Coventry and Warwickshire Partnership NHS

NHS Trust

Report to: **Coventry Health and Social Care Scrutiny Board (5)**
Date: **14th September 2016**
Subject: **Adult Mental Health Services**

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1. Purpose of Report

The report is to provide Scrutiny members with an update on key activity challenges in respect Adult Mental Health Services in Coventry. The report also identifies current actions that the mental health leadership team have planned or put in place to provide greater assurances on the clinical pathway from referral to intervention.

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2. Background

2.1 In common with most other mental health services Coventry Adult Mental Health services remain under pressure. The community teams deliver over 2500 patient contacts per week and the average active caseloads amount to an average of 3000 a week and we discharge 150 clients back to primary care or community a week. To give members some idea of the increase in referral numbers we received 1983 referrals in April 2015 and 2283 referrals in April 2016 to an increase of approximately 15%.

2.2 We reviewed our adult mental health pathway and established our Integrated Practice Units (IPUs) in June 2014. Between 9am and 5pm Monday to Friday all external referrals for mental health come through our Central Booking Service (CBS) and then are clinically triaged. Out of hours all of our referrals come through our crisis teams.

2.3 Domestic Violence notifications also come through CBS which need to be clinically triaged and managed effectively. This can be up to 200 referrals per week.

2.4 Overall we currently have an increased waiting times for patients for assessment. DNAs have increased and the numbers of cancellations for assessment appointments have also risen. In addition, there have been concerns that there had been an increase in the number of PALs complaints from service users regarding clinic appointments that have been cancelled and rearranged causing a significant time delay. This was with both assessment and follow up appointments.

2.5 A plan has been formulated to address the significant waits in clinical triage and to put in place a trajectory to redress the problem and bring the waiting list back into a more clinically acceptable position.

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3. Specific areas of challenge in Coventry

3.1 IPU 3-8 (non-psychosis)

This team deals with high levels of referrals. It is the default team that assesses anyone with an appearance or diagnosis of mental health "un-wellness". CWPT are providing a secondary care service and need to look at partnership working with the third sector to signpost people with the management of low level mental health needs. Over last 12 months the Improving Access to Psychological Therapy (IAPT) team has been working in closer liaison with the 3-8 team and providing joint IAPT working more closer liaison with the team and providing joint triage and discussion around potential referrals either way. The Coventry team are providing clinic base support to people who have some need of support or who require short term psychological interventions.

3.2 Early Intervention (EI)

The new national target of referral to NICE intervention is within 2 weeks. Currently achieving this but it is challenging and caseloads have increased. CWPT are completing a self-assessment for this service which will assist in creating an action plan on how we can be compliant with other KPIs. In October there is a new target for access to CBT for people with psychosis. Although there are some staff trained in this therapy CWPT does not currently have sufficient numbers to achieve the KPI. Clinical staff are being trained from September this year on a 2 year course.

3.3 IPU 10-17 (Recovery)

This is a large team and unfortunately, given the kind of work that is undertaken, there is a turnover of staff, particularly at band 5 CPN. We have a rolling programme of recruitment happening. We are "fishing in the same pond" for this staff and compete with the other Midlands MH trust and this turnover also impacts on team consistency. The acuity of patients within this service has increased, there are more patients now living in the community on section 37/41 (approx. 20 in Coventry) and the team also carries approximately 80 clients with Community treatment orders. This necessitates a high degree of Mental Act administration within the team and complexity is high with patients requiring support from Recovery partnership (if willing) in addition to housing, debt management and criminal justice support. The Recovery team works closely with CRHT to minimise the risk when this happens.

3.4 Section 75 arrangements

The only team without Social Care input is Early Intervention (EI), all other teams are fully integrated under the Section 75 agreement with CCC. AMHP work sits outside the agreement but does impact on time that social care staff can care manage caseloads, MHA assessments and administration is mandatory for local councils and as such take precedent over all other work, there has been an increase in assessments within Coventry which has

diverted resource from the case management element within all teams. MHA assessments have increased nationally.

3.5 IPU 18-21 (Dementia)

The Coventry service is really busy and performing really well. We have recently undertaken a review and the Trust have created an action plan to support improvements and enable a more focussed plan around how we deliver interventions to service users in a more appropriate way. Coventry and Rugby CCG have a target of referral to assessment within 12 weeks which is being achieved. The Trust clinical leads in Dementia have worked in partnership with the CCGs and GP leads to develop a primary care pathway for diagnosis for non-complex patients. This is a 12 month pilot covering 10 GP practices in Coventry with clinical support from the Consultants from this service. Internal links with new Integrated Neighbourhood Team, (INT) is being created with the dementia lead providing clinical supervision to the CPNs within INT and further thoughts of integration are being considered.

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4. Urgent Care Services in Mental Health

4.1 Crisis Response and Home Treatment (CRHT)

This is our busiest service. We received over 120 referrals per week and on average deliver 840 contacts per week. This team have been more busy than usual due to pressures on our in-patient beds. They are also supporting the high level activity in IPU 3-8. They function at an extremely high level and are working well with other parts of the service. As a Trust we were delighted when in our recent CQC inspection Mental Health Crisis Services and Health Based Places of Safety were scored “Good” overall.

4.2 Street Triage

Street Triage services are continuing to go well with an appointed senior practitioner providing support across the Coventry. Currently we operate 7 days a week from 3pm – 11am.

4.3 AMHAT (Psychiatric Liaison)

The AMHAT service provides a liaison service to A&E and the wards at all of the Acute Hospitals across Coventry. and Warwickshire. The service provides valuable support and continues to receive positive feedback form the clinicians across the acute hospitals. In terms of performance the service continues to perform well against its target response times.

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5. Summary

The process of clinical triage and assessments within the mental health services continues to be a challenge and of concern for the leadership team. We understand there needs to be significant changes to the current pathway and any proposals need to ensure that service users are triaged in a more timely manner by clinical MDT and service users are assessed by the most appropriate clinicians or combination of clinicians, again, in a more timely way. As a result of these concerns, we have developed a range of actions that we intend to progress and implement forthwith.

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6. Actions

6.1 Patient flows

Given the continuing high number of referrals coming into the service from primary care, it has been agreed that we will pilot a different model of working in future. As from September, for Coventry, we have developed a Primary Care Liaison model whereby a Consultant with several practitioners will work directly with a number of high referring primary care practices. This should help to divert people away from services, enable GPs to continue to work with patients without the need for referral into service and stem the flow into CBS. This model will also include IAPT and 3-8 practitioners to assist with patient flows in both these services. For IAPT it will increase the appropriate referral rates and for 3-8 better management of patients within this IPU. This model also supports the expected outcomes within the 5 Year Forward Vision for mental health in that we are aligning services much closer to primary care.

6.2 Clinical Triage/Assessments

Given the pressure to ensure robust and appropriate assessments for our patients, we believe there is a potentially better and more timely way for us to undertake this work. From November each locality will develop an MDT clinical decision team, whereby patients can be diverted directly from CBS into the correct locality and a more timely and holisitic assessment can be made, therefore enhancing the patient pathway at an early stage and ensuring that a more timely assessment by the right person is carried out.

6.3 DNAs

We will monitor the effectiveness of the use of the texting service. We also aim to undertake a deep dive into the number of cancelled clinics/assessment slots by our own staff to understand why there is such a number and how we can improve on current behaviours.

6.4 Addressing long waits

In September we are going to begin a pilot project with the voluntary sector to provide a “Safe & Well” check for patients waiting significant periods for intervention. The ambition is to undertake a similar exercise within Coventry during the Autumn.

6.5 Managing Capacity and Demand

We know that our patient flows are different depending on geography, structure of IPU, and a range of other issues. We expect to undertake a thorough capacity and demand exercise which will look in greater depth at our patient flows and our IPU capacity the outcome of which will enable us to develop plans to ensure equity of service across Coventry and Warwickshire and to determine IPU structures that reflect patient need.

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7. Recommendation

For the content of the report and the actions which are embedded within it to be noted by the Committee.

Barry Day
Deputy Director of Operations

5 September 2016