Delivering Together Newcastle & Gateshead

Understanding Needs Workshop 2 Summary Report

18th – 22nd September 2017

Introduction and Context

In June 2016, following public consultation, decisions were taken around services in Newcastle and Gateshead:

1. Creation of new inpatient facilities at Newcastle's St Nicholas' Hospital, and the opportunity to innovate a wider range of improved and new community services
2. Closure of Gateshead's standalone Tranwell Unit, as well as the Hadrian Clinic in Newcastle
3. Older people's services in Newcastle consolidated at St Nicholas' Hospital, closing wards based on the former Newcastle General Hospital site

The money released from these changes will be invested into new and enhanced services that will create a better way for people to be supported and cared for in their own communities, minimising the need for inpatient care because new innovative services will support people when needed.

Since then, further stakeholder workshops took place in February and July of this year, which have confirmed a widened scope – this now also includes:

- Older people's mental health services in Gateshead
- Third sector mental health services, and the wider community and voluntary sector
- Social care and other local authority services
- Interface with GP services
- Interface with employment and housing

This report captures the second of a series of four events, which was held from 18th-22nd September 2017, and which focussed on 'Understanding What is Needed, including Assessment'. Professionals from a range of providers worked alongside Service Users and Carers in what was another challenging week.

Building on Workshop 1's ideas of a telephone/electronic Single Point of Access and Walk-In Hubs for Mental Health, this event considered how information is gathered and recorded, how assessment by the relevant agencies and organisations could be coordinated, and what those assessments will include. The skill set of those working in this multi-agency system was considered. Training and ongoing support for those working within the new service, for Carers, and for GPs and Practice Nurses was all discussed.

The following pages aim to provide a summary of the second design event, the discussions, ideas and products designed. The full discussion notes and outputs of this workshop, along with workshop one, are reported separately for brevity, and they feed directly into the forthcoming events on the remainder of the pathway.

The second workshop was held at the Royal Station Hotel, Newcastle and was attended by 35 participants and stakeholders across the week from a range of organisations, both statutory and voluntary sectors, and Service User and Carer representatives:

- Newcastle/Gateshead CCG
- Newcastle City Council
- Gateshead Council
- Public Health Gateshead
- Mental Health Concern
- Mental Health Matters
- Gateshead Health NHS Foundation Trust
- Northumberland Tyne & Wear NHS Foundation Trust
- VOLSAG
- Gateshead Mental Health User Voice
- Healthwatch Gateshead and Newcastle
- Newcastle Carers

Welcome

Ian Renwick (Chief Executive, Gateshead Health NHS Foundation Trust) opened the first day as the sponsor of the programme – as with the first event, he challenged the group to design the best service for Newcastle and Gateshead – "there is no blueprint – it is up to you to design it to provide a better service".

Ian was unable to attend the Report Out on Friday, so thanks to the group for their efforts was given by Chris Piercy of the CCG.

Workshops were held in July 2017 with stakeholders, who were asked to consider what 'good' services would look and feel like:

- Holistic patient assessments and support offered, looking at the whole person, in a timely manner and carried out in a location that works for the patient
- Support for Carers to access Carer's Needs Assessments through referral from a variety of locations/organisations in a timely, more holistic but efficient manner. Also, more support via respite opportunities and a better understanding of the mental health system
- Great Service User and Carer involvement in their care. They want to be listened to and seen as equals to healthcare professionals, they want to know what their journey to recovery will look like at the outset and for professionals to check they understand the process. Common sense confidentiality rules are also needed for Carers to support their loved ones
- Care packages should be needs-based not time-based
- Continuity of care in terms of having a key support worker through the recovery process
- Joined-up working to share information and provide a standardised service at any access point
- Able to access urgent support 24/7 at any time

The participants in the second workshop were given a list of things they needed to work on during the week:

- Specifications for how assessments will be carried out by different organisations, and how information sharing will take place
- Specification of how this understanding of need then moves to delivery of service in each provider, and how they plan service delivery with the Service User and Carers
- Consideration of administrative and IT processes
- Consideration of specialist assessments and how these interface with more routine understanding of need
- Ensuring consent and confidentiality are built into the system, and that communication between all parties is timely and effective
- Understanding of the skills and roles of staff undertaking the process
- Open to new ways of working, including technological solutions

Activities – Idea Generation:

The tables were asked to discuss various elements of existing ways of working, to think of the problems in the current pathway when dealing with understanding needs, and then discuss possible solutions. These were shared with the rest of the group and ideas for the week generated.

