SOUTH OF TYNE AND WEAR

MENTAL HEALTH

MODEL OF CARE

APRIL 2010
Foreword:

Mental Health provision in South of Tyne and Wear is commissioned and delivered via a myriad of agencies: NHS and Local Authority statutory bodies, General Practitioners, Independent providers and Third Sector organisations; all working within a climate of shifting policy initiatives, a changing legislative framework and a move to the development of meaningful outcomes for service users and carers. A wide variety of staff provide services: psychiatrists, psychologists, social workers, psychiatric nurses, nursing assistants, housing support workers, occupational therapists, day service staff, employment workers, counsellors and support workers – and that is by no means a complete list.

The challenge for the South of Tyne and Wear Mental Health Model of Care Programme is to bring together this complex web of organisations, professionals, service-users and carers to re-design the delivery of high quality mental health care to the people of Gateshead, Sunderland and South Tyneside.

Throughout the first year of the programme a great deal of time and effort has been invested in bringing people together; each with their own organisational and professional interests and each with their sometimes conflicting views on how services should be delivered. The programme has developed a transparency and dialogue which has challenged the organisational and professional ‘resistance to change’ typically encountered in systems reliant on effective partnership working and collaboration. The system will not begin to change unless all parties agree what the future should look like.

We now have the momentum to change in South of Tyne and Wear: the outcomes we want to achieve have been agreed and articulated; the structural model described and the processes and cross-cutting themes identified to deliver the model. Over the next 12 months we will begin to see some significant changes in how services are delivered: changes will be implemented in secondary care services alongside new processes for referral and ‘shared care’; the review of primary care mental health services will be completed and options presented for future delivery; the personalisation agenda will become embedded within care planning processes; whole population health and well-being strategies will be implemented across all localities; and ‘memory services’ for people with dementia will become more accessible.

This challenging and ambitious agenda will be delivered through the continued commitment of the partners within the programme, developed over the past 12 months, to bring about effective change for the good of our population.

David Hambleton, Director of Commissioning and Reform, NHS SoTW
Ian Holliday, Model of Care Programme Director
Gail Bayes, Model of Care Project Manager
Executive Summary .............................................................................................................. 3
1. Introduction & Initial Work ......................................................................................... 4
2. Structure ..................................................................................................................... 7
3. Process (Figure 7) .................................................................................................... 18
4. Outcomes .................................................................................................................. 21
5. How the model can be used.................................................................................... 22
6. Estates/Finance ......................................................................................................... 27
7. Work Programme & timescale for 2010 ................................................................. 29
8. Glossary of terms ..................................................................................................... 31
9. References used in this document ........................................................................... 34
10. References not directly used but which may be of use .......................................... 38
11. Programme Board membership .............................................................................. 39
12. Programme Management Group membership ...................................................... 40
13. Model of Care - Key Relationships as described in the Project Initiation Document, December 2008 ................................................................. 41
14. Key documents and their relationship to the Model of Care work ....................... 42
Executive Summary

The development of a ‘model of care’ has been discussed and debated in South of Tyne and Wear for a considerable period of time.

By December 2008, an urgent need was recognised in South of Tyne and Wear to establish agreement between all stakeholders on the strategic direction and the preferred model of care for Mental Health services. A project was launched with work beginning in March 2009.

This document is

- an articulation of the work progressed during 2009, including the creation of a visual model
- a work plan for 2010 to progress through the next stage of development
- a framework to which all stakeholders can refer

The Model of Care produced is a quality framework that helps service providers assess and treat the individual based on clinical and social need, whilst paying due attention to the cross cutting themes, processes and outcomes to offer a holistic approach

Given the scope of the project, it is recognised the whole Model of Care will continue to be ‘works in progress’ for some considerable time.

As such, the document should be assumed to have a life span of 12 months (maximum) from the date of circulation and then it will need to be renewed.

This paper is aimed at a wide range of stakeholder groups and, as such, it attempts to avoid over-use of jargon, and be an easy-to-read, user-friendly document.

It is not intended to replace in depth understanding of specific policy for a service area but gives a high level view of the world in which we operate by referencing key documents.
1. Introduction & Initial Work

The Project Initiation Document (PID) identified several objectives for the Model of Care

- Develop and commission a model of care for South of Tyne and Wear (SoTW) that addresses the fragmentation of services, is innovative, and strengthens the interfaces between services/agencies embracing the eleven principles of the Mental Health National Service Framework (NSF ref 1) and reflecting the principles included within the North East Strategic Plan for Mental Health (ref 2)

- Enable a cultural shift in the delivery of mental health services; establishing a system in which professional and organisational/stakeholder boundaries are open and transparent

- Promote the mental health and well being of the whole population, increase the resilience of local communities; tackle discrimination against people with mental health problems and promote equality of access to services

- Offer an optimistic, holistic, recovery focused approach to all people who use mental health services, including those with a learning disability, upholding the values of dignity, choice and respect. Where an individual’s level of recovery is limited, we want to support and enable them to maximise their abilities, their independence and their health

- Meet users’ requirements for assessment, treatment, care, protection, recovery and quality of life through timely access to services and resources designed around the needs and aspirations of service users and carers

The objectives were underpinned by seven principles to provide services that:

1. **Are safe**: Services that ensure the safety of individuals, their carers, staff and the wider public.

2. **Are built on best practice**: Commissioning services and treatment options that build on evidence of effectiveness drawn from a range of sources including academic research, user led research, national expert programmes and local service evaluations; and demonstrate improved outcomes over time that enables individuals to recover and regain a meaningful life.
3. **Are service user and carer focused:** Empowering service users and carers so that they can influence and inform commissioning and service improvements; offering a range of assessment and treatment options that are effective and beneficial for service users; services that value diversity, particularly through the development of policies and practices to serve members of black and minority ethnic communities.

4. **Support social inclusion:** Ensuring that the system is not simply a ‘mental illness’ service but seeks to promote and de-stigmatise disability in communities through education and awareness raising; with effective links and partnerships with organisations that can provide housing, work opportunities, social networks and educational opportunities; promoting the objective that, wherever possible, needs should be met through ordinary daily living solutions and community services, not disability services.

5. **Work in Partnerships:** Delivering well coordinated pathways that prevent organisational boundaries from inhibiting the delivery of high quality services. These pathways must include enabling people to return to or maintain good physical health.

6. **Are local, timely and equitable:** Ensure the provision of services close to where users and carers live, with specialist services being concentrated to ensure sustainable clinical quality; ensuring that equity of access and quality is not dependent on where service users and carers live.

7. **Are efficient and cost effective:** making use of benchmarking information to ensure we get the maximum benefit from the 100% of resources used to improve the health and well being of people with mental health problems and learning disabilities;

The PID also described several project benefits and key deliverables, with communication and risk management plans being monitored by the Project Management Group.

Whilst the work has been structured on the basis of PRINCE (Projects in Controlled Environments), it is recognised that the work across SoTW is unique in its approach. A formal project management approach is therefore not possible.

Full details can be found in the PID (ref 3).

The scope of the work was originally to cover services for working age adults and older people. Over the last 12 months this terminology has changed in line with the move towards ‘ageless’ services and the phrase now being used is ‘services for adults aged 18 or over with no upper age limit’.
The PID specifically excluded services for the under-18 age group at this stage.

The use of NETS principles (North East Transformation System, ref 4) was expected, where possible, to apply a leaner approach to the future service delivery. Whilst the NETS approach in itself is prescriptive, the high level principles of ‘compact, vision, tools’ can be seen throughout the model

- Compact – the Programme Board initial sign up and continued and renewed collaboration
- Vision – the articulation of a visual model
- Tools – many national, regional and local drivers come complete with their own tools in the form of quality frameworks, assurance processes and compliance directives

Engagement and listening was a key initial step in bringing on board the wider stakeholder group across SoTW. In the first 6 months in particular a lot of time and effort was dedicated to engagement events of all levels of stakeholder involvement to promote inclusiveness and understanding.

The continued engagement of all parties is of vital importance and cannot be underestimated.

A visual model, understood across multi-agencies and applicable to all aspects of mental health services was the primary ‘product’ of the initial phase of the Model of Care work.

