MENTAL HEALTH UTILISATION REVIEW (MHUR) PROGRAMME

An update report to the Joint Overview and Scrutiny Committee Meeting of 12.02.13

Report Draft: 23rd January 2013

Overview:
The purpose of this (draft) report is to provide members of the Joint Overview and Scrutiny Committee with an update on a two-year programme to implement the recommendations of a review of the use of inpatient Mental Health Rehabilitation Services which took place in 2011. This report provides updates on action by partner organisations to implement the recommendations and on how various stakeholders are being involved in the programme.

Reviewing the Utilisation of Residential Mental Health Rehabilitation Services
An initial report on this programme was made to the July '12 JOSC meeting. A full account was given of the review of Residential Rehabilitation services in the City and County of Nottinghamshire. The services reviewed were six inpatient units (110 beds) provided by Nottinghamshire Healthcare trust at a cost of £10 million. At the time of the review, of the 95 inpatients, 55 (50%) were thought to be in the wrong care setting.

The Review Findings
The main conclusions of the review were:
a) The pathway into and out of the service needs to be redesigned
b) The service model needs to be revisited
c) A priority is to secure appropriate accommodation
d) Changes must be supported by a reconfigured workforce with strong community team input to ensure the continuation of the therapeutic, clinical relationship

The detailed review report is 165 pages long, available from jaynelingard@btinternet.com

The MHUR Programme
The MHUR Programme is a two-year programme consisting of existing projects which were already underway and additional actions to deliver the recommendations of the review. The change programme's first objective is to enable the discharge of people who, due to various factors, have become 'stuck' in mental health services beyond the point at which they are progressing and to address these factors, creating processes to prevent this happening in future

An inter-agency programme board meets bi-monthly to identify ways to manage programme risks, resolve issues and recognise progress made. Membership includes Nottinghamshire City and Nottinghamshire County Councils, Newark and Sherwood Clinical Commissioning Group (CCG) leading for County CCGs), Nottingham City CCG and Nottinghamshire Healthcare Trust. The programme board is chaired by Nottingham City CCG.

A programme Quality Group identifies risks and issues and holds the programme to account. The fixed membership of 14 people was invited from NHS and voluntary sector providers of services as well as patients and their relatives. The group has met monthly since July 2012 to challenge, advise and encourage commissioners and the programme manager. The group shares a monthly account of its work in the form of an update.

All stakeholders have been advised how they can contribute to, be included in and remain informed about planned changes. A monthly update to staff has invited their comments. An involvement forum run by the Trust is open to inpatients and their families. This has a quarterly meeting underpinned by consultative processes within each inpatient unit.

Progress on the programme to date:
A clear action plan has been developed with all partners. A summary is at Appendix A.

Pump-Priming the changes:
The July report noted that non-recurrent funding of £900,000 has been provided to Nottinghamshire County Council and £800,000 to Nottingham City Council by their partner Clinical Commissioning Groups to enable the two-year programme of change. Both councils have been asked to report monthly to the board on how this funding is being deployed.

Progress on Actions:

- *Discharges*
  By the end of January, Nottingham City Council will have carried out assessments on 19 of the 24 people identified for discharge in September 2012. In fact two may turn out to be the responsibility of the County and two others are not ready for discharge. One person has already been discharged so that all required assessments are now complete.

  41 people with ordinary residence in Nottinghamshire County were identified for discharge in September 2012. 17 discharge assessments have been completed.

  Please see Appendices C and E for a detailed account of progress

- *Service specification*
  A draft service specification for inpatient mental health rehabilitation services is now in first draft and awaiting comment from an expert group before circulation for wider comment. The quality group and Making Waves (a service user led organisation) provided rich input to the specification. However, people are most interested in what can be provided to help patients leave the service. To this end, work is being done to model the current service or care pathway for someone with complex mental health needs so that different scenarios can be modelled. This is being done using sophisticated software which was used as part of the review (see page 55).

- *Understanding Demand for inpatient care*
  The review found that 55 inpatients were no longer in need of an inpatient rehabilitation service in September 2011. By September 2012 this number had risen to 66. Work is now being done to understand how many of these people were ready for discharge and not unduly delayed other than by inefficiency which can be improved and how many were delayed due to a lack of suitable discharge options or other reason. Analysis of the waiting lists for inpatient services is also being undertaken.

