



**ourNHS**  
*our future*

**SOUTH EAST COAST  
MENTAL HEALTH CLINICAL PATHWAY REVIEW  
GROUP  
FINAL REPORT  
FEBRUARY 2008**

**OUR NHS, OUR FUTURE – NATIONAL REVIEW OF THE NHS**  
**SEC Mental Health Clinical Pathway Review Group Report**

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## **CHAIRMANS PREFACE**

Mental Health is being given a real place within the integrated planning for the “Our NHS, Our Future” review with the intention being to ensure that the NHS is truly “world class, personalised, fair, safe and effective”. I sense, from what I have seen so far, a genuine determination to use this review to go beyond rhetoric, driving the NHS to be an enterprise in which staff have pride and, most importantly, in which patients and public (i.e. all of us) feel able to place their trust. The principle of “fairness” even challenges the NHS, as now the world’s largest employer, to look outside of itself and consider ways in which it may influence global attitudes on health inequality and models of health and social care.

A conceptual “mind-body gap” and focus on the individual are defining features of health care in the western world, especially in secondary health care. This is evident on every level from the way symptoms are perceived, people are treated, staff are trained and services are delivered. Such dualism and Individualism has been eroded by recent developments: (a) a greater understanding about the psychological, emotional and social determinants of health, (b) a new awareness, openness and respect for those who are mentally ill and the absolute legitimacy of their voice in all aspects of care and service planning, and (c) a greater effectiveness and tolerability of modern mental health treatments, therapeutic environments, methods of team working and service delivery. If this analysis is correct, it is surely all the more important to embed the health care agenda within its social and cultural context and to further narrow the gap between the mental and physical.

I am very grateful to all those who have contributed to this report and particularly to the members of the group and Trusts who attended workshops or contributed to case studies; to Marion Dinwoodie for commissioning the exercise; to Laretta Kavanagh for her expertise in commissioning and facilitation; to Kim Shamash for her insights and support; and especially to Susan Gibbin for her painstaking work in collating and organising so much, so quickly, so calmly.

Dr Malcolm Hawthorne  
February 2008

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## **EXECUTIVE SUMMARY**

The South East Coast (SEC) Mental Health Clinical Pathway Group, subsequent deliberative events and the extraordinary examples of good practice (see appendices) collected across the South East Coast are testimony to a remarkable base of innovation, leadership and partnership working in this area.

However an appraisal of available evidence and local observation did highlight a number of specific weaknesses in the approach to mental health provision across the South East Coast Health Authority. These included:

- gaps in capacity in primary and community based provision against specific care pathways in particular limited access to, and long waiting times for, psychological therapies
- variable access to specialist services both those for people with personality disorders and separately for mothers & babies
- a rise in the suicide rate particularly for men over 40 years old
- inconsistencies and variation in the level of engagement and support for users and carers
- commissioning focused on a narrow set of objectives with limited multi agency integration and lack of a national financial (PbR) and outcome framework to effectively improve provider performance

Reflecting on both personal experience and evidence presented throughout the process the group proposes a number of key recommendations for action across the SEC community.

- The values and principles set out in this document under the headings “fair, personalised, safe and effective NHS” now need to be translated into meaningful measures including targets or a benchmarking framework to improve access to high quality care and a recovery orientated approach which secures better outcomes for service users

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- Specific pathway development is needed focusing on areas which are most likely to impact on system change. Commissioners and providers should consider the use of ‘map of medicine’ to facilitate pathway development and dissemination.
- A more effective commissioning framework is required which integrates across physical/mental health and social care; based on population need and includes a currency based on measures of quality and user-defined outcome.
- The underpinning infrastructure, workforce and settings should be strengthened through a series of enabling strategies which offer meaningful, real time information for front line teams and services, facilitate collaborative clinical networks, deliver stronger clinical leadership and foster a culture of reflective practice and a therapeutic alliance with service users.
- A fully accountable clinical steering board for the SEC should be established to oversee the next stage of the review and disseminate its findings including the development of local pathways and offering clinical support to enable a stronger provider capability.

The work of the group has been underpinned by the mantra “there is no health without mental health” and from this has evolved a set of values and principles which would appear to reflect the views of practitioners across the SEC. Through these the group seek actions that will:

- reduce the personal burden facing both individuals and society as a whole
- recognise that a holistic approach is needed to tackling mental illness and it cannot be isolated as simply a health care responsibility
- respond to the clear evidence that although mental health systems can deliver excellent quality there remains too much unnecessary variation in quality
- ameliorate the growing fragmentation between specialist services

In taking forward better mental health there now is a need to build on a growing awareness of the extent to which mental health cross-cuts all other areas of health (and “wellbeing”) and the need to break down the barriers to further progress.

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## **INTRODUCTION**

This report documents the work of the South East Coast (SEC) Mental Health Clinical Pathway Review Group (MHCPG) as part of the 'NHS Next Stage Review' led by Lord Ara Darzi. A key aim of this review is to support the NHS in becoming a world class service and to ensure that "front line staff" are at the heart of decision making about service delivery and the future of the NHS. The national review and terms of reference specifically use the term 'clinical' to apply to health and social care professional practice and, for consistency this terminology is used throughout this report.

The group, chaired by Dr Malcolm Hawthorne, Medical Director, at Surrey & Borders Partnership Trust and facilitated by Laretta Kavanagh, Kent and Medway Director of Commissioning for Adult Mental Health services, had a membership of over 30 clinicians (See Appendix 1). The group met over a period of two months (though not all could attend every meeting) and notes and proposed actions were shared with all parties, including PCT commissioners, and their observations sought.

The process sought to:

- review national and local evidence of clinical practice
- scope the strengths and weaknesses of mental health services across SEC with a particular focus on:

Mental Health Promotion Primary care and access to services Acute mental health services Support for carers Suicide prevention
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- within this to consider the needs of those with Learning Disabilities (LD) as well as people with dementia
- offer a vehicle to promote areas of good practice
- identify enablers to support areas needing improvement and change

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- develop links with the other mental health groups nationally
- engage with other SEC clinical groups (see below), as well as service user and carer focus groups (see Appendix 2)

Links with other SEC care pathway groups around areas of significant overlap:

- **Maternity and Newborn:** perinatal maternal mental ill-health and its associated impact on child development and mental health
- **Children:** child and adolescent mental health
- **Acute:** acute mental health presentations in general health sector
- **Long Term Conditions:** severe and enduring mental illness, community delivery systems (e.g. Care Programme Approach), and the impact of mental ill-health on self-care in chronic physical illnesses
- **Staying Healthy:** mental health promotion
- **End of Life:** dementia, other mental health conditions associated with the end of life (including depression) and bereavement
- **Planned care:** overlaps were not identified, but might include psychological therapies

This engagement process has generated a wide range of clinical case studies as evidence of innovation and good practice. Although some will be used to illustrate points in this report the main benefit will be to produce a directory or data base to support dissemination and sharing of good practice and experience. In addition, there has been very interesting feedback from the national deliberative event, user and carer forums and other clinical pathway groups, some of which has informed the final recommendations.

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## **OVERVIEW AND CONTEXT**

The scale and pervasive nature of problems relating to mental health has been well described but there are still very substantial barriers (attitudinal, educational, institutional and clinical) to them being regarded as “everyone’s business”. Even the interim review has been reluctant to refer to an illness such as schizophrenia in the same breath as cancer or heart disease. Priority is now being paid to mental illness by raising the profile of dementia and it is the intention of the clinical pathway groups to ensure that a similar level of attention is paid to serious functional mental disorder, alcohol and substance misuse, learning disability and developmental disorder.

At the other end of the spectrum there are: many people with unrecognised and under-treated “common mental disorders”, a large proportion (as much as 50%) of presentations with medically unexplained symptoms, a lack of service mechanisms and models of thinking that promote recovery (linking health care to employment, education, housing and wider society) and a failure to attend to the physical needs of those with severe mental illness, many of whom are managed predominantly in primary care.

A vision for the next phase of the “revolution” in mental health care has been very well put by Louis Appleby in “Breaking down Barriers – a reform underpinned by workforce reform, modern treatments, a better quality of life, social opportunities and improved physical health”.

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_074579](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_074579)

Already mental health and social care services:

- have moved care from largely inpatient to community settings
- have a track record of managing resources
- have made significant progress in patient and user involvement
- are good (often) at working in partnerships
- have established multidisciplinary teams and some new ways of working

We now need to consider how the experience gained to date within the world of mental health can benefit the NHS as a whole.

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The group supporting the report encompassed a very wide range of experience and was both professionally and geographically diverse. It was itself only one of many groups around the country. The chairs of the regional mental health groups have also been meeting and the following key message (with some local flavouring) has been agreed nationally:

**“THERE IS NO HEALTH WITHOUT MENTAL HEALTH”<sup>1</sup>**

**The Personal Burden**

*Mental Health problems create high levels of personal suffering and a high financial burden both for individuals and society as a whole. The interaction of mental ill health and physical ill health is often not identified resulting in increased use of physical health care services in terms of investigations and occupied bed days. Individuals failing to access appropriate services for mental ill health do not achieve their full potential. There is a major impact on their productivity and on the lives and productivity of their carers. The latter includes, for example, the social burden of caring for sufferers of dementia who require long term care which is both very significant and expected to increase over the next ten to fifteen years.*

**Holistic approach**

*Mental health services cannot be viewed in isolation as a health care responsibility and cannot simply be addressed by reactive health interventions or by specialist mental health services. Commissioning therefore needs to take a whole systems approach. Mental health problems must be identified and tackled by ensuring that there are sufficient people, with appropriate skills, wherever such problems arise – including physical care settings.*

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<sup>1</sup>cf 'Mens sana in corpore sano' A sound mind in a sound body Juvenalis 2nd century AD

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**Effective Care pathways**

*There is clear evidence that mental health systems can deliver excellent quality but there remains too much unnecessary variation in quality. The effective use of care pathways is the best way of improving quality in a meaningful way – i.e. in a way which reflects that the service user and their quality of life is at the core of service design and delivery whilst taking into account carer, public and clinical staff expertise and views on outcomes.*

*A core care pathway, clearly defined and understandable to service users, carers and professionals, is also essential to allow a real choice of both the intervention delivered, the site of delivery and the professionals involved.*

*Primary care should be a key focus working within collaborative disease management models of care. This is particularly relevant in the management of those with co-morbid conditions, multiple illnesses and long-term conditions. This would assist in identifying early interventions for those with a diagnosis of mental illness or supporting transition from child and adolescent to adult services and from adult to old adult services.*

**World Class Commissioning**

*Commissioners need to focus on the care pathway, not just the individual provider(s) of care. The aim should be to ameliorate the growing issues of fragmentation between specialist services, across age-range and disease groups. It should enable joint Primary Care – Specialist - Social Care - Third Sector proposals for pathway provision.*

*The inclusion of service user defined outcomes, in addition to outputs and targets for all delivery agencies, should also encourage a move from disparate packages currently available, to a more seamless delivery. Commissioning goals need to be more actively directed to include mental wellbeing and health promotion, thus encouraging the creation of healthier communities.*

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**VALUES AND PRINCIPLES**

Building on the values outlined in the Next Steps Review the SEC MHCPG, in consultation with the national forum for mental health chairs, has developed a set of principles for the delivery and development of better mental health. It is hoped that they be found useful as a basis for further discussion amongst practitioners and with others.

***FAIR, PERSONALISED, EFFECTIVE, SAFE***

***Fair***

- be receptive and respectful of the individual's needs and their contribution
- offer care choices that are meaningful - being available, accessible and appropriate and being prompt and clear in the advice and response provided
- be open, sensitive and constructive about problems, including difficult diagnoses
- base service provision on population need with best use of resources
- support diversity and reduce stigma in the care pathway and society

***Personalised***

- be focused on recovery, well being and inclusion to help maintain or improve the dignity and quality of life of both the individual and their carers
- apply the principles of the single assessment process by sharing information effectively between those teams and individuals responsible for care delivery
- encourage full participation and engagement by individuals with mental health problems in their personal care plan and in the development of services
- ensure that carers are, whenever possible, welcomed, informed, supported and included in the delivery of care plans and the development of systems or services

***Effective***

- always base advice and decisions on sound evidence and best practice
- ensure that all resources are used efficiently and effectively
- seek and apply meaningful measures of outcome

***Safe***

- ensure that safety is paramount but always considered in the light of an individual's right to self determination and the safety of others
- share information confidentially and only when it is in the individuals' interest and subject to the law
- help and expect the individual to share responsibility for thinking about how to manage their own risk

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## **LESSONS FROM THE EVIDENCE**

An appraisal of available evidence and local observation highlighted a number of weaknesses in the approach to mental health provision across the South East Coast (SEC) Health Authority.

In reviewing data from the Autumn Position Statements of the Local Implementation Team (LIT), there appears to be considerable variation in response to national targets. Although a good response is seen around the delivery of crisis resolution and intensive care there appears to have been less success in increasing:

- capacity in primary and community based provision;
- the quality and scope of services in primary care against specific care pathways;
- access to specialist services both those for people with personality disorders and separately for mothers & babies
- access to, and therefore reducing waiting times for, psychological therapies

Against the Health Care Commissions (HCC) standards ratings for the three mental health trusts performance is shown at levels 'Fair' to 'Good'.

<http://2007ratings.healthcarecommission.org.uk/healthcareproviders.cfm>

In terms of the HCC review of the patient experience of mental health services the community mental health survey 2007 highlighted a series of weaknesses in the relationship and level of engagement between service users and carers and the professional offering the service. However it is recognised that this survey reflects the views from 2005 and changes in the way the service engages and communicates with its clients continue to be addressed.

<http://www.healthcarecommission.org.uk/healthcareproviders/nationalfindings/surveys/healthcareproviders/surveysofpatients/mentalhealth/a-zreports2007.cfm>

From a public health perspective suicides constitute a major health issue as well as personal and family tragedies. From an analysis of information from the Office of National Statistics for Primary Care Trusts and Local Authorities in the South East for years up to 2003<sup>2</sup> it would appear that the suicide rate is on the increase across SEC. Within the region there are significantly higher rates in Hove, Eastbourne, Worthing,

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<sup>2</sup> South East Development Centre Briefing Paper: A profile of suicide mortality in the South East

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Arun, Thanet and East Kent Coastal. It was noted that particular attention should focus on men of all age groups, including those over 75.

The South East Coastal area has also been reviewed with respect to services to A&E that support assessment and management of suicide – recommendations include the provision of dedicated services located on site:

<http://www.southeast.csip.org.uk/silo/files/mapping-document-summary.doc>

South East Coasts planned investment per head of weighted working age population (15 – 64) in adult mental health services for 2006/07 was £160 compared to a national average of £161<sup>3</sup>. When compared with the previous year SEC has seen a decrease of 0.1% from 2005/6. It should also be noted that although SEC offers reasonable investment compared to the national average this is likely to mask significant local variations within the organisations' boundaries.

[www.library.nhs.uk/SpecialistLibrarySearch/Download.aspx?resID=271013](http://www.library.nhs.uk/SpecialistLibrarySearch/Download.aspx?resID=271013)

Local observations by members during the three workshops raised additional concerns and associated areas for further action. These included:

#### ***Clinical Pathway Development***

- the observation that 50% of medical outpatient referrals are for unexplained medical symptoms, many of which are linked to mental distress. There is currently no sustainable strategy to support this need and only limited or highly variable access to health psychology and liaison psychiatry
- insufficient emphasis on alternative approaches to securing positive mental health
- need to recognise that a third of people who present in primary care services have difficulty with depression
- access to secondary care mental health is seen as weak and unsupportive to the primary care referrer compared to other areas of secondary care
- a gateway to mental health services which is too wide and a need to be better at defining the role of health (in the context of partner organisations)

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<sup>3</sup> Mental Health Strategies: the 2006/07 National Survey of Investment in Mental Health Services

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- a lack of national criteria for defining access to mental health services which is often seen by primary care as distorted by an undue emphasis on risk to the detriment of other criteria such as chronicity and complexity
- current pathways appear not to recognise the strength of GP decision making and as such lead to duplication and wasted resources
- insufficient support for intermediate care for complex patients who are moderately stable but still have severe enduring mental health problems and complex drug regimes (most GPs do not have the skills nor the capacity to manage, especially if unwell)
- the clinical workforce is not deployed in the best way e.g. most inexperienced working Out Of Hours (OOH) and at weekend in secondary care
- too many teams within teams have been developed resulting in increased barriers within the patient pathway
- the future delivery of Early Intervention Psychosis needs to recognise the particular needs of 14 - 25 year olds and set the service in the context of a wider youth culture focused service linking support for psychosis and substance misuse
- challenges presented around the transition between children and adult services and in particular that services can not yet respond effectively to preparing young people more effectively as they move between services
- there are serious concerns around the inability to support adults who suffer from Attention Deficit Hyperactivity Disorder (ADHD) and autistic spectrum disorders, particularly those who do not have an intellectual disability (these can access LD services)
- the need to do further work to develop a range of support for women with peri natal mental health problems at a primary and secondary care level. There is a need to recognise that suicide is now the most common cause of maternal deaths
- the need for a more effective response for offenders with mental health problems, including those who have been diverted into secure services, due to an inadequate attention to this care pathway. This pathway needs to address the direct and indirect risks to individuals and society of potentially dangerous individuals

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***Effectiveness***

- NICE (National Institute of Clinical Excellence) guidance is based on ‘soft’ evidence that people are not able to interpret appropriately and as such this can actually limit options for treatment.
- services are often based on evidence which is anecdotal and not on robust measures of quality improvement and often in areas where quality outcomes are unavailable
- the use of the Primary Care Quality Outcomes Framework (QOF) in raising the quality of assessment by measuring severity of ill health when it would be better to measure need
- DNA rates approach 20% which suggest further work is needed to consider how this gross waste of resources can be prevented
- there is a need for further consideration of the challenges and the solutions of providing holistic, safe and effective acute inpatient care, ensuring that client groups with complex needs can be managed with an effective well trained workforce
- need for a single system of risk management operating across professional groups which encourages more assertive action in support of vulnerable service users
- Trusts need more robust systems to prevent illness and provide proper rehabilitation to get staff back to work through effective occupational health service.
- the recognition that developing new ways of working requires good processes with effective support for staff. Yet often redesign is expected with no training so reducing the sustainability for staff and for clinical outcomes
- a better way of sharing and spreading examples of good practice
- current IT systems that get in the way of clinical practice; in particular the lack of a single patient record

***User and carer experience***

- need to recognise that mental health is a social and political issue and that currently a medicalised approach to mental health is overwhelming the system. This has the potential to result in over treatment and a failure to recognise the social context of the sufferer

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- awareness that 90% of people who use secondary mental health services have mental health medicines prescribed to help them with their difficulties. However, studies show that 50% of people discontinue their use of medicine; in fact discontinuation rates from mental health medicine for people with schizophrenia may be up to 75%.
- no obvious nationally and locally recognised connection between healthy lifestyles and good mental health. There is no equivalent of 5 fruit and vegetables a day for mental health
- a gap in maximising benefits of the expert user and carer
- still too many confused service users and carers with too many barriers to services due to a lack of understandable and consistent clear pathways
- further work needed to secure continuity of care in primary and secondary care to reduce duplication in investigation, referral and potentially unnecessary admission
- a failure to better meet the needs of service users and carers out of hours through a lack of understanding of the real need
- priority be given to the need for individuals to have a therapeutic alliance with their practitioners and teams; this requires staff, teams and organisations to create and sustain the skills and “reflective space” to support such an alliance
- a lack of recognition in service delivery models that local geography still affects service users and carers ability to access care
- the need to recognise that primary and secondary care needs to work more closely together in supporting service users physical health needs. The life expectancy of many of the people who use mental health services is reduced by up to 25 years due to associated co-morbidities of both cardiovascular and respiratory disease
- considerable discrimination in access to housing for people who have or who are experiencing mental health distress
- challenges in increasing and promoting social inclusion e.g. increasing the number of people with mental health problems in paid employment

***Commissioning / Contracting***

- an observation that the use of the National Service Framework (NSF) has steered decisions around too narrow a set of objectives and a that there is a need to now broaden the scope to include the wider social inclusion agenda

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- the need for a strategy to support the move of resources from historic patterns of spending to one based on population needs demonstrating best value
- a lack of clarity around how practice based commissioning can be used as the driver to deliver more mental health services in primary care
- a lack of a national tariff and process for defining such a tariff that is subsequently undermining the commissioning process
- many places still seeing commissioning as adversarial and so unable to draw partners together to capture the essence of the service
- contracting processes which can cross a multitude of organisations driving competition for a single resource
- an apparently limited range of partnership working that does not appear to be drawing on potential opportunities to deliver a coordinated response to mental health needs i.e. insufficient pooled resources and collaboration and maximising the use of Local Strategic Partnerships (LSPs) and Local Area Agreements (LAA),
- whilst there are high level strategic commitments to achieve integration this is often piecemeal and without widespread operational understanding or ownership
- the recognition that success is built on effective relationships, enthusiasm and leadership, and that now is the time for organisational stability to re-build relationships between with clinicians and commissioners

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## **CELEBRATING SUCCESS**

There has been success in delivery of the NSF, functionalised models of service delivery and 'New Ways of Working'. The clinical pathway group obtained an impressive number of examples describing innovative practice in improving mental well being for service users and carers as well as the wider public. They offer an insight into how some of the challenges facing mental health services can be overcome however further work is still required to develop ways of connecting teams and individuals who wish to learn from the successes and experience of others. *See Appendix 3 for a list of Case Studies – more details can be found on the Community Portal and the intention is to publish these on the SHA web site.*

### ***Health Promotion and Social Inclusion***

Examples have focused on both the mental well being of the wider population as well as those who need to be supported through a period of recovery. They include a number of locally based initiatives including a 'Well Being Resource Centre' in Newhaven as part of a Newhaven community partnership project and a 'Healthy Living Group' for older people in Surrey to discuss memory loss, anxiety management and healthy lifestyles. Support from within general practice includes a weekly 'Back to Work' clinic (see below), and a county wide 'Books on Prescription' initiative.

Weekly “**Back to Work**” clinics in G.P. surgeries in Surrey are provided for clients who have been signed off sick by their G.P. and whose medical condition is no longer the predominant reason for not returning to work.

People are assisted to develop an Action Plan to facilitate their return to work. This could include, for example:

- learning basic techniques for managing work related stress
- planning a graduated return to work programme
- investigating reasonable adjustments in the work place
- improving time management skills
- identifying support available in the workplace and how to access it
- protective factors to utilise in the workplace

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More targeted initiatives for mental health service users include approaches such as the 'Evolve' project in Kent to support service users into work and Vocational Leads / Champions in Surrey developing recovery action plans to support social inclusion.

**Primary Care**

The need for services within and supporting General Medical Practices (GPs) are emerging with an increasing emphasis on access to supportive talking therapies (see below). This also recognises the primary care expertise in managing uncertainty without recourse to avoidable investigation, referral and admission – and the evident economic value that arises from this

**Stepped care directory in Sussex** - Local directory of services put together to match stepped care delivery of treatment of depression and other mental illnesses

At present only for professionals, starting with general info, then contacts for signposting for local services both statutory and non statutory including:

- mood management group
- guidelines
- information around contacting secondary services, including private providers
- information around contacting wards, social workers for assessments
- what to expect on discharge

In addition the PCTs through their specialist community teams (e.g. respiratory services) are tackling the mental health of clients as part of their holistic support to clients. This is in addition to a number of more specific joint health and social care response teams providing support packages in the home for people with dementia.

The ability to secure speedy access to specialist assessment was also highlighted as an important measure of a quality service and new models are emerging across the counties.

Kent **Fast Track Clinic** offers full mental health assessment for new patients referred by their GP to secondary mental health services. Referral to assessment takes place within two weeks. Patients are given choice around appointments times and the service will sign post into other services as required.

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***Access to specialist services***

Although highlighted earlier as a weakness, a number of examples of good practice did emerge around services for people with personality disorders and parent and infant mental health. These sit along side a wide range of other established services such as targeted specialist psychological therapy, the development of new initiatives such as neuro-psychiatry; medication management initiatives; services for people with dementia and the full implementation of Early Intervention Psychosis (EIP) services.

West Kent **Early Intervention Service** provides care co-ordination under CPA using a recovery and assertive-outreach model to people (aged 14yrs to 35yrs) who have a first episode of psychosis. The service is provided on a hub and spoke delivery model, with multi-professional needs-led social, occupational and clinical interventions. The service has a commitment to audit and research.

Cognitive behavioural therapy for psychosis and family work are considered key interventions. The service is available 8am to 8pm 7 days a week (5pm to 8pm and weekends advice only).

The aim of the service is to:

- reduce duration of untreated psychosis
- reduce rates of suicide in this population
- successfully treat the symptoms of psychosis
- reduce frequency and length of in-patient stays
- provide evidence-based clinical interventions
- provide a person-centred service, rated as highly satisfactory by service users (clients and their families)
- Add to the theoretical understanding of psychosis, its causes and treatment

***Carers***

Both from a clinical perspective and from early feedback from the SEC service users and carers focus group a key measure of a successful mental health service is its response and support to carers. Each of the three represented Partnership Trusts as well as the established voluntary sector has been active in developing strategies and services to support this important workforce.

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Trust staff and the **Carers Centre** in Sussex work together to train carers in the skills required to lead a Carers Support Group in the Locality. About 15 – 20 carers attend the monthly group which provides emotional and social support and regularly has an information slot where Trust staff are invited by Carers to speak on mental health topics e.g. Acute Home Treatment teams, side effects of medication ,etc. The ‘Carers Centre’ in Brighton and Hove has carers’ link staff in GP surgeries that are able to signpost carers to support.

Alongside the work done with the mental health trust, the ‘Carers Centre’ run a number of carer’s support groups and a newsletter which is widely circulated to many carers and includes information and news on mental health. Locality managers and staff meet with carers at a regular quarterly forum to discuss policy and practice issues and for carers to feedback any concerns they have about services

***Suicide***

The main focus from the Partnership Trusts has been on risk assessment and raising awareness (see below). However there are a number of wider well being strategies as well as the work of the EIP teams that also aim to support the reduction of suicides in the community.

**ASIST** is a Canadian programme which trains members of the public to watch out for people displaying risky suicidal behaviour and appropriately intervening. Courses have been run in Sussex involving health care professionals as well as NCP car park attendants

***Other***

Although not the specific remit of the group a number of initiatives which support people with a learning disability were highlighted which have been captured particularly around accessing acute hospital services as well as projects (as below) which support local social inclusion strategies.

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Loddon Alliance provides domiciliary care for adults with learning disabilities in North Hampshire and West Surrey. The management team was made up of a General and Commercial Manager and three Project Facilitators responsible for managing and supporting the staff providing services directly to people.

Loddon Alliance has worked with a local advocacy organisation to recruit two new Project Facilitators (**Expert by Experience**). These part-time employees are now members of the local management team and are influencing both operational management decisions and the governance arrangements for the organisation.

The new Project Facilitators are both people with experience of using services for people with learning disabilities (one of the individuals currently receives support from Loddon Alliance and the other lives in a residential home provided by a separate organisation).

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## **ENABLERS FOR POSITIVE CHANGE**

Following a wide ranging discussion and consultation the group identified a number of relevant enablers to overcome barriers and support implementation. These included the need for:

### ***Strengthened commissioning***

- active practitioner engagement to tackle variation in service and practice and secure high quality and consistent commissioning
- best practice and evidence based care pathways to clearly specify roles and responsibilities in what will be an increasingly diverse supply market including Foundation Trusts and an enhanced voluntary sector
- good data and a focus on the use of consistent and nationally agreed outcome measures to drive up the quality of care and an improved patient experience
- resource allocation/distribution to ensure a maintained focus on the delivery of NSF models of treatment and delivery, ‘New Ways of Working’ and modern practice / treatment / intervention (e.g. NICE)

### ***Effective Partnerships***

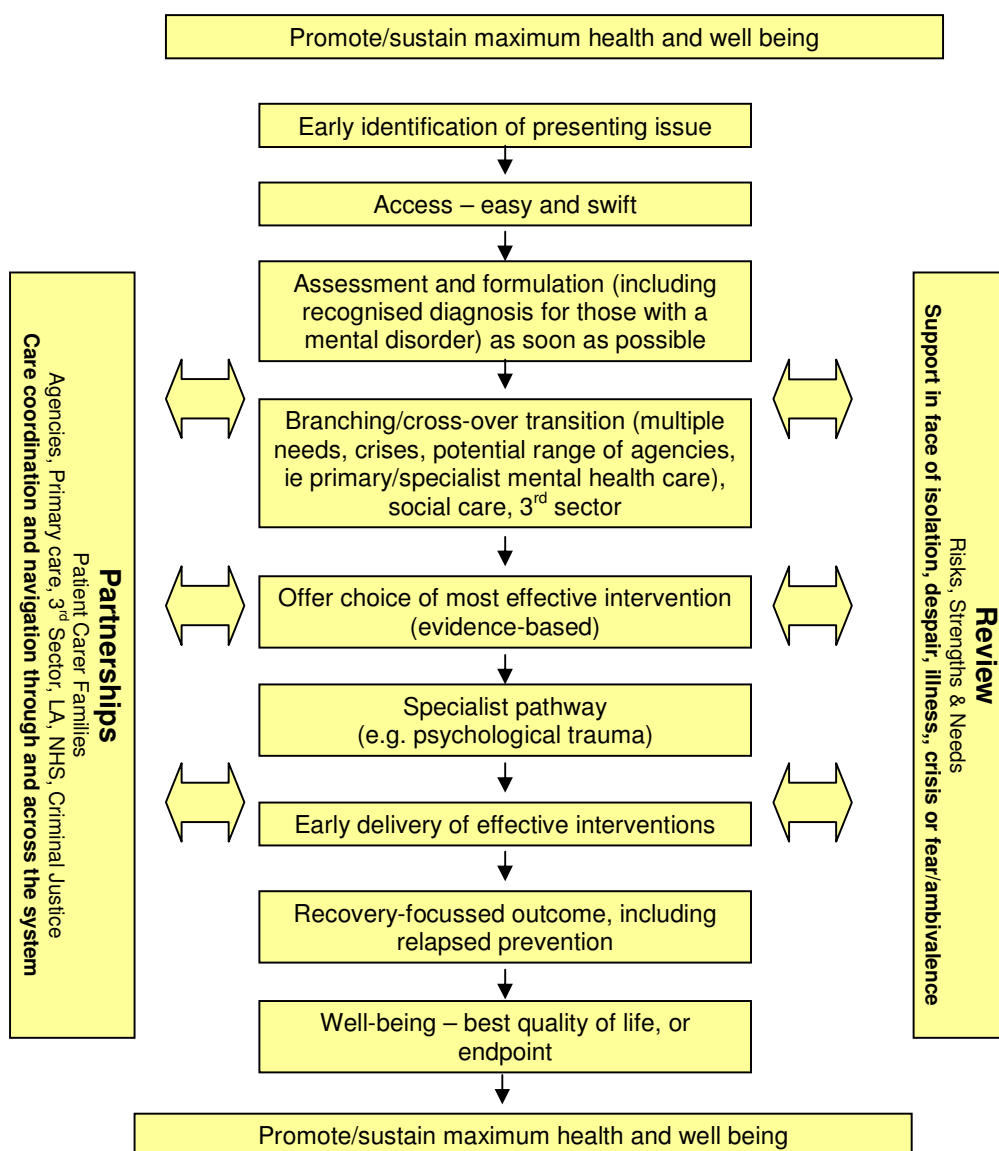
- mechanisms for effective partnership working across primary, acute, mental health and other providers including:
  - full engagement of service users/ carers
  - primary care teams empowered to support long term care management
  - consideration of partnership board or joint management arrangements for overseeing the development of the primary care-CMHT interface locally
  - clear care pathway standards (or national policy implementation guidance) on liaison psychiatry services within acute trusts
- collaborative practice networks across SEC (and beyond) to support the development, delivery and monitoring of innovative, high quality care and treatment
- systems and standards that ensure that front-line staff (i.e. health and social care practice leads) are at the heart of decision making about service delivery and the future

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**Care Pathway Framework <sup>4</sup>**

Pathways consistent with underpinning values and derived from a common framework



Offering:

- information and help to promote mental health and wellbeing
- good diagnosis and formulation to include a focus on strengths
- information about self management and signposting

<sup>4</sup> (chart, with modifications, from Dr Hobbs, SCHA, with kind permission)

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- choice of evidence based interventions
- access to expertise, if needed, as early as possible
- timely delivery of an effective intervention with intended outcomes
- branching to reflect different needs due to co-morbidity, choice of outcome or intervention, times of crisis
- review in terms of risks, strengths and needs

***Workforce Reform***

***Skilling for life; not just training for jobs***

- mental health care workforce equipped with the up-to-date skills providing the best evidence based interventions delivered in the most appropriate settings
- education and training of the NHS workforce focused on attitudes, behaviours and values first and foremost e.g. ensuring care is non stigmatising and empowers the individual whilst satisfying the imperatives of societal protection and excellence in use of resources
- leadership skills training and the development of peer-peer and mutual support networks placing wellbeing promotion and mental illness care at the heart of NHS practice
- recognition that senior leaders are “healers, leaders and partners” for their organisations
- attention to the well being of staff groups and employment of people with mental health and learning difficulties

***Intelligent Information & IT support***

- better information and IT to support high quality clinical care (including links to provide reports from pathology laboratories), performance delivery (including the primary care targets on mental health), front-line ownership (e.g. via devolvement of responsibility and service line reporting) and commissioning
- common measurement tools that are reliable, valid and applicable for front line professionals and the data is easy to collect
- database of best practice and mechanisms to easily link people locally and nationally with each other

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## **RECOMMENDATIONS**

In the context of the groups' values and principles, the strengths and weaknesses of mental health pathways across SEC and the mantra that "there is no health without mental health" the SEC MHCPG proposes a number of key recommendations for action across the SEC community. Commissioners and Provider organisations across each health economy are invited to consider these recommendations:

**Principles for better outcomes:** A "fair, personalised, safe and effective NHS" and the related clinical values now need to be translated into meaningful measures including targets or a benchmarking framework to improve:

- access times
- sound diagnosis and risk management approaches,
- a range of treatments and resources to enable choice,
- user agreed responsibilities in support of safety and recovery,
- real involvement of carers and users in design and delivery of high quality care

In addition a recovery oriented approach is needed that seeks to:

- maximise self-reliance and the need to challenge stigma,
- improve links with the voluntary sector
- recognise the unique relationships afforded in primary care and the expertise in secondary care (for example, in rehabilitation psychiatry)

**Pathway Development:** Specific pathway development around a number of "nodes" (i.e. those pathways that most capture the ideas from the pathway group and are most likely to impact on system change) must be:

- NICE compliant and cost effective,
- informed by users and carers and concerned with maximising social opportunity as well as clinical improvement,
- support best practice, signposting, the "expert patient" and self help

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Recommended nodal pathways, and elements of them, for early local development (work is being done in other regional pathway groups for conditions such as dementia and psychological trauma) are:

- Stepped care for those with common mental disorder and empowerment (including consideration of direct support from psychiatry – primary care liaison) of “primary care tiers” to reinforce the potential for health promotion, prevention, early intervention and cost containment by virtue of referral management experience in general practice
- Maintained focus on delivery of NSF compliant teams (e.g. assertive outreach)
- Potentially dangerous co-morbidity (severe mental illness and substance misuse)
- Psychological medicine, including treatment of those with long term conditions and those with medically unexplained symptoms in primary and secondary care
- Access to services for assessment, management and support of those who are at risk of suicide (e.g. see ASIST above re. psychological first aid and recommendations on care provided in acute hospitals)
- Shared care protocols of those with psychosis (e.g. schizophrenia and bipolar disorder) to safely meet mental, physical and social needs
- Transitional care for young people such as those with a need for early intervention in psychosis, Attention Deficit Hyperactivity Disorder (ADHD) and Autistic Spectrum Disorders (e.g. Asperger syndrome)
- Perinatal care and access to specialist services (community or in patient mother and baby care)

This work should build on the work of CSIP. It should also consider the use of "map of medicine" to facilitate pathway development and dissemination

**Partnership in Commissioning:** This needs to be integrated across physical/mental health and social care, be based on population need and include a currency based on measures of quality and user-defined outcome. Commissioning, which should presumably be subject to the same principles as NHS delivery of care<sup>5</sup>, must ensure that there is swift access to assessments and then to the onward intervention once the

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<sup>5</sup> “Clinically led, patient centred, locally driven”; this challenging NHS direction must also be reflected in LSPs

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problems and potential solutions have been identified. There should also be a focus on early return to employment or occupation for those who could benefit.

**Provider Capability:** To strengthen the underpinning infrastructure, workforce and settings a series of enabling processes are needed which will address the need for:

- Meaningful, real time information for front line teams and services
- Reliable and user friendly care records systems
- Virtual team methodology to facilitate networks
- Collaborative methodology applied to a small number of critical areas (either a subset of the above care pathways or elements of them such as the development of high performing primary or secondary care CMHTs)
- High level strategic and management coordination of the primary and secondary care interface such as a partnership board
- Training and development of health and social care practitioners who wish to lead at team, service or organisational level
- Workforce reform including further progress on new ways of working
- Support for “reflective practice” including a culture that fosters the therapeutic alliance (including communication skills and breaking bad news), learns from experience (re. serious incidents) and encourages inter-organisational cooperation

**Practitioner / Clinical Leadership:** A fully accountable clinical steering board for the SEC should be established to oversee the following areas:

- Next stage of this review and dissemination of its findings
- Elaboration of principles and values with extension into practice
- Development of “nodal” clinical pathways locally
- Integration of relevant recommendations across the clinical pathway groups
- Provision of appropriate clinical input into the enablers for improved provider capacity
- Dissemination of good practice between teams and services

Support is now required to administer and facilitate the board and its work streams.

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## **CONCLUSION**

The national direction is to create a world class NHS that is “clinically led, patient centred and locally driven”. The fact that this statement needs to be translated into language more appropriate to contemporary “mental health care” tells its own story – a story that highlights the advances made in our sector towards integrated working and inclusion, and away from a narrow bio-medical model. The clinical pathway group, subsequent deliberative events and the extraordinary examples of good practice (appendices) collected across the South East Coast are testimony to a remarkable base of innovation, leadership and partnership working in this area.

The context of such discussions (and of reports such as this as a whole) should take account also of the recent CSIP consultation on guidance on “finding a shared vision on how people’s mental health problems should be understood”.

[http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH\\_080913](http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_080913)

In taking forward better mental health there is a need to build on a growing awareness of the extent to which mental health cross-cuts all other areas of health (and “wellbeing”) and the need to break down the final barriers to real progress.

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**APPENDIX 1: Membership / Network**

<b>NAME</b>	<b>SPECIALTY/JOB TITLE</b>	<b>ROLE / nominated organisation</b>
Dr Malcolm Hawthorne	Medical Director and Consultant with special responsibility for Liaison Psychiatry	Chair Surrey & Borders Partnership Trust
Lauretta Kavanagh	Director of Commissioning for Mental Health	Facilitator Medway PCT
Susan Gibbin	Project Consultant	Facilitator Medway PCT
Professor Anthony Hale	Consultant Psychiatrist Royal College Adviser for Kent, Sussex & Surrey	BMA Representative Kent & Medway NHS & Social Care Partnership Trust
Kevin Lindsay	Director of Mental Health services (West)	Kent & Medway NHS & Social Care Partnership Trust
Nikki Oatham	Professional Head of Psychological Services	Kent & Medway NHS & Social Care Partnership Trust
Kim Solly	Redesign team (East)	Kent & Medway NHS & Social Care Partnership Trust
Gwen O'Brian	Acute Services manager (Nurse)	Kent & Medway NHS & Social Care Partnership Trust
Dr Nagy Gabriel	GP	BMA Representative Kent GP
Dr Andrew Heller	Clinical Director Health Care for Older People	East Kent Hospitals NHS Trust
Avril McConnachie	Asst Director of Nursing	East Kent Hospitals NHS Trust
Graham Robin	Senior Practitioner Older People Mental Health ,	East Kent Social Services KCC
Marie Gallagher	Social Worker	Kent County Council
Dr David Stephens	GP	RCGP & Kent GP
Samantha Downie	Operations and Development Manager	KCA UK
Dr Gill Farhger	GP	Medway PCT
Dr Sara Kelly	GP	West Sussex PCT
Dr Ron White	GP	ESDW PCT

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<b>NAME</b>	<b>SPECIALTY/JOB TITLE</b>	<b>ROLE / nominated organisation</b>
Dr Ihtesham Sabri	GP	RCGP & Sussex GP
Dr Brian Higginson	GP	RCGP & Sussex GP
Dr Howard Bloom	GP	RCGP & Sussex GP
Dr David Mannings	GP	RCGP & Sussex GP
John Rosser	Deputy Director, Working Age Mental Health	Sussex Partnership Trust
Ajita Pal	Consultant Psychiatrist	Sussex Partnership Trust
Martin Robinson	Rehabilitation and Assertive Outreach	Sussex Partnership Trust
Dr Kim Shamash	Medical Director & Consultant Psychiatrist	Sussex Partnership Trust
Kate Hunt	Associate Director of Psychology and Psychological Therapies	Sussex Partnership Trust
Ray Lyon	Pharmacist	Sussex Partnership Trust
Chrissie Caines	Social worker	Surrey Council / Surrey & Borders Partnership Trust
Dr Liz Lawn	GP	Surrey PCT
Dr Cathy Bratty	GP	Surrey PCT
Joanne Pennell	Manager Primary Care Mental Health (Occupational Therapist)	Surrey PCT
Andy Edeleanu	Director of Specialist therapies	Surrey & Borders Partnership Trust
Shonagh Eastwell	Modern Matron	Surrey & Borders Partnership Trust
Phil Boulter	Nurse Consultant	Surrey & Borders Partnership Trust
Lisa Poynor	Community Learning Disability Nurse	Surrey & Borders Partnership Trust
Bryony Webb	Infection Prevention	Surrey & Borders Partnership Trust
Dr Glen Cornish	Consultant Psychiatrist	Surrey & Borders Partnership Trust
Sue Gurney	Head of nurse education	Surrey & Borders Partnership Trust
Judi Mallalieu	Programme Director for MH	CSIP / NIMHE

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## **APPENDIX 2: Response from the User and Carer Focus Group**

### **Issues raised:**

- Dignity and treatment and the importance of listening within that (and how this is a tension with the short GP appointments).
- Experience with professionals: the importance of building relationships (and how this is difficult when people keep changing).
- The confusing use of buzz words and jargon and a plethora of policies – what is required is a people centred approach

### **Highs/positive experiences:**

- Positive pockets of new and good practice are given in the voluntary sector as well as new forms of governance with users and the NHS

### **Lows:**

- Access issues around
- Support for the carer Information and support from the voluntary sector. Lack of information and what is happening when service users are between 16 and 18 years old
- Cannot be diagnosed and prescribed in minutes
- Transition times and the difficulties of e.g. joining up services at transition times particularly in respect to community and housing

### **Lists of recommendations were made including:**

- The NHS, Social care and Community Health should all work as teams and get together as individuals
- Take a people centred approach
  - The right care and the right diagnosis
  - Understand the need for consistent relationships.
- Half way house
- Carer assessments (particularly with annual needs assessment and information).

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**APPENDIX 3 – List of Case Studies**

Case Study	Locality
<b>Health Promotion and Social Inclusion</b>	
The Evolve project- partnership project to support mental health users into work	Kent & Medway Partnership Trust
Library Based Reading Group (part of the social inclusion project)	Surrey PCT
Healthy Living Group	Surrey PCT & Surrey & Borders Partnership Trust
Back To Work (part of the primary care social inclusion project)	Surrey PCT
Vocational Leads/Champions	SABP/Surrey Social Services
Partnership between general practice and Employment Opportunities	Hastings and Rother PCT
Well being resource centre <a href="http://www.ncda.org.uk/projects/Summerhayes/More-Information-About-Summerhayes.php">http://www.ncda.org.uk/projects/Summerhayes/More-Information-About-Summerhayes.php</a>	Newhaven Sussex
Books on prescription	West Sussex
Proposed service-Job centre plus in GP practices	West Sussex
<b>Primary Care and Assessment</b>	
Primary Care Liaison group for people with LD	Surrey & Borders Partnership Trust
Constipation management team	Surrey & Borders Partnership Trust
Community Respiratory Occupational Therapy (OT) Service (within Respiratory Care Team)	Surrey PCT
Mental Health Occupational Therapist Intermediate Care Team	Surrey PCT
Diagnostic Service for Adults with suspected Autistic Spectrum Disorder	Surrey and Borders NHS Partnership Trust
Surrey Younger Peoples Memory Services	Surrey & Borders Partnership Trust
Specialist Therapies – improving access to psychological therapies	Surrey & Borders Partnership Trust

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Case Study	Locality
Stepped care directory	West Sussex
Improving access to psychological therapies in Brighton and Hove	Sussex Partnership Trust
Mood management group	West Sussex PCT
Primary care dementia workers	West Sussex
ICAST Plus	Sussex Partnership Trust
Acute / secondary care (community and residential settings)	
Home Treatment Service (HTS)	Kent & Medway Partnership Trust
Fast Track Clinic	Kent & Medway Partnership Trust
Brenchly unit for personality Disorders	Kent & Medway Partnership Trust
AIMS Accreditation- identified standards of inpatient care within adult acute service	Kent & Medway Partnership Trust
Women's only unit	Kent & Medway Partnership Trust
West Kent Early Intervention Psychosis service ( <i>links also to suicide prevention</i> )	Kent & Medway Partnership Trust
Leave and discharge support team	Kent & Medway Partnership Trust
Use of Dementia Care Mapping in Older People Mental health	Surrey & Borders Partnership Trust
One Stop Dispensing	Surrey & Borders Partnership Trust
Service reviews in Older Adults In Patients	Surrey & Borders Partnership Trust
Surrey Heath & NE Hants Acute Care Services	SABP/Surrey Social Services
Epsom Continuing Needs Service (CNS) ( <i>Both an Assertive Outreach Team (AOT) and a Rehabilitation &amp; Recovery Team (RRT)</i> )	Surrey & Borders Partnership Trust
Multi Family Group for Depression	Surrey & Borders Partnership Trust
Multi family Group for Young Adults and their Families	Surrey & Borders Partnership Trust
Parent Infant Mental Health Service	Surrey & Borders Partnership Trust
Skill based training for inpatients staff at Guildford	Surrey & Borders Partnership Trust

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<b>Case Study</b>	<b>Locality</b>
Managing Your Relationships Service ( <i>MBT service in the North West Surrey Area</i> )	Surrey & Borders Partnership Trust
Managing Your Emotions Course ( <i>the DBT service in the North West Surrey locality of the Trust</i> )	Surrey & Borders Partnership Trust
Personality Disorder Referral Service, North West Surrey locality	Surrey & Borders Partnership Trust
Group Partnership Programme ( <i>Therapeutic programmes for clients with severe and enduring mental illness, personality disorders and dual diagnosis.</i> )	Surrey and Borders Partnership Trust
Adult ADHD management Group	Surrey & Borders Partnership Trust
Neurodevelopmental Assessment	Surrey & Borders Partnership Trust
Family work with psychosis.	Surrey & Borders Partnership Trust
R+D Training for SABP	Surrey & Borders Partnership Trust
Building The Governance Structures To Mental Health Nurses To Prescribe Mental Health Medicines Independently	Surrey & Borders Partnership Trust
Enhancing Knowledge and Professional Self Esteem Within Acute Inpatient Services	Surrey & Borders Partnership Trust
Foundation Course in Systemic Family Therapy.	Surrey & Borders Partnership Trust
Education and training as part of liaison services in Brighton	Sussex Partnership Trust
Minimise the risks associated with prescribing and medicines administration.	Sussex Partnership Trust
Weekly medication education group run at Meadowfield, Worthing	Sussex Partnership Trust
<b>Carers</b>	
Dementia Outreach Service; 1-2-1 Dementia Outreach for Carers	Age Concern Herne Bay Kent; also Age Concern Canterbury & Whitstable
Surrey Carers Charter	Surrey & Borders Partnership Trust
Carers Information Pack	Surrey & Borders Partnership Trust

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Case Study	Locality
Carer's support and education groups for carers with service users in Adult Community Mental Health services	Sussex Partnership Trust
Carer's Support, Advice and Information Service	Sussex Partnership Trust
Suicide	
Risk Management Panel	Surrey & Borders Partnership Trust
ASIST	West Sussex PCT
Risk Panel Pilot	Sussex Partnership Trust
Others – Learning Disability Services	
Special Needs Housing Panel – Surrey Heath	Surrey County Council/Surrey Heath Borough Council/SABP
Dementia Care Pathway for Learning Disability	Surrey & Borders Partnership Trust
Acute Hospital Liaison project – providing a strategic link between acute general hospitals and people with learning disabilities	Surrey & Borders Partnership Trust
Acute Liaison Nurse to support people with learning disabilities if admitted to an acute hospital	Surrey & Borders Partnership Trust
Psychodynamic Psychotherapy: Consultation service for People with Learning disability	Surrey & Borders Partnership Trust
Using the Period Service Review model to determine & improve the quality of social care services for adults with learning disabilities	Surrey & Borders Partnership Trust
Employing people who use services as Experts by Experience to support the management of the organisation	Surrey & Borders Partnership Trust

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**APPENDIX 4 – Pathway Development example for Deliberative event**

What happens NOW for potentially dangerous dual diagnosis  
 (mental illness + substance/alcohol misuse + violence potential)

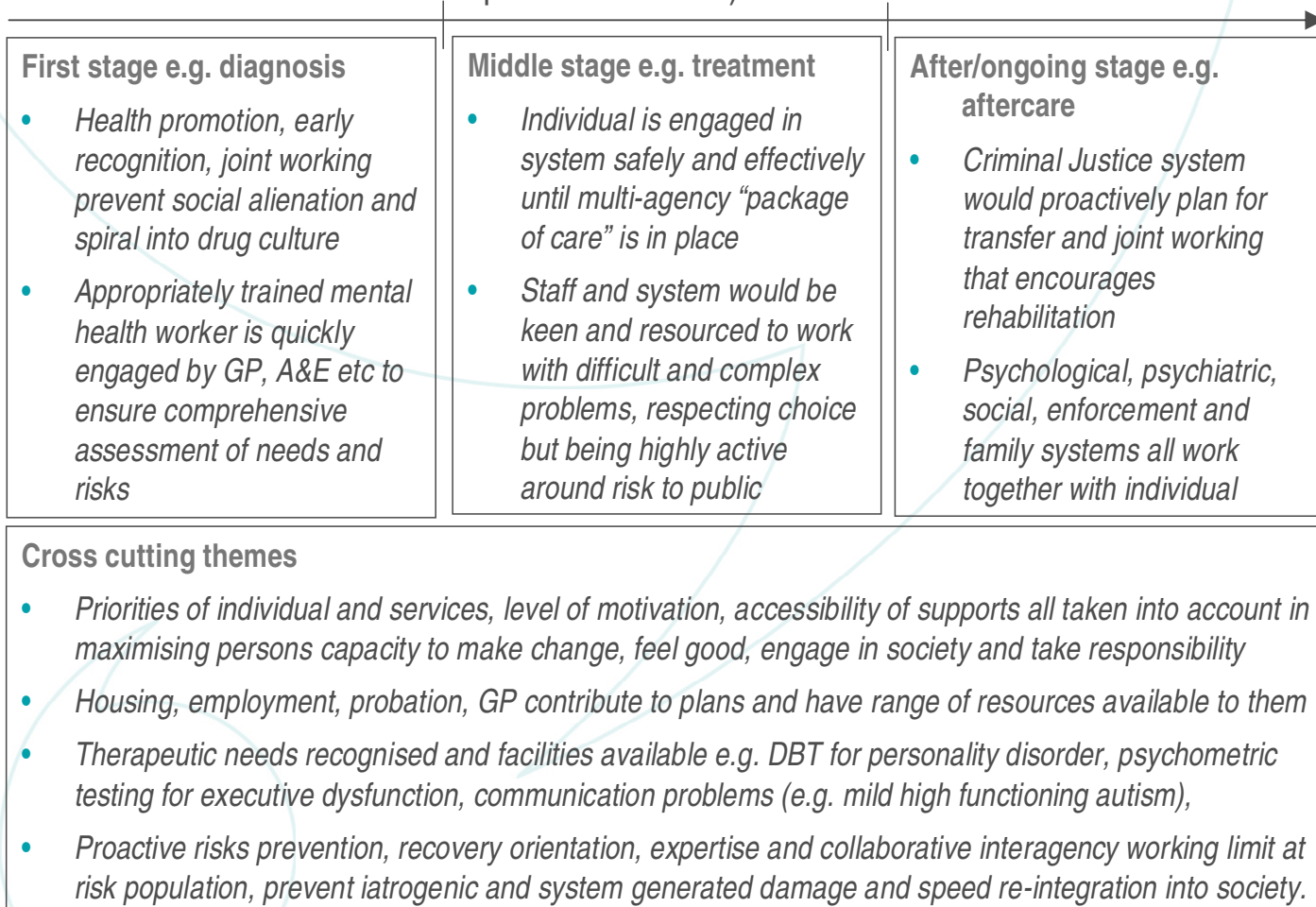
South East Coast

<p><b>First stage e.g. diagnosis</b></p> <ul style="list-style-type: none"> <li>• <i>Service users needs may be unrecognised as focus is on behaviour (e.g. offending, self harm, physically ill) rather than underlying condition</i></li> <li>• <i>Seen by GP, police, A&amp;E nurse and referred to available specialist team e.g. Drugs team, Liaison, court diversion, CMHT, CRHT etc.</i></li> </ul>	<p><b>Middle stage e.g. treatment</b></p> <ul style="list-style-type: none"> <li>• <i>Teams may not work clearly together to manage all needs: social (e.g. safe housing), psychological (e.g. past trauma, borderline pd), illness (e.g. covert psychosis, co-morbid ADHD, depression), risk (e.g. concerns of family, non-compliance, police alert)</i></li> </ul>	<p><b>After/ongoing stage</b></p> <ul style="list-style-type: none"> <li>• <i>Behaviours may entrain in criminal justice system where mental health care is difficult to deliver</i></li> <li>• <i>CMHT with limited specialist resources for this group will work with substance services and forensic team</i></li> <li>• <i>Highly specialist resources very limited</i></li> </ul>
<p><b>Cross cutting themes</b></p> <ul style="list-style-type: none"> <li>• <i>Individual may be expected to make choices that are too difficult due to underlying illness, intractable social problems, level of motivation that has not been identified, problem linking to trusted care worker</i></li> <li>• <i>Stigma and complexity militate against real ownership by services as the problems seem so difficult</i></li> <li>• <i>Lack of reliable advance information sharing systems, clear care pathways and inter-team protocols</i></li> <li>• <i>Early recognition and intervention, problems with transition into adulthood, distrust of the system delay proper management from childhood onwards.</i></li> <li>• <i>Approach dominated by risk rather than recovery outcome with client taking responsibility.</i></li> </ul>		

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What could happen in the FUTURE for potentially dangerous dual diagnosis (mental illness+substance misuse+potential violence)

South East Coast



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Main differences between now and the future for the pathway as a whole

South East Coast

- *Services would be modern and tuned to recognise potential risks and have the confidence to manage risk assertively when needed. Backup systems such as risk panels and supporting infrastructure such as reflective learning seminars for staff would support this.*
- *Communication via IT systems that facilitate advance sharing of concerns (“these problems seldom come out of the blue”) and hold easy to access information including up to date risk histories, care plans, contingency management protocols. Inter agency IT links are especially important for this group along with the information sharing protocols that underpin them.*
- *In-reach into other organisations provides education, support, early recognition and early intervention whether these are schools, prisons, acute hospitals (via effective Liaison Psychiatry teams), or voluntary/third sector services (eg homeless accommodation centres) ensures that individuals are tracked and supported throughout their care path.*
- *Statutory requirements are fully met with respect to Mental Health Act, Section 117, MAPPA*
- *Commissioning is joined up with NTA, Home Office and Social Services to recognise the complexity of this pathway and the need for a fully integrated approach if the problem is to be tackled safely. Attention needs to be given to raise public awareness of the service to this group of clients and to de-stigmatise. Most clients have unrecognised co-morbidity.*
- *Use of coercion minimised as individual given chance to take more responsibility and choices driven by recovery outcomes*

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**Feedback from the Deliberative event 24<sup>th</sup> Jan**

Participants were much more positive about the potential future scenario but questioned whether there are the resources to make this real. They felt it was much more person-centred and offered people like Jimmy a lot more support.

- It is acknowledged that there is a difficulty in identifying those at risk unless they identify themselves or want to be identified. So it was felt that it is a good idea to use things like unemployment as a mental health ‘trigger’ so that earlier intervention can take place. This may have prevented his involvement with drugs in the first place
- There is still the issue of stigma. It is important that people are made more aware of mental health issues in society e.g. if you have been diagnosed with a mental health problem it can make it harder to return to work.
- Participants wanted clarity about the roles of the different organisations in care e.g. of voluntary (mental health) services and the police. There were questions over who the first point of contact is, who leads the care, who the mental health workers are and how the patient seeks help.
- It was thought that prison is probably not the best solution for people with mental health issues. It would be better to support them in the community
- It is important that people are not just given drugs to treat mental health issues but are able to access therapy too
- Again, there were questions about whether there are adequate resources to make these changes

The most important priority for participants was ‘joint working with other organisations such as schools, prisons, homeless accommodation centres etc to provide education, support and early recognition’. It was felt that by identifying and tackling mental health problems early, and through different services, then other problems might be avoided e.g. criminal offences.

There was some feeling that although the future scenario was much improved, more could still be done.

Participants also felt that it was important to educate society, and specifically young people, about mental health issues and de-stigmatise these problems. It was also important to provide more support and information for families of individuals with mental health problems.

They also wanted better communication between different agencies to deal with mental health problems (including voluntary organisations)