REPORT TO:	**Healthy Halton Policy and Performance Board**
DATE:	**13th January 2009**
REPORTING OFFICER:	**Strategic Director, Health and Community**
SUBJECT:	**Mental Health Single Point of Access**
WARDS:	**Boroughwide**

1.0 PURPOSE OF REPORT

1.1 This Report describes the development of the new Single Point of Access for Mental Health Services across Halton and St Helens, as a part of a wider "Together for Wellness" service. It considers the structure of the service and the holistic approach to recovery and responding to mental health needs that the service is intended to deliver.

2.0 RECOMMENDATION

2.1 It is RECOMMENDED that:

1) The contents of this Report are noted
2) The Board are invited to make any comments or recommendations to support the delivery of this service

3.0 SUPPORTING INFORMATION

3.1 **Background:**

3.1.1 In April 2007, the 5BoroughsPartnership implemented a large process of service redesign, prompted by the document "Change for the Better", which was the subject of substantial consultation in Halton and across the remaining Boroughs within the Trust footprint.

3.1.2 As a part of the redesign, a new Single Point of Access (SPA) service was established in Halton within the 5BoroughsPartnership, staffed entirely by health service employees. Under this model, all mental health referrals for adults were sent directly to the SPA upon which they were screened and sent to the most appropriate service within the 5Boroughs. The service also delivers an Enhanced Day Therapies approach, which provides counselling support to people with more complex mental health needs.

3.1.3 Overall, the Single Point of Access service within the 5Boroughs has fulfilled its aims of providing a smooth referral pathway for people

with mental health problems into the 5Boroughs. However, it has become clear that this service only deals with people with the most complex mental health problems – those who need referral to a very specialist hospital service – but there are many more people in primary care services, and known to the Local Authority, who would benefit from this approach.

3.1.4 As a result, the service has undergone a detailed review by the Halton and St Helens Primary Care Trust. A new model for delivering this service has been developed which aims to meet the needs of the wider community in Halton and St Helens, and aims to address the full range of needs and issues that people with mental health problems can experience in the community.

3.1.5 In her report to the PCT Clinical Executive Committee, the project lead, Collette Walsh, made the following points:

"The case for change is irrefutable. Whilst the principal of an SPA ensures that referrers have a clear point of access for mental health services…it does not fully take into account that people with problems will present in multiple settings and ensure that people who work in those settings have sufficient knowledge and skills to offer an early intervention or signpost appropriately. Nor does it consider that mental illness and emotional distress can have social causes such as the breakdown of family relationships, unemployment, debt or loneliness; and that whilst a medical response may alleviate symptoms it may not always address the route cause of the problem."

3.2 The proposed model

3.2.1 <u>The process:</u> in September 2008, Halton & St Helens PCT commissioned a review of mental health care pathways across primary and secondary care with particular focus on access into services. A project team was established, with representatives from key stakeholders across Halton and St Helens. This Team has developed the proposed model for the new "Together for Wellness" service, and detailed consultation has been taking place with a range of interested groups and stakeholders.

3.2.2 The model has now been presented to – and approved by – the Halton and St Helens PCT Clinical Executive Committee (CEC), which means that it has the support of the medical practitioners within the PCT. A full business case will now be developed and presented the PCT Management Executive Team in January 2009, and the project team will be developing the full service, in time for delivery by April 2009.

3.2.3 The model requires a full reorganisation of the current Single Point of Access based within the 5BoroughsPartnership, and the

introduction of a model instead based within Primary Care Services, adopting a whole-system approach to the assessment and delivery of care and support to people with mental health needs in Halton and St Helens.

3.2.4 The following paragraphs are taken directly from Collette Walsh's report to the CEC and explain the proposed model and approach:

3.2.4.1 "The Together for Wellness Centre will be based in primary care and will refocus PCT efforts to promote 'complete health' which is defined by the World Health Organisation as 'a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity'. To do this we need to move towards a preventative health system.

3.2.4.2 The Together for Wellness Centre will contain a single point of access for all primary and secondary care referrals for adults (16 and over) in Halton and St Helens with functional mental illness. At the very core of this model there will be screening for all patients which will be carried out by a team of multi-professionals from primary care, secondary care and social care ensuring that expertise is shared at this vital stage to ensure that the most appropriate care pathway is identified and referrals do not bounce from one service to another.

3.2.4.3 For people with critical needs a face to face assessment will be carried out the same day. For those with moderate and significant risk again a face to face assessment will be carried out within a specified timeframe.

3.2.4.4 The co-location of secondary care within the Centre will ensure that the appropriateness of referrals to secondary care can be explored in a multi-disciplinary environment and there will be a facilitation of referrals across services and between organisations.