Through discussion on current problems and ideas to solve them, the group noted 'What would I want if it were me?'

- For people to hear what I want/need – talk to me in a relaxing way
- For people with lived experience to be involved in the delivery of services
- For it to be a fluid process, based on an "emergent conversation"
- For there to be one key person, so that I can build a relationship and that they care about me.
- Timely involvement
- Being clear about waiting times
- That the person assessing me is skilled and able to ask me the right questions at the right time and to understand what I'm telling them.
- Consider protective factors, hobbies, housing, cultural differences, communication difficulties, re-engagement including reference to WRAP plans and advanced statements, co-morbidities including drug and alcohol and physical health issues
- For the assessor to have direct access to systems to book appointments and to refer on.
- At the end of the assessment there's clarity when my treatment &/or support starts
- That the treatment may not be binary – in that I can have both clinical and non-clinical support at the same time.
- Don't underestimate the skill set required to do this.
- Don't underestimate how important it is just to listen
- Don't forget carers of the person – making sure that this is properly considered
- Don't forget to think about the person's strengths and assets available – protective factors

and 'What's not working well? What we need'

- True and honest integration & joint work.
- Shared accountability – where one service isn't leading or dominating the others
- Senior staff being based together
- Single IT system & co-location
- Shared and agreed processes, including assessment
- Agreement on core assessment process and tool

Workshop One Outputs Review:

Those who had been part of workshop one and had returned for workshop two were asked to briefly review the first Outputs Report created, to ensure nothing was omitted unintentionally. It was noted that some discussions had been captured only as drawings without accompanying text in that workshop, and some were held on individual laptops and not centrally so had not been added to that initial report – lessons learned will flow forward into future events, and the initial report has been updated.

The idea of the 'A team' supporting the Single Point of Access was firmed up:
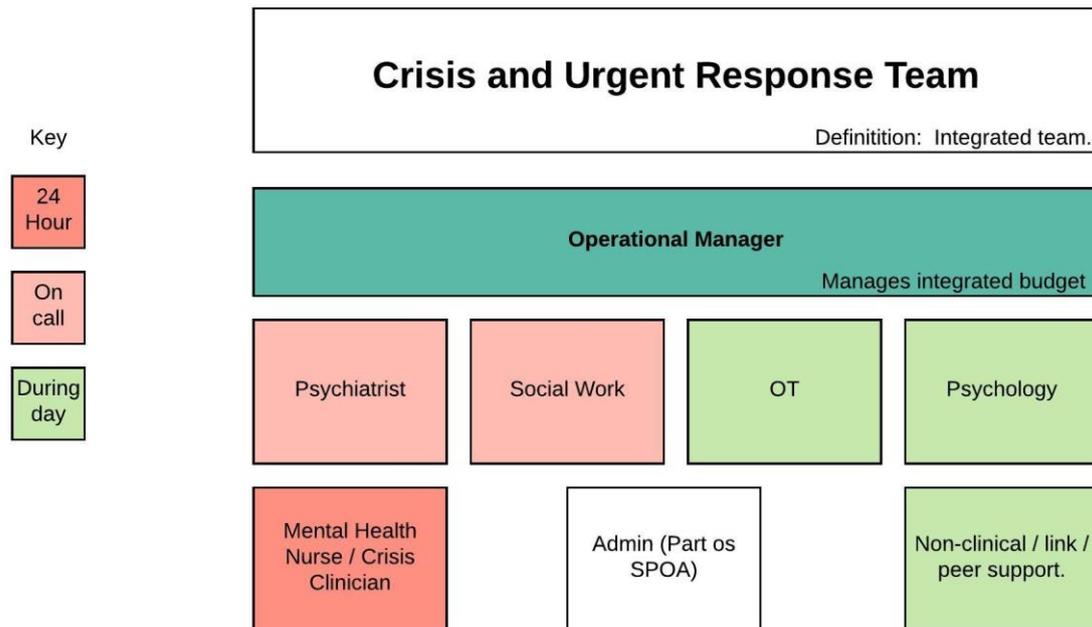
Challenges noted from the previous workshop on Access include:

- Ensuring people feel their needs are understood and they are not being 'processed'
- People friendly rather than date friendly
- Service User feels they can trust information is listened to and will be acted upon
- First Responder should have good interpersonal skills - warm, genuine, trustworthy
- Right people, get to the right place in a timely fashion with appropriate risk dealt with
- Workforce in A-team - consider skill set as to who else may be able to carry out assessment (skill mix)
- Include narrative assessment
- Clinical triage is through the A Team
- Consider those from " out of area" + those with no GP or those who present for care who are not entitled - does same pathway apply?