A third layer of analysis is still needed which is more difficult because data is not easily available. This is needed to understand the numbers of
a) people not being referred because it was known there were no available beds and
b) people who could have been discharged if increased or a different pattern of community based mental health rehabilitation provision was available.

- *Improving service quality*
  Nottinghamshire Healthcare NHS Trust (NHT) have an action plan to address the issues of service quality raised by the review. These actions do not have an inter-agency dimension (other than responding to the commissioner's new service specification) and the outcomes will be related to an improved patient focus and service effectiveness.

- *Reorganising for best value*
  NHT are also developing and implementing an action plan to improve the way services are organised to ensure value for money is achieved. This plan will also deliver changes proposed by the programme in relation to working with other organisations particularly from the work being done by the pathways working group.

- *Future Pathways*
  A working group is being led by a senior manager from the County Council with input from all other organisations to look at how well health and social care work together to move people as quickly as possible to get them in the right place in the service and care pathway. They are looking at referral and assessment processes and the communications needed to deliver effectively around the patient. A detailed report on this can be found at Appendix F.

  Both the City and County Councils are also looking at what accommodation options are available to people and how they can be improved and maximised. This includes a dialogue with their strategic housing partners and also housing providers. Detailed reports can be found at Appendix B and Appendix D.

Report prepared by Jayne Lingard, Programme Manager

Appendix A MHUR Programme Action Plan (*Summarised)*

The MHUR programme action plan has 6 outcome areas against which the MHUR recommendations have been mapped. All actions are the responsibility of a named programme board member and there is a named lead manager. Those who will support the action are also named.

OUTCOME AREAS & Action Plans

1. **Individual Change: People using the service need the service**
   Action: Discharge patients who no longer need Residential Rehabilitation
   - 1.1 *Undertake social care led Priority Discharge Assessments*
   - 1.2 *Enable nursing staff to participate in discharge planning*
   - 1.3 *Use a modern legislative protocol to support discharges*
   - 1.4 *Use Personal health budgets and personal social care budgets*

2. **Purpose: There is a clear service purpose**
   Action: Proactively commission RR services
   - 2.1 *Commission recovery-focussed rehabilitation services*

3. **Quantity: the service is the right size**
   Action: Manage demand effectively
   - 3.1 *Manage an inter-agency service change process*
   - 3.2 *Establish the level of demand for inpatient services*
   - 3.3 *Model the demand in an effective pathway*

4. **Quality: the service is effective and efficient**
   Action: Deliver good outcomes
   - 4.1 *provide inpatient services to the new service model (see 2.1)*
   - 4.2 *share service monitoring information with commissioners*
   - 4.3 *involve carers in workforce*
   - 4.4 *plan ahead for discharge from early in the admission*
   - 4.5 *develop activities of daily living skills*
   - 4.6 *ensure patients have support with their finances*
   - 4.7 *enable patients to have access to the internet*

5. **Reorganisation: Services are well organised for best value**
   Action: Use resources efficiently
   - *5.1. review role and function of all residential rehabilitation units*
   - *5.2 explore efficiencies across the service*
   - *5.3 standardise processes/documentation across the service*
   - *5.4 operate clear criteria for community services to improve capacity*
   - *5.5 review how the services are resourced*
   - *5.6 review the recovery team caseload to improve capacity*

6. ***Pathway: There are clear overall service pathways***
   Action: Create and maintain a dynamic service pathway
   - *6.1 Establish an inter-agency recovery network to promote excellence*
   - *6.2.1 provide social care support to enable proactive discharge planning*
   - *6.2.2 develop a discharge policy for people with no local rights*
   - *6.3 increase accommodation options for people leaving inpatient care*
   - *6.4 Include needs of res'l rehabilitation patients in social care commissioning*
   - *6.5 Ensure timely access to tenancies*
   - *6.6.1 Regularise the use of the Hughenden 'respite bed'*
   - *6.6.1 Explore spot contracting opportunities for other respite services*
   - *6.8 Develop clear discharge planning processes*
   - *6.9 Develop community-based Clozapine and depot medication clinics*
   - *6.11 Frequently review the Mental Health Act status of patients*

Lead board members are responsible for ensuring progress against the recommendations they lead on. **Lead managers** will

- develop a project plan with SMART objectives and take it forward, involving everyone who needs to contribute to the work, confirming how their contribution will be taken forward, utilising existing forums or set up specific Task and Finish Groups
- keep the Programme Manager informed of progress and notify any risks or issues falling outside their remit or that of colleagues involved

Appendix B **NOTTINGHAM CITY COUNCIL MHUR PROGRAMME Action Plans for Recommendations 6.2 - 6.4 *WHERE NCC IS LEAD***

OUTCOME AREA: PATHWAYS: Clear overall service pathways

OUTCOME: A suitable range of robust housing and social care options is available within the pathway to enable people a) to avoid unnecessary admission to inpatient services or b) to leave inpatient services as soon as possible

6.2 Support the development and delivery of proactive discharge planning practices across mental health services (see 6.8) ensuring social care resources are available at the right time such as care management and personal budgets and support to access accommodation options including a clear procedure for those people with no known housing and social care rights e.g. those seeking asylum			**Lead Board member** Colin Monckton	**Lead manager** Oliver Bolam	**Supporting the work** Geoff Culpin
6.2 Objectives - • **What needs to be done?** • **What steps do we need to take?**	**How will we measure this / know when we have completed this?**	**Who will do this? And / Or Which forum will be used?**	**What are the timescales for this?**	**Narrative Update: Progress / Risks and Issues**	
Reorganisation of referral pathways for discharge from acute and new residential rehabilitation service model Develop effective referral pathways from the wards and rehab facilities for both reablement and assessment for Personal budgets Develop clearer pathway that is understood and used by ward staff in a timely manner	Timely referrals from wards Reduction in delayed discharges from acute and rehab Reduction in emergency residential placements Evidence that ward staff are using systems that have been developed	Oliver will work with Social Care CMHT Team Managers and SenPract	April 2013	*Risk that ward staff will not engage in agreed referral processes- need for acute rep on Key group other risks are that ward staff may be have unrealistic expectations about ability to accommodate all people with housing needs*	
Develop and implement a clear discharge planning policy across mental health services for people with no housing and social care rights including those seeking asylum	Local Guidance note available to health and social care staff	as above	April 2013	Liaise with County colleagues to develop a shared process *Risk of differing City/County legal/political perspectives*	

6.3Increase responsive and accessible accommodation options: LAs to work with a range of providers to open up suitable accommodation for OATs residents and all needing to step down from mental health services			**Lead Board member**	**Lead manager**	**Supporting the work**
			Colin Monckton	Antony Dixon	Alan Lowen, Rasool Gore, Geoff Culpin, Charlotte Wilcockson, Bev Johnson
6.3 Objectives -	**How will we measure this?**	**Who will do this?**	**Timescales**	**Narrative Update: Progress / Risks and Issues**	
Development of new model of accommodation provision in the City	New model approved	Alan Lowen Steering Group	**Feb 13**	New model developed and currently out for consultation **On Track**	
New Resettlement Service commissioned	Service accepting new placements	Alan Lowen	**March 13**	Contract awarded to NCHA. Current residents of Stephanie Lodge to be resettled prior to new service going live. Provider plan in place to deliver this **On Track**	
Regular liaison with NHS Trust residential co-ordinators	Understanding of likely accommodation needs of current and future residential residents	Geoff Culpin	**Ongoing**	This work has commenced as part of care pathways programme of the MHUR **On Track**	
New model Floating Support Service (independent Living Support Service) commissioned	New service operational	Alan Lowen	**April 13**	Revised service spec to be developed. Call off from framework to be undertaken. Referral process to be developed with assessment function **Some Slippage Likely**	
New model of supported accommodation provision commissioned	New services operational	Alan Lowen Steering Group	**Oct 13**	Fit of current model against new model to be assessed – procurement options identified Development of revised service specifications Tender of new provision (if required) **Some Slippage Likely**	
Development of New Residential Care Framework	Specification agreed Framework in Place	Rasool Gore	**Oct 13**	Initial steering group formed **Some Slippage Likely**	
Development of process for accessing personal budgets for those with long-term accommodation needs	Citizens able to choose support care and support options with own accommodation	Alan Lowen Geoff Culpin Steering Group	**Oct 13**	Part of the new model of accommodation pathway **On Track**	
Development of new Care support & Enablement Framework	Choice of providers able to support those with mental health needs in their own homes	Sharon Bramwell Steering Group	**Oct 13**	Consultation ongoing as to requirements for new service specification **On Track**	

6.3Increase responsive and accessible accommodation options: LAs to work with a range of providers to open up suitable accommodation for OATs residents and all needing to step down from mental health services			**Lead Board member**	**Lead manager**	**Supporting the work**
			Colin Monckton	Antony Dixon	Alan Lowen, Rasool Gore, Geoff Culpin, Charlotte Wilcockson, Bev Johnson
Identification of OATS residents and likely future accommodation needs	Report produced	Geoff Culpin	**Oct 13**	Not commenced	
Creation of specific social work post to source accommodation options and assist transition through services for all of those in contact with Statutory Mental Health services	Worker in post	Alan Lowen and Geoff Culpin Steering Group	**Oct 13**	Work has commenced as part of the development of the mental health accommodation pathway **On Track**	
Ensure the scope of supported living tenders and reviews include the needs profile of rehabilitation service residents who will need accommodation in the future (was 6.4)	Evidence in tender documents	NCC commissioning teams	**Sept 12**	**Achieved**	

6.4 Ensure timely access to good quality tenancies for people leaving mental health services through effective strategic and operational links with housing authority partners			**Lead Board member**	**Lead manager**	**Supporting the work**
			Colin Monckton	Antony Dixon	Alan Lowen, Sarah Andrews, Geoff Culpin
6.4Objectives -	**How will we measure this**	**Who will do this?**	**timescales**	**Progress / Risks and Issues**	
Support bids for new accommodation that can be accessed outside of the Homelink bidding process	Self contained accommodation available reserved for those with acute mental health needs	Antony Dixon Sarah Andrews	January 2013 and Ongoing	2013 HCA bids supported **On Track**	
Mechanism created for dialogue between housing providers and social care re accommodation requirements	Quicker access to permanent accommodation for those with acute mental health needs	Sarah Andrews Geoff Culpin Housing Strategic Partnership	October 2013	Not commenced	
Provision of accessible information on likely demand for accommodation for those with acute mental health needs	Publication of market position statement	Irene Andrews Internet	March 2013 and ongoing	MPS Drafted **On Track**	

Appendix C

<u>Nottingham City Council</u> MHUR Programme Priority Discharge Social Work Assessments
Report from G. Culpin, Social Work Team Manager Jan 13

Enright Close (0 City patients)

- It was initially thought one person was from the City but they had been discharged when the social worker made contact to assess

Dovecote House (10 City patients)

- All Community Care Assessments are now complete
- Once healthcare assessments are complete, we will attend a multi-agency meeting to identify each person's discharge options and to agree how to engage patients and their families in the next steps

Broomhill House (3 City patients)

- All assessments now completed

Thorneywood Mount (6 City patients)

- All assessments will be complete by the end of January after which discharge options will be considered with the multi-agency team and the person and their family (where relevant)

Heather Close (1 City patient)

- This assessment will be undertaken in February

Macmillan Close (3 City patients)

- Assessments will be undertaken in February

General Update

- The social worker appointed to do this work has spent a great deal of time laying the foundations of each patient's assessment process and how to engage them in that

- The patients' needs are very complex and their communication requirements need a lot of consideration. Assessments are taking longer than anticipated because of this.

Appendix D: NOTTINGHAMSHIRE COUNTY COUNCIL MHUR PROGRAMME Action Plans 6.3 and 6.4 Report from Sarah Howarth, Commissioning Officer

6.3 Increase responsive and accessible accommodation options: *"LAs to work with a range of providers to open up suitable accommodation for OATs residents and all needing to step down from mental health service" and*

Development of supported living across the County. All the properties will be staffed 24 hours and aimed at people leaving rehabilitation services (open and locked) and people leaving acute wards who would otherwise have gone onto a rehab ward or into residential care. The aim is to develop these services across the whole of the county and so far the following has been developed or is in the process of being developed.

- **Supported Living scheme in Bassetlaw** - ongoing Supported Living service for 4 people (Sept 12). Possibility of 6 additional units in Worksop or Retford – (April 14)

- **Supported Living in Newark** - Lombard street will be available from June 13. There will be 10 self-contained units with some communal space and a possible respite unit. We are starting to identify potential tenants with priority given to people moving from Enright.

- **Supported living in Mansfield/Ashfield -** Midworth street (5 beds) is currently being refurbished. Available from February 13. Five prospective tenants identified - 2 from Heather, 1 from Enright and 2 from Bracken. We may have the option to use more units at Midworth. We are still considering 8 flats at Clipstone as potential supported living but making sure that there is no recent evidence of ASB before we pursue this further. Also possible capital bid for the development of supported living (see below).

- **Rushcliffe Supported living- Radcliffe Road -** we have identified a 4 bedroomed property to be used for supported living. This is still at an early stage but as the property requires minimal work we are hopeful that this will be available from June/July 2013. We have identified one person from Heather so far who may be suitable from this property.

  We are hopeful that additional units will be developed via the use of the £160m Department of Health capital funding for housing to meet the needs of older people and adults with disabilities outside of London. This funding may be supplemented by up to a further £80m capital funding in the first two years of the programme. We are supporting bids by Framework and NCHA to develop additional supported living schemes for people with MH needs: 5/6 flats in Broxtowe, 6 flats in Gedling and 6 flats in Mansfield or Ashfield. Bids have to be in mid Jan with an outcome within a couple of months.

6.4 ***Ensure timely access to good quality tenancies*** *for people leaving mental health services through effective strategic and operational links with housing authority partners.*

Work with Strategic housing authorities
Having met with him in December, the strategic housing lead for Rushcliffe and Gedling has subsequently met with the relevant managers from the ALMOs in these areas. Metropolitan do not have accommodation of the type needed in Rushcliffe i.e. 3 and 4 bedroom bungalows. They do not have any difficulty in letting their sheltered schemes, so there is probably not much chance of finding anything other than through the general Choice Based Lettings route. Gedling Homes are prepared to discuss further the mental health client group. I have arranged to meet the appropriate person to discuss options. They did assure us that any client currently in NHS residential rehab is effectively bed blocking in hospital, and so should be Band 2 under their joint housing allocations policy, which is a high priority.

Appendix E: Nottinghamshire County Council MHUR Programme Priority Discharge Social Work Assessments Jan 13 Report from N. Sills, New Lifestyles Team Manager

Enright Close (9 county patients)

- All nine Community Care Assessments (CCAs) are completed
- Seven assessments have been completed of people's mental capacity to make a decision about their discharge options
- Potential accommodation has been identified for four individuals. This is 'core and cluster' accommodation with staff support on site at all times. Additional individual support will be made available as required. This will be determined by each person's CCA. One person's accommodation will be ready in February 2013, the others in June 2013. These four people do not have the mental capacity to make their own decision so best interest decisions[1] under the mental capacity act are needed and then the options will need to be discussed with the individuals and their families as appropriate
- There is a potential idea for three other people to live together but further work is needed as to their compatibility.
- More information needs to be gathered in relation to the remaining two residents

Dovecote House (2 county patients)

- One person potentially needs nursing care and a CCA has been completed.
- Discussions are required about how to discuss issues about being discharged with the other person in order to assess their capacity. There are worries that this could be very anxiety provoking and cause some difficult behaviour. A CCA has been completed.

Heather Close (13 county patients)

- 5 of the 13 people have now moved out
- 1 person's assessment is fully completed with a firm plan for move on
- Potential accommodation has been identified for two further individuals. If this is appropriate they will be moving in February. CCAs have been started.
- 5 other people are awaiting assessment

Broomhill House (4 county patients)

- Assessments not yet started

Thorneywood Mount (4 county patients)

- Assessments not yet started

Macmillan Close (9 county patients)

- Assessments not yet started.

General Update

- The first round of recruitment of social workers to undertake this work was not successful. A further recruitment round took place in early January. Suitable candidates were identified. Once these candidates are in place we will have a full team of Social Workers (2.5 wte).
- No applicants attended the occupational therapy (OT) interviews so we will need to make alternative arrangements for OT assessments.
- Good engagement is reported from staff teams at the Residential Rehab Units so that joint working between social workers and nursing staff is positive.

[1] See http://www.nhs.uk/CarersDirect/moneyandlegal/legal/Pages/MentalCapacityAct.aspx

Appendix F: NOTTINGHAMSHIRE COUNTY COUNCIL
MHUR Pathways Group Report from Tessa Diment, Group Manager Mental Health

6.2 Support the development and delivery of proactive discharge planning practices across mental health services ensuring social care resources are available at the right time, such as care management and personal budgets and support to access accommodation options including a clear procedure for those people with no known housing and social care rights e.g. those seeking asylum.

Objectives

- Ensure good communication across all partners so county wide mapping is effective.
- Ensure all issues from health and social care workers are identified and responded to
- Total reorganisation of referral pathways for discharge from acute and new residential rehabilitation service model.
- Develop effective referral pathways from the wards and rehab facilities for both reablement and assessment for Personal budgets.
- Develop a clearer pathway that is understood and used by ward staff in a timely manner.
- Develop and implement a clear discharge planning policy across mental health services for people with no housing.
- Develop supported Living Alternatives across the County.
- Integrate the referral for housing related support into the care pathway.
- Ensure the scope of supported living tenders and reviews include the needs profile of rehabilitation service residents who will need accommodation in the future.
- Make contact with the seven District Housing Authorities to notify them of the MHUR programme to ensure they are aware of the housing rights of patients.
- Promote opportunities for mutual information exchange between inpatient MH services and housing staff (as per planned City exchange).

Outcomes

Clear pathways from
- community to acute ward and from acute ward to community.
- acute ward to residential rehab unit
- residential rehab unit to the community
- community to residential rehab

All the above pathways are communicated and understood by staff

A pathways working group has met to work on the above action points from the MHUR Programme in relation to Nottinghamshire County Council's responsibilities. Nottingham City Council were invited to attend in relation to 6.2 to develop consistency when working in partnership with the inpatient services. The group now has representation from all of agencies working on mental health care, admission and discharge processes i.e. Nottinghamshire Healthcare NHS Trust, the Clinical Commissioning Groups and the two local authorities. Meetings are being held monthly from October to April 2013 after which there will be a report back to the programme board.

The meetings look at 'what's working...what's not working' in relation to how people move between services and how they are assessed and supported. The aim is to bring together everyone to understand what each other does now. The aim is clear and effective pathways both now and in the future.

Work was been done to identify the present Pathways model in Diagram form. The group concurred with the review findings that discharge options are limited and Supporting People accommodation services full. Differing views were found as to whether people should only have one move when leaving residential rehabilitation or whether they should be discharged to a shorter term Supported Living project and then onto an individual tenancy. Further work is needed on this point as the new model will have options for permanent tenancies but it is uncertain how many will be needed or possible at this stage: the affordability of individually commissioned services has to be borne in mind. However, it was agreed there is a need for a combination of long term support and flexible support for people whose needs change and want to move on. Transitional arrangements need to be in place to enable people to have continued support from the same staff when leaving and going into their own tenancy.

Some people with tenancies may need to access support or support groups to enable this to be sustained such as the Key Ring model of mutual and neighbourhood support. The core and cluster approach of Broomhill house was discussed although it is not known how many people this will this suit although it works well for the current group of people.

It was agreed that there is a need to set up a service to unblock residential rehabilitation beds on a continuing basis. Once the NHS trust has implemented the new model of service, the Local Authorities need to understand it to avoid duplication.

- November's meeting focussed on a patient's journey from the community to an acute inpatient ward.
- January's meeting focussed on the journey from the acute ward to residential rehabilitation.
- February's meeting will focus on the journey from residential rehabilitation back to the community.

All of this work will be drawn together in a report for the programme board meeting in April.