3.2.4.5 Professionals undertaking screening and assessment will be supported by a GP with Special Interest in Mental Health and a Clinical Psychologist. The Together for Wellness Centre will establish a link to ensure that GPs have access to a Consultant Psychiatrist for advice where appropriate.

3.2.4.6 If following screening the individual is thought to have limited or no risk then that person will not receive a face to face assessment but will be directed to steps 1 and 2 provision. This could include:

- "Watchful waiting with the GP" – this is a regular programme of contact with the GP to assess the progress of the person's mental health condition and progress of treatment
- Counselling with the voluntary sector
- CBT type intervention with a Graduate Mental Health Worker

- Social care interventions
- Community referrals e.g. Social Prescriptions
- Lifestyle interventions, e.g. exercise on prescription.
- Bibliotherapy – self help
- A health promotion specialist will be present in the new SPA to provide pertinent information and provide alternative interventions.

3.2.4.7

The Together for Wellness Centre will also have a dual outreach function providing:

- Education and advice to GPs to ensure that GPs are empowered to manage steps 1 and 2 of the stepped care model.
- Health Promotion interventions.
- An access and advice line for people, carers and professionals for which is capable of effective and consistent signposting – available during extended opening hours.
- Advice and information regarding the way in which the voluntary sector can assist.
- Support in relation to keeping and supporting people in maintaining employment."

3.2.5 The model is based on the stepped care model, which promotes appropriate levels of intervention in a timely way according to an individual's needs. Appendix A is a pictorial representation of the model, whilst Appendix B is a high level process map showing the referral routes. The model will provide an inclusive care pathway from primary care through to secondary mental health services with a tracking function which is capable of monitoring the entire patient journey.

3.3 **Social Care Input:**

3.3.1 To support the new team a full-time social work post would be established within this new service. This post will be funded on a 50/50 basis by the Borough Council and the Halton and St Helens PCT.

3.3.2 This new post will be a central part of the initial assessment and triage service, and will also be expected to carry responsibility for social care interventions in a number of ongoing cases. In particular, the post will:

- Provide a full social care perspective to the management and gatekeeping of referrals – both those which will be dealt with by primary care and those which will subsequently be referred on to secondary care services
- Manage the social care assessment and care management

component of people who may be eligible for assessment under the NHS and Community Care Act, who have not previously received support through the current Single Point of Access service
- Act as the referral and management point for referrals under the Vulnerable Adults procedures for people only known to primary care services
- Provide a formal link into Children's Services and the Common Assessment Framework
- Undertake assessments of carers needs of people with complex mental health conditions who are not referred to secondary care services
- Provide advice and support to the Single Point of Access about community services and resources in Halton which can be accessed by people with mental health needs. This will involve close linkages with the Community Bridge Building service.

3.3.3 The expected benefits of this approach are:

- More people who should be eligible for assessments under the NHS and Community Care Act will receive these assessments
- As a result of the assessment, more people will be signposted towards lower level services at an earlier stage in their condition
- Improved performance reporting for mental health services, particularly in terms of people "helped to live at home"
- More carers assessments being completed, leading to the provision of more support for carers
- More vulnerable adults being subject appropriately to the Adult Protection procedures
- Stronger front line linkages will be developed between primary care mental health services and children's services – the social worker will be expected to have a key link role between these services
- Full inclusion of social care and social inclusion in the model from the start will promote holistic assessment and service delivery across Halton and St Helens
- More people being appropriately diverted from a pathway that takes them into secondary care services – with a consequent improvement in the delivery of key secondary services, particularly the Crisis Resolution/Home Treatment service

3.3.4 There are two other key areas of potential benefit, although these may not appear until after the model has been put in place:

- A primary care service with social care input will receive referrals about people who do not "fit" standard eligibility

criteria for specialist services. A number of these situations currently exist and are dealt with by all service areas, but without the development of consistent expertise to effectively manage individual needs. This includes – but is not limited to – people with an Autistic Spectrum Disorder, who can present in a chaotic and disruptive manner and who require a considerable resource. There is real potential for the primary care service, over time, to develop experience in this type of service provision, and for resources to be diverted from existing services to sustain this.

- If the service works as it is intended to – and it will be closely evaluated to ensure that it does – then an obvious consequence should be a reduction of referrals to secondary mental health services, with an increased focus on supporting people in the community. This "preventive" approach may provide scope for further service redesign, for both assessment staff and provider services.

3.3.5 The social work post will be employed by the Borough Council, but managed on a day-to-day basis by the management structure within the Single Point of Access in the PCT. It will be the subject of a partnership agreement between the Council and the PCT, with lines of accountability through the existing mental health partnership board.