This workshop built upon previously discussed concepts, with consideration of how and when the First Responder may ask for help/support/supervision from the team around them 'in the room', as they develop their own skills and expertise:

In this, the group acknowledged the additional expertise available to the First Responder in the new model, in the room and beyond (e.g. psychiatry/Mental Health, physical health, risk assessment and forensic understanding, Safeguarding, Domestic Violence, Learning Disabilities, Social Circumstance expertise such as in Housing, Benefits, Education, etc.).

Discussion on Joint Working – Physical and Mental Health:

Some services already work shoulder to shoulder across physical and mental health boundaries, providing joined up care for patients with joint needs such as in Mental Health Liaison Services in Acute hospitals or joint perinatal care. The Single Point of Access would not replace this joint working, nor add an extra step, but would be a resource for all in matching to onward and complimentary services.

Information Gathering:

The group discussed 'knowledge trees', where the First Responder would have guidance as to when, in each kind of scenario, they needed to pass a call onward to someone with specific additional expertise. The group were clear this was not to be a scripted conversation between the First Responder and the caller, but simply a guide for staff as they were trained and supervised.

Actions from the initial assessment by the First Responder and colleagues may include Talking Therapies, social solutions, lifestyle interventions, as well as full assessment leading to care and treatment plans overseen by a Care Coordinator, and onward referrals to services/hospitals identified.

The group discussed the idea of creating an initial 'plan' for the individual, which outlines which services can support them, and how this will be achieved.

Information sharing and recording:

The group spent a significant proportion of the week discussing the challenges and benefits of sharing information between organisations and professionals, how consent is understood and managed, and how this affects Service Users and Carers.

Ideas were put forward around different ways information could be recorded, options around single record systems, and designs for the initial 'plan' for multi-organisation assessments of individuals.

The group agreed that these needed much more work and that expertise from IT colleagues across the organisations, and those working on the Great North Care Record would be sought, to help a consensus to be achieved.

Following Up:

Following up on the initial plan created for involvement of services was felt to be an important responsibility, with those in the Single Point of Access and Hubs checking back to see if initial appointments have happened and arranging further action if not, particularly where risk is apparent.

Service User, Carer and Wider Community Feedback Plan:

The summary from the first day of the workshop was fed back to Steph Edusei (Chief Executive, Healthwatch Newcastle), along with a short set of questions which had arisen during the day that warranted further opinion. Healthwatch Newcastle and Healthwatch Gateshead ran 'fringe' events on evenings during the week to allow more members of the public, experts by experience, and voluntary and community sector representatives to make their voices heard and contribute to the new service design.

Feedback from the first 'fringe' event was given to the workshop at the start of day 2, and again at day 3/4. Following the feedback, the workshop attendees were able to take on board the constructive criticism and ideas, and worked towards finalising the assessment element of the pathway.

In addition, the same information and questions arising were shared with staff from NTW and Gateshead Health during the week, and their feedback was again taken on board by those in the workshop.

Word clouds were created from feedback on day two, from Healthwatch, NTW staff and Gateshead Health staff, where the most commonly used words by staff are the largest:

Healthwatch:

NTW staff:

Gateshead Health:

GP Feedback:

The group were joined for the week by a local GP who is also a Lead for Mental Health in the CCG, and they discussed what the pathway might include for a GP referral to the new Single Point:

GP preferences for the immediate interface with the new model:

- A consistently helpful response, whether the caller is the GP, Practice Nurse or trainee, with flexibility in response/procedure
- Minimal call waiting and acceptance of e-referrals
- Flexibility around support to Older People/intermediate care
- Could Hubs address Physical Health issues in those with Mental Health problems?

