Health & Adult Services

Mental Health Pathway

North Yorkshire County Council

Journey so far…

- 2016 launch of the Mental Health Pathway Review – phase 1
- 2017/18 launch phase 2 - Service Configuration
- May 2019 Launch of the key pathway elements

Aim: To develop and implement a distinctive Social Care Mental Health offer across North Yorkshire for working age adults that supports the benefits of joint approaches with NHS partners.

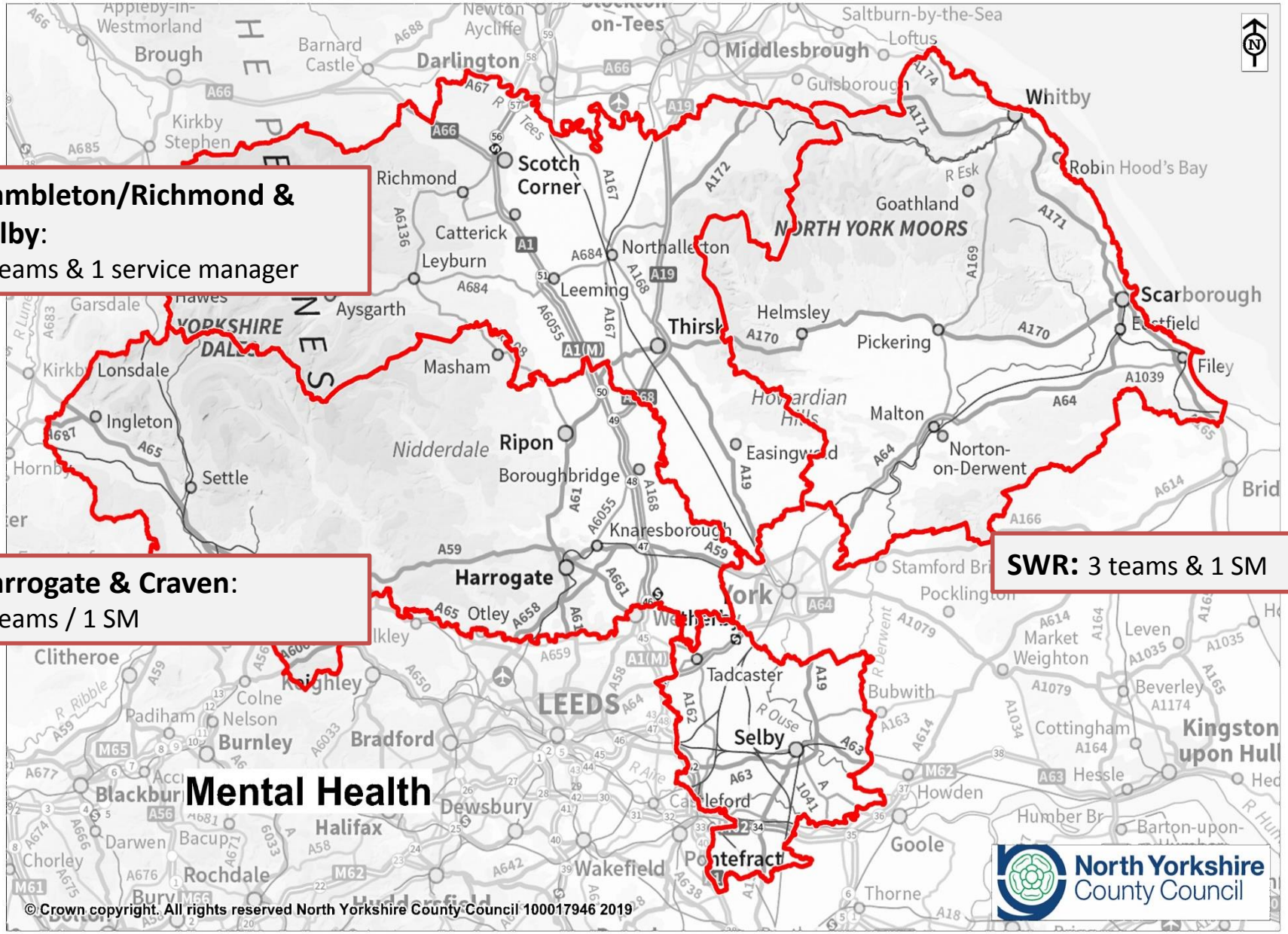
Scope of the challenge (non negotiable)

- ✓ Compliance with the Care Act 2014
- ✓ Strengthen the prevention offer and ensure a 'strengths based approach' (SBA) to assessment, care and support.
- ✓ Relinquish care coordination role (CPA approach)
- ✓ Change the primary electronic recording system to LLA
- ✓ Continue to co-locate with health colleagues
- ✓ Engagement in existing health processes for daily management of care & support
- ✓ Include over 65year functional illness.

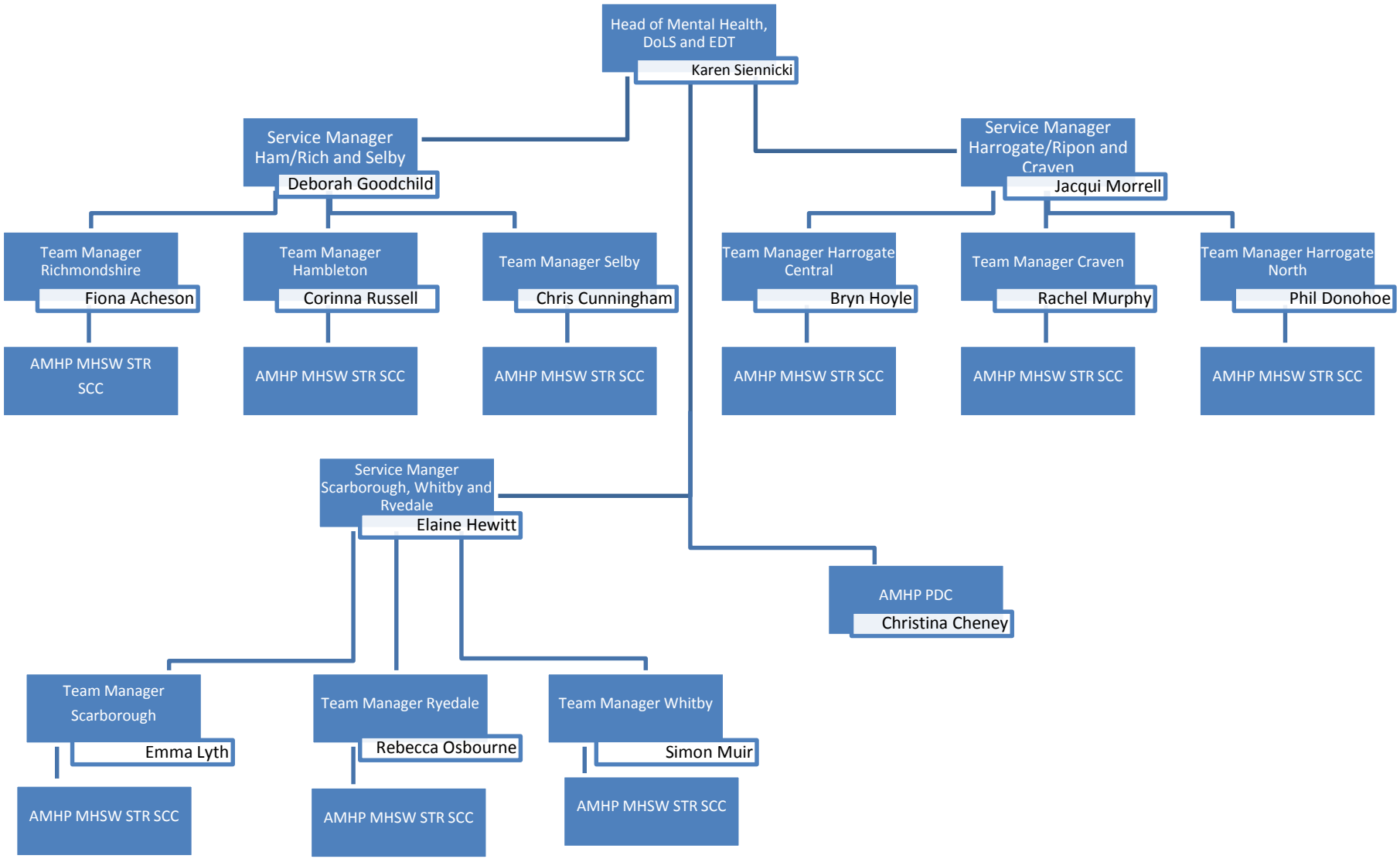
Vision & Aims for Mental Health Services

- Confident, consistent practice, that is focussed on a strength-based approach
- Develop new opportunities to strengthen the prevention within mental health
- Deliver an all age specialist service
- Explore future use of technology and technology within the pathway
- Align to North Yorkshire County Council Health & Adult Services care pathway
- Build on relationships and continue to develop and work effectively with all external partners
- Be the employer of choice

New Mental Health Team Boundaries



Mental Health Service Structure



April Pathway Development Event

- ✓ Established a shared understanding of the reason ***why*** mental health social care has to change, ***what*** needed to happen and by ***when***.
- ✓ Mapped a distinctive pathway for mental health within social care for North Yorkshire.
- ✓ Developed a clear action plan detailing next steps in preparation for a planned roll out from 1st May 2019.
- ✓ Mapped different customer journeys
- ✓ Clarified service criteria
- ✓ 147 unique actions identified across:

PROCESS

- Front door care & support team
- Referrals
- Safeguardings
- Over 65yrs
- Internal/external interface

ORGANISATION & WORKFORCE

- Role clarification
- AMHP model

TECHNOLOGY

- Use of equipment
- LLA

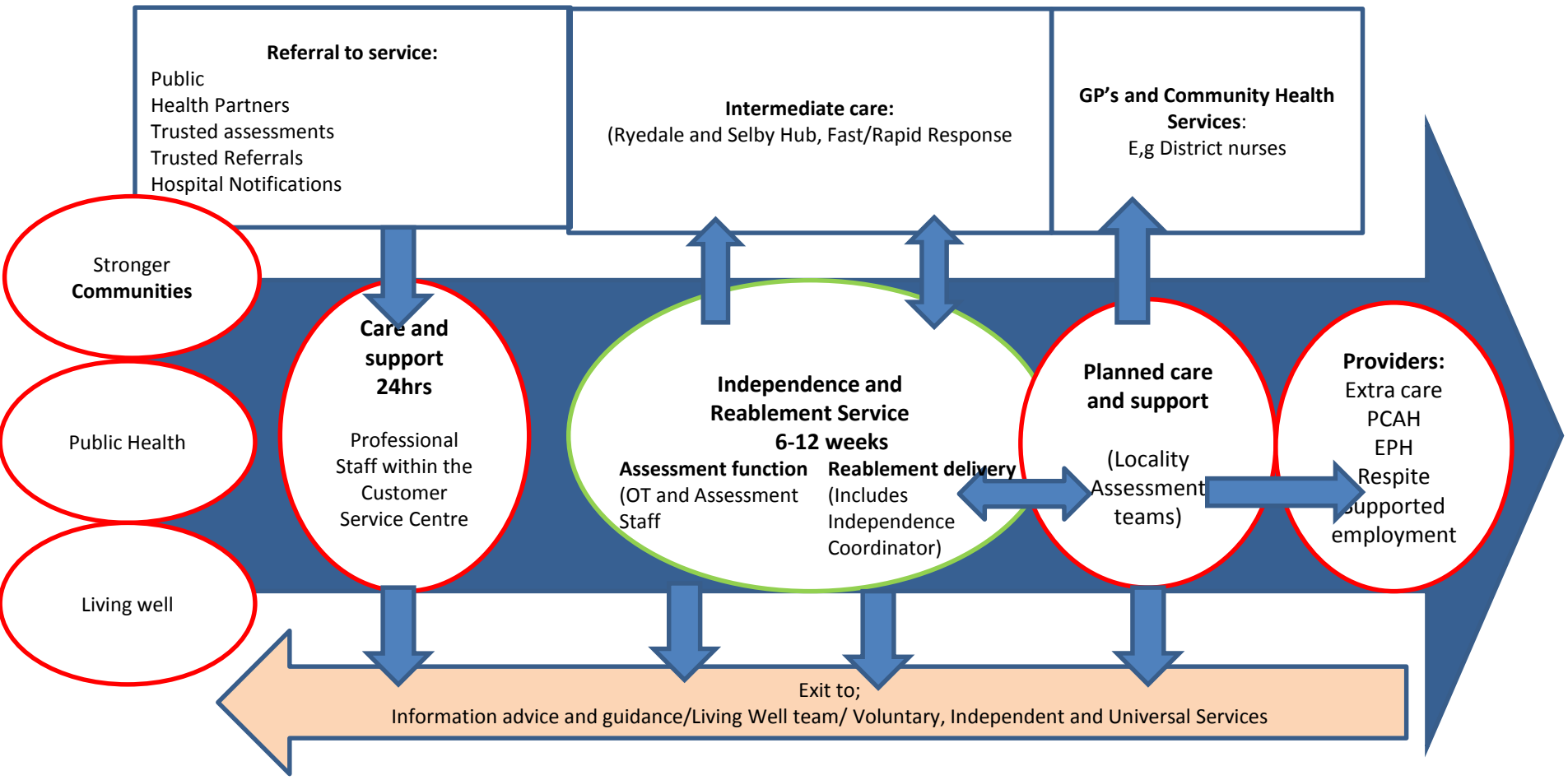
INFORMATION

- Development of KPIs/Dashboard
- Comms strategy

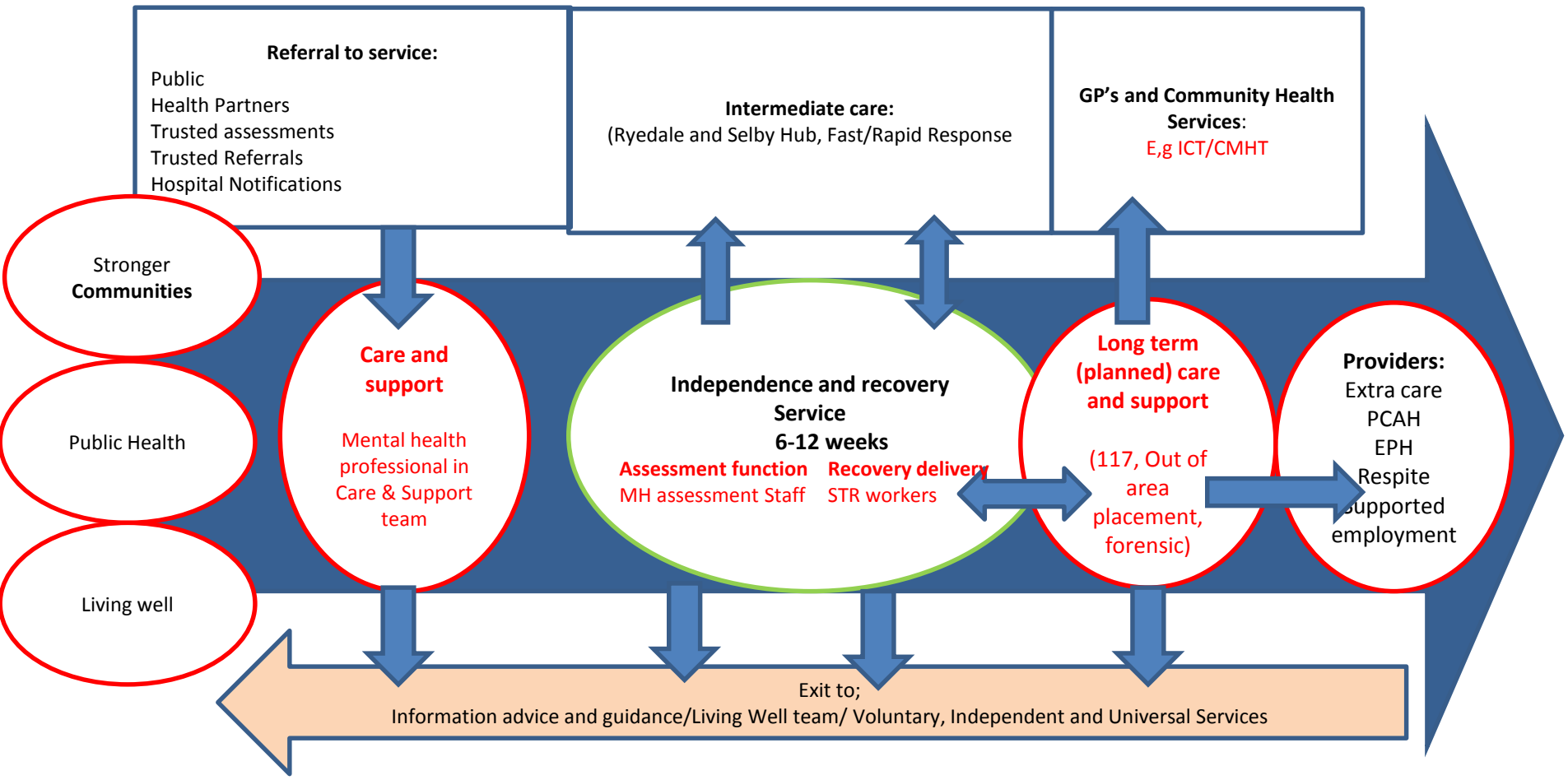
Service Criteria:

- 18+ - To include those over the age of 65 open to MHSOP with a functional diagnosis
- Referred into local mental health services within the last 3 months (integrated Triage, First Response, Access Team)
- Who are currently experiencing mental distress that is impacting on mental wellbeing resulting in social care need

Care Pathway – Health and Adult Services 2017



Mental Health Pathway – Health and Adult Services 2019



Referral into Service: Triage & Prevention

MH within the Care & support team to support triage of closed or not known/new referrals

Signposting

Information, advice, guidance

Safeguarding

Stronger communities

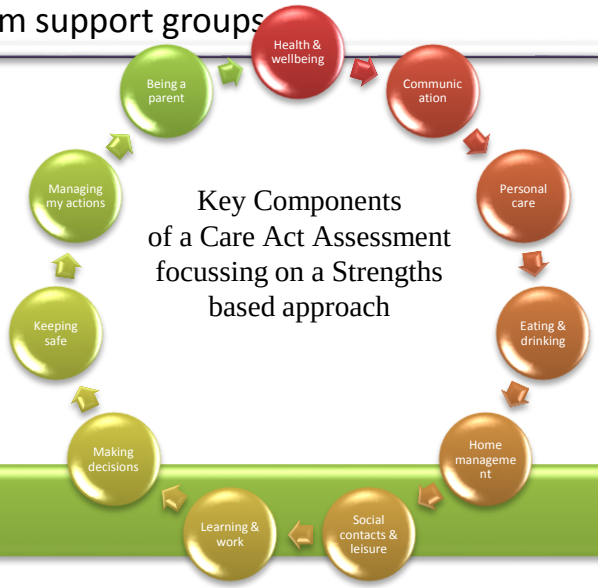
Living Well

VCS

Public Health

Carers

Referrals to GP, Advocacy, Self help groups & victim support groups



Independence & Recovery : 6-12 weeks

(Assessment to be completed with 28 days)

Recovery orientated services

Independent / daily living skills

Confidence/skills development

Group work

Social inclusion/integration

Supported housing

Measured outcomes

Maximise independence

Supported employment Service

Income maximisation team

Family group work

Access to commissioned services

Crisis intervention (non MHA)

Reablement support

Professional support through low level therapeutic interventions

Long term (planned) care

DToC

Hospital in-reach

Safeguarding

MHA work (ie:117)

Court of protection

Guardianships

Personalisation

Direct payments/ personal budgets

Out of area placements

Transitions

Complex needs

CHC

Specialist placement review

Prevent, reduce, delay

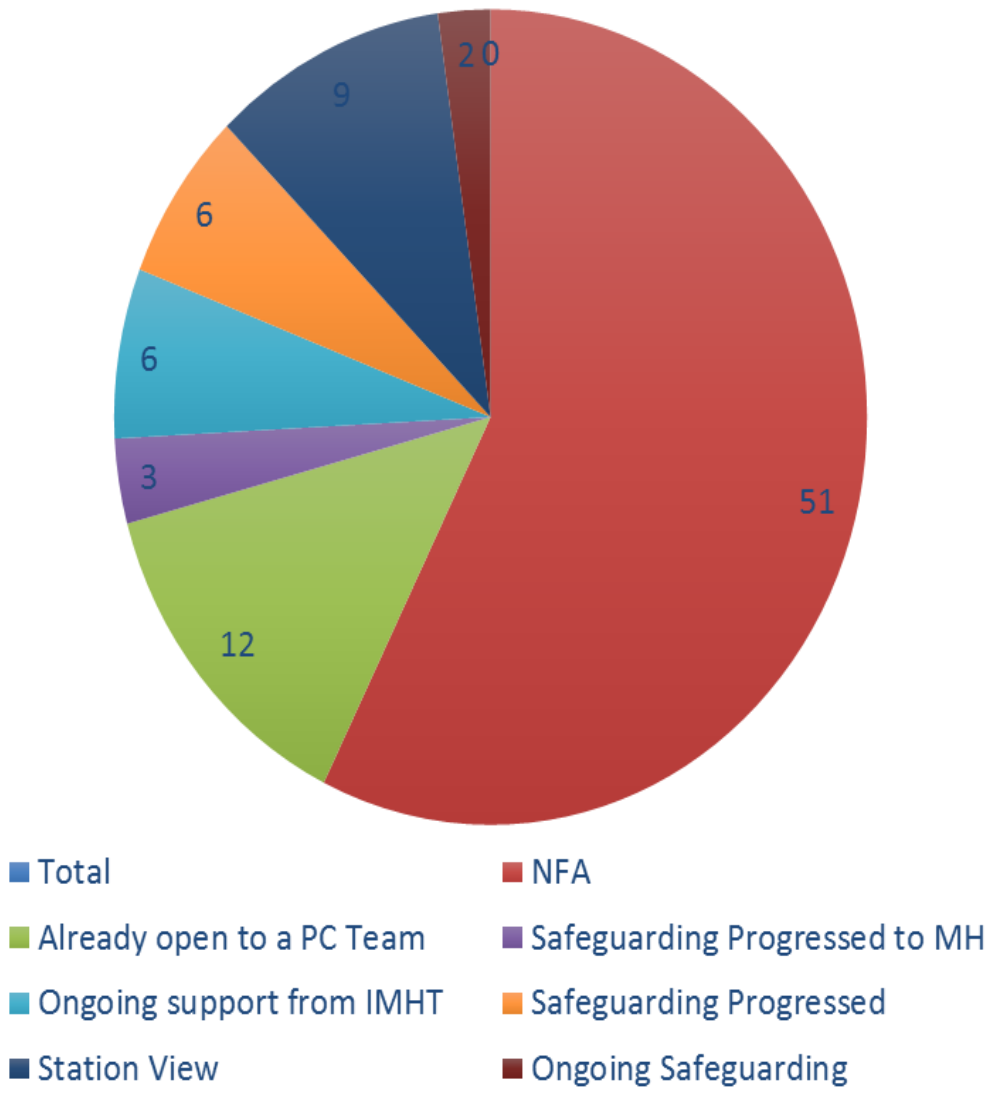
Integrated Mental Health Team

Item 5

Pilot

- 5 staff seconded from TEWV
  - 1 ANP (Advanced Nurse Practitioner) Team Lead
  - 1 Physio
  - 3 Specialist mental health nurses
- Previously involved in Harrogate Vanguard and instrumental in testing the IRS model.
- 29th April 2019 pilot the team sat within Care & Support Front Doors services (4 days per week)
- So far 89 people/cases reviewed with 57% prevented from going any further into HAS services.
- Feedback so far :
  - Reduced the delay in receiving the necessary information to make the right decision
  - 'reduced the generalist opinion' when triaging and putting meaning to mental health terminology in referrals
  - Reduced number of complaints from locality teams because of point 2
  - LLA limited with information. Access to PARIS informs and supports the triage process and SALT returns

Outcome



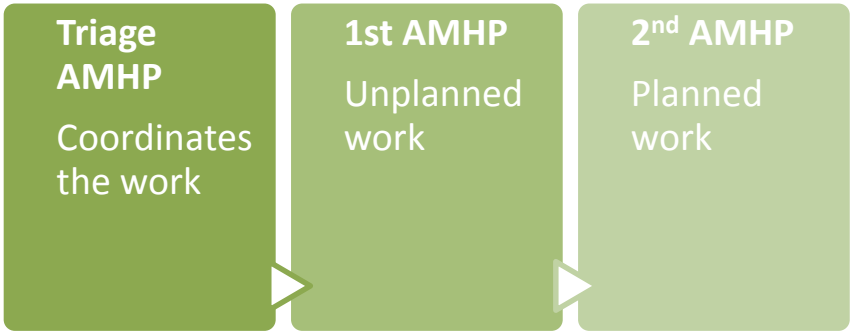
Duty Work Role:
AMHP/MHSW/SCC

5 Duty Workers across the County:
Harrogate N&C/ Craven/ Selby / SWR / Ham & Rich

Introduction of internal governance reporting framework for mental health teams

To offer assurance and monitoring of quality, risks and mitigation

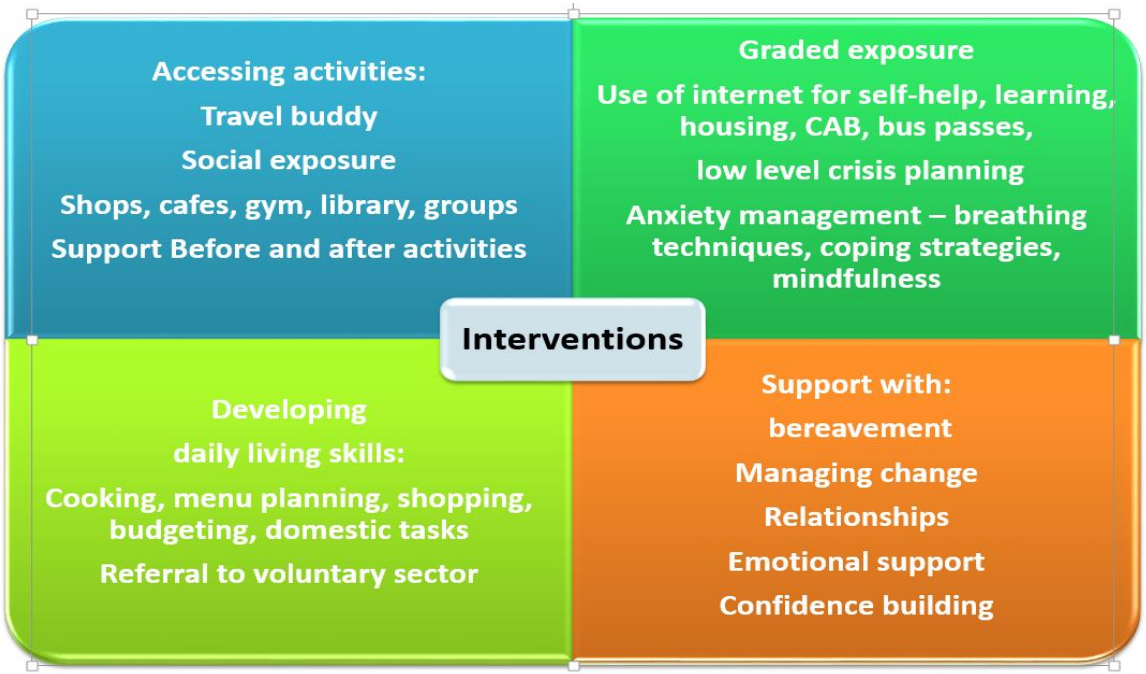
County Wide AMHP model pilot



- Each locality to adopt the above model
- If required triage AMHP can cover other localities
- Cross locality working according to need (ie: out of locality assessment/placement)
- Closer working relationship with EDT

Support Time & Recovery Workers (STR)

- Redefined the role and returned to the original Sainsbury's model
- Referrals now directed from SCC/MHSW/AMHP following a social care needs assessment identifying a person has eligible needs under the care act.
- Agreed outcome measure tool (7 domains)
- Developed recovery plans that can be recorded on LLA and reported on monthly



Managing mental health

Physical wellbeing

Connecting with the community

Relationships

Independence, choice and control

Meaning & purpose

Trust, identity, hope & self esteem

Visual Control Tool

	Scarborough	Whitby	Ryedale	Harrogate north	Harrogate Central	Craven	Hambleton	Richmond	Selby
Preparation									
Case loads analysed and action plans developed									
transfer of all care coordination cases									
Re-allocation of cases in LLA to the correct team									
Workforce									
All new positions recruited to									
all staff moved to new teams									
implementation of modern council working and changes to bases									
Practice									
Delivery of SBA training									
use of REM process for practice development									
introduction of case file audits									

KEY FOR PATHWAY IMPLEMENTATION PROGRESS	
	not yet implemented
	started but under 50%
	started and over 50% implemented
	In place
	Embedded / Complete

GUIDANCE	
1	On a monthly basis, the Team Manager is responsible for rating the current status of their team against each step prior to AMT. detailed narrative to be added in the team progress sheet.
2	Mitigating actions required for those steps rated yellow/amber and red.
3	Report to be given to the Service Manager who will includen as part of the locality assurance report

Scarborough

	COMMENTS
Preparation	
Case loads analysed and action plans developed	
transfer of all care coordination cases	
Re-allocation of cases in LLA to the correct team	

Key Performance Indicators – KPI

Item 5

Process

- Timescale for referral to reach correct MH team/worker
- Number of assessments by type – fit into Assessments Dashboard (in progress min 4 weeks)
- Timescale from referral date to assessment start date (to measure timeliness in work being carried out)
- Timescale from referral date to assessment end date (to measure time for assessment to be carried out from contact with client)
- Timescale from assessment start to assessment end date (to measure how long assessments are taking)
- Overdue reviews
- Timescale from referral start to referral end
- Number of cases with involvements from others on LLA but not reported
  - Internal – measure 'involvements' in LLA – and TEWV involvement
  - External – mechanism to record Eg. TEWV involvement
- MH Act : How many
  - Admission – voluntary/ not voluntary
  - Not admitted

Inputs

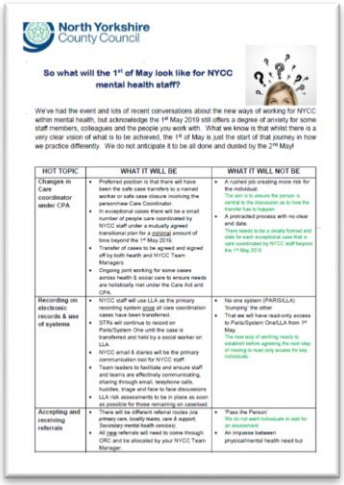
- Number & source of referrals into MH teams
- Timescale between referral date & caseworker start date (to measure if referrals are being sent to correct teams & worker allocated in a timely manner)
- Number of referrals being dealt with by C&S team (potentially require new options on C&S form in LLA) – measure how many are sent to triage team
- Breakdown of triage outcomes by type (currently recorded on a spreadsheet) AMHP MH Act Assessments (recorded on spreadsheets)

Outputs

- Number of referrals that don't result in an assessment
  - Number by referral and reason
- Assessment outcomes
  - Number of assessments resulting in each outcome
- Recovery star scores/ chime scores – compare score at start of process to end, to measure impact of interventions
- Return rate of clients and timescale

Progress so far…

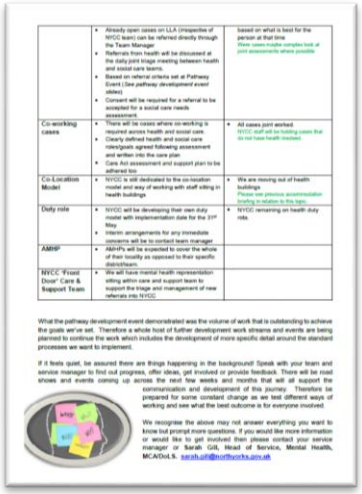
Communication bulletins:


North Yorkshire County Council

So what will the 1st of May look like for NYCC mental health staff?

We've had the event and lots of recent conversations about the new ways of working for NYCC within mental health, but acknowledge the 1st May 2019 still offers a degree of anxiety for some staff members, colleagues and the people you work with. What we know is that whilst there is a very clear vision of what is to be achieved, the 1st of May is just the start of that journey in how we practice differently. We do not anticipate it to be all done and dusted by the 2nd May!

HOT TOPIC	WHAT IT WILL BE	WHAT IT WILL NOT BE
Changes in Care coordinator under CPA	• Preferred position is that there will have been the safe case transfers to a named worker or safe case closure involving the person/new Care Coordinator. • In exceptional cases there will be a small number of people care coordinated by NYCC staff under a mutually agreed transitional plan for a minimal amount of time beyond the 1st May 2019. • Transfer of cases to be agreed and signed off by both health and NYCC Team Manager's • Ongoing joint working for some cases across health & social care to ensure needs are holistically met under the Care Act and CPA.	• A rushed job creating more risk for the individual. The aim is to ensure the person is central to the discussion as to how the transfer has to happen • A protracted process with no clear end date. There needs to be a clearly formed end date for each exceptional case that is care coordinated by NYCC staff beyond the 1st May 2019
Recording on electronic records & use of systems	• NYCC staff will use LLA as the primary recording system once all care coordination cases have been transferred. • STRs will continue to record on Paris/System One until the case is transferred and held by a social worker on LLA. • NYCC email & diaries will be the primary communication tool for NYCC staff. • Team leaders to facilitate and ensure staff and teams are effectively communicating, sharing through email, telephone calls, huddles, triage and face to face discussions • LLA risk assessments to be in place as soon as possible for those remaining on caseload.	• No one system (PARIS/LLA) 'trumping' the other • That we will have read-only access to Paris/System One/LLA from 1st May. The new way of working needs to establish before agreeing the next step of moving to read only access for key individuals
Accepting and receiving referrals	• There will be different referral routes (via primary care, locality teams, care & support, Secondary mental health services). • All new referrals will need to come through ORC and be allocated by your NYCC Team Manager.	• 'Pass the Person' We do not want individuals to wait for an assessment • An impasse between physical/mental health need but


	• Already open cases on LLA (irrespective of NYCC team) can be referred directly through the Team Manager • Referrals from health will be discussed at the daily joint triage meeting between health and social care teams. • Based on referral criteria set at Pathway Event (See pathway development event slides) • Consent will be required for a referral to be accepted for a social care needs assessment	based on what is best for the person at that time Rare cases maybe complex look at joint assessments where possible
Co-working cases	• There will be cases where co-working is required across health and social care. • Clearly defined health and social care roles/goals agreed following assessment and written into the care plan. • Care Act assessment and support plan to be adhered too	• All cases joint worked. NYCC staff will be holding cases that do not have health involved
Co-Location Model	• NYCC is still dedicated to the co-location model and way of working with staff sitting in health buildings	• We are moving out of health buildings Please see previous accommodation briefing in relation to this topic.
Duty role	• NYCC will be developing their own duty model with implementation date for the 31st May. • Interim arrangements for any immediate concerns will be to contact team manager	• NYCC remaining on health duty rota.
AMHP	• AMHPs will be expected to cover the whole of their locality as opposed to their specific district/team	
NYCC 'Front Door' Care & Support Team	• We will have mental health representation sitting within care and support team to support the triage and management of new referrals into NYCC	

What the pathway development event demonstrated was the volume of work that is outstanding to achieve the goals we've set. Therefore a whole host of further development work streams and events are being planned to continue the work which includes the development of more specific detail around the standard processes we want to implement.

If it feels quiet, be assured there are things happening in the background! Speak with your team and service manager to find out progress, offer ideas, get involved or provide feedback. There will be road shows and events coming up across the next few weeks and months that will all support the communication and development of this journey. Therefore be prepared for some constant change as we test different ways of working and see what the best outcome is for everyone involved.

We recognise the above may not answer everything you want to know but prompt more questions. If you would like more information or would like to get involved then please contact your service manager or Sarah Gill, Head of Service, Mental Health, MCA/DoLS. sarah.gill@northyorks.gov.uk


North Yorkshire County Council

2020 MODERN COUNCIL & COMMUNITY MENTAL HEALTH SERVICES

April 2019

As part of the service changes from 1st May 2019, I am in the process of agreeing formal arrangen… with TEWV and BDCT in respect of the accommodation arrangements for NYCC staff co-located … mental health bases. The detail is still being discussed and will be communicated as so…

North Yorkshire County Council

COMMUNITY MENTAL HEALTH SERVICES CO-LOCATION UPDATE

May 2019

I felt it would be useful to update you all in terms of the current situation with agreeing formal arrangements with TEWV and BDCT in respect of the accommodation arrangements for NYCC staff co-located in the community mental health bases.

North Yorkshire County Council

Mental Health Pathway Development Event Briefing:

April 2019

What was this about?

Following the agreed restructure of Mental Health Social Care, a four day event was held on the 2nd -5th April 2019 to co-develop the Mental Health Pathway and new service offer.

The ambition for the new pathway is have a distinctive service that enhances prevention through implementing a strengths based approach when assessing and offering care and support.

The event was focused on sharing ideas and expertise in order to produce real practical outputs by the end of the week, which could be implemented and tested in the near future.

Who came together?

- Service Users
- Carers
- Tees, Esk and Wear Valley NHS FT
- Bradford District Care Trust
- Public Health
- Representatives from across Health and Adult Services
- CCG Commissioning

What did we do?

We explored the customer journey for people in different circumstances who may require a mental health service.

By ensuring the customer was central to the process, we were able to identify the impact on our customers and partners around the following four areas:

- Process
- Organisation
- Technology
- Information and communication

What was the outcome?

A pathway that reflects the existing care & support Health and Adult services pathway was designed, with 147 unique actions identified. These have been themed and prioritised to form a clear action plan.

Mental Health Pathway – Health and Adult Services: 2019

Next steps?

While the focus was on producing plans and proposals at the end of the week, it is recognised that some areas will need further work and resources. The aim of this is to maintain the momentum by having a series of further, inclusive events as soon as possible.

If you would like to get involved or would like more information then please contact Sarah Gill, Head of Service, Mental Health, MCA/DoLS. sarah.gill@northyorks.gov.uk

Internal Workshops:

- Governance and reporting structures with the team/locality & AMT
- Duty worker role / STR work Role / AMHP triage model
- Pilot to strengthen the mental health triage at the front door of NYCC/Care & Support

Roadshows:

- One in each of the localities for all key stakeholders

Team work:

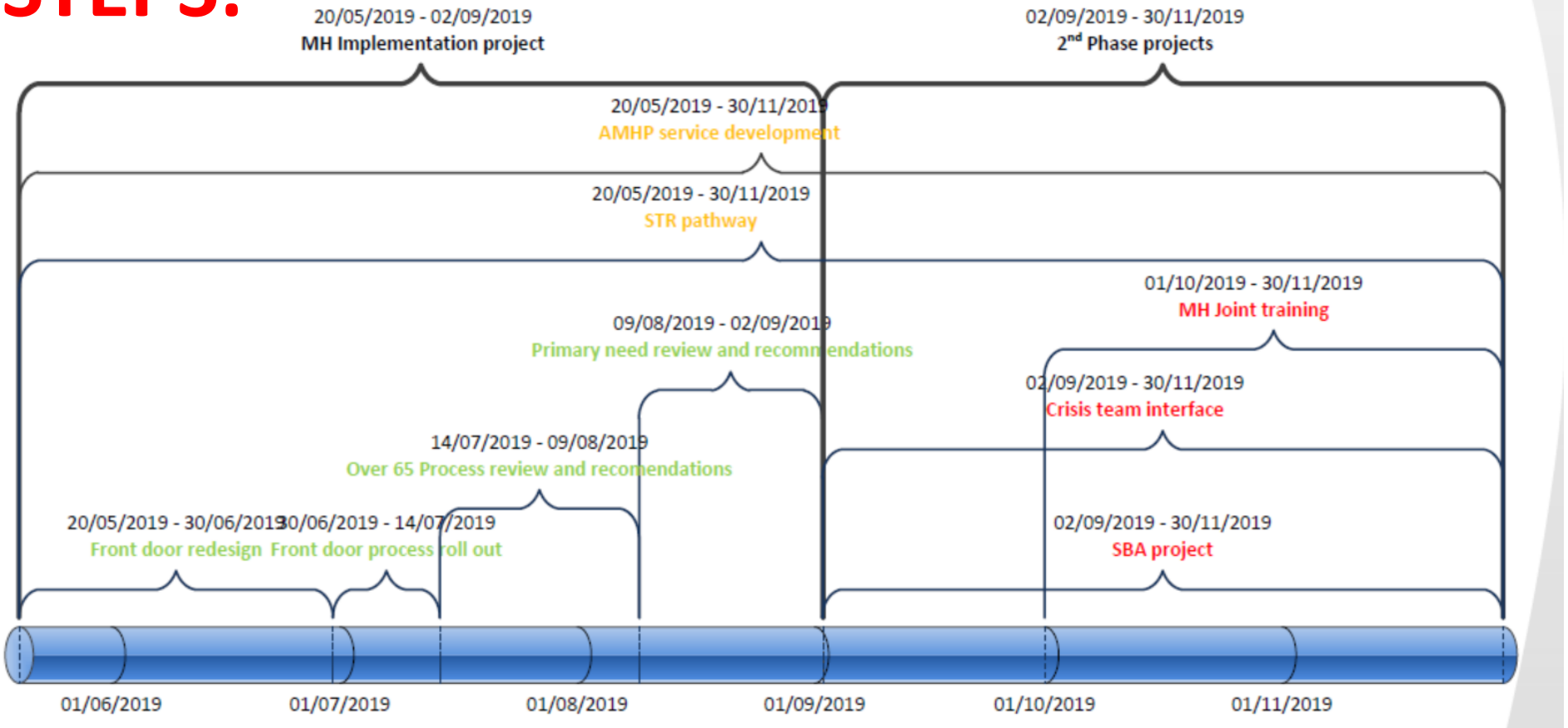
- Transition of cases to health
- Changes to team structures

Tools to support delivery:

- Thematic action plan and visual control for implementation across teams

NEXT STEPS:

Mental Health Service Redesign Road Map



/05/2019 30/11/2019

Ongoing in house workshops

Care act practice, LLA usage, Data intelligence work, Duty worker, Ward liaison, Locality team interface

Expected Benefits

- Ability to meet the statutory obligation under the Care Act
- Reduction in people requiring mental health services through offering a stronger prevention offer at the front door.
- Specialist advice, support and input for people with comorbidities and are over 65years of age
- Continued Co-location with health colleagues providing a holistic response to need
- Minimise the impact of a crisis for an individual where there is a social care need identified
- Increase in number of assessment staff
- Clarity of role, expectations and job satisfaction
- Aligned pathway with care and support (HAS)
- County wide AMHP model leading to a consistent approach through having a clearly identified pathway
- Clearly defined and distinctive social care pathway for North Yorkshire that is outcome focussed, strength based and responsive to the needs of the local population.

Customer feedback

Group of 8 customers participated Across the workshops & one focus group Discussed 5 key themes;

1. Raising awareness & communication

"need greater communication"

2. Information sharing

"I want to hear about the status of my referral regularly and a timely fashion and I want to know who to ring directly that best knows what is going on with my care"

3. Social care crisis response – what could the offer look like?

"What would it look like?"

4. Ongoing future involvement

"MH carer and service user consistent offer across county in terms of strategy, support groups, involvement (i.e. involvement in recruitment, access to leadership, service design/change)"

5. Carer specific Mental Health

"SU in their own right re: prevention & key to co-production in their role as carers"

A question for the Committee- are they further areas of development you would like to see moving forward?