Using a ‘structure, process, outcome’ approach, this has been achieved.
2. Structure
   a) Steps
   b) Pathways
   c) Access
   d) Cross-cutting themes
   e) Care packages & pathways

   a) The basic model structure describes 5 main ‘steps’ of care (Figure 1)

   ![Figure 1](image)

1. Emotional Health & Well Being – The DH publication ‘New Horizons: a shared vision for mental health’ (December 2009, ref 5a) puts an emphasis on improving the mental well being of the general population. This is the community part of life for the general population who require some support from time to time to keep their emotional health resilient. It is also of vital importance to those individuals who have a mental health problem and the basics of emotional well being form a key part of the recovery process. This is often in the form of support from family and friends and, increasingly, from a variety of community organisations.

   The South of Tyne & Wear Emotional Health and Well-Being Strategy (ref 5b) applies a local context to the New Horizons document, whilst specific groups within Gateshead, South Tyneside and Sunderland will be taking responsibility for the implementation of well-being recommendations at this level. It is likely that existing Local
Implementation Teams (LITs) and Partnerships, set up to oversee the National Service Framework ten years ago, will re-form to provide this local focus.

2. Primary Care – This step assumes the GP and primary care services are the first port of call for many ailments, mental health included

3. Shared Care – This is defined as ‘where more than one service is working collaboratively to meet the health and social care needs of the individual’.
   It is almost impossible to define shared care more specifically as it takes on a different meaning and emphasis depending on the needs of the individual.
   Using this definition, it is technically a ‘cross cutting theme’ (see later section for examples). However, it remains in the structure of the model as a step in the system as it defines a vital stage of care for those individuals requiring more complex input and/or for those on a recovery pathway

4. Secondary care – Usually a hospital referral or community treatment team referral for more specific treatment. This step is also where urgent care services are placed, i.e. where a crisis arises and emergency services are required

5. Tertiary care – required where an individual requires expert treatment of a specific nature. Tertiary services are high cost, low volume services, often available only regionally

b) The model then describes 3 ‘pathways’ within the steps (Figure 2)
Within the levels of care, there are three main recognised clinical pathways, as defined by the National Care Pathways & Packages Work (CPP, ref 6) which cut across the levels of care offered.

- **Common Mental Health Problems** – predominantly anxiety and depression and including, but not exclusive to, the national IAPT Programme (Improving Access to Psychological Therapies)
- **Psychosis** – psychotic disorders of varying severity, including those individuals who can be supported to live in community settings
- **Organic Mental Health** – predominantly, but not exclusively, dementia care services as defined in the National Dementia Strategy, including the development of memory clinics. Those individuals with organic mental health needs arising from other conditions would be considered in the clusters of care identified in this pathway

There are a number of specific conditions which are not instantly recognisable as belonging to one of the above groups, e.g. autism spectrum disorder, peri-natal conditions, eating disorders, to name but a few.

It is accepted that not every individual in need of mental health care will ‘fit’ neatly into a single pathway but most individuals will benefit from the specialist skills available in each of the pathway clusters. This is described further later in the document with the Care Pathways and Packages work.

c) Access points are then described (Figure 3)
Accessing services has long been considered a major issue with a strong view from service users, carers and providers that systems are unnecessarily complicated. Much debate has taken place across SoTW around a ‘single point of access’ being desirable. However, exploring this issue at length has led to the conclusion that a single point is no less complicated that multiple points – what is more desirable is a simplified, well-communicated system which ‘connects people’s needs to the services they require’.

This approach reflects the multiple ways in which people access physical health care and we would not wish to narrow choice.

It should be noted that the term ‘access’ is used here in its broadest sense. Whilst it defines traditional access to services via a referral, it also encompasses a referrer’s access to expert knowledge, e.g. a G.P. may be able to access expert psychiatry advice over the phone or via a specialist helpline without the need for a formal referral.

Within the Common Mental Health & Psychosis Pathways, the outcome of debate has been to aim for the establishment of 2 main access points, one at primary care level and the other at secondary care. Referrers are very keen to see a simple and clearly defined point of access for those in crisis. The words ‘crisis’, ‘complex’ and ‘urgent’ are frequently used interchangeably and GPs in particular would like to see crisis services extended to offer advice and signposting, 24 hours a day.

Clearly, the relationship between the teams at primary and secondary care levels is of crucial importance and work is in hand to facilitate improvements (see programme of work, section 7).

With the National Dementia Strategy (ref 7) comes the advent of memory clinics, designed to identify dementia at an early stage and offer suitable interventions quickly. The access point to these services should therefore, sensibly, be at the lowest possible level of need although this is not always possible. As such, access to dementia care services can, and will be, at all levels of care.

If it becomes apparent that the service user has alternative or additional needs to those originally identified, systems will need to be in place between all access point teams to ‘cross-refer’ to other pathways.
d) Cross cutting themes (Figure 4)

The Model of Care has identified a number of ‘cross-cutting’ themes which should be considered. Some of these themes are identified nationally and locally as having distinct pathways of their own (e.g. dual diagnosis or personality disorder). However, to keep the Model of Care as simple as possible, our approach has been to identify these issues as cross-cutting themes, and to consider their impact on individuals within the three main pathways.

There is some overlap in this section with the ‘process’ section as it is sometimes difficult to distinguish between theme and process. Where a particular subject sits is not important – of much more importance is its recognition and how it is addressed.

**Personality Disorder**

The paper ‘Personality Disorder, no longer a diagnosis of exclusion’ (ref 8) is a national approach to ensure individuals with a personality disorder were able to access mental health services in the same way as anyone else.

Since its inception in 2004, a number of regional strategies have emerged and the North East is no exception. Our regional approach is articulated in the paper (ref 9) which describes the services available for this client group. In addition, the emphasis of the paper is to offer skills to practitioners at all levels of are so that the needs of those with a personality disorder can be met alongside any co-existing condition. Service providers should refer to the strategy and use it accordingly to ensure any clients with specific needs in this area are treated appropriately.
Physical Health
Often overlooked in situations of mental ill health, physical healthcare is of vital importance, especially in some of the more vulnerable groups, e.g. those with a long-term mental illness, those in long stay in-patient facilities or individuals who are homeless.
Choosing Health (Ref 10) puts an emphasis on healthy eating, smoking cessation and screening for common conditions such as diabetes. For those individuals in the community who GPs find ‘hard to reach’, targeted services are being piloted across SoTW, funded by Public Health. Nurses are being specifically recruited to work with GPs to focus on those individuals who are Severely Mentally Ill (SMI), making sure information is up-to-date and that annual health checks and health promotion campaigns are available to this vulnerable group.
Within the Model of Care, this is a key theme to remind provider services to consider the physical health state of the individual in their care and be prompted to seek advice and input from the appropriate health care professional if there are concerns. Whilst this often forms a part of the initial basic assessment of an individual, it can be overlooked.

Equality & Diversity
This is a large and complex area and is best described as ‘ensuring that services are available equally to individuals irrespective of their race, gender, age, religious belief, disability or sexual orientation’. The Department of Health website on this subject gives a wide variety of information and links (ref 11)
Across SoTW, a Black and Minority Ethnic (BME) Mental Health Needs Assessment has been done and illustrates particular findings for this client group (ref 11a). Similarly, a health needs assessment is being carried out within the Lesbian, Gay, Bisexual and Transgender communities (LGBT) and is expected later in 2010.
Each service provider is expected to comply with this policy to ensure no individual is excluded from services for any of the above reasons. Individual organisations have their own Equality Impact processes and are expected to follow these as part of their own governance and adherence to the Mental Health contract requirements.

Suicide Prevention
It is recognised anecdotally and supported by regular audit findings nationally that an individual does not need to have a mental illness to be actively suicidal. However, more than 50% (ref 12a) of suicides in the area are by people with mental health problems and all service providers must be aware of this issue. It is a complex task to dictate one approach by providers to identify the individuals at risk as the range of skills and presenting problems varies enormously.
The Safer Care North East work identifies suicide as one of its key themes (ref 12b) and promotes the use of the NETS (ref 4) as an enabler to make the transformational change required of our services.
For the Model of Care purposes, each organisation providing services is required to ensure it applies its own suicide prevention standards and document these for each individual according to its own policies. As this is
directly linked to risk assessment, each organisation will have its own parameters of what it can and does address according to the competency levels of its workforce.

There is work ongoing to produce a Regional Suicide Reduction and Prevention Strategy and, as such, it is not appropriate for SoTW to create its own strategy. This work is expected to be available in the coming months (ref 13, contact information for further details).

Social Inclusion
This is a large and complex subject area covering a variety of aspects of social care. It is nationally recognised that people with mental health problems experience high levels of social exclusion ranging from housing problems to social isolation including bullying and harassment. Local Authority services across SoTW actively seek to address these issues across communities. Each Local Authority has a number of strategies (all with slightly different titles) which emanate from the national paper, Sustainable Communities Strategy (ref 14). Issues such as housing, debt, employment, benefit etc are specifically addressed through Local Area Agreements and can be accessed via each Local Authority website (ref 15).
The Bradley Report (ref 16) has highlighted a number of examples of poor social inclusion which impacts on the lives of young people in particular and New Horizons (ref 17) promotes the issues of social inclusion throughout.
The SoTW Mental Health Needs Assessment of 2009 (ref 18) makes specific reference to vulnerable groups.

Carers & Family
The words ‘carer’ and ‘family’ are often used interchangeably by people who can easily make assumptions that a carer is a family member and that a family member is automatically a carer. Whilst this can be the case, it should be noted that they can be quite different.
In recent years the role of carers in mental health services has become more recognised but there is still a lot of work to do.

Nationally, a carer is defined as someone who ‘spends a significant proportion of their life providing unpaid support to family or potentially friends. This could be caring for a relative, partner or friend, who is ill, frail, disabled or has mental health or substance misuse problems’ (ref 19.)

Across SoTW, each locality has a multi-agency approach to supporting carers and describes three main categories of carer

- the adult carer
- the parent carer
- the young carer

Early identification of young carers is vital. The document, ‘Recognising Young Carers, a guide for practitioners’ (ref 20, 20a) is helpful in understanding how caring can impact on young people in different ways.
Each Local Authority area has its own multi-agency approach to carers (ref 21) which gives comprehensive detail around strategies and describes how national and local policy has shaped its intentions in the coming years. It is recommended these documents be read for an excellent understanding of what is available in a particular area. Support for carers themselves is also vital.

In secondary care services, the NTW (Northumberland, Tyne and Wear NHS Foundation Trust) Carers’ Charter (ref 22) has also been well received and raises the profile of carers as a valuable part of the care and treatment of individuals. It also supports and signposts carers to access specific services with local authority partners where required.

In primary care settings, there is specific guidance for general practitioners and their teams on how to recognise and support carers (ref 23).

One of the key concerns raised frequently by carers and service providers is the thorny issue of confidentiality and information sharing. Legislation and service user confidentiality have often left professionals confused about what they can share and left carers feeling they are isolated and working in the dark.

Carers themselves recognise the difficulties this presents for all parties and have made some very sensible proposals about how this might be addressed (ref 24). Each organisation involved in the Model of Care work is asked to consider these proposals alongside its own governance arrangements.

**Learning Disability**

Valuing People Now (ref 25) is the latest document to set out a three year strategy for how best to improve care and support for those individuals with learning disabilities and their family and carers.

An excellent Green Light summary paper (ref 26) has been written for individuals with a learning disability to describe how mainstream mental health services should be available to them. The Green Light tool kit (ref 27) is a comprehensive document for service providers to assess themselves and take appropriate action to improve their services to meet the needs of people with learning disabilities. This document also details further useful information.

**Dual Diagnosis**

For many years individuals with alcohol or drug addiction problems have found it difficult to access services for any co-existing mental health problem.

Service providers have struggled to cope with the effects of addictions alongside a treatment package for mental health problems and all too often these individuals were excluded from services. Over the past eight months there has been a lot of work led by SoTW commissioners to address this problem and the Dual Diagnosis Commissioning Plan (ref 28)
sets out the desired direction of travel. Similar to the personality disorder approach, it is designed to offer skills to practitioners at all levels of service to recognise the problems and seek help where appropriate from specialist services to enable individuals to receive a comprehensive service.

If an individual is identified as having a co-existing addictions problem alongside their mental health problem, then the provider should refer to the commissioning framework, apply the tools therein and be able to access appropriate skills (if needed) to create a suitable package of care for the individual's needs.

The commissioning plan is comprehensive and cannot be described in detail here but is aimed at mainstreaming the necessary skills of staff into mental health teams so the service user needs are met more coherently.

**Organisational culture**

A key principle of the Model of Care work is to apply the tools of NETS (North East Transformation System, ref 4) where possible and a key component of NETS is the creation of a 'compact' between participants. It is recognised that NETS features predominantly in NHS organisations and other agencies will have their own transformation tools which are similar.

In NETS language, a compact describes the 'gives' and 'gets' of a relationship and crucially, unlike a traditional contract between parties, articulates the softer issues (e.g. respect, value, sense of worth) which are imperative in making a relationship work.

Much has been written on organisational culture and how to influence it but key in the Model of Care work is to have a basic understanding of it and acknowledge its existence.

As a cross cutting theme, it permeates everything we do whilst being difficult to articulate. Each stakeholder using the Model of Care is expected to consider its organisational culture (and sub cultures within it) and examine the impact it is having on its service provision.

**Veterans**

In recent years the media interest in veterans has risen substantially and the 2010/11 NHS Operating Framework (ref 29) makes specific mention of this group of individuals and their needs. Health Service Guideline HSG (97) 31 issued in December 2007 (ref 30) states what is expected regarding priority to mental health services for this group. As a cross-cutting theme, provider services should be aware of the service user’s background and apply the parameters of the guidance where appropriate.

**Shared Care**

This area is first described as a ‘step’ in the system of care and secondly as a cross-cutting theme. In fact, it is both.

To recap, shared care is ‘where more than one service is working collaboratively to meet the health and social care needs of the individual’.

It is almost impossible to define shared care more specifically as it takes on a different meaning and emphasis depending on the needs of the individual. For the purposes of the model, each service provider should
consider where it works with another service provider and/or carer and ensure the specifics of information sharing, partnerships, transitions and discharges are given due attention.

Workforce
It is out-with the scope of the Model of Care work to address the workforce issues experienced by all provider services. However, within the Model, there is a clear emphasis on holistic assessment and treatment of the service user and this is dependant on provider services being able to equip staff with the necessary skills and levels of competency to meet the demands of the role. Clearly not every service is expected to provide every skill; rather, every service is expected to recognise its skills and limitations and to either draw in specific areas of expertise as appropriate or ensure the service user’s needs are ‘connected with the services they require’ (a principle introduced in the access to services section).

Each individual organisation is required to examine its workforce issues within its own processes for service delivery. At this early stage, each organisation is expected to refer to the Model of Care to recognise interdependencies of services and skills so that proposed changes and developments can be directly ‘impact assessed’ on other parts of the system.

An obvious example of this is the national development of IAPT (Improving Access to Psychological Services) services which potentially could be taking skilled staff from one service area to enable another to work.

e) Care packages & pathways (figure 5, taken from the CPPP Mental Health Clustering Tool 2010, ref 31)
The national Care Packages and Pathways Project (CPPP) has defined three clinical pathways which have been used in the Model of Care work, namely, common mental health problems (or non-psychosis), psychosis and organic. Within each of these pathways, 21 clusters of need have been identified. The tool is lengthy and will be of limited interest to some stakeholders so only a summary is given here.

To illustrate where in the Model of Care these needs might be met, the clusters have been super-imposed onto the model to give some visual context (figure 6). This is not a direction of where needs WILL be met, but an indication of where they might most commonly be met.

Cluster 16 (dual diagnosis) is not shown within a specific pathway as the SoTW Model of Care assumes this is a cross cutting theme.

Clearly any individual can move up or down the steps of care as their needs increase or decrease. The CPPP document gives excellent indicators of when this should happen for each cluster and it is recommended that all service providers are aware of this work.

---

Figure 6
3. Process (Figure 7)

The Model of Care recognises that processes are of vital importance in ensuring the various parts of the any system work together. A number of processes have been identified where, historically, systems have failed and service users have not received the care they need. The list is by no means exhaustive but identifies the most common areas where issues arise.

There is some overlap in this section with the cross-cutting themes as it is sometimes difficult to distinguish between theme and process. Where a particular subject sits is not important – of much more importance is its recognition and how it is addressed.

Figure 7

Care Co-ordination/Care Management

These terms are sometimes used interchangeably in everyday conversation. Whilst they have many similarities in supporting an individual, they have one key difference regarding funding:

- The Care Co-ordination system, introduced in health care services in 1999 (ref 32) was designed to ensure individuals received continuity of care when they moved between services, across geographical locations or failed to attend for treatment.
• The Care Management system in local authority services which came from the 1990 NHS and Community Care Act (ref 33) gave the lead to local authorities to fund packages of care.

Clearly they are both of vital importance although each individual service user may, or may not, be part of either system depending on their individual circumstances.

Inclusion
This is very similar in fashion to social inclusion as a cross cutting theme and appears throughout the Model of Care. Too frequently individuals have been excluded from services with little or no alternative being offered. In today’s integrated health and social care systems there is a much greater emphasis on an individualised approach where a service is expected to deliver an individualised approach rather than expecting the service user to ‘fit’ the service. Recognising that there are always limitations to this in terms of skills and expertise available, the emphasis is on the service provider to liaise with other parts of the services to find a suitable alternative.

Referrals
Referrals tend to broadly fall into two main areas
1. referrals ‘up’ the system (e.g. from GPs to primary care mental health services (PCMHS) and from primary care to secondary care)
2. referrals between services at a similar level (e.g. from secondary care urgent care services to planned care services)

All service providers have criteria against which their service is offered and this is necessary to ensure the skills and competency levels are appropriate to the services provided. However, too often there has been lack of knowledge and lack of communication between service providers. Where an individual was felt to be ‘unsuitable’ for a service, the referral was sent back to its source and the referrer (often the GP) was left to play a guessing game as to where to go next.

The Model of Care aims to promote better understanding, better communication and better co-operation between service providers and referrers to ensure a referral is not simply passed around the system but gets to the most appropriate service as quickly as possible. To this end, a number of work programmes address this issue as standard when assessing their pathways, and options around a consultation model of primary care psychiatry are being discussed.

Transitions
Transitions between services should happen in a planned way (e.g. when one set of needs has been met and the service user would benefit from a longer period of rehabilitation or where a shared care approach would be appropriate in enabling the service user to return to primary care).
The emphasis in the Model of Care is on service providers co-operating with each other (across organisations and/or within organisations) to ensure smooth transitions and continuity for the service user.

**Partnerships**

An internet search of the word ‘partnership’ will give multiple definitions from legally binding contracts to an informal meeting for a cup of coffee. For the purposes of the Model of Care, it must be assumed that ‘partnership working’ relates to any situation where more than one agency is working together for the benefit of the service user and each other. Organisations will have their own governance which will dictate where a relationship needs to be formally defined and backed up legally. In other circumstances, it is part of the vision of the Model of Care partners across SoTW that they can work together collaboratively to bring about improvement in services.

This assumption should be tested regularly by organisations and the Model of Care Board where it seems there are blockages in collaborative working.

**Contracts**

Historically, NHS contracts have been about counting numbers but the new standardised NHS contact (ref 34), expected to be fully operational from April 2010, puts more emphasis on service descriptions, referrals, transitions, inter-dependencies between providers and outcomes – indeed, all of the things the Model of Care supports. There is a heavy emphasis on commissioners and service providers to work closely together to make massive improvements in this area.

For the first time ever, there is a built-in quality component (CQUIN – Commissioning for Quality and Innovation)) which allows commissioners to ‘withhold’ a percentage of payment until they are satisfied that the quality components agreed have been met. Clearly this is new to both commissioners and service providers but it is the start of a new approach to care provision which can only be of benefit to the service user.

**Personalisation**

In social care, the origins of personalisation are in the Transformation of Adult Social Care various documents (ref 35). This is a value-based approach which supports working with people on an individual basis. Direct payments, a specific part of the personalisation agenda, may be available to people with a mental health difficulty. People can be enabled to have increased choice and control over their life via a personal budget, accessed in the form of a direct payment, depending on the eligibility criteria of the specific local authority area in which they live. The Fairer Access to Care document (ref 36) gives full details of this and eligibility criteria can be found on each local authority website as it varies from place to place.

The summary document (ref 37) produced by Mental Health North East (MHNE) describes the system in a simple and concise manner. In addition, the National Mental Health development Unit (NMHDU) have produced a ‘Pathways to Personalisation’ website (ref 37a) designed to enable the
concept of personalisation to be simply applied across a range of mental health services and interventions
Many of the documents referenced in the Model of Care work have personalisation in its broadest sense as a key feature and, as a 'personal' approach would suggest, it is quite appropriate to mix and match elements of personal care planning from several organisations, to meet the needs of an individual.

Leaving Services
This may mean leaving a particular part of a service because a course of treatment has ended or indeed leaving formal mental health services all together as the individual no longer needs them. Leaving services has a lot in common with the transitions element of processes and the success of leaving services often depends on good communication and information sharing with the service user and carer.

4. Outcomes

Outcomes are described in two main areas (Figure 8)
- Those for services and organisations
- Those for individual service users and carers
As described in the ‘contract’ part of process, outcomes for mental health services have traditionally been around counting numbers of people in the service against the amount of funding invested. In more recent years, various standards of performance have been imposed on service provider organisations and the Care Quality Commission (CQC) now monitors both Health and Social Care organisations using a variety of monitoring tools (website reference 38).

Whilst of vital importance for organisations, the CQC does not in itself measure outcomes for service users. Outcomes from the ‘Recovery Star’ (ref 39) are far more relevant and commissioners in SoTW are piloting work in this area with some service providers. This will meet the quality component of the contracting process (outlined above) and provide a meaningful measurement of outcomes for service users. It is likely that each organisation will have its own CQUIN indicators (Commissioning for Quality & Innovation) linked to outcomes to reflect the type and scope of services provided. As the CQUIN part of the contract is worth 1.5% value of the whole contract, it represents a significant pressure for the service provider yet an excellent opportunity for all stakeholders to see service improvements.

5. How the model can be used

The Model of Care has multiple applications.

First and foremost, it is a ‘Model of Care’ quality framework that helps service providers assess and treat the individual based on clinical and social need, whilst paying due attention to the cross cutting themes, processes and outcomes to offer a holistic approach

It can also be

- A commissioning tool to allow commissioners to see the ‘big picture’ of what needs to be achieved, identify gaps and commission services accordingly
- A framework for service providers against which to describe their service and recognise the inter-dependencies and impacts of any service changes
- A high level visual guide for all stakeholders who can see ‘at a glance’ which part of the service they are interested in and go straight to that provider for more information
- A detailed description of mental health services which allows the stakeholder to understand the inter-dependencies of services and recognise the national, regional and local drivers behind the systems and processes
- A model for all stakeholders on which to map new developments, policy guidance etc. so everyone can see the impact and understand the implications
The application as ‘a commissioning tool to allow commissioners to see the ‘big picture’ of what needs to be achieved, identify gaps and commission services accordingly’ has led to the work programme identified in section 7.

There are potentially many further uses for this model which will only become apparent as it develops over the next few years and the language within it becomes commonly used by all stakeholders across SoTW.

Standards for the cross cutting themes and processes

Using a quality framework approach, the following table can be used to ‘check’ that basic standards are in place to address the cross-cutting themes and processes.

As this applies to all mental health services across SoTW it cannot be specific and some areas will not apply to some services (e.g. care co-ordination will not apply to primary care or voluntary sector services).

The use of this simple framework will prompt thought and complement the requirements of the Mental Health Contract.

