Annual Report to the City of York Health Overview and Scrutiny Committee from the Chief Executive of Leeds and York Partnership NHS Foundation Trust.

1. Introduction

Mental health and learning disability services in York, Selby, Tadcaster and Easingwold have been provided by Leeds and York Partnership NHS Foundation Trust (LYPFT) since February 2012. This paper sets out key areas of service development since that date; and areas for focus on further improvement over coming months.

An important service development which is not included in this paper is the planned new health based Place of Safety (Section 136) suite, due to open at Bootham Park Hospital shortly. This will represent an important improvement to the experience of mental health service users in York; and we are delighted to have been able to agree a model for this service with commissioners. Commissioners are presenting a paper to the Health Overview and Scrutiny Committee on this development so it is not duplicated here.

2. York and North Yorkshire model for mental health community services and services providing alternatives to hospital admission

We have completely redesigned our model for community mental health services and alternatives to hospital admission across York and North Yorkshire (Y&NY). We aim to deliver services which are better, simpler, and more efficient; and which deliver improved outcomes for service users, and a better experience for people who use our services and their carers. At our public consultation events, people have told us that:

- We need to address gaps in services including out of hours provision, crisis support, section 136 place of safety
- Early interventions for older people make a difference
- They want to be offered alternatives to hospital
- They want integrated care pathways that are recovery focused
- We should work in a more integrated way across the community
- They do not want to tell same story many times to many people

- They want a single pathway into services
- They want to see better partnership work between health and social care.

All of these areas will be addressed through the implementation of our new model.

We used evidence-based process mapping and analysis to understand the detailed working of current services and how we might maximise effective and efficient use of our workforce. Some of the key issues which the analysis revealed were that many service users were experiencing multiple assessments and frequent 'hand offs' between services (a hand off is when a person is moved from one worker to another or referred from one service to another); that we had different routes of access and variation in waiting times; services varied in how they used the Care Programme Approach; record keeping varied, as did routes for accessing beds and age restrictions for access to some services. Multiple community-based teams also represented duplication in some work and so presented opportunities for efficiencies, particularly managerial and administrative resources.

The new service model

Central to the new model is an improved service user pathway that ensures:

- Care is based on best evidence and the highest clinical standards
- Care is based on a comprehensive assessment of need and individualised care planning
- People are directed to the part of the service that best meets their needs
- People are seen by clinical staff with the skills to meet their needs
- A single point of access to secondary mental health services
- Duplication and repetition of assessments is minimised
- Hand-offs are minimised.

Key elements of the new model are as follows:

An age inclusive service that does not discriminate on the basis of age or diagnosis and is able to respond appropriately to needs.

Two integrated locality teams, delivering services across the full adult age span. These integrated services will bring together the functions of the current adult Community Mental Health Teams (CMHTs), older people's CMHTs, the Community Recovery Team, the Homelessness Service, and the Community Alcohol Team. The Memory Service and Psychological Therapy resources will also be integrated into the locality teams. The Care Homes Liaison Team and Assertive Outreach Team will remain city wide services but will be based in one of the integrated locality community team hubs.

A single point of access (SPA) for all referrals to secondary services. (Please note that this is for general adult secondary mental health services, but will not include specialist services such as forensic mental health, child and adolescent mental health, or learning disability services). All referrals will be via a single telephone number, postal address or e-mail address. This will remove any uncertainty for referrers and ensure that the service gives a high quality, consistent and prompt response.

An integrated bed management function will be delivered through a new Bed Manager role, ensuring access to inpatient beds is achieved in a timely way through a single route.

Maintaining specialist skills within integrated teams. Our proposed model is an integrated one; however that does not mean that everyone's skills are interchangeable. Our model aims to balance the need to maintain specialist skills, whilst developing flexible integrated working to address the complexities of people's needs. In the new model care is assessed and delivered along evidence-based, needs-led care pathways:

- Common mental health
- Psychosis
- Cognitive impairment, dementia and late onset mental health problems.

The service will retain a full range of specialist skills and expertise to meet service user needs within these pathways, whilst enabling more integrated and flexible working. The model recognises that service users' individual needs do not fit into clinical compartments and there are overlaps between care pathways, requiring shared expertise and transitions. The needs led pathways will be delivered by staff with the right skills and expertise; and include a balanced professional mix.

The new model will integrate with Primary Care Mental Health and Counselling services, allowing for a seamless stepped care service across primary and secondary care; and ensuring that our service is comprehensive and able to respond to a full range of needs**.**

Location of the hubs. The majority of community services are provided in people's own homes; and it is important that staff are easily able to access different parts of York, Selby district and Easingwold from their staff bases. We have therefore decided that the two integrated locality teams will be based in two hubs, one covering the north and east of the service and the other covering the south and west. This takes account of accessibility by public transport, the course of the river Ouse; and the impact that the river has on travelling across and around York, particularly when it is in flood. We have identified preferred sites for hubs and are working with commissioners to finalise plans. Importantly, service users will continue to be seen at the best and most accessible location for them.

The new service model will support the delivery of excellent clinical care for service users and their carers, which is evidence based, achieves effective outcomes and safe. Care will be delivered based on need through a simplified service user pathway, eliminating duplication and delay, demonstrating improved efficiency through embedding integrated care. We have set out key outcome measures and standards against which performance can be measured; and will carefully evaluate the model as it becomes operational. The Single Point of Access will begin to operate in late 2013 (determined by recruitment) and will be fully operational by April 2014.

3. Proposed changes to the St Andrew's Counselling and Psychotherapy Service

Background

Over the past year, we have reviewed the way that we provide psychological therapies in York, including St Andrew's Counselling and Psychotherapy Service. This service currently provides a 3.5 day intensive group therapy programme, run as a Therapeutic Community. It also provides psychological therapies, including types of one-to-one and group interventions that are currently not provided elsewhere in York's secondary care services, such as specialist interpersonal/psychodynamic therapies.

St. Andrews is a valuable resource and provides a service that is very well regarded by its clients; however it is not a discretely commissioned service so it is appropriate that it is included in scope when we consider how best to meet the full range of needs of our service user population.

Specifically this review set out to achieve the following objectives:

- A single and coherent secondary care psychological therapies service for Y&NY, as part of our new community service. To date we have had multiple points of access and various waiting lists for therapy. In future all referrals for secondary care psychological therapy will be via the Single Point of Access.
- A robust personality disorder pathway, in line with the best practice network model provided in Leeds, accessible to those in greatest need and able to respond to high levels of distress and significant risk issues.
- An achievable plan to deliver required efficiency savings, whilst ensuring that the service is as comprehensive as possible within available resources; and delivers best value for money.

To inform the review we mapped the current pathway for people with a diagnosis of personality disorder (PD), to understand some of the difficulties in accessing specialist personality disorder services within York. Our review has resulted in a recommended model for a single Trust-wide Personality Disorder service, but with local variation in York to reflect local service user feedback and priorities. We are now consulting widely on the proposals, ensuring that we understand the views of all stakeholders, especially people who use our services and their carers; and our staff.

Personality Disorder Pathway.

Components of the model are as follows:

- **A two-day Therapeutic Community.** The aim of a therapeutic community (TC) is that the whole community works to run the service and members take on jobs and responsibilities with the staff to make this happen. It is this democratic way of working that is at the heart of the community's life and this helps to give people a sense of empowerment, choice and responsibility that may be missing in their lives. The community helps with learning more about relationships and how to feel more effective in communicating, as well as with learning new skills or refreshing the ones that might feel to have been lost.

We propose that the Y&NY model incorporates a two day TC as part of the Leeds and York Managed Clinical Network. The two-day model reflects the importance attributed to a longer TC as we have developed this proposal locally. It maintains the therapeutic components most valued by St Andrew's service users.

It can continue to be provided from the current St Andrew's building if this is what staff and service users prefer.

- **Dialectical Behavioural Therapy (DBT) Skills Group Training.** DBT skills training aims to help people to learn new skills to help them cope when they feel suicidal, or want to use self-harming or life threatening behaviours to manage distress. It recognises that people develop such ways of coping due to invalidating experiences in their lives, which could include abuse, neglect or other kinds of personal trauma.
- **Consultation and support for the wider workforce.** This will be primarily through delivery of the nationally accredited PD Knowledge and Understanding Framework (KUF) Awareness Level training. This programme is delivered by a range of staff from the existing LYPFT PD services, alongside service user co-facilitators, and has been positively evaluated over the past 18 months. We have trained approximately 1000 staff from across a wide range of agencies, which has helped to build relationships between specialist PD services and colleagues from other parts of the service. The Leeds and York Managed Clinical Network will deliver training to approximately 160 staff per year, resulting in a significant systemic impact.
- **Vocational work.** Y&NY services have a well-established vocational pathway, staffed by occupational therapists and support workers, which will be part of the new community hubs. It has links with York St John University, work placement training opportunities and access to meaningful activity. The hubs will also each provide dedicated staff time to deliver the elements of the *Journey* programme. This aims to provide group members with the skills and knowledge to create an individual balance of activity, to promote health and wellbeing. Focusing on activity rather than talk, *Journey* helps people towards greater employment and inclusion, key to good mental health.
- **Specialist Case Management.** There are a number of people with a diagnosis of personality disorder who experience high levels of distress and significant risk issues. It can be difficult for mental health services to offer meaningful engagement in these circumstances. This can lead to avoidable acute admissions and out of area placements, including for Psychiatric Intensive Care.

Specialist psychologically informed case management can actively engage these clients, develop meaningful relationships and strategies for safety and containment. Our proposal is for two senior clinicians per hub to develop and maintain specific specialist skills in PD; and work with an active caseload of people with a diagnosis of personality disorder. A clinical lead in each hub will also be identified to "champion" the PD pathway.

- **Housing and Resettlement Support.** Y&NY has an established mental health housing officer and a supported housing pathway. The community teams currently have integrated social workers and Support, Time and Recovery (STR) workers, employed by City of York Council and North Yorkshire County Council, which can be accessed for social care assessment and on-going housing support.

- **Service User Involvement.** The proposed model actively involves service users in the delivery and evaluation of the service. From the regional PD Pathway Development Service we support an involvement initiative already based in York. *Creative Personalities* is an arts-based project which has engaged significant numbers of service users from York and across the region. Building upon this we propose to establish *Emergence North*, linking to *Emergence*, a national service user-led organisation which has been involved in advancing understanding of personality disorder. We will develop a range of service user-led initiatives and envisage that service user consultants, employed by Emergence, will be key to taking this forward.

Risks of adopting this proposal

Concerns have been raised that the proposed changes could jeopardise the ability of the service to provide psychological therapies in accordance with NICE guidance; and will increase risks in service user safety and wellbeing. Proposals for capacity within new locality teams have, however, taken account of modelled measures of capacity and demand, referral rates, contact data, maximum caseload capacity and anticipated efficiencies gained from integration of other community resource. The establishment of three consultant clinical psychologist posts in the community hubs to provide clinical expertise and professional leadership will also ensure that the profile of psychological therapies remains strong. The integrated community model means that staff can work flexibly to ensure priorities are always met and no service element is left unsupported.

This proposed model identifies significant benefits for service users with a diagnosis of personality disorder in York and North Yorkshire. We are committed to continuous improvement and to working towards a 'blueprint' for an ideal service, as and when we are able to attract new income.

4. A new low secure forensic unit for women

It has been long established that there is a gap in the provision of low secure care for women nationally; and this is the case in North Yorkshire and York. Currently women who require specialist low secure care are often placed outside of the Yorkshire and Humber area, many within the independent sector. This can result in accessibility problems for carers, relatives and friends as well as a high cost of care.

The plans for a new low secure service for women in the North Yorkshire and York area have been under development since 2008 in this current form and have been taken forward in partnership with the Specialist Commissioning Group (SCG). In working with the SCG the development has addressed both the local North Yorkshire and York needs together with a wider sub-regional requirement for Yorkshire and Humber as a whole.

The project involves developing a Women's Low Secure Unit on the Clifton House site. The new unit will be integrated into the existing Forensic Psychiatry Service and will accommodate patients from Yorkshire and Humberside in two 10 bedded units. One of the wards will also have intensive nursing facilities. An adjoining section of the building will link the new wards to Clifton House. This adjoining section will feature new facilities including a gym, art room and other therapeutic and social spaces. Once completed, these facilities can be shared by both the male and female sides of the Clifton site.

Work is well under way with the contract work and Mansell Balfour Beatty, the builders, envisage the unit being completed mid- April 2014. The recruitment of a new clinical team is progressing well with many applicants showing an enthusiasm to work in the new service.

5. Improving Access to Psychological Therapies (IAPT) Services

The NY&Y IAPT service is undergoing a comprehensive service improvement programme, reviewing the current service's structure, processes, evidence based interventions, clinical activity, staffing and use of technology.

We are creating a Single Point of Access and Referral (SPAR) for the North Yorkshire-wide IAPT service. Streamlining the referral process will allow us to utilise our administrators more efficiently and consistently triage all of our referrals electronically.

To address our waiting lists we are undertaking a screening exercise; contacting everyone on our current waiting list to ensure that they are still waiting for the right service and wish to be seen. Once this has been re-established we aim to provide a wider range of evidence based interventions that patients can engage with. These will include a greater use of group work, computerised cognitive behavioural therapy (cCBT) as well as telephone interventions and face to face sessions. The combination of creating a SPAR and increasing the type of interventions available will mean the service is much more flexible in its approach. Particularly at step two, Psychological Wellbeing Practitioners will be able to work with patients from across North Yorkshire instead of just in the locality they are assigned to. This will allow us to respond to waiting list pressures as they develop and deploy resources accordingly.

We are developing a new patient contract that will define more clearly the expectations on those entering our service. The service has examined non-attendance and is putting in place a number of measures to reduce these further including the use of text messaging as a prompt. In relation to the use of information technology, the IAPT service's new IT hardware will allow greater connectivity and flexibility in the way we work. This combined with IAPTus (the IAPT patient information system) means that we will be able to consider new ways of working with patients that embraces newer technologies and that takes into account the geography of North Yorkshire. Improved technology will mean that we are able to make more effective use of time should patients fail to attend appointments.

A further challenge faced by the national IAPT Programme has been the recruitment and retention of appropriately qualified staff. We have recently undertaken a number of successful recruitment campaigns; and to help prevent future recruitment and retention issues we have been working closely with Sheffield University, which is the approved IAPT training provider in the

Yorkshire region. This has allowed us to create a career pathway for our existing Psychological Wellbeing Practitioners by training them to become High Intensity Workers. This will ultimately make a significant impact on the number of CBT sessions we are able to provide in the future.

Notwithstanding all of these improvement plans, the IAPT service remains significantly under-funded and we are working with commissioners to identify the funding shortfall that is required if we are to meet the target access rate of 15% by March 2015. To achieve this, the trajectory for 2012/13 should have seen the service treating 10.9% of prevalence, where it actually achieved a rate of 3.3% of prevalence. (Note that the target set by the DH for 2012/13 was 2.8%, in acknowledgement of the limitations in capacity faced by the service). A workforce analysis undertaken in February 2012 shows a shortfall of 20 trained Psychological Wellbeing Practitioners (PWP's) and over 70 High Intensity Workers (HIW) in the current service (based on prevalence rates from the Psychiatric Morbidity Survey).

6. Out of Area Transfers (OATs)

For some years Leeds services provided by LYPFT have successfully managed their out of area budget, instead of the commissioners. This has allowed internal investment to reduce the numbers of placements out of area, leading to improved quality of care; improved patient experience; and financial benefits for both commissioner and provider. LYPFT and York commissioners would like to agree a similar arrangement; and work on this has now begun.

Some out of area placements are for acute beds, when no beds are available in York. York services have recently completed a capacity and demand review to ascertain whether its bed base is sufficient to meet the current and future demand. The results of this review indicate that we currently have fewer acute beds than we need. We cannot expand the current bed base within existing in-patient wards at Bootham Park Hospital; however if funding currently spent on out-of-area placements were reinvested we may be able to open further beds and invest in the alternative to hospital admission provision, so reducing whole system costs and improving quality of care and the experience of our service users and carers.

In the longer term we need to provide our in-patient services in a more fit-for-purpose environment than Bootham Park Hospital (BPH), which is not a suitable environment from which to provide modern mental health services. Commissioners fully support the need to develop a retraction plan for BPH; and NHS Property Services are sighted on this as a medium to long term capital requirement.

7. Section 75 agreements

York's community services have health and social care staff working in integrated teams. Joint funding arrangements exist which have yet to be confirmed in Section 75 agreements. The community service re-design will change the existing management and reporting structures and any transfer of delegation or functions from one partner to another will be confirmed in Section 75 agreements. A shadow Partnership Board with City of York is being established where a draft Section 75 agreement can be discussed and finalised.

8. Other issues

In recognition of the performance and governance issues within services at the point of service transfer, NYYPCT agreed that the CQUINs for 2012/13 and 2013/14 would be the delivery of an action plan to meet compliance with the Care Quality Commission's essential standards and with Monitor targets. Actions in this plan have now been delivered.

The service achieved its efficiency savings for 2012/13 and is almost in a break-even position.

Integration with Leeds services has been successful: policies and procedures are harmonised across LYPFT, YNY staff participate fully in the Trusts governance and other key decision-making groups and a consultant psychiatrist from YNY services has been appointed to the post of LYPFT Medical Director.

The significant back-log in fire safety and maintenance is being addressed and nearing completion.

These developments have been included in LYPFT's refreshed strategy and will contribute to the Trust achieving its overarching objectives.

Chris Butler
Chief Executive
October 2013