pathway. We will further develop this pathway to build resilience in the whole system of care by providing specialist support, supervision, consultation and training, including the development of Service User and Carer networks. We will consider how best to provide care for the most complex and high risk Service Users, which may be via a specialist team which 'reaches into' the CMHTs using a hub and spoke model.
- **Early Intervention in Psychosis (EIP):** The skills of our EIP teams will be made available to the rest of the team working with a wider spectrum of presentation, as the needs of these individuals can be augmented by the skills held in the specialist team. There are a variety of ways to achieve this.

One is by embedding the team within CMHTs, defining and monitoring patient flow to ensure that capacity is not overwhelmed. Another approach is to maintain separate service groupings but ensuring that the expertise in EIP is available to support clinicians working in the CMHTs. In addition, we will ensure that services plan for the transition for when an individual reaches 35 years old.

- **Difficult to reach/high intensity users:** we will expand on the work that we have started on treatment-resistant long term conditions, working with GPs, the ambulance service, social services and other organisations to develop a plan that meets the needs of this cohort.
- **Dual Diagnosis:** we will ensure that care is well coordinated across services both within and beyond the Trust.

The redesign of CMHTs and alignment of resource to evidence based pathways presents an opportunity for our services to develop further specialisms that enhance the quality of care that service users receive.

### Examples of good practice

#### *Case study: Redesign of the acute care pathway - Greater Manchester West Mental Health NHS Foundation Trust*

60% of relatively short inpatient admissions were occurring outside the hours of 9-5 Monday – Friday. The obvious conclusion was not that people were more ill then, but that their community services were not structured or extensive enough to offer the service required. Service-redesign started from the premise of “what should first class community services look like” and how to deliver them for less cost.

CMHTs – now open 8am-8pm Monday-Friday and 9am-5pm Saturday and Sunday. The Crisis Teams have been redesigned and expanded and have adopted the name of “Home Based Treatment”. This multi-disciplinary service works 24/7 and is modelled to enable capacity to ensure individuals can receive up to three intensive visits in any 24 hour period. This avoids admission and accelerates safer discharge. A seven-day telephone helpline has been implemented for “known” patients to enable instant access for talking to a professionally qualified member of staff.

**Outcome:** Whilst the community team developments were “pump-primed” with non-recurrent resources c. £1m, the redesign enabled the **closure of 50 beds**, which released £3.5m per annum. Of this, £1.3 million was recurrently reinvested to expand the community services and the remaining £2.2m to support the Trust’s CIP.

#### *Case Study: Specialist Personality Disorder service locally – Leeds Personality Disorder Managed Clinical Network*

The Network is a city-wide multi-agency and multidisciplinary service that aims to work effectively with people who present with personality disorder, complex needs or are at significant risk. To meet the needs of the people it serves, the Network provides a range of different services such as care co-ordination, Journey Occupational Therapy Group work programme, dialectical behaviour therapy (DBT), and informed skills groups as part of the city wide DBT service.

**Outcome:** The benefits recorded include, reduced mental distress, improved recovery and improved quality of life for each Service User living in Leeds, compared with their counterpart in Sheffield (where no specialist service exists).

<sup>1</sup> A cost and economic evaluation: Kane, E Reeder N, Keane K, Prince S. *Personality and Mental Health*. 2016 Aug; 10(3):169-80.

## ii) Dementia and functional illness (in older adults)

The development of a needs-led ethos underpinning services will mean more flexibility and agility around the needs of Service Users, based on the development of needs-led pathways rather than criteria that is based on age. This will mean that our current OPMH services will integrate much more closely with adult mental health pathways.

Access to our services, and urgent response will not discriminate on the basis of age but will always make reasonable adjustments for older people including staff with the appropriate skills to offer home-visiting in coordination with physical care support services, and robust out of hours support. The development of a single point of access will also provide support to those providing care in the community including Care Homes and GPs.

A key next step will be to design how needs-led services and pathways will be configured for older people versus adults. There is a national debate as to how Older People's services are best delivered within Mental Health, via specialist teams or ageless services. There is little hard evidence to support either argument and we will ensure that robust outcome measurement is built into any service developments.

We will ensure that the needs of older people with **functional mental illness** are addressed according to a consistent pathway regardless of age, so that the standards of care delivered are the same. We will work to design how we will deliver needs-led pathways, which may be done via standardised pathways across both older people's teams and adult teams, or it could mean moving to merging resource and eligibility criteria, with support provided by the older people's specialism into the community team who assess and treat all people with functional illness. When further developing our pathways, we will consider how best to deliver needs-led pathways to older adults with functional illness.

We will ensure that needs of all people suffering from **memory difficulties and dementia** are met according to an organic pathway in line with the national dementia strategy, regardless of age. This will mean that the skills to support memory difficulties and dementia in younger patients will be supported by the teams with skills in these areas. We will also ensure that our services are proactive and recovery-oriented, and as with functional illness we will further develop specialisms, such as challenging behaviour, to ensure that we have specialist pathways that support all levels of need. As part of this we will also ensure that carers have appropriate support and are linked into the support that exists, working in partnership with other agencies.

Whilst the development of needs-led pathways will closer align our current OPMH services with adult mental health, it is critical for all pathways that care is clinically integrated with physical health services. A recent report by the Old Age Faculty of the Royal College of Psychiatrists highlights the importance of integration of physical and mental health for older people, the success of which is reliant on the establishment of effective working relationships.<sup>54</sup> In redefining the older people's pathway, we will continue to ensure that the way in which our services interact with other services in the local delivery systems is joined up and seamless.

Our adult mental health and older people's mental health services will work together with service users to co-design pathways to ensure seamless care and to draw on appropriate resources around the needs of the person regardless of age and focussed on need.

### **Example of good practice**

#### *Case study: The Newcastle Challenging Behaviour model*

The Newcastle Challenging Behaviour model provides a framework and process in which to understand people living with dementia who present with behaviours that challenge. Its main premise is that behaviour that challenges is a poorly communicated expression of unmet need.

The model is a process that aids the clinical formulation, helping to understand why a person behaves as they do and the triggers associated with this. This then becomes the basis of a Behavioural Support Care Plan that is developed in collaboration with carers and family members which supports carers to manage behaviours using a biopsychosocial model.

**Outcome:** The model and the clinical expertise within it has achieved significant positive outcomes for Service Users and Carers, with residential home staff who receive formulation-led individualised-case interventions attributing much of the change to increased understanding of the individual's personality and history, which leads to a new conceptualisation of the challenging behaviour.

<sup>54</sup> Integration of care and its impact on older people's mental health. The Faculty of Old Age Psychiatrists, Royal College of Psychiatrists, November 2016.

## Patient story

### Carl

*Christine is a carer for Carl, a 45 year old gentleman with a long history of depression. Carl is currently receiving treatment for his depression from Julie, a CPN in the Community Mental Health Team.*

*Julie has received several concerns from Christine about Carl's memory. Julie contacts her colleagues in the Cognitive and Functionally Frail (CFF) Specialist Team to ask for some advice. The team suggest a Multi-Disciplinary Team (MDT) meeting to discuss Carl's care, treatment and current symptoms. Following the MDT meeting it is decided that an assessment by the CFF service would be beneficial. Julie agreed to do a joint visit with her colleague from CFF as Carl is familiar with her.*

*After the assessments, it was agreed by the MDT that Carl was suffering from dementia as well as depression. It was agreed by Carl, Christine and both teams that Julie would continue to treat Carl for his depression as this remains his primary problem. In addition though, they would all receive specialist support from the CFF team regarding Carl's emerging dementia, and they would work jointly in order to provide the best possible care for Carl, and support for Christine.*

*Carl and Christine feel that he is receiving the best possible care and the expertise for all of his needs.*

### iii) Learning Disabilities pathways

As in Mental Health, we will ensure that we deliver person-centred, recovery-oriented care around needs-led pathways for people with Learning Disabilities. Delivering needs-led services will mean that our services no longer discriminate or distinguish based on intellectual ability, but are instead based on responding to the individual needs of the person in the most appropriate way. This may mean that more care for people with a learning disability who have mental health needs is delivered in mainstream services with reasonable adjustments to support care. This will require our staff to have the appropriate skills and training to ensure this.

We are a key partner within the Southampton, Hampshire, Isle of Wight and Portsmouth Transforming Care Partnership. At the heart of this our system-wide vision is "to build on a child/young person/adult's strengths and abilities, getting it right first time giving the right care in the right place at the right time" through working closely with other health and care partners.

We are committed to ensuring that people with learning disabilities have their needs met in the community as much as possible, by delivering a series of needs-led pathways to support people with specialist needs to live in the community. We will also ensure that the services that we provide are proactive and preventive, around the needs of the person. We will continue to work seamlessly and proactively with the wider system to ensure that the care that people with a learning disability receive is appropriate to their needs, through a number of initiatives that join up specialist care with the wider system. This includes the providing liaison services into acute hospital settings and supporting Primary Care, noting the increased prevalence of epilepsy, dysphagia, dementia, and stroke and kidney disease amongst people with learning disabilities.<sup>55</sup> We will work with the system to develop 'at risk' registers, where placements are at risk of breaking down, and developing multi-agency relapse strategies with the people who use services will ensure that there are contingency strategies to prevent deterioration.

Our Intensive Support Teams will continue to focus on Positive Behavioural Support strategies with Carers, paid and unpaid, of individuals whose behaviour challenges. In addition, the developments in access and urgent response functions will be open to all users of our services including those individuals with learning disabilities. We will ensure that staff in the single point of access and urgent response functions are equipped with appropriate skills and training, to ensure that there are reasonable adjustments in place to deliver high quality 24/7 appropriate support.

In line with 'Building the Right Support', we will ensure that hospital admissions are limited to times when this is the best clinical option for care and treatment. We will ensure that goals for admission and

<sup>55</sup> Public Health England - Public Health Profile 'Fingertips'.

discharge is planned from the outset with service users, families and carers. Again, we will work closely with other agencies are to deliver this.

We are committed to improving the transitions for children with Learning Disabilities who need to move into adult services, working closely with other service providers, and providing expertise to ensure that children are appropriately supported as they transition to adult services.

In all of this, Service Users and Carers will be fully engaged in the transformation process, at a local and strategic level, as well as on a personal level in their own treatment and support. Viewing Service Users and Carers as partners in the delivery of care and support, and coordinating that across agencies, will ensure proactivity at the earliest possible point in the service delivery pathway. Where individuals need additional support to engage and participate, we will work collaboratively with advocacy services across the region.



**We will deliver consistent, purposeful, high quality inpatient care when it is needed**

## Our aims and vision

By improving access to both services for people with urgent needs and planned services, we will ensure that people can be cared for in the community as much as possible, and we will eradicate the need to send people out of area, unless there is a clear reason for this. When inpatient support is needed, we will ensure that there is a consistent approach across all inpatient areas ensuring that people are cared for in the **most appropriate setting** according to their needs, with a clear purpose, and a plan developed with the Service User, and a clear path to recovery. We will ensure that our inpatient services work closely with families, carers and community services to ensure a seamless transition into and out of our inpatient facilities.

### Outcomes for service users and Carers:



- Reduction in length of stay and improved independence
- Improved patient experience and outcomes
- Reduction in the need for out of area placements
- Seamless transitions into and out of in patient care.

## How we will deliver this

We will ensure that the people in our inpatient beds are there as a result of a need to have the augmented services available in those settings and not other factors such as the absence of community support. We will ensure that every admission has a clear **purpose, aims and a plan**, and wards will follow the mantra of 'know your patients and what you are doing with them'. The care plan each Service User will be co-developed, and treatment will be relevant and purposeful as well as being delivered efficiently in a timely way. This will include having clear admissions and discharge criteria, ensuring the right adopting standardised protocols and pathways. Linked to this we will ensure that the range of interventions is comprehensive and accessible for the full duration of the admission.

This approach to inpatient care will be underpinned by a systematic and robust use of performance metrics and outcome measures such as HONOS to measure the effectiveness of inpatient care across the whole inpatient episode.

The development of **needs-led pathways** within the community will extend to our inpatient wards, to ensure that people are cared for in the most appropriate setting. We will need to undertake more work to understand the implication of this, but it is expected that this will provide opportunities to specialise resource to deliver on the needs of inpatients.



We will ensure that the **recovery ethos** is central to planning, and this will be co-developed with Service Users, Families, Carers and partner organisations, which will include further developing the peer worker role. Linked to this we will ensure that community teams in-reach into the wards, although the continuing locus of clinical responsibility will be clear so there is no risk when a patient is transferred. Our Community mental health teams will establish close links with wards to facilitate both admission and discharge so that care is provided seamlessly. In ensuring that transitions are as seamless as possible, we will design how teams interface with each other across community teams, urgent teams and the inpatient pathway.

In order to ensure that our inpatient services comply with the Healthcare Commission's 'Standards for Better Health' and implement NICE Guidelines and the National Service Framework, we will explore using a tool to drive improvements in acute psychiatric wards such as the Accreditation for Inpatient Mental Health Services (AIMS).

### Good practice examples

#### *Case study: The Purposeful Inpatient Admissions model – Tees, Esk and Wear Valleys NHS FT*

The Trust looked at new ways of working to remove waste and maximise quality through a 'Rapid Process Improvement Workshop' method learned from Seattle's Virginia Mason Medical Centre.

Occupancy was running at up to **106%** in two of the Trust's adult wards with an average length of stay of 29 and 47 days.

The main output of this project –the Purposeful Inpatients Admissions model (PIPA) set out a completely new way of working on the wards which included the introduction of an MDT formulation meeting, held 72 hours after admission, to assess the patients current state and agree the purpose of admission. Standard work processes were then developed for every step of the patient journey and for each staff member.

**Outcome:** In the 12 months following the work there was a **22%** reduction in bed occupancy, **57%** reduction in length of stay, **63%** reduction in sickness absence, and **72%** reduction in reports of violence.

#### *Case study: Digital Patient Status "At-a-Glance" Tool (5 Boroughs Partnership NHS FT)*

The Trust was trying to improve multi-disciplinary coordination and create opportunities for recovery-focused care. The teams from two wards developed a Digital Patient Status "At-a-Glance" Tool to support multi-disciplinary coordination of case planning, discharge planning and risk management.

Ward teams worked together to identify strengths and weaknesses using information from care planning, risk management, safeguarding data and management, and performance information. The data showed one ward should focus more on individual physical health needs and the other on a more person-centred approach to assessment risk and intervention. They involved service users using the Recovery-Focused Pathway to reflect the service user journey.

**Outcome:** By improving multi-disciplinary coordination and involving service users, the teams determined the need to introduce initiatives to support recovery, including - Assistant Practitioners and Activity Co-ordinators to focus on improving therapeutic engagement with service users and a weekly magazine to summarise service user achievements. The project also helped ward efficiency in relation to discharge planning and bed management.



**We will develop tertiary services to provide care across a complete pathway with pathways that are consistent across the trust**

### Our aim and vision

We will provide highly skilled tertiary services for adults, young people and people with learning disabilities who have additional needs. We will ensure that the standard of practice in all tertiary services, is consistent across the Trust to ensure that reliable safe and effective care is provided by all services no matter what the specialism.

We will also look to develop services where this could benefit those who use services. We will work with commissioners to ensure (as part of a wider network of providers), that the forensic pathways have provision that allows for people to be cared for in the setting most appropriate to their needs, which will entail further developing our tertiary services for people with low secure needs across both adults and children, and reaching a conclusion about how adult secure services can best be provided safely with the available estate.

### Benefits to service users and Carers



- Improved outcomes as people are cared for in the least restrictive environment
- Improved transitions as standards of pathways are consistent across the trust
- Reduced out of area placements
- Fit for purpose environment for adult services will improve patient experience

### How we will deliver this

#### *Continuity of standards and sharing of expertise*

We will ensure that our needs led pathways of care extend to and are consistent with our forensic services. We also have a vast amount of expertise across the many pathways within our organisation, and there is a significant opportunity for teams and services to learn from each other, enhancing the quality of services and aiding transitions between services. Examples of this include aligning forensic wards with psychiatric inpatient units to draw on similar skills; and further developing community forensic pathways in conjunction with CMHTs and rehabilitation pathways.

We will ensure that the skill base in forensic services is shared with other services using the reasonable adjustment model. Similarly there will be the routine use of addiction expertise and psychology skills and services to inform, advise, support and provide high level care as is required for each individual patient. This will require a careful assessment and analysis of skill base and capacity, to ensure feasibility and timely, high quality delivery.

#### *Adults*

A continued key priority for forensic adult services is to agree the nature of the re-provision of beds to ensure that the needs of the people who use our services are met. This includes addressing the issues of the physical environment at Ravenswood House. As part of this there is an opportunity to increase the provision of acute low secure beds, to ensure that people are cared for in the most appropriate setting as close to home as possible.

As well as the inpatient pathway, we are committed to developing services to support people with forensic needs in the community whose needs cannot met in an adult CMHT. We will build on a number of existing services around the needs of this group of Service Users, including augmenting the role our community forensic service, and ensuring that innovative services such as the NOMS Personality Disorder Pilot and Stalking Treatment Service are integrated as part of a wider network of community support.

In addition to developing the pathway in Hampshire, the Oxford and Thames Valley tertiary new care models pilot presents exciting opportunities to develop innovative solutions that meet the needs of Service Users and Carers across a larger footprint that we are keen to play an active role in.

#### *Children and Young people:*

Within children's forensics services we will work with commissioners to develop our tertiary services, including a low secure provision to ensure that our service users can be supported in the most appropriate setting. This will both ensure that people who have been in a medium secure setting and are ready to be stepped down can be rehabilitated in the most suitable setting, and that people with low secure needs can be cared for in the appropriate setting, closer to home. Within this, there are also

opportunities to develop low secure provision for children and young people with learning disabilities, which will also help to repatriate people from out of area.

In addition to the extra capacity required in low secure pathways, we are committed to working with the wider system to strategically plan for adolescent secure and enhanced needs across the pathway. The new care models programme offers an opportunity to plan for Tier 4, PICU and low secure more strategically across the South that we are keen to contribute to. Considerations around the CAMHS pathway will be developed as part of a wider regional strategy for CAMHS, which also provides the context within which rehabilitation of patients from our Specialist services return to the community in Hampshire.



## We will develop primary care based mental health services to keep people well

### Our aims and vision

We will continue to improve access to psychological therapies and ensure that as many people as possible are benefiting from the service, with continued strong outcomes. In addition we will work with primary care and local delivery systems to consider how people with mental health needs are best supported in primary care to ensure that people receive the right support as early as possible.

#### Benefits to service users and Carers:



- Improved access to support in primary care will reduce the escalation of need and demand in secondary care services
- Improved patient experience

#### *italk*

We will improve access to italk to deliver the ambitions set out in the 5YFV by working in partnership with Solent Mind, GPs and other key partners to publicise our services.

We will continue to innovate and develop relevant services for those who need it, including an assessment and treatment service for Carers to help support those who are likely to require support; the continued development of italk Health for people with long term conditions, who may not recognise that they have mental health needs; and the development of italk@work focussing on improving wellbeing in the workplace.

We will also explore different modes of access to the service such as a digital platform to increase choice and access opportunities for patients and upskill and train primary care staff to identify and deliver low intensity interventions.

As we expand access we will ensure that we have the workforce to support this to ensure that waiting times do not deteriorate as more people access the service, and to help reduce waits between first and second appointment. As part of this, we will review the service (including the proportion of people being stepped up to step 3) to ensure that the right people are within the right part of the service and that capacity is being maximised to best effect.

#### *A strategy for broader primary care based mental health*

In addition to expanding our italk service, and ensuring that our CMHTs are well integrated with local delivery systems, we will work with commissioners and primary care to ascertain how best to strengthen primary care based support, to work proactively, and ensure that people receive support as early as possible in the pathway.

## Examples of good practice:<sup>56</sup>

### *Case study: Primary Care Plus, West London*

Primary Care Plus is a service in West London (Hammersmith and Fulham, Hounslow and Ealing) based in GP practices for those who may need some extra mental health support over and above what is available from their GP. By moving those with stable mental health problems from receiving support from specialist services to their GP practice, they receive care in the least restrictive setting, closer to home, and they'll have both their physical and mental health needs met.

Primary care mental health workers are employed by West London Mental Health NHS Trust and are attached to GP practices. GPs are able to refer people directly to them. Importantly there is no strict criteria for referral, except for an assessment to determine whether people require more support.

Other mental health professionals such as consultant psychiatrists and psychologists also provide support to the service. The primary care mental health workers provide one-to-one support to people within GP practices, helping with discharge from secondary care, liaising between services and providing ongoing mental health support. They are also able to signpost to wider social support in the community. These workers also provide support to other primary care staff by providing advice on consultations, as well as training for staff (reception staff, practice nurses, GPs etc.) to meet their needs.

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<sup>56</sup> Mental health in primary care: A briefing for Clinical Commissioning Groups. Mind, June 2016.

# 7 What do we need to deliver our strategy?

There are a number critical success factors that will need to be in place in order for us to successfully implement this strategy:



**Service User, Families and Carers at the centre**



**Strong leadership & culture**



**Transformation tools: Quality Improvement Methodology & resource**



**System-wide vision and strong partnerships**



**A sustainable workforce**



**Finance and other enablers**



**Service users, families and carers at the centre**

One of the core standards in the Care Quality Commission Standards for Mental Health Services is that the views of patients, their Families, Carers and others are sought and taken into account in decisions, planning, delivering and improving health care services.<sup>57</sup> Service Users, Families and Carers are “experts by experience” by actively involving them we will ensure that our services are shaped by the people best placed to know what works and what doesn’t.

Just as we have put Service User, Families and Carers at the heart of the development of this strategy, Service User, Families and Carers should continue to be at the centre of the delivery of the strategy as well.

Adapting our approach to truly engage and collaboratively lead with service users, families and carers throughout the organisation is a key priority within this strategy. This will entail a significant cultural shift for the organisation, making sure that everything - from clinical services through to corporate services - is based in the needs of service users. This is critical in ensuring quality, accountability and value and importantly ensuring that positive change occurs.

By being accountable to ‘experts by experience’ our transformation will be held to its true purpose. When people are equipped and supported to help design, deliver and quality check the services they and their peers use, those services improve and the people involved gain in confidence, skills and an enhanced experience.

*“Only by transforming services in the way that the people who use them want us to can better outcomes be achieved at a time of real budget constraint.”*

Dr Geraldine Strathdee, National Clinical Director for Mental Health, NHS England.

<sup>57</sup> Core Standard 17, Standards for Better Health, Department of Health (April 2006)

Linked to this, we will pursue a relentless focus on outcomes, which is critical to driving improvement and delivering truly patient centred care. This will require teams to work to systematically measure and evaluate outcomes data, which requires access to the right granularity of clinical data.



## Leadership, governance and culture

Critical to the successful implementation of this strategy will be having expert, committed and stable leadership in place to drive service improvement and the cultural change required. Additional and complementary skills and capabilities are likely to be required as well as expertise in transformational change experience.

In looking to address criticisms levelled at the Trust in the past, and delivery of the future strategy, the Trust Board will require strengthened expertise in running Mental Health and Learning Disabilities services, accompanied by extensive experience of Quality Improvement, service user and carer inclusion and clinical service expertise.

Leadership qualities must extend to individuals and teams regarding service transformation and change management, where the importance of good governance and accountability is critical. Leaders must set out clearly the need for change and support the process to make the changes happen, operationalising them and ensuring that outcomes are continually and closely monitored and that the change “sticks”.

The Board will foster an environment that is open, accountable and compassionate, and puts patients first. This will entail a cultural shift towards autonomy, responsibility and accountability, whereby devolved decision making is predicated on clear lines of accountability, good governance, earned autonomy and continuous improvement. This will represent a significant change for the organisation. Creating an atmosphere of accountability is critical to leadership and is reliant on establishing clarity on roles and expectations, ongoing dialogue, and an organisational commitment to accountability rather than blame. In this way a culture of earned autonomy accompanied by accountability will foster ongoing improvement.

This will require effective leadership, that is able to lead change in a complex and changing environment, with multiple stakeholders who do not all share the same interests.

### *Clinical leadership*

Clinical Governance is often cited as the main vehicle for continuously improving the quality of patient care.<sup>58</sup> Clinical governance and leadership are both central to the delivery mechanisms of the strategy. Whilst this is part of ongoing organisational form discussions, including debate around introducing more formalised and bolstered service and professional governance structures, stronger clinical involvement, and leadership in the delivery of the strategy will be central to the enacting of this strategy, regardless of organisational form. Embedding a culture of accountability will be critical to this.

Engagement with clinical staff has been a key element of the approach to the development of the strategy, but key to the successful implementation of it will be their support and ownership of the recommendations. As such, along with greater Board and management focus, consideration will be made of the requirement to have clinical staff lead the planning and implementation of the proposed changes, sitting on, and driving key governance and oversight groups set up to deliver the resulting transformation programme.

Our Clinical Reference Group has representatives from senior clinical staff within the Trust whilst the Mental Health Alliance Clinical Reference Group, has commissioner and GP representatives on in addition. These two groups should be used as the central clinical voice to oversee the implementation of the strategy and be the interface to the wider local clinical community.

### *Culture*

<sup>58</sup> Clinica *‘the combination of organisational inspiration and purpose, motives and beliefs of individuals, and the norms and patterns of interactions of groups, which provides the meaning to drive leaders’ and employees’ behaviours and results’*  
**Hay group organisational culture model**

A significant proportion of feedback from our staff cited a lack of vision, cultural issues and difficult working environment as contributory factors to the need to change. This has been associated with the issues around standards and quality of service provision in certain parts of the Trust, but has also led to dissatisfaction with the way the Trust has been run, and staff recruitment and retention issues.

A fundamental shift in the culture of our organisation, to put patients at the centre of everything that we do, will be critical to the success of this transformation. This will start by proactively involving Service Users, Families, Carers and staff in the design, development and implementation of the transformation. In addition, our culture will require a shift in emphasis to clinical leadership and earned autonomy, which will require sharper systems of accountability. In this way, our staff will feel empowered to make positive changes and do their jobs, but at the same time, there will be an atmosphere of accountability that is constructive and supports the delivery of high quality, safe services.

However, the culture of an organisation is not changed overnight, and neither will the delivery of a new clinical strategy guarantee this. A number of the priorities described in this chapter will help to improve the culture of the organisation, and other key techniques to help when embarking on cultural change include:

- *Changing structure and process:* Decentralising operations within a clear framework, increasing autonomy and reviewing spans of control can lead to behavioural changes in leadership which can subsequently foster positive behavioural and cultural change in staff too.
- *People:* Bringing in new leadership or people at all levels with a different perspective, skill set and capability can lead to behavioral and performance changes that, in turn, can affect new ways of thinking and culture change.
- *Incentives:* Incentives affect behavior and performance and attract new resources and capabilities, which can lead to culture change. Incentives should look to improve job and service satisfaction.
- *Changing and enforcement:* Learning from the past, including mistakes, and use the lessons learned to change is vital. This includes holding people accountable for performance in an appropriate manner. These actions or emphases will help to shape new behaviours that will create a culture of learning and achievement.



### The tools for transformation: a Quality Improvement Methodology and resource to support transformation

#### *The tools to transform: Quality Improvement Methodology*

High performing NHS organisations are increasingly adopting new ways of working around the concept of continuous improvement, Lean or Quality Improvement (QI). This will provide an approach and a methodology that will underpin our transformation and equip us to be better able to implement change.

There is no one single QI methodology that is recommended for a Mental Health trust and currently a number of different approaches are used in the NHS. Most of the well-known methodologies have evolved from industry and can trace their DNA to the Toyota Production System (TPS). In recent years these methodologies have been refined to use in healthcare but most can be further adapted and customised to use in Mental Health settings.

Our next step will be to decide what quality improvement methodology is right for us. We will do this by involving service users, families and carers and other stakeholders in a process to identify the best option for the needs of our organisation. This will underpin **our** way of doing things, and become an embedded approach to ongoing improvement.

#### *The resource to transform*

The delivery of this strategy will require full board and senior management support; an investment of both time and money by the organisation to design and build the most effective, suitable and affordable model for delivery; and an investment in the skills required to ensure its successful delivery at a good pace.

The scale of this transformation will require focus around a specific programme of work, that has its own Programme Board (as a committee of the Board) led by a senior responsible owner (SRO) who is accountable for delivery of programme outcomes and realisation of benefits. The Board will be responsible for coordinating all projects and work streams that form part of that programme. In order to deliver this, the development of a Strategy Implementation Team, led by an Executive Director will provide the resource required to support teams to implement the strategy. This will be a pragmatic resource that supports managers and clinicians to deliver the transformation. In addition to this, operational managers and clinicians will need to be released from some of their current commitments and have appropriate support to implement change.

The Strategy Implementation Team will:

- Provide strategic oversight and challenge;
- Maintain a central information hub (to facilitate clear and transparent reporting of progress);
- Manage the programme governance framework;
- Establish and maintain agreed corporate systems and standards for programme and project management;
- Provide support for a culture of continuous improvement, and
- Align resources to strategic effort.

Evidence suggests that as many as 70% of all programmes fail to realise the main benefits they set out to deliver and fail because they over-focus on activity, suffer mission creep, avoid tackling behaviours that hinder change, or were simply not clear from the outset about the purpose of the programme. We will therefore ensure that the management and realisation of benefits is core to how we organise and support the programmes of work.

It will be the responsibility of the programme board to ensure at a detailed level that:

- For every benefit to be achieved by the programme it is clear who has ownership of the benefit, what outcome is required to derive that benefit and what activity and outputs will lead to this;
- For every activity and output, it is clear how it contributes to the delivery of expected benefits; and
- Performance towards benefits realisation is monitored and remedial action taken where necessary, integrating this work with risk and issue management.

All programmes will require the input of supporting functions. In some areas this function may require a dedicated project or work-stream as part of the programme, in others there may be only a need for finite tasks, information or guidance. Communications and engagement matters will be assigned to a communications and engagement work-stream, with others such as workforce, finance, estates and information also forming part of the programme.



### **System wide vision and strong partnerships**

Our services operate in a much wider system that includes other health providers, social services, community-based support and the voluntary sector. We cannot work in isolation in delivering this transformation. We are committed to working in collaboration with our commissioners, other providers (including General Practice) and the voluntary sector to drive positive change.

It will be critical that our services are mapped onto local delivery systems including primary care and general community care to link completely with these services and provide joined up care around the needs of the person. We will work closely with Local Delivery Systems to ensure that local delivery is at the heart of the services that we provide.

We currently provide Mental Health and Learning Disabilities services to five different CCGs, two different local authorities and NHS England. A number of the changes that this strategy is proposing will require



the alignment and agreement of our commissioners. We are committed to working closely with commissioners to take this strategy forwards.

As a wider system of health, care and the voluntary sector we need to work together to agree a coherent vision and strategy for Mental Health and Learning Disabilities on a system wide basis. A Mental Health Alliance for Hampshire and the Isle of Wight has been set up as part of the Hampshire and Isle of Wight STP, which brings together the relevant commissioners and providers from across the NHS, Local Government and voluntary sector. The Alliance should be instrumental in shaping a shared strategy across Hampshire and the Isle of Wight spanning health, social care and voluntary sector organisations, Service Users, Carers and Families.



## Workforce and talent

A risk to the implementation of this transformation is the availability of the right workforce. We will develop a robust workforce strategy that will underpin the delivery of the transformation of Mental Health and Learning Disabilities services. This will also inform the wider Hampshire and Isle of Wight workforce strategy, which is working across organisations in Hampshire and the Isle of Wight to ensure there is a sustainable quality workforce for the delivery of services.

A critical success factor in building for the future is attracting and retaining the right staff. In order to ensure that the services delivered are fit for purpose, understanding the number, skills and capabilities of the workforce is critical. A detailed level of profiling, including skill base and mix will inform recruitment, and training needs across the Trust.

There is a nationwide shortage of registered mental health nurses, and as a result we will need to think flexibly and creatively about how to deliver care. This may mean the development of new roles as services evolve.

As well as recruitment of staff, the retention of staff is critical, particularly in the light of the attention there has been on the Trust. We will ensure that the Trust is an attractive place to work, through demonstrating that staff are valued and supported, and providing development opportunities.



## Finance and other enablers

### *Finance*

Key to the considerations of the deliverability of the strategy will be the financial sustainability of the model proposed both now and in the future, and the cost of implementation.

A more detailed assessment of the cost of the service model is still to be made and will need to form part of a larger assessment of the costs and benefits of implementing the strategy. This will also need to consider the system wide savings that could be made from implementing this strategy that could be used to fund any additional costs (or one-off transition costs). Such savings are likely to include avoiding admissions, reduction in the use of out-of-area beds and fewer attendances at A&E (of Service Users who should have otherwise been seen in the community). We will continue to involve commissioners in the co-production and detailed design process of the model, and seek approval for our proposals where appropriate. We will seek support from NHS Improvement to set up the transformation programme of work.

### *Technology*

The delivery of this transformation must be supported by a robust approach to information technology. Our vision for technology and informatics recognises the critical role of technology in enabling the delivery of high quality services including putting Service Users at the centre of information and technology; enabling integrated seamless care via information sharing; facilitating efficient ways of

working; and establishing an information-led culture which encourages transparency and improvement of services.<sup>59</sup>

Other areas where technology could support the successful implementation of the strategy include:

<i>Data sharing between organisations</i>	<p>Sharing pertinent data and information with primary care services, other provider organisations, and the wider health and care community including the third sector will facilitate the provision of integrated care.</p> <p>We have some data sharing mechanisms in place, such as protocols with Acute Providers to obtain patient identifiable A&amp;E and emergency admission data - but further work is needed to ensure this integrated clinical intelligence is fully utilised across all relevant pathways. In addition, clinicians have access to the Hampshire Health Record (HHR) which integrates Primary Care, Secondary Care and Community Care data across physical and mental health pathways. Better use of this tool would ensure the benefits of a shared clinical record are fully recognised in all appropriate clinical interactions.</p>
<i>Access Points and Technological Solutions</i>	<p>Telephony systems which incorporate live directories of services and allow warm transfers between call handlers, clinical staff and other external services, can be of great benefit when managing service performance in Access Points. They enhance the experience for the caller, including Service Users in distress, by better managing the flow of calls, avoiding answerphones and being put on hold for long periods, and losing connection during transfers.</p> <p>Use of a wide range of communication methods, including email, web chat, text messaging, etc. can increase engagement and improve communication with Service Users, Carers and other partners, and will be explored as part of this transformation.</p>
<i>Supporting efficient ways of working</i>	<p>Ensuring that staff have access to technology that supports more efficient ways of working, which reduces the amount of time away from direct clinical care is a key enabler of improving services. This includes implementing clinical applications that support mobile and agile working, and reduces the administrative burden on clinicians. This will enable services to be more responsive to Service Users.</p>

### *Information based organisation*

In order to deliver high quality services and improve the consistency and effectiveness of care delivered, access to robust data, including outcomes, performance and clinical data is critical. Quick access to accurate, live data which is comprehensive yet easy to navigate is critical to the delivery of effective and safe services.

A systematic and robust use of outcomes data is critical to driving improvement. We will support teams to record and interpret outcomes data to inform learning cycles. This will be underpinned by a robust understanding of the underlying clinical data – i.e. who the Trust is caring for (stratification of patients), how they are doing this (operational data), and with what result (outcomes and feedback.) This will allow outcomes measures to be evaluated and compared to ensure that services are working in the best way possible. Sufficient granularity of clinical data will ensure that resource can be deployed as effectively as possible around pathways and the needs of Service Users.

The introduction of Tableau performance software, has greatly enhanced the ability to use both operational and clinical data in a timely manner in order to drive performance and improvement. As the Information Team continues to enhance the system, it is critical that as well as performance data, outcomes data and clinical data is made available, and that a culture of analysis and interpretation of data is fostered in the organisation.

In order to drive out variation of clinical care between teams and understand the quality of services provided, the organisation will need to make better use of benchmarked and weighted data. These can be

<sup>59</sup> Informatics and Technology Strategy Refresh for 2015/16, SHFT, March 2015

used as a starting point in improvement programmes to discover where and why variation occurs. The Trust Tableau system does contain weighted data, in the form of performance reports, but the use of these for the purposes of improvement has been limited in the organisation and will need to increase to ensure the strategy can be implemented.

### *Estates*

The configuration of the estate in which care and treatment is provided can have a great effect on the experience of Service Users. A fit for purpose configuration and design can lighten the burden on staff and therefore enhance care both in the community and inpatient settings.

The environment in which care is provided needs to:

- Be safe, healthy, comfortable and therapeutic, to ensure high quality of care can be delivered which is centred on the needs of the Service User.
- Be in the best locations to maximise accessibility.
- Be able to support activities for Service Users, this includes occupational therapy and education activities for inpatients.
- Provide an environment which preserves privacy and dignity of patients in the care environment.
- Take the needs of staff and visitors into account in order to provide them with a pleasant working environment
- Allow for separation of groups based on gender, vulnerability, ability, and acuity.
- Be designed and maintained in collaboration with services users, Carers, and staff. Good communication between estate and ward staff is key to ensuring this happens.

Whilst the statements above may be somewhat obvious they are not always easy to implement and this strategy provides an opportunity to make more strategic decisions around environment and estate to follow the services. The service need should drive the configuration of the care environment rather than the existing estate dictating the delivery of clinical services.

### *Communications*

A key enabler of change is communication. Our approach to communication could be amalgamated within a broader engagement programme or the Service User, Families, Carer and staff inclusion strategy, but in either scenario, the amount of communication required to successfully deliver this strategy is not underestimated.

We need to build on the positive momentum and communication and engagement that went into developing the strategy as this will be even more important when moving to implementing change. We will develop a communications strategy that takes a systematised approach to keeping the various groups of stakeholders informed, including defining the communication channels and the frequency of communication with different stakeholders, according to their needs. We will ensure the smooth implementation of the strategy via open and transparent communication with staff, service users, their families and carers and other stakeholders.

# 8 Next Steps

In taking forward this Strategy, we have identified a number of important initial next steps that are required to progress the programme and ensure that it progresses at pace. Further details of these are currently being planned including clearly defined objectives, success criteria and milestones. We have outlined a number of our initial next steps below:

**1. We will determine with Service Users, Families and Carers how we will best work in partnership to deliver the transformation.**

Our first step will be to work with service users, families and carers to define how best we will work together to co-develop services. This will be led by one of our Executive Directors. It is critical that this is progressed first, as we require service user, family and carer inclusion to the next steps that follow in designing our transformation.

**2. We will identify the right Quality Improvement Methodology for our organisation**

We will convene a task and finish group including service users, carers and other stakeholders that will identify the methodology for quality improvement that we will use. This group work at pace to explore the options so that we can procure the methodology as quickly as possible to enable us to move to implementation.

**3. We set up the programme required to deliver our transformation**

We will establish the infrastructure required to support our transformation including securing the resource to support the implementation of the strategy, and ensuring that clinicians and managers are freed up to deliver the transformation. This team will set up a programme structure and associated governance structure to take the work forwards including establishing work streams with clear accountability and action plans to drive the pace of change, at the same time ensuring that this is pragmatic and agile.

**4. We will develop an Organisational Development plan that will support our transformation**

We will work to develop an Organisational Development plan at pace that will support the delivery of the cultural change required to deliver our ambitions. This will include clarifying the planning cycle, developing levels of empowerment within the organisation including a how authority will be devolved, and accountability sharpened, and how performance will be measured to support this.

**5. We will invest in developing our senior clinical leadership through a leadership training programme**

Our clinical leaders are crucial to the success of this strategy, and as such an immediate next step will be to identify and invest in procuring leadership training for our senior clinical leaders to ensure that they are equipped with the necessary skills to lead our transformation.

Full detailed plans are being developed that will enable the implementation of this strategy at pace.

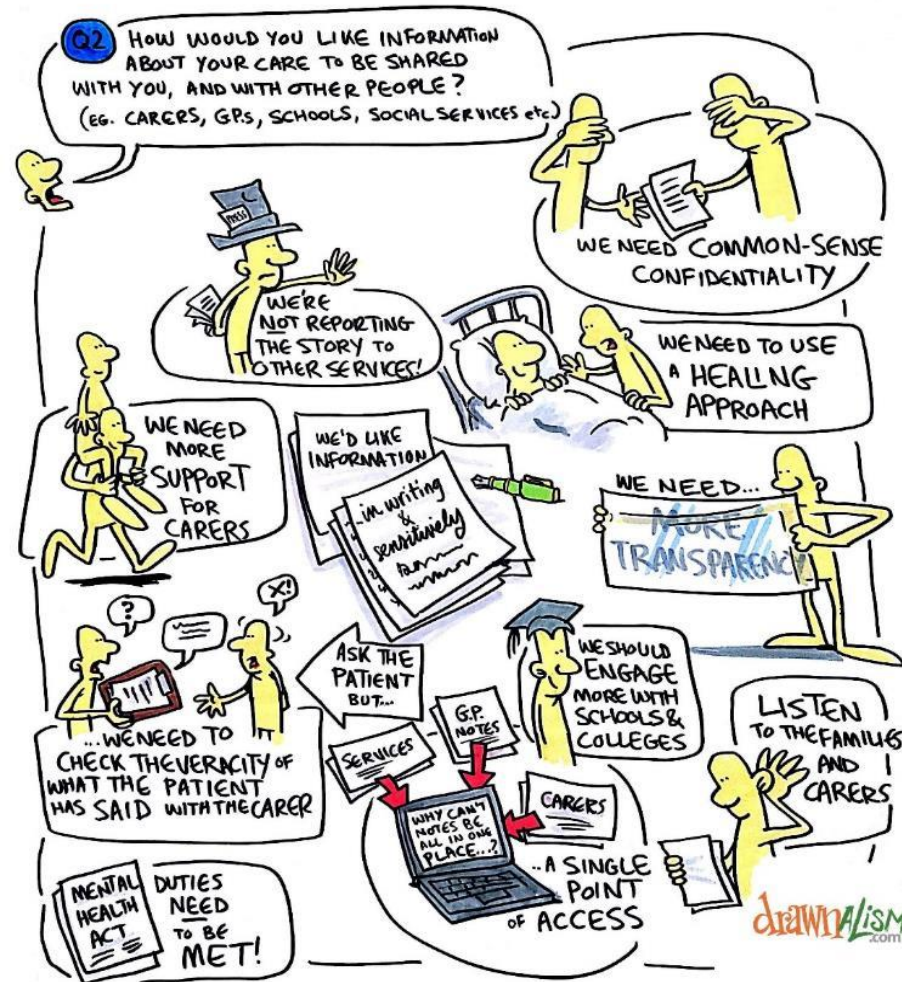
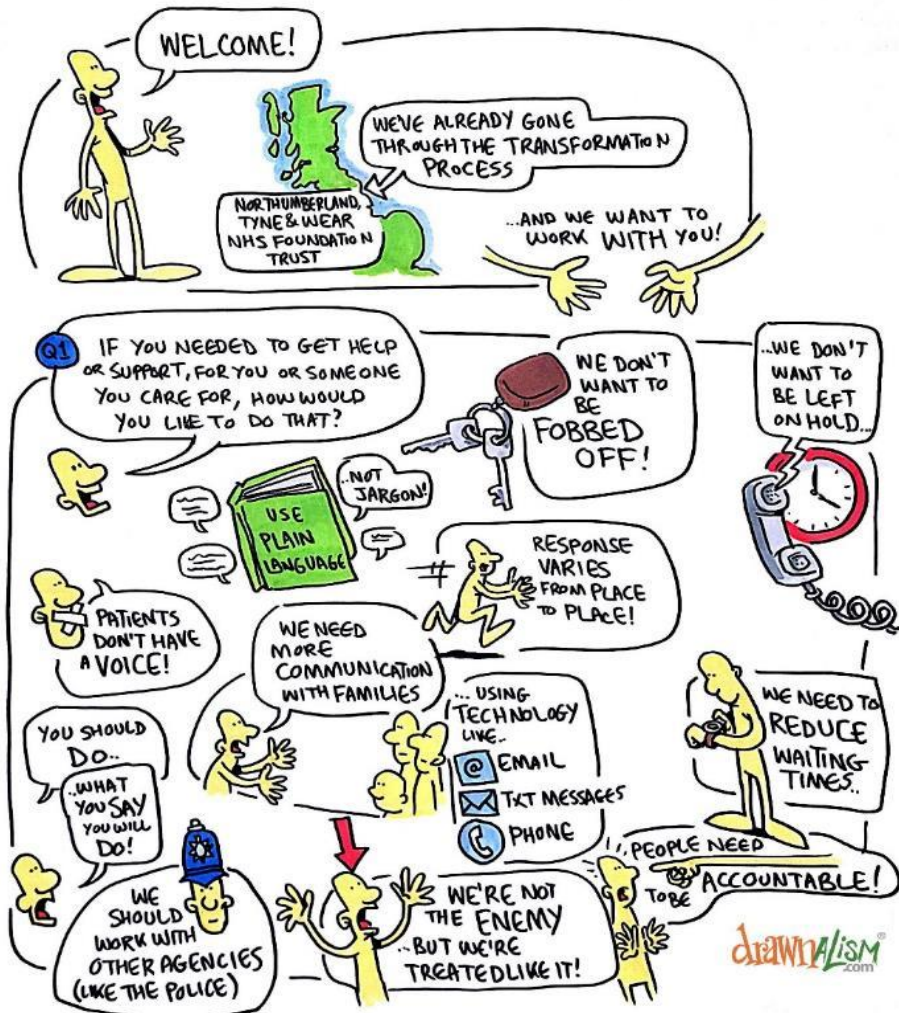
# 9 Appendices

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## **Appendix 1: Service User, Carer, and Families Feedback**

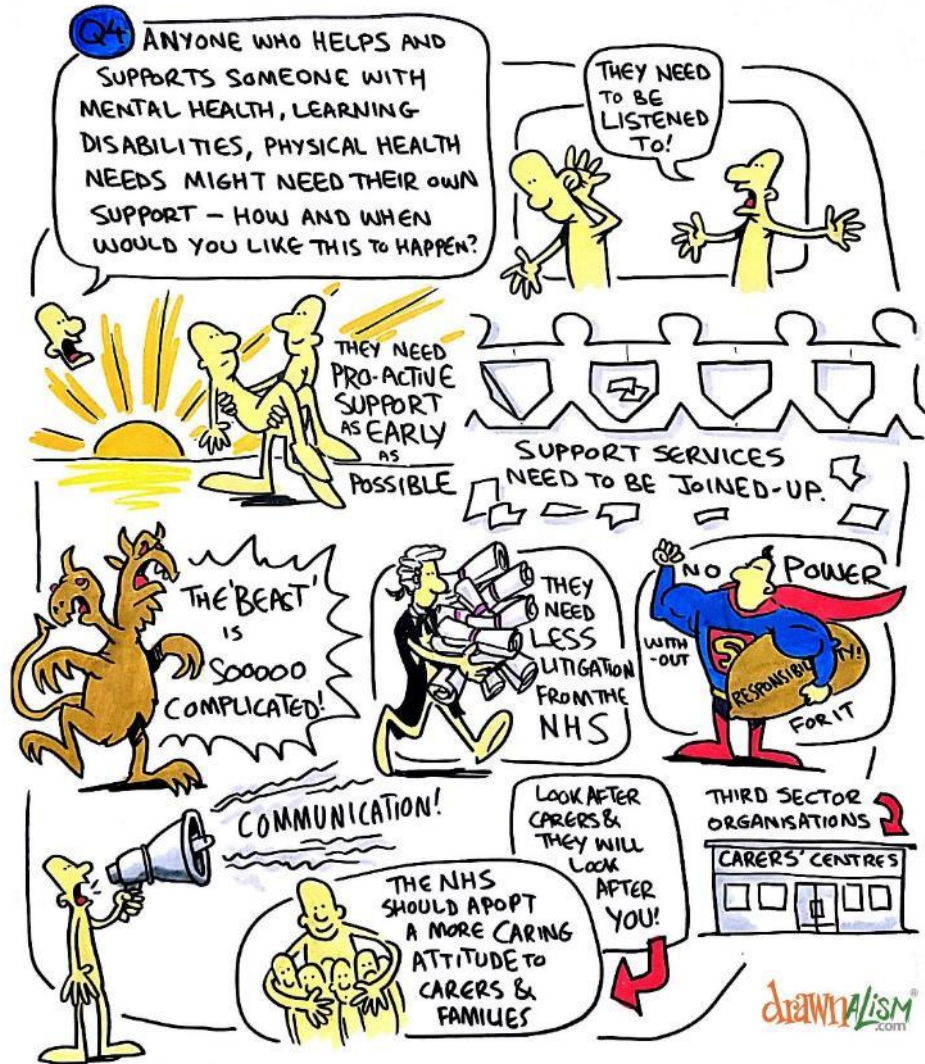
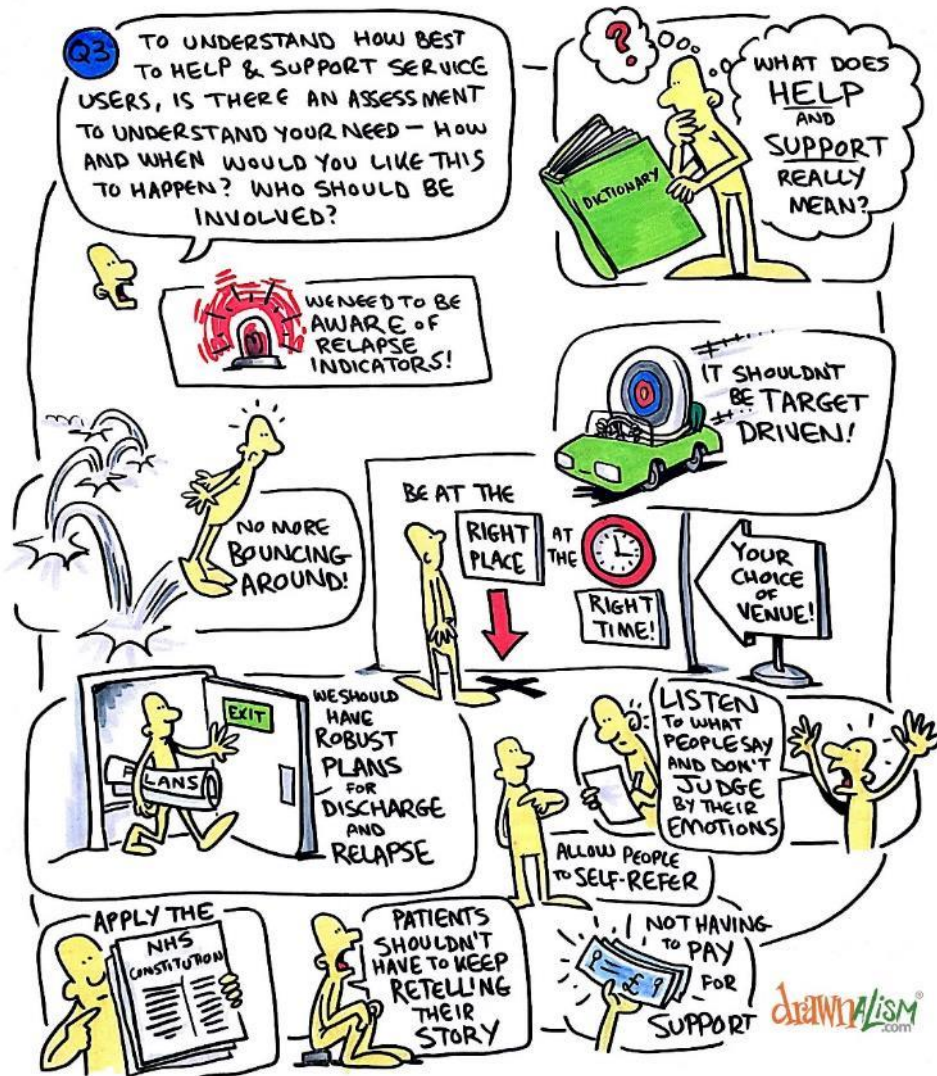
# Mental Health Service User, Carer, and Families Feedback

Lysses House Hotel, Farnham, Thursday 17<sup>th</sup> November 2016



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# Mental Health Service User, Carer, and Families Feedback

Lysses House Hotel, Farnham, Thursday 17<sup>th</sup> November 2016

**2** PHYSICAL HEALTH IS AS IMPORTANT AS MENTAL HEALTH - HOW CAN WE MAKE SURE WE CAN LOOK AFTER BOTH?

MEDICATION 'SANITY' CHECKS

HOSPITAL SHOULD BE AWARE OF ALL NEEDS

£ + € = \$ PROVIDE FINANCIAL EDUCATION & SUPPORT

HOW CAN WE WORK TOGETHER TO UNDERSTAND YOUR NEEDS, PLAN AND DELIVER YOUR CARE? (SERVICE USERS, CARERS, THE TRUST, OTHER ORGANISATIONS, GROUPS WORKING TOGETHER)

TRAVELING MILES TO VISIT RELATIVES IN HOSPITAL

CONTINUITY OF CARE

POSTCODE LOTTERY

CLOSING WARDS BUT NOT PROVIDING SUPPORT IN THE COMMUNITY

**3** SUPPORTING SERVICE USERS TO MOVE ON AFTER THEIR CARE & TREATMENT IS IMPORTANT - HOW CAN WE DO THIS TOGETHER?

KICKED OUT OF THE DOOR EVEN THOUGH THEY KNOW MORE TREATMENT IS NEEDED

SUPPORT 24-7 ACCESS

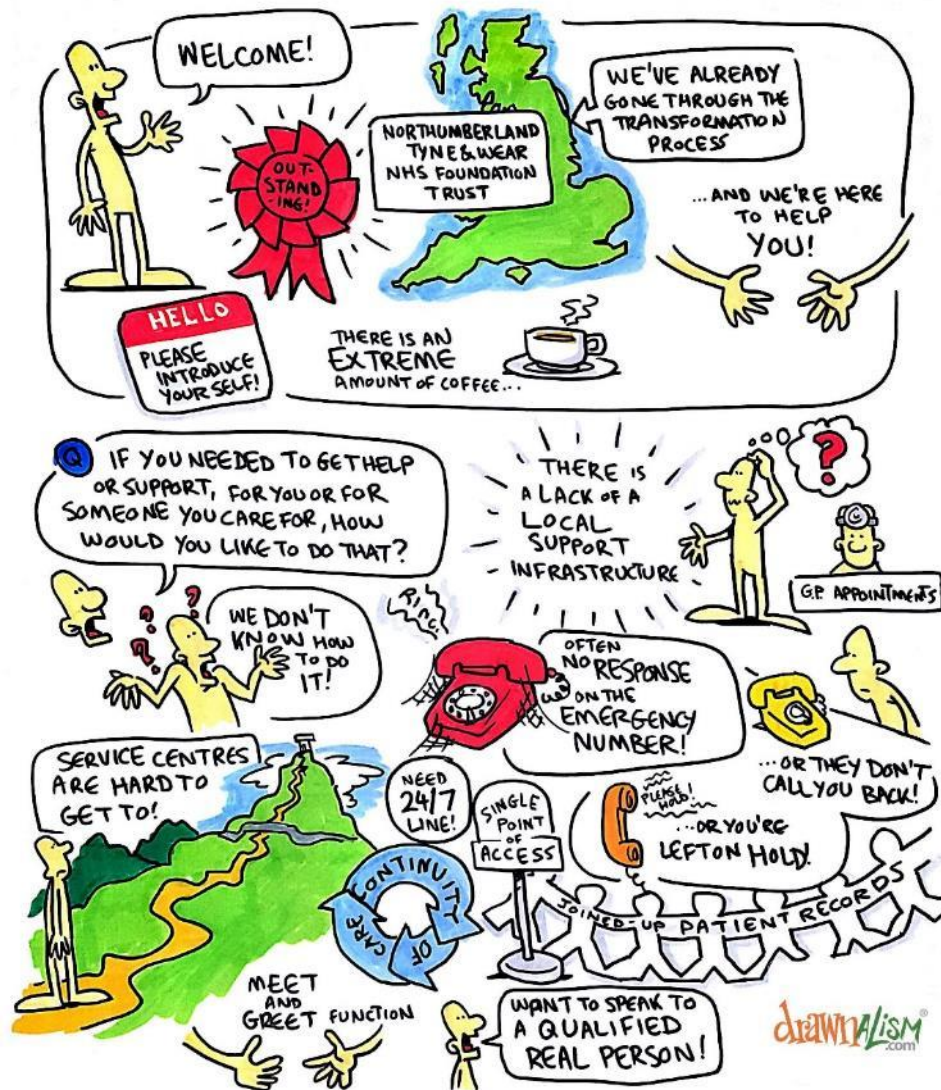
SERVICE HAVE BEEN CUT TOO FAR!

...AND YOU HAVE TO BATTLE TO GET BACK IN!

IS THERE A PATHWAY THAT IS FOCUSED ON PATIENTS NOT FINANCES?

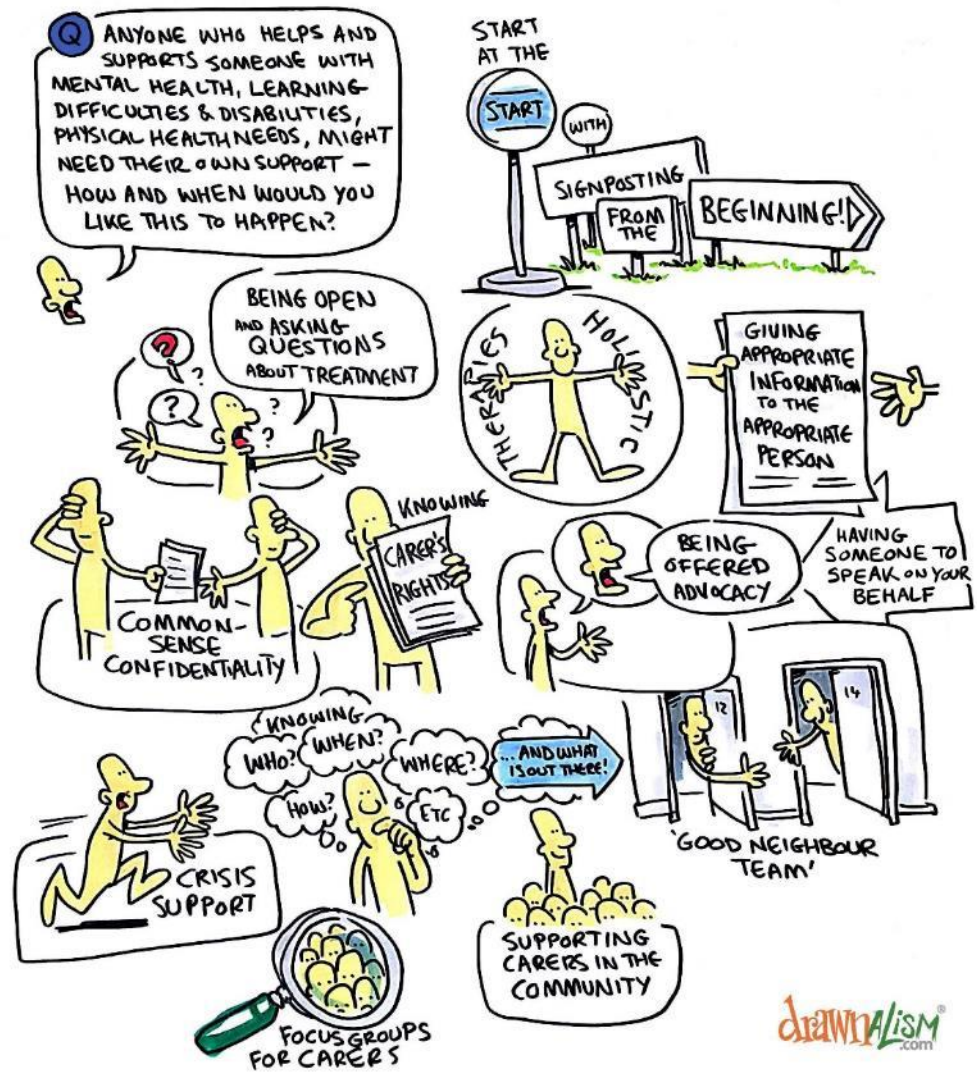
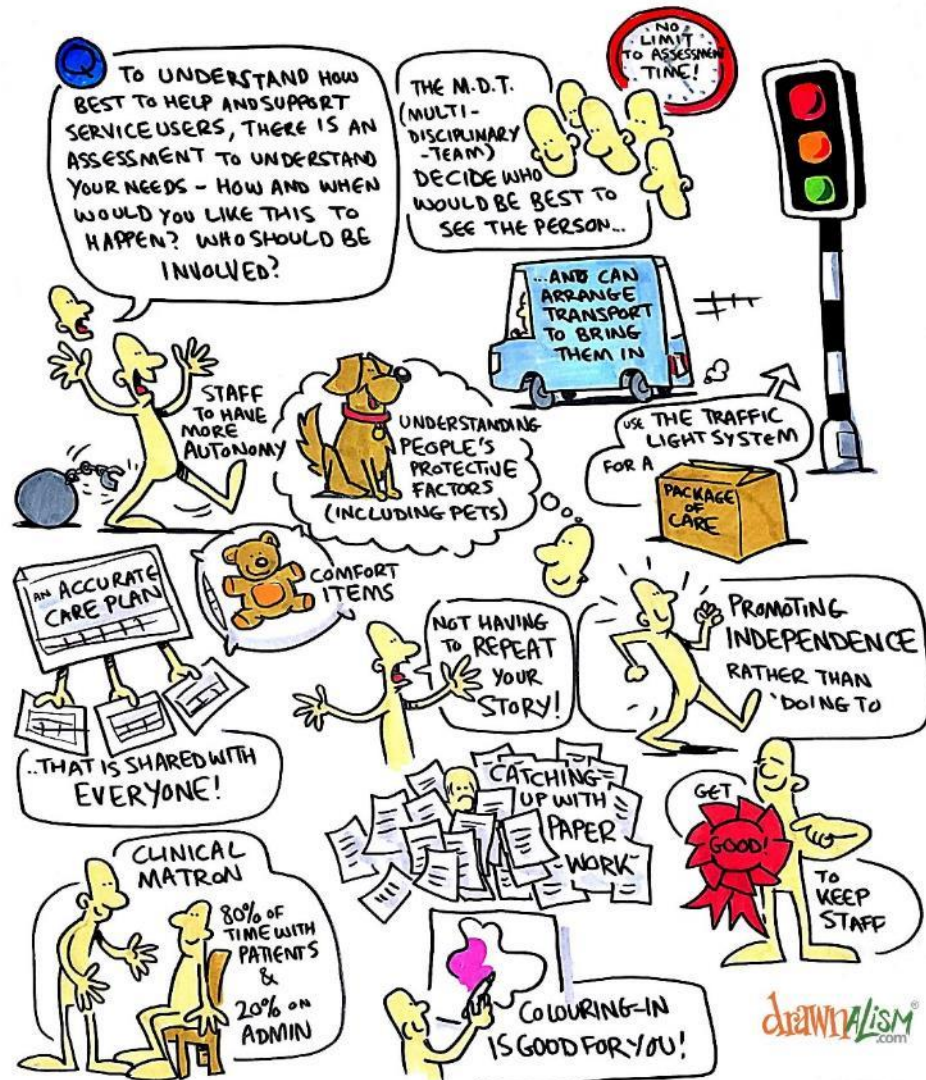
# Mental Health Service User, Carer, and Families Feedback

Weybrook Park Golf Club, Basingstoke, Friday 18<sup>th</sup> November 2016



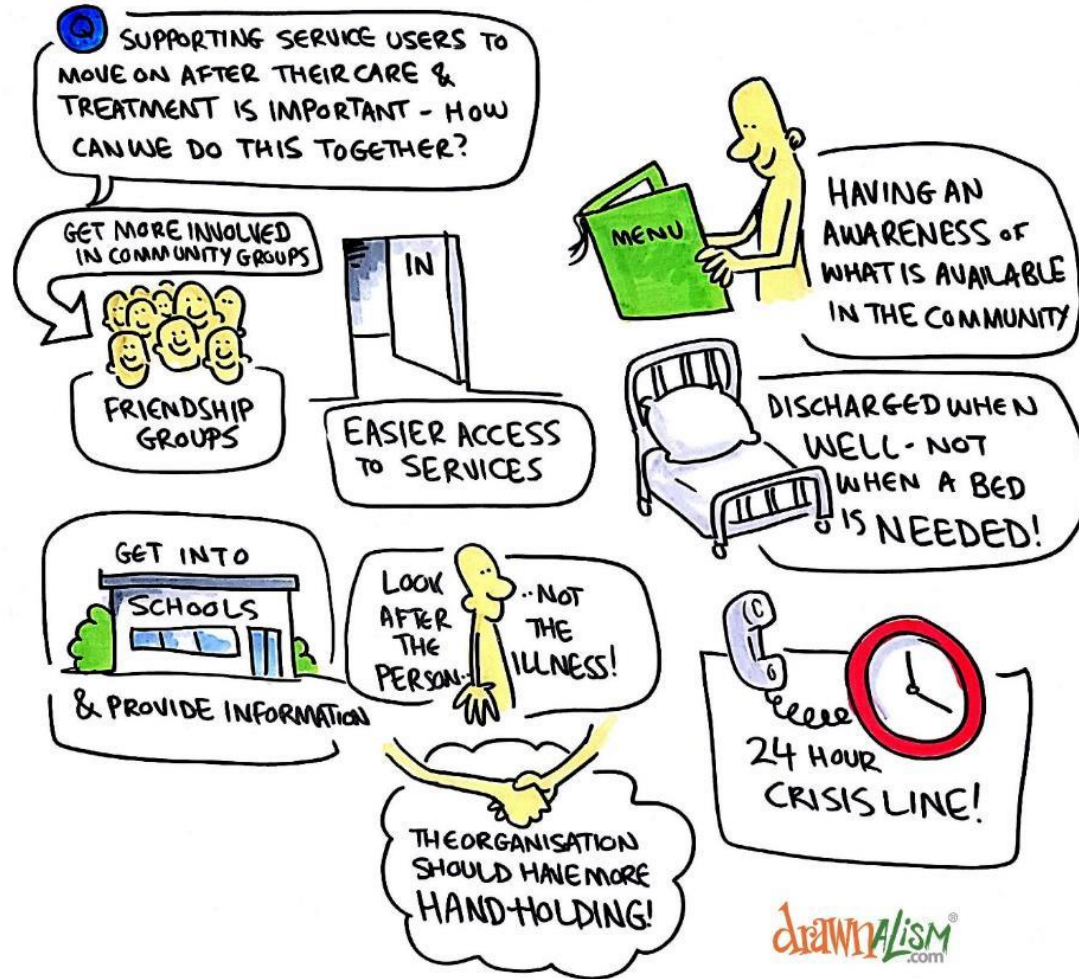
# Mental Health Service User, Carer, and Families Feedback

Weybrook Park Golf Club, Basingstoke, Friday 18<sup>th</sup> November 2016



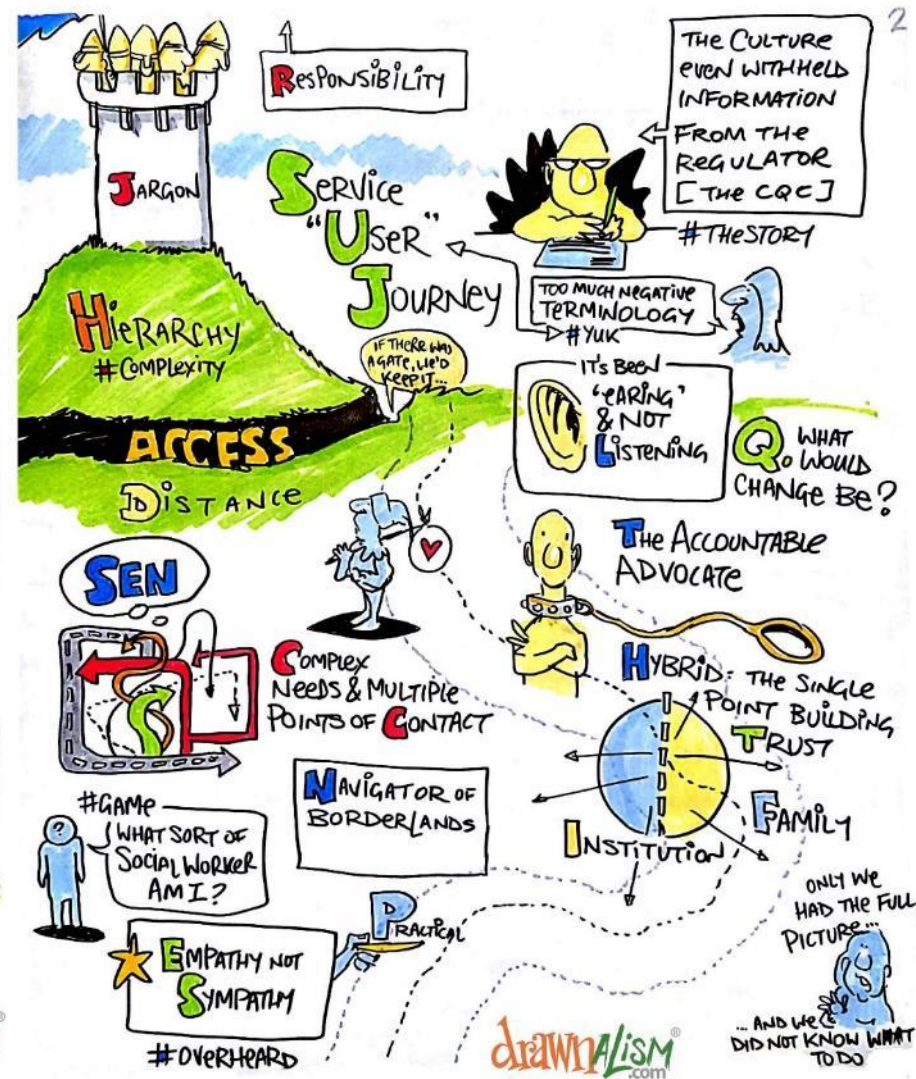
# Mental Health Service User, Carer, and Families Feedback

Weybrook Park Golf Club, Basingstoke, Friday 18<sup>th</sup> November 2016



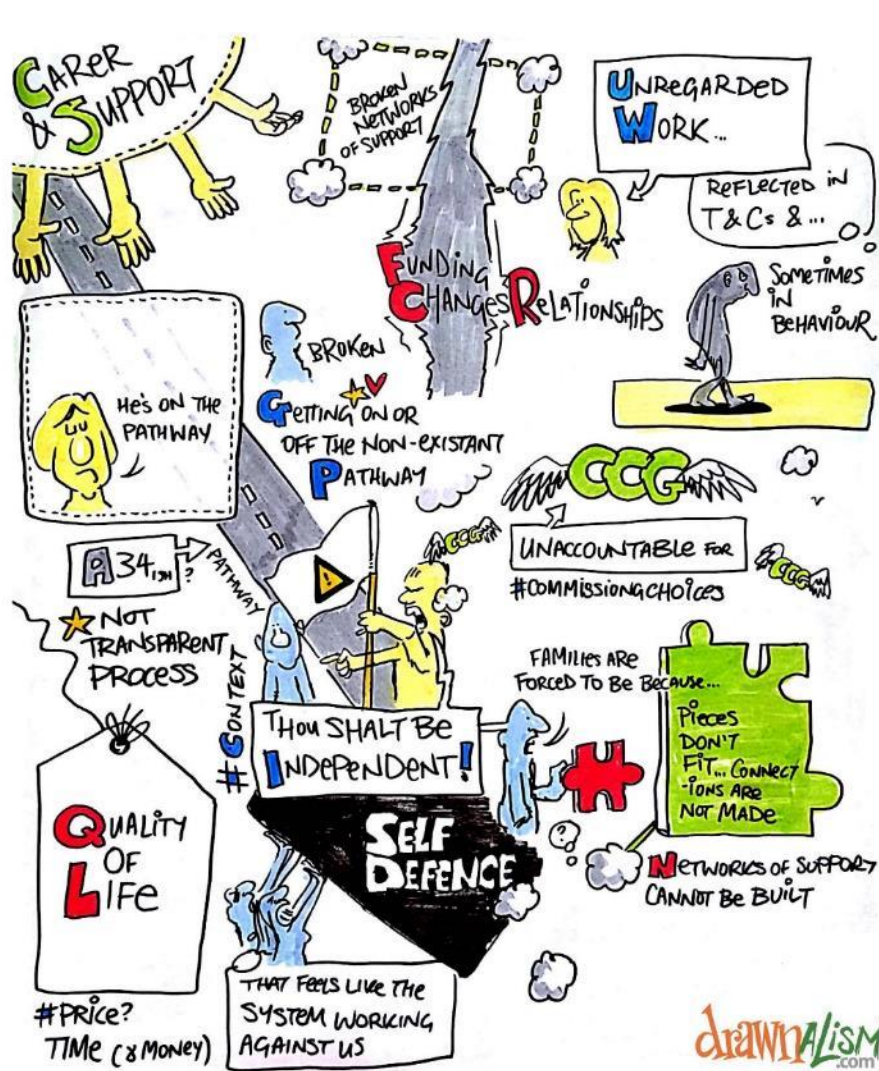
# Mental Health Service User, Carer, and Families Feedback

Great Western Park Community Centre, Didcot, Wednesday 23<sup>rd</sup> November 2016



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Great Western Park Community Centre, Didcot, Wednesday 23<sup>rd</sup> November 2016

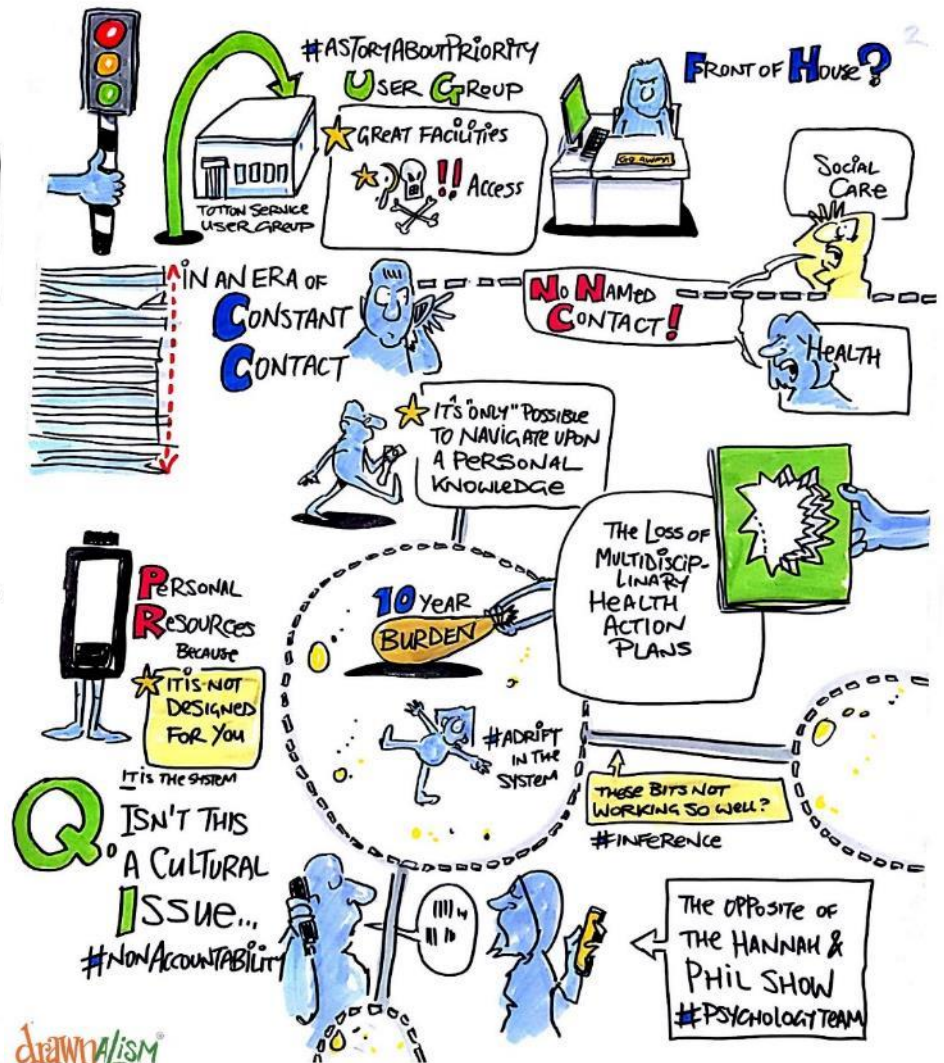
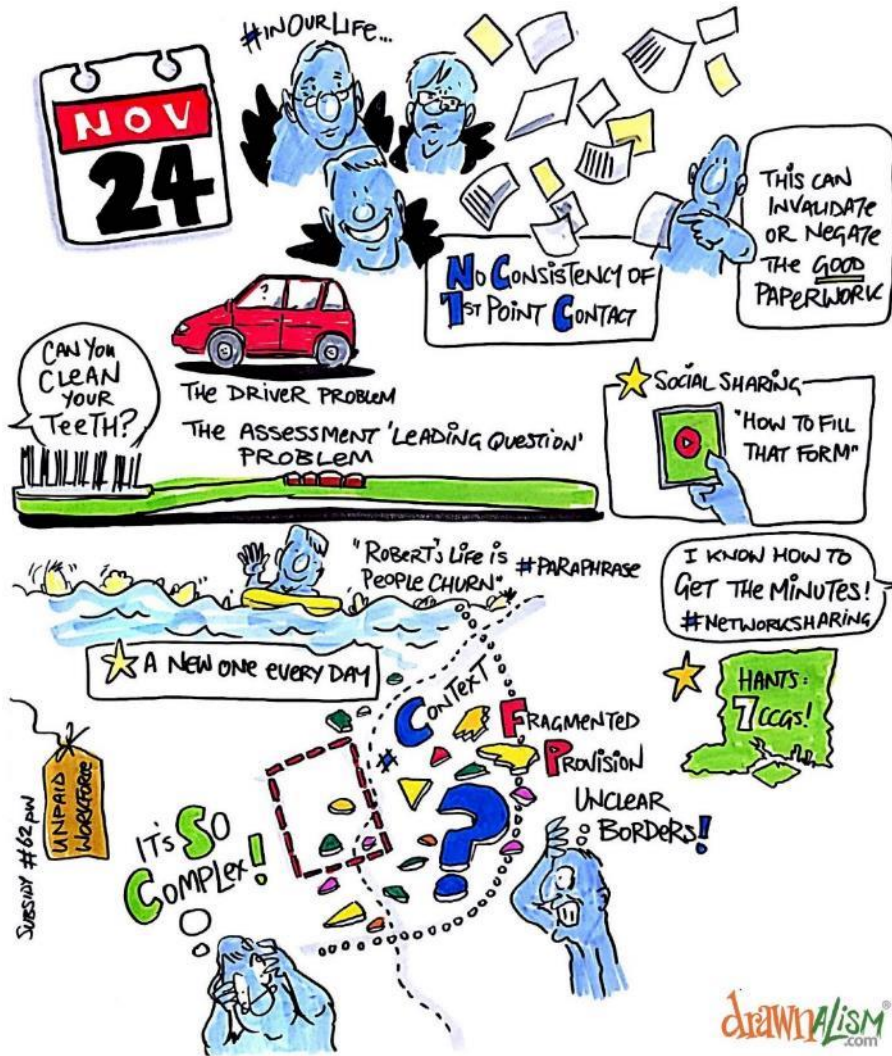


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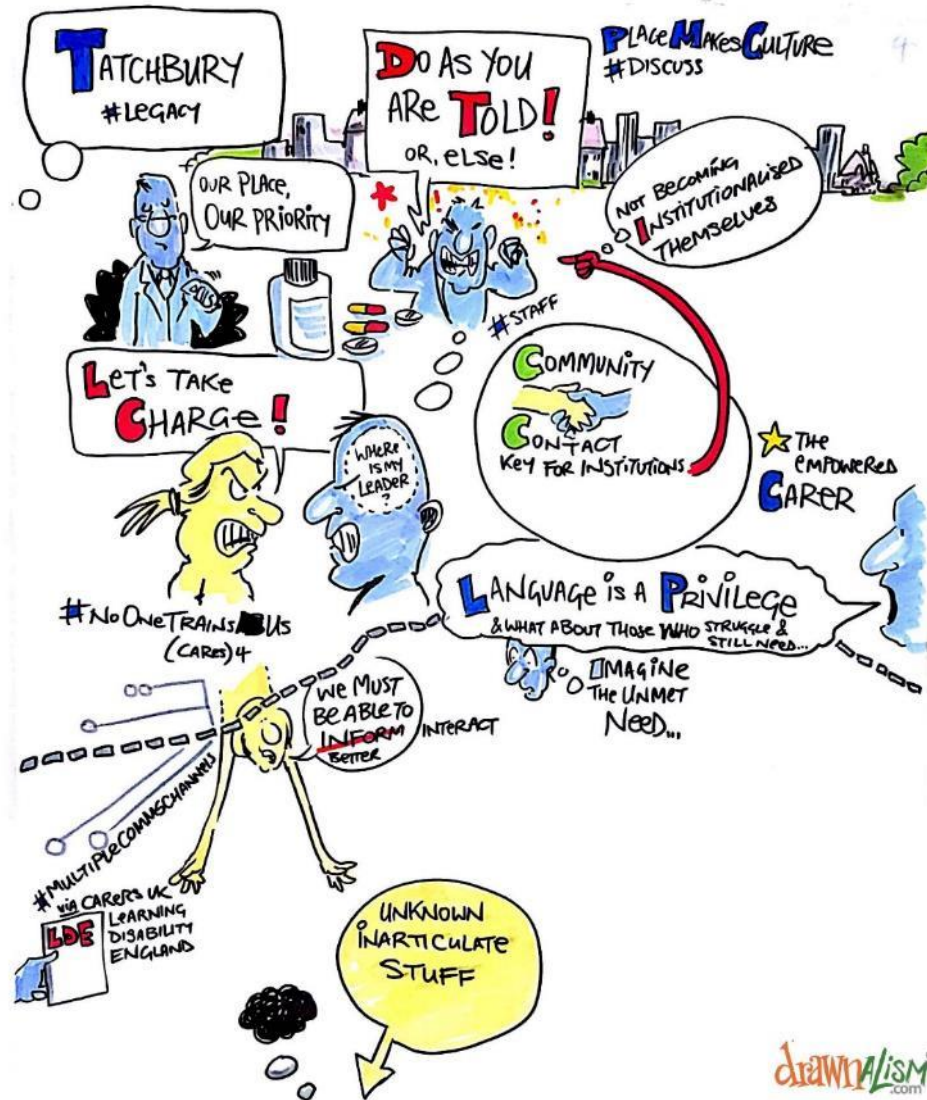
# Mental Health Service User, Carer, and Families Feedback

Shirley Freemantle Community Centre, Southampton, Thursday 24<sup>th</sup> November 2016



# Mental Health Service User, Carer, and Families Feedback

Shirley Freemantle Community Centre, Southampton, Thursday 24<sup>th</sup> November 2016





## **Appendix 2: Expert Reference Group**

## Expert Reference Group Membership

NAME	POSITION
Geraldine Strathdee	National Clinical Lead, Mental Health Intelligence Network PHE Specialist Adviser on Population Mental Health, Integrated Care and Prevention Hon. Consultant Psychiatrist, Oxleas NHSFT Visiting Professor, Integrated Mental Health Programme, UCL Partners Patron, Positive Practice Collaborative
Carole Kaplan	Clinical Lead for Clinical Services Programme Director Transformation Programme, Northumberland Tyne and Wear NHS Foundation Trust
Tim Kendall	Psychiatrist & Current National Clinical Director
Dominic Slowie	GP & NHSE Professional Advisor, Learning Disability
Julie Hankin	Nottingham Medical Director & Vanguard: MCP Former CQC National
Professor Paul French	Associate Director (Greater Manchester West NHS Mental Health Trust) Clinical Lead (Greater Manchester Lancashire and South Cumbria) Strategic Clinical Network Regional Clinical Lead (N.W. EIP, NHSE) North Honorary Professor Institute of Psychology Health and Society, (University of Liverpool)
Emma Tiffin	GP, East of England, Vanguard
Esther Cohen-Tovee	Lead IAPT Psychologist, NTW & Chair BPS Clinical Faculty
Mark Trewin	Bradford Integrated Care Service and Vanguard Service Manager Mental Health Principal Social Worker (Adult and Community Department, City of Bradford Metropolitan District Council)
Stephen Finn	Clinician & CEO expertise for Integrated Mental Health and Community Providers and Specialised Commissioning
Alan Worthington	User/Carer Representative, National Expert Advocate
David Fearnley	Medical Director (Mersey Care NHS Foundation Trust) Associate National Clinical Director for Secure Mental Health (NHS England) Chair of Adult Secure Clinical Reference Group (NHS England)
Rafik Hamalzia	Care Quality Commission, Committee Member at NICE, CEO at JTI, Expert by Experience Lead at Cygnet, NHS England
Professor Harold Pincus	USA Integrated Care Expert
Helen Wood	CEO, MHT and Primary Care Strategy Expert
Chris Nas	Dutch Outcomes Measurement Expert
Professor Pat McGorry	CYP Expert, Australia

# Expert Reference Group

## Terms of Reference

### **Key Responsibilities (Duties)**

The Expert Group will have an advisory role, with direct access to the Trust Board Chair and Chief Executive. The key role of the Expert Reference Group will be to:

- Provide advice to the clinical services strategy programme to ensure that the models developed are consistent with wider system thinking
- Review and test the emerging thinking and strategy, highlighting risks and issues requiring action.

This will be through a combination of proactive engagement to share insight and experience, and providing advice and views on the clinical service strategy in response to requests from the Programme.

### **Mode of Working**

It is not expected that the Expert Group will hold regular meetings, but will work virtually and through establishing a strong network co-ordinated by the Expert Group chair, with meetings convened as required.

Requests to the Expert Working Group will be co-ordinated through the Clinical Service Strategy Programme Management Office, with leadership provided the Programme Clinical Lead, Dr Carole Kaplan.

The Chair of the Expert Working Group, and other members may be invited to attend key forums through the course of the work.

### **Reporting Arrangements**

The Expert Reference Group will work in an advisory capacity to the Trust Board and Programme Steering Group. It will be overseen by the Southern Health Medical Director and the Clinical Services Strategy Clinical Lead.

### **Conduct of work**

Any meetings of the Expert Reference Group that are required will be supported with an agenda and papers distributed in advance of the meeting.

Requests for advice will be co-ordinated by the Clinical Services Strategy Clinical Lead, Dr Carole Kaplan who will agree the timeline for responses with the Expert Group Chair.

## **Appendix 3: Care Cluster Groups**

# Care Clustering

## (Mental Health Clustering Booklet, V5.0, 2016/17, NHS England)

### Introduction

The Mental Health currencies have been mandated for use since April 2012. For most provider and commissioning organisations completeness and accuracy of cluster allocations is now a key concern and a great deal of audit/assurance work is being undertaken. This manual is not intended to replace face-to-face training sessions, but to provide clinicians with all the information needed to accurately use the model.

### What is a Cluster?

In this context a cluster is a global description of a group of people with similar characteristics as identified from a holistic assessment and then rated using the Mental Health Clustering Tool (MHCT). The clusters allow for a degree of variation in the combination and severity of rated needs. However, as the clusters are statistically underpinned, definite patterns in the MHCT ratings exist for each of them. These ranges are indicated by the colour coded grids (Appendix 3) and are supplemented by the contextual information on the left hand side of each page, which is particularly useful when reviewing the appropriateness of previous cluster allocations.

### When should I cluster someone?

People's needs change over time, and over the course of their treatment. A payment system for mental healthcare must reflect the differing levels of input that are provided throughout changing and unpredictable episodes of care. In order to achieve this, it is essential that people are not only assessed and clustered at the point of referral, but also re-assessed and re-clustered periodically. In practice this will equate to assessing and clustering people at:

- The end of the initial assessment (typically within 2 contacts).
- All planned CPA or other formal care reviews.
- Any other point where a significant change in planned care is deemed necessary (e.g. unplanned reviews, urgent admissions etc.)

Organisations should ensure there is clarity about who is responsible for clustering, particularly when more than one professional is involved.

### How do I Cluster someone who is newly referred?

As organisations use different IT systems, the exact procedures will vary from provider to provider. However all providers will follow these basic steps:

**Step 1:** Based on the information you have gathered during your routine screening/assessment process, rate the individual's identified needs using the Mental Health Clustering Tool - Version 5.0 (Appendix 1).

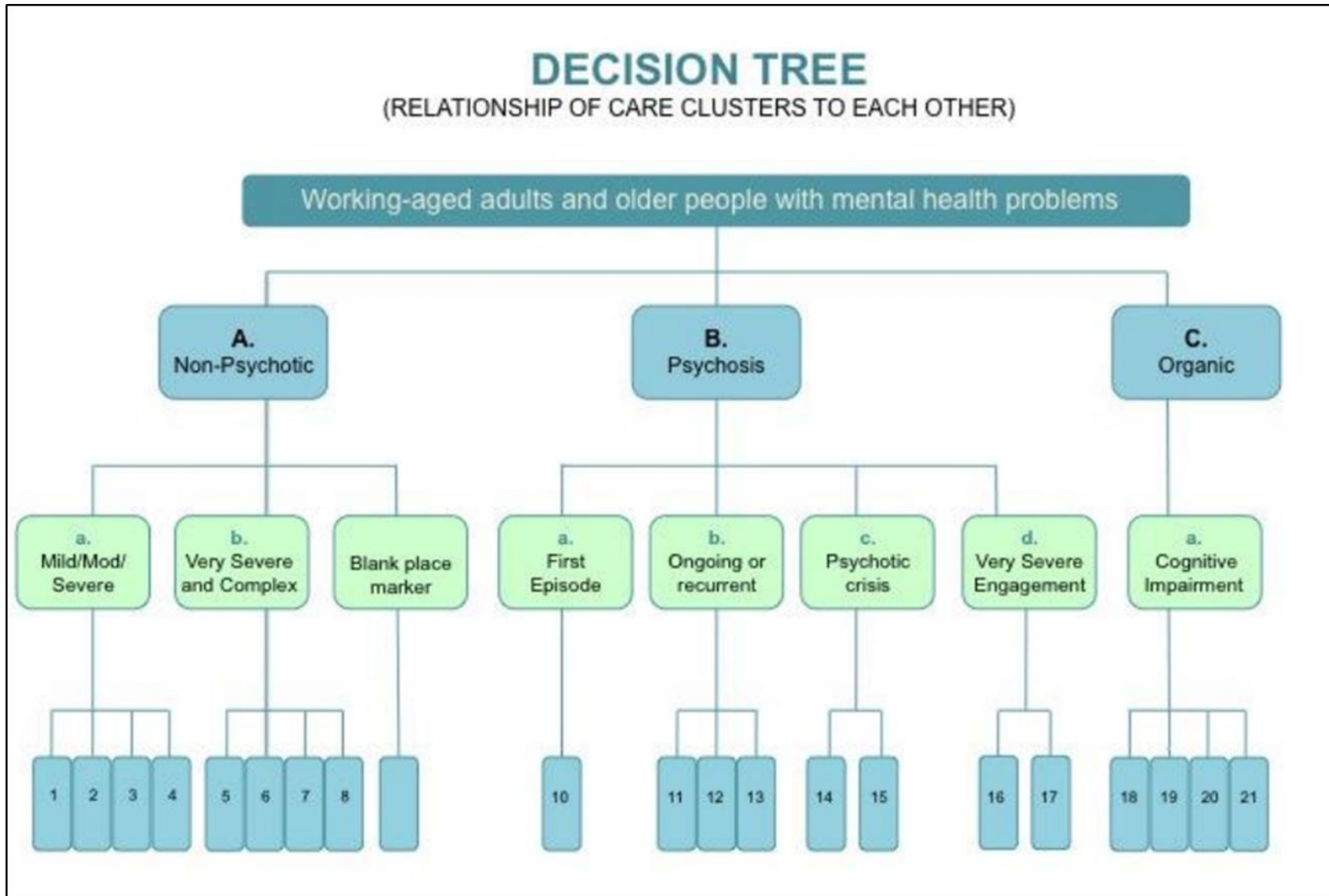
**Step 2:** Use the Decision Tree (Appendix 2) to decide if the presenting needs are non-psychotic, psychotic or organic in origin. Then decide which of the next level of headings is most accurate. This will have narrowed down the list of clusters that are likely to describe the person's needs.

**Step 3:** Look at the rating grids (Appendix 3) to decide which one is the most appropriate by using the colour-coded key.

- Start with the Red ratings. These indicate the type and level of need which must be apparent in order to be a member of this cluster. If the ratings do not match, try another cluster.
- Next, consider the Orange ratings. These represent expected ratings. You may allocate a person to a cluster if the orange ratings do not exactly match the coloured grids. However, this reflects a "weaker fit" to that cluster.

## Care Clustering

(Mental Health Clustering Booklet, V5.0, 2016/17, NHS England)



## **Appendix 4: NHS Benchmarking data**

### ***Inpatient and Community Mental Health Benchmarking, November 2016 (weighted data)***

## NHS Benchmarking data

This report summarises the main findings from the 2016 benchmarking process that has taken place across NHS mental health services.

**Southern Health NHS FT is named MH20 on the charts.**

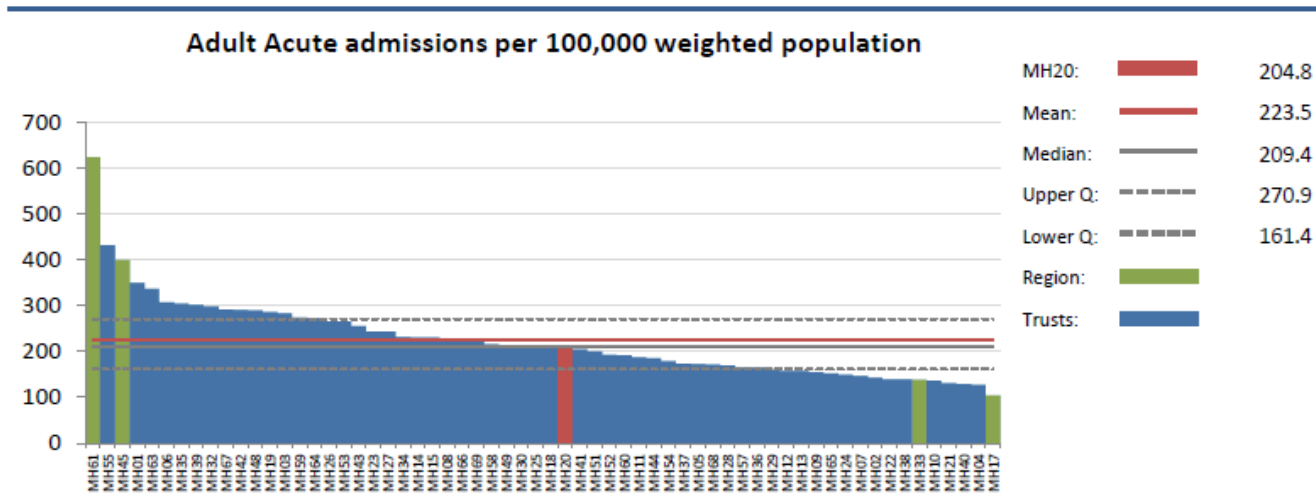
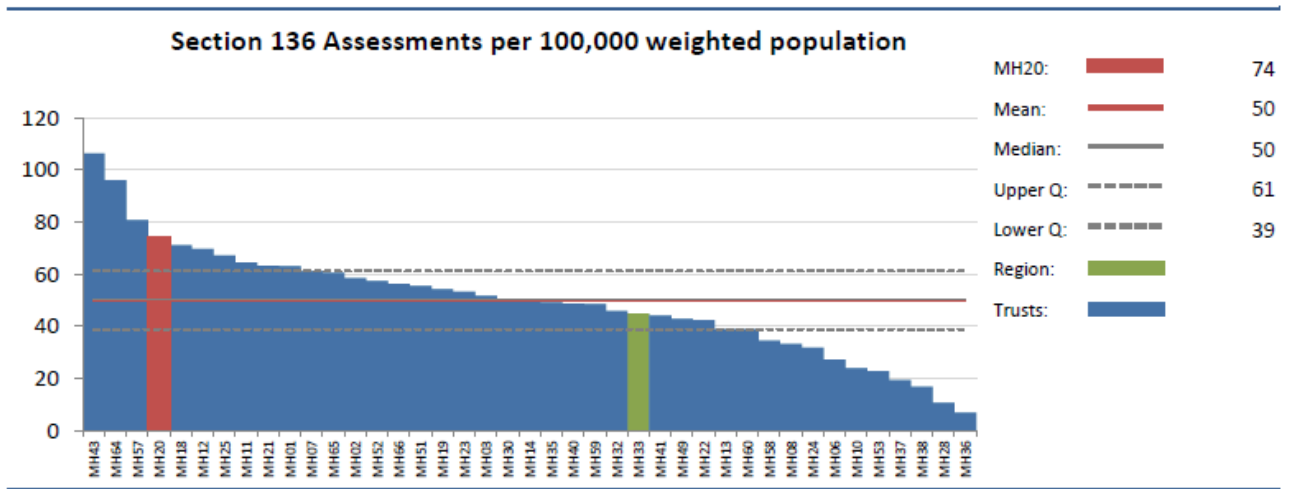
The charts on the following pages are a selection from a full pack of NHS Benchmarking Information that is available from the Trust.



Benchmarking Network

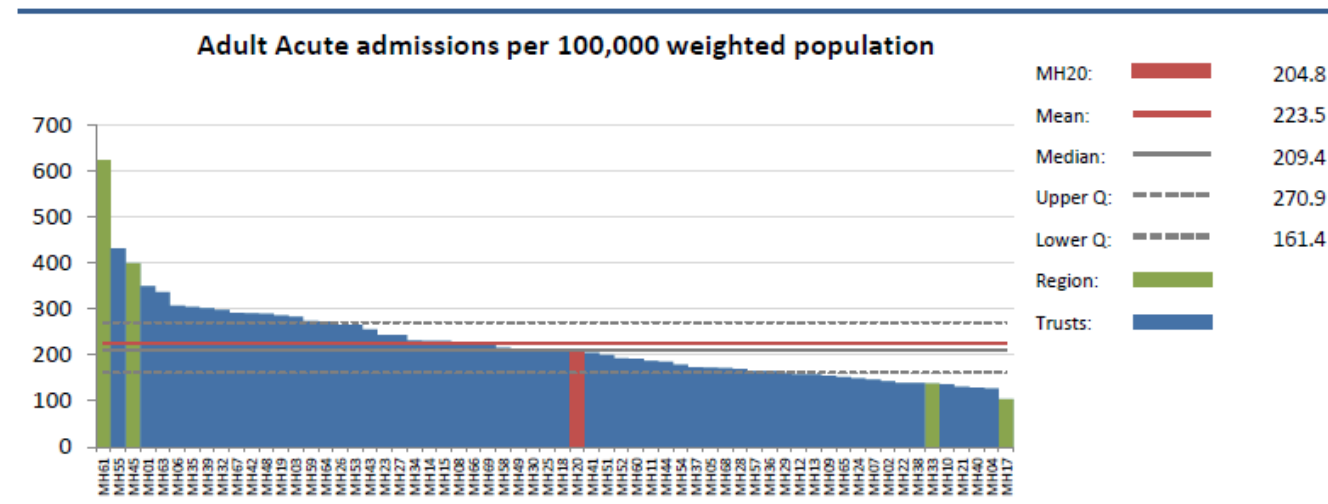
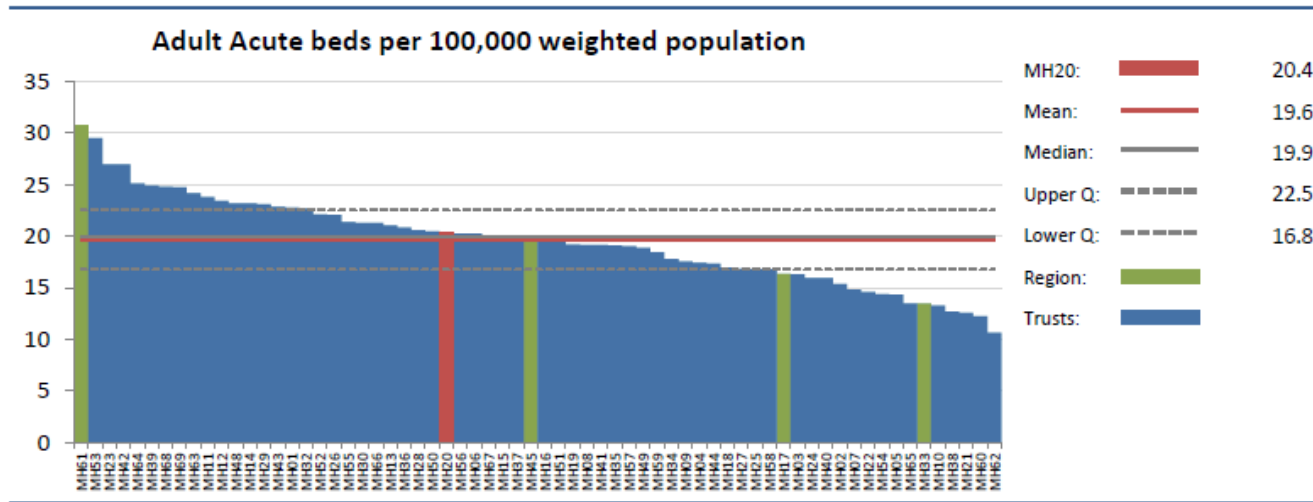


## NHS Benchmarking data: Section 136 and Acute admissions per 100,000 weighted population

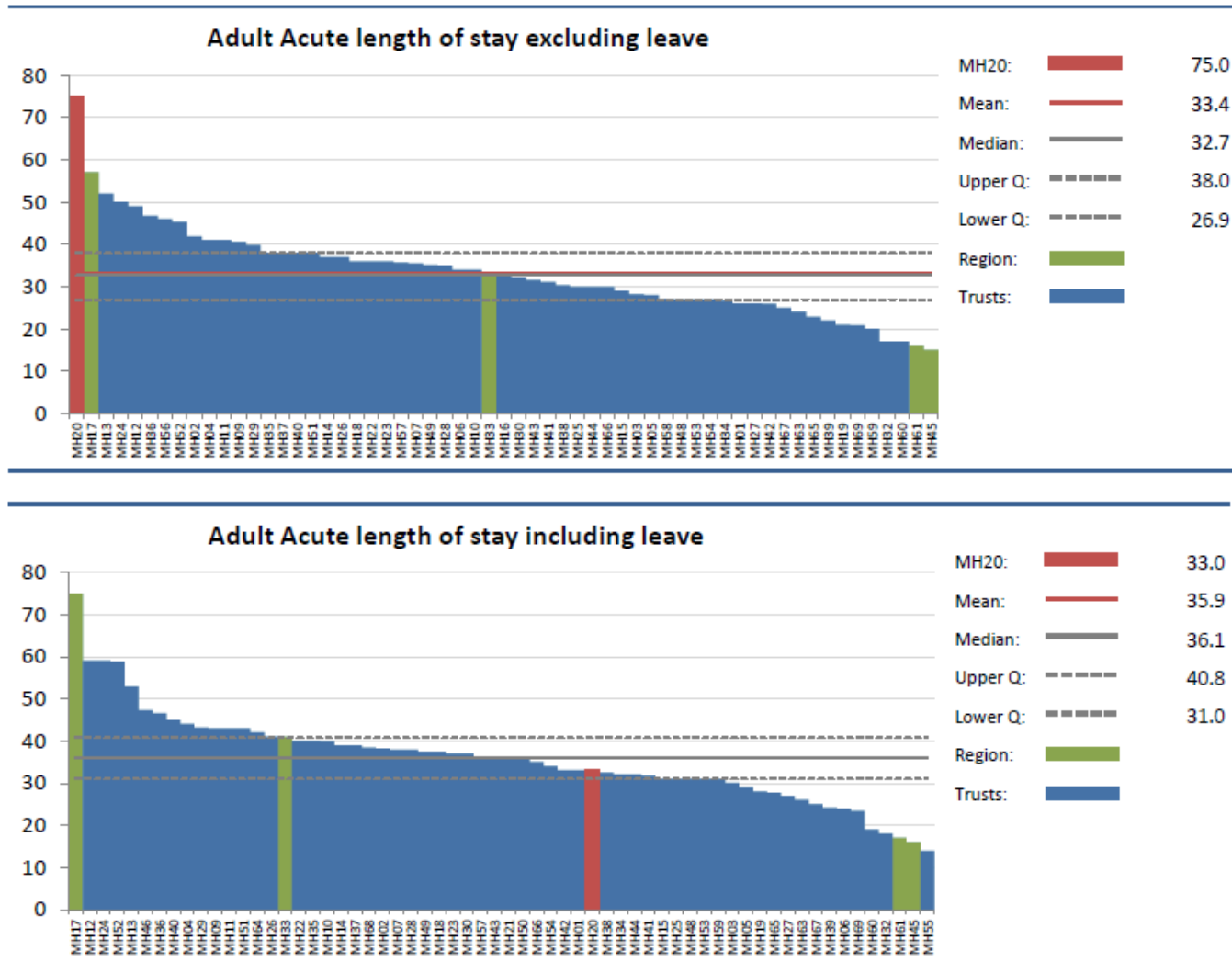


Source: NHS Benchmarking Data - NHS Benchmarking Network, Inpatient and Community Mental Health Benchmarking, November 2016

## NHS Benchmarking data: Adult beds/admissions per 100,000 weighted population

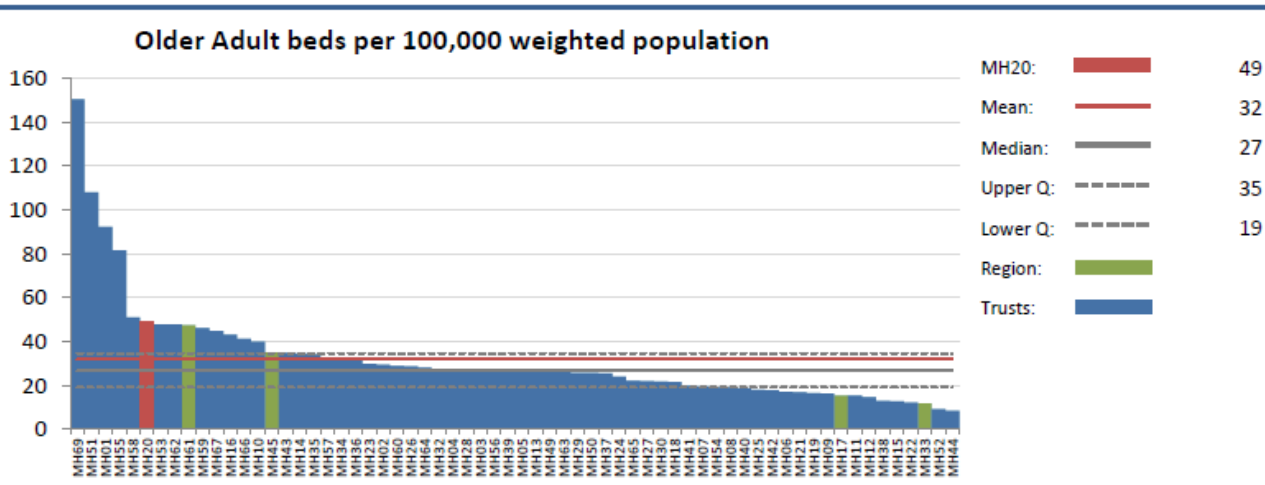
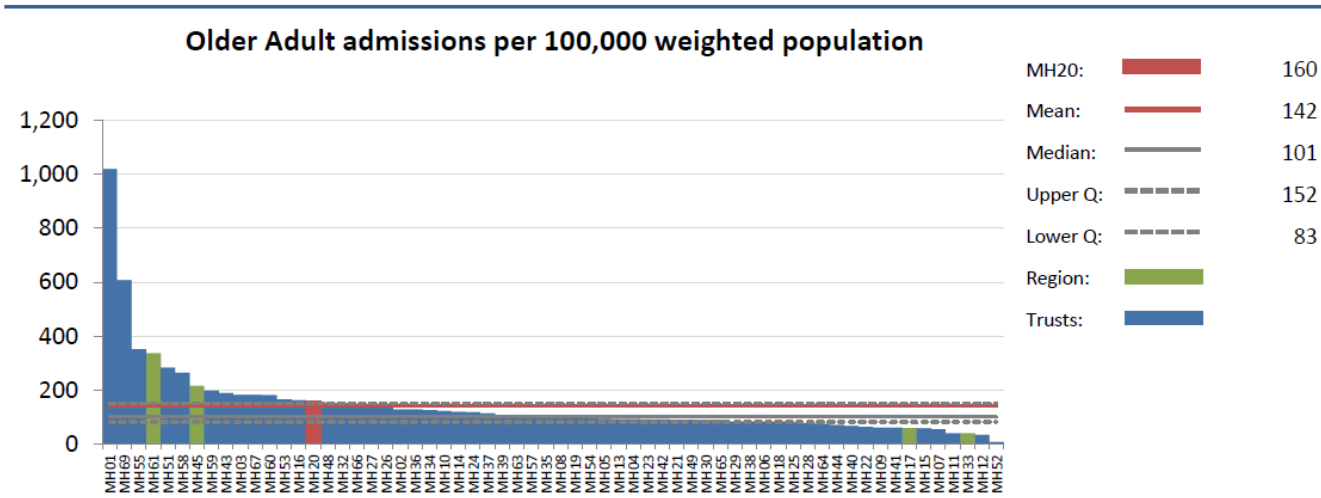


## NHS Benchmarking data: Adult Length of stay



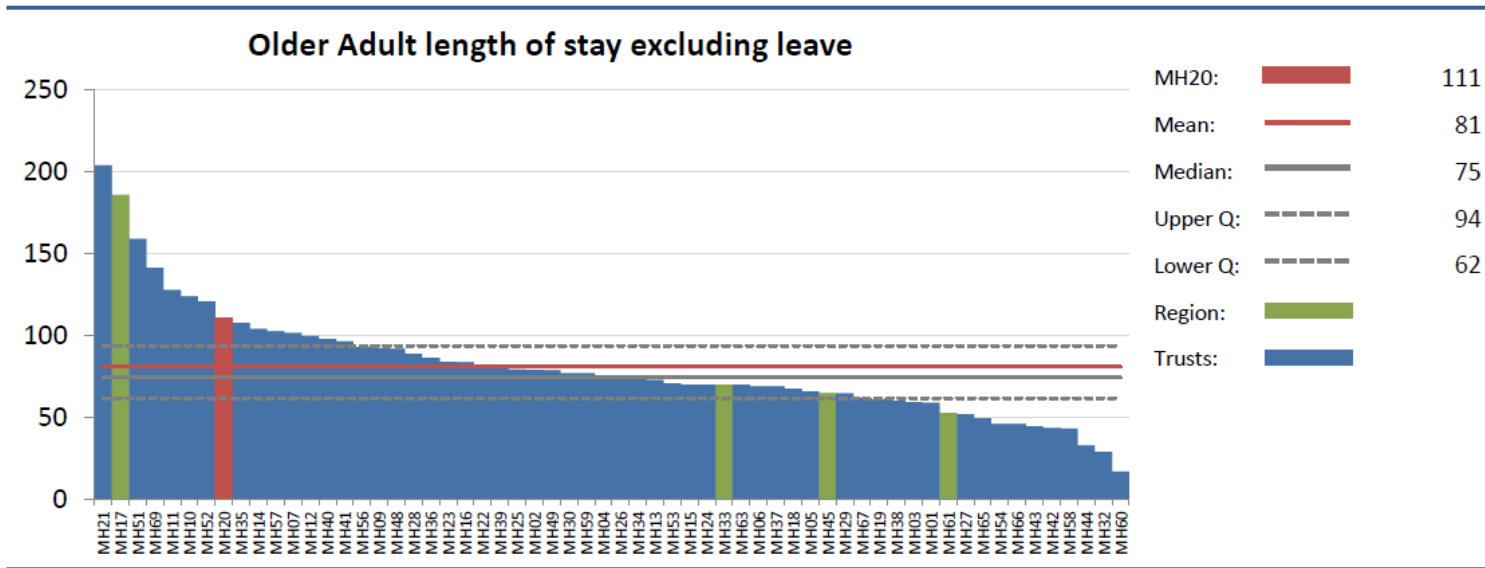
Source: NHS Benchmarking Data - NHS Benchmarking Network, Inpatient and Community Mental Health Benchmarking, November 2016

# NHS Benchmarking data: Older Adults beds and admissions per 100,000 weighted population



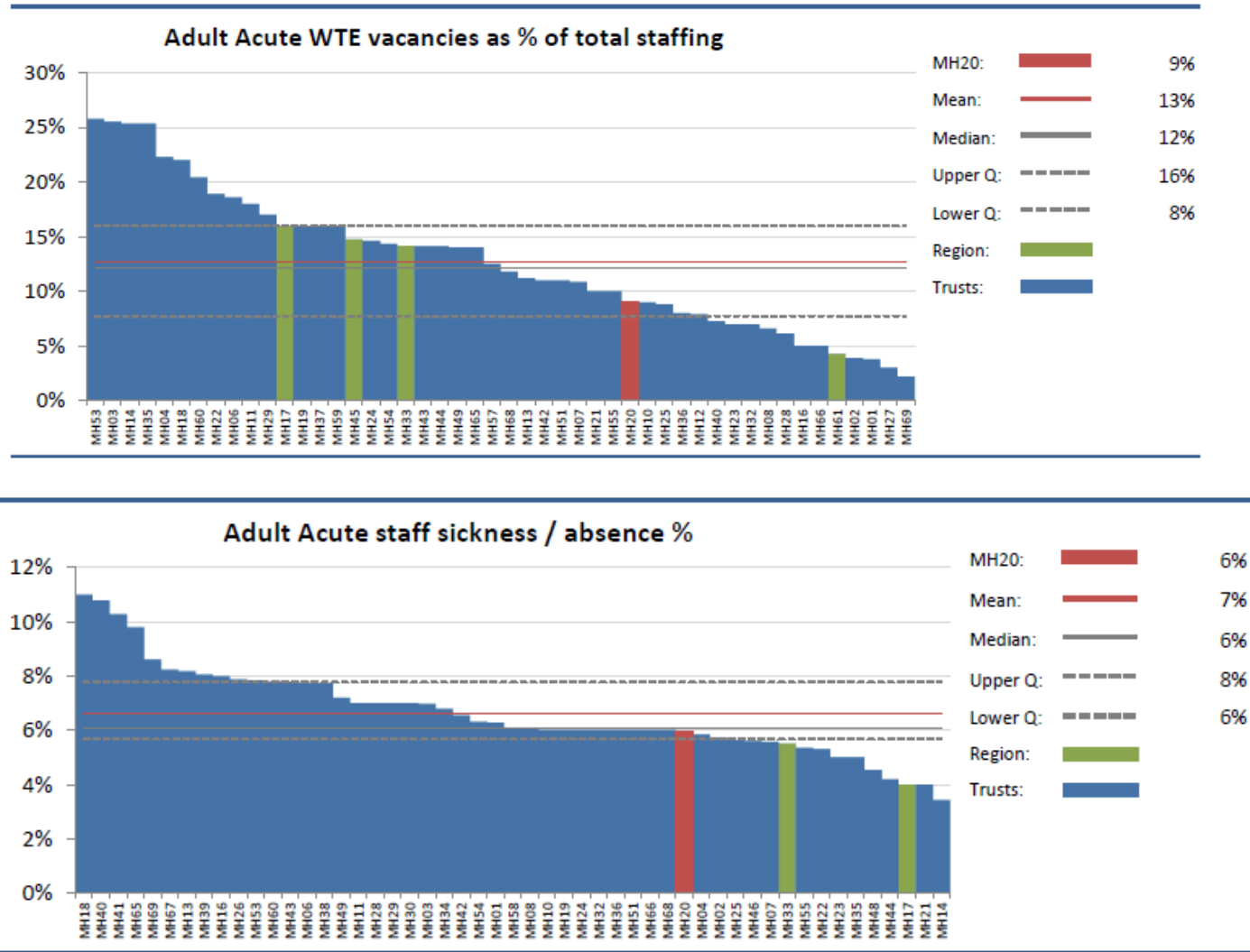
Source: NHS Benchmarking Data - NHS Benchmarking Network, Inpatient and Community Mental Health Benchmarking, November 2016

## NHS Benchmarking data: Older Adults Length of stay

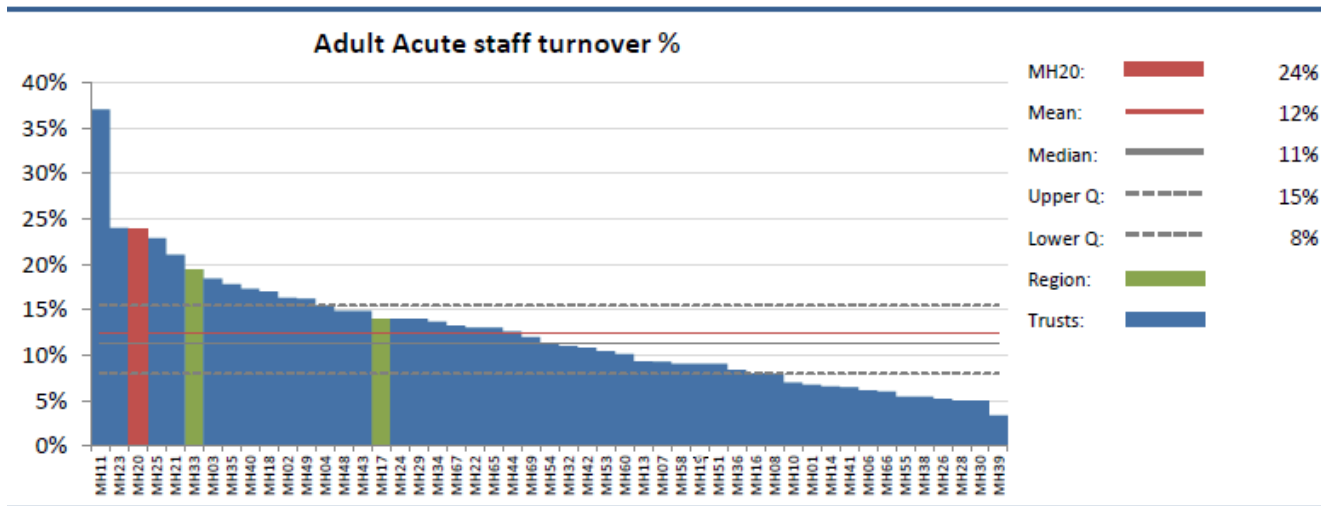


Source: NHS Benchmarking Data - NHS Benchmarking Network, Inpatient and Community Mental Health Benchmarking, November 2016

## NHS Benchmarking data: Workforce metrics



## NHS Benchmarking data: Workforce metrics



Source: NHS Benchmarking Data - NHS Benchmarking Network, Inpatient and Community Mental Health Benchmarking, November 2016