<table>
<thead>
<tr>
<th>Cross-cutting theme/ process</th>
<th>Quality Standard</th>
<th>Key documents, where appropriate References in section 9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personality Disorder</td>
<td>Individuals with this diagnosis access the service</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Staff have competency levels appropriate to their level of involvement</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Service users have additional support from appropriate sources</td>
<td>Personality Disorder – no longer a diagnosis of exclusion. January 2003 (8)</td>
</tr>
<tr>
<td>Physical Health</td>
<td>Physical health screening is part of initial assessment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Service users are actively supported to address their physical health needs</td>
<td>Choosing Health. Making healthy choices easier. Executive Summary November 2004 (10)</td>
</tr>
<tr>
<td>Equality &amp; Diversity</td>
<td>Impact assessments are regularly carried out according to each organisation’s governance</td>
<td>Department of Health Website link (11)</td>
</tr>
<tr>
<td>Suicide prevention</td>
<td>Risk management plans are in place</td>
<td></td>
</tr>
<tr>
<td></td>
<td>There is evidence of sharing information across agencies to reduce risk</td>
<td>Safer Care North East – Patient Safety Framework (12b)</td>
</tr>
<tr>
<td>Social Inclusion</td>
<td>The social needs of a service user are assessed</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Appropriate services and assistance are signposted</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Care plans are ‘joint’ where appropriate and/or make reference to the social needs element of care</td>
<td>Sustainable communities in the North East, 2003 (14,15)</td>
</tr>
</tbody>
</table>
| Carers & Family | Carers have been identified  
Family members have been identified  
Carers are involved in care delivery as agreed  
Carers are aware of their rights to a carer’s assessment | Carers at the heart of 21st-century families and communities. June 2008 (19-24) |
| Learning Disability | Service users with a Learning Disability are being treated in the service  
Services have assessed themselves against Green Light toolkit  
Where gaps exist, additional services/skills are available elsewhere | Valuing People Now, Executive Summary, January 2009 (25) |
| Dual Diagnosis | Service users with a dual diagnosis are being treated in the service  
The dual diagnosis compliance filter is being used to meet need | SoTW Dual Diagnosis Commissioning Plan (28) |
| Organisational Culture | The organisation is engaged in transformational change or organisational development which can be described and evidenced | |
| Veterans | Service users are routinely asked if they are war veterans  
Service providers are aware of the complexities of this group | The Operating Framework for the NHS in England 2010/11 (29)  
NHS Health Service Guideline 31 (30) |
| Shared Care | Service providers consider other partners involved in the provision of the care package  
Documentation is clear about this. Information sharing is agreed and implemented | |
| Workforce | Staff have the competency level to meet the needs of the service user  
Other resources are available to assist | |
| Care Co-ordination | Service users have a care co-ordinator and a personal care plan | Effective Care Co-ordination in Mental Health Services (32) |
| Care Management | Service users have a care manager and a personal care plan | National Health Service and Community Care Act 1990 (33) |
| Inclusion | The social needs of a service user are assessed  
Appropriate services and assistance are signposted  
Care plans are 'joint' where appropriate and/or make reference to the social needs element of care | Transformation of Adult Social Care  
Fairer Access to Care – latest updated version from April 2010 (35,36) |
| Referrals | Services demonstrate good relationships with their main referrer(s)  
Where the referral does not seem appropriate for a service, an alternative is discussed and suggested without the need for 'bouncing back' to the referrer | |
| Transitions | Communication (verbal and written) is shared between all parties  
Contingency plans are agreed | Care Co-ordination (32) |
| Partnerships | Services work collaboratively with other agencies to meet service user need  
Where blockages arise, organisations work together to establish solutions  
Commissioners are involved in any major blockages which appear un-resolvable at an early stage | |
Contracts
Service providers are clear of their obligations under the Mental Health Contract Commissioners regularly review these contracts Issues raised by both parties are addressed in a timely manner NHS Contract 2010 (34)

Personalisation
The service user has a personal care plan The service user’s needs have been discussed and documented Appropriate input is available from other services to meet needs Direct payments are discussed with the service user and implemented where appropriate Personalisation – MHNE Summary (37)

Leaving Services
A clear discharge plan is written and communicated with all parties (service user, carer, GP etc) A contingency plan is known to all parties. Care Co-ordination (32)

Examples of achievements using the Model of Care collaborative approach

The work plan detailed in section 7 shows the major pieces of work which will be undertaken within the next 12 months. However, it is often the smaller changes which can make the biggest differences in transformational processes, and a number of smaller positive changes have already been agreed or have happened.

This is by no means an exhaustive list but gives examples at various points across the model to show

- What has been achieved
- Which organisations have been involved
- Which specific cross-cutting themes and/or processes have been addressed

IAPT Sunderland

NTW primary care services, Washington MIND, Sunderland MIND and Sunderland Counselling Services have agreed one common set of paperwork to be used for initial screening of anyone referred to their services. This will incorporate the new Sunderland IAPT service from autumn 2010.

In practice, it means the service user has a choice of where to access the service, but can be guaranteed the same basic information will be collected on initial contact. Irrespective of the level of need identified, this information will follow the service user and will not have to be repeated.

This is a unique agreement in a unique model for delivering IAPT services

Key themes: partnerships, communications, organisational culture, referrals, transitions
Dual Diagnosis
Over 400 mental health and substance misuse staff across SOT&W have received (alcohol) Brief Intervention training over the last 8 months. These individuals came from a variety of voluntary and third sector providers, as well as statutory agencies.
Concurrently, drugs and alcohol services’ staff have received mental health first aid training
This is part of the Dual Diagnosis Commissioning Plan across SoTW (to be fully ratified) and was designed to facilitate staff working to an integrated care pathway.

Key themes: dual diagnosis, integration, communications, referrals, partnerships, social inclusion

Embedding the MOC across SoTW
The Primary Care Review (ongoing) uses the Model of Care as its focal reference point
The Emotional Health and Well-Being Strategy refers to the SoTW Model of Care for its context whilst the detail in the Dual Diagnosis Plan ‘standards filter’ can usefully be applied to many of the cross cutting themes within the Model of Care.

Key themes: inclusion, communication, partnerships

National Dementia Strategy (NDS)
Whilst the NDS is a key part of the work plan for the coming twelve months, there has been good progress in many areas.
Joint commissioning strategies have been developed and are going to the PCT Statutory Boards in April 2009. A multitude of partners and stakeholders have been engaged in this work, demonstrating the competencies required for World Class Commissioning.

Key themes: partnerships, inclusion, transition, personalisation, contracts

Continued Engagement
The Model of Care Board consists of members from 26 organisations and stakeholder groups across SoTW and over 20 of them regularly engage with the Model of Care work, either through attendance at events or by email and telephone. This is a remarkable achievement and, to the knowledge of the Programme Board, is unique, certainly in the north east of England.
It is a credit to the input of these stakeholders that the Model of Care has progressed this far and we have the outputs described in this paper.

Key themes: partnerships, inclusion, organisational culture, equality & diversity, outcomes

New Horizons – the next ten years – local integration with the Model of Care
When the Model of Care was first initiated, Local Implementation Teams/Partnerships in each locality (formed as part of the National Service Framework, NSF, in 1999) were key stakeholders in the work (see diagram of key relationships on the last page of this booklet).
With the end of the NSF, the advent of New Horizons has led the existing groups to reconsider their future. Various options are currently being
considered in Gateshead, South Tyneside and Sunderland but an outcome from all three localities is that the Model of Care Board forms part of the governance arrangements across SoTW for the new groups. This explicit ‘sign up’ to the Model of Care work is a powerful message from these key groups.

6. Estates/Finance

Estates (summary)

The PrlDE project (Providing Improved Mental Health and Learning Disability Environments in Sunderland and South Tyneside) is the biggest estates issue in SoTW in the mental health arena at this time. A number of consultation processes have been carried out and stakeholders have been invited to participate in a variety of events around this project (ref 40).

At the Tranwell Unit in Gateshead, several ward moves and refurbishments are happening to upgrade existing accommodation and improve the environment for patient care. Work is expected to be completed here in autumn 2010.

In South Tyneside, Bede I and Bede II are undergoing refurbishment to improve the environment for service users and staff.

Community space continues to be in demand for various mental health teams and organisations to see service users. This is especially true in the primary care mental health teams where the advent of IAPT services has seen a welcome rise in the number of therapists in post, but an associated pressure to find suitable accommodation to house them and the new service.

In times of economic downturn and tight budgets, accommodation is at a premium. Challenges remain in finding accommodation in suitably accessible places which are acceptable by service users, but are not costly to use by provider services.

It is out with the scope of this paper to address the issues in detail but the principles outlined in the partnership working section should be applied where possible to maximise the benefit of accommodation to all parties concerned.

Finance (high level summary)

The Model of Care programme will ensure services provided are ‘efficient and cost effective: making use of benchmarking information to ensure we get the maximum benefit from the 100% of resources used to improve the health and well being of people with mental health problems’ (Programme Design Principle, page 3)

Comparing spend nationally is extremely difficult given the multitude of ways in which information is collected. Two sets of figures, whilst seeming comparative, can be very different. Please see the two examples below
a. SoTW spend on Adult and Older People’s Mental Health Services (NHS and Local Authority) 2009/10

Substantial financial resources are currently deployed across South of Tyne and Wear both from the NHS and Local Authorities to provide Mental Health services. The exact total spend is difficult to quantify as mental health appears as a function in numerous instances, e.g. within other health conditions, prescribing, and in social care situations. However there is an annual ‘mapping’ exercise conducted nationally which asks local areas to indicate spend across prescribed areas. This is linked to the LIT (local implementation teams) functioning and, until recently, was reflective of working age adults only. This has changed and now includes older people’s services. Results are compared nationally and comparisons made up to 2008/09 (ref 41).

The 09/10 submission (which includes older people) for the three localities in South of Tyne and Wear is summarised below:

<table>
<thead>
<tr>
<th></th>
<th>Gateshead £’000,000</th>
<th>S. Tyneside £’000,000</th>
<th>Sunderland £’000,000</th>
<th>SoTW Total £’000,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local Authority</td>
<td>2.8</td>
<td>5.1</td>
<td>6.2</td>
<td>14.1</td>
</tr>
<tr>
<td>NHS PCT</td>
<td>35.0</td>
<td>19.1</td>
<td>43.6</td>
<td>97.7</td>
</tr>
<tr>
<td>Total</td>
<td>37.8</td>
<td>24.2</td>
<td>49.8</td>
<td>111.8</td>
</tr>
</tbody>
</table>

N.B. Previous years’ comparisons may be for working age adults only.

b. SoTW NHS spend on all Mental Health Services (all age groups, NHS spend only) 2008/09

The NHS Programme Budgeting project provides a retrospective appraisal of NHS resources broken down into programmes. The project maps all NHS expenditure, including that on primary care services, to 23 programmes of care based on medical conditions such as mental health, cardiovascular disease and cancer (ref 42).

The 08/09 return for NHS South of Tyne and Wear spend on mental health services is summarised below

<table>
<thead>
<tr>
<th>Gateshead Gross spend £’000,000</th>
<th>% PCT total spend</th>
<th>S. Tyneside Gross spend £’000,000</th>
<th>% PCT total spend</th>
<th>Sunderland Gross spend £’000,000</th>
<th>% PCT total spend</th>
<th>SoTW Total Spend £’000,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>55.5</td>
<td>16.0%</td>
<td>40.4</td>
<td>14.18%</td>
<td>80.6</td>
<td>16.57%</td>
<td>176.5</td>
</tr>
</tbody>
</table>
Understanding where current resources are deployed across the model will be crucial to ensuring cost effectiveness. Work programmes within the SoTW PCT will be completed in 10/11 to

- fully disaggregate current ‘block’ contracts
- complete ‘rebasing’ of finance across PCT localities
- introduce ‘shadow’ currencies in line with the aforementioned Care Packages and Pathways project
- gain a full understanding of the 100% of resource currently available in mental health.

7. Work Programme & timescale for 2010

The full work plan for the Model of Care is reviewed monthly by the Programme Management Group.

In this work plan, several programmes of work are identified which will be the focus of attention during 2010/11. A programme can be defined in many ways, e.g.

- an identified step in the model (e.g. review of primary care mental health services)
- a clinical pathway (psychosis, dementia)
- a cross-cutting theme such as dual diagnosis

By being adaptive about the nature of a programme of work, the model can be ‘cut’ in a variety of ways to suit the identified need.

This is a summary of the key programmes for 2010.

<table>
<thead>
<tr>
<th>Key area of work</th>
<th>Summary of action</th>
</tr>
</thead>
</table>
| Review of Primary Care Mental Health Services – for all services within step 2 of the model (and into step 3), including IAPT | Awareness raising and agreed tool – Dec 09/Jan 2010  
Visit to services and tool completion – Feb to May 2010  
Concurrently, discussions taking place re. best practice and innovations to include a workshop for invited stakeholders on 5 March 2010  
Evaluation - July/ Aug 2010  
Recommendations to Board - Sept 2010  
Progressing well and on time to deliver from autumn 2010 |
| Key lead: SoTW commissioners                          |                                                                                                                                                                                                                      |
| Implementation of IAPT in Sunderland                      |                                                                                                                                                                                                                      |
| Review of Shared Care Services – for all combinations of services in step 3 of the model, including interfaces with primary and secondary care – a key component of several programmes of work | Applies to :-  
Primary care mental health service review  
Psychosis work  
Dual diagnosis  
Dementia strategy                                                                 |
| Review of Community Treatment Teams (CTT) in secondary care services including interfaces with shared care and primary care services – some work already done and in progress (using NETS approach) to be further developed | Pilot site in Sunderland NETS work is identifying ways to improve the current system whilst more major incremental work is being done to transform the way in which services are delivered in an integrated way |
| Key lead: NTW | Cross reference to the Psychosis work below |
| Continued development of the NTW internal work stream - now integrated into other work streams although still reporting separately to SoTW PCT | Improved use of Information Technology solutions for users and carers – scoping work Feb 2010 Engagement of GPs (Sunderland) – March 2010 onwards Scoping of good practice models – Feb 2010 onwards |
| Key lead: NTW and NHS SoTW | Cross reference to the CTT work above |
| Continued development of the Psychosis Pathway work | Clinicians’ workshops – January, June, July 2010 Focus groups – February/March 2010 Business case (first draft) for local memory services – April 2010 Data collection – to begin May 2010 Tender process (or alternative) - tba Implement memory clinics - latter half of 2010/11 |
| Key lead: NTW | Development of Memory Services in localities |
| Key lead: NHS SoTW | Local Authorities planning together to define their joint issues Introductory presentation to the Board in March 2010. Key workshops being planned for 2010 to educate other stakeholders in LA issues |
| Development of a wider awareness of the role of Local Authority work within the model of care leading to a fuller understanding to be articulated during the year | Re-provision of Sunderland in-patient services (PRIDE) – some delay in the expected option appraisal dates due to change of plans involving Easington area. |
| Key leads: LA Programme Management group representatives | Preferred option was expected March 2010 but now delayed. |
| Emotional Health & Well Being | Emotional Health & Well Being Strategy agreed February 2010 |
| Key lead: NHS SoTW Public Health | Local Action Plans developed March – Aug 2010 Implemented from September 2010 |
| Cross cutting themes – there are a number of these and the example of dual diagnosis is given here | Commissioning strategy finalised March 2010 Establish and fill 12-15 lead DD posts across SoTW by September 2010 Develop ongoing skills/competency training by September 2010 |
| Key lead: NHS SoTW | |
8. Glossary of terms

Most terminology is explained within the paper. These definitions are provided for additional clarity.

Access - For the Model of Care purposes the term ‘access’ means two main things:
- an entry to a service for assessment and/or treatment by a service user;
- a service provider being able to ‘access’ specialist advice from another team without having to make a formal referral.

Commissioning for Quality & Innovation (payment framework)
CQUIN - A compulsory part of the new Mental Health Contract which allows commissioners to link part payment of a contract to a specific quality performance indicator. If provider services do not meet the quality standard, the identified percentage of the contract is not paid.

Community Treatment Team (CTT) - This is a secondary care service made up of nursing, psychiatry, psychology, social work and occupational therapy professionals and support staff. Not all CTTs have all of these staff.

Cross cutting themes - In the Model of Care, cross cutting themes describe a number of diagnoses, disabilities or other life-influencing states which can and do impact on an individual’s needs. Where a service user has a mental health problem, these cross cutting themes usually make the condition more complex to address and, as such, need to be acknowledged and addressed as part of a holistic approach to care. In the past, some service users have been excluded from adequate mental health services because of their co-exiting learning disability or personality disorder, or because they cannot give an address if they are homeless. The Model of Care seeks to address this by providing prompts to constantly remind service providers of the complexities caused by these themes. Cross cutting themes are sometimes confused with processes – technically, it does not matter which category an issue fits into. It is much more important that the issue is addressed.

Emotional Health & Well Being (EHWB) - A key theme of New Horizons. This is the community part of life for the general population who require some support from time to time to keep their emotional health resilient. It is also of vital importance to those individuals who have a mental health problem and the basics of emotional well being form a key part of the recovery process. This is often in the form of support from family and friends and, increasingly, from a variety of community organisations. This is also known as Mental Health and Well Being.

Equality impact - Equality impact assessment is the process by which organisations assess their policies and practice to identify any areas where people may be adversely treated on the grounds of their gender, ethnic background, disability, age, religion, sexual orientation or different social group.
Improving Access to Psychological Therapies (IAPT) - This is a national initiative being implemented in phases across the UK. It aims to encourage and facilitate a more psychological approach to anxiety and depression in communities by increasing the number of therapists available at primary care level. It is tasked, amongst other things, to increasing the numbers of people who are sick with anxiety or depression returning to work or to the jobs' market.

It became operational in South Tyneside in October 2008, in Gateshead in October 2009 and is due to commence in Sunderland in October 2010.

Local Area Agreements (LAA) - The Sustainable Communities Strategy requires each local authority area to have LAAs to address issues such as housing, debt, employment, benefit etc. They can be accessed via each Local Authority website

Mental Health & Well Being (MHWB) - See Emotional Health and Well Being

Mental Health Contract - This is a new form of contract which applies to ALL providers of commissioned mental health services. It was tested in 2009 and becomes mandatory from April 2010. It is made up of 3 main parts, a service specification, a financial agreement and a CQUIN to agree quality measures

National Service Framework – NSF - mental health - A key document produced in 1999 which gave a ten year direction for the development of mental health services. It requires each local area to have a LIT (Local Implementation Team), a multi-agency group tasked with overseeing the implementation of the NSF recommendations. It has now come to an end and the new leading document is New Horizons (see references) also with a ten year plan.

Organisational culture - This describes the internal set of values and working practices which define an organisation. Over time this can change naturally, and can be encouraged to change more pro-actively. It heavily influences partnerships and collaboration, both positively and negatively, and cannot always be clearly recognised.

Partnership - In this document the term describes organisations working together in a collaborative manner for the benefit of the service user. It does not imply any formal or legal agreement although these may be required in some circumstances.

Project Initiation Document (PID) - This is the document which described the original aims and objectives of the Model of Care and gave it the direction to start in February 2009. It also described the resources available and the principles by which the model should operate. Although some changes to terminology have been made, and some key groups have changed their names, the vision of the PID can be seen in the model described in this paper.
PRINCE (Projects IN Controlled Environments) - A project management tool widely used in the UK in the public and private sectors.

Processes - A variety of procedures and methods designed to make systems work. In most cases, when things go wrong, the fault is in one or more of the processes.
Processes are sometimes confused with cross cutting themes – technically, it does not matter which category an issue fits into. It is much more important that the issue is addressed.

Programme Management Group PMG - The ‘steering group’, made up of senior representatives from a number of organisations, which oversees the work plan.

Recovery Star - A tool which measures progress for service users receiving support in order to increase independence or achieve other goals. There are several versions of the start available, depending on the service user’s needs.

Safer Care North East - The work of the North East Strategic Health Authority. It has produced a patient safety strategic framework for a number of services to facilitate change and continue to make improvements in the area of patient safety.

Shared care - Where more than one service is working collaboratively to meet the health and social care needs of the individual

South of Tyne and Wear (SoTW) - An area comprising Gateshead, South Tyneside and Sunderland primary care trusts and local authorities.

Transition - The process applies when an individual needs to move from one service to another because their needs have changed (e.g. from adolescent to adult services, from an in-patient ward to a community setting).

Veteran - This term refers to any individual who has served in the armed forces, irrespective of length of service or how recently or in the past that service was, but who is now a civilian.
9. References used in this document

1. National Service Framework for mental health, September 1999  

2. North East Strategic Plan for Mental Health 2008  
   http://online.gateshead.gov.uk/docushare/dsweb/Get/Document-
   22758/Item+05+-+Proposed+Strategic+Plan+for+Mental+Health.doc

   http://www.sotw.nhs.uk/content.aspx?id=698

4. North East Transformation System  
   http://www.northeast.nhs.uk/vision/nets/


   http://www.stpct.nhs.uk/content.aspx?id=2770

6. National Care Packages & Pathways Project  
   http://www.cppconsortium.nhs.uk/

7. Living well with dementia – a National Dementia Strategy February 2009  
   http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PoliciesAndGuidance/DH_094058


9. Regional PD Strategy – available in early summer 2010. For further information please contact Caris.vardy@nhs.net


11. Department of Health Equality and Diversity – several resources and links to other services  
11a. SoTW BME Mental Health Needs Assessment
http://www.stpct.nhs.uk/content.aspx?id=2770

12a. Suicide Prevention
NHS South of Tyne and Wear Audit of Cases of Suicide and Open Verdict, 2007 and 2008 (Non-confidential)
http://www.sotw.nhs.uk/content.aspx?id=698

12b. Safer Care North East – Patient Safety Framework
http://www.northeast.nhs.uk/what-were-doing/patient-safety/

13. Regional suicide prevention – expected spring/summer 2010. Contact Neil Johnson for further information neiljohnson@nhs.net


15. Local Authority Websites
http://www.southtyneside.info/
http://www.gateshead.gov.uk/Home.aspx

16. Bradley Report
Improving Health, Supporting Justice, November 2009

17. New Horizons (Inclusion initiatives)

http://www.stpct.nhs.uk/content.aspx?id=2770
(find the report at the bottom of this web page)


20. A Guide for Practitioners, Recognising young carers
The Princess Royal Trust, Sunderland Carers Centre
http://www.sunderland.nhs.uk/carers

20a. Young Carers Good Practice Guide
21. Local authority links:

Carers Strategy 2010-13 – Consultation February 2010 (Gateshead)

Carers Strategy 2008-11 (South Tyneside)
http://www.southtyneside.info/search/tempDocuments/tmp_41451.pdf

Recognising and Valuing Carers in Sunderland, 2009-25 (Sunderland)
http://www.sunderland.gov.uk/CHttpHandler.ashx?id=5713&p=0

22. Carers’ Charter, Northumberland, Tyne and Wear NHS Foundation Trust


24. Carers proposals SoTW
http://www.sotw.nhs.uk/content.aspx?id=698

25. Valuing People Now, Executive Summary, January 2009

26. Green Light

27. Green Light Tool Kit

28. SoTW Dual Diagnosis Commissioning Plan
http://www.sotw.nhs.uk/content.aspx?id=698

29. The Operating Framework for the NHS in England 2010/11

30. NHS Health Service Guideline 31
31. CPPP  

32. Effective Care Co-ordination in Mental Health Services  

33. Care Management - National Health Service and Community Care Act 1990  
http://www.opsi.gov.uk/ACTS/acts1990/ukpga_19900019_en_1

34. NHS Contract 2010  

35. Transformation of Adult Social Care  

36. Fairer Access to Care – latest updated version from April 2010  

37. Personalisation – MHNE Summary  
http://www.mhne.co.uk/pge.asp?id=40

37a. National Mental Health Development Unit – Paths to Personalisation  
http://www.pathstopersonalisation.org.uk/

38. CQC (Care Quality Commission)  
http://www.cqc.org.uk/

39. Recovery Star  

40. PrIDE  

41. National comparative spend on Mental Health services  

42. Comparative spend on programmes in the NHS  
http://www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/Programmebudgeting/index.htm
10. References not directly used but which may be of use

Our Vision, Our Future, June 2009
Our strategic vision for transforming healthcare services within the north east of England

Better Health, Fairer Health, Feb 2008
A strategy for 21st Century Health and Well-being in the North East of England
http://www.gos.gov.uk/nestore/docs/health/strategy/better_health_final.pdf

The Commissioning Friend for Mental Health Services, Dec 2009
A guide for health and social care commissioners

High Quality Care for All – the Journey so far, June 2009 (Lord Darzi)

World Class Commissioning

Building the National Care Service, White Paper April 2010
### 11. Programme Board membership

<table>
<thead>
<tr>
<th>Name</th>
<th>Position/Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>David Hambleton</td>
<td>Director Commissioning and Reform</td>
</tr>
<tr>
<td>Ian Holliday</td>
<td>Lead Commissioner LD / MH NE Cluster</td>
</tr>
<tr>
<td>Gail Bayes</td>
<td>Project Manager</td>
</tr>
<tr>
<td>Brendan Hill</td>
<td>Chair, MHNE</td>
</tr>
<tr>
<td>Ron Cullen</td>
<td>Advisor to SoTW</td>
</tr>
<tr>
<td>Michael Laing</td>
<td>Director, Adult Care and Housing, Gateshead</td>
</tr>
<tr>
<td>Sue Winfield</td>
<td>Chair, Sunderland TPCT</td>
</tr>
<tr>
<td>Brian Key</td>
<td>NE Director of Commissioning for MH and Disabilities</td>
</tr>
<tr>
<td>Vicki Taylor</td>
<td>Director of HR &amp; Organisational Development</td>
</tr>
<tr>
<td>Siobhan Jones</td>
<td>Communications Lead, SoTW</td>
</tr>
<tr>
<td>Brent Kilmurray</td>
<td>Commercial Director, SoTW Provider Services</td>
</tr>
<tr>
<td>Pat Harle</td>
<td>Non-Executive Director, Sunderland Teaching PCT</td>
</tr>
<tr>
<td>Alyson Learmonth</td>
<td>Sunderland Director of Public Health NHS SoTW</td>
</tr>
<tr>
<td>Yvonne Evans</td>
<td>SHA Head of Patient Safety</td>
</tr>
<tr>
<td>Dr Gillian Fairfield</td>
<td>Chief Executive Officer, Northumberland, Tyne and</td>
</tr>
<tr>
<td></td>
<td>Wear NHS Foundation Trust (NTW)</td>
</tr>
<tr>
<td>Dr Suresh Joseph</td>
<td>Acting Medical Director, NTW</td>
</tr>
<tr>
<td>Dr Steve Brown</td>
<td>Associate Medical Director, (NTW)</td>
</tr>
<tr>
<td>Yvonne Ormston</td>
<td>Director of Health Development and Modernisation,</td>
</tr>
<tr>
<td></td>
<td>Gateshead Health NHS Foundation Trust</td>
</tr>
<tr>
<td>Neil Revely</td>
<td>Director, Health, Housing &amp; Adult Services,</td>
</tr>
<tr>
<td></td>
<td>Sunderland</td>
</tr>
<tr>
<td>Jane Robinson</td>
<td>Head of Adult Services, South Tyneside</td>
</tr>
<tr>
<td>Gary O'Hare</td>
<td>Director of Nursing &amp; Operations, NTW</td>
</tr>
<tr>
<td>Trisha Doyle</td>
<td>Development Manager, Sunderland Headlight</td>
</tr>
<tr>
<td>Jan Pyrke</td>
<td>Gateshead Mental Health User Forum</td>
</tr>
<tr>
<td>Margaret Adams</td>
<td>South Tyneside Carers</td>
</tr>
<tr>
<td>Alisa Martin</td>
<td>Sunderland Carers' Centre</td>
</tr>
<tr>
<td>Joe Lewis</td>
<td>Gateshead Crossroads Caring for Carers</td>
</tr>
<tr>
<td>Martin Haskin</td>
<td>Chair CONSENSUS, South Tyneside</td>
</tr>
<tr>
<td>Dr. Johannes Dahluijsen</td>
<td>G.P. Liaison for SoTW commissioners</td>
</tr>
<tr>
<td>Dr Helen Pepper</td>
<td>G.P. Sunwest Cluster</td>
</tr>
<tr>
<td>Dr Peter Young</td>
<td>G.P.Gatnet Cluster</td>
</tr>
<tr>
<td>Dr Iain Gilmour</td>
<td>Sunderland Central PBC</td>
</tr>
<tr>
<td>Dr Roger Ford</td>
<td>Wearside PBC</td>
</tr>
<tr>
<td>Dr Matthew Walmsley</td>
<td>C7 PBC</td>
</tr>
<tr>
<td>Dr Anji Curry</td>
<td>Lead GP for Alliance PBC</td>
</tr>
<tr>
<td>David Robinson</td>
<td>Alliance NHS</td>
</tr>
<tr>
<td>Linda Coulson/</td>
<td>Sunderland Clusters x 3</td>
</tr>
<tr>
<td>Donna Bradbury</td>
<td></td>
</tr>
<tr>
<td>Ann Donnan</td>
<td>C7</td>
</tr>
<tr>
<td>Sam Hood</td>
<td>Gatnet</td>
</tr>
</tbody>
</table>

Light grey print denotes key leads in GP areas. Some attend Boards where possible.
### 12. Programme Management Group membership

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Role in the PMG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ian Holliday</td>
<td>SOTW Lead Commissioner</td>
<td>MOC Programme Director</td>
</tr>
<tr>
<td>Gail Bayes</td>
<td>MOC Project Manager</td>
<td>MOC Project Manager</td>
</tr>
<tr>
<td>Lynn Bradford</td>
<td>SOTW commissioner</td>
<td>Lead for IAPT and partnerships/LITs (Gateshead &amp; S/T) and services for carers.</td>
</tr>
<tr>
<td>Michelle Turnbull</td>
<td>SOTW commissioner</td>
<td>Lead for IAPT and partnerships/LITs (Sunderland)</td>
</tr>
<tr>
<td>Mike Brown</td>
<td>SOTW commissioner</td>
<td>Lead for service mapping and dual diagnosis</td>
</tr>
<tr>
<td>Alan Cormack</td>
<td>SOTW commissioner</td>
<td>Lead for diversity &amp; Commissioning Lead for LD</td>
</tr>
<tr>
<td>Graham King</td>
<td>LA Commissioner (Sunderland)</td>
<td>Strategic Lead for Mental Health</td>
</tr>
<tr>
<td>Sharon Lowes</td>
<td>LA Commissioner Sunderland</td>
<td>National Dementia Strategic Lead</td>
</tr>
<tr>
<td>Sheila Lewis</td>
<td>LA Commissioner (S Tyneside)</td>
<td>Strategic Lead for Mental Health</td>
</tr>
<tr>
<td>Rosemary Wilson</td>
<td>Assessment (Gateshead LA)</td>
<td>Mental Health Lead</td>
</tr>
<tr>
<td>Michael Brown</td>
<td>Commissioning (Gateshead LA)</td>
<td>Commissioning Lead</td>
</tr>
<tr>
<td>Steve Brown</td>
<td>Associate Medical Director, SOTW, NTW</td>
<td>Lead for link to MOC from NTW internal Service Improvement work</td>
</tr>
<tr>
<td>Paul Bamber (or deputy)</td>
<td>NTW Divisional Manager</td>
<td>Lead for the SIT work in CTTs</td>
</tr>
<tr>
<td>Wendy Kaiser</td>
<td>National Dementia Strategic Lead SOTW</td>
<td>NDS Lead and older people’s MH link across SOTW</td>
</tr>
<tr>
<td>Catherine Mackereth</td>
<td>Public Health SOTW</td>
<td>Lead for the MH Public Health Strategy</td>
</tr>
<tr>
<td>Liz Allan</td>
<td>PPI Lead SOTW,</td>
<td>PPI Lead</td>
</tr>
</tbody>
</table>
13. Model of Care - Key Relationships as described in the Project Initiation Document, December 2008

**Mental Health Model of Care Programme South of Tyne and Wear**

**COMMISSIONERS**
- Local Authority Cabinet/Committee
- GATEHEAD SOUTHWYNDLES SUNDERLAND
- NHS South of Tyne and Wear Commissioning Board
- ME Commissioning Collaboration MODEL

**PROVIDERS**
- Primary Care Providers
- General Practitioners
- South of Tyne and Wear Foundation Trust Board
- Gatedhead Acute NHS Foundation Trust Board
- Third Sector/Independent Providers

**ACCOUNTABILITIES**

**PROGRAMME BOARD**
- Programme Director / Project Manager
- Project Management Group

**TASK GROUPS**
- Service Models: To map existing services, identify gaps in services, and produce service models and options for discussion/consultation including workforce implications
- Finance & Estates: To map existing expenditure and set out the financial framework, and cost the workforce/estates implications emerging from the service models and options
- Communications: To produce a range of materials that will support the consultation, establish feedback and response mechanisms, and manage any consultation processes

**DESIGN PRINCIPLES**
- Safe services: built on best practice; are service user and carer focused; support social inclusion; work in partnerships; are local, timely and equitable; and are efficient and cost effective.
14. Key documents and their relationship to the Model of Care work