HEALTH & WELLBEING SCRUTINY COMMITTEE

INTERNAL SERVICE DEVELOPMENT PROGRAMME

REPORT OF NORTHUMBERLAND TYNE AND WEAR FOUNDATION TRUST **9 JUNE 2010**
STRATEGIC PRIORITIES: SP2: Healthy City.

CORPORATE PRIORITIES: CIO1: Delivering Customer Focused Services, CIO4: Improving Partnership Working to Deliver 'One City'.

1. Purpose of the Report

1.1 To provide a briefing to members of the Health and Wellbeing Scrutiny Committee on Northumberland Tyne and Wear Foundation Trust internal service developments.

2. Background

2.1 Following an independent inquiry in relation to the treatment of Garry Taylor by secondary mental health services in Sunderland, there were a number of recommendations made in relation to areas of services that need to be developed and improved. In response, working in collaboration with commissioners, the Trust started an Internal Service Development Programme which is focused on addressing those areas.

2.2 The specified areas for development are as follows:

- Multidisciplinary Team Working
- Team and Service Redesign
- Deep Implementation of Care Coordination
- Risk Assessment and Risk Management
- Records without Fuss
- Transitions
- Safeguarding
- Involving Carers

2.3 In addition, the Trust is working with commissioners to develop new models of care for mental health to ensure effective service models in the future which will contribute to reducing risk and providing an improved patient experience. This paper focuses on developments associated with the Internal Service Development Programme.

3. Current Position

3.1 Currently, services in Sunderland are fragmented and there is a significant lack of multidisciplinary team working. It has been shown that, when done properly, the multidisciplinary team approach provides positive measurable outcomes including improved safety, reduced risk and a more positive patient experience. With a diverse group of professionals, such as consultant psychiatrists, nurses, psychologists, occupational therapists, and social workers there is more certainty that all of the needs of the service user will be met. The implementation of the multidisciplinary team structure will also enable a much more holistic approach to mental health care to be taken.

3.2 The Internal Service Development Programme aims to implement multidisciplinary team working, provide improved access to services, improved core assessments of service users and develop shared care arrangements which ensure service users are receiving the right intervention at the right time in the right place. Currently the programme has established three main projects which all have the aim of making improvements to the secondary mental health care services being delivered by the Trust in Sunderland.

3.3 These projects are as follows:

Team and Service Development (Phase I)

AIM: Design and implement new multidisciplinary community mental health teams in Sunderland.

Access and Assessment

AIM: Design, develop and implement a single point of access to secondary mental health services for the people of Sunderland.

AIM: Develop an agreed format for core assessment ensuring high quality assessments are being done by staff with the right skills.

Step down, Discharge and Shared Care

AIM: Provide a system of appropriate, stepped, planned continuing care to patients as they transition out of our services, in order to promote recovery and independence, prevent relapse and ensure service users are receiving the right intervention at the right time in the right place.

4. Proposed Changes

4.1 As part of the Team and Service Redesign (Phase I) Project a number of engagement events were held involving staff, commissioners, primary care, social care, service user and carer representatives.

These events focused upon the improvements that needed to be made and how these could be achieved.

4.2 Currently, secondary mental health services in Sunderland are confusing and are not arranged in a way which supports clinical best practice. Several of the teams do not have a full multidisciplinary team, and some teams do not have any routine access to consultant psychiatrists.

4.3 Clearly this situation cannot continue and through discussions at these engagement events it was agreed to develop and implement two new fully integrated, multidisciplinary specialist community mental health teams, each aligned to GP practices, serving approximately half of the city.

4.4 In order to implement these new teams we intend to realign the current community teams and case loads of individual psychiatrists to ensure that all specialist teams have adequate access to the key specialist disciplines.

4.5 Three consultants Dr's Perera, Rastogi and Sharma will provide dedicated support for inpatients. The remainder of consultants will be allocated to one of the two community teams which will serve different areas of the city. This will mean that inpatient consultants are able to specialise in supporting the recovery of patients with complex acute needs in an inpatient setting. Community consultants will engage in an individual patients care and discharge arrangements and take responsibility for their care once they leave hospital. A care coordinator will provide consistency of care across the patient's pathway.

