Proposal for the Development of a Stepped Care Model for Adult Mental Health Services

DIRECTORATE OF MENTAL HEALTH AND DISABILITY

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Proposal for the Development of a Stepped Care Model for Adult Mental Health Services – Steps 1-5 (V0_01)

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Appendix 1: Southern HSC Trust Stepped Care Model
1 INTRODUCTION

This document sets out a proposal for the development of a Stepped Care Model for Mental Health Services within the Southern Health and Social Care Trust.

The aim of this document is to provide an outline description of the proposed stepped care model for adult mental health services in the Southern Health and Social Care Trust. It will describe a stepped care model of mental health service delivery based on 5 steps or levels of service provision.

This proposal has been prepared in response to a request from the Regional Health and Social Care Board on the 20th April 2009, to set out the proposals with regard to the development of an overall Stepped Care Model.

2 BACKGROUND

The “Change in Mind” review of Mental Health Services in the Southern Health and Social Care Trust was initiated in May 2008 and was prompted by:

- The publication of the Bamford Review of Mental Health and Learning Disability (NI) 2002 – which outlines a blueprint for reform and modernisation of adult mental health services.
- The national programme to improve access to psychological therapies launched in May 2006, which has been regionally brought forward by the DHSSPS publication: “A Strategy for the Development of Psychological Therapies” December 2008.
- The amalgamation of the 4 legacy Trusts in April 2007 and the need to provide a uniform mental health service throughout the Trust.

It was within this local and strategic context that the Directorate of Mental Health and Disability commenced a review and modernisation programme for mental health, namely the “Change in Mind” Project.
The aim of the review is to inform future service provision and introduce a new stepped care model approach that will support the Trust in meeting the service delivery challenges it faces in the next 3 years and beyond.

The stepped care model of service provision described in this proposal has emerged from the work carried out to date by the Trust’s “Change in Mind” Project. The Trust proposes to adopt a 5 step model of service provision that has been developed from the stepped care framework outlined in the NICE clinical guidance for the management of depression in primary and secondary care, (Clinical Guideline 23 (amended) April 2007), and the clinical guidance for the management of anxiety (Clinical Guideline 22 (amended) April 2007)

The model is underpinned by two main principles:

- Treatment should always have the best chance of delivering positive outcomes while burdening the patient as little as possible.

- A system of scheduled review is in place that detects and acts on non-improvement to enable stepping up to more intensive treatments or stepping down where a less intensive treatment becomes appropriate and stepping out when an alternative treatment becomes appropriate.

This 5 Step model aims to support the improvement of access, intervention, treatment and care to patients and service users in the community and hospital setting. The stepped care model is illustrated in Appendix 1 and described more fully in Section 6 of this document.
3 STRATEGIC DIRECTION

3.1 The Strategic Framework for Adult Mental Health Services of the Bamford Review (2005) sets out the following principles:

- Primary Care teams must have access to a named mental health professional (a Link Worker) in order to provide timely, appropriate and accessible assessment and management of people with mental health problems.
- Mental Health Services must be accessible in order to provide timely and appropriate assessment and treatment in a manner valued by service users, their carers and by practitioners.
- People receiving care at primary care level must have access to a high standard of psychosocial care and to a range of psychological therapies delivered by people working in managed clinical teams.

This proposal will focus on enhancing community services infrastructure.

3.2 The Southern Health and Social Services Board Health and Well Being Investment Plan (HWIP) sets out the following proposal which it envisages the Trust to take forward in 2009/10:

Development of the Stepped Care Model/Primary Care Mental Health service and must specifically reflect the establishment and delivery of mental health services within the primary care setting. The focus should be to establish posts which deliver level 1 & 2 service inputs, i.e. primary care based mental health therapies and care.

3.3 A key Priorities for Action Target 2009/10 is to ensure new referrals are assessed within the 9/13 week regional targets, i.e. by March 2010 generic type referrals arising from primary care should be assessed within 9 weeks, with specialist referrals assessed within a 13 week period. The Stepped Care model will assist in achieving this target. Each step of the stepped care model is interdependent and therefore cannot be considered in isolation. Also activities in all five
3.4 Mental Health: New Ways of Working for Everyone, April 2007, presents a sustained piece of work between NIMHE and all professional bodies which provide an explicit strategy and direction for the whole of the mental health workforce.

New ways of working is about promoting a model where responsibility is distributed amongst team members rather than delegated by a single professional. The Trust’s proposed stepped care model aims to incorporate the principles of New Ways of Working so that the service model is designed to ensure that those with the most experience and skills work face to face with those with the most complex needs, and to supervise and support other staff to undertake less complex or more routine work.