GP preferences for communication via the new model:

- Supply all practices with information about the new service, including standards and process for making referrals
- Send summary to Service User, copied to GP – plain language for all
- Summaries at intervals, including risk information and medicine information – no more than one sheet of A4
- Training for staff doing assessments in the narrative model, supported by 'experts by experience'
- E-transfer direct to Primary Care file

Discussion around two-way support between Primary Care and this new model:

- Links to Practice Navigators
- Promote attendance at other services for physical health
- Better GP links with Secondary Mental Health services – create links between GPs and Psychiatrists for advice and guidance (direct, electronic and via Hubs)
- Consider co-location, and/or rostered sessions in Hubs for GPs and Psychiatrists
- Coordination of Physical Health Checks to avoid missing and duplication

Ideas for training and support from all organisations for General Practice staff including GPs and Practice Nurses were generated, noting that these professionals have regular contact with many Mental Health Service Users and Carers:

- Consistency of training, e.g. Mental Health First Aid model
- What resources are available to support: Directory – LA offer, 111
- VCS capacity of 'link workers' to support : patient care/Carers/PT's
- IAPT – training offer? Capacity building
- Involve experts by experience and Primary Care Navigators – across system including primary care – consider having in-house Mental Health expert
- Give us a greater understanding of Social Care
- Share experiences – user and carer delivered and paid for delivery employed – Triangle of Care
- Assessment
- Communication skills, listening skills, information sharing
- Early identification of signs and symptoms and opportunities for further interventions including through physical health 'checks'
- Highlight opportunities for prevention and early intervention
- Carer and patient 'alerts' to change in behaviour – GP to support seeking further advice or escalation
- Chronic illness impact on mental health
- Topic knowledge of common mental health issues
- Management of Mental Health by Practice Nurse/Nurse Prescriber/Practice Pharmacist involved
- Make Every Contact Count

Urgent and Liaison assessments:

Principles around urgent assessment and liaison assessment were revisited from workshop one, which included fast response in any possible location, and the importance of involving Carers and family members.

Issues were noted with duplication in record-keeping in liaison services, who have to make entries into general notes as well as Mental Health notes.

The group agreed that the opportunity for Crisis and Liaison teams to have same day access to Social Services and Voluntary Services support for individuals would be of great benefit to all, and should be part of the new model.

The group discussed safety within the new Walk in Hubs, if they were open to all and therefore potentially used by individuals who may pose a risk to others, as well as those who are vulnerable.

All agreed that:

- Establishment of acceptable codes of behaviour would be key, as this is how many charitable services manage their facilities, with minimal issues experienced
- Further work on the environment and design of these new spaces would need to maximise the welcoming and supportive feel, while also including appropriate safety systems to protect everyone. In discussion, Service Users and Carers in the workshop were not aware of current systems in place in community mental health team bases, such as alarm systems that staff can activate, and so felt these kind of systems are not intrusive for users.

24/7 Integrated Community Frailty Service proposed:

In addition to current urgent services which are focussed on individuals between the ages of 18 and 65, the group discussed the needs of individuals who present with added complexity resulting from frailty and/or conditions such as Dementia. The idea of a 24/7 service for these individuals was proposed (outlined in brief below), and will be further considered in workshops 3 and 4, which focus on equitable service delivery for all.

24/7:

- Older people's Specialist Physical Health Nurse
- Older person's Mental Health Nurse
- Domiciliary Care

Crisis and Home Based Treatment:

- Up to 4 week intervention

Intermediate Care model:

- MDT Daily
- Social Worker (OP)
- Geriatrician

- Old Age Psychiatrist
- GP
- Occupational Therapist
- Physiotherapist

Triggers to include this team

- Picked up/referred by GP with infection and cognitive impairment
- Known cognitive impairment – includes young onset dementia
- Over 75 unless needs better suited to Standard Crisis Team or vice versa
- Carer stress
- Pre-existing package of care or in a care home
- Functional decline recently
- Unplanned admission to Mental Health or Physical Health in the last year
- Open to OPMH services unless better met by Crisis Team

Voluntary Sector role in Assessment:

The group felt that this new way of working gave significant opportunities to acknowledge and value the role of the Voluntary Sector in understanding the needs of the individual and their Carers/family members, as part of an assessment process.