4.0 POLICY IMPLICATIONS

4.1 Under this proposed model, a range of national and local policy and targets is addressed, particularly with the inclusion of social care within the service. This includes:

- National Service Framework for Mental Health – Standard 1 – Mental Health Promotion
- Carers Recognition Act
- No Secrets – Adult Protection Policies and Procedures
- A range of targets to keep people in employment or help them return to employment or voluntary work
- Action on Mental Health – a guide to promoting Social Inclusion
- National guidance on Access to Psychological Therapies
- Social Services Performance Indicator: people with mental health problems helped to live at home

4.2 There are also national requirements to deliver effective mental health services across secondary care services, which are identified in a range of Performance Implementation Guides and which are performance managed by inspectorates. The proposed model, as described above, ensures that only appropriate work is referred to secondary care services, and frees up those services to operate more effectively.

5.0 FINANCIAL/RESOURCE IMPLICATIONS

5.1 The initial financial commitment for this proposal is of £16,263 (full year cost, assuming mid-point Spinal Column Point) for the provision of half a social worker post, which will be matched by equal funding from the Primary Care Trust. This will be funded through the Mental Health Grant and will be recurrent. The Grant will also fund the advertising costs.

5.2 Further financial implications are harder to quantify, and to some extent will only be known once the service is up and running. The development of this new service will ensure that people who have been inappropriately diverted from social care assessments will now receive assessments under the NHS and Community Care Act, and it is reasonable to assume that this will impact on the associated budget. It is also likely that more carers will receive an assessment and that some will require a service as a result.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children and Young People in Halton

6.1.1 The new service will focus on the needs of people with mental health problems who are over the age of 16. The Single Point of Access will therefore provide a strong and consistent assessment and support service to a group of people who have not necessarily previously been able to access support, if their needs were not so serious as to require a referral to the CAMHS service. This will also support the development of stronger between CAMHS services and local community services, and the establishment of clearer pathways for referral and transition for younger adults with mental health needs.

6.1.2 In addition, more people who have mental health problems who also have children will be supported in their communities by the Single Point of Access and Together for Wellness Service. There will inevitably be contacts between these service and both Children's services and the Common Assessment Framework process. As part of the delivery of the project, close working links and protocols will be developed across these services.

6.1.3 Finally, one of the key functions of the new service will be the ability to act as an advice and information-sharing resource. It is expected that this will be particularly helpful for staff who work in a range of children's services who may wish for general advice about parents they work with.

6.2 **Employment, Learning and Skills in Halton**

6.2.1 One of the key roles identified in this model is that of the Employment Support Officer. Research is clear and shows that people with mental health problems are much more likely to lack employment than other groups, and also that the earlier an intervention in a person's condition, the less likely they are to lose their job.

6.2.2 The addition of an Employment Support worker within this service will give greater impetus to existing efforts to improve job retention and return-to-work opportunities for people with mental health problems in the Borough. The post will also allow the development of stronger links between mental health and employment services, both within the Council and outside.

6.2.3 Halton has a very successful Community Bridge Building Service, which works with people with a range of needs to support them to engage with mainstream community services. There is real potential for the Bridge Building service and the Together for Wellness Centre to work together to support people to access educational, voluntary, vocational and employment opportunities.

6.3 **A Healthy Halton**

6.3.1 This service is designed to deliver an enhanced service to people in Halton with mental health problems, at an earlier stage in their condition when the potential for improvement and recovery is greater. To that extent the service will immediately be addressing this Priority.

6.3.2 In addition, the service approach will be to consider the physical health needs of the people referred with mental health problems. Appendix 1 shows two key elements of this:

- The involvement of the Wellbeing Nurses, who can provide physical health screening for people with mental health needs
- Health promotion services, which can provide advice and support about such things as healthy lifestyles, alcohol use and healthy eating.

6.4 **A Safer Halton**

6.4.1 The Single Point of Access will be offering support to a range of vulnerable people who may not previously have had a service. As such the service will potentially impact on this priority in a number of ways, which include (but are not limited to)

- Ensuring that any vulnerable adults who are potentially subject to abuse are dealt with through the Council's Adult Protection procedures
- Providing a greater range of therapies and services to help people manage their own conditions – which would include such things as anger management
- Although not a main focus of their role, there will be many people referred to the service who have mental health problems that are combined with misuse of drugs or alcohol. The service will provide advice and support on these matters and will also signpost them towards specialist supports as required.

6.5 **Halton's Urban Renewal**

None identified.

7.0 **RISK ANALYSIS**

7.1 The opportunities and potential benefits have been identified in paragraphs 3.3.3 and 3.3.4 of this Report, and it is suggested that the risks of not developing this service are greater than the risks of development.

7.2 There are however specific risks that will need to be managed as part of overall project planning, as follows:

- Levels of work: at this stage it is not possible to quantify the amount of work that this initiative will create for the social worker within the team – this will need to be closely monitored by the manager of the team. There may also be an increase in workloads for associated teams in Halton, such as the Mental Health Outreach Team and the Community Bridge Building service
- Effects on budgets: as with the levels of work, it is also not possible at this stage to assess what impact there will be on the existing community care budget. It is likely that this will not be considerable because many people referred will have lower level needs that can be met by simple community interventions

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 This proposal is designed to improve the overall quality of service to a range of people who experience disadvantage and stigma because of their mental health condition. It will be open to all people to access, but there will be a pressing need to ensure that this is extended to hard-to-reach groups.

8.2 An Equalities Impact Assessment will be developed once the

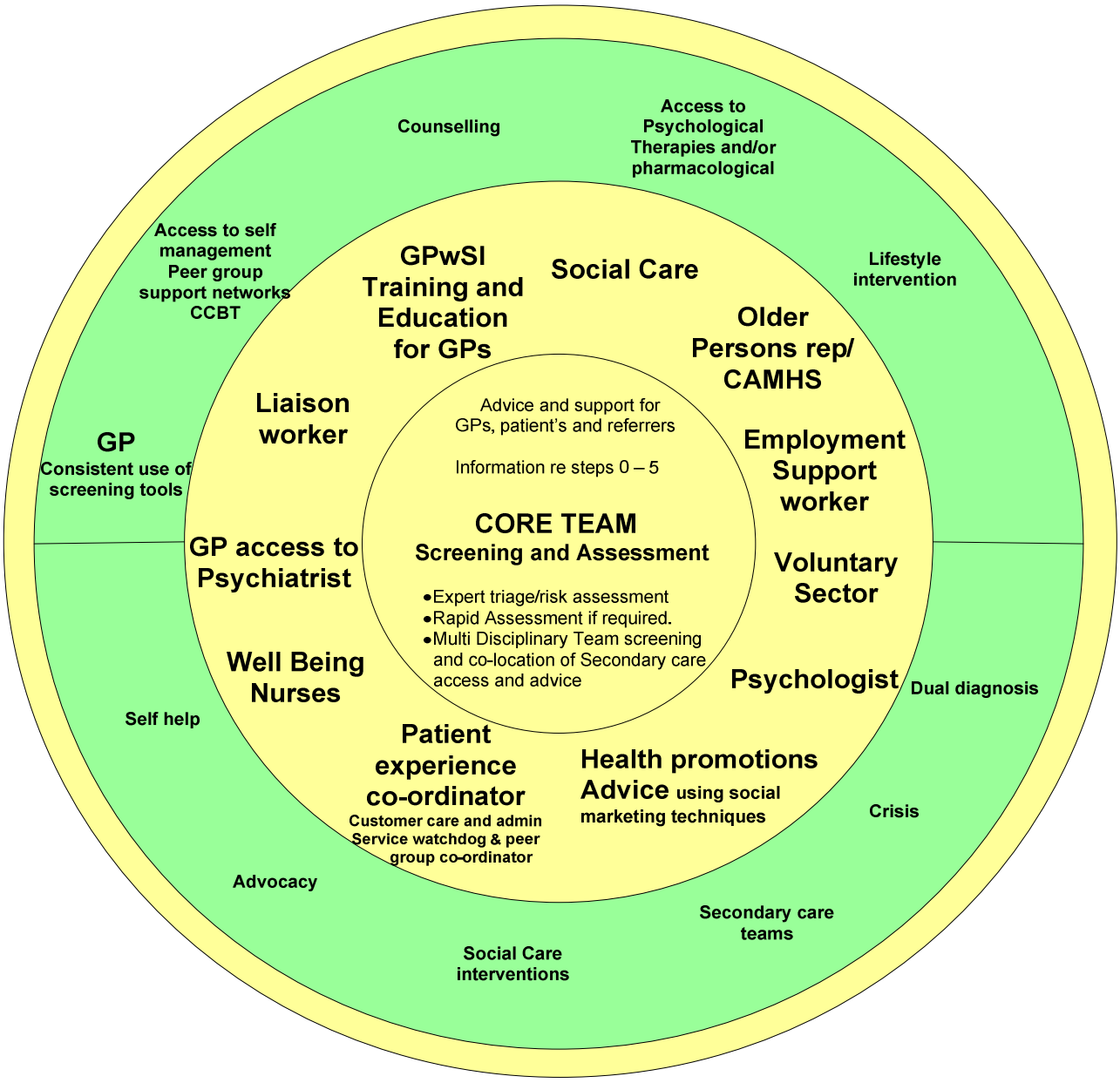
service is in the process of being established.

9.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

9.1 There are no background documents under the meaning of the Act.

APPENDIX 1

Together for Wellness Centre Model **20.11.08**



"Step Up → Step Down → Step Out"

Appendix 2

Holistic Patient

Process map for SPA referrals

Appendix B