Southern Health NHS
NHS Foundation Trust

ADULT MENTAL HEALTH SERVICE REDESIGN

DRAFT CASE FOR CHANGE

Implementing the Joint Commissioning Strategies for Adult Mental Health in Hampshire

For presentation to the Hampshire Overview & Scrutiny Committee on 26 July 2011

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1. Executive Summary

On 1 April 2011 Hampshire Partnership NHS Foundation Trust merged with Hampshire Community Health Care to form Southern Health NHS Foundation Trust. As well as providing mental health, social care and learning disability services across Hampshire and Southampton, the new Trust will also provide for the physical health care of the Hampshire population.

Southern Health NHS Foundation Trust (SHFT) Adult Mental Health (AMH) Division has been engaging with a wide range of stakeholders across Hampshire and Southampton to identify ways of improving services for local people in order to develop a set of proposals for service provision over the next three years. The Division provides specialist mental health services for adults of working age who experience severe and enduring mental health problems, which cannot be managed effectively within primary care alone.

The Case for Change sets out proposals which reflect the respective Joint Commissioning Strategies for Hampshire (in draft) and Southampton as well the national strategy 'No health without mental health' launched by the Coalition Government at the beginning of 2011. They build on developments over a number of years to deliver more care closer to home, and as such represent the next stage of a journey which began some years ago.

Our vision for these services is to maximise independence, choice and recovery, through the provision of high quality, meaningful and timely signposting, assessment, care and treatment.

The key themes of our proposals are:

- To embed a culture of recovery within our services
- To strengthen community services for those who present with complex needs by simplifying care pathways and focusing on interventions which deliver clear outcomes
- To strengthen 'Hospital at Home' services
- To reduce reliance on acute inpatient care
- To deliver better value for money

In order to strengthen opportunities for people to receive care in their own environment and develop pathways in line with the Joint Commissioning Strategies, a shift of investment is required. The funding required to support these developments is proposed to be released from resources currently allocated to acute inpatient and reablement services. These are services which aim to support people to regain skills they have lost as a consequence of severe mental illness, or as a result of spending a prolonged time in hospital services. This means that the proposals include a reduction in inpatient beds, the savings from which will, in part, be re–invested in alternatives to hospital, and in part, contribute to the cost reductions required within the local health and social care economy.

Implementation of the proposals will be on a phased basis in order to ensure service continuity and safety, resulting in a transitional period of 'double-running' as the new model replaces the current model.

Purpose of the Case for Change

The purpose of this Case for Change is to describe the proposed AMH service pathway, the rationale for it, its benefits and its costs. It will also set out the involvement of key stakeholders in formulating the service pathway.

2. Introduction and Overview

2.1 The overarching aim of SHFT is to improve the health, wellbeing and independence of the population it serves. To deliver this aim we have the following key strategic goals:

2.2 The Case for Change describes how we will deliver these goals by making our services more flexible, better able to respond to service users' individual needs and those of their carers. We have already started to change our adult mental health services in the community so they are easier for service users to access. Assessments are of high quality and are not duplicated, and our staff have the right skills to provide the right help at the right time. We want to progress this change and take the opportunity to get the balance right between our inpatient and community services.

2.3 The detail of these changes has been developed with the engagement and involvement of GPs, service users and carers, staff and a wide range of local stakeholders. We value the role of primary care colleagues in managing the majority of people who present with mental health needs. We want to strengthen our specialist support to primary care for those people with more complex needs and so have paid particular attention to their consistent feedback and frustration with multiple access points and unresponsive out of hours interventions.

2.4 We are building a thriving future for community mental health care, and are looking forward to creating a service that provides the best possible outcome for our service users. Alongside these developments, we want to improve the services that we provide for our most unwell service users who have intensive needs during acute phases of illness.

3. Background and Strategy

3.1 There has been a plethora of guidance and national policy regarding the direction of adult mental health services. The national service framework (mental health) provided a platform for substantial change within specialist secondary care services for adults with mental health needs. Over the past decade the national service framework (NSF) heralded the change from

traditional institutional bed based services to strengthened community based services. A new national strategy '*No health without mental health*' was launched at the beginning of 2011 building on the substantial change that the NSF initiated.

3.2 This strategy provides us with new opportunities to tailor local services to the needs of local communities. We now have more flexibility to respond to feedback from people who use and work in our services. We want to build on the work we have been doing over recent years to further enhance our services, offer more options for care at home, more choice, more support for carers and better access to care and treatment when it is needed. We need to achieve this within a reduced financial envelope by making more efficient use of our resources.