3.5 Improving Access to Psychological Therapies (IAPT) Programme was developed in 2005, following a white paper commitment in “Our Health, Our Care, Our Say”. The primary aim of the IAPT programme in England is to help Trusts implement the NICE guidelines for people suffering from depression and anxiety disorders. In December 2008, the DHSSPS issued a consultation document “A Strategy for the Development of Psychological Therapy Services in Northern Ireland” which recommends a stepped care model for the provision of psychological therapies. This fits into the overall view of the Trust’s stepped care model for mental health service provision.

3.6 Mental Health Service Framework (DHSSPS) for Northern Ireland, will provide standards of care and set out performance standards and targets in respect of day-to-day delivery of mental health services across the HPSS. The Framework will therefore provide a potential vehicle against which the quality of service provision may be judged by members of the public, HSC Commissioners and other organisations which are required to report on the performance and quality of services and care. The Trust’s stepped care service model will reflect the standards...
identified within the Service Framework, especially the philosophy and ethos of the recovery model.

4 DEFINITION OF STEPPED CARE

4.1 Stepped Care is a system of delivering and monitoring treatments, so that the most effective yet least resource intensive treatment is delivered to patients first. (Needham, M and Gask, L., (CSIP 2006)) in other words “Having the right service in the right place, at the right time delivered by the right person.”

The stepped care model provides a framework for organising mental health care by adopting a whole systems approach in matching presenting need with the least intensive intervention that is still expected to provide significant patient centred health benefit outcomes.

4.2 The main aim of a stepped care approach is to simplify patient pathways, and provide more tailored care in accordance with self help/recovery approaches. The stepped care model therefore supports the coherent reorganisation of services into steps underpinned by clear evidenced based and integrated care pathways across primary, secondary and tertiary care services.

The stepped model of care promotes early intervention, consultancy, signposting to the most appropriate care, co-working, single points of access and effective case management

4.3 A number of principles underpin the delivery of an effective and efficient stepped care model of service delivery and include:

- Treatment should always have the best chance of delivering positive outcomes while burdening the patient as little as possible.
Proposal for the Development of a Stepped Care Model for Adult Mental Health Services – Steps 1-5 (V0_01)

- A system of scheduled review is in place that detects and acts on non-improvement to enable stepping up to more intensive treatments or stepping down where a less intensive treatment becomes appropriate and stepping out when an alternative treatment becomes appropriate.

- The establishment of a single point of access in association with a robust screening, triage and assessment function.

- A focus on early intervention and signposting people to the most appropriate care and services which are provided by the Trust and/or voluntary/community/independent sector organisations.

4.4 In the Southern Health and Social Care Trust, the new service model will create new levels of service provision in the form of delivering services at steps 1 and 2 and augmenting services at step 3. The Trust is calling this new service development Primary Mental Health Care, which will not only deliver at steps 1 and 2 but also step 3. The Primary Mental Health Care Service will facilitate a single point of access to mental health services, offering pre-referral advice, screening, assessment and treatment or onward referral. The proposed model will provide a clear care pathway which will set out how people will move through the service, ensuring they get the most appropriate care by the right part of the service.

5 CURRENT SERVICE PROVISION

The following is a description of the current service provision in the Southern H&SC Trust mapped against the stepped care model as outlined in RHSCB’s Draft Community Mental Health Services “Stepped Care” Model of Service Provision: Commissioning Framework, March 2009.
5.1 Step One  **Primary Care - Services users with mild up to moderate mental health needs.**

At step 1 the Trust currently provides services in the form of contracted services from the voluntary and community sector. The Trust has service level agreements with a broad range of voluntary and community organisations that deliver at step 1 and these include:

- ADAPT – Eating Disorders Support Network
- Nexus – Counselling service for adult survivors of childhood sexual abuse.
- CAUSE – Carers support, advocacy and information service
- Relate – Relationship counselling service
- REACT – Counselling service
- Breakthrough – Counselling Service
- CRUSE – bereavement support
- Aware Defeat Depression – Supportive counselling

Individuals can self refer, and GP’s can signpost their patients or refer directly to these services. The total level of investment in 08/09, both recurrent and non-current, by the Trust in the services listed was £125,000.

5.2 Step Two  **Screening, Assessment and Brief Psychological/Psychosocial Interventions – Service users with mild/moderate mental health needs.**

The Trust currently provides a limited service at step 2 due to historical commissioning being focused on step 4 and 5 service provision.

In Armagh and Dungannon, the Primary Care Counselling Service provides both a step 2 and step 3 service. This service, delivered in GP practices provides assessment and treatment for people experiencing mild to moderate common mental health disorders, i.e. depression, anxiety.

In the Craigavon and Banbridge area, step 2 service provision has been provided by 0.5wte CBT Practitioner and 0.56wte Mental Health Nurse for a primary care triage project and both posts had been commissioned by the LHSCG.
In the Newry and Mourne area there were no step 2 statutory commissioned/funded mental health services.

The Condition Management Service, commissioned by DEL and provided by the Trust to support those people on incapacity benefit returning to work, would also be considered a step 2 service. Patients can be signposted to this service as appropriate and referral is via the Pathway Personal Advisors based in the Jobs and Benefits Office.

5.3 Step Three Primary Mental Health Care Service – Service users with moderate mental illness.

As already referenced, in Armagh and Dungannon, the Primary Care Counselling Service provides a service at step 2 and step 3.

In the Craigavon and Banbridge area, step 3 service provision has been provided by 3.0wte Mental Health Nurses as part of a primary mental health care service commissioned by the LHSCG.

In the Newry and Mourne area, there are no funded services at step 3.

1.5 wte Trauma Counselling staff resource provide services at steps 3, 4 and 5, with 0.5 wte for each of the three localities, Armagh and Dungannon, Newry and Mourne, and Craigavon and Banbridge.

Throughout the Trust Consultant Psychiatrist Out-Patient Clinics would have reflected step 3 and 4 interventions. 2.8 wte Consultant Psychiatrist resource has been identified as reflecting the step 3 demand.

There is also Consultant Clinical Psychology clinical assessment, and supervision and support to practitioners delivering at step 3.
Over the past 12 to 18 months with the introduction of the regional access targets the Southern Health and Social Care Trust has had to move existing Community Mental Health Team resource, along with significant temporary resource to face elective referrals. This was to ensure patients were assessed and treatment commenced within the required timeframe. However, this has been at a cost to the traditional work of the CMHT’s, i.e. focusing on those needs of patients with severe and enduring mental illness and cannot be sustained.

5.4 Step Four  **Support and Recovery Services – Service users with severe and enduring mental health needs.**

These services are currently being provided by the traditional statutory secondary care mental health services, i.e. in-patient, day patient, out-patient and domiciliary services and by the Trust’s Voluntary sector partners via service level agreements. i.e. PRAXIS, NIAMH, Mind wise, Action Mental Health, Rural Health Partnership,

In-patient care includes both the acute and continuing care in-patient services, provided at Bluestone Unit, Craigavon Area Hospital and St Luke’s Hospital, Armagh, As well as the specialist in-patient services such as those provided in the Psychiatric Intensive Care Unit and the Addictions In-Patient Unit,

Outpatient care is delivered on a clinic basis by the Consultant Psychiatrists, Consultant Clinical Psychologists and Cognitive Behavioural Therapists.

The Psychiatric Day Hospital, Daisy Hill Hospital, Newry provides day patient services.

The Community Mental Health Teams deliver both clinic based and domiciliary based care and interventions for people experiencing moderate/severe mental illness or complex psychological presentations, and approaches include assertive outreach and early intervention for people with first presentation psychosis.
A Trust wide community addiction service is also provided with specialist practitioners in the areas of dual diagnosis.

Unscheduled care services include the Psychiatric liaison Services, inclusive of specialist addiction liaison practitioners, to Craigavon Area Hospital and Daisy Hill Hospital, Newry. It also includes the Crisis Response service that straddles both steps 3 and 4 providing a response within 24 hours to psychiatric emergencies and the Home Treatment Service which provides acute care at home for patients who would otherwise require admission to hospital.

Support services to people experiencing severe mental illness are also provided by the Trust and include:

- Day Care Services delivered from Trasna Day Center, Lurgan and the Orchard Center, Newry.
- Trust Support Living Schemes in Newry, Armagh and Portadown alongside supported living schemes provided by the Voluntary Sector in joint partnership with the Trust and the NIHE.
- Domiciliary support services provided by the Trust and contracted from independent providers.
- Residential and nursing home care contracted from the independent sector.

5.5 Step Five  **Specialist Mental Health Services- Chronic, atypical, refractory and recurrent mental health needs.**

Step 5 in-patient services include the Psychiatric Intensive Care Unit and the Addictions In-Patient Service, as well as our community forensic and eating disorder services, clinical psychology, CBT and specialist community addiction services, such as the Opiate Substitute Prescribing Service.

Outpatient care at step 5 is delivered on a clinic basis by the Consultant Psychiatrists, Consultant Clinical Psychologists, Cognitive Behavioural Therapists and Trauma Counsellors.
Specialist tertiary community mental health services, such as forensic and eating disorder services are delivered by the Trust and would constitute step 5 services within the step care model. As would the opiate substitute prescribing clinic within the community addictions service.