Sharing of information between statutory and charitable organisations was noted as a significant challenge in need of much further discussion, but something that would be of great benefit to the Service User and their Carers/family.

The possibility of agreeing a comprehensive holistic plan for both the Service User and their Carers/family at the earliest point of contact was felt by all to be a key principle of this new model.

As noted earlier, further significant work will be required to understand how information sharing can be agreed and delivered between statutory and voluntary organisations.

Concept of the 'Trusted Assessor':

In discussion and in feedback from staff across services, challenges were noted by Service Users and Carers, where an individual has been assessed but the next service in line begins the assessment again, asking the same questions, and thereby not trusting all of the information supplied, whoever it has come from.

The group agreed that the concept of the 'Trusted Assessor' should be a key part of this new service model, not only increasing the efficiency of the pathway but most importantly improving the experience and quality of service for the Service User and Carers.

In expanding upon this, the group felt that Carers should be considered as 'Trusted Assessors', particularly where they have ongoing contact with the individual and the services involved, so a 'working relationship' can be developed between services, Service Users and Carers. Concerns over trusting the opinions of those who only have occasional contact with the Service User were noted by all.

This discussion was linked with that on consent, and on improved listening to Service Users, Carers and family members, which was a theme throughout the week.

In Report Out, feedback received from the audience echoed the need to trust Service Users as well as Carers when they are reaching out for help, and not to dismiss this as 'professionals know better'.

Principles of Carer ('Significant Others') involvement in the assessment of the Service User :

- Start at the beginning - when the Service User is being assessed the "Carer" should always be offered an assessment too - they should feel listened to
- Establish at the earliest opportunity if someone in your life supports you? Such as a family member or friend? "Who in your life do you get support from?"
- Honest and robust conversation with that person/people and have a debate about what is best for that person - expert by profession vs expert by experience
  - o Should you be involved?
  - o Do you want to be involved?
  - o If yes, tripartite assessment – continuum – equal partner in the plan and fully involved – Significant Other is co-professional – 2 way – able to disagree – have a debate
- 3rd party concerns are taken seriously and are listened to
- Equal partnership, treat with mutual respect – we must change the culture! – this should be robust + 2 way
- "Getting to know me too"- we must get to know the supporter(s) in the Service User's life
- Information and rational for decisions should always be explained - open and transparent
- Common sense used and answer questions generally + legal advice sort + information passed on
- Always take the "Carers" confidentiality into account

The group agreed that we must recruit, train and supervise our workforce to understand how to involve Carers, including children, and that this is as important as parity of esteem with Physical Health.

Carers Assessments

The group discussed ideas for best practice in assessing the needs of Carers and Significant Others in this new multi-agency way of working, noting issues raised in stakeholder events:

- Holistic Wellness Plan
- What will help? What does the person want? What is available?
- Explain what a carers assessment is, support on their terms
- Evaluation of service at each point – could be web based or paper
- Different levels of support
  - o Voluntary Sector
  - o Physical (usually GP)
  - o Local Authority assessment (statutory obligation)
  - o Hub Assessment
- Simple document, a conversation not just form filling
- What is caring role/responsibility? Ensure young carers are included
- Look at health, finances and benefits (access to Welfare Rights)
- Offer joint assessment with cared for person (if appropriate)
- Is there anyone else who helps? Do you care for anyone else?
- Any imminent/urgent needs? Emergency support?
- Who to contact / what to do if things change/become urgent
- Set review time and follow up
- Ideally face to face – home visit if necessary - advocacy is important
- Carers centres to feed information to the hub records and link records on IT
- Carer Peer Support Workers to be employed – involve people with lived experience

In addition, the group considered the idea proposed by a fringe event, that Carers including children may benefit from receiving training in what to expect from someone's condition/presentation, and in supporting them to develop resilience – an outline of what such training may consist of was developed

- Include 'experts by experience' and employees with their own experience of using services and caring for others in delivering training
- Case studies of journeys – consider what could be different, what went well
- Compassion – de-escalation skills – communication 'non patronising'
- Competencies – within the role of the Carer
- Multi-agency training – complicit of message
- Assessment including 'good' narrative assessment
- Use of video 'snaps' of stories
- Carer and patient 'alerts' to change in behaviour – GP to support seeking further advice or escalation
- Chronic illness impact on mental health
- Topic knowledge of common mental health issues

NTW Specialist Services - The group discussed the feedback from NTW Community Teams around challenges with the availability of 'specialist' expertise from within Mental Health services (e.g. expertise available to community mental health teams from forensic services, specialist psychology services, etc.).

