

# Sefton Mental Health Task Group Report

*“The health care system that can solve-for the really big challenges – dementia, obesity, inequalities, mental health and wellbeing, personalisation, prevention and empowerment - that’s the health system that will prosper in the 21st century”  
Simon Stevens, NHS England Chief Executive*

## Contents

<b>Section</b>	<b>Page(s)</b>
1. Foreword	2
2. Executive Summary	3-9
3. Introduction	10-12
4. Background	13
5. The impact of mental health and dementia on the population of Sefton	14-16
6. Local Needs Analysis for Mental Health and Dementia in Sefton	17-20
7. Current mental health and dementia service provision	21-24
8. Finance	25-26
9. Issues identified	27-29
10. Parity of Esteem and best practice within future mental health and dementia services in Sefton	30-31
11. Priority Areas - Moving Forward	32-60
12. How the vision can be achieved	61-66
13. Conclusion	67
14. Recommendations/Next Steps	68
<b>Appendix</b>	
Appendix 1: Site Visit Information	69-73

## 1. Foreword

Improving mental health and dementia alongside physical health has been identified as a major challenge by both NHS Southport and Formby CCG and NHS South Sefton CCG. To meet this challenge a joint CCG Mental Health Task Group was established in May 2014 to enable both CCGs to identify what provision was in place – what works and what does not in the mental health and dementia pathways, identify the gaps and provide radical solutions within a new a vision for mental health and dementia to be implemented from 2015/16 onwards.

I would like to place on record my thanks to the following; Mersey Care NHS Trust staff and those from other organisations who made time for us to visit their services. Without their engagement and openness this report would not have had the rich seam of insight upon which to base its findings.

My Task Group colleagues, Geraldine O'Carroll, Kevin Thorne and Gordon Jones who on top of their other duties have taken the time to play active roles as members of the Task Group and contribute to this report.

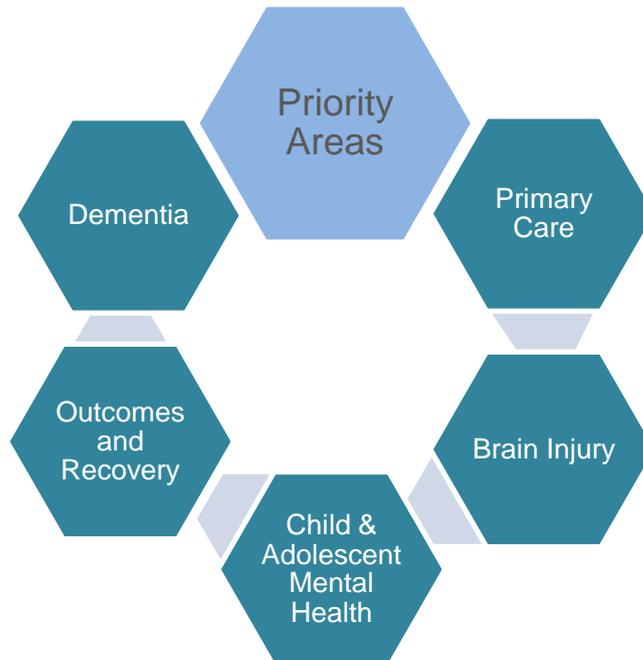
I commend this report to you and ask that you work with us to enable the vision contained within it to be realised.



Dr Hilal Mulla, Sefton Mental Health Task Group lead and NHS Southport and Formby CCG Mental Health Lead

## 2. Executive Summary

NHS South Sefton and NHS Southport and Formby CCG have identified mental health as a key priority and as such the Sefton Mental Health Task Group was established in April 2014 to review the current pathways and services covering the Sefton populations. Under the aegis of parity of esteem the Task Group has identified the following priority areas for action in 2015/16 and onwards:



The above areas identified through the task group have been prioritised for 2015/16, however both CCGs will continue to work with all Providers to ensure delivery of safe and effective services which deliver improved outcomes for all commissioned mental health and dementia services.

The vision is to have an all age mental health service across Sefton which is recovery focussed, visible, easily accessible, of high quality, safe and will deliver beneficial outcomes. Emphasis will be placed on early intervention, recovery and integrated mental and physical health to enable patients to be managed better in the community with a reduced reliance on acute interventions. Dementia will be treated as a long term condition within community based networks of care.

Table one outlines the components of the future model for delivery of community mental health and dementia services across Sefton.

**Table one: The Future components, outputs and anticipated outcomes**

<b>Service Component</b>	<b>Outputs and anticipated outcomes</b>
<b>Ageless Access</b>	<p>Timely identification and treatment of all people with serious mental illness who also have untreated physical health care needs. The right service and interventions are to be identified early in their treatment journey.</p> <p>Improved joint working between mental health specialists and primary care to ensure faster access as well as use shared electronic records, screening of high risk groups and proactive use of disease registers.</p> <p>Service users, families and carers and professionals will have a better understanding of the mental health and dementia services in Sefton.</p>
<b>Locality based multidisciplinary teams providing integrated care including the VCF Sector</b>	<p>Identification and treatment of people with long term health conditions who also have co-morbid mental health problems ensuring integrated personalised care plans are developed to enable access to a range of mental health and dementia support.</p> <p>Robust communications in place to support transfer of care from secondary to primary care as patients recover and/or become more stable.</p> <p>Effective case management, systematic follow up and close collaboration between primary and secondary care.</p> <p>IAPT therapists working collaboratively with chronic disease specialists through collaborative care models e.g. for people with anxiety, depression and a long term condition.</p> <p>Treatment for patients at a locality level closer to their homes.</p> <p>Localities working with partners to develop tailored public health messages for individual localities e.g. Dementia friendly, young persons mental health.</p>
<b>Liaison psychiatry with hospitals and care homes.</b>	<p>Liaison psychiatry services embedded within acute hospitals and care homes to provide the interface between physical and psychological health.</p>

All future commissioning undertaken by both CCGs will, as routine, consider mental health and dementia as part of the pathway. An ageless pathway under the aegis of parity of esteem is central to this vision. Commissioning will begin at locality level upwards within the local health economy in Sefton so as to ensure that local needs are met.

The Task Group has put forward a number of recommendations contained within this Report; these have been developed following the site visits and dialogue with

providers, GPs, patients, voluntary sector and the council. Site visits demonstrated that there is good practice being undertaken by dedicated staff in often challenging conditions however there is an appetite for change.

To deliver the vision the best of both primary care and secondary mental health provision need to work very differently than at present to ensure delivery of better patient outcomes.

## **2.1 Barriers in current provision**

Several barriers exist in the provision of the mental health and dementia namely:

- Age
- Geographical location of services
- Gender
- Limited collaborative working with acute and other physical health services
- Disjointed pathways
- Incompatible IT systems

In addition the current mental health contracting currencies are out of date and focus on quantitative measures rather than qualitative measures and beneficial health outcomes.

It is essential for patients that any future service provision intervenes early, to provide the right intervention at the right time, and to get it right first time, preventing the development of morbidity, reducing the risk of harm and promoting recovery. It is therefore vital that any future service models provide interventions that are evidence based and cost effective in the prevention and treatment of mental illness and in the management of dementia.

## **2.2 The new models of care**

It is the Task Group's view that current dementia provision, which predominantly sits within Mersey Care NHS Trust, should be more integrated with primary and community physical health services and developed at a locality level. Future community mental health services should also be delivered at a locality level so as to address differing population profiles and correspondingly the level of mental health and dementia input from secondary services will take account of local morbidity.

The future models of mental health and dementia care envisage patients being predominantly managed by primary care within locality settings in collaboration with specialist services to enable tailored care that meets the identified needs of locality populations.

These new models will reduce the current multiplicity of teams that provide care and further reduce the sense of isolation between primary care and specialist mental health services. Primary care will have even further direct access to Consultants and other professionals for advice and support.

Primary care confidence in the new models of care will require support for shared care to enable primary care to manage stable patients. The building of professional relationships between primary care and specialist mental health services will be critical to the success of locality working. In addition information sharing and interoperable IT systems will be a key facet of the new model of working.

Access arrangements which are not service or age specific will be simplified so as to reduce multiple access points.

For dementia the expected increase in prevalence will result in a strengthened role for primary care across Sefton in the identification, assessment and diagnosis of dementia with more interventions taking place closer to the patient's home. It is proposed that Care Navigators will be developed to provide signposting and information services to assist people with dementia and their carers to live well with dementia.

The Virtual Ward and Care Closer to Home transformation programmes already in place in South Sefton and Southport and Formby provide the catalyst to develop locality based primary care led dementia services. Similar to mental health the future dementia model for Sefton will be integrated and combine primary community and social care and Sefton Voluntary Community Faith (VCF) Sector provision delivering improved care for patients. The dementia model will have the following clear objectives:

- Timely access to assessment and diagnosis by an appropriate clinician.
- Reduced number of people entering nursing home cares through post diagnostic support at all levels of the patient's journey.
- People living in care homes with dementia will have their physical and mental health needs regularly assessed and met, this can help to reduce avoidable admissions to hospital through integrated and effective care home liaison.
- Reduced numbers of people being admitted to hospital and for those who are admitted length of stay is reduced through effective hospital liaison.
- Reduction in anti-psychotic prescribing for those patients with dementia, enabled through education.
- Encouragement and nurturing of dementia friendly communities.

For mental health services the challenge will be to work with Providers to configure flexible services on a locality basis in Sefton. This will be a shift away from delivering community services on a wider footprint.

The future care pathways for mental health will not be only be treatment focused but they will encompass the following social based interventions that reflect wider determinants of mental health and wellbeing:

- Advocacy and welfare advice

- Education
- Employment
- Housing
- Good parenting
- Healthy start in life for children
- Good relationships
- Wider social inclusion and reducing loneliness
- Increased self confidence

In mental health, the goal of recovery will be embedded at the very start of every patient's journey. A recovery based approach to mental illness will build resilience, reduce the risk of relapse and the need for crisis intervention or on-going support; ultimately improving the quality of life for the individual and their families.

The locality focus for future community mental health and dementia care will be challenging to implement but the current status cannot be maintained and any lasting change to the mental health and dementia pathways can only be done in partnership at a strategic and operational level within the local health economy.

The proposed community mental health and dementia locality model outlined below aligns to the locality model currently being developed by both Sefton CCGs. It will be based on the health needs of each locality taking account of prevalence, activity, growing demand and population increases. This model is in draft format whilst further detailed needs analysis is undertaken, however it does begin to outline the level of mental health and dementia services required for each of the existing eight localities.

# Model One: Proposed Community Mental Health and Dementia locality model

## DRAFT Mental Health and Dementia Locality Model

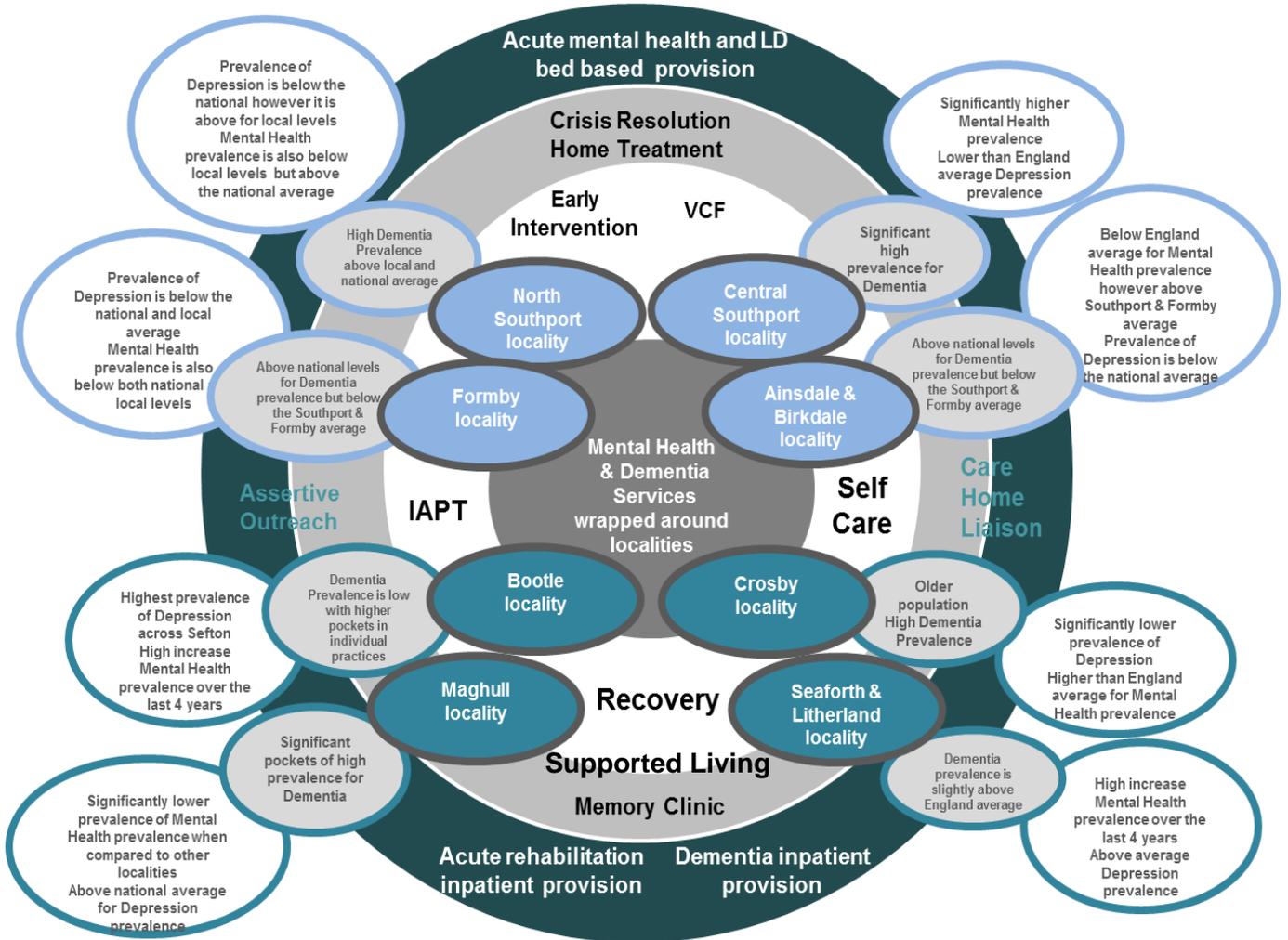
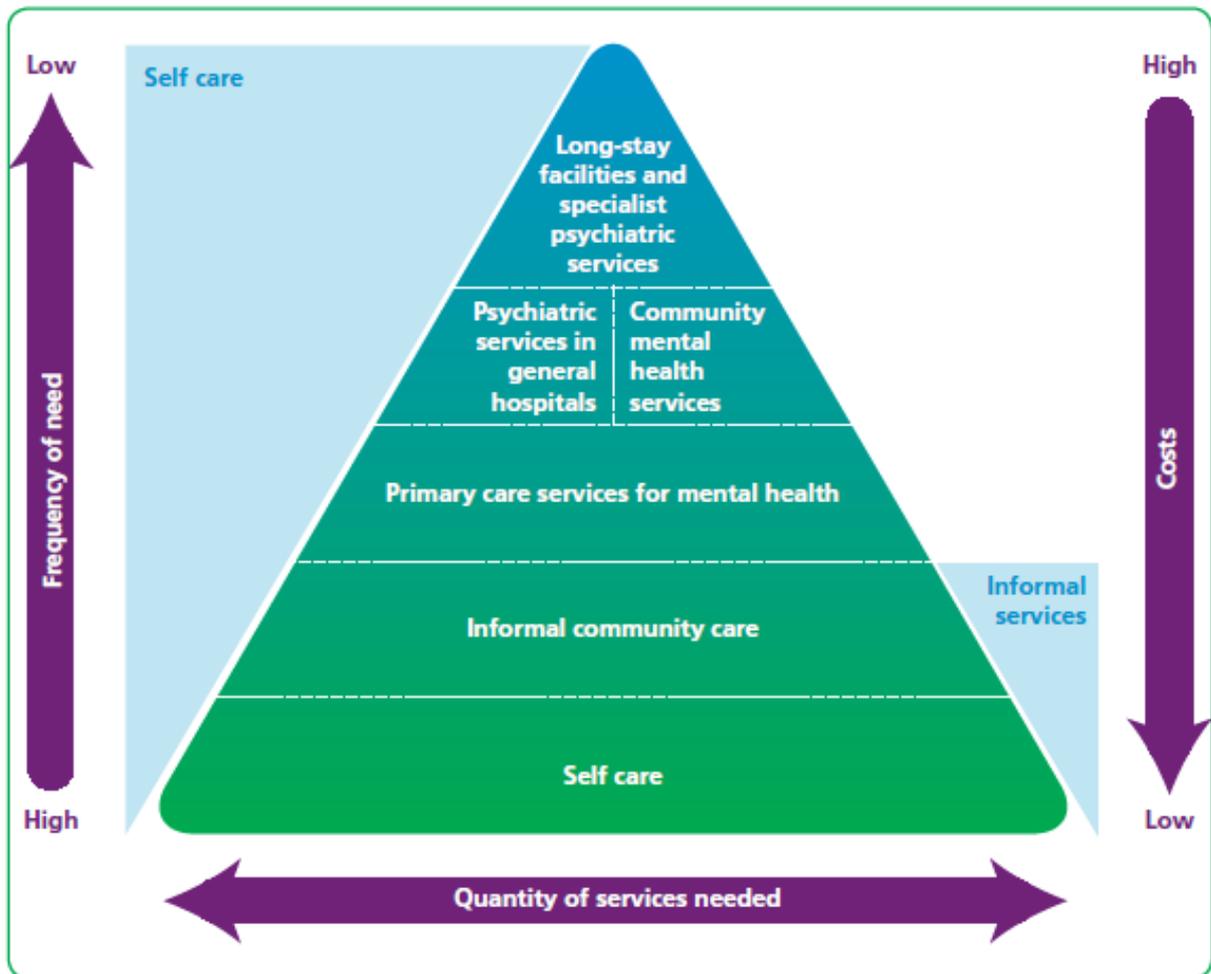


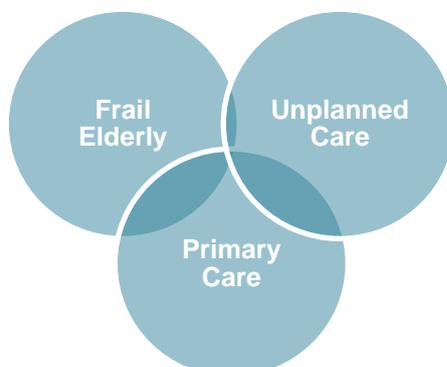
Diagram one below outlines the varying levels of interventions for patients with mental health and dementia needs with the focus being on self care and informal/VCF community care.

Diagram one: Addressing the needs of people living with mental health conditions:



### 3. Introduction

This report is integral to the overall strategic objectives of NHS Southport and Formby CCG and NHS South Sefton CCG whose shared priorities are:



Across Sefton, mental health conditions and dementia present a real challenge to health services and the wider community and this report is the first stage on a journey of reform for the commissioning of mental health and dementia services to achieve parity of esteem, equity and consistency across these pathways.

The aim is to support the Sefton Health and Wellbeing Board in developing a partnership with an over-arching Mental Health Strategy and takes cognisance of the Government's Mental Health Strategy: *No Health Without Mental Health* (DH, 2011)<sup>1</sup> and its six key objectives:

1. More people will have good mental health
2. More people with mental health problems will recover
3. More people with mental health problems will have good physical health
4. More people will have a positive experience of care and support
5. Fewer people will suffer avoidable harm
6. Fewer people will experience stigma and discrimination

The Government strategy requires individuals, communities and the organisations within them to take responsibility for improving their own mental health and wellbeing and/or taking care of that of other people. Challenging “the blight of stigma and discrimination” is also prioritised as both an individual and collective responsibility. Good mental health is recognised as central to an individual's quality of life, central to the nation's economic success and interdependent with success in improving education, training and employment outcomes and tackling some of the persistent societal problems ranging from homelessness, violence and abuse, to substance misuse and crime

The NHS *Five Year Forward View* (DH, October 2014)<sup>2</sup> reinforces the rapidly growing body of evidence emphasising the need for services to deliver a better coordination of care and a deeper integration of services. The visioning document

<sup>1</sup> [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/213761/dh\\_124058.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf)

<sup>2</sup> <http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>

places “new partnerships, with local communities, local authorities and employers” at the fore. New proposals for out-of-hospital, multi-specialty provider models and integrated primary and acute care systems highlight more than ever, the need for leadership which facilitates and supports an integrated approach to quality care. In respect of mental health and parity of esteem the *Five Year Forward View* is unequivocal in that “**Over the next five years the NHS must drive towards an equal response to mental and physical health, and towards the two being treated together**” and this should be the impetus to make real and lasting changes to the provision of mental health and dementia services across Sefton.

The traditional divide between primary care, community services, and hospitals - largely unaltered since the inception of NHS in 1948 is increasingly being viewed as a barrier to the meeting of personalised and co-ordinated care for patients and this divide has also influenced commissioning. The commissioning approach needs to change to meet the existing and future needs of the population in Sefton.

In April 2014 the CCG Mental Health Task Group was established with a clear remit to articulate a future vision for mental health and dementia services across Sefton and in the course of its work it undertook to identify the following:

- What have we got**
  - What works and what could be improved
- Service provision gaps**
  - Issues within the existing pathways
- Provide Solutions**
  - Explore and provide solutions which can be implemented from 2015/16 onwards

The Task Group, through this report, considers existing mental health and dementia provision in Sefton and it should be noted that there is a lot of innovative work being undertaken by providers which should be celebrated. The report draws upon a variety of sources including site visit observation, demographics and morbidity, statistics, current literature, GP feedback and Big Chat events with the public to enable a vision to be articulated for the population of Sefton. The report outlines a number of priority areas to be considered for development that are cognisant of the need to square the circle between the desire to improve quality, respond to rising patient volumes, and operate within funding constraints.

### 3.1 Main Provider Plans

Mersey Care NHS Trust, as the main mental health provider in Sefton, has also embarked on a service transformation programme, it was imperative that links were forged with the Trust to ensure that their work compliments that of the Sefton CCGs in the future development of services. Mersey Care’s transformation programme is aimed at redesigning services within a newly reconfigured local services division.

Titled the *Local Service Division Care Strategy 2014-19*, the Trust's strategy document is a vision that describes its proposed plans for how Mersey Care NHS Trust wants to change local mental health, addiction, learning disability and brain injury services over the next five years. Its overall aim is to deliver patient care by focusing on the following:

- Safe – avoiding injuries to patients from the care that is intended to help them.
- Effective – providing services that are based upon scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse).
- Patient-centred – providing care that is respectful of and responsive to individual patient's preferences, needs and values, and ensuring that patient values guide all clinical decisions.
- Timely – reducing waits and sometimes harmful delays for both those who receive and those who give care.
- Efficient – avoiding waste in particular waste of equipment, supplies, ideas and energy.
- Equitable – providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

The Trust has also identified the following key principles that will underpin any changes that are made to achieve transformed service delivery:

- Place quality of care above everything else, by focusing on individual needs, recovery and outcomes.
- Make the best use of financial resources.
- Have simple; integrated (connected) pathways and co-ordinated services that maintain continuity of care, using shared technology across the whole pathway.
- Support clinically led, multi-disciplinary team working and care planning by investing time and effort in staff and team development.
- Develop new partnerships with organisations that support recovery and integrated pathways.
- Clear clinical accountability with experienced clinicians responsible for all assessments and treatment of people with the most complex needs.
- All systems and processes must be designed to support clinicians in their day to day clinical practice, for example successfully deliver the new electronic patient records system.

The *Local Service Division Care Strategy 2014-19* document makes reference of the need for parity of esteem within the local health economy and articulates a community recovery and wellbeing service that aligns to the CCGs' vision of locality working.

## **4. Background**

### **4.1 Mental health and dementia clinical leadership in Sefton**

This review has been led by Dr Hilal Mulla who chairs the Clinical Quality and Performance Group which contractually oversees the quality and performance relating to the Mersey Care NHS Trust contract for Sefton and its associate commissioners.

The two Sefton CCGs also have a contract, quality and performance mechanism in place to monitor and manage the Improving Access to Psychological Therapy (IAPT) contract.

Liverpool CCG is the lead commissioner on behalf of South Sefton and Southport and Formby CCGs, for Alder Hey Children's NHS Foundation NHS Trust, they oversee all quality and performance including CAMHS through contract monitoring arrangements.

Nationally and locally mental health and dementia have not been given detailed consideration in wider physical health commissioning and this in turn has led to the mental health and physical health of patients being treated in varying degrees of isolation when in fact they are interlinked. Social needs which also impact on mental health and/or dementia and physical health should, again as with physical health, be addressed in unison with the principle of parity of esteem to ensure that all people are entitled to the best care available, whatever their diagnosis or personal characteristics (such as age or gender).

### **4.2 NHS Finance**

The slowdown in the growth of NHS funding in England since 2010 has resulted in the NHS having to pursue the most ambitious programme of improved efficiency since its foundation. The gap between need and available funding is widening.

The challenge facing commissioners is to prove that services provide best value for money and deliver effective outcomes. The proposed introduction of a mental health tariff system offers an opportunity to engage in a different way with providers to face this challenge. We will evaluate current use of resources with a greater emphasis on the impact they have in providing effective treatment and recovery programmes And improved outcomes for our population.

Much of the focus on current mental health provision has been on improving the outcomes of those with existing mental health problems. As mental health stigma is challenged and mental health becomes more prevalent there needs to be a focus on prevention to reduce future demand on services.

Funding reductions to local authority allocations could have a significant impact, Sefton Council need to achieve £55 million in savings over the next two years. This could further reduce the capacity to invest in interventions to support positive mental health and the prevention of mental health.

## 5. The impact of mental health and dementia on the population of Sefton

### 5.1 The determinants of mental illness

Good mental health is integral to physical health and wellbeing. An individual's mental health is shaped by various social, economic, and physical environments operating at different stages of life.

The determinants of mental health and wellbeing are multiple and complex they include:

- The wider determinants of education, finances, employment, housing, transport systems, the physical environment and access to green spaces.
- The circumstances in which people live such as neighbourhood safety and community strengths (assets), the settings in which people work, study and play/socialise, engagement in local life and opportunities for social participation, social norms and levels of discrimination, levels of violence, crime and abuse.
- The individual's emotional resilience, family history and developmental factors, individuals physical health and health behaviours, life events and opportunities, psychosocial factors such as access to support, sense of belonging, feeling respected and a sense of autonomy and control over one's life.

### 5.2 The impact of mental illness

*No Health Without Mental Health* (DH, 2011)<sup>3</sup> notes the following:

At least one in four people will experience a mental health problem at some point in our lives.

One in six adults has a mental health problem at any given time.

One in ten children (aged 5-15) has a mental health problem and half of all people with lifelong mental health problems have developed them by the age of 14.

<sup>3</sup> [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/213761/dh\\_124058.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf)

Mental health illness does not just affect individuals but also their families, friends and colleagues. In determining the financial impact of mental illness *No Health Without Mental Health* notes:

- *Sickness absence due to mental health problems costs the UK economy £8.4 billion a year and also results in £15.1 billion in reduced productivity.*
- *Mental ill health is the largest single cause of disability in the UK, representing up to 23% of the total burden of ill health.*
- *Mental health is the largest area of NHS spending (spending on mental health services accounts for 11% of the NHS secondary health care budget, more than spending on either cardiovascular disease or cancer services).*
- *The total cost of mental health in England is estimated to be around £105 billion and it has been estimated that the cost of health services to treat mental illness could double over the next 20 years.*

Many people with long-term physical health conditions also have mental health problems. These can lead to significantly poorer health outcomes and reduced quality of life. The links between mental health and long term conditions are well documented. The King's Fund and Centre for Mental Health document, *Long-term conditions and mental health – The cost of co—morbidity* (2012)<sup>4</sup> estimated that in terms of NHS spending; at least £1 in every £8 spent on long-term conditions is linked to poor mental health and wellbeing and they estimated that 30% of people with a long-term condition have a mental health problem and 46% of people with a mental health problem have a long-term condition (approximately 4.6 million people). The costs to the health care system are significant – by interacting with and exacerbating physical illness, co-morbid mental health problems raise total health care costs by at least 45 per cent for each person with a long-term condition and co-morbid mental health problem.

The health consequences of mental illness are most extreme for people with a psychosis (schizophrenia or bipolar disorder). Nationally men with schizophrenia living in the community have a 20.5 year reduced life expectancy; women have 16.4 year reduced life expectancy. The main cause of this reduced life expectancy is primarily cardiovascular disease, which suggests that the deaths are mostly preventable.

The King's Fund and Centre for Mental Health document, *Long-term conditions and mental health – The cost of co—morbidity* (2012)<sup>5</sup> document also evidenced that the relationship between having multiple long-term conditions and experiencing psychological distress is exacerbated by socio-economic deprivation in two ways. First, a greater proportion of people in poorer areas have multiple long-term conditions and second, the effect of this multi-morbidity on mental health is stronger when deprivation is also present.

---

<sup>4</sup> <http://www.kingsfund.org.uk/publications/long-term-conditions-and-mental-health>

<sup>5</sup> <http://www.kingsfund.org.uk/publications/long-term-conditions-and-mental-health>

### 5.3 The determinants of dementia

Most experts believe that the majority of dementia conditions occur as a result of complex interactions among genes and other risk factors. Age, family history and heredity are all risk factors. Research is beginning to suggest that other risk factors including general lifestyle and wellness choices and effective management of other health conditions are also a contributor.

### 5.4 The impact of dementia

Nationally there are around 800,000 people with dementia in the UK, the disease costs the economy £23 billion a year and if trends continue, the number of people with dementia will double over the next 40 years.

One in 20 people over 65 in the UK has some form of dementia, rising to one in five people over 80.

People with dementia are frequent users of health and social care services. A quarter of hospital beds (Alzheimer's Society, 2009)<sup>6</sup> and up to 70% of places in care homes are occupied by people with dementia (Alzheimer's Society, 2014a)<sup>7</sup>, and over 60% of people receiving homecare services have dementia (UKHCA, 2013)<sup>8</sup>. In addition the, *Quality Outcomes for People with dementia* document (DH, 2010)<sup>9</sup> notes that:

Diagnosis	<ul style="list-style-type: none"><li>• Two thirds of people with dementia never receive a diagnosis;</li><li>• the UK is in the bottom third of countries in Europe for diagnosis and treatment of people with dementia;</li><li>• only a third of GPs feel they have adequate training in diagnosis of dementia.</li><li>• GP register data shows that 393,613 people have a confirmed diagnosis; this figure is the prevalence gap.</li></ul>
Acute Hospitals	<ul style="list-style-type: none"><li>• 40% of people in hospital have dementia;</li><li>• the excess cost is estimated to be £6m per annum in the average General Hospital;</li><li>• co-morbidity with general medical conditions is high, people with dementia stay longer in hospital.</li></ul>
Care Homes	<ul style="list-style-type: none"><li>• Two thirds of people in care homes have dementia;</li><li>• dependency is increasing;</li><li>• over half are poorly occupied;</li><li>• behavioural disturbances are highly prevalent and are often treated with antipsychotic drugs.</li></ul>
Antipsychotic Drugs	<ul style="list-style-type: none"><li>• There are an estimated 180,000 people with dementia on antipsychotic drugs.</li><li>• In only about one third of these cases are the drugs having a beneficial effect</li><li>• there are 1800 excess deaths per year as a result of their prescription.</li></ul>

<sup>6</sup> <http://www.alz.co.uk/research/files/WorldAlzheimerReport.pdf>

<sup>7</sup> [http://alzheimers.org.uk/site/scripts/download\\_info.php?fileID=2317](http://alzheimers.org.uk/site/scripts/download_info.php?fileID=2317)

<sup>8</sup> <http://www.ukhca.co.uk/pdfs/UKHCADementiaStrategy201202final.pdf>

<sup>9</sup> [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/213811/dh\\_119828.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213811/dh_119828.pdf)

## 6. Local Needs Analysis for common Mental Health conditions and Dementia in Sefton

### 6.1 Mental Health

Risk factors for many mental health conditions are heavily associated with social inequalities, whereby the greater the inequality the higher the risk. Sefton is ranked 92 out of 326 English authorities in the 2010 Index of Deprivation (1 is most deprived). Approximately 18% of Sefton's residents live within the most deprived 10% of areas within England and Wales.

### 6.2 Dementia

Sefton has one of the highest proportions of adults with dementia in the UK compared to other local authorities, and figures produced by Oxford Brookes University predict there are considerably more people affected by dementia than are registered with GPs. Current estimates suggest there may be 4,446 people aged over 65 affected by dementia in Sefton, more than double the number registered with our GPs. In addition, estimates suggest there may be a further 77 people who are affected by early onset dementia.

Sefton's ageing population inevitably means costs will rise and services are likely to become increasingly unsustainable without service re-design. Sefton also has a high proportion of older people who live alone and combined with the increase in numbers of older citizens developing some form of dementia and the increase in associated costs, Sefton is likely to continue to exceed the national average.

It is forecast that by 2030 the number of over 65's in Sefton affected by dementia will increase by 49% to 6,624.

Table two: Predicted Dementia incidence in Sefton 2014 - 2030

Age Band	2014	2015	2020	2025	2030
People aged 65-69	215	220	207	231	253
People aged 70-74	378	381	459	434	486
People aged 75-79	714	714	741	895	855
People aged 80-84	1,146	1,156	1,206	1,270	1,549
People aged 85-89	1,094	1,133	1,328	1,467	1,578
People aged 90 and over	899	957	1,194	1,549	1,903
Total	4,446	4,561	5,135	5,846	6,624

Source: Projecting Older People Population Information (POPPI)

NHS England analysis undertaken in December 2014 indicates that for Southport and Formby CCG the actual dementia diagnosis rate is 53.6% against an estimated prevalence for people with dementia of 2,469. This identifies a prevalence gap of 1,143 people who may benefit from access to support by way of a dementia diagnosis. The same analysis indicated that in NHS South Sefton CCG the actual diagnosis rate is 60.6% against an estimated prevalence for people with dementia of 1,982. Again, this identifies an estimated prevalence gap of 781 people who may benefit from access to support by way of a dementia diagnosis.

### 6.3 Quality and Outcomes Framework (QOF)

The data to support the following analysis has been extracted from the Quality and Outcomes Framework (QOF) database, which is provided to Public Health by the Health and Social Care information Centre.

Using this information to target localities will assist in informing the future provision of services as the current one size fit all approach to service provision does not always meet the needs of each locality.

#### 6.3.1 South Sefton Mental Health Needs summary

- According to 2013/14 QOF data, **dementia prevalence** in South Sefton stood at 0.68% with 1,061 patients registered with dementia. Prevalence in South Sefton is marginally higher than the national average which is 0.57%, which may be explained by the higher proportion of elderly people in South Sefton compared to the national average with an estimated 19.5% of the population over the age of 65 in South Sefton compared to 17.5% nationally.
- **Dementia prevalence** appears to have increased across South Sefton over the past four years with a consistent rise of approximately 0.1% across all localities. This may be due to increased case-finding, and a slight increase in the elderly population as opposed to an actual increase in disease prevalence.
- Crosby locality has the highest **prevalence of dementia** in South Sefton at 0.86%, which is to be expected given their older population with almost one third of the registered population in the locality aged over 65 and 38% aged over 85 . Within Crosby one practice is significantly higher than both the CCG and England average with a prevalence of 2.2%, but a corresponding high elderly register of patients. More than half of the practices within Crosby have a higher prevalence than the England average, but again this is explained by a high elderly population.
- **Depression prevalence** across South Sefton remains above the England average at 8.1% compared to 6.5% nationally.
- **Depression prevalence** has increased over the past two years in South Sefton with all localities showing a rise of up to 1%, but this is a new QOF measure since 2012/13, so increases year-on-year are to be expected while GPs establish these new registers. Prevalence in Bootle, Seaforth and Litherland and Maghull is higher than the national average which is 6.5%. Prevalence in Seaforth and Litherland has increased the greatest over the past two years but Bootle still consistently has the highest prevalence of depression across Sefton at 9.9% followed by Seaforth and Litherland at 9%. All practices across Bootle sit higher than the England average apart from one with a prevalence of 2.9%. Crosby has a significantly lower prevalence of depression at 5.6%.
- **Depression prevalence** across South Sefton varies with some outliers in each locality, including Eastview in Crosby (11.2%), Maghull Health Centre in Maghull (14.2%), Seaforth Village Practice (13.85%) and Netherton SSP (11.56%).

- **Mental Health prevalence** is captured in QOF and is defined as a register of patients with schizophrenia, bipolar affective disorder and other psychoses and other patients on lithium therapy. Prevalence in South Sefton in 2013/14 was 1.2%. This is higher than the England average of 0.86%. Within South Sefton, Bootle, and Seaforth and Litherland localities show the biggest increase in Mental Health prevalence over the past four years with prevalence of 1.54% and 1.4% respectively. Maghull has a significantly low prevalence compared with other localities across Sefton.
- Across the Bootle locality all practices are above the England average for **Mental Health prevalence** with Concept House being significantly higher at 2.5%.
- **The Community Mental Health profile 2014**<sup>10</sup> indicates that treatment across South Sefton is suboptimal in parts. Namely the proportion of patients with a mental health diagnosis recorded in primary care is significantly lower than the national average at 6.8% compared to the national average of 17.8%; the proportion of patients with a severity of depression assessed is the lowest nationally at 77.4% compared to the national average of 90.6%; Carers of people with Mental Health conditions receiving an assessment is nearly half the England average. However, some indicators of treatment are favourable: Attendances at A&E for psychiatric disorder are significantly lower than the England average; the proportion of patients with a comprehensive care plan is significantly higher than the national average at 90%; people in contact with mental health services is also significantly higher than the national average

### 6.3.2 Southport and Formby Mental Health Needs summary

- **Dementia prevalence** across Southport and Formby in 2013/14 was estimated to be 1.04%. This is considerably higher than the national average of 0.62% and may be partially explained by the higher proportion of elderly people in Southport and Formby compared to the national average. More than 25% of the population are estimated to be over 65 compared to 17.5% nationally.
- Within Southport and Formby localities, **dementia prevalence** is fairly consistent with the exception of Central Southport, where an extremely high prevalence of dementia is apparent (nearly double the CCG average and three times the England average). The other localities have remained fairly static over the last four years, although North Southport has seen a rise in prevalence of 0.2%.
- Grange Surgery in Ainsdale and Birkdale is an outlier compared with other practices, with a prevalence of dementia (1.5%) more than twice that of any other practice in the locality. Trinity Surgery in Central Southport has a significantly higher **Dementia prevalence** (6.4%) than any other practice within the CCG. However, it has dropped from over 10% in last four years, showing a steady downward trend each year.

---

<sup>10</sup> <http://fingertips.phe.org.uk/profile-group/mental-health/profile/cmhp/data#gid/8000053/pat/44/ati/19/page/1/par/E4000001/are/E38000161>

- **Depression prevalence** across Southport and Formby remains below the England average at 5% compared to 6.5% nationally. A slight increase can be seen across all localities within the CCG over the past four years with the highest prevalence being found in North Southport (5.6%) and Central Southport (5.5%).
- The key outliers for **prevalence of depression** within the CCG fall in Central Southport at Cumberland House (8.2%) and Curzon Road (8.1%), and in North Southport at Churchtown Medical Centre (8.8%). These three practices all sit well above the England average and are significantly higher than any other practices across the CCG.
- **Mental Health prevalence** is captured in QOF and is defined as a register of patients with schizophrenia, bipolar affective disorder and other psychoses and other patients on lithium therapy. Prevalence in Southport and Formby in 2013/14 was 1.06%. This is higher than the England average of 0.86%. Rates of these mental health conditions have generally increased across all localities over the past four years, with the exception of Central Southport, which experienced a reduction. Even with a reduction in Central Southport the locality still falls well above the CCG and England average with a prevalence of 1.72%.
- **The Community Mental Health profile 2014**<sup>11</sup> indicates that treatment across Southport and Formby is suboptimal in parts. Namely the proportion of patients with a mental health diagnosis recorded in primary care is significantly lower than the national average at 9.9% compared to the national average of 17.8%; the rate of carers of people with Mental Health conditions receiving an assessment is approximately 40% less than the England average; Attendance rates at A&E for psychiatric disorder are significantly higher than the England average. However, some indicators of treatment are favourable: the proportion of patients with a comprehensive care plan is similar to the national average at 89%; people in contact with mental health services is also significantly higher than the national average.

---

<sup>11</sup> <http://fingertips.phe.org.uk/profile-group/mental-health/profile/cmhp/data#gid/8000053/pat/44/ati/19/page/1/par/E4000001/are/E38000170>

## 7. Current mental health and dementia service provision

### 7.1 Overview of current mental health and dementia provision

Following the reforms introduced by the Health and Social Care Act 2012 local responsibility for mental health and wellbeing lies primarily with NHS Southport and Formby CCG and NHS South Sefton CCG who operate under a single management structure.

In Sefton the traditional divide for mental health services between primary care, community services, and hospitals - largely unaltered since the inception of the NHS in 1948 - is typically no different to the rest of England.

### 7.2 Primary Care

Primary care is often the first point of contact for individuals to seek health care and the majority of people who come into contact with NHS services as a result of mental illness do so in general practice. Numerous studies indicate that the majority of patients have their mental health needs served by their GP practice.

The table below details GP practice information for both Sefton CCGs:

Table three: GP Summary for Sefton CCGs

<b>CCG</b>	<b>Number of Practices</b>	<b>Average List Size</b>	<b>Total Population</b>	<b>CCG</b>
NHS Southport and Formby	20	6,110	122,000	
NHS South Sefton	33	4,699	155,067	

#### 7.2.1 Primary Care National Targets

There are no specific mental health targets relating to primary care but improving the identification and care of patients with dementia has been declared a major national priority by NHS England. Achieving early diagnosis of dementia is recognised as a primary aim within the National Dementia Strategy: Living well with Dementia (DH, 2009) and is championed by the Government.

Primary care is required to achieve the following target:

**Dementia diagnosis:** Improve the diagnosis rate for dementia to 67.1% by March 2015.

### 7.3 Main Provider Trust

The vast majority of mental health and dementia services are provided by Mersey Care NHS Trust which is aspiring to achieve Foundation Trust (FT) status. For 10 years in Sefton a Section 75 agreement has been in place enabling Sefton Local Authority staff to be seconded into Mersey Care NHS Trust to provide integrated support to adult and older people mental health services.

The Trust predominantly provides the following services for adults within the populations of Sefton, Liverpool and Knowsley (Kirkby):

<b>Mersey Care NHS Trust Service Provision</b>	
<b>Learning Disabilities</b>	<ul style="list-style-type: none"> <li>• Inpatient Unit</li> <li>• Outpatient clinic</li> <li>• Community Service including community consultant</li> <li>• Asperger's Team</li> </ul>
<b>Adult Mental Health</b>	<ul style="list-style-type: none"> <li>• Inpatient beds</li> <li>• Rehabilitation Unit</li> <li>• Brain Injuries Services</li> <li>• Psychiatric Intensive Care (PICU)</li> <li>• Outpatient clinics</li> <li>• ADHD outpatient service</li> <li>• Community Mental Health Teams</li> <li>• Community Consultant</li> <li>• Mental Health Liaison</li> <li>• Crisis Resolution Home Treatment</li> <li>• Assertive Outreach Team</li> <li>• Early Intervention in Psychosis</li> <li>• Rotunda Day Therapeutic Community Programme</li> </ul>
<b>Older People</b>	<ul style="list-style-type: none"> <li>• Inpatient facilities</li> <li>• Outpatient clinics</li> <li>• Community Mental Health Teams</li> <li>• Community Consultant</li> <li>• Care Home Inreach</li> </ul>
<b>Offender Health</b>	<ul style="list-style-type: none"> <li>• Criminal Justice Liaison</li> <li>• Triage Car</li> </ul>
<b>Psychological Service</b>	<ul style="list-style-type: none"> <li>• Psychotherapy</li> <li>• Eating Disorders</li> <li>• Personality Disorder</li> </ul>
<b>Specialist Teams</b>	<ul style="list-style-type: none"> <li>• Crisis Resolution Home Treatment</li> <li>• Assertive Outreach Teams</li> <li>• Early Intervention in Psychosis</li> <li>• Dietician Services</li> </ul>

In addition to the services commissioned by the CCGs, the Trust, through specialist commissioning, also provides high, low and medium secure services.

### 7.3.1 Main Provider National Targets

Mersey Care NHS Trust is required to achieve the following national mandated targets specific to mental health:

**Care Programme Approach (CPA):** The proportion of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care during the period is 95%

**Access:** In 2015/16 the provider will be required to achieve treatment within 2 weeks for more than 50% of people experiencing a first episode of psychosis. This target is currently in development.

## 7.4 Improving Access to Psychological Services (IAPT)

As part of the Government's Improving Access to Psychological Therapies initiative, South Staffordshire and Shropshire NHS Foundation Trust, through Inclusion Matters Sefton, provided IAPT services to Sefton residents until March 2015. From April 2015, following a competitive tender process, IAPT services will be provided by Cheshire & Wirral Partnership NHS Foundation Trust.

The provider delivers a stepped care psychological service providing early access to, and delivery of, psychological therapies in primary care and community settings with hubs established in Bootle and Southport. Steps 2, 3, and 4 of the IAPT stepped care model, which is delivered by a multi-disciplinary team, consists of:

- Step 2 - low intensity interventions delivered by a mix of workers with appropriate training, supported and supervised by professionals with the relevant competencies.
- Steps 3 and 4 high - intensity interventions delivered by professionals competent in the delivery of Cognitive Behavioural Therapy and other evidence- based interventions.

The service supports social inclusion and assists people to retain or gain meaningful employment opportunities.

### 7.4.1 IAPT National Targets

All IAPT providers are required to achieve the following national mandated targets specific to IAPT:

**Prevalence:** Achieve penetration prevalence for people entering psychological therapies to be 15% of the local prevalence figure by 2014/15. This requires providers to achieve 3.75% prevalence in Quarter 4.

**Recovery:** The proportion of people moving to recovery will be a minimum of 50% by 2014/15.

**Access:** In 2015/16 the new provider will be required to achieve treatment within 6 weeks for 75% of people referred to the Improving Access to Psychological Therapies programme, with 95% of people being treated within 18 weeks. This target is currently in development:

## 7.5 Child and Adolescent Mental Health Services (CAMHS)

Alder Hey Children's NHS Foundation Trust is the provider of targeted and specialist community child and adolescent mental health services across the borough of

Sefton. The service provides a single point of access through the Mulberry Centre located on the Alder Hey site for all referrals for aged 0 to 18 years of age.

Alder Hey Children's NHS Foundation Trust offers community based specialist services to support children and young people in Sefton, up to the age of 18, who are experiencing mental health difficulties. CAMHS services have a greater interface with an array of services that are commissioned across multiple agencies and professional disciplines.

The CAMHS service offers the following:

- Assessment and appropriate interventions for children and young people with severe and complex mental health and developmental needs
- Contributes to mental health training, education and consultation to partner agencies, parents, carers, children and young people
- Collaboratively works with staff within other internal and external services and agencies to meet the complex mental health needs of children and young people in Sefton.

There is overlap between Alder Hey Children's NHS Foundation Trust and Mersey Care NHS Trust for some patient groups (e.g. Early Intervention Psychosis). Transition protocols have been developed between the two organisations.

Liverpool CCG are the lead commissioner for Alder Hey Children's NHS Foundation Trust community services contract which includes CAMHS.

## **7.6 Voluntary, Community and Faith Sector**

There is a vibrant Voluntary, Community and Faith (VCF) sector in Sefton. Sefton Council for Voluntary Service (SCVS) is key in delivering these services. Sefton CCGs have been working with SCVS in looking at how they can offer support to individuals. Sefton CVS also manage a variety of projects, networks and forums that encourage volunteering and promote community engagement, many of which support people with mental health or dementia. The following services below are just a few that support people with mental health and dementia in Sefton:

- Crosby Housing and Resettlement Team
- Imagine (Employment support)
- Alzheimer's Society
- Citizens Advice Bureau
- Sefton Women's Advisory Network
- Expect (Domiciliary and residential service, providing a range of services for people living with mental illness and/ or learning disabilities)

## 8. Financial Information

### 8.1 CCG Budget

In 2014/15 the total expenditure on health provision across both CCGs was budgeted to be £392.7 million. The table below details the breakdown of this expenditure.

Table nine: NHS spending across Sefton by category

Area of Spend	2014/15 Funding (£000s)	% of Total
Acute Services	£224,187	57.1%
Primary Care Services	£55,779	14.2%
Mental Health Services	£44,495	11.3%
Community Health Services	£37,201	9.5%
Continuing Care Services	£16,695	4.3%
Other Programme Services	£14,248	3.6%
<b>Total</b>	<b>£392,652</b>	

Source: Source: NHS Southport and Formby CCG and NHS South Sefton CCG

### 8.2 Parity of Esteem and 2015/16 mental health funding

In line with NHS England expectations that mental health funding should increase by 1.94% to help achieve parity of esteem in 2015/16, the table below illustrate that both Sefton CCGs are planning to increase mental funding in excess of 1.94%.

Table eleven: NHS Mental Health Funding across Sefton 2014/15 – 2015/16

CCG	2014/15 Mental Health Funding (£000s)	2015/16 Mental Health Funding (£000s)	Increase (£000s)	%
NHS Southport and Formby	£20,642	£21,116	£0.474	2.3%
NHS South Sefton	£23,853	£25,212	£1,359*	5.7%

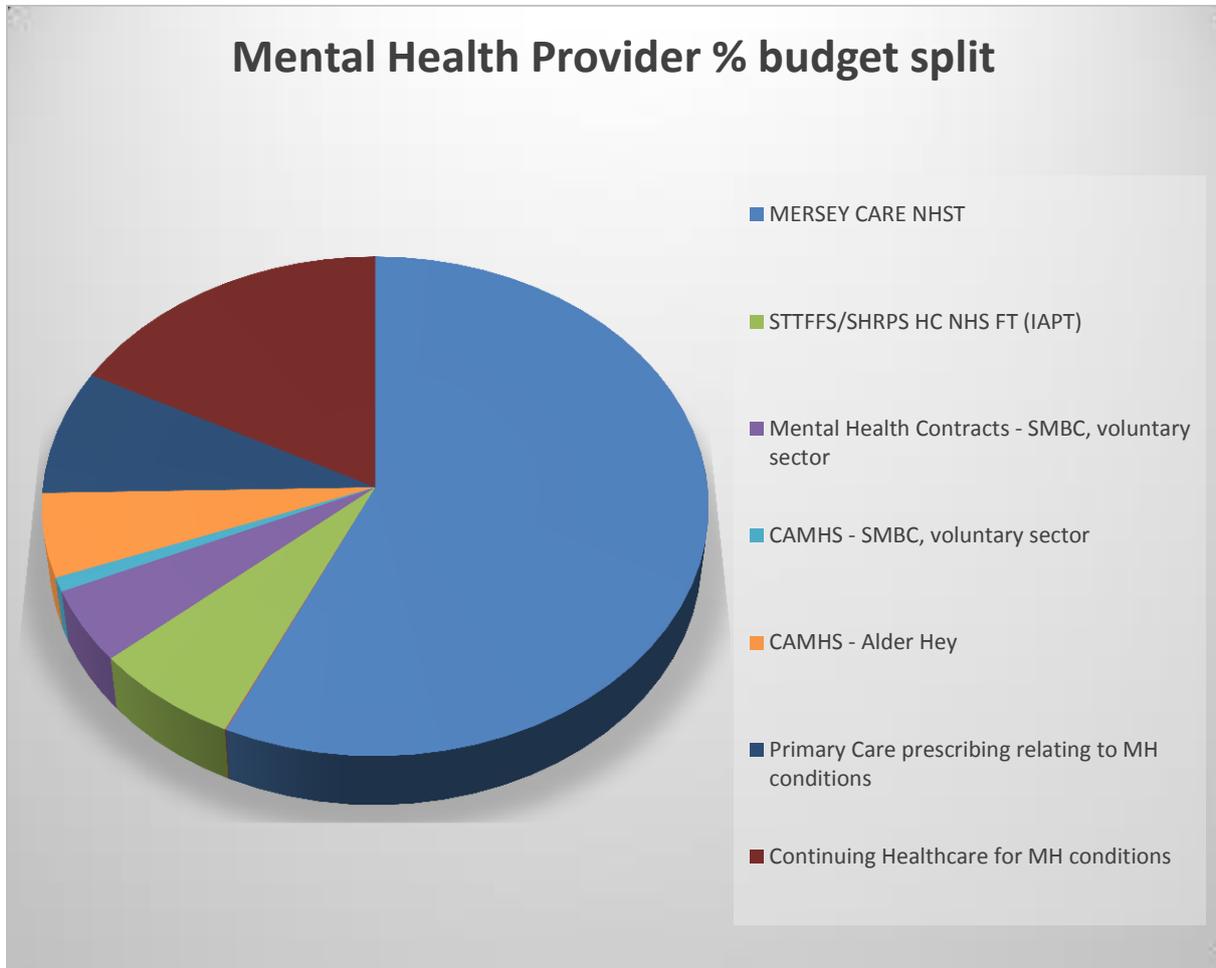
Source: NHS Southport and Formby CCG and NHS South Sefton CCG

\*Includes £1M investment in the Mersey Care NHS Trust Clock View inpatient facility.

### 8.3 Mental Health and Dementia Services budget breakdown by Provider

The chart below highlights the % breakdown of the overall mental health and dementia budget.

Chart one: Mental Health and Dementia Spend by Provider 2014/15



## 9. Issues identified through the Task Group

The Task Group undertook a number of visits to various sites that provided mental health services across Sefton and spoke with staff, patients and carers, as well as reviewed services. A full list of the site visit details are outlined in Appendix 1.

A number of issues were identified, some site specific and some more generic, these have been summarised below under the following 5 headings:

### 9.1 Access

- Referral mechanisms are in place, but for GPs they can still be confusing, referral and access to CAMHS services was cited as being of particular difficulty and issues relating to consent have caused difficulties in getting appointments for patients.
- GPs experience difficulties in accessing health visitors/school nurses for certain young populations.
- The lack of clinical space in Southport and Formby is impacting on access to IAPT primary care mental health services.
- Access to secondary mental health and dementia services are weighted towards routine referrals rather than crisis and the response to GPs with patients in crisis is different to that for patients in A&E.
- Waiting times for referral to treatment in CAMHS are 17 weeks.

### 9.2 Links with Physical Health

- There is little formal integrated joint physical health working for mental health and dementia patients. Where services are co-located with physical health services a combination of formal and informal links appear to be in place and partially dependent on the relationships between individual clinicians.
- Mental health services find it difficult to get community based physical health services to engage with them in trying to achieve the best outcomes for patients.
- Liaison psychiatry can provide better support for co-morbid mental health needs and can reduce physical health care costs in acute hospitals than at present. For example in Southport and Ormskirk Hospital NHS Trust, Mersey Care NHS Trust provides a liaison service but they have no permanent presence and they have to return to the Hesketh Centre to input onto clinical systems. Feedback from the Frail and Elderly unit at Southport and Ormskirk Hospital NHS Trust suggests that if good links were to be established inpatient stays and health outcomes could be improved.
- Mental health patients were reported to be contributing to 4 hour wait breaches due to existing mental health cover arrangements at Aintree University Hospital NHS Foundation Trust.
- The transfer of adult and dementia inpatient services from Stoddart House on the Aintree site to the new Clock View facility in February 2015 highlights the need for mental health and physical services to work much more closely than at present.
- Dialogue between Aintree University Hospital NHS Foundation Trust and Mersey NHS Trust appears to be limited in the commissioning of psychiatry input into the Trauma Centre.

### 9.3 Pathways

- There are many organisations involved in children and young people services and care staff are unclear what all these functions are.
- Co-ordination and care to support children and young people is difficult to navigate and there are several barriers at a local level.
- Transition arrangements for 16-18 year old pathways are unclear and by having two organisations involved in CAMHS and transition (Mersey Care NHS Trust and Alder Hey Children's NHS Foundation Trust) can exacerbate this issue and carries an element of risk for the patient group.
- Services, criteria and geographical boundaries, plus transition points have been centred on the needs of the providers and not based upon the needs of young people.
- Mental health patients mainly present to primary care in crisis which highlights a gap in prevention work being undertaken at a primary care and locality level.
- There are opportunities within the Voluntary Community and Faith sector in Sefton to further collaborate to improve patient experiences in localities, closer to where people live. For example the Alzheimer's Society could provide more post diagnostic support for dementia patients in an environment that is familiar to them.
- There is evidence of patients remaining in services for longer than necessary. For example, dementia patients are assessed and retained by Memory Clinic services when these patients could be managed in a primary care setting.
- Acute hospital inpatients' with mental health or dementia experience longer lengths of stay when compared to patients without these co-morbidities.
- Discharge support arrangements for adult inpatients in South Sefton were praised by the Mersey Care NHS Trust for enabling shorter length of stays. Wrap around services such as dedicated inpatient social work, Citizens Advice, and Crosby Housing and Resettlement Team were cited as being of great benefit to the adult mental health pathway resulting in quicker discharge, however inpatient services in Southport and Formby do not have the same level of wraparound support.
- A Recovery College has been established outside of the commissioning process by Mersey Care NHS Trust.
- Patients with Personality Disorder are becoming more prevalent and these patients require more psychological input than currently present this is leading to out of area placements and complex after care packages of support.
- The need for more psychology input within services was highlighted by Mersey Care NHS Trust staff for inpatient, community and rehabilitation services.
- There are significant numbers of patients being held by Mersey Care NHS Trust whose needs could better be served in a primary care setting. For example patients with Mild Cognitive Impairment are within secondary services when their care could best be managed in primary care.
- The Rehabilitation component of service provision has historically felt isolated from the wider mental health pathway; however the restructuring within Mersey Care NHS Trust, of service delivery into a local services division should enable Rehabilitation to be a vital component in the mental health pathway.
- The Brain Injury service provided by Mersey Care NHS Trust offers a comprehensive service to patients, however, although links are in place with the wider neurological rehabilitation network the pathway appears disjointed.

- There is variation in the delivery of the two Memory Clinic services provided in Southport and South Sefton. This is, in part, the result of the varying levels of involvement by the Alzheimer's Society and different styles of working across the two Memory services.

#### 9.4 Commissioning and Finance

- NHS reorganisations has resulted in some services evolving differently than originally intended. For example the evolution of the Care Home Liaison service.
- A number of patients in crisis attend A&E as first presentation to the NHS and are subsequently referred to the Mersey Care NHS Trust liaison service. Our plan would be to ensure that the management of these patients is undertaken directly by Mersey Care NHS Trust without the need for registration at A&E to ensure unnecessary delays or processes for patients.
- It is often unclear when newly mandated finance is available and this has been an impediment to service planning and design.
- Detailed data relating to service provision in Mersey Care NHS Trust is limited. For example it was not possible to extract financial information and activity data relating solely to dementia.

#### 9.5 Information

- Sefton Local Authority's Liquid Logic system and Mersey Care NHS Trust ePEX clinical system do not "talk" to each other and this may impede the ability of each organisation to provide a comprehensive service. For example the manager in South Sefton Neighbourhood has to input similar data separately into the two different systems to satisfy data recording requirements.
- The ePEX system is obsolete and is currently not fit for purpose for the new activity and outcome requirements.
- The current mental health contracting currencies are out of date and many activity indicators are catchment and not CCG based. At present there is very little data being captured which can demonstrate recovery and outcomes.
- In Southport and Ormskirk Hospital NHS Trust, Mersey Care NHS Trust provide a liaison service but they have no permanent base within the hospital or access to IT, therefore, they have to return to the Hesketh Centre to input the relevant information onto their ePEX system.

In the course of its site visits the Task Group noted the enthusiasm and appetite for innovation from our main provider, Mersey Care NHS Trust services, and believe that this should be harnessed for future working.

## 10. Parity of Esteem and best practice within future mental health and dementia services in Sefton

The Task Group believes that the principle of parity of esteem should be embedded as best practice within all the priority areas identified. The key principle of parity of esteem is that all people are entitled to the best care available, whatever their diagnosis or personal characteristics (such as age or gender etc).

The Five Year Forward View<sup>12</sup> is unequivocal in that “*Over the next five years the NHS must drive towards an equal response to mental and physical health, and towards the two being treated together*” and this should be the impetus to make real and lasting changes to the provision of mental health and dementia services across Sefton. The Government’s Mental Health Strategy: *No Health Without Mental Health* (DH, 2011)<sup>13</sup> states that people with severe mental illnesses die on average 20 years earlier than the general population, we want to ensure that our services narrow this gap.

Nationally and locally mental health and dementia have not been given the required consideration in the context of wider physical health commissioning and this in turn has led to the mental health and physical health of patients being treated in varying degrees of isolation when in fact the two conditions are interlinked. Social needs which impact on mental health and/or dementia and physical health should also be addressed in unison.

It is recognised that collaborative work across mental health and primary care has been undertaken since 2013/14. Primary care mental health liaison workers have been employed by Mersey Care NHS Trust via the CCG Collaborative CQUIN and in addition to these the Trust provides screening, health promotion and smoking cessation within inpatient settings.

The aim of the Collaborative CQUIN is to establish a process to improve collaboration and relationships between primary care and mental health services and support the provision of high quality care in the prevention, care and treatment of those with mental and physical illness. Delivery is also predicated on the Trust taking a visible and proactive approach to engaging with GPs across Sefton.

In the course of its visits the Task Group received feedback from mental health services about the difficulties encountered by staff trying to access physical health services for patients. See examples below

- When patients at Stoddart House are suspected of physical health complications requiring treatment they will require an ambulance to take them 200 metres from Stoddart House to Aintree University Hospital A&E, after which if they are not admitted a hospital porter will convey them back to Stoddart House.
- The Hesketh Centre which houses the bulk of Mersey Care NHS Trust provision which cover NHS Southport and Formby CCG has an excellent physical health facility to enable health checks to be undertaken and staff are trained to

---

<sup>12</sup> <http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>

<sup>13</sup> [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/213761/dh\\_124058.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf)

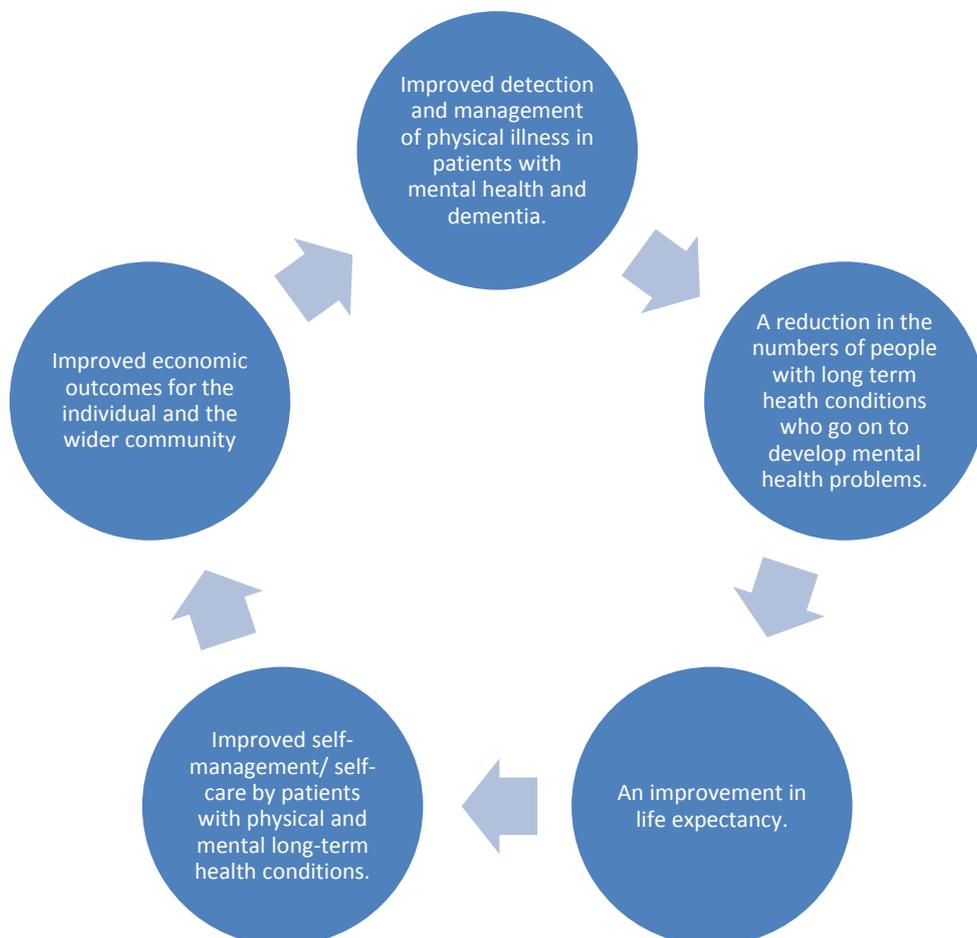
undertake ECGs with equipment located on site but they encounter difficulties in getting community based physical health staff to come and support patients.

- There has also been a particular difficulty in accessing Speech and Language Therapy (SALT) for mental health patients in NHS Southport and Formby CCG.
- The Older People's ward at the Boothroyd Unit in Southport used to have access to a Geriatrician provided by Southport and Ormskirk Hospital NHS Trust but this is no longer provided by the Trust and patients now have to access A&E to receive interventions previously provided on site.

Care for large numbers of people with long-term conditions could be improved by better integrating mental health and dementia support with primary care and chronic disease management programmes, with closer working between mental health specialists and other professionals. It is unacceptable that patients with dementia in acute wards who are receiving routine interventions should have a longer stay than those who do not have dementia but are receiving the same intervention.

All services will share the responsibility of improving physical health of people with mental illness and all care plans should be co-produced, holistic, and recovery focused where appropriate, and include social care, this requires the sharing of information among all agencies involved in patient care.

Developing a proactive approach to responding to patients with co-morbid health needs will result in the following outcomes:



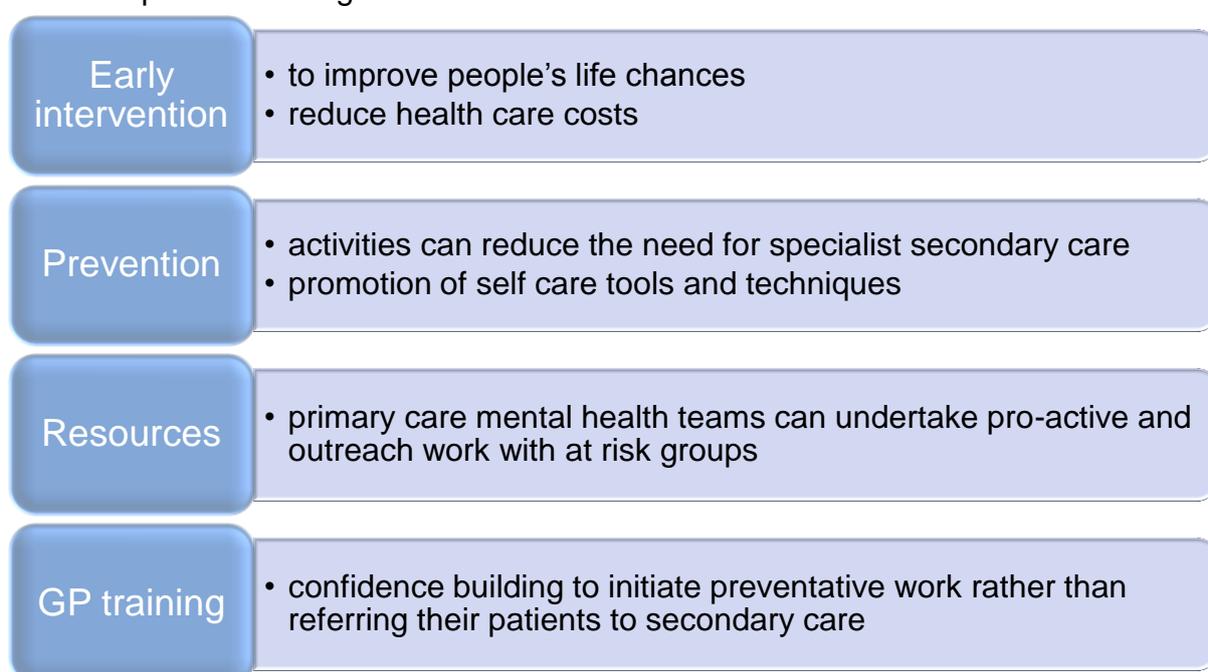
## 11. Priority Areas - Moving Forward

As outlined earlier in this report, the Task Group have identified five priority areas to address in 2015/6, these are outlined in more detail below along with key recommendations.

### 11.1 Primary Care

Primary care is the first point of contact with a patient, delivered by general practitioners and other health professionals. After families and friends, it is most people's first point of call in times of healthcare need. Around 30% of those people attending general practice have a mental health component to their illness.

Primary care can play a greater role in the management of mental health and dementia patients through:



The Collaborative CQUIN, outlined earlier can act as a conduit to enhancing collaborative working at a locality level to enable a greater role for Mersey Care NHS Trust within primary care settings. The 2015/16 updated Collaborative CQUIN, currently in development, will act as a further stepping stone in the transformation of delivery of mental health and dementia care in the Sefton localities for services to be more integrated and respond effectively to the needs of their patients.

This CQUIN has been largely successful in improving the interface at a GP level and whilst there has been engagement at Virtual Ward level in NHS South Sefton CCG it is recognised that more needs to be done to engage the Mersey Care Trust in community working across all eight localities.

Focusing specialist input on the most complex patients can reduce emergency admissions and considerably save costs associated with both acute and specialist mental health service activity. It will also ensure that patients are dealt with and

treated appropriately by the right medical teams. Pathways within secondary care need to ensure dementia and/or mental health is embedded within them to successfully treat and support these patients.

### **11.1.2 The future model for primary care and mental health**

Mental health services should be embedded in all localities so as to be more accessible and take account of the holistic needs of individuals. The Task Group believes that there should be proactive targeting of services for patients with complex and ongoing needs, such as the frail elderly or those with chronic conditions. These patients require more integrated management to enhance their recovery. To do this networks of care should be established which move away from traditional models of care. Mental health services will work alongside community and primary care services to support people to stay well and remain safe in their own homes for as long as possible. Primary care mental health workers will be an important asset in the future model of care.

The future model supports the principle of patient care being stepped up and down as their needs change so as to ensure that patients are being treated within appropriate pathways.

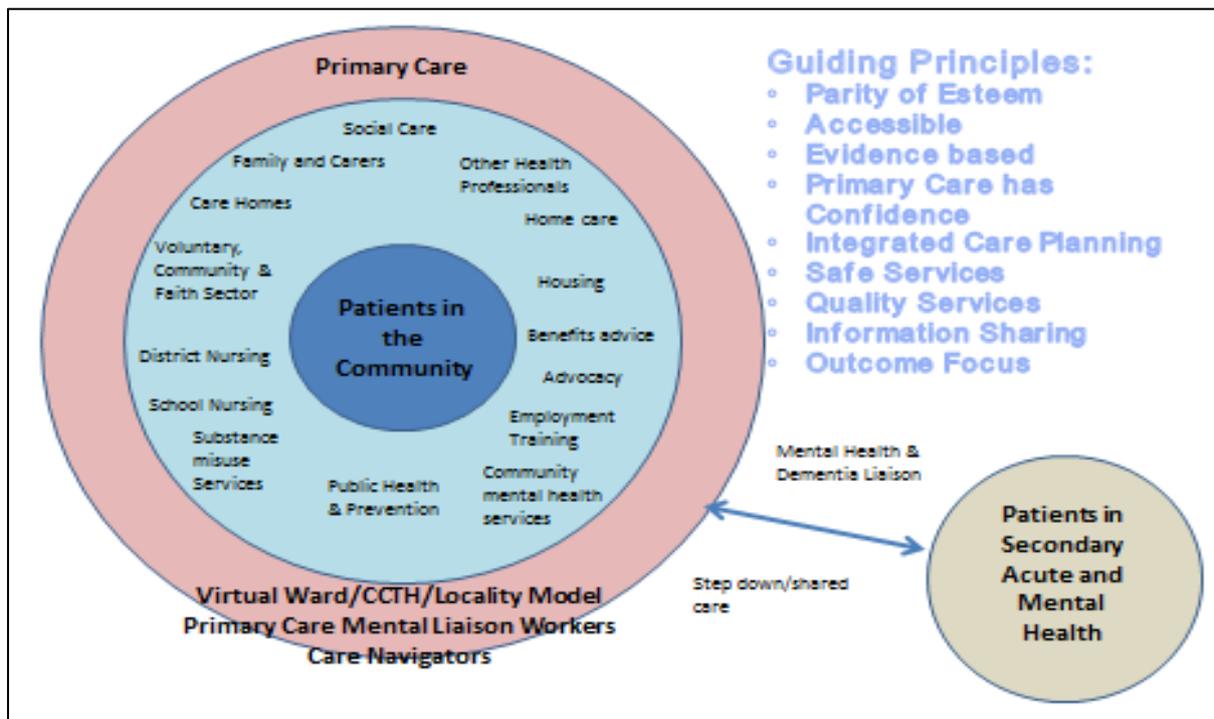
The locality model of working currently being developed across both Sefton CCGs would enable patient centric care to be undertaken in a holistic manner. Preventative work should also be undertaken at a locality level with public health input to support people to self-care and equip them with knowledge and resources to make healthier lifestyle choices.

There is an opportunity to improve collaborative working between GPs and Mersey Care NHS Trust to enable primary care and the wider locality teams to manage stable patients themselves. Primary care professionals have existing skills that could be further enhanced by specialist mental health education and training thereby building greater community resilience. This would enable specialist services, who currently have limited capacity due to managing stable patients, to have greater capacity to respond to complex cases and crisis situations.

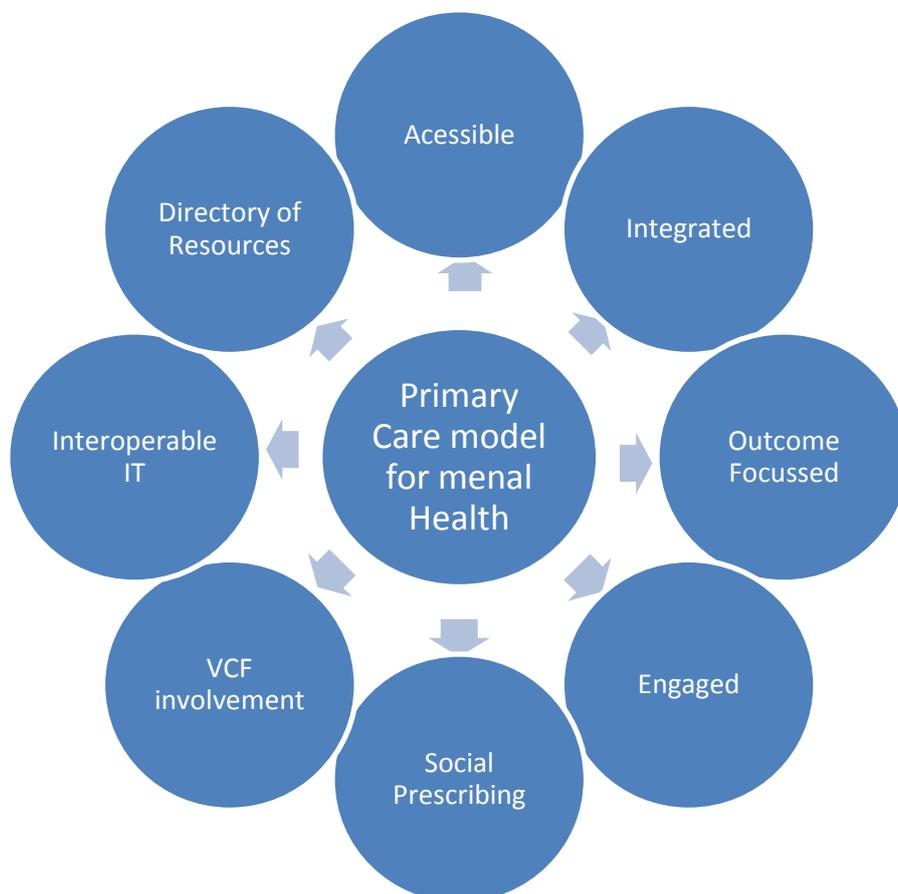
There is strong evidence that enhancing psychological and social interventions for people with co-morbid physical conditions can reduce emergency admissions and improve patient outcomes. Building on the local work so far with virtual ward schemes and better care schemes there is an opportunity to apply a bio-psychosocial MDT approach to treatment of long term conditions and for those who are at risk of emergency admissions. In the network of care there will be strong links with employment and accommodation services which if not properly integrated will impair a person's recovery, leading to further treatment and potential re-admission to an acute setting. The proposed model will require closer working with Sefton VCF Sector organisations.

The following diagram below illustrates how the future network of care could look for patients with mental health and dementia with primary care being critical to its success.

Diagram two: The future network of care for Sefton



The new model of primary care working will have the following features:



- Equitable accessibility for all.
- Integrated personalised care planning to ensure resources are appropriately utilised to meet need. Physical and Mental health will work together with patients.
- Common focus on achieving positive outcomes for patients which address health and social need through recovery.
- Primary Mental Health Workers attached to localities leading on the preventative agenda.
- Social prescribing to helping people to cope with mild to moderate mental health conditions. Social prescribing can include schemes like regular art, or activity programmes.
- Integral Voluntary Community and Faith involvement to:
  - Reduce social isolation
  - Provide and encourage employment opportunities
  - Provide education and training
- A detailed and regularly updated directory of mental health and well-being resources and activities would help promote access to all related services.
- Information sharing supported by interoperable IT systems.

For most people, mental health problems will be managed mainly in primary care by the primary health care team working collaboratively with other services, with access to specialist expertise and to a range of secondary care services as required. This will prevent the need for secondary health or social care services for some, for others it will aid recovery and prevent a return to more intensive treatment.

### 11.1.3 Liaison services and the future model for primary care and mental health

Ensuring that a person's mental health needs are also addressed when they are in an acute hospital for treatment for their physical health removes one of the potential barriers to provision of good health care. Liaison services can reduce the risk of self-harm and suicide whilst also addressing the long-term conditions and medically unexplained symptoms with which many patients present.

In 2004 the Royal College of Psychiatrists and the British Association for Accident and Emergency Medicine<sup>14</sup> estimated that mental illness accounted for around 5% of A&E attendances, 25% of primary care attendances, 30% of acute inpatient bed occupancy and 30% of acute readmissions.

The Task Group believes that existing acute liaison services operate as an “add on” to acute services however it believes that acute liaison should be an equal partner in the effective delivery of care within the future model of care. Services should be provided to meet the needs of patients with a mental health condition secondary to their physical health problem, or a physical health condition alongside their mental illness including dementia.

<sup>14</sup> <http://pb.rcpsych.org/content/28/5/187>

The Task Group further believes that a liaison service should be an integral part of all pathways provided within acute hospital trusts – trusts that have incorporated a liaison service have importantly demonstrated much better health outcomes for patients, at the same time as using resources more effectively. A good example is the Rapid Assessment Interface and Discharge (RAID) model which is an age-inclusive, drugs/alcohol inclusive, consultant-led service that is fully integrated into the structure and function of an acute hospital in Birmingham. It has shown dramatic reductions in bed use, particularly use of acute/elderly ward beds by patients with dementia.

Economic evaluation of RAID, undertaken by the Centre for Mental Health in 2011<sup>15</sup> demonstrated that it can achieve the following outcomes, over and above traditional liaison services:

- Reduce admissions, leading to a reduction in daily bed requirement of 44 beds per day, saving the local NHS £3.55m per annum through decommissioning acute beds
- Reduce discharges to institutional care for elderly people by 50%, saving local authorities £3m per annum in contributions to residential care.
- Produce a consequent cost-to-return ratio of £1 to £4.

Across the local health economy detailed work should be undertaken to ascertain the optimum level of liaison psychiatry required. A model of acute liaison that is entirely managed by acute services should also be considered for the local health economy.

#### **11.1.4 The Crisis Concordat and the future model for primary care and mental health**

The Mental Health Crisis Care Concordat<sup>16</sup> is a national agreement between services and agencies involved in the care and support of people in crisis. It sets out how organisations will work together better to make sure that people get the help they need when they are having a mental health crisis. The Crisis Concordat expects that, in every locality in England, local partnerships of health, criminal justice and local authority agencies will agree actions that will meet the principles of the national concordat. The Crisis Concordat will support the new primary care model in Sefton by enabling GPs to be involved in achieving four objectives.

1. Urgent and emergency access to crisis care – making sure that a mental health crisis is treated with the same urgency as a physical health emergency.
2. Access to support before crisis point – making sure people with mental health problems can get help 24 hours a day and that when they ask for help, they are taken seriously.

---

<sup>15</sup> [http://www.centreformentalhealth.org.uk/pdfs/economic\\_evaluation.pdf](http://www.centreformentalhealth.org.uk/pdfs/economic_evaluation.pdf)

<sup>16</sup>

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/281242/36353\\_Mental\\_Health\\_Crisis\\_accessible.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281242/36353_Mental_Health_Crisis_accessible.pdf)

3. Quality of treatment and care when in crisis – making sure that people are treated with dignity and respect, in a therapeutic environment.
4. Recovery and staying well – preventing future crises by making sure people are referred to appropriate services.

Commissioners within the Mersey Care NHS Trust footprint are developing a programme of work to support primary care to work collaboratively with other services. This will facilitate access to specialist expertise and to a range of secondary care services such as crisis care mental health and substance misuse services. The Collaborative CQUIN for 2015/16 reflects the objectives of the Crisis Concordat by supporting, developing and improving GP knowledge and experience of management of severe mental illness including physical health and crisis care.

#### **11.1.5 Personal health budgets and the future model for primary care and mental health**

Personal health budgets offer the opportunity for mental health and physical health to work in equal partnership. They enable patients to have more choice and control over their healthcare and support. Personal health budgets are being introduced to:

- Help people with long term conditions and disabilities manage their care in a way that suits them.
- Help improve people's quality of life and wellbeing.
- Reduce the amount of times people attend hospital or other NHS services.

The Government's Mandate to the NHS states that by 2015, people with long term health conditions, who could benefit, will be given the option of a personal health budget. Currently seven demonstrator sites in England are piloting personal health budgets for the following patient groups:

- People with long term conditions, including frail elderly people at risk of care home admission.
- Children with complex needs.
- People with learning disabilities.
- People with severe and enduring mental health problems.

The wider roll out of Personal Health Budgets is expected in 2016/17, and the Better Care Fund could be enabled for this initiative.

In Sefton the right to a personal health budget is currently only available to those children and young people who are eligible for NHS Continuing Care (up to 18) and NHS Continuing Health Care (19-25). From 1st April 2015 this will be extended to those people with a long term or mental health condition.

Personal health budgets within mental health are a tool to support recovery by allowing individuals to define their own outcomes and design their own packages of care and support.

### 11.1.6 Information sharing and the future model for primary care and mental health

The Task Group has noted that information flows between mental health services and the Council are hindered by differing IT systems not being able to “talk to each other”. A similar situation exists within the wider NHS and if parity of esteem is to be realised sufficient patient information needs to be shared safely among all parties involved to ensure patients receive the best care. At the very minimum, from a mental health aspect, this should be developed for those patients who present in crisis.

#### **Task Group recommendations**

*Commitment to collaborative work with GPs and mental health services including the VCF Sector. Patients require access to appropriate interventions ranging from active monitoring and guided self-help through to higher intensity interventions such as psychological therapy. Collaborative working is crucial in the supervision and case management of patients.*

*Primary Care training should be resourced appropriately and encouragement must be given to those GPs who feel that they require further training in mental health and dementia.*

*The existing collaborative CQUIN is mainstreamed within Mersey Care NHS Trust provision for 2016/17 so as to accelerate the pace of integrated working at primary care level and with virtual ward models.*

*Design pathways that are more accessible and easier for patients to navigate. Within each pathway there should be the provision of self-help to empower patients to manage their own health.*

*More targeted mental health interventions should take place at a locality and GP level which is equivalent to the level of physical health related intervention.*

*Continue to work with Local Authority colleagues to ensure that programmes are continually developed to support the prevention of mental illness and dementia.*

*Work with primary care to enable it to feel confident to embrace innovative mental health and dementia related ways of working with a parity of esteem focus.*

*Develop greater resilience and confidence within primary care to enable patients to be stepped down to primary care.*

*For patients deemed more at risk ensure that they have extended care /safety plans in place to reflect the objectives of the Crisis Concordat.*

*Ensure greater collaboration exists to support primary care to help patients in pre and post crisis.*

*Acute liaison arrangements should be embedded by the Acute Provider in all patients pathways, the focus should not be primarily mental health and dementia.*

*Prior to roll out of personal budgets in 2016/17 commissioners need to work with Mersey Care NHS Trust and all physical health providers to ensure that the physical health needs of mental health and dementia patients are met in a timely and co-ordinated manner. A future model which envisages services working in an integrated way is to be developed.*

*Work to ensure that the development of personal health budgets should factor in both the physical and mental health needs of individuals. The Better Care Fund should be explored as an opportunity to drive forward personal health budgets as*

*they are a good example of how care can be integrated.*

*Develop agreed joint care plans containing a shared responsibility for delivering care across mental health, physical health, social care and primary care.*

*Information sharing governance protocols should be developed with all providers in Merseyside including North West Ambulance NHS Trust.*

*To assist in information sharing, the various information systems across all providers should be interoperable.*

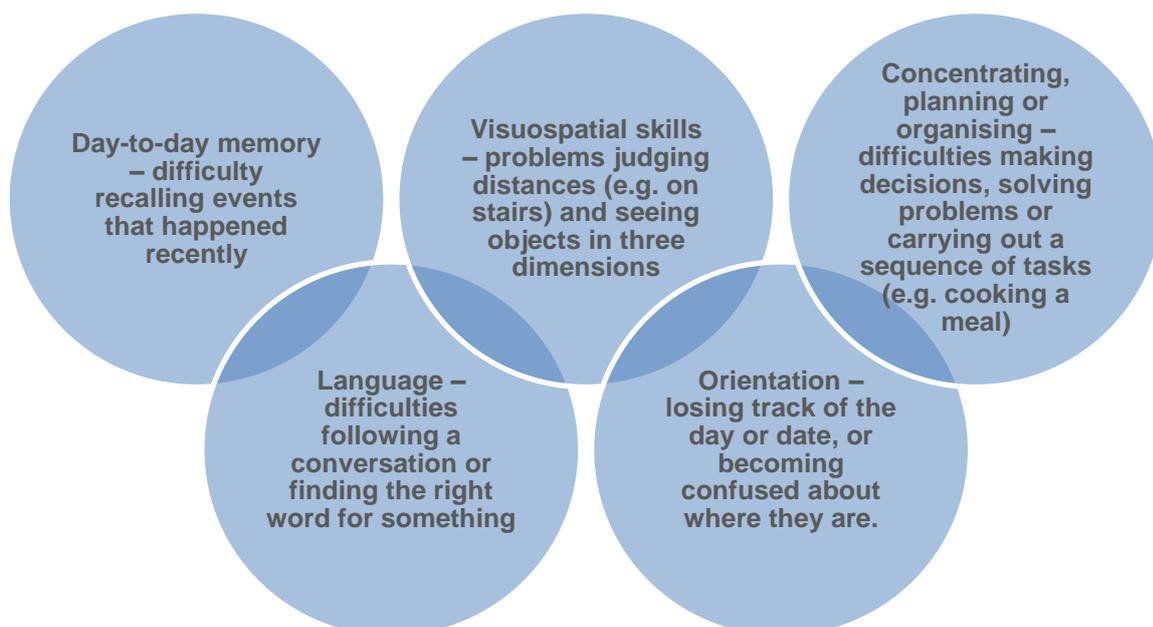
*Commissioners will work with Mersey Care NHS Trust to ensure that their RiO system which is currently being procured will link to the primary care EMIS system so as to enable GPs to have access timely, reliable clinical information pertinent to the health needs of the patient.*

## 11.2 Dementia

The word dementia describes a set of symptoms that may include memory loss and difficulties with thinking, problem-solving or language. These changes are often small to start with, but for someone with dementia they have become severe enough to affect daily life. A person with dementia may also experience changes in their mood or behaviour.

Dementia is caused when the brain is damaged by diseases, such as Alzheimer's disease or a series of strokes. Alzheimer's disease is the most common cause of dementia but not all dementia is due to Alzheimer's. The specific symptoms of dementia will depend on the parts of the brain that are damaged and the disease that is causing the dementia.

A person with dementia will have cognitive symptoms (problems with thinking or memory). They will often have problems with some or all of the following:



As well as these cognitive symptoms, a person with dementia will often have changes in their mood. For example, they may become frustrated or irritable,

withdrawn, anxious, easily upset or unusually sad. Dementia is a progressive illness and how quickly dementia progresses varies greatly from person to person.

### **11.2.1 Mild cognitive impairment**

Some people have problems with their memory or thinking but these are not severe enough to interfere with everyday life. In this case, a doctor may diagnose mild cognitive impairment (MCI). Research shows that people with MCI have an increased risk of developing dementia; about 10–15 per cent of this group will develop dementia each year.

However, MCI can also be caused by other conditions such as anxiety, depression, physical illness and side effects of medication. Because of this, some people with MCI do not go on to develop dementia, however other mental health conditions may be the cause.

### **11.2.2 Dementia in Sefton**

In line with national trends, Sefton is experiencing a continuing rapid increase in the proportion of older people in its population. Older people in Sefton generally enjoy good physical and mental health, and they are a great asset to their communities through their many contributions to local organisations, neighbourhoods and their own families.

The ageing population in Sefton may result in increased incidence of long term conditions and co-morbidities, costs may rise and services are likely to become increasingly unsustainable without service re-design. Sefton also has a high proportion of older people who live alone and combined with the increase in numbers of older citizens developing some form of dementia and the increase in associated costs, Sefton is likely to continue to exceed the national average.

Given the data available on the scale and impact of dementia, the evidence base for cost-effective intervention and the growing consensus for action among health and social care bodies, the opportunity now exists to address the challenges.

People with dementia, their family and carers can live well if they have access to good quality, integrated care that is affordable, and if they live in a housing environment that meets their needs.

For historical reasons current service provision is predominantly based in Mersey Care NHS Trust and whilst there are links with physical health services and the VCF Sector the physical needs of patients are not being reflected in the current pathways. The Task Group believes that dementia should be viewed as a long term neurological condition and should therefore be commissioned on a locality model based on need.

### **11.2.3 Current dementia provision**

Current Sefton dementia provision needs to be more integrated with physical health services. The current service is centred on the following:

- Memory Assessment clinics (one located in each CCG)
- Older Peoples mental health teams
- Care Home Liaison
- Hospital liaison
- Dementia inpatient ward (Clarence ward – Stoddart House)

Dementia provision is actively complemented by the Alzheimer’s Society which provides support for people accessing memory clinics and peer support activities including music and reading groups.

Access to services from GP referral to assessment and onward diagnosis is at present timely when compared to the rest of England as illustrated the table below.

Table twelve: Memory Clinic waiting times comparison

	Sefton	North of England Average	North of England Shortest	North of England Longest
Waiting time – referral to assessment (weeks)	3	5	1	21
Waiting time – referral to diagnosis (weeks)	2	9	1	18

Source: NHS England data request: November 2014

Whilst access times are timely at present the Task Group believes that with the current numbers of undiagnosed people and efforts already being undertaken to improve diagnosis that this will impact of the current model to meet increasing demand.

The Task Group has initiated the following developments aimed at improving diagnosis through:

- **Access Secondary Uses Service (SUS) secondary care data:** GP practices are now able to compare their practice dementia registers with SUS information (a list of people registered to the GP practice, who have been coded in SUS data with a diagnosis of dementia). This can then be used by practices to update their dementia QOF register and enable them to take any other action to determine the needs and/or diagnosis of the individual patient.
- **Use of the National Dementia Quality Toolkit (DQT):** The DQT consists of a series of reports and queries run directly on GP systems to identify patients who may have dementia, but who are not coded as such within the practice.
- **Care Home Liaison:** Across Sefton there are a significant number of people with dementia who are resident in care homes. Ensuring that residents have a diagnosis and care plan in place would benefit patients, care homes and the system. The existing care home liaison specification with Mersey Care NHS Trust has been revised to improve identification and onward referral from nursing homes.

#### 11.2.4 The future model of dementia care

Any future models of dementia must include the existing functions but they should be truly integrated and at the centre of the model should sit primary care, similar to the future model for mental health described previously. The Task Group believes that assessment and diagnosis currently being undertaken at the two Memory Assessment sites could be complemented by similar activity being undertaken at a primary care level. GPs routinely provide dementia care, but they may lack the clinical skills and awareness of available resources to provide optimal care.

The Gnosall primary care model<sup>17</sup> of dementia care delivered in Staffordshire offers a template upon which to develop dementia service across Sefton. Memory problems and possible dementia or related conditions are assessed, investigated and treated without delay and enable physical health interventions to be initiated in concert with dementia interventions in a holistic approach. This approach maximises the strengths of primary care in assessment and investigation and ensures the ongoing support of individuals who remain recognised, respected, and not displaced from their natural community.

In Sefton the Virtual Ward and Care Closer to Home transformation programmes have the potential to ensure a more network driven approach to the clinical management of dementia. The future dementia model for Sefton should be integrated and combine primary care, hospital, community, social care and VCF Sector provision delivering improved care for patients. The dementia services should have clear measurable outcomes, these include:

- Timely access to assessment and diagnosis by an appropriate clinician.
- Reduced number of people entering nursing home care and that those people living in care homes with dementia get their health needs regularly assessed and met this can help reduce avoidable admissions to hospital.
- Embedded liaison services that reduce the number of people being admitted to hospital and for those who are admitted length of stay is reduced.
- Reduction in anti-psychotic prescribing for those patients in nursing homes
- Dementia friendly communities are actively encouraged and nurtured.

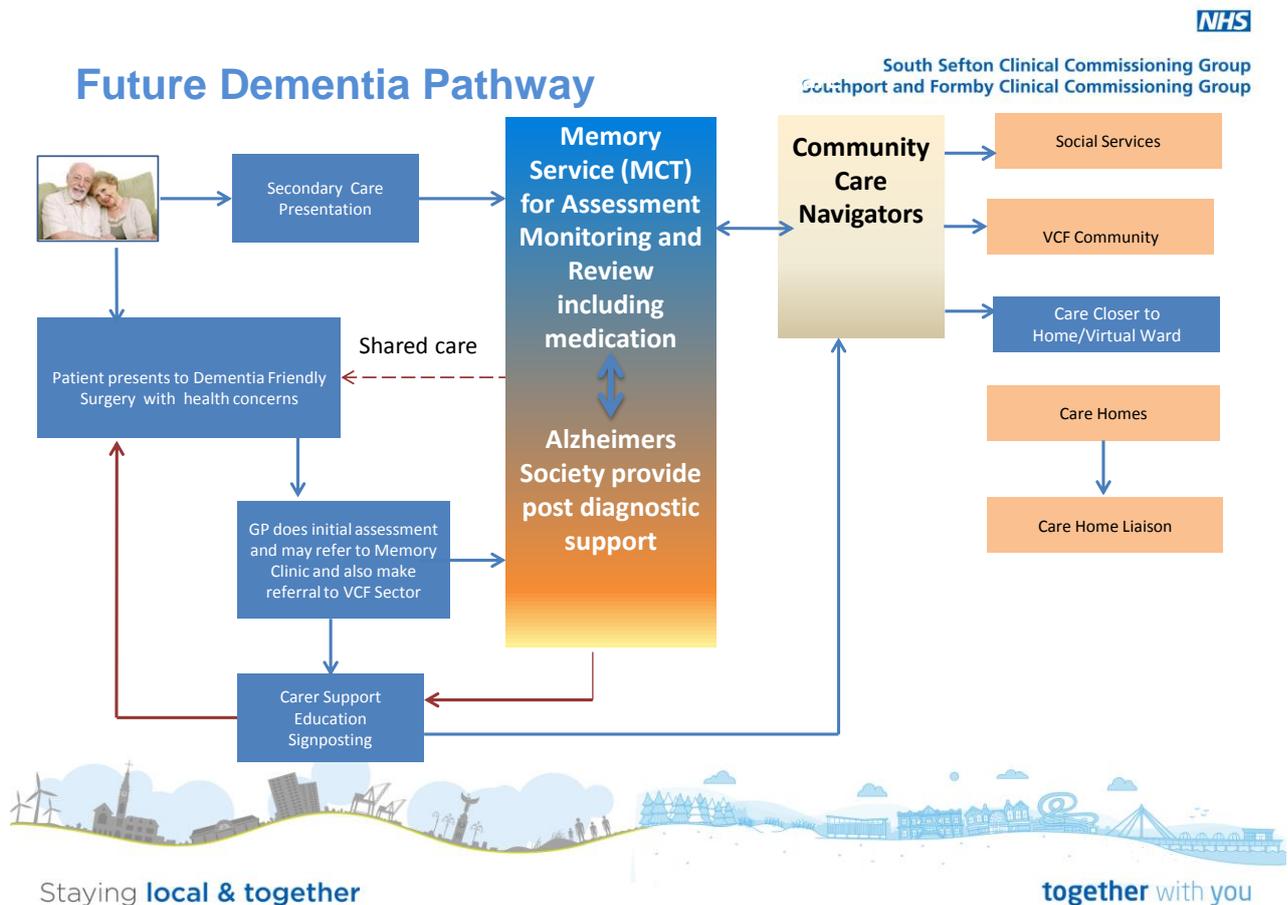
Dementia services currently provided by Mersey Care NHS Trust will be integrated into localities, via the Virtual Ward and Care Closer to Home programmes to enable a more unified approach to preventing avoidable admissions and to improve response times for people who may require urgent care. With the right care packages people who have declining functionality can be supported to live well at home; this will require improved service integration and shared information across organisations. The new model will seek to improve access to post diagnostic support particularly for people who live alone and for those with other long term conditions.

The future model will have a strong focus on raising dementia awareness within providers and the promotion of dementia friendly communities will be advocated. The model below illustrates the future dementia pathway for Sefton.

---

<sup>17</sup> [http://www.gnosallsurgery.co.uk/website/M83070/files/gnosall\\_memory\\_clinic.pdf](http://www.gnosallsurgery.co.uk/website/M83070/files/gnosall_memory_clinic.pdf)

## Model two: The Future Dementia pathway



The future pathway model for dementia in Sefton will have the following features:

- Strengthened role for general practice in the identification, assessment and diagnosis of dementia.
- Memory services will be accessible in the local community, either as part of primary care provision or in neutral settings close to where people live.
- The benefits of GP led and nurse led memory assessment services should be considered where appropriate, this could be linked to a frail elderly 'hub' where residents would be invited in for regular checks.
- GPs will know when memory services appointments are available to enable speedy referral and follow up for post diagnostic support with patients and carers.
- Post diagnostic support needs will be clear and available at the point of diagnosis and / or when the patient or carer feels they can cope with knowing more.
- Access to information needs to be available when the person with dementia (and /or carer) has questions but more importantly a suitably qualified person should be available to help answer questions, when the person or carer need assistance.
- Care Navigators will provide a useful signposting and information service to assist people with dementia and their carers to live well with dementia.

- A dementia directory of services will be established that is accessible to GPs and all partner organisations across Sefton.
- Newly diagnosed people with dementia should be offered the opportunity to access counselling by suitably qualified and experienced staff.
- Personalised care planning will ensure people receive the best possible care and support. Care plans need to be both understandable to patients and accessible to other workers involved in the persons care.
- People with dementia will have Advanced Care Planning discussed at an appropriate time.
- Access to appropriate respite care may be required as the person with dementia's functionality declines. Care Home utilisation will be explored as it can provide a useful setting in which weekly/monthly respite could be offered.
- People with dementia who have been admitted to an acute ward should not be, as routine, then directly admitted to a care/nursing home.
- Closer working with VCF sector organisations, Independent Sector and the Local Authority to share data and information, to identify people living alone who may have dementia and who will become increasingly vulnerable.
- Information sharing supported by interoperable IT systems.
- Strong emphasis on dementia awareness within providers and the promotion of dementia friendly communities.

The future dementia model has the potential to impact on all the CCG strategic objectives of NHS Southport and Formby CCG and NHS South Sefton CCG however effectiveness will be enhanced if hospital liaison and care home liaison are integrated into the future model to enable a reduction in A&E and non-elective admissions to acute services this will enable realised savings to be re-invested in appropriate local health economy services.

#### **11.2.5 The future model of dementia care and Hospital Liaison**

Reducing the impact of dementia on acute hospitals will be key to the success of the future model of dementia care in Sefton. The Alzheimer's Report '*Counting the Cost: Caring for people with dementia on hospital wards*' (2009)<sup>18</sup> found that at any one time, a quarter of all beds in the hospitals surveyed were occupied by people with dementia. In addition the Alzheimer's report found that people with dementia had higher lengths of hospital stay than those patients without dementia.

Local work undertaken by Sefton PCT in 2008/09 indicated that lengths of stay for patients with dementia were more than double than those without dementia. Since 2012/13 there has been a national CQUIN in place within all acute hospitals in England to incentivise the identification of patients with dementia and other causes of cognitive impairment alongside their other medical conditions and to prompt appropriate referral and follow up after they leave hospital. Across Merseyside there has been mixed success in achieving this CQUIN and whilst there has been

---

<sup>18</sup> [http://www.alzheimers.org.uk/site/scripts/download\\_info.php?downloadID=356](http://www.alzheimers.org.uk/site/scripts/download_info.php?downloadID=356)

improvement the Task Group agrees that more work should be done with acute hospitals to ensure faster identification and intervention.

Reducing length of stay for patients with dementia has the potential to release significant cash savings. Whilst psychiatric liaison arrangements have since been put in place work needs to be undertaken to ensure they can provide the required service to meet the increasing dementia challenge. The RAID model described previously is a recognised model upon which to base future hospital liaison provision.

### 11.2.6 The future model of dementia care and Care Home Liaison

Care Home Liaison will be a vital component of the future dementia model. There has been a Care Home Liaison service provided by Mersey Care NHS Trust in place since 2012/13, however in the run up to the dissolution of the PCTs in March 2013, the service originally envisaged by Sefton PCT evolved differently under the interim commissioning arrangements established NHS Merseyside. The current service provides a significant medicines monitoring role which was not originally envisaged.

The original vision was that the Care Home Liaison service would assist with promoting training opportunities and help pick up early health issues with residents and care home staff, this in turn would enhance links with local community health teams. Combined benefits of good general hospital liaison; a reduction in antipsychotic drugs prescriptions; early detection of resident's health problems and extra support available to care homes will significantly reduce acute admissions. There is evidence that the service has reduced admissions from care homes to Mersey Care NHS inpatient dementia services, but there is no evidence in any reduction in admissions to acute hospitals.

Commissioners have engaged with Mersey Care NHS Trust to re-specify the service that has a greater training role and is focused on enabling those *targeted* homes to identify dementia and refer, and be subsequently skilled to manage dementia patients in a safe and compassionate manner which meets all the patient needs. However, it is recognised that existing liaison resources are limited and what is really required is a fully integrated care home liaison service.

#### **Task Group recommendations**

*The existing dementia work stream is refocused to explore and recommend to the CCGs a new model for care for dementia that has parity of esteem at its core.*

*Acute liaison arrangements for dementia should be mapped out to enable an understanding of existing resource so as to identify and inform any future enhanced liaison commitments.*

*Implement the revised Care Home Liaison specification in 2015/16 on an interim basis and through the pathway/network development; work up an integrated model of care home liaison.*

*Commissioners will work Alzheimer's Society to lead developments around dementia friendly communities across all of Sefton to enable people with dementia to be supported and continue to participate in their community.*

### 11.3 Child and Adolescent Mental Health Services

The prevalence and recognition of mental health conditions in young people is growing and the number of children and young people in need of support and treatment from mental health services is increasing. A number of disorders are persistent and will continue into adult life unless properly treated. Others show recurrent episodes emerging in childhood and adolescence but continuing into adult life. It is known that 50% of lifetime mental illness (except dementia) begins by the age of 14 and 75% by the age of 25, and that 75% of adults requiring secondary care mental health services developed problems before the age of 18.

The Sefton Children and Young Peoples Emotional Wellbeing Strategy that is currently being developed anticipates the following needs in Sefton estimated on the number of children / young people who may experience mental health problems appropriate to a response from CAMHS.

**Table thirteen: CAMHS activity**

<b>CCG</b>	<b>Tier 1</b>	<b>Tier 2</b>	<b>Tier 3</b>	<b>Tier 4</b>
NHS South Sefton CCG	3,305	1,545	410	20
NHS Southport & Formby CCG	4,570	565	565	25
<b>TOTAL</b>	<b>7,875</b>	<b>2,110</b>	<b>975</b>	<b>45</b>

Source: Sefton Public Health (2012)

As a joint commissioning partnership (CCG, Local Authority and Education) commissioners want to achieve the following:

- The creation of clearer service and support pathways for children and young people through the establishment of partnership agreements, referral processes, marketing and better working relationships between partnership agencies in order to improve youth access to services across Tiers 1-4.
- Increase knowledge, experience and understanding across the commissioning arrangements about how to most effectively utilise pathways and measure the impacts and outcomes achieved as a result of practitioners and beneficiaries using them.
- Build on professional development through IAPT learning and in applying thresholds to planning, coordinating and delivering support at the right time and place for children, young people and families. This will involve trialling routine outcome measures and using the voluntary sector to embed self-referral models in partnership with local NHS providers across tiers 1-2/3.
- The input of children, young people and families to design, develop and review the emotional wellbeing care and support they receive at different pathway points in order to inform ongoing improvement cycles as part of commissioning arrangements moving forward.
- Develop a model of best practice which maximises use of local assets, meets the needs of local young people and encourages CCG, Social Care and Education commissioners to provide ongoing collaborative commitment to an integrated 'youth mental health' model of commissioning.

There is a growing evidence base documenting the significant mortality and morbidity risks in relation to young people's acute and long-term health and wellbeing if disengagement and non-concordance with their recommended health care plan occurs during adolescence and young adulthood. Young people with mental health problems who do not transition well are more likely to present in crisis, and struggle to maintain their independence and remain in education or employment.

The point of transfer from child and adolescent or youth to adult or other services and engagement with a new team and culture in adult health care is recognised as a potential risk escalator. It is therefore essential that interventions occur early when diagnosed so as to mitigate against long term engagement with mental health services.

The structure and operation of Child and Adolescent Mental Health Services (CAMHS) can appear complex as the service delivery model differs for both traditional secondary care mental health services for adults and the majority of general physical health services for children and young people (specifically in regard to multi-agency relationships and interdependencies). The complex fragmented nature of the current CAMHS commissioning arrangements, in part due to the lack of co-ordination between agencies in some areas has the potential for children and young people to fall through the net. This has been highlighted in several reports including the recent Tier 4 CAMHS report published by NHS England in July 2014<sup>19</sup>.

Locally Liverpool and Sefton have a complex commissioning structure for young people, split between Alder Hey Children's NHS Foundation Trust and Mersey Care NHS Trust and with additional provision from the Third Sector. Inpatient Tier 4 CAMHS services are provided through Cheshire and Wirral Partnership NHS Foundation Trust which are commissioned directly by NHS England.

Current care pathways for 16 and 17 year olds can also be complex due to the commissioning arrangements involving Alder Hey Children's NHS Foundation Trust and Mersey Care NHS Trust and consequently access and criteria for services have been recognised as not being clear and generating inconsistent referral destinations and care packages. This in turn has led to frustration among GPs in Sefton who have regularly voiced their concerns over the lack of access into CAMHS.

There is a lack of early intervention for problems other than psychosis, with a system where people have to reach a high level of mental health need before being able to access adult mental health services. Once young people have turned 18, the access to a youth friendly psychological interventions is limited.

It is the Task Group's view that organisational barriers in any future mental health pathways should be eradicated wherever possible.

---

<sup>19</sup> <http://www.england.nhs.uk/wp-content/uploads/2014/07/camhs-tier-4-rep.pdf>

### **11.3.1 Transitions CQUIN**

Since 2013/14 a Transition CQUIN has been in place with Alder Hey Children's Hospital NHS Foundation Trust and Mersey Care NHS Trust. The Transition CQUIN has explored transitions between CAMHS and Adult services and has showed evidence of good practice with specialist 16-18 teams and early psychosis services. In addition local innovations such as transition of care meetings and transition posts have improved transition planning with joint working particularly around complex cases. Transition policies have been redeveloped to give a single jointly owned pathway between Alder Hey Children's NHS Foundation Trust and Mersey Care NHS Trust. This CQUIN has allowed development of agreements between organisations to remove barriers caused by multiple assessments.

Further exploration via the CQUIN has shown that there are major gaps in service provision for those with Autistic Spectrum Disorders between the ages of 16 and 18 in Liverpool, and beyond 16 for Sefton; for those with moderate learning disability from 16-18 and gaps in medical care for Learning Disability young people from 16-18 and these require urgent work to address.

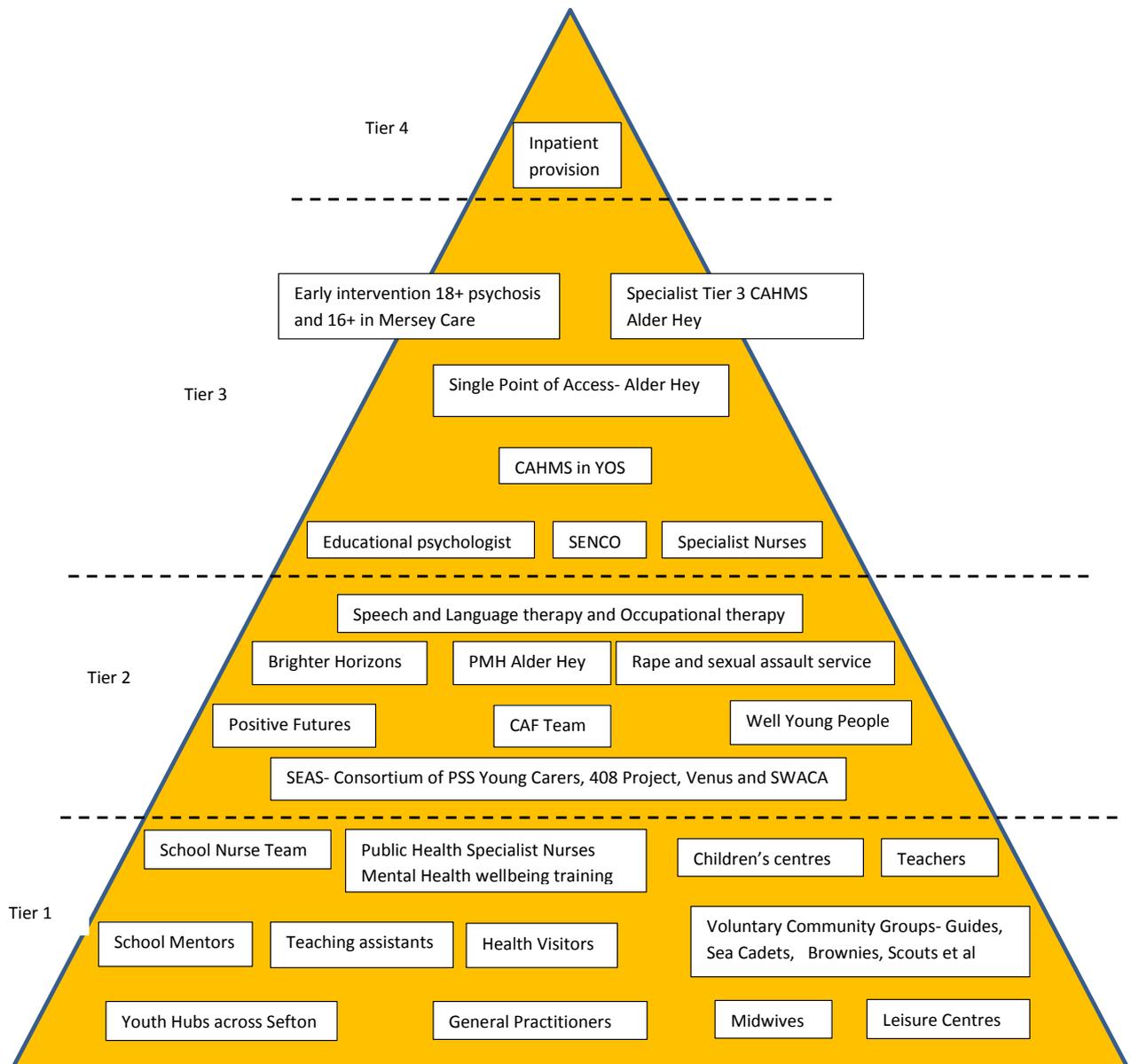
Young people may have protracted journeys to treatment, with multiple assessments, moving through urgent assessment in Mersey Care NHS Trust, referral to and re-assessment into CAMHS single point of access with a further wait to access interventions with specialist CAMHS. Services, criteria and boundaries, plus transition points appear to be centred on the needs of the two providers and not based upon the needs of young people.

### **11.3.2 The Sefton Emotional and Wellbeing Triangle of care and support**

For some young people, their care may also require increased engagement with local primary and secondary health services and in some cases with the youth voluntary sector. In addition to health service providers, it will also require integration with social care and educational planning processes. In Sefton there is a diverse range of agencies supporting young people and a number of organisations provide support with housing and occupation. Alongside the growing partnership between Alder Hey Children's Hospital NHS Foundation Trust and Mersey Care NHS Trust, alignment of these elements has the potential, through strengthening of pathways, to make a contribution to better meeting the needs of children and young people in Sefton.

Diagram three illustrates the extensive list of services in Sefton who may be involved in the care of children and young people. The recognised tiers of CAMHS provision are marked and described in further detail in notes below the diagram.

**Diagram three:** Services involved in the care of children and young people with Sefton.



Source: Sefton Children and Young People Mental Health and Emotional Wellbeing Strategy

## CAMHS Tiers

### Tier 1: Universal services

These are services whose primary remit is not that of providing a mental health service, but as part of their duties they are involved in both assessing and/or supporting children and young people who have mental health problems. Universal services include GPs, health visitors, schools, early years' provision and others. Universal services are commissioned by CCGs and Local Authorities and schools themselves, and may be provided by a range of agencies.

## **Tier 2: Targeted services**

These include services for children and young people with milder problems which may be delivered by professionals who are based in schools or in children's centres. Targeted services also include those provided to specific groups of children and young people who are at increased risk of developing mental health problems (e.g. youth offending teams and looked after children's teams, paediatric psychologists based in acute care settings). Targeted services are commissioned by CCGs and Local Authorities and schools, and are provided by a range of agencies.

## **Tier 3: Specialist services**

These are multi-disciplinary teams of child and adolescent mental health professionals providing a range of interventions. Access to the team is often via referral from a GP, but referrals may also be accepted from schools and other agencies, and in some cases self-referral. These services are commissioned by CCGs although there may be a contribution from Local Authorities.

## **Tier 4: Specialised CAMHS**

These include day and inpatient services and some highly specialist outpatient services including services for children/young people with gender dysphoria ; CAMHS for children and young people who are deaf; highly specialised autism spectrum disorder (ASD) services; and highly specialised obsessive compulsive disorder services. These services have, since April 2013, been commissioned directly by NHS England.

### **11.3.3 The future model for CAMHS in Sefton**

Given the multi-agency nature of services, and complex commissioning arrangements, there is also potential for a lack of integration between agencies, particularly at a time of shrinking resources. This can result in children and young people falling through the net, or alternatively escalating up the care pathway and experiencing greater distress and potentially requiring more expensive services.

The mental Health policy document *Closing the Gap: Priorities for essential change in mental health (DH, 2014)*<sup>20</sup> brings Early Intervention and Young People's mental health into focus, with promises to tackle inequalities in access to health systems, increase access to psychological therapies for children and young people, supporting schools to recognise mental health problems earlier, and to end the cliff-edge of lost support as children and young people with mental health needs reach the age of 18.

Future services need to intervene early, to provide the right intervention at right time, and get it right first time, preventing the development of morbidity, reducing the risk of harm and promoting recovery. This approach will lead to future savings for the health and social economy. The Children and Families Act 2014<sup>21</sup> begins to take the growing idea of emerging adulthood into a policy framework with a focus on the

---

<sup>20</sup>

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/281250/Closing\\_the\\_gap\\_V2\\_-\\_17\\_Feb\\_2014.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281250/Closing_the_gap_V2_-_17_Feb_2014.pdf)

<sup>21</sup> <http://www.legislation.gov.uk/ukpga/2014/6/contents/enacted>

period up to 25 years and this should be reflected in any future service development through an ageless service.

Whilst the Transitions CQUIN has allowed development of agreements between Alder Hey Children's Hospital NHS Foundation Trust and Mersey Care NHS Trust to remove barriers caused by multiple assessments it is the Task Group's view that young people with mental health issues would be better served by a single mental health provider which would enable improved co-ordination of care at a local level.

The Task Group acknowledge that any work in redesigning the CAMHS pathway within one provider may require collaboration with Liverpool CCG so as to agree joint commissioning intentions for 2016/17. Locally the 5 Boroughs Partnership NHS Foundation Trust provides CAMHS services within a single organisation.

The future model of CAMHS in Sefton will have the following features:

- Accessible through a single point of access with no age criteria service demarcation.
- CAMHS services will be accessible in the local community, either as part of primary care provision or in neutral settings close to where people live.
- Emphasis on prevention and working in other settings (eg Education and Youth Offending)
- Early intervention and multi-agency working strongly feature in the new model.
- IAPT interventions will be a key feature of the new model.
- A directory of Childrens and Young People's services that is accessible for GPs and all partner organisations across Sefton.

#### **11.3.4 Accelerating and Sharing Good Practice in Joint Commissioning to Improve Child and Adolescent Mental Health**

In December 2014, a consortium, comprising of NHS South Sefton CCG, NHS Southport and Formby CCG, Sefton Council and the local voluntary sector became successful in becoming a pilot site in leading and accelerating collaborative commissioning arrangements for children and young people's mental health. The pilot will enable stakeholders to reassess the systems in place to commission CAMHS - from schools through to inpatient beds - and try to affect change through new ideas aimed at putting in place youth focused emotional wellbeing services in the community which will deliver specific services that meet the needs of young people.

#### ***Task Group recommendations***

*Work with Liverpool CCG, as the lead commissioner for Alder Hey Children's Hospital NHS Foundation Trust, to share the Sefton vision and ascertain if there is an appetite for an ageless service. If not the provision of a standalone mental health service for CAMHS should be considered following a full options appraisal to inform decision making.*

*In developing new models of care within an ageless pathway compelling evidence should be used to inform planning and investment so as to support patient outcomes*

*and long term savings.*

*Support the ongoing development of IAPT services for children and young people.*

*Ensure the existing Transitions CQUIN is mainstreamed in Mersey Care NHS Trust provision in 2016/17.*

*Review with NHS England the role of School Nurses/Health Visitors and Voluntary, Community and Faith sector in establishing community awareness of mental illness in younger populations.*

## **11.4 Brain Injury**

Since 1995 Mersey Care NHS Trust has provided an Acquired Brain Injury (ABI) service which is commissioned locally. The service provides rehabilitation for individuals with cognitive and behavioural problems through acquired brain injury in adulthood. The service is primarily an inpatient based services with 8 beds commissioned and a small element of community provision.

In addition to nursing and medical staff the service contains Occupational Therapy, Speech therapy and Social work staff. The service can demonstrate good outcomes with just fewer than 50% of patients being discharged to home without extra support and a further 25% are discharged to home with care packages. The remaining 25% of patients are discharged to either supported accommodation or nursing homes.

There are links in place with Walton Centre NHS Foundation Trust and its bespoke unit through the provision of Neuropsychology and Neuropsychiatry and these links will be strengthened further by relocation of the existing unit, which is currently based at Mossley Hill Hospital to a new build facility shared with The Walton Centre NHS Foundation Trust in early 2015.

Despite close working with The Walton Centre NHS Foundation Trust the pathway is disjointed. The service is currently not part of the extended rehabilitation pathway. Since January 2013, the Cheshire and Merseyside Rehabilitation Network has been commissioned to provide specialist rehabilitation for patients following traumatic injury or illness across hub, spoke and community services. The service was commissioned as part of the Quality Innovation Productivity and Prevention (QIPP) programme of work established under NHS Merseyside. The principle being that investment in this pathway would improve quality of care for this group of patients and would deliver efficiency savings by preventing patients going into long term care within the independent sector.

The pilot project is due to finish in March 2015 and funding has now been approved for a further 12 month period to extend contracts until March 2016.

The model of care is delivered through collaborative partnership working:

- Hub Hyper Acute Specialist Rehabilitation Unit - 10 beds commissioned for Cheshire and Merseyside patients requiring hyper acute rehabilitation, delivered by The Walton Centre NHS Foundation Trust.

- Hub Complex Rehabilitation Unit - 20 beds commissioned for Cheshire and Merseyside patients requiring supportive rehabilitation, delivered by The Walton Centre NHS Foundation Trust.
- Bespoke Specialist Rehabilitation Unit - 20 beds commissioned for Merseyside patients requiring active rehabilitation, delivered by St Helens and Knowsley Teaching Hospitals NHS Trust
- Bespoke Specialist Rehabilitation Unit - 15 beds commissioned for Merseyside patients requiring active rehabilitation, delivered by The Royal Liverpool and Broadgreen University Hospitals NHS Trust.
- Specialist Rehabilitation Community Service - commissioned by NHS St Helens and NHS Knowsley CCGs , provided by Bridgewater Community Healthcare NHS Trust
- Specialist Rehabilitation Community Service – commissioned by NHS Liverpool CCG and the two Sefton CCGs, provided by Liverpool Neuro Physio, and Health and Social Care Partnerships.

#### 11.4.1 The future model for Acquired Brain Injury in Sefton

The relocation of the Mersey Care NHS Trust Brain Injury service to a new build facility shared with The Walton Centre NHS Foundation Trust makes subcontracting a practicable option to consider as it is the Task Group's view that the pathway would be better integrated within the wider rehabilitation pathway. North Mersey CCGs are looking to commission an independent review of the services covered within Rehabilitation Network Pathway which will include the Mersey Care NHS Trust element of provision and as such any revised contracting arrangements should be subject to the results of this review which will be concluded later in 2015/16.

#### **Task Group recommendation**

*Commissioners will await the outcomes of the wider review being undertaken by the Cheshire and Merseyside Rehabilitation Network before undertaking any change to the existing contracting arrangements, which would require of support of the other North Mersey CCGs.*

### 11.5 Outcomes and Recovery

#### 11.5.1 Outcomes

Under the Health and Social Care Act 2012<sup>22</sup>, CCGs are accountable for improving health and treatment outcomes in the NHS. This requires CCGs to monitor achievement of outcomes within the five NHS Outcomes Framework<sup>23</sup> domains and indicators:

- Domain 1: Preventing people from dying prematurely

<sup>22</sup> <https://www.gov.uk/government/publications/health-and-social-care-act-2012-fact-sheets>

<sup>23</sup> [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/213055/121109-NHS-Outcomes-Framework-2013-14.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213055/121109-NHS-Outcomes-Framework-2013-14.pdf)

- Domain 2: Enhancing quality of life for people with long-term conditions
- Domain 3: Helping people to recover from episodes of ill-health or following injury
- Domain 4: Ensuring people have a positive experience of care
- Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm

The development of outcomes for mental health and dementia services will support the achievement of all five NHS Outcomes Framework domains and indicators. In addition preventative working will support the achievement of the following Public Health Outcomes Framework domains and indicators:

- Domain 2: Health Improvement
- Domain 4: Healthcare, public health and preventing premature mortality

The development of mental health services which will support the recovery of patients, their families, friends and carers is now a central theme in national policy but in order to support recovery, patients and services, commissioners require outcome based measures so as to monitor progress and by April 2017 it is anticipated that there will be a wholesale shift to outcome-focused contracting which move away from block contracts which have historically not worked in the interests of commissioners, providers and more importantly, patients.

For people with common health problems, IAPT services have, since 2008, been using recognised tools such as Generalised Anxiety Disorder (GAD) and Patient Health Questionnaires (PHQ) which can demonstrate a patient's progress in their treatment journey leading to recovery. Bespoke clinical systems are in place which provide patient management and reporting solutions for psychological therapists providing cognitive behavioral therapy (CBT) and other related treatments. Patient level data recording recovery is routinely sent to GPs and they are able to track a patient's progress through treatment. In addition the Third Sector in Sefton has a strong track record of using recovery based outcomes.

Within Mersey Care NHS Trust the current mental health contracting currencies are out of date and many activity indicators are catchment and not CCG based. The information that GPs receive does not reveal if a patient is making demonstrable progress in their treatment journey.

Measuring recovery outcomes is an important objective for mental health services to achieve but it remains a challenge due to the complexity of mental health conditions and the subjectivity of recovery. The challenge is to agree which measures to use that are relevant, measurable and reportable and that they meet the needs of:

- Service users
- Commissioners and GPs
- Providers

For Mersey Care NHS Trust, as outlined earlier in this document, this challenge is further exacerbated by its ePEX clinical system which is not suitable for further

development to enable the capture of outcomes. The Task Group acknowledges that the development of measurable outcomes is a significant challenge for the Trust.

Mersey Care NHS Trust is in the process of procuring a clinical system to replace ePEX and this provides the opportunity to ensure that measurable outcomes are captured. The RiO system has been identified. RiO is predominantly operational in Mental Health and Community Health settings. It can also be deployed to support social care requirements and has the technology to be interoperable with GP practices to interface with their patient records.

The Task Group believes that future outcomes must not be medically focused but that they should be broadly based on wellbeing and social functioning so as to measure recovery. As part of its *Local Service Division Care Strategy 2014-19* Mersey Care NHS Trust has tasked a senior clinician to identify outcome measures within 2015/16 that can subsequently be agreed at a clinical commissioning level. These will be captured on the RiO system and then incorporated into the 2016/17 contract. Dialogue with the Trust suggests that there is no divergence of opinion in the need for outcomes to be based on wellbeing and social functioning leading to recovery.

#### **11.5.2 Proposed mental health tariff CQUIN for 2015/16**

Building on the work that has been done by Mersey Care NHS Trust in the clustering of patients using the mental health cluster tool methodology Sefton commissioners are requiring the Trust to produce the specifications/packages of care and outcomes that accompany each cluster. During the course of 2015/16 commissioners will be routinely kept informed of progress and will be given the opportunity to review progress and make amendments so as to ensure “fit” with CCG requirements. This CQUIN will incentivise the Trust to be in a position to report meaningful outcomes in 2016/17 onwards.

#### **11.5.3 The emerging outcome measures**

There are a range of outcome measures that can be used to determine the quality of mental health and dementia care and these can be grouped around three areas of measurement.

- Clinical Related Outcome Measures
- Patient Related Outcome Measures
- Patient Related Experience Measures

#### **11.5.4 Clinical Related Outcome Measures (CROMS)**

The Health of the Nation Outcome Scale (HoNOS)<sup>24</sup> was developed by the Royal College of Psychiatrists in 1996 and it is a widely used outcome measure within specialist mental services.

---

<sup>24</sup> <http://www.rcpsych.ac.uk/crtu/healthofthenation.aspx>

The HoNOS provides professionals with a framework to measure risk and vulnerability. It provides a systematic summary of behaviours and functioning, is easy to use, provides consistent measurements and provides basic monitoring and outcome information.

Within HoNOS there are a set of 12 scales with a 5-point rating scale which are completed by mental health professionals after routine clinical assessment, CPA reviews. The scales are:

- Are designed for use in any setting in secondary mental health care services
- Are based on a rating of the worst symptoms/problems within a specified time period
- To provide a numerical record of the clinical assessment
- Are ratings of mental health outcome, not health care outcomes

For mental health tariff clustering purposes HoNOS is used in conjunction with the Mental Health Clustering Tool to enable clinicians to allocate patients to each of the 21 care clusters.

Recently a mandatory shortened four factor model of the HoNOS has been developed and the Health and Social Care Information Centre (HSCIC) will be reporting the results from the mandated clinician rated outcome measure (CROM) from 2015 onwards which will be analysed at a mental health cluster level and reported at Provider/CCG level.

**Table fourteen: Four Factor HoNOS Model**

<b>FACTOR 1 Personal Well Being</b>	<b>FACTOR 2 Emotional Well Being</b>	<b>FACTOR 3 Social Well Being</b>	<b>FACTOR 4 Severe Disturbance</b>
Item 4: Cognitive Problems	Item 2: Non-accidental Injury	Item 3: Problem-drinking or drug taking	Item 1: Overactive, aggressive, disruptive or agitated behaviour
Item 5: Physical Illness or disability or disability problems	Item 7: Problems with depressed mood	Item 9: Problems with relationships	Item 6: Problems associated with hallucinations & delusions
Item 10: Problems with activities of daily living	Item 8: Other mental and behavioural problems	Item 11: Problems with living conditions	
Item 12: Problems with occupation and activities		Item 12: Problems with occupation and activities	

Source: Care Pathways and Packages Project

A zero-four score is applied to each of the items:

- 0 - No problem
- 1 - Minor problem require no action
- 2 - Mild problem but definitely present
- 3 - Moderately severe problem
- 4 - Severe to very severe problem

Average scores for each factor are derived from the score at the start and the end of each cluster episode of care. If it were to see an improvement in service users' symptoms then a clinically significant reduction in the average scores for the *emotional well-being* and/or the *severe disturbance* factors might be a reasonable expectation and indicative of a good outcome if it were achieved. If it were to see an improvement in service users' relationships and occupational activities as well as their mental health symptoms, then a clinically significant reduction in the average scores for the *social well-being* and *emotional well-being* factors might be considered a good outcome if it were achieved. In both these examples a clinically significant reduction in the scores would indicate the care packages are meeting their aims and the needs of service users.

For some clusters, the expected outcome and the aims of the care packages may be to maintain current levels of health and social well-being. In such cases no clinically significant change in the average factor scores might be considered a good outcome and indicative of the care package meeting its aims and the needs of service users. Similarly, deterioration in some aspects of service users' health and social well-being might be expected in some clusters.

In addition to HoNOS there are a number of clinical outcome measures that are used in different clinical settings which could be adapted for use:

- **Social Functioning Questionnaire (SFQ)** This measure was developed originally for the assessment of mental health rehabilitation service users. It has only recently undergone psychometric assessment but appears to have good reliability and validity, is quick to complete and provides a useful graphical presentation of the results.
- **Camberwell Assessment of Needs Short Appraisal Schedule (CANSAS)** This is a widely used. It is a brief and easily completed measure which has good psychometric properties. It reports on met, unmet and total needs in 22 domains and may be especially important for rehabilitation services to evidence the degree to which they are addressing service users' complex problems (i.e. by increasing the proportion of met to unmet needs) even when total needs don't change (as is often the case for people with complex needs).
- **Accreditation for Inpatient Mental Health Services (AIMS)** This provides a comprehensive quality assessment of units registered with the AIMS program, that includes assessment of quality standards agreed by an expert reference group through review of policies, processes and protocols, interviews and assessments with staff, service users and carers and a visit by a peer assessment team. Mersey Care NHS Trust is an accredited member of AIMS.
- **Quality Indicator for Rehabilitative Care (QuIRC)** is a web based self-assessment tool for mental health rehabilitation wards and community based

rehabilitation facilities that provide 24 hour support to people with longer term mental health problems. It is completed by the manager of the facility and has been validated against service user experiences of care.

### **11.5.5 Patient Rated Experience Measures (PREM)**

Currently mental health trusts are rolling out the Friends and Family Test (FFT). The FFT has been in place with acute trusts since 2013/14. FFT is an important feedback tool that supports the principle that people who use NHS services should have the opportunity to provide feedback on their experience.

The FFT asks people if they would recommend the services they have used and offers a range of responses. When combined with supplementary follow-up questions, the FFT provides a mechanism to highlight both good and poor patient experience.

The question and responses are nationally set:

*“How likely are you to recommend our ward/ service (if community) to friends and family if they needed similar care or treatment?”*

Those people that decide to complete the NHS FFT can choose from the following range of responses:

- Extremely likely
- Likely
- Neither likely nor unlikely
- Unlikely
- Extremely unlikely
- Don't know

The responses to the FFT question are used to produce a score for the provider, which can also be aggregated to national level. In future, the nationally aggregated NHS FFT score will be used as an indicator in the NHS Outcomes Framework.

### **11.5.6 Patient Reported Outcome Measures (PROMS)**

The Warwick Edinburgh Mental Wellbeing Scale (WEMWBS) is a generic wellbeing scale for mental health covering 14 items. WEMWBS is referenced in *No Health Without Mental Health (DH, 2011)* as a well evidenced and validated measure for wellbeing.

It is suggested that where no PROM is currently being used within an organisation, consideration should be given to using the shorter 7 item version of WEMWBS as the PROM of choice and this is currently being evaluated by Mersey Care NHS Trust as a future PROM.

Using the statements in the table below, patients are asked to tick or circle the box that best describes their experience of each over the last 2 weeks.

**Table fifteen: Shortened Warwick Edinburgh Mental Wellbeing Scale**

<b>Statements</b>	<b>None of the time</b>	<b>Rarely</b>	<b>Some of the time</b>	<b>Often</b>	<b>All of the time</b>
I've been feeling optimistic about the future	1	2	3	4	5
I've been feeling useful	1	2	3	4	5
I've been feeling relaxed	1	2	3	4	5
I've been dealing with problems well	1	2	3	4	5
I've been thinking clearly	1	2	3	4	5
I've been feeling close to other people	1	2	3	4	5
I've been able to make up my own mind about things	1	2	3	4	5

Source: Care Pathways and Packages Project

Scores can be analysed over a period of time at a patient or patient group /mental health cluster level to determine if wellbeing has improved.

An agreed set of outcomes is critical to the redesign of mental health and dementia services and is it imperative that Sefton CCGs understand what outcomes they are getting in return for the investments they make into mental health provision, this can potentially be used to inform strategic decisions. It is vital that progress is made in agreeing outcomes in 2015/16 for inclusion into 2016/17 contracts.

Commissioners will want to use outcomes related information to inform their discussions with Mersey Care NHS Trust and other providers about where improvement may be required and what incentives might be agreed in order to achieve them.

### **Task Group recommendations**

*Work closely with Mersey Care NHS Trust, and other Providers to agree the future outcome measures which are relevant, measurable and reportable.*

*Work with Mersey Care NHS Trust and iMersey to ensure that the RiO system has inter-operability with primary care systems and where possible with local authority systems.*

*Monitor progress of the mental health tariff/ CQUIN and ensure that milestones and objectives are achieved in 2015/16.*

### **11.5.7 Recovery**

Recovery is inextricably linked to outcomes in mental health. National mental health policy recommends the development of Recovery Colleges as a key lever for

change. There is good evidence that a 'Recovery College' has the potential to transform mainstream services by moving the focus from treatment and risk management to education, growth and self-fulfilment.

Mersey Care NHS Trust was one of the early adopters of the 'Recovery College' idea, and it now provides one as part of a comprehensive programme of organisational change. The Recovery College was launched in September 2013, however, it appears to have been established outside of the commissioning process and Sefton commissioners were not involved in its establishment, this may in part be due to the previous commissioning arrangements when Liverpool PCT was the lead commissioner for the Trust.

The Task Group believe that the Recovery College should be an integral part of the contract held with Mersey Care NHS Trust.

The defining features of the recovery college are:

- Co-production between people with personal and professional experience of mental health and it operates on college (not day care) principles
- It is for everyone – professionals, service users, carers, families and friends
- There is a Personal Tutor (or equivalent) who offers information advice and guidance
- The College is not a substitute for traditional assessment and treatment, it is not a substitute for mainstream colleges
- It reflects recovery principles in all aspects of its culture and operation
- Access to a physical base (building) with classrooms and a library where people can do their own research

The Task Group believe that all mental health provision should be recovery focused. A recovery ethos can help empower people to take an active role in determining their needs and goals. Services should support and encourage individuals to achieve these goals and sustain recovery.

Housing, employment and disposable income are the key building blocks in most people's recovery and it is therefore important to ensure that effective methods for achieving these goals are available for everyone attending mental health services.

The Task Group believes that the Recovery College should enable more patient throughput to enable individuals to exit secondary care and fulfil their goal and ambitions. All patients who exit secondary care should have rapid access back in services should their circumstances change and Mersey Care NHS Trust already offer this facility through the promotion of their Rapid Access Card.

### ***Task Group recommendations***

*The Recovery College should be an integral component of the Mersey Care NHS Trust contract with its outcomes being reported from 2016/17 onwards.*

*The Commissioners should continue to support Mersey Care NHS Trust Care Strategy 2014-19 aims of embedding recovery based practice as part of its transformation programme.*

## **12. How the vision can be achieved**

Drawing on the findings from the site visits, the opinions of stakeholders and the literature on mental health and dementia transformation, the Task Group propose a number of steps to meet the vision for mental health and dementia in Sefton.

### **12.1 Achieving the vision through commissioning**

For too long, strategic planning and commissioning have been skewed towards acute and community commissioning to ensure that the physical health needs of local populations are met. This approach has little cognisance of the impact of mental health and dementia.

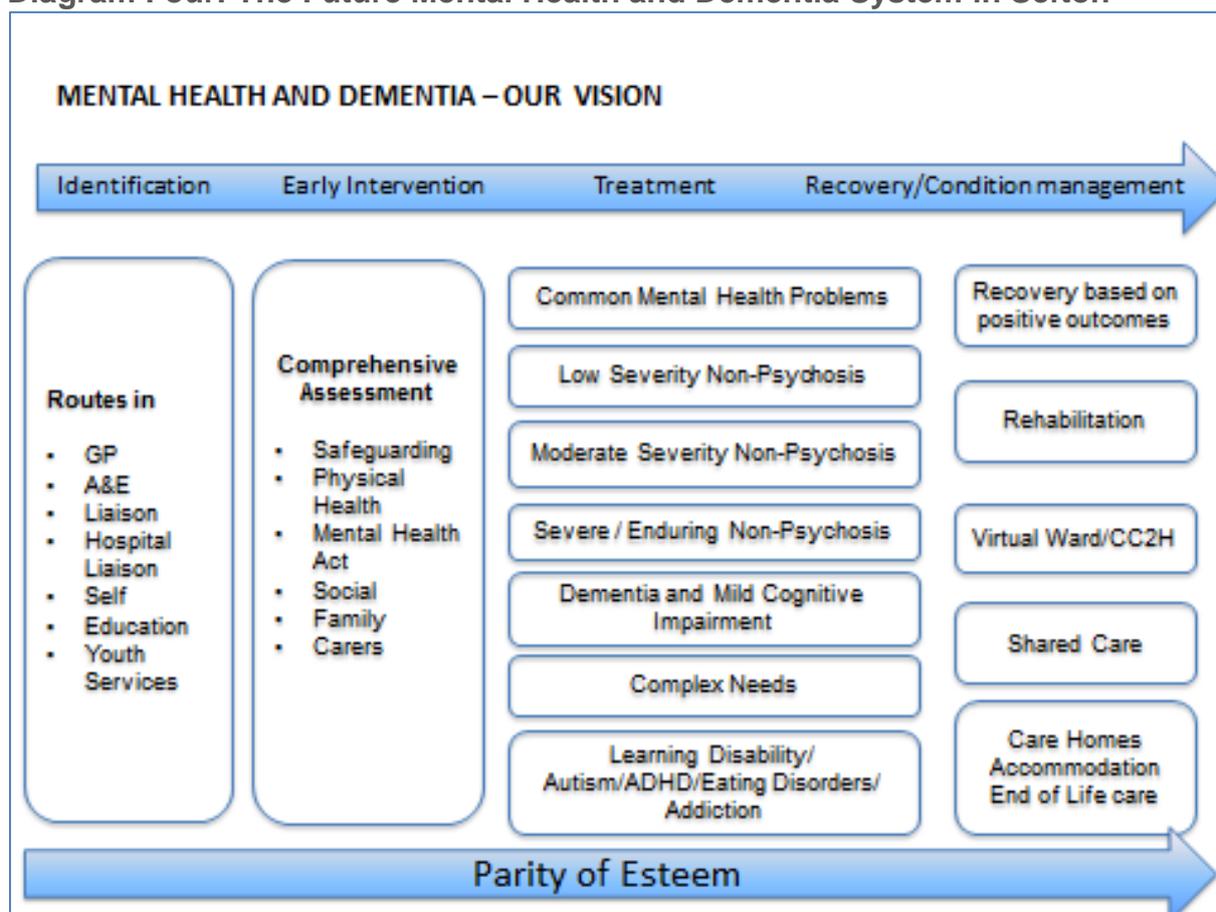
The Task Group believes that mental health and dementia should be embedded in all strategic planning. For example in the course of its visits the Task Group noted that the Aintree Trauma Centre staff had highlighted the need for more psychiatric input to support people with post traumatic syndrome/amnesia but it was not clear if formal arrangements had been put in place for psychiatric liaison to provide input nor was it clear whether staff are provided with training to help them identify the common mental health disorders which occur in response to major trauma.

By adopting a commissioning approach that views mental and physical health as inseparable and inter-related, commissioners will be addressing the stigma that derives from the artificial separation of physical and mental health and increasing public and professional understanding of their frequent coexistence.

Commissioning will be a key component in driving change within Sefton. The commissioning function should be supported with finance and business intelligence to enable transformational work to be undertaken and ensure that sufficient resources are available within the mental health and dementia pathway to ensure patient safety, enable service user and patient choice and for individuals to be treated close to home. All commissioned mental health services should have a recovery focus. The need for real and relevant data on outcomes will underpin the commissioning of high quality and effective mental health and dementia services. All future commissioning activity should have a locality focus as neighbourhood profiles indicate that “a one size fits all” approach is unsuitable in meeting the needs of localities.

The achievement of parity of esteem will be impeded if the appropriate commissioning is not in place. The diagram below illustrates the model for mental health and dementia services which commissioners should strive for.

Diagram Four: The Future Mental Health and Dementia System in Sefton



### Task Group recommendations

*Commissioners need to maintain a close working relationship based on mutual respect for providers so as to enable transformation work to be undertaken.*

*Mental health and dementia commissioning should not be done in isolation of any locality or wider commissioning – it is an integral part of commissioning activity. The inclusion of mental health and dementia commissioning within the Sefton Locality model of working will enable appropriate targeting of resources based on local needs.*

*The existing CCG partnership arrangement with the Local Authority should be followed through to ensure a co-ordinated preventative approach to mental health. This will ensure commissioners from health and the local authority get the best results from the “Sefton” pound.*

*Both CCGs should consider the deployment of financial and business intelligence resource to model mental health tariff/activity scenarios. This will enable commissioners and governing bodies to understand and mitigate against potential risks.*

*Through the contracting mechanism commissioners should ensure that reporting requirements are agreed and that they receive up to date activity and outcome information necessary for the payment of the mental health tariff/*

## 12.2 Achieving the vision through partnership

Commissioning alone cannot deliver the vision, any lasting change to the mental health and dementia pathways can only be done in partnership. The redesign and transformation of these services across Sefton requires much more careful consideration. This applies to almost all aspects of design including: the structuring of provision, the relationship between primary, secondary and social care, the geographical distribution of facilities, the funding flows and the monitoring of performance and outcomes.

It is clear that the successful NHS organisations of the future will have demonstrated their ability to collaborate across the healthcare sector taking on board the views of partners to establish quality service provision. It is vital that organisational interests become secondary when compared to improving patient outcomes and the collective leadership is harnessed to deliver the levels of service change required:

- The principle of parity of esteem is upheld which includes:
  - Equity in terms of resource allocation
  - Equity of access and services
  - Mental health patients can recover from episode of ill health.
- The transparency and accessibility of services and systems.
- Services are integrated around the patient.
- Integration between primary and secondary care, as well as social care and the VCF Sector.
- Use of collaborative and co-production approaches in the treatment of co-morbid patients.
- Services are embedded within the community.

The Mersey Care NHS Trust *Local Service Division Care Strategy 2014-19* has aims and objectives, some of which reflect the direction of travel for mental and dementia services and it is important that this developmental work is reflected within future partnership arrangements.

The Task Group believes that a Transformation Board at senior executive level should be established. All members should have the authority to enable change and the terms of reference should be clear about being committed to driving change. The Board should consist of members from:

- Patient representatives
- Healthwatch Sefton
- Aintree University Hospital NHS Foundation Trust
- Alder Hey Children's NHS Foundation Trust
- Liverpool Community Health NHS Trust
- Mersey Care NHS Trust
- NHS South Sefton CCG
- NHS Southport and Ormskirk CCG
- Southport and Ormskirk NHS Trust including the Integrated Care Organisation.

- Sefton Council for Voluntary Services
- Sefton Metropolitan Borough Council

The Transformation Board would ensure that collectively commissioners and providers will enable transformational change on the scale required and further demonstrate commitment to achieving parity of esteem for the patient group.

The delivery of this model of working will require effective partnership at a strategic and operational level and a program management approach.

### ***Task Group recommendations***

*Establish a Transformation Board with appropriate membership and a clear mandate to deliver parity of esteem within the local health economy by driving the necessary service changes.*

*The Transformation Board is empowered to support the health economy to develop and implement new models of integrated service delivery to reflect the changing needs of the population served.*

### **12.3 Achieving the vision through patients and carers**

Mental health and dementia services should be shaped on what matters most to patients and the public. Active patient involvement can assist in changing practice and helping to improve the patient experience and can aid their journey. Patients are experts about their own illness and what their needs are for care, their active involvement in their own care can be therapeutic in itself and it may also encourage greater social inclusion and to support in the breaking down of the stigma of mental health and in shaping its image. Our model involves patient representatives being active members of the Proposed Transformation Board alongside Healthwatch Sefton who are working to help people get the best out of their local health and social care services.

If services are to collaborate and form networks of care around patients it is important for patients to be involved in the decision making around their care and they should be at the heart of any service transformation. Meaningful engagement with patients and carers will be need to be undertaken through various mechanisms so as to enable them to be involved in the decision making and design process rather than having new models of care imposed upon them. In addition patient insight and experience will be invaluable to ensuring:

- Care should be simple for people to access, understand and navigate.
- Improving the response to patients in crisis.
- Improving the interfaces of care so that they are transparent and understood and that they reduce duplication.
- Services are embedded in the community taking account of their holistic needs including employment, education and housing support.
- Enabling patients to take a greater role through self-management/self-care

- Patients are at the heart of the recovery model so that they be empowered to take an active role in identifying their needs and goals and that they are supported to achieve them.

Patients need to be given access to the support, tools and knowledge to fully participate in working with commissioners and providers to redesign and develop pathways.

The value of patient and carer involvement in future transformation cannot be understated and transformation undertaken without patients and carers will result in pathways that will not deliver improved outcomes or patient experience. There is good work being undertaken with patients and carers within the Sefton Voluntary, Community and Faith sector and Mersey Care NHS Trust, this can facilitate the foundation for further meaningful and engagement.

### ***Task Group recommendation***

*Ensure that transformation work will be undertaken with the meaningful engagement of patients, carers and their families and that they will have significant input into future strategic and operational planning that is valued and meaningful.*

## **12.4 Achieving the vision by recognising equality and diversity**

The Public Sector Equality Duty should be considered and flow throughout the development and implementation of the any new models of mental health and dementia care. In order to meet statutory equality legislation both CCGs will have to consider the issues of:

- Eliminating discrimination, harassment and victimisation.
- Advancing equality of opportunity.
- Fostering good relations between different groups and people.

Any major transformation work will need to reflect the mechanisms used to ensure Equality considerations are outlined in the CCG's Equality and Diversity strategies and Equality Objective Plan. Key pieces of work will involve undertaking a Pre Equality Impact Assessment, which will:

- Identify within the services under review any potential equality implication – these will be reported to the CCGs and other key partners.
- Identify particular protected characteristics that appear in the process and develop a robust method of:
  - Consulting, engaging and informing.
  - Ensure that their views are recorded and reported back to the decision makers within the CCG and partner organisation.
  - To help develop a consultation process that analyses views from interested parties and different protected characteristics.
  - Ascertain whether the individual changes in the services are changes in thresholds or criteria.
  - Ascertain whether score/weighting will need to be used for evaluation of options.

A Full Equality Impact assessment will provide commissioners to assess risks associated with a breach in the Equality Act 2010 and view a range of recommendations to enable fair and equal access and outcomes.

***Task Group recommendation***

*Ensure that Equality and Diversity obligations are met within any transformational work to reflect the population characteristics of Sefton.*

### 13. Conclusion

The case to transform mental health and dementia care across Sefton is compelling, as maintaining the status quo will perpetuate an ossified model of care that acts against the interests and needs of patients. The two Sefton CCGs face a number of mental health and dementia challenges that, if not addressed now, have the potential to impact on the sustainability of local services and on health outcomes for local people.

The Task Group believe we must act now to address these challenges, which include an ageing population, unacceptable inequalities in health, as well as wide variations in the quality of and access to services.

In essence there need be a shift in mental health and dementia services towards:

- Consider the mental health and dementia needs in all newly commissioned services and also when redesigning current pathways
- Increased efforts to embed prevention in services starting from primary care.
- Earlier diagnosis and intervention that result in people being less dependent on intensive services
- When people become ill, recovery and care takes place in the most appropriate setting and enable people to regain their wellbeing and independence.
- Transparent interfaces of care.

This report makes recommendations which if adopted will enable mental health and dementia services to be fit for purpose in the 21<sup>st</sup> century within a wider local health care system that is innovative and responsive to patient needs. The Task Group believe now is the time to act.

## **14. Next Steps**

This report outlines the recommendations to be taken forward in order to make a fundamental shift in the way mental health and Dementia services are delivered to the population of Sefton.

These recommendations are to act as an enabler to progressing the transformational change required.

### **14.1 Establish a Mental Health Transformation Board**

- The Mental Health Transformation Board should have appropriate membership to make decisions on the future provision of Mental Health and Dementia Services which should be driven by patient need and designed by patients and carers
- It will have a clear mandate to deliver parity of esteem within the local health economy by driving the necessary service changes.

### **14.2 Work with Providers**

- Work with current providers to redesign services into responsive assessment and treatment teams aligned to neighbourhood localities
- Development of the model for Community Mental Health Teams that will ensure the psychiatric morbidity within a locality is managed safely, efficiently and effectively. Work in partnership with Mersey Care NHS Trust to align the current structures of multiple teams
- Review of rehabilitation service specifications and pathways to cater for a number of rehab levels of care
- Develop Integrated clinical IT solutions to share patient level data across Primary, Community and Secondary care systems. Effective Information Sharing across services, supporting the Integrated Working agenda

**Appendix 1:** Issues identified from site visits undertaken by the Sefton Mental Health Task Group.

No.	Site Visits Identified Issue
	<b>Boothroyd 02.05.2014 / Attendees:</b> Dr Steve Allington, Sharon Ball, Joanne Sutton, Kieran Daly (Mersey Care NHS Trust) Dr Hilal Mulla Geraldine O'Carroll, Kevin Thorne and Gordon Jones (NHS South Sefton and NHS Southport & Formby CCGs)
1.	Dual Diagnosis Screening and Co-ordination – links are in place but they need to be updated to reflect the new substance misuse arrangements.
2.	Lack of local dementia inpatient provision in Southport. All Sefton dementia inpatients are treated within Stoddart House on the Aintree site.
3.	Integrated Health/Mental Health Care Home Liaison service (including dedicated psychiatric input) requested.
4.	Training in Dementia awareness/medication in care homes needs to be provided. Training was in the original care home liaison service specification drawn up by Sefton PCT, however, has not been implemented recently.
5.	End of Life and Dementia care does not feel aligned.
6.	Home/Community based Memory Assessment and Diagnosis would aid dementia diagnosis rates.
	<b>Stoddart 16.05.2014 / Attendees:</b> Dr Steve O'Brien, Dr Mark Allington, Effion Ingman, Ward Managers (Mersey Care NHS Trust) Dr Hilal Mulla Geraldine O'Carroll, Kevin Thorne and Gordon Jones (NHS South Sefton and NHS Southport & Formby CCGs)
7.	Dual Diagnosis protocols are in place but they need to be updated to reflect the new substance misuse arrangements in Sefton as 1 above.
8	Limited availability of Step 4 Psychotherapy/Psychology in community and inpatient settings was identified as an issue by clinicians. The existing post which delivers services in an inpatient and onward community setting is a limited resource.
9.	A geriatrician from AUH used to visit but due to retirement the post was not replaced by AUH. MCT staff reported that when Stoddart House was part of AUH they held shared values and internal referral was easier and discharges (involving physical conditions) could be better managed. Good relationships survive due to existing relationships but have to be rebuilt when AUH staff move on. There is an SLA in place.
10.	Physical health/Dentistry/Respiratory/SALT for inpatients were cited as being problematic to obtain.
11.	Crosby Housing and Resettlement Team (CHART, Citizens Advice Bureau and dedicated Sefton Social Work support) was cited by MCT as being beneficial to improving inpatient discharges when compared to Liverpool patients in the same unit.
	<b>Hesketh 20.06.2015 / Attendees:</b> Dr Debbie Marsden, Gill McGee, Alex Henderson, Barry Farrington, Physical Health Liaison nurse (ECG room) (Mersey Care NHS Trust) Dr Hilal Mulla, Kevin Thorne and Gordon Jones (NHS South Sefton and NHS Southport & Formby CCGs)

12.	Hesketh Centre is in a central location but the building is old and is constantly being refurbished/repared.
13.	The current provision of psychology for patients is seen as gap – the trust plans to develop a PD hub in South Sefton which will also be accessible for Southport & Formby patients.
14.	Access to community based physical health staff is difficult – despite the site having a room to enable health intervention to be undertaken. Access to SALT has been a particular difficulty.
15.	Early Intervention Psychosis (EIP) - Those aged 14-15 are seen in partnership with Alder Hey CAMHS – good relationship established with CAMHS.  EIP currently has 50-60 people accessing the service.  Young males with cannabis problems are a significant cohort.
	<b>Aintree University Hospital (AUH) 04.07.2014 / Attendees:</b> Dr Mark Allington, Dr Clegg, ITU consultant, Ortho consultants (AUH) Dr Hilal Mulla, Geraldine O’Carroll, Kevin Thorne (NHS South Sefton and NHS Southport & Formby CCGs)
16.	No electronic links between Aintree University Hospital (AUH) and MCT in respect of patients presenting at A&E.
17.	Possible duplication of payment to AUH A&E to clerk mental health patients in and out of A&E prior to MCT assessing and providing the relevant services to those patients.
18.	Alcohol admissions – links to MCT services and the in-house AUH alcohol service need to be established.
19.	The liaison service finishes duty (reverts to on call) at 8pm – leaving a 4hour gap in the peak time identified by Aintree (6-midnight) AUH claim that complex patients at peak times are only seen by a junior member of staff.
20.	Arrangements need to be clarified when MCT move to Clock View in Feb 2015.
21.	Current patient transfer arrangements from Stoddart to AUH A&E (200 metres different) are made via NWS – does this provide value for money.
22.	Issues with Acute Hospital Liaison on Friday and Out of Hours admissions.
23.	AUH reported that MCT response times to A&E is impacting on AUH 4 hour wait time target.
24.	Lack of Trauma Centre linkages with MCT in respect of Post Trauma Amnesia, PTSD and suicide attempt patients. The NHSE specification requires 24 hour access, it appears that the Trauma Centre is accessing the <i>existing</i> arrangements rather than new links being put in place.
25.	The Trauma Centre is a regional facility, if mental health pathways and links were in place the impact on other CCG patients accessing local MCT services would need to be considered.
26.	Linked to 23 above – No contact with MCT at a clinical level to develop pathways.
27.	Lack of grief provision – e.g. support for children who may have been lost their parent(s) through car accident.
28.	ITU linkages with MCT in respect of assessments resulting in delayed discharges, lack of confidence in prescribing and lack of a pathway. Linked to 23 above – no formal contact between AUH and MCT at clinical level.

	<b>South Sefton Neighbourhood Visit 18.07.2014 / Attendees:</b> Kieran Daley, Dr Majunda, Peter Terry, Noreen Clark, Dr Kuban Naidoo, Ron White, Nicky Fearon (Mersey Care NHS Trust) Dr Hilal Mulla, Kevin Thorne and Gordon Jones (NHS South Sefton and NHS Southport & Formby CCGs)
29.	Service coverage in Nethererton and Maghull – at present only depot clinics are operating in each area.
30.	LA and NHS systems are not interoperable resulting in duplication. Staff have to use both systems independently.
31.	Any withdrawal of adult social workers by the LA could potentially increase the level of management of mental health patients in the community.
32.	Peri-natal mental health – funding for Sefton needs to be clarified.
33.	Peri-natal mental health arrangements in Southport & Formby are unclear.
34.	ADHD – Capacity issues with the service which may be improved by shared care arrangements.
35.	ADHD – If shared care is implemented appropriate prescribing monies will be required to be transferred over.
36.	CAMHS –CAMHS Transition is making a positive difference however gaps in 16-18 age group remain.
37.	Personality Disorder (PD) – more people with PD on the caseload – more psychological input is required.
38.	Clock View – diverting patients from AUH A&E will require targeted publicity and communication.
39.	Joint Psychiatric post with AUH as per Oxford – review of feasibility, benefits etc.
	<b>Waterloo Memory Clinic visit 08.08.2014 / Attendees:</b> Kieran Daley, Rachel Smith, Amanda Coventry, Dr Majunda (Mersey Care NHS Trust) Dr Hilal Mulla Geraldine O’Carroll, Kevin Thorne and Gordon Jones (NHS South Sefton and NHS Southport & Formby CCGs)
40.	Trust in past have informed commissioners that Consultants do not record diagnosis except on discharge. Dr Majunda reported on site visit that diagnosis was now recorded.
41.	Transfer of Dementia patients between acute and dementia wards – MCT have questioned if they are medically fit.
42.	Waterloo Memory service is experiencing difficulties due to lack of shared care for dementia and MCI patients. Only discharge back to GP takes place for vascular dementia.
43.	New patients in Waterloo are seen by a Consultant. In North Sefton they can be seen by either nurse or doctor – however the diagnosis rates are the same for both areas.
44.	End of Life – It was felt that Dementia patients are treated differently from those who are at end of life with other conditions.
	<b>Walton Centre for Neurology and Neurosurgery (WCNN) 22.08.2014</b> <b>Attendees:</b> Louise Jenkinson, Michelle Montrose, Divisional Manager (WCNN) Dr Hilal Mulla, Kevin Thorne and Gordon Jones (NHS South Sefton and NHS Southport & Formby CCGs)
45.	Long lengths of stay in MCT reported by Walton Centre for Neurology and Neurosurgery (WCNN).

46.	Pathways between MCT and WCNN do not appear aligned.
47.	To WCNNN the criteria for Mersey Care ABI service hinders throughput of patients.
	<b>Mersey Care NHS Trust ABI Visit 15.09.2014 / Attendees:</b> Dr Kevin Foy, MDT Team, (Mersey Care NHS Trust) Dr Hilal Mulla, Geraldine O'Carroll, Kevin Thorne and Gordon Jones (NHS South Sefton and NHS Southport & Formby CCGs)
48.	A shortfall in post-traumatic amnesia is having an impact on the wider rehab pathway.
49.	Links in place with the wider rehab pathway. MCT appear to be operating in isolation from WCNN, the move to WCNN might ease this.
	<b>Southport and Ormskirk A&amp;E Visit 24.10.2014 /Attendees:</b> Dr Mark Allington, Sharon Ball, Frail Elderly link Nurse, West Lancs Liaison Nurse (S&O) Dr Hilal Mulla, Kevin Thorne and Gordon Jones (NHS South Sefton and NHS Southport & Formby CCGs)
50.	No presence of mental health support on site (except SHO) after 5pm.
51.	An SLA does not appear to be in place between MCT and Southport & Ormskirk Hospital for the provision of liaison services.
52.	Flow of patients to Frail & Elderly unit and criteria for acceptance requires review.
53.	Physical space for mental health assessments, although improved is still limited.
54.	No IT connectivity for MCT staff, they have to return to Hesketh Centre to input onto ePEX .
55.	Enhanced training in the management of dementia patients needs to be undertaken
	<b>Rathbon Rehab Visit 07.11.2014 / Attendees:</b> Dr Arpan Dutta, Alison Booth, Paula Lacey (Mersey Care NHS Trust) Geraldine O'Carroll, Kevin Thorne (NHS South Sefton and NHS Southport & Formby CCGs)
56.	The profile of the service provided by rehab within the mental health pathway needs to be raised.
57.	Sefton commissioners wish to be involved in pathway redesign and need to consider how this would impact and enhance the community element of provision.
58.	Consideration for more work to be undertaken upstream – the interface between the service and wider community mental services should be developed further.
59.	Community rehabilitation element of provision could play a role in developing packages for onward transit of patients into the community.
60.	Recovery measures for rehabilitation are being reflected in the wider MCT work that Dr Sudip Sitkar is leading on.
	<b>Eating Disorder Visit 03.12.2014 / Attendees:</b> Ruth Carson (Mersey Care NHS Trust) Dr Hilal Mulla, Gordon Jones (NHS South Sefton and NHS Southport & Formby CCGs)
61.	Eating Disorders service is oversubscribed. Patients are triaged and assessed within 18 weeks

62.	Recognised that Eating Disorders prevention work is limited.
63.	Public Transport links to Rathbone Hospital from Sefton are limited, but service is looking to develop a weekly satellite clinic in Southport
64.	Staff from the service believe it would be beneficial to lower the minimum referral age to 14 years so as to enable early intervention. (The 5 Boroughs Partnership services in St Helens and Knowsley is 14 plus)
65.	Links with Sefton VCF sector could be explored further e.g. Sefton Women's Advisory Network
	<b>Alder Hey SPA visit 05.12.2014 / Attendees:</b> Jo Fyne (Alder Hey) Dr Hilal Mulla, Gordon Jones (NHS South Sefton and NHS Southport & Formby CCGs)
66.	The 4 page referral form is time consuming for GPs to complete and it relies on GPs gathering information/consent from other partners prior to be being sent to Alder Hey.
67.	The website used by Alder Hey Single Point of Access (SPA) needs to be adapted for Sefton patients
68.	The SPA cover 0-18 years old however referrals from patients aged 16+ may go to Mersey Care NHS Trust. For the period Nov 13-Nov14: 1,135 referrals had been received. Currently 577 people were on the waiting list (average wait is 21-22 weeks). 50% of referrals are referred back
69.	Service accepted it would be beneficial to have the criteria accompany the referral form so as to aid referrers.
70.	Links with Mersey Care NHS Trust in place and transition protocols are in place via the Transition CQUIN but the access points for the patient group are still confusing to GPs.
71.	The SPA has an establishment of 21.0 WTE but it is currently carrying 6.3 WTE vacancies.