3.3 This Case for Change represents the implementation of the respective Joint Commissioning Strategies for Hampshire (Draft) & Southampton (Final).

The key local commissioners (health and social care) priorities which reflect national guidance include:

- **More people will have good mental health -** More people of all ages and backgrounds will have better wellbeing and good mental health. Fewer people will develop mental health problems – by starting well, developing well, working well, living well and ageing well.

- **More people with mental health problems will recover -** More people who develop mental health problems will have a good quality of life – greater ability to manage their own lives, stronger social relationships, a greater sense of purpose, the skills they need for living and working, improved chances in education, better employment rates and a suitable and stable place to live.

- **More people with mental health problems will have good physical health -** Fewer people with mental health problems will die prematurely, and more people with physical ill health will have better mental health.

- **More people will have a positive experience of care and support -** Care and support, wherever it takes place, should offer access to timely, evidence-based interventions and approaches that give people the greatest choice and control over their own lives, in the least restrictive environment, and should ensure that people's human rights are protected.

- **Fewer people will suffer avoidable harm -** People receiving care and support should have confidence that the services they use are of the highest quality and at least as safe as any other public service.

- **Fewer people will experience stigma and discrimination -** Public understanding of mental health will improve and, as a result, negative attitudes and behaviours to people with mental health problems will decrease.

3.4 As the main provider of mental health services in Hampshire, SHFT has a significant role in ensuring this strategy for working with people with specialist mental health needs becomes reality for service users and staff, in response to commissioning requirements at local and national levels. The AMH Division has worked with key stakeholders including commissioners, service users, carers and staff to develop this set of proposals, which represent our clinical strategy for service provision over the next three years. See section 15 for more details on engagement.

3.5 We are seeking to take a phased approach to the development of our new model and ways of working. The proposals for redesigning services set out in this document describe how we intend to do this

4. Scope

4.1 The key themes of our proposals are:

- To embed a culture of recovery within our services, which promotes choice, opportunity and independence as the basis for individual recovery
- To strengthen community services for those who present with complex needs by simplifying care pathways and focusing on interventions which deliver clear outcomes
- To strengthen 'Hospital at Home' (home treatment) services, offering a greater range of alternatives to admission
- To reduce the reliance on inpatient care for people with acute needs
- To deliver better value for money by becoming more efficient in our resource use

5. National and Local Context

5.1 Commissioners Joint Strategic Needs Assessment outlines the current population and demographic needs in relation to mental health within Hampshire.

Patterns of recorded mental illness prevalence in Hampshire were assessed using QOF (Quality and Outcomes Framework) data.

The prevalence data shows that mental illness rates across Hampshire are just below the national prevalence of 0.7% except for Havant, Rushmoor and Gosport where figures are in line with the national prevalence. In 2009, we had 38,608 people with a psychotic or personality disorder and a predicted increase to 39,102 by 2020

The numbers of people with psychotic illness, most of whom will need some care from secondary mental health services at some point is much less than the number of people with neurotic illness. Many of the latter will never seek help from any statutory service; many will be treated by primary care services and some with more complex problems will be treated in secondary services. This demonstrates that there is the need for a wide range and quantity of services to help people with varying complexities of need.

Women are more likely to experience common mental health problems such as depression and anxiety – around 20% of women at any one time compared with about 12.5% of men. Half of all women and a quarter of men will be affected by depression at some time in their life and l5% experience a disabling depression. Men have higher rates of suicide and addictions. Physical health affects our mental health, and vice versa. The most mentally healthy people also have the lowest rates of cardiovascular disease.

5.2 Nationally during 2009/10 over 1.25 million people used NHS specialist mental health services delivered in the community as well as in hospital. This represented a rise of 4.0 per cent on 2008/09.

5.3 Nationally over 90 per cent of the people who used services did not spend any time as an inpatient during the year but received their care outside of hospital (reference ONS website)

5.4 For the 8.5 per cent who used inpatient services, the proportion of voluntary patients fell by 6.6 percent in 2009/10 whilst those being compulsorily detained in hospital under the Mental Health Act rose by 30.1 per cent. These figures suggest that NHS inpatient services are increasingly used to care for and manage people who pose a risk to themselves or others.

5.5 SHFT has worked with two independent organisations, the Audit Commission and Consilium Consulting, to benchmark its adult mental health acute care services against the national position. Nationally some mental health trusts provide between 15-18 adult acute and PICU beds per 100,000 population and deliver good or excellent standards of care (using regulator measures). Services provided by SHFT use 28 AMH acute and PICU beds per 100,000 population. Common features of the services in the high-performing Trusts include an integrated approach to the provision of inpatient and 'hospital at home' care.

5.6 Data provided through Consilium Consultancy shows SHFT has an acute admission rate of 221 per 100,000 population compared to below 150 in other Trusts. In addition our acute and PICU combined average length of stay is 51 days (including leave) compared to below 30 days (excluding leave) in other Trusts.

5.7 More detailed analysis work commissioned from the Audit Commission, undertaken through an inpatient census, showed that bed usage appeared to be influenced by factors other than population need, such as the availability of alternatives to admission and clinical practice.

5. Currently a disproportionate amount of our resources is focused on inpatient services providing for a small percentage of the population. An example of this was shown by our recent Payment by Results work which has shown that 9% of our service users take up 52% of the total cost of our services, while 91% do not require inpatient care and use only 48% of the cost. Reallocation of these resources will provide improved access and strengthened community services.

6. Case for change

6.1 AMH services have been evolving over recent decades as our understanding of the wide-ranging causes and management of mental ill health has developed. Increasingly, service users expect to receive care which is tailored to their needs and offered in the least restrictive setting possible.

6.2 The ten years of the NSF for mental health, saw the growth of specialist functions within dedicated teams in the community. These functions covered Crisis Resolution and Home Treatment, Assertive Outreach and Early Intervention in Psychosis.

6.3 We have also integrated our mental health and social care provision very successfully, and in the last two years, we have seen new primary care services established under the national initiative called *Increasing Access to Psychological Therapies*. In Hampshire approximately half of the county is covered by 'italk' and 'Talkplus' which are services that provide access to Psychological Therapies. There are plans for expansion in 2011/12.

6.4 We have made significant progress in developing high quality recovery-focused practice and are committed to embedding a recovery culture at all levels of the organisation. As a result we have been selected as one of six national pilot sites for the ImROC Project (Implementing Recovery - Organisational Change) which will help to improve the quality of our services, supporting service users to lead meaningful and productive lives. ImROC was launched alongside the new national strategy and is seen as a significant vehicle in the delivery of a transformation in modern mental health care.

6.5 Throughout this period our learning has grown and our workforce has developed evidence-based skills which were limited in the past. However, as these services were established across England there was not a fundamental review of the way in which the total community pathway operated. Instead, new teams were 'bolted onto' the traditional Community Mental Health Team (CMHT). As a result, we receive feedback that pathways are complex, assessment is duplicated, flow is inhibited, and the culture is one of maintenance, not recovery. While we have seen many benefits over recent years, we have an opportunity to answer two fundamental questions – what are we here to do, and how best can we do it?

6.6 As described in section 5, benchmarking our services demonstrates that our lengths of stay and rates of admission locally are higher than average based on national statistics. This is reflected in the current investment in bed-based services. We have been engaged in a gradual process to reduce beds over recent years and with a significant shift in 2006 through the 'Moving Ahead' initiative. We are now preparing to move to a substantial shift in our acute care pathway in which we propose a reduction of circa 30% (c50 acute beds) across Hampshire and Southampton, alongside a significant growth in our capacity to treat people at home .

6.7 Our acute care proposals are based on a reinvestment of approximately a third of the total savings. The reinvestment will be targeted at strengthened Hospital at Home capacity, in the form of staff, intensive day support, accommodation support (discharge facilitation), support for carers and flexible crisis budgets.

6.8 The overall cost of our mental health services demonstrate that we provide value for money and are committed to using reinvested funding to best effect.

7. Current service provision

7.1 AMH services in secondary care in Hampshire are organised around three geographic areas (East, North and West Hampshire respectively).

7.2 The services are currently configured into Community Mental Health Teams (CMHTs), separate Assertive Outreach (AO), Crisis Resolution and Home Treatment (CR&HT) and Early Intervention in Psychosis (EIP) teams. In addition acute inpatient care and residential rehabilitation services are provided from a range of sites across the three geographical Areas.

Full details of the above services are contained in **Appendix 1.**

8. Current Investment

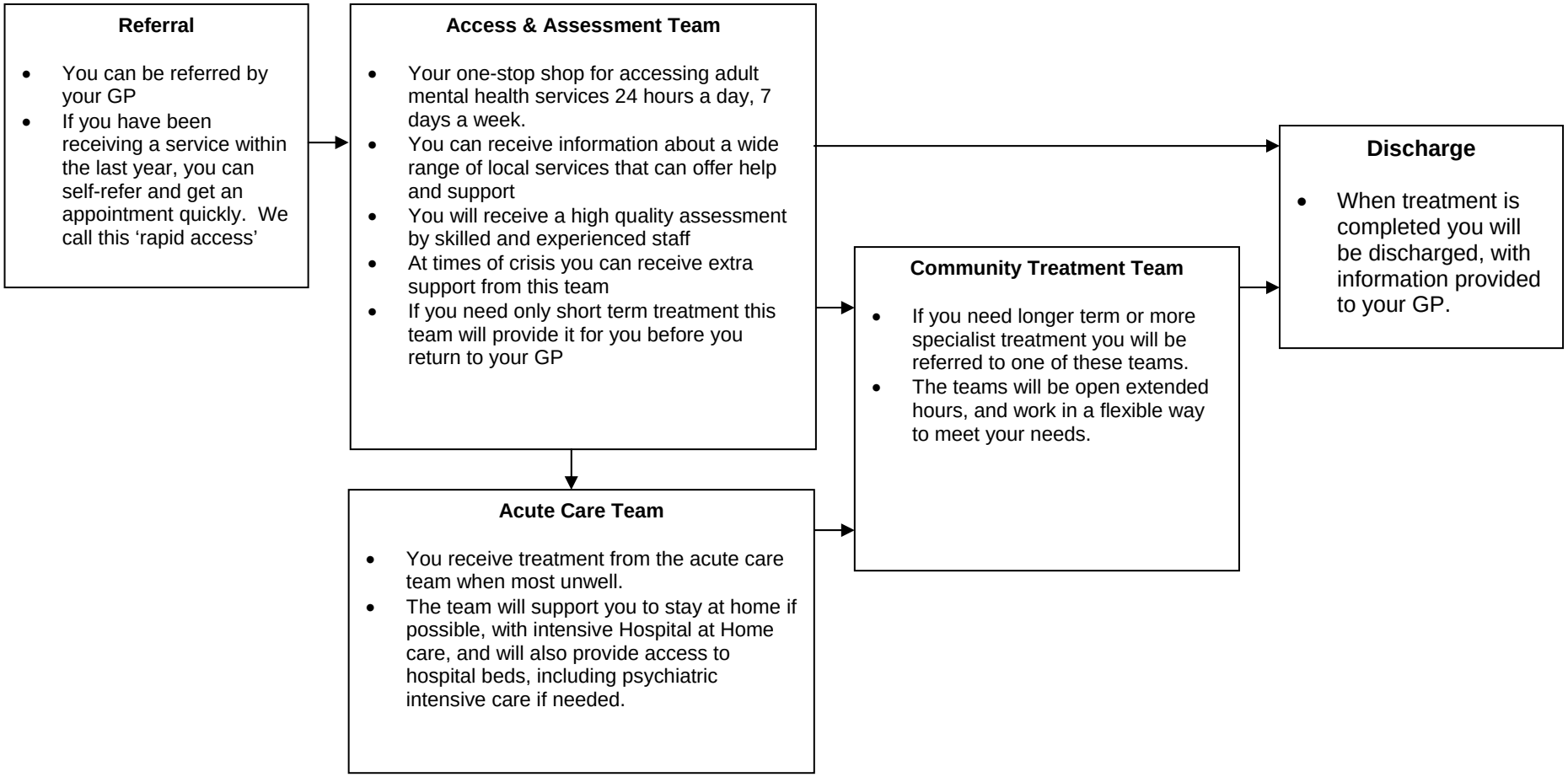
SHFT has a block contract with NHS Hampshire which funds a significant proportion of mental health services provided by the Trust. NHS Southampton City is the other major commissioner. A small proportion of income is received from other local commissioners. Each year, indicative levels of investment are estimated across individual services and these form part of the contract documentation between SHFT and commissioners. The analysis of indicative investment in AMH in-patient services in Hampshire is summarised below, based on contract income received in 2010/11.

	NHS Hampshire £m
North Area	4.2
West Area	5.5
East Area	7.3
South Area	2.2
TOTAL	19.2

9. Proposed model of care

9.1 Our vision for adult mental health services is to maximise the independence, choice and recovery that service users and carers experience through the provision of high quality, meaningful and timely signposting, assessment, care and treatment.

The diagram below outlines the proposed AMH Service Pathway for secondary care:



9.2 Across Community, Acute Care and Reablement services the following is proposed:

Community Services Pathway

The key features we are designing into the way our AMH community services work are:

- A **single point of entry** into local service pathways. This will offer a single 'one stop shop' that will offer the full range of services currently provided by separate teams. This will include crisis resolution.

- A **core assessment** undertaken by appropriately skilled practitioners as soon as a Service User enters the service. This core assessment will act as a 'passport' around the system of care. It will be regularly reviewed but will only be updated when there is value in doing so. This means an assessment will not take place at every point in the system or pathway if it is not needed and be driven by the Service Users' needs.

- An **integrated community service** does not mean that the Community Treatment Teams will simply absorb the specialist functions or that they will be lost or diluted. We are going back to the drawing board to make sure we are clear about the purpose of the integrated community service so that it is fit to cater for all specialist needs.

- **Personalised and recovery focused care**. We will work with our staff to make sure they support Service Users to make the best use of self directed support and embrace the notion of the Service User as the 'expert' in their care.

- Systematic **planning and management** of the work our staff do to make sure Service Users are always receiving the support they need from the most appropriate person, in line with their identified needs. This will be instead of the more traditional 'just in case' approach to care.

- **Rapid access** to care, especially for those who have used our services before.

- Partnership working with **carers**, involving them in the assessment, treatment and recovery process

- **Closer working** with other care providers, including GPs, Practice Nursing, District Nursing, Health Visiting and IAPT (Improving Access to Psychological Therapies) services. We will also look for opportunities to share our bases with existing primary care and community services.

Implementation of these changes will deliver these benefits:

- Improve the quality of assessment that will ensure people access the services they need when they need them
- Provide a standardised approach, reducing unjustifiable variation in practice and outcomes
- Break down the difficulties caused by having several services running independently of each other to ensure that service users can move easily through services in the pathway in line with their needs

- Improve choice through the increased use of personal budgets
- Bring mental health services into the mainstream, reducing stigma and improving life outcomes for people who have mental health needs

9.3 Acute Care Pathway

The acute care pathway will comprise:

- Acute inpatient services
- 'Hospital at home' services (home treatment)

Other services which have a significant interface with the acute care pathway are:

- Psychiatric liaison services – as part of the crisis resolution and home treatment services in Winchester and Basingstoke. They provide specialist mental health assessment and signposting in general hospitals, with a particular focus in Emergency Departments
- Criminal justice services (Police, courts etc). This includes provision of hospital-based places of safety under Section 136 of the Mental Health Act, which are now in place across all areas and hosted by AMH.

The home treatment part of Crisis Resolution and Home Treatment teams will join the inpatient services to deliver a more integrated model of acute care, with the potential for staff to work both within the hospital and in service users' own homes. The acute care team will deliver a pathway that will consist of beds in wards, places in intensive day care services and 'virtual beds' with treatment delivered in the individual's home or alternative community setting. There will be some flexibility about how these resources are used, so that the care delivered is matched to need and choice of the service user.

Providing alternatives to inpatient care (both for acute and reablement services) is a priority for us as we do not want to treat people in the restrictive environment of a hospital ward any longer than is necessary. We are very aware of the feedback from service users that this is something they want us to address, and of the concern by staff, service users and carers that hospital admission may cause service users to lose their independence and make social problems associated with being separated from friends and family, as well as issues with housing and work, harder to tackle.

Work has already begun on a number of initiatives to prepare the acute care system for the changes we are proposing and to test out what works:

- Intensive day support to people with acute needs in the New Forest and Eastleigh
- Better crisis planning in collaboration with service users in East Hampshire
- Better support for people leaving hospital, in partnership with our social care provider, TQtwentyone, in East Hampshire
- The Discharge Facilitator role in North Hampshire; a dedicated role which works towards discharge from the point of admission. The role and functions it provides are extremely flexible and dedicated to providing whatever package is required working closely with housing and community teams, to ensure a smooth and appropriate discharge
- Pilot of the 'hospital at home' in Southampton
- Mobile working in our home treatment teams, allowing electronic patient records to be accessed easily in community settings around the clock

- Use of flexible budgets to aid crisis planning
- Working in partnership with Solent MIND through a specific initiative to be launched in the summer. This will review the needs of carers, and ensure that practitioners consider carer and family needs to be 'their business'
- Development of clinical care pathways to standardise assessment and treatment, which is based on evidence and best practice. This has started with Borderline Personality Disorder where we know that our practice is not consistent for these services users during their acute illness. We are planning shortly to develop a psychosis pathway
- Practice development amongst a wide group of acute care staff in relation to managing risk effectively and with a recovery-oriented approach
- ImROC pilot pathways within AMH, to tackle the cultural challenges and embed recovery-orientated practice across the system.

9.4 Reablement Services

Reablement is a new term for rehabilitation in adult mental health care which is being adopted across the country. We recognise that this term is used in a physical care context as well and so we are still considering whether this is the right term for our pathway, and gathering views through engagement work to do this. Reablement services aim to support people to regain skills they have lost as a consequence of severe mental illness, or as a result of spending a prolonged time in hospital. Traditionally these services have been delivered in inpatient units, but increasingly these are now via community based services. More specialist teams, such as Early Intervention in Psychosis teams and Assertive Outreach teams adopt a reablement approach to working with service users.

We are proposing to offer a more flexible approach to the delivery of reablement services so that it can offer more choice for the individual, and move away from a 'one size fits all' approach. This will include developing and enhancing some existing services and units, and closing one unit (Copper Beeches) located in New Milton.

Across the county we have had success by gradually moving away from traditional residential rehabilitation services to community teams working in partnership with other organisations to provide support for people in their homes. We still have some inpatient reablement beds but these are now focusing on helping service users to prepare to live in their own home, be it in private or independent accommodation or supported housing. We want to continue to build on the success of this approach.

Hollybank, a 14 bed unit located in Havant, currently provides care and treatment for people who require complex reablement interventions. The unit is now seeking ways to broaden the service it provides so that it is able to meet a greater level of reablement need, for example working with people who are moving on from low secure care. This will allow us to make better use of the current bed capacity and ensure that service users are more able to receive their care locally.

10 Proposals for Acute Care Pathway

10.1 We will strengthen our 'Hospital at Home' (home treatment) services through an area-wide team working closely with the acute inpatient service, which together will form the acute care pathway. Staff will work more flexibly across both elements of the pathway. The proportion of beds in hospital versus home will shift over 12 months in a phased way. The acute care pathway will include a range of support which the teams can deploy, including intensive day

support, accommodation and discharge facilitation, and flexible budgets for home treatment packages.

10.2 East & West Areas

We have two inpatient units in the East and two in the West. We are proposing to maintain acute beds in both the East and West but withdraw from one inpatient unit in each area and actively seek an alternative (NHS) use for these facilities.

10.3 West Area

We propose to strengthen the community reablement service looking to develop alternatives to residential support for those people who need a longer period of time to develop confidence and skills of daily living. Over time, the need to retain our current rehabilitation facility (Copper Beeches) in the New Forest will reduce. This building is not owned by the Trust, we therefore propose not to renew the lease on this property in 2012/13.

10.3 Southampton

We propose to change the use of ten beds in the new purpose-built acute inpatient unit, Antelope House, to be used for service users with reablement needs whose illness also means they have challenging behaviour. This function is currently provided in Abbotts Lodge in Netley which has 16 beds. Geographically isolated, the quality of this building and grounds is poor. Within the service provision operated by Southampton Area, there is a longstanding arrangement for six rehabilitation beds to be provided to Hampshire residents. This dates back to the large hospital closure programme (Knowle). Through this proposal, this provision of 6 beds will transfer to Hollybank in Havant. As a result of these changes the Abbotts Lodge building would no longer be needed. This proposal has received support from the Southampton Overview and Scrutiny Panel.

10.4 North Hampshire

We do not propose any change to the number of beds in Parklands Hospital in Basingstoke. However, the improvements to community and acute services described in this document will be implemented in North Hampshire. This will mean they will have more beds available for service users from other areas, if they are needed.

11. Option Appraisal

11.1 East and West Hampshire

In East and West Hampshire an option appraisal is being developed to assess which of the two sites in each area is best suited to meet service needs in the future. A number of factors have been identified to be taken into account in this process, including engagement of service users and carers, the physical environment, flexibility of beds, access to specialist support such as Psychiatric Intensive Care or electroconvulsive therapy (ECT), and scope for alternative use of the building.

Any final decision regarding the units will not be a reflection on the commitment of staff or the quality of service they provide at those or any of our units.

12. Benefits Realisation

12.1 We have identified a number of benefits that can be realised as a result of our proposals. These are:

- More care that is **personalised** to the needs of the individual. We will address both their mental and physical health concerns through a flexible approach that encompasses accommodation, occupation, education and other social care needs. As a result everyone will receive care that is designed for them. This will further support close working with other service providers in the local community, including social services, housing departments and third sector organisations.

- Providing more **recovery-oriented services** that focus on strengths of individuals and encourage them to maintain their independence, choice and control. We know that this type of approach when offering care and treatment is very important to people and recognises that service users are 'experts by experience'.

- Developing effective **partnership working with carers**. We recognise the crucial role of carers, and recognise they are, in effect, members of the extended care team, and need appropriate information and support in their own right.

- Delivering **improved value for money**, by reducing inefficiency. We are realistic about the current financial climate in the public sector and know we have to reduce costs in our services and become more efficient whilst maintaining high quality clinical care. Releasing resources that are tied up in expensive inpatient care and shifting towards more treatment in community settings will give better outcomes for service users. Our proposals will provide the right balance between investing in high quality care close to home, and only paying for expensive hospital services that service users actually need.

- An **equitable service** in all our areas. The resources we have for community services in our different areas, and the way staff deliver their care, is vary different. We are now addressing this variation in practice. Our teams will not become carbon copies of each other but will vary according to local need. This will ensure that the clinical model we deliver, and the outcomes and service user experience will be equitable across all areas.

13. Economic Case/ Financial Planning 2011/12 and 12/13

The national economic climate has heightened the need for SHFT to ensure cost as well as clinical effectiveness is achieved in the delivery of service. The redesign of services set out in this Case for Change is in line with clinical trends and best practice guidance and will ensure the best use is made of all our resources. This will be achieved by reviewing the services we provide, listening to our patients, service users, carers, staff, commissioners and other members of the community, to understand how we can best achieve this. Where this identifies where we can stop providing services that people do not value, or that actually diminish the quality of service they receive (such as having to do things twice or having to come into hospital when they could be supported at home) then we will do so. This will ensure that as well as achieving our main goal of developing the best quality, safe services that are highly

valued by our community, we can also transform services within existing funds, mindful of the wider national pressures to reduce costs across all public services.

In this context, in 2011/12, SHFT, along with all other NHS organisations, were required to deliver efficiency savings of 4.0% as described in the Operating Framework for 2011/12. In addition, NHS Hampshire reduced SHFT's contract income for Mental Health and Learning Disability services in 2011/12 to contribute towards QIPP savings. While contract income for 2012/13 and 2013/14 has yet to be agreed, SHFT anticipate that further savings plans will be required in future years to which this programme of service redesign will contribute.

The consultation and engagement process has and will influence the final model of care that will be implemented and hence the resources required to deliver the service proposed in this case for change.

At this stage it is anticipated that approximately £4.4m of direct cost reduction will be achieved over three years from 2011/12 to 2012/13. This would be across both Hampshire and Southampton City, with approximately £1.5m (34%) of this reinvested in community based services. SHFT are committed to delivering services within the agreed contract envelope for 2011/12 meet commissioner requirements across defined QIPP schemes.

14. Implementation Considerations

14.1 The revised model will require:

- Commitment and co-operation across partner agencies including Adult Social Services and Hampshire Overview and Scrutiny Committee
- Re-investment to bolster 'Hospital at Home' capacity
- A period of double-running, if the current model is phased out and the new model phased in

15. Governance and Stakeholder Involvement

15.1 SHFT aims to offer services that will drive continual improvement in mental health and wellbeing for our service users.

15.2 In ensuring that we continue to provide high quality services which have been influenced by what our service users, carers and commissioners have told us, we remain committed to involving and engaging as many people as possible in the development of our plans.

15.3 SHFT has a proven history in involving service users, carers the public and our partners at every level, from involvement in individual care plans through to the design of future services across a wide geographic area.

15.4 In developing the proposals as outlined in this document, we have taken account of the wealth of feedback we have already received from a variety of sources:

- Individual service user/carer stories
- Listening events
- Service User/carer networks
- Foundation Trust Governors and members
- Our staff
- Public events

- Voluntary and advocacy groups e.g. MIND, Rethink
- GP survey feedback
- Local Involvement Networks (LINks)
- National and local service user surveys
- Complaints
- Hampshire and Southampton Overview & Scrutiny Committees
- Compliments
- Online feedback e.g. service user opinion, Trust website

15.5 SHFT has taken into full consideration the need to address the Government's 4 keys tests:

Test 1 support from clinical commissioning groups - we have engaged with our current commissioners and GPCC/mental health leads by letter and offering 1 to 1 or group meetings. We have also made personal contact with all of our partner NHS Trusts and with SCSHA. Each contact is being scored as follows: support secured (4), support with reservations (3), ambivalence (2), not supported (1). This will offer assurance that we have sought to gain support for our proposals.

Test 2 strengthened public and patient engagement - as described at 15.4 we have undertaken extensive engagement of public, patients and other key stakeholders over the past 18 months and our proposals have taken into account what people have been telling us. This has included work with service users, carers, LINks, voluntary and third sector organisations and the public. We have held 7 bespoke events in public, written to all local MPs, identified and contacted local service user/support groups, attended meetings of the 'Support our Mental Health Services' group, chaired by Julian Lewis MP, delivered presentations to Hampshire & Southampton LINks management boards, presented at Hampshire LINks Mental Health Question Time event, spoken with Borough, District and Parish Council members.

Test 3 clarity on the clinical evidence base – section 5 for further details

Test 4 consistency with current and prospective patient choice - as at Test 2, we can demonstrate that our proposals fit with what our service users and carers have been telling us they want from our services. We believe the proposed changes will enhance choice for service users (see section 9 above).

16. Equality and Impact Assessments

16.1 Equality Impact assessments will be undertaken for each area by staff involved in the development of the proposals, service users and carers, and our Governors. We feel this will demonstrate our commitment to involvement and engagement, and offer further transparency to the process.

17. Decision sought from Hampshire Health Overview and Scrutiny Committee

- Reach agreement about the requirements of public consultation

18. References

- 'No Health without Mental Health' – Department of Health Mental Health Strategy published February 2011

- ‘NHS Southampton & Southampton City Council Joint Commissioning Strategy for Adult Mental Health in Southampton. January 2010

- Draft Joint Hampshire Mental Health Commissioning Strategy ‘Building Mental Health & Well Being’. Hampshire County Council and NHS Hampshire 2010

- Southern Health Foundation Trust – Vision & Strategic Objectives (April 2011)

19. Appendices

Appendix 1 – Adult Mental Health Directorate Current Service Provision

APPENDIX 1

Adult Mental Health Directorate Current Service Provision (Secondary Care)

North Area

Psychiatric Intensive Care Unit
Parklands Hospital
Inpatient Unit
Parklands Hospital
Rehab Inpatient
Eastrop House
Community Mental Health Team
Bridge Centre
Elizabeth Dibben Centre
Mulfords Hill Centre
Early Intervention in Psychosis Service
Church Square Resource Centre
Assertive Outreach Team
Parklands Hospital
Crisis Resolution and Home Treatment Team (CRHT)
Parklands Hospital

West Area

Inpatient Unit
Woodhaven
Melbury Lodge
Rehab Inpatient
Crowlin House
Copper Beeches
Community Mental Health Team
Anchor House
Waterford House
Test Valley South CMHT
Connaught House
Andover CMHT
Desborough House
Early Intervention in Psychosis Service
Westlink
Assertive Outreach Team
Old School House
Melbury Lodge
Mother and Baby Unit (Perinatal Services)
Melbury Lodge
Crisis Resolution and Home Treatment Team (CRHT)
Melbury Lodge
Woodhaven

East Area

Psychiatric Intensive Care Unit
Elmleigh
Inpatient Unit
Elmleigh
The Meadows
Rehab Inpatient
Hollybank
Community Mental Health Team
Langston Centre, St James Hospital
Waterlooville CMHT Parkway Centre
Petersfield Hospital
Hewat House
Early Intervention in Psychosis Service
Fareham Reach
Assertive Outreach Team
Elmleigh
The Meadows
Crisis Resolution and Home Treatment Team (CRHT)
The Meadows and Elmleigh

Southampton Area

Psychiatric Intensive Care Unit
Antelope House
Inpatient Unit
Antelope House
Rehab Inpatient
Abbots Lodge
Crowlin House
Forest Lodge
Community Mental Health Team
Cannon House
College Keep
Hawthorn Lodge
Early Intervention in Psychosis Service
Fairways House
Assertive Outreach Team
Thomas Lewis House
Substance Misuse Service
New Road Centre
Crisis Resolution and Home Treatment Team (CRHT)
Antelope House
Psychiatric Liaison Team
Southampton General Hospital
Primary Care Counselling
Grove House, Ocean Way

Future Adult Mental Health Service Provision (Secondary Care)

For each geographical Area covered by Southern Health Foundation Trust there will be:

- An Access and Assessment Service
- A Community Treatment Service
- Access to acute inpatient and psychiatric intensive care beds
- Access to reablement community service and beds if required