6 PROPOSED NEW SERVICE MODEL

6.1 The Trust proposes to adopt a 5 step model of service provision that has been developed in part from the stepped care framework outlined in the NICE clinical guidance for the management of depression in primary and secondary care, (Clinical Guideline 23 (amended) April 2007), and the clinical guidance for the management of anxiety (Clinical Guideline 22 (amended) April 2007), the IAPT Commissioning Tool 2008, the evidence base in relation to the recovery model and work carried out by the various “Change in Mind” Project work packages over 2008/2009.

6.2 All 5 steps of the service model are interdependent. Steps 1 and 2 can be described as Primary Care integrated. Step 3 can be described as Primary Care orientated or facing and steps 4 and 5 are what would be considered the traditional secondary and tertiary mental health care services. The Southern Trust's stepped care model is illustrated in Appendix 1,

6.3 The Southern Health and Socials Services Board Health and Well Being Investment Plan (HWIP) 2008/09 and 2009/10 sought the Trust’s proposals on the development of the Stepped Care Model/Primary Care Mental Health services based on an investment of £1,550,000 over a 3 year period, 08/09-10/11. This proposal was to specifically reflect the establishment and delivery of mental health services within the primary care setting. Reflecting commissioning intent the proposal submitted not only reflected the proposed service development at Steps 1 and 2, but also the delivery of services at step 3. Steps 1-3 of the service are interdependent and cannot be considered in isolation.
Services delivered in all three steps will contribute to effective management of demand and capacity, and ultimate achievement of access targets. Therefore on 5th May 2009 the Trust submitted its proposal, which has since been approved, for the development of its Primary Mental Health Care Service, i.e. steps 1-3. The proposal submitted to the Southern Local Commissioning Group is enclosed so that the detail can be referenced.

It is important to be note that the recruitment of 38.5WTE posts for Primary Mental Health Care is based on the available ring fenced SHSSB funding of £1,500,000. This is just under half of the total funded staffing resource required to implement steps 1-3 of the proposed service model. i.e 85.5 WTE. Therefore, on the basis of the funding currently available, and on the demand and capacity analysis completed, based on 07/08 demand and agreed workforce capacity assumptions, only half the workforce capacity would be available to meet the anticipated demand. Appendix 2 provides the detailed Demand and Capacity Analysis on which the workforce requirements of 85.5WTE are based.

The following provides a brief outline description of the commissioned service.

6.4 Steps 1-3

At step 1 it is proposed that services will be provided by local General Practice and or the voluntary and community sector, and will include early intervention, mental health promotion and self help. Screening by Primary Care Staff will be undertaken for step two services. Primary Mental Health Care Practitioners in a link worker role will support training for screening and provide pre-referral advice and signposting. It is proposed that 1 session per week of the Primary Mental Health Care Practitioner’s job plan will be dedicated to a link worker role with a cluster of GP practices.

At Step 2, Primary Mental Health Care practitioners in partnership with the primary care team will screen, assess
and treat, or signpost or refer to the appropriate statutory or voluntary/community service for intervention.

At Step 3, the service will provide elective short term psychological, psychosocial, occupational and medical intervention within multidisciplinary context based in primary care/community settings. The multi-disciplinary team will provide a triage function for mental health services, as well as delivering assessment and clinical interventions for people with moderate mental health and psychological problems.

In order to implement steps 1-3 a single point of access and an effective triage system is required and this has been progressed within the Southern Trust.

**Single Point of Access**

To support the development of a stepped care model a single point of access for adult mental health services has been established in the Southern Trust. This has taken the form of a centralised Mental Health Referral and Booking Centre which became operational on the 1st March 2009. From this date all adult mental health referrals are being directed to the Mental Health Referral and Booking Centre Southern Health and Social Services Trust, 68 Logan Road Port down where there is triage and booking system in place for all referrals to adult mental health services: Consultant Psychiatry, Clinical Psychology, Cognitive Behavioural Therapy, Community Mental Health Services, Home Treatment, Crisis Response Service, Addiction Services, Eating Disorder Services and Trauma Counselling.

**6.5 Triage**

A robust triage function is required to support the delivery of a stepped care model. The regionally agreed Mental Health Referral Form will be introduced to facilitate an effective and efficient triage. Triage of all elective routine and urgent referrals is taking place at the referral and booking centre. Triage is being carried out by experienced Mental Health Practitioners on a daily bases, supported by the Primary
Mental Health Care Consultant Psychