New Care Models and Provider Collaboratives; the new women's services landscape
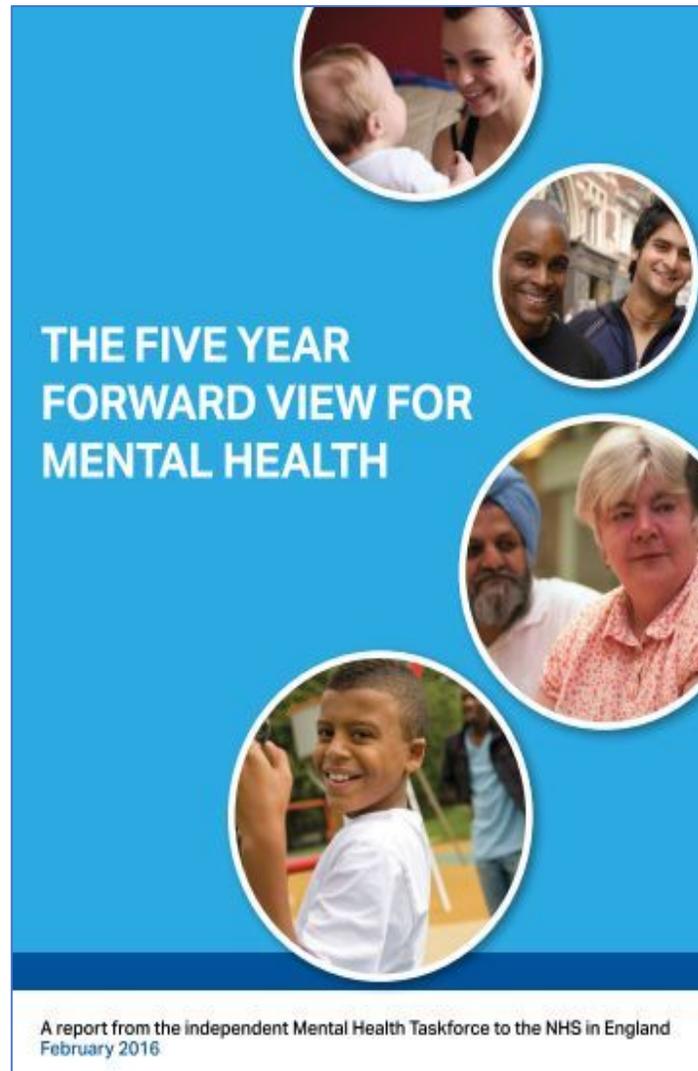
Debbie Stanton

Service Specialist and Supplier Manager NHS England & Improvement

Midlands Region

NHS England and NHS Improvement
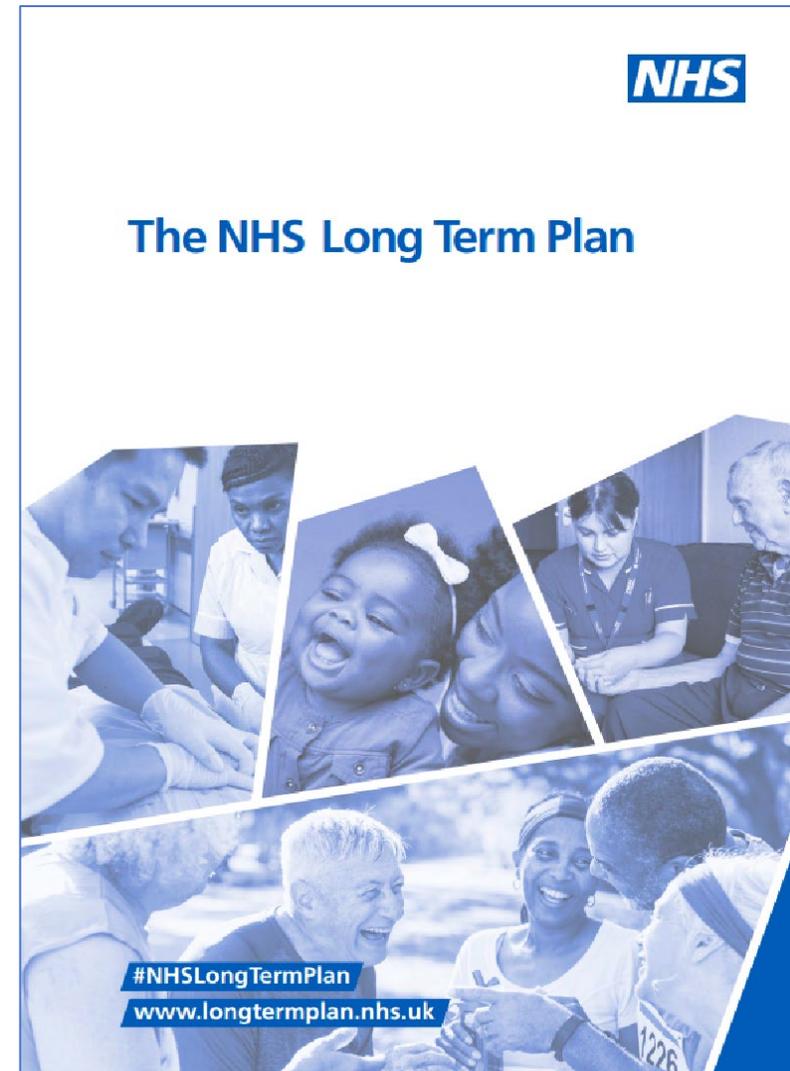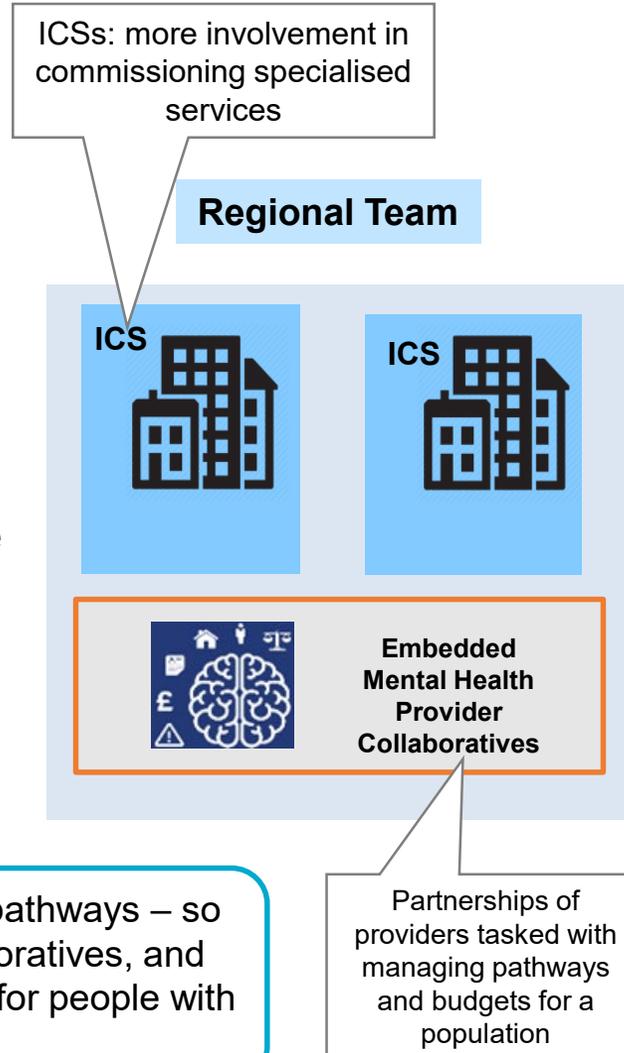
2016

THE FIVE YEAR FORWARD VIEW FOR MENTAL HEALTH

A report from the independent Mental Health Taskforce to the NHS in England
February 2016

2019

NHS

The NHS Long Term Plan

#NHSLongTermPlan
www.longtermplan.nhs.uk

Mainstreaming New Care Models is in line with the Long Term Plan

- The Long Term Plan sets out a vision for greater local system integration and autonomy

- In specialised mental health we are implementing this aspiration by giving responsibility for specialised mental health services at a population level to Provider Collaboratives (piloted as New Care Models)

- Provider Collaboratives will become the delivery vehicle for our ambitions in improving services: including service reviews in CAMHS, Adult Secure and aspects of non-specialised mental health programme

ICSs: more involvement in commissioning specialised services

Regional Team

ICS

ICS

Embedded Mental Health Provider Collaboratives

Partnerships of providers tasked with managing pathways and budgets for a population
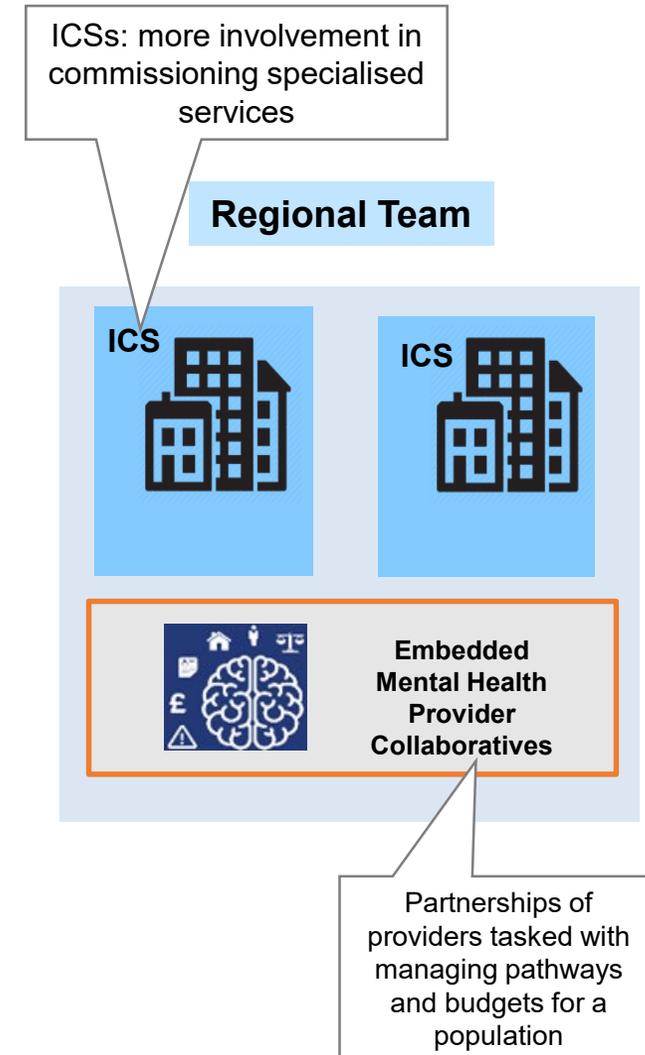
Our long term ambition is to fully join up mental health commissioning pathways – so that coordinated decisions are made across ICSs and Provider Collaboratives, and funding is used in the most effective way possible to improve outcomes for people with mental health problems
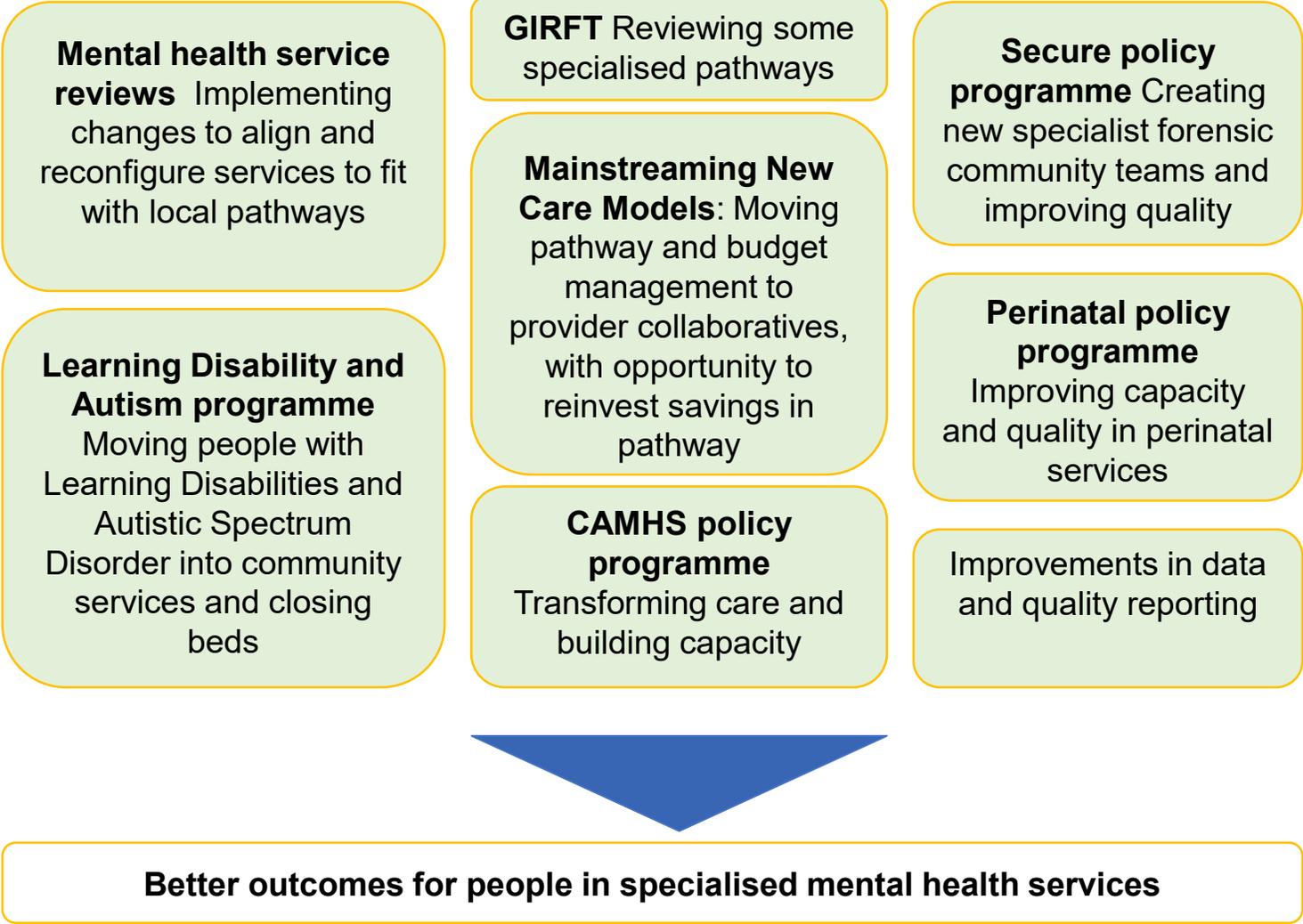
Mainstreaming New Care Models is in line with the Long Term Plan

For specialised services, Provider Collaboratives should:

- Improve continuity in patient pathways and ensure that financial incentives are focused on patient outcomes

- Make services locally and clinically led, giving local health systems the freedom to innovate to improve services, whilst maintaining national consistency in clinical standards and quality

- Improve value for money in specialised mental health spending and reinvest savings in community and step down services

- Create a basis for further integration with locally commissioned mental health services

ICSs: more involvement in commissioning specialised services

Regional Team

ICS

ICS

Embedded Mental Health Provider Collaboratives

Partnerships of providers tasked with managing pathways and budgets for a population

NHS England works across a range of programmes to improve quality of services for people in specialised mental health

Mental health service reviews Implementing changes to align and reconfigure services to fit with local pathways

GIRFT Reviewing some specialised pathways

Secure policy programme Creating new specialist forensic community teams and improving quality

Mainstreaming New Care Models: Moving pathway and budget management to provider collaboratives, with opportunity to reinvest savings in pathway

Learning Disability and Autism programme Moving people with Learning Disabilities and Autistic Spectrum Disorder into community services and closing beds

Perinatal policy programme Improving capacity and quality in perinatal services

CAMHS policy programme Transforming care and building capacity

Improvements in data and quality reporting

Better outcomes for people in specialised mental health services

NCM evaluation findings

An independent evaluation of the New Care Models (NCM) in mental health programme was conducted based on both quantitative and qualitative methods including, all 17 of the wave 1 and wave 2 New Care Model pilot sites over the summer of 2018, including interviews with a wide range of local stakeholders.

Key Findings:

➢ Substantial support for the model across a range of internal and external stakeholders

➢ Good evidence of improvements in some outcomes: treatment closer to home for CYP; repatriation to local services for adults; falling admission rates across services; significant savings achieved; and re-invested in local services

➢ Strong sense of ownership and empowerment amongst providers and a notable shift towards a more cooperative culture across all stakeholders

➢ Some Financial management meant in 2018/19 >580m managed by 14 NCM sites gave an estimated £25m freed for reinvestment.

➢ New services created: includes: Adolescent Outreach Teams, 72-hour admission model, DBT Teams, Urgent Care Pathway model, enhanced talking therapy service, Forensic Recovery Support Team, Assertive Transitions Team, Women's forensic step-down, Crisis Care and Home Treatment Teams.
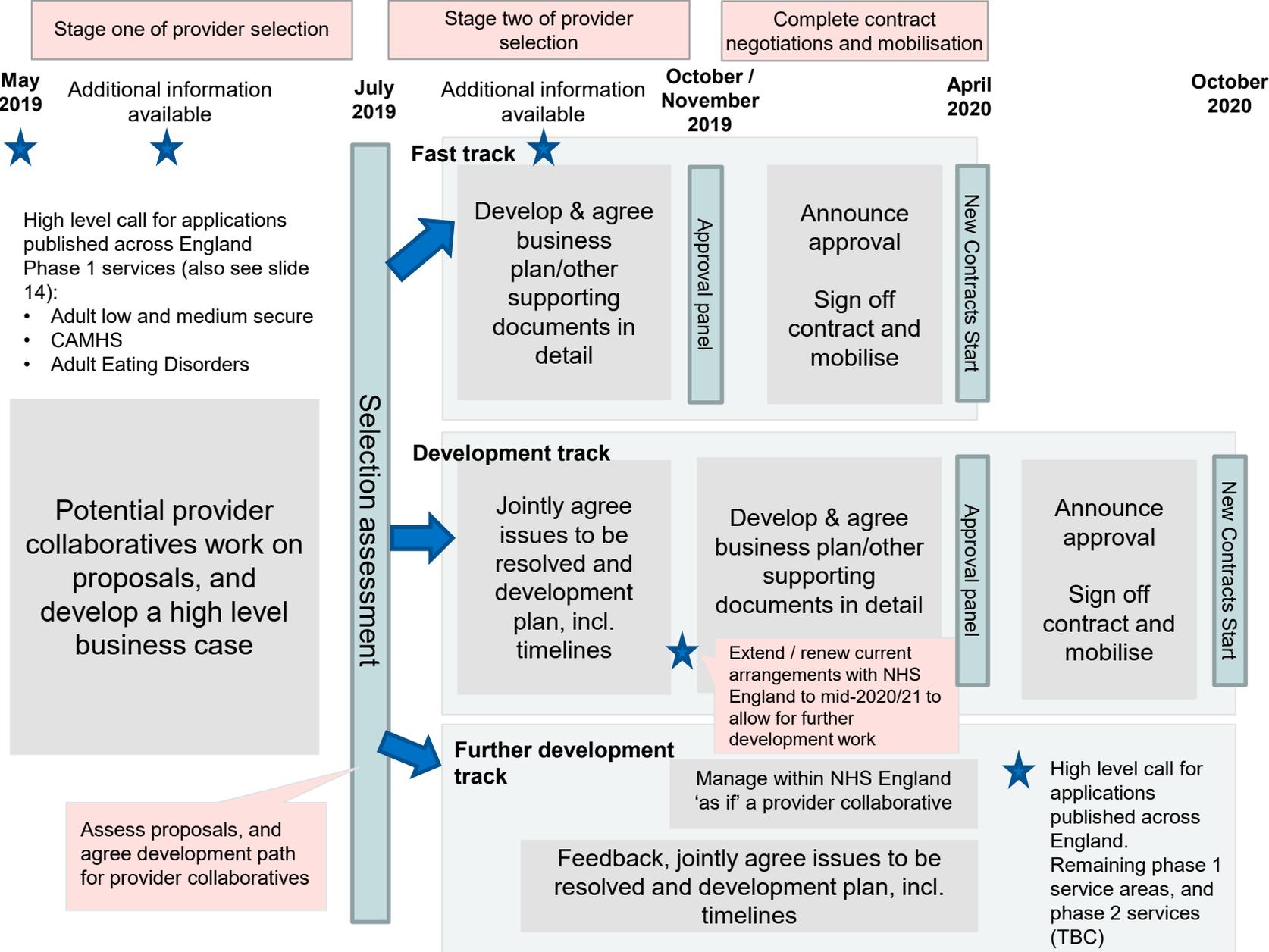
Themes Identified from Evaluation as requiring further consideration

- Change to length of inpatient stay
- Evidence of people in secure adult services being treated closer to home
- Ensuring savings in secure adult inpatient costs
- Improvements in quality, patient experience and outcomes
- Clarity of vision and reason for becoming a provider collaborative
- Clinical and management leadership including succession planning
- Data management
- Partnership working including case and pathway management
- Sustainable approaches if significant savings are not realised
- Improvements in patient outcomes and experience
- Addressing inequalities

Services included in provider collaboratives will be built up over time

Service Area	Phase one (from April 2020)	Phase two
Adult Secure	Adult Low and Medium Secure Mental Illness and Personality Disorder	Adult Low and Medium Secure Acquired Brain Injury, Deaf and Women's Enhanced Medium Secure. High Secure (commissioning for High Secure services being considered as part of the High Secure Commissioning Plan)
CAMHS	CAMHS, General, Psychiatric Intensive Care Units (PICU), Eating Disorders, Low Secure	Children's (under 13s), Medium Secure and Deaf.
Specialist services	Adult Eating Disorders	Obsessive Compulsive Disorder, Body Dysmorphic Disorder, Tier 4 Personality Disorder, non-secure Adult Deaf
Perinatal	-	Mother and Baby Units

Provider selection process

Stage one of provider selection

Stage two of provider selection

Complete contract negotiations and mobilisation

May 2019

July 2019

October / November 2019

April 2020

October 2020

Additional information available

Additional information available

High level call for applications published across England Phase 1 services (also see slide 14):
- Adult low and medium secure
- CAMHS
- Adult Eating Disorders

Potential provider collaboratives work on proposals, and develop a high level business case

Selection assessment

Assess proposals, and agree development path for provider collaboratives

Fast track

Develop & agree business plan/other supporting documents in detail

Approval panel

Announce approval

Sign off contract and mobilise

New Contracts Start

Development track

Jointly agree issues to be resolved and development plan, incl. timelines

Develop & agree business plan/other supporting documents in detail

Approval panel

Announce approval

Sign off contract and mobilise

New Contracts Start

Extend / renew current arrangements with NHS England to mid-2020/21 to allow for further development work

Further development track

Manage within NHS England 'as if' a provider collaborative

Feedback, jointly agree issues to be resolved and development plan, incl. timelines

High level call for applications published across England. Remaining phase 1 service areas, and phase 2 services (TBC)

A provider collaborative is…

- A collective of mental health providers **led by a Lead Provider working in partnership** to provide specialised mental health services for a given population, to improve and standardise services

- Clinically led, with improved **patient experience and outcomes** at the centre of their approach

- **Financially and clinically responsible** for their patient population, which will span a number of CCGs

- Able to **pool financial risk across the partnership**, allowing resilience to volatility in demand, having the flexibility to make savings and reinvest in community and step-down services to improve the whole pathway and reduce reliance on the most specialised services

- Responsible and accountable for the placement and care of a cohort of patients

- **Accountable to NHS England** for the decisions made and the quality of care provided

- Supported by **appropriate governance, contract and decision making processes,** with NHS England involved in collaboration at a strategic level

So what does all this mean in the East Midlands?

- There are three proposed provider collaboratives being developed

  - Eating Disorders – Lead provider is Leicestershire Partnership NHS Trust

  - CAMHS – Lead provider is Northamptonshire Healthcare NHS Foundation Trust

  - Adult Secure Services – Lead Provider is Nottinghamshire Healthcare NHS Foundation Trust

EAST MIDLANDS ADULT SECURE CARE SERVICES

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IMPACT Provider Collaborative Vision

Better Community Support

Culture change across regional secure care system incentivizing collaboration for patient benefit

Less reliance on inpatient bed based services

Primacy of Patient experience & patient outcomes

Integration with health & social care systems

Population needs based service provision

Personalised, co-produced, outcome focused services

EAST MIDLANDS ADULT SECURE CARE SERVICES
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2019 Co-Production Events

Date	Topic	Attendees
January 2019 Leicester	▪ Co-Production & Values ▪ How can secure services improve/ what works well	40
February 2019 Nottingham Improving admissions	▪ Improving admissions task & finish group ▪ Values for the programme- service user groups ▪ Name for the programme- service user groups	62
April 2019 Northampton Discharge & effective support in the community	▪ Community task & finish group: new Assertive Transitions Service as per the CFS bid. ▪ Recovery & Outcomes presentation: Ian Callaghan	80
June 2019 Nottingham Improving transitions through secure services	▪ Women's Blended Pilot: presentation by the Expert by Experience team and St Andrew's Healthcare ▪ Senior Leadership Panel- representation from each provider within the collaborative to demonstrate commitment to the programme.	80+
September 2019 Learning disability & autism	▪ Clinical model update ▪ Learning disability & autism	85+

ImROC
Implementing Recovery
through Organisational Change

![NHS logo]

Mental Health Secure Care Programme

Five Year Forward View for Mental Health: Recommendation 23

"NHS England should lead a comprehensive programme of work to increase access to high quality care that prevents avoidable admissions and supports recovery for people of all ages who have severe mental health problems and significant risk or safety issues in the least restrictive setting, as close to home as possible. This should seek to address existing fragmented pathways in secure care, increase provision of community based services such as residential rehabilitation, supported housing and forensic or assertive outreach teams and trial new co-commissioning, funding and service models."

Specialist Community Forensic Model Pilots

Culturally specific provision for Black men

Women's pathways: Secure Blended Service & Peer Mentoring

Workforce development

Interface with MoJ

Context of the work

➢ Member of the NHSE Women's Strategy Task & Finish group as **Experts by Experience**

➢ Purpose: to gather **women's experiences in & perspectives of** secure care

➢ Inform the **co-design of ideas** to address challenges through Design Thinking Workshops

The Facts:

Women make up **22% of the total population** in low and medium (MI & PD); **20% of the total population** in similar LD services

Total of **1350 beds** for women in secure care services (50 High Secure)

Women have different **routes into** secure services and **distinct needs** compared to men

A higher proportion of women are in **independent sector** beds than men

**Personality disorder** is the largest diagnosis group in women's secure services

Women have **longer average lengths of stay** than men – recorded by NHS Benchmarking as **728 days**

Gathering women's perspectives

Who: **200**+ women who have personal experience of secure care services.

Where: Recovery & Outcome Groups; all North West Region and East Midlands Region Women's Secure Units; The Orchard Unit (WLMHT).

How: questionnaires & face to face interviews
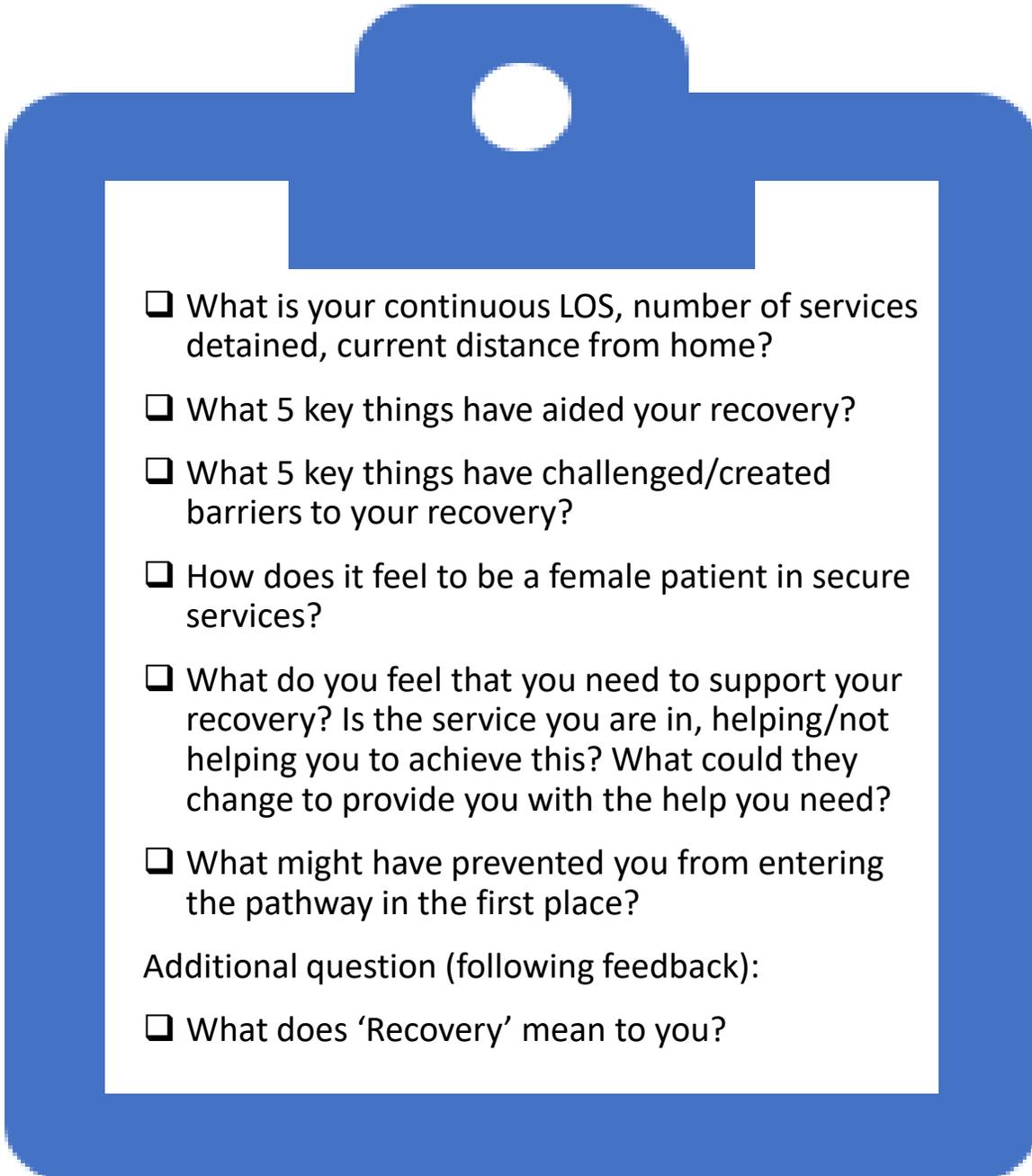
- ❑ What is your continuous LOS, number of services detained, current distance from home?

- ❑ What 5 key things have aided your recovery?

- ❑ What 5 key things have challenged/created barriers to your recovery?

- ❑ How does it feel to be a female patient in secure services?

- ❑ What do you feel that you need to support your recovery? Is the service you are in, helping/not helping you to achieve this? What could they change to provide you with the help you need?

- ❑ What might have prevented you from entering the pathway in the first place?

Additional question (following feedback):

- ❑ What does 'Recovery' mean to you?

About the women

- Aged between **18 – 78 years**

- Predominantly white females

- Evidence of mixed sexuality

- Prison, High, WEMSS, MSU, LSU, Locked Rehab and Community

- Mainstream Adult, Learning Disability, ASD Services

- NHS and Independent Providers across the whole country

- Mix of Mental illness & Personality Disorder (evident high rate of PD diagnosis)

- Over **70%** respondents related to care over an hour from 'home'

- Length of stay ranged from 2 months to **46 years**

- Over **80%** have been detained in MHSC hospitals for over 3 years (still detained)

- Over **10%** have been detained in MHSC hospitals for over 20 years (still detained)

- Over **60%** have been detained in 3 different services or more

- Estimated **30%+** have come through the care system

Headline Statistics:

190+ Women's Secure Care Experience:

Average distance from home:
1.6 hours

Average number of hospitals:
3.8

Average length of stay:
3,320 days
(NBD = 728 days)

77 East Midlands Women's Secure Care Experience:

Average distance from home:
1.8 hours

Average number of hospitals:
4.2

Average length of stay:
3,497 days
(NBD = 728 days)

Key themes

Importance of the following on women's journeys through Secure Care:

➤ **STABILTY**
➤ **INTERNAL RELATIONSHIPS**
➤ **EXTERNAL CONNECTIONS**
➤ **PURPOSEFUL ENGAGEMENT**

With a strong message about

the importance of reflecting **'NORMALITY'**

East Midlands Feedback:

Question: **What 5 key things have aided your recovery?**

Top 5 responses:

No.	Response	/77	%
1	**Activity and keeping busy**	64	**83**
2	**Leave and Community Access**	63	**82**
3	**Staff support and positive relationships with them**	63	**82**
4	**Talking with staff and 1-1 time**	62	**81**
5	**Psychology/Therapy**	56	**73**

East Midlands Feedback:

Question: **What 5 key things have challenged your recovery?**

Top 5 responses:

No.	Response	/77	%
1	**Not enough staff - cancellations**	62	**81**
2	**Negative staff practice**	50	**65**
3	**Peers behavior and illness**	50	**65**
4	**Restrictive Practice**	42	**55**
5	**Negative relationships with staff**	42	**55**

East Midlands: What might have prevented you entering the secure pathway?

	Responses	77	%
1	Better support from community team	44	57
2	Not being ignored when I asked for help	32	42
3	Access to drug and alcohol support	27	35
4	GP having a better understanding of Mental Health	25	32
5	A&E having a better understanding & more compassionate	18	23

Emerging messages:

➢ Women are exceptionally **resilient** & have demonstrated significant personal strength in overcoming adversity. This is contrasted with:

> ➢ A passive, **'fix me'** approach with little ownership of recovery
>
> ➢ An over **dependence on staff** for practical and emotional support with a high demand on staff for a **'time to talk'** and a sense of competition for staff time with other patients.
>
> ➢ A high need for **'reassurance'** in addition to wanting to feel listened to and understood
>
> ➢ Low levels of confidence, self-esteem and identity
>
> ➢ Women are troubled by issues of **'attachment'** and an associated **'fear of rejection'**

➢ Women want to **'keep busy'** and be **'distracted'**, but express little motivation or aspiration for activities that might result in a specific achievement or developing skills and competencies.

➢ Women have a inadequate understanding of **'recovery'** and limited perception **'hope'.**

Empowering 'Recovery': Next Steps?

1. What can services do to **address** patient's **over - dependency** on staff for practical and emotional support?

2. What can services do to **increase** patient's **involvement** and **ownership** of <u>their</u> recovery?

3. What can services do to support patient's **growth** in **confidence, self esteem** and **identity**?

4. What can services do to **raise** patient's **aspirations** for a life beyond hospital?
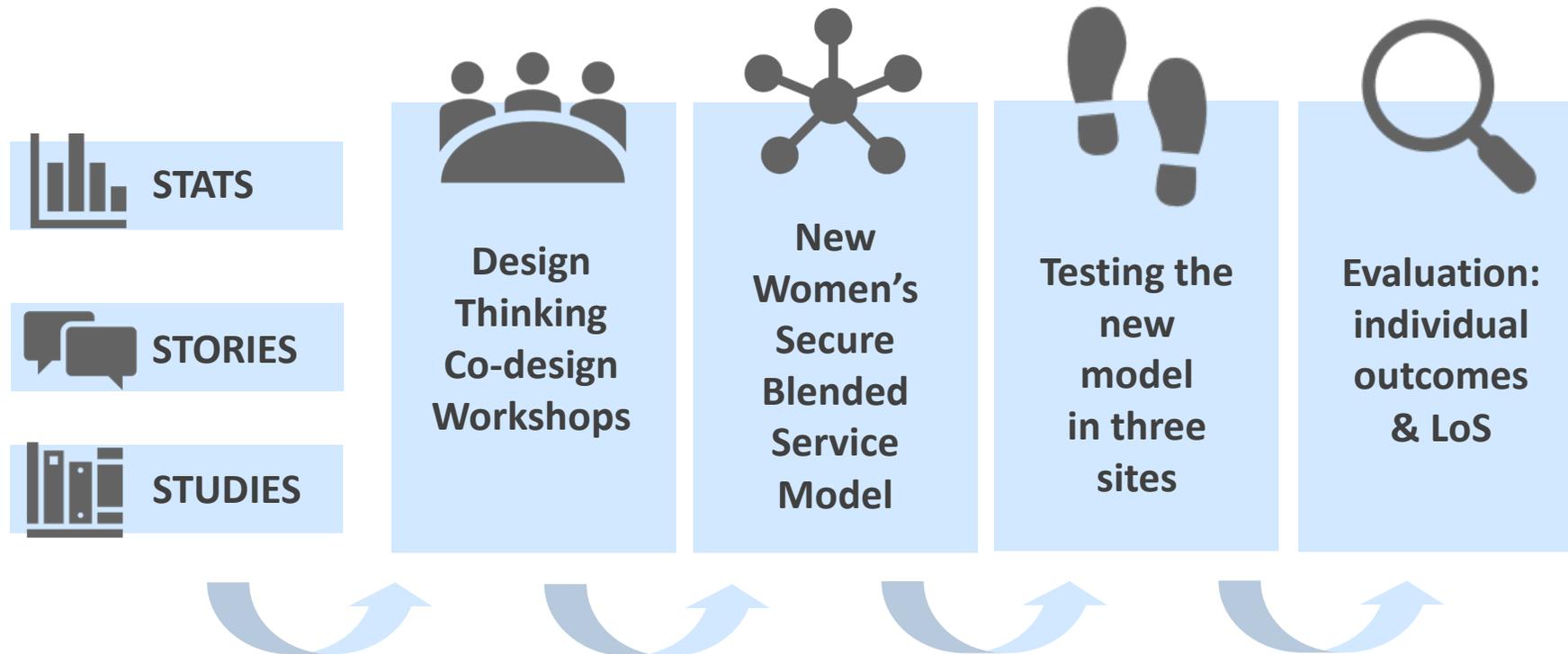
Three pilot sites

Birmingham and Solihull **NHS**
Mental Health
NHS Foundation Trust

Greater Manchester West **NHS**
Mental Health NHS Foundation Trust

St Andrew's
HEALTHCARE

Core components of WSBS

- ✓ Designed to ensure that all aspects (procedures, process, relational and environmental aspects) are operating in a **trauma informed way**;
- ✓ Integrates into **local pathways**;
- ✓ Understands and prioritises **relational security**;
- ✓ Engage intensively during the pre-discharge phase to provide a **seamless transition** from inpatient services to the community or other discharge destination;
- ✓ Ensures access to **peer mentorship** and **buddying**;
- ✓ Delivers effective outcome and evidence based **offence specific therapeutic interventions**, both group and individual;
- ✓ Delivers effective outcome and evidence based psychosocial interventions, supporting **personalised recovery** and maximising social functioning;
- ✓ Delivers effective outcome and evidence based interventions to address **substance misuse**;
- ✓ Works effectively and supportively with **carers**, taking into account their needs, and restoring and nurturing relationships, particularly with children, where required.

IMPACT Governance Structure

Task and Finish Groups

- Improved Admissions

- Community Infrastructure

- Improved Transitions & Discharges

- Learning Disability & Autism

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Improved Admissions Task & Finish Group

- Established in December 2018
  - Key Objectives
    - Person centred care
    - Improved patient experience
    - Streamlined assessment and admission process
    - Establish a more responsive process
    - Achieved through collaborative working between all secure services in East Midlands

Referral to admission 'AS IS' Pathway

Referrals are mostly from:
Prisons, Community Teams and Other Providers, Criminal Justice system

All other TC assessments are completed by Community Teams – Medium secure go to current provider for that specialist

Transforming Care

Do have a women's service

Referral received (via email) to a Case Managers for areas:

NHS Providers ONLY

Lincolnshire & Nottinghamshire

Derbyshire & Northamptonshire

Leicestershire

The referral is reviewed and sent to the following providers for an Access Assessment dependent on:

MEN Medium Secure

Women Medium Secure

Men Medium Secure

Women Medium Secure

Women Medium Secure

Women Medium Secure

Women Medium Secure

Arnold Lodge

MEN Medium Secure

Women Medium Secure

Women Low Secure

MEN Low Secure

Wells Road

If the assessment is not completed in the timeframe it is marked as a breach and chased by the Case Managers

Transforming Care
Lister, Wells Road, Hazelwood House & Calverton Hill
St Andrews

Women Low Secure

MEN Low Secure

Francis Willis

No women's service

MEN Low Secure

Women Low Secure

The Kedleston Unit

Men Medium Secure

Wathwood

Once an assessment is done within the timeframe one of the following decisions is made:

1. Not suitable for admission into hospital under MHA
2. Not for this level of security
3. Suitable – cant admit
4. Suitable – can admit
5. Require hospital but not for treatment we can offer

MEN Low Secure

Women Low Secure

Wheatfield

MEN Low Secure

Women Low Secure

Herschel Prince

Both assessor and receiver need to agree the level of security before it can be accepted

No women's service

No women's service

1. If this decision is made the assessment is sent back to the referrer with recommendations (usually) and is closed

2. If the level of security is rated as higher than medium the assessor will refer to high secure who will then assess. If the decision from high is not the same then it goes back to medium secure. If the decision is agreed then the patient is admitted.
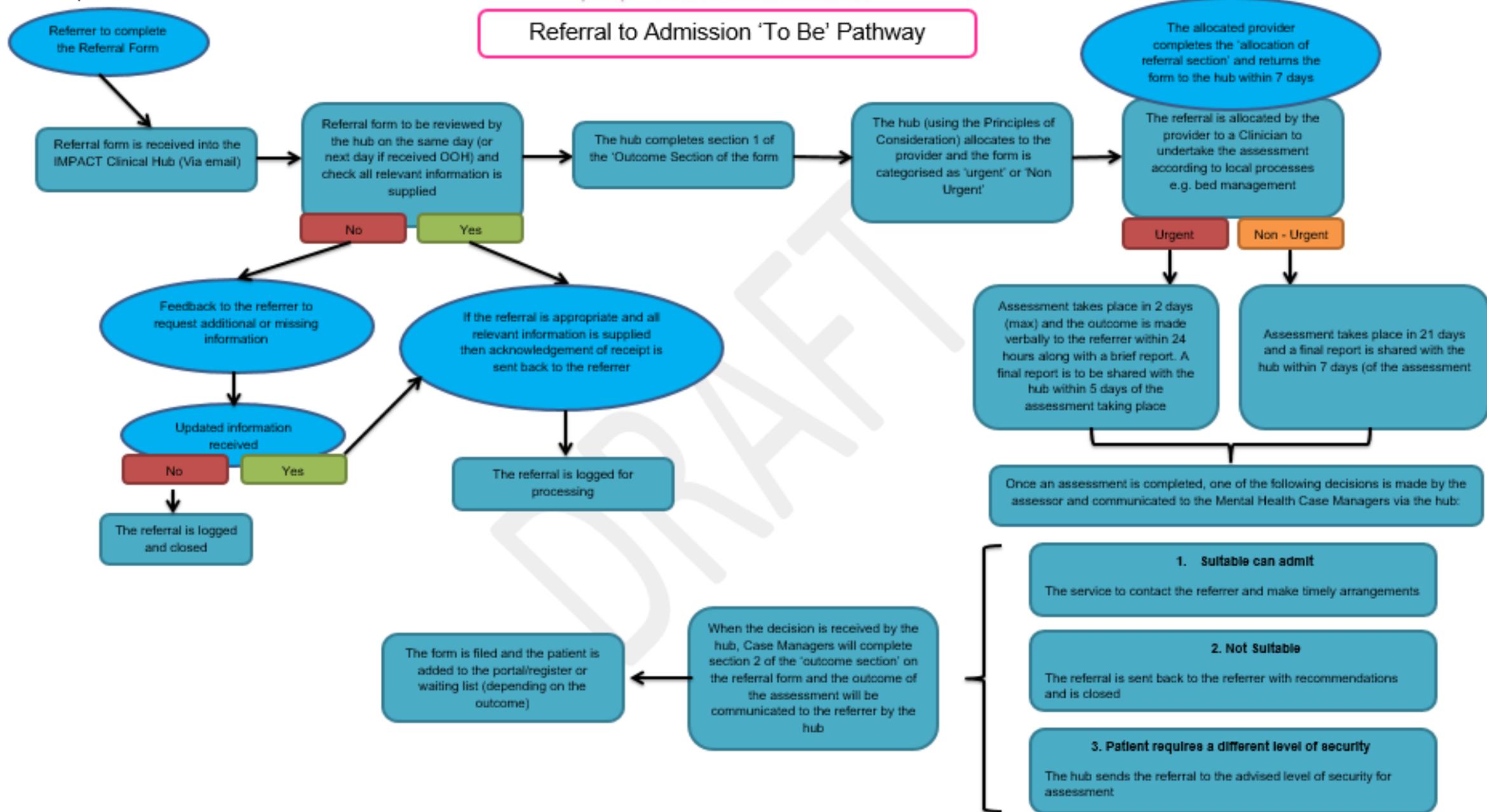
3. The CM makes a referral to find another bed in another hospital with the same security and requirements etc. If the patient is accepted NHSE will agree the admission (if there is no bed then the patient may be put on a waiting list) If the patient is not accepted for any reasons then the CM looks for another suitable provider.

4. NHSE agree funding and the patient is admitted to the unit.

5. NHSE refer the patient to a specialist service e.g. – PD Men to Clifton Cygnet

Other Information

*The referral to admission process takes roughly 3 months

*Some referrals are still going direct to the provider (roughly 25%)

*Referrals are reviewed and if there is not enough information they are sent back by CM

*SMH portal only has information on admitted patients (patients in the process are tracked locally through a spreadsheet) and the team have a referrals phone call every Friday to review the flow

*Once a patient is admitted the Case Manager for the region is allocated to them for their entire stay (based on where they are admitted)

*Case Managers have between 50-170 patients on their caseload at any one time

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Significant changes

- The independent sector will now carry out access assessments

- A Standard Operational Procedure (SOP) has been agreed across all the providers and is supported by NHS England

- There is new recall guidance contained within it that is supported by the Ministry of Justice

- There is a new dispute resolution process in the SOP that is managed within the provider collaborative and arbitrated by Nottinghamshire Healthcare as the lead provider.

Referral to Admission 'To Be' Pathway

Referrer to complete the Referral Form

Referral form is received into the IMPACT Clinical Hub (Via email)

Referral form to be reviewed by the hub on the same day (or next day if received OOH) and check all relevant information is supplied
- No
- Yes

Feedback to the referrer to request additional or missing information

If the referral is appropriate and all relevant information is supplied then acknowledgement of receipt is sent back to the referrer

Updated information received
- No
- Yes

The referral is logged and closed

The referral is logged for processing

The hub completes section 1 of the 'Outcome Section of the form

The hub (using the Principles of Consideration) allocates to the provider and the form is categorised as 'urgent' or 'Non Urgent'

The allocated provider completes the 'allocation of referral section' and returns the form to the hub within 7 days

The referral is allocated by the provider to a Clinician to undertake the assessment according to local processes e.g. bed management
- Urgent
- Non - Urgent

Assessment takes place in 2 days (max) and the outcome is made verbally to the referrer within 24 hours along with a brief report. A final report is to be shared with the hub within 5 days of the assessment taking place

Assessment takes place in 21 days and a final report is shared with the hub within 7 days (of the assessment

Once an assessment is completed, one of the following decisions is made by the assessor and communicated to the Mental Health Case Managers via the hub:

1. Suitable can admit

The service to contact the referrer and make timely arrangements

2. Not Suitable

The referral is sent back to the referrer with recommendations and is closed

3. Patient requires a different level of security

The hub sends the referral to the advised level of security for assessment

When the decision is received by the hub, Case Managers will complete section 2 of the 'outcome section' on the referral form and the outcome of the assessment will be communicated to the referrer by the hub

The form is filed and the patient is added to the portal/register or waiting list (depending on the outcome)

Changes from the 1st October

We have a referrals form

We have an email address

england.impactreferrals@nhs.net

We have case managers

Principles for consideration

HOME AREA LOCALITY

This includes identfying responsible commissioner

PATIENT & CARER CHOICE

LEVEL OF SECURITY REQUIRED

PATIENT

UNIT RESOURCES:

These will include bed availability, current patient acuity & staffing levels , Service Quality Issues, CQC rating.

TREATMENT PATHWAY AND THERAPIES AVALIABLE

SPECIAL CONSIDERATIONS:

These may include issues around any offence ie location of victim or others involved and any other restrictions ie exlusion areas that have been put in place

Weekly Situation Report (By Unit)		Unit
General Information	Total number of Beds	0
	Total number of commissioned beds	0
	Total number of occupied beds	0
	Total number of EM patients	0
	Total number of vacant beds	0
Clinical Activity	Total number of patients in LTS	0
	Total number of patients on enhanced support	0
	Total number of restraints	0
	Total number of Seclusions	0
	Total number of patients secluded	0
	Total hours of Seclusion	0

Outcomes/ Benefits

- Reduced assessments and delays in accessing a bed
- Organisational ownership of the referral, assessment and admission process and improved collaboration between providers and clinicians
- More person centred approach
- Monitoring of the whole process from referral to admission through new performance reporting systems.
- Improved quality of referrals and assessment reports- these will be monitored by IMPACT.

Thank You

Thank you for listening

debbiestanton@nhs.net

NHS England and NHS Improvement

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