Challenges:

- Don't want to dilute specialist services - intensive specialist supervision, acknowledge the difference between specialist treatment and specialist advice/input during assessment
- Hope to prevent specialist treatment being needed by supporting community teams more - conversations require relationships between services
- "Complex case" discussion plans are noted to be of significant benefit

Assessment process best practice:

- Access to specialist expertise when needed in the community
- Specialist services accessed for those with complex needs

Communication Difficulties - the group discussed how individuals with a range of communication difficulties would be able to access services, complete an assessment and access any subsequent treatment/support.

Discussions around those hearing loss noted significant challenges faced in accessing face to face, telephone, written and electronic support, and acknowledged that many individuals with significant hearing loss also have difficulties with written/typed English, which further complicates access. In addition, having to rely on family members and friends as interpreters adds challenges in terms of confidentiality and information sharing, as it does with those whose first language is not English.

Challenges faced by individuals with a Learning Disability in accessing the new model were discussed and, while Learning Disability services are not within the scope of the Delivering Together programme, individuals with Learning Disabilities should be able to contact the Single Point of Access and Hubs without hinderance. In this, training/awareness raising would be needed among associated staff, along with access to appropriate expertise.

Conditions such as Dementia and Autism were discussed, and similarly the principle that services should be accessible was maintained, with further work required to build awareness among staff in the Single Point and in the new Hubs, as well as consideration of the physical environment, and how these individuals can be best supported.

As noted above, involvement of specialised services and awareness raising/training for all staff around communication, use of language and how to meet additional needs will be important as the new model is operationalised.

Communication needs should be alerted and flagged on the shared system - **all** patients should be asked what their communication and information needs are

The group discussed the challenges faced by Homeless individuals, asylum seekers and those with failed immigration status.

In discussing the proposed pathway created to date with the manager of the Homelessness Team, NTW Newcastle, the following points were noted:

- Hostels in the area should be linked into the new network – also need to be aware that people come to these from other parts of the country, so information may be limited
- Need to go where homeless people go, and advertise the help and support – consider how people will access the service who find access difficult – have Navigators to help that person
- Need to consider Dual Diagnosis services and how they link into the pathway, where to go for support, and waiting times
- Identify GPs who are willing to see people with no fixed abode – why is this only a few?

Recent changes to government policy (August 17) indicate that some of the new model proposed will not be free for everyone who tries to access it.

The group noted there is a responsibility to check for entitlement to treatment through extending charging from August 2017 "NHS charging regulations" - for community health organisations:

- CMHT services
- Support groups
- Advocacy services
- Specialist services for homeless people and asylum seekers (NHS charging regulations)
- Substance abuse

The group noted that some individuals do have entitlement to treatment where it may not always be obvious that they do, e.g. prisoners and immigration detainees, victims of modern slavery, those under agreed Deprivation of Liberty plans, and those with an application submitted for asylum status.

The group agreed that how such individuals would be welcomed and supported by the proposed multi-agency service needs more consideration, and that this would be picked up in the next workshop, where specialist advice would be sought.

Types of Assessment - summary

The term 'assessment' has negative associations for lots of people because it is often linked to eligibility of services. In the new model, the term 'assessment' means 'getting to know you'. With this in mind, the new model will be getting to know people in a variety of situations and within different degrees of urgency.

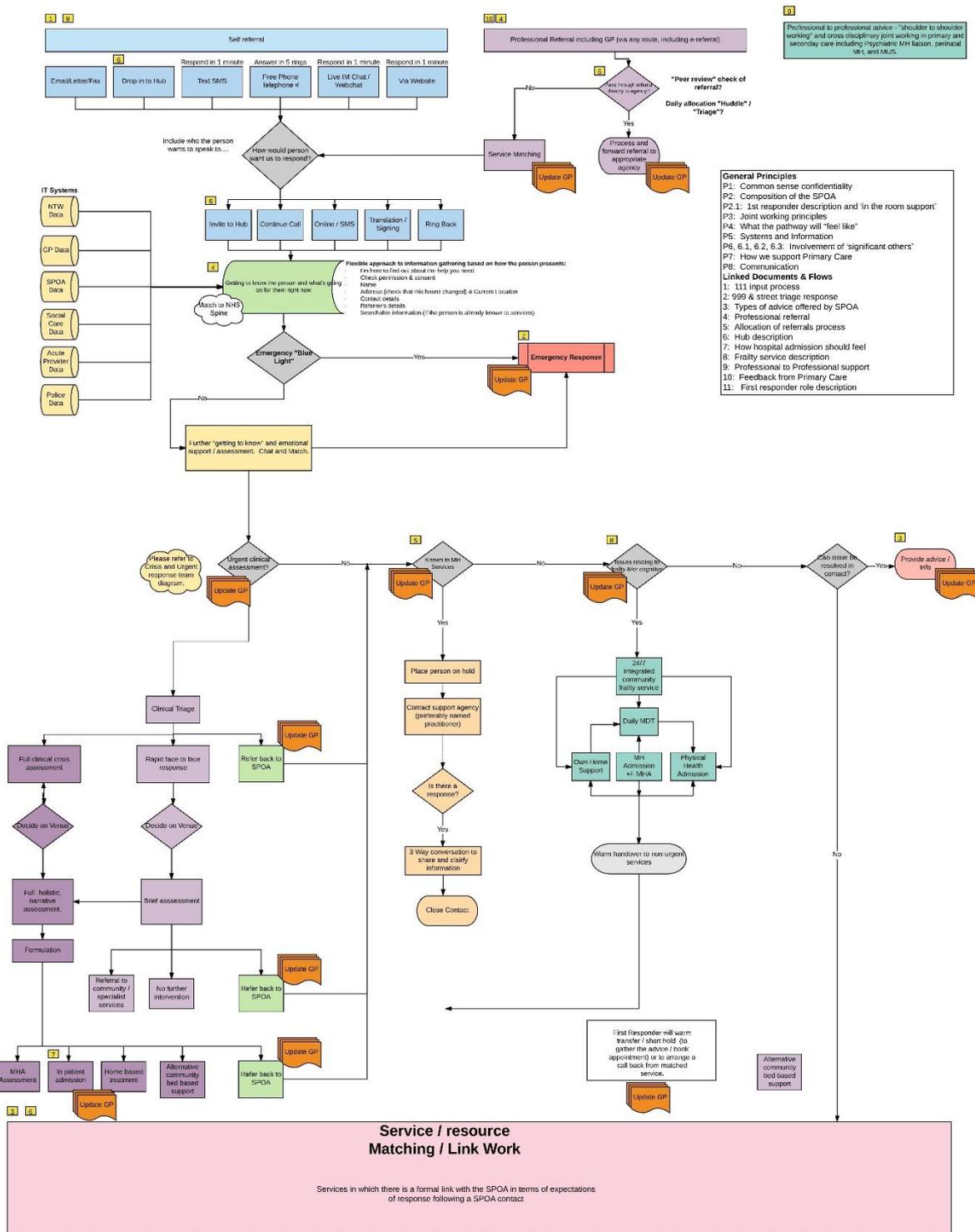The group described some consistent principles of assessment.

The assessment may take place within our Hub or over the phone, or the assessment may be place-based. For example, it may take place in your own home, in a community service, or in a general hospital within the Mental Health Liaison Team.

Our assessment is also to different degrees of depth, our first responders are understanding the story, identifying needs, then arranging the right services for further assessment and help.

More specialist service both in the statutory and voluntary sector will carry out more detailed assessments to get to know what is needed.

The model aims to respond in the right time frame for the need, narrowing the gap that can exist between urgent and routine services. It plans to cross the traditional boundaries with the assessments provided, and won't ask the same questions, so that our service users and the person who supports them tell their story only once.

Day 5 of the workshop concentrated on pulling together all of the work that had been produced throughout the week and 'reporting out' to the sponsor, stakeholders and anyone else with an interest. The group had continued to add to the Pathway Drawing for future services in this workshop, which will continue to be reviewed, added to and evolve as the workshops progress – the drawing below only shows process flow, with documents on values, culture, process and standards referenced in it, which are held together in the full reports created: