Community Mental Health Review Update

1. Background

A paper proposing changes to the Lewisham Adult Mental Health Services was brought to the Healthier Communities Select Committee of 29th May 2013. The paper sets out a proposed restructure of the community mental health teams provided by South London and Maudsley NHS Foundation Trust (SLaM).

1.1 Main changes

The main changes proposed were:

- A move away from the current three locality structure to a four locality diagnosis specific structure, bringing the catchment areas for each team into line with the four primary care neighbourhoods. This will allow a better interface between primary and secondary care supporting the agenda to improve physical health care for people with mental health problems reducing the widely reported inequalities in this area. It will also allow better access to the community care funds and neighbourhood investment funds to people with mental health problems further reducing stigma and discrimination faced by this group.
- A restructured Assessment & Brief Treatment and Support & Recovery service (appendices 1&2). The three key areas of focus within the new model are:
    1. Relapse prevention;
    2. Improving the capacity and competency of assessment and crisis resolution services;
    3. To provide new pathways for people not requiring secondary services.
- An addition of staffing into the current Home Treatment Team to allow for the urgent assessment of people referred from GPs between 5-8pm and on Saturday mornings. This will mean people in crisis can be seen at home or in the GP surgery as they would be between 9-5 Monday to Friday, rather than requiring referral to Accident and Emergency for assessment.
- A borough wide multi-professional Early Intervention team co-located together in one team base, rather than the current model with team members spread across a number of different bases. This does not require additional staffing resources, but does require a move of services between buildings, to allow the staff base and clinical space required for this service.
- An increase to the borough wide Enhanced Recovery team who provide placements assessment, monitoring and support to people placed in specialist health placements outside of SLaM Services and in residential accommodation funded through the London Borough of Lewisham. This requires a move of 3 staff from current generic teams into this team to allow the team capacity to work with all those people who require the service.

1.2 Assumptions

The enhanced community support requires an investment in the teams, both in terms of an increased financial commitment of £1m from SLaM and also enhanced training for staff. Where ever possible health staff being released in one area will be redeployed into another area subject to the skills and experience being a good match to requirements. There are no current plans to change the staffing

establishments for Local Authority staff. All staff may be required to change where they are based and the team they are based in.

The revised model as stated above focuses on relapse prevention and so a reduction in the reliance on bed based services. It should be noted that it is not anticipated that any change in the use of beds will be seen in the first 18 months as service users will require support using the increased interventions to be provided before their relapses reduce.

1.3 Future bed requirements

There are two separate strands of work in progress in relation to future bed use:

i. Improvement of the communal entrance area and garden at the Ladywell Unit to improve safety and security for all using the building. Also redecoration of the wards to improve the physical environment. This work should keep the building fit for purpose for the next 5 years
ii. A four borough Commissioners review of bed use across all SLaM boroughs. It is noted that any changes to commissioning of beds for people with mental health problems in the borough would need to be fully considered by this committee prior to agreement.

The meeting noted the report of the changes and that there would be a formal stakeholder engagement process. This update provides further detail of the formal stakeholder engagement process and seeks agree the next steps.

2. Formal stakeholder engagement

The Healthier Communities Select Committee of 29th May 2013 noted the review had been carried out with consultation with the GPs and the CCG. It noted there would be a formal stakeholder engagement process. Engagement work is focusing people who currently use the service and their family members and on staff working within the service and interface services such as General Practice.

2.1 Engagement events undertaken

Since that meeting 7 engagement events have been arranged for service users and carers (appendix 3). An engagement event for staff was held on 16th September.

2.2 Future events

- A borough wide stakeholder event for all Lewisham primary & secondary care staff and residents of the Borough has been scheduled for 19th November.
- Monthly meetings between the CCG & SLaM will continue focusing on the role out of the changes. These will ensure good communication between primary and secondary care and allow for planning of individual service users moves within the teams.
- Service User and Carer representation will be sought for the workstream meetings around the development and roll out of the clinical and operational models
- Staff representation will be sought for the workstream meetings around the development and roll out of the clinical and operational models
- Service User and carer representation will be sought for interview processes

- Individual meetings with Service users and carers will be held with their care co-ordinators to ensure people are clear about the impact of changes on them
- The implementation plan would include individual meetings with each service user and where appropriate their carer to ensure they have a clear and planned transfer between services.
- A further series of service user & carer and staff briefing events will be set up to support engagement
- Newsletters and web based information will be available on each step of the changes

3. Staff consultation

It is proposed that formal consultation with staff within the service commences on the changes to the service from 1st December. The consultation would run for 1 month and include a presentation on the service changes set out in appendices 1&2. It would also include formal meetings with staff and staff side representatives for all staff affected by the changes. Written feedback will be provided to all questions raised at the end of the 1 month period. This process would be in line with SLaM Human Resources policy and allow changes to the service to be implemented from 1st April 2014.

4. Benefits of the change

The proposed change will allow:

- Access to a greater range of services, including a wide range of talking therapies
- Urgent out of hours (Mon-Friday 8-8 and Saturday morning) assessments in primary care.
- Smaller caseloads per care co-ordinator
- More joined up working between primary and secondary care, improving communication and the availability for physical health care assessments and treatments for people with mental health problems
- Support for people to move back to primary care, once stable and considered low risk of relapse
- Support and training for primary care services in the care and treatment of people with serious mental illness
- A formal research evaluation to demonstrate the effectiveness of the model before further changes are suggested

Because the changes will provide an enhanced service it is suggested a longer engagement and consultation process would delay the improvements to the service and benefits to those who use them.

Appendix 1

Assessment and Brief Treatment (ABT) teams

Current Structure

The Lewisham ABT teams are three small teams split across three sectors. They do time limited work and any service user that needs an allocated worker will be referred into the Support and Recovery service. This model of ABT working differs significantly from that now provided by equivalent services in the other boroughs served by SLAM, as the relatively small level of staffing in the ABT teams does not allow them to provide longer term or specialised treatment for non-psychotic conditions such as depression, anxiety disorders, traumatic stress disorder or personality disorder (to those cases requiring a level of input which cannot be provided by the recently formed Lewisham Integrated Psychological Therapies Service (IPTT), which also provides talking therapy treatments for these conditions).
The benefits of the condition specific care pathways being delivered in other boroughs to patients with these conditions cannot be offered in Lewisham, and the positive aspects of SLaM's reconfiguration into Clinical Academic Groups cannot be fully realised.

Each of the three current sectors relates to a defined group of GP practices but the three sectors do not map onto the four GP neighbourhoods. Thus currently each of teams in the three sectors must develop its own working relationships with the practices in its area, without being able to take advantage of the networks and opportunities for face to face contact available at neighbourhood level.

The current Home Treatment Team can be described as providing a medical and psychosocial service focussing on being a substitute for hospital admission for people in crisis and on facilitating early discharge from hospital. The team also provides a service to those patients who are being initiated on medications in the community and in those cases can visit as many as four times a day to monitor the effects and side-effects. They work along side the community teams delivering high intensity interventions, visiting where necessary several times per day to service users in crisis and who are becoming unwell who would otherwise need admission, as well as support to their carers.

Proposed Restructure

The initial referral for a mental health assessment is arguably the most important part of the system to get right. This is in terms of an individual, along with their family wanting a better experience, the referrer wanting a more responsive service with better communication, Services needing to gatekeep the resources available and commissioner wanting quality outcomes that are value for money.

Enhancing the 'front-end' assessment function by redesigning the assessment and home treatment services to work more closely together will make it easier and quicker for GPs (and others) to refer patients into the system, strengthen the trust's ability to

manage demand for services and ensure that patients are directed to the most appropriate mental health service to meet their needs.
It is also important that once a person is assessed as needing a secondary mental health service for Mood, Anxiety or Personality Disorders they receive an effective evidenced based treatment. The assessment services have always been good at engaging people and stabilising their distress, however up until now evidence based treatments in community teams have been mainly for people with psychotic illnesses.

The Home Treatment Team (HTT) in Lewisham has concentrated on gatekeeping in-patient beds by providing an alternative to admission and facilitating speedy discharge from hospital. Enhancing the services will allow the HTT but become a much more integrated part of the range of responses available to primary care for urgent same-day assessments and early support to people who are showing signs of becoming unwell.

Enhancing the assessment, treatment and HTT services will improve the experience, manage the demand and deliver evidenced based treatments and interventions. Key features would include:

- Improved access to mental health assessments for primary care referrals including extended/out of hours services linking to practice opening times
- Improved patient experience by working closely with service user advisory groups to design and develop better services with a more skilled workforce
- Closer working between the Assessment team and the Home Treatment Team to provide a single seamless front facing service will allow more people to remain in primary care, gatekeeping entry into secondary mental health services.
- Improving the quality of the assessment by reviewing the skill mix of the assessment teams. The most experienced staff would be deployed in the assessment and triage function to formulate best treatment approach and ensure patients are seen in the most appropriate setting for their needs.
- Delivering talking therapies that adhere to NICE guidance and are outcome focused and evidence based to people with serious non-psychotic mental health problems such as treatment resistant depression significant trauma and personality disorders.
- Working closely with the Local Authorities to provide a stronger re-ablement function to facilitate, where appropriate, the management of those patients with social care needs in primary care.

Outcomes

The outcomes expected from the redesign of these services will be as follows and an evaluation framework will be developed in partnership with the Mood, Anxiety Disorder and Personality Disorder service user advisory group to monitor the progress:

- A reduction in the number of people entering secondary mental health services
- A reduction in the number of people with non-psychotic presentations using in-patient beds

- A better experience for people using assessment and treatment services
- A better experience for GPs and primary care teams
- Efficient and effective working with reablement services

The Services

The current assessment and brief treatment teams need to become more expert in assessment, formulation and planning and there also needs to be specialist treatment services delivering evidence based treatment to people with non-psychotic conditions who have complex health and social care needs. Alongside this will be the new MIND service providing reablement as well as a Service User Network.

Assessment Service
Pre-consultation meetings with service users, carers and GPs have identified the need to provide more intensive support to people in primary care as well as developing appropriate training packages and developing better ways of providing advice and consultation.

The enhanced assessment service will consist of:

- Consultant psychiatrist,
- Consultant nurses with specific skills in assessment and psychological treatments, Psychologists
- Social workers
- Administrator

This restructure will provide more senior health roles. The service will consist of four sub teams that map onto the four neighbourhood health networks in the borough. The Home Treatment Team will support the service to provide same day assessment for people needing to be seen urgently out of hours.

The key elements to the service will be:

- Assessment
- Formulation
- Planning
- Medication
- Short term stabilisation and engagement
- Behavioural activation
- Access to talking therapies services
- Reablement
- Safeguarding

Home Treatment Service
The Home Treatment Team will provide an improved crisis response along-side the assessment service to primary care and also prevent hospital admission through provision of intensive non hospital based care for those who are relapsing or at risk of relapse, by intervening at an earlier stage through improved in-reach and earlier co-working with other teams at an earlier point. It is proposed to recruit extra staff to ensure the delivery of a responsive service to both primary and secondary care need.

The new model will differ from current operations in being required to deliver, in partnership with the assessment service, a front end service to GPs and in providing increased activity associated with gate keeping and bed substitution, which will be central to reducing the numbers of in-patient beds required. This function will require very close working arrangements with providing outreach to treatment teams engaging service users at the right point before they become too unwell to be home treated.

Home treatment will continue to work closely with the bed co-ordination system to help support in-patients back into the community and to provide home support solutions to reduce the incidence of delayed discharges.

Mood, Anxiety and Personality Disorder Treatment Service

The new treatment services will provide evidence based talking therapies alongside key working and dual diagnosis working within a multidisciplinary community team for people with complex presentations. The treatment service will also oversee a Service User Network providing on-going structured, supervised support in the community.

The treatment services will provide to all of elements of the assessment service but combined with targeted therapeutic interventions either provided within the teams or with co-working across the talking therapies services. The key elements to the service will be:

- Assessment
- Formulation
- Planning
- Medication
- Long term stabilisation and engagement
- Behavioural activation
- Access to talking therapies with key worker
- Therapy by key worker
- Psycho-education
- Dual diagnosis support
- Reablement
- Personal Budgets
- Safeguarding

It is proposed to develop a number of pathways for:

- depression and bipolar disorder
- anxiety, trauma, post traumatic stress disorder (PTSD) and hoarding
- personality disorders

Of these three main pathways roughly:

- 50% have a depressive / bi-polar disorder
- 25% have an anxiety disorder
- 25% have a personality disorder

The structure will have ‘hub’ specialists providing therapy and key working and will also provide clinical supervision and training to less experienced ‘spoke’ key workers in the community teams. The teams will provide mental health act assessments, carer’s assessment and retain the safeguarding role as well as be able to liaise effectively with local authority personalisation services.

Training and Supervision

Training and supervision of staff will take place in house.

Team and Caseload size:

The new assessment teams will not carry a traditional caseload, the emphasis will be on assessment and planning. Based on the current level of referrals the clinical team will be working with up to 20 service users at any one time and will need to assess and discharge or transfer 3 to 4 people per week.

The new treatment team will work with caseloads of up to 25 people per wte staff member with specialist workers in a range of evidence based talking therapies carrying smaller case of up to 12 people whilst also providing supervision to key workers. Based on treatment caseloads in other boroughs it is anticipated that there will be 14 wte equivalent staff key working with approximately 300 people.

The enhanced home treatment teams will need an extra 5 wte staff to provide out of hours cover to primary care as well providing home treatment to an additional 100 patients per year.

The Service User Network project will need 3 wte staff to contribute to the Trust wide offer of peer led support.

Appendix 2

Psychosis Recovery Services

Current Structure

The current Recovery and Support Teams are split across three sectors and work with a people with a range of diagnoses who require long term support, care co-ordination and treatment. This model is significantly different from that now provided within the other boroughs service by SLaM and they do not benefit from the condition specific care pathways provided elsewhere.

Each of the current teams relate to a defined geographical area, in line with the current assessment and brief treatment teams, however these localities do not match the four GP neighbourhoods that have been developed across Lewisham.

Proposed Restructure.

Psychosis is a Long Term Condition which may have a relapsing and remitting course. There is some evidence that using specific early warning sign focussed interventions leads to a significant reduction in the number of people who relapse compared with usual care, although the *time* to relapse does not differ between these two groups. Similarly the risk of rehospitalisation is significantly lower with early warning sign interventions compared with usual care although the *time* to rehospitalisation does not differ between these two groups (Training to Recognise the Early Signs of Recurrence in Schizophrenia, Cochrane Review 2013).

At the moment Service Users with a diagnosis of psychosis in Lewisham fall into four groups:

1. No admissions in past 3 years (55%)
2. One admission in past 3 years (23%)
3. Two admissions in past 3 years (12%)
4. Three or more admissions in the past 3 years (11%)

For Service Users who relapse there are a range of interventions set out within NICE guidelines, research and best practice reports to treat and prevent relapse. The intention within the new model would be to develop the range and volume of interventions available and to provide them earlier, so reducing both the number and severity of relapses. The interventions include:

- Antipsychotic medication
- CBT for Psychosis
- Family Interventions
- Vocational interventions

There are also a range of activities that support people in their lives by ensuring that they are able to manage and maintain their activities of daily living and achieve their recovery goals, these include:

- Assessment of need and eligibility for services and development of recovery and support plans to meet identified needs
- Assessment, procurement and monitoring of funded support packages
- Assessment of risk and implementation of plans to minimise their impact
- Child and adult safeguarding assessments and formulation and delivery of care plans in relation to identified risks
- Education and support in relation to lifestyle, for example, the impact of drug use on psychosis, this includes motivation interviewing
- Interventions and education which promote medication concordance
- Administration of medication including depot injections and blood monitoring
- Physical health checks
- Monitoring for early warning signs of relapse and putting actions in place to reduce risk of major relapse at this point (this may include review and alteration to medication regimes, increased contact for people who are socially isolated, daily supervised medication or assessment and introduction of a specific personalised support package).

At times people will also require more intensive interventions involving up to twice daily visits for a period of time provided within the Home Treatment Team. A proportion of Service Users are admitted to in-patient care.

Current staffing resources (both in terms of numbers and qualification/experience) limit the range, number and frequency of the interventions that can be undertaken, this leads to a focus on crisis management rather than proactive early intervention and hence impact on the availability to reduce the number and severity of relapses.

The proposal is to enhance the staff resources (both numbers and skills) and operate with smaller caseloads such that care co-ordinators are more proactive, able to deliver more interventions more frequently, and better able to direct the focus of activity promptly to those in greatest risk of relapse.

Current care co-ordinator caseloads are high so people in crisis may receive increased visits at the expense of those who are at less risk of relapse at that time. The teams also have limited access to medication advice, review and changes to medication regimes. There is also limited availability of Cognitive Behavioural Therapy (CBT) for Psychosis and Family Interventions, so not all people who would benefit are able to receive them. Vocational input to teams is minimal which means either assessments of need or interventions, or both, are missing.

The Promoting Recovery teams would have systems in place to allow the Care Co-ordinators to focus on non-crisis work for set times in the week and other times when they actively manage patients in crisis or showing early signs of relapse. The Care Coordinators need to have comprehensive assessments and formulations of their patients' needs with a resultant plan to address them. This is likely to involve a combination of interventions including medication, psychology and vocational interventions as well as looking at social care needs and liaison with other services. Crisis work slots will involve more working across the team so the Service Users are held by the team as well as having input from the Care Co-ordinators. This will include

a small group of Service Users in each team receiving daily supervised medication either through their attendance at the team base or via daily visits.

The team will consist of:
Consultant Psychiatrist
Team Leader
Psychologist
Occupational Therapist
Social Worker
Nursing staff
Administrators

Care co-ordinators will come from a range of disciplines and will have a caseload of no more than 20 per WTE staff member

Overall the Promoting Recovery teams will aim to move the Service Users ‘up a group’ so that people in group 4 would move to group 3, group 3 to 2, 2 to 1 and group 1 will be in primary care.

Low Intensity Treatment Team (LITT)

A new service (Low Intensity Treatment Team, LITT) will be developed to support people who are stable and at low risk of relapse having had no admissions in the last 3 years to prepare for discharge to primary care. The team will provide:

- A medication service
- An assessment and implementation of support of packages that help support the Service User to remain well
- A service to provide support and advice to primary care to enable them to take back responsibility for on-going care and treatment where appropriate

50% of current Service Users fall into the cohort of people who are stable and at low risk of relapse. Of this group 40% cannot be discharged because of the complexity of their medications, 40% have on going social care needs that require them to remain within services with the current model of provision and 20% (10% of total caseload) can be supported through the LiTT team back into primary care.

Training and supervision

Training and supervision of staff will take place through a combination of in house training and through courses commissioned from local provider universities. Low Intensity Psychological Interventions training and medication management training will be provided via King’s College and supervision will be provided in house to maintain and further enhance skills within each team.

Appendix 3

Service user/carer engagement meetings Sept & Oct 2013.

Meeting	Date	Time	Venue Details
Lewisham Users Forum (LUF)	Tues 17th Sept.	SLaM slot will be: 3.15 until 3.45	Salvation Army Hall Albion Way Lewisham SE13
LUF 'Hear Us' Event	Tues 24th Sept	12.00 – 3.00 SLaM slot 12.15-12.45	Civic Suite 1 Catford Road Catford SE6 4RU Tel: 020 8314 7000
Speedwell CMHT service users	Mon 30th Sept	2 - 4.30	Compass Centre 32/34 Watson Street Deptford SE8 4AU Tel: 020 8694 6519
Carers	Mon 30th Sept.	5.00 – 7.30	Carers Lewisham Waldram Place, Forest Hill SE23 2LB Tel: 0208 699 8686
Family Health Isis Members – social gathering	Weds 2nd Oct	To attend the social gathering 2 – 4 pm	The Lee Centre 1 Aislibie Road Lee SE12 8QH
Lewisham Joint Consultation Partnership Board	Thurs 3rd Oct	1 – 4	Ladywell Unit.
Southbrook Road & Northover CMHT service users	Fri 4th October	2 - 5	Civic Suite 1 Catford Road Catford SE6 4RU Tel: 020 8314 7000