4.6 During the summer we will write to individual patients whose current consultant will change, to explain the process. They will be given the opportunity to discuss any concerns about the changes to their care arrangements with their existing consultant. We will also invite patients and carers affected to attend a briefing session to provide an opportunity to ask any questions they may have. The Trust has discussed the proposals with the LMC and will write to all GPs in the City to explain how changes will be managed. GPs will be copied into all correspondence to their patients.

5. Conclusion

5.1 The development of two new specialist community mental health teams in Sunderland and the implementation of the multidisciplinary team working approach is expected to have a positive impact on increasing patient safety, ensuring service users have all of their needs met, by the right person, with the right skills at the right time and should improve the overall patent experience.

6. Recommendations

6.1 That Members note and comment on the contents of the report.

APPENDIX 1

Questions and Answers – Changes to Consultant caseloads

Why is this change necessary?
Following the tragic incidents reported in the Garry Taylor inquiry, the Trust has been working very hard in collaboration with PCT Commissioners to make improvements to local services and developing new models of care for mental health to ensure effective service models in the future. There are currently up to 9 Consultants working into each of the acute admission wards at Cherry Knowle. This means that ward teams are not able to provide consistent enough care for patients with very complex clinical needs. There are also community teams in Sunderland with no access to consultant psychiatrists. This cannot continue.

Who will the new Consultants be?
The new inpatient consultants will be:

Dr Chrys Perera
Dr Sanjay Rastogi
Dr Ashok Sharma

The community consultants will be:

Dr Iain Cameron
Dr Arun Gupta
Dr Andrew Lawrie
Dr Pratapa Murthy
Dr Dawn Potkins
Dr Andrea Tocca

What about continuity of care?
Continuity will be provided by care coordinators and community consultants. Each patient who requires one will have a care coordinator who stays with them across the whole pathway (inpatient and community). Discharge planning and discharge meetings will also be very important and will be the place where patients meet their new community consultants for the first time following their first initial inpatient admission. When their patients are admitted, community consultants will be involved in ensuring there is a comprehensive assessment. They will help set the goals of admission and will remain in touch with the patient throughout the admission (as per agreed protocol). They will also be part of discharge planning.

Will any current patients be discharged as part of this process?
No – all patients who currently have one of the inpatient consultants as their named psychiatrist will have their care transferred to a new psychiatrist. The only patients who will be discharged are those who have naturally reached the end of their treatment.

Will there be any other changes?
Yes – This is the first of a series of changes to improve the services. The next steps will be:

- To streamline services by creating two geographically based community teams
- To streamline access by creating a single point for referrals to secondary services
- To provide direct contact between GP's and consultants and enable clinical discussions on the best course of action for individual patients

How will patients and their families be informed and involved
We will write to each patient who will be affected by this change. The letter will be copied to the patients GP. The letter will explain why the changes need to take place and what the process will be. Patients and carers will also be invited to attend a question and answer session if they would like more information. We will also work with service user and carers organisations in Sunderland to support people.

How will services cope during the transition?
We recognise that any change places pressure on existing systems, and it is important to recognise that improving services in Sunderland has been a long term project which has been well resourced. To support this specific change the Trust has provided 2 locum consultants to enable existing consultants to focus on ensuring successful transitions for each patient.

When will these changes happen?
We plan to start writing to patients to inform them of their new consultant during June. We expect the process to be finished by the end of September 2010.

Will there be any changes to the team bases?
Yes, we are hoping to identify a new central office base for the community teams, however people will still be offered appointments at the nearest community base.

How will the community teams be set up?
There will be a blue community team which will be aligned to GP practices North of the river Wear and west of the A19 and a red community team which will be aligned to GP practices south of the river Wear and east up to the A19.

How can I get more information?
If you would like to get more information please contact the Project Manager, Sam Mansy on 07768 466 711 or sam.mansy@ntw.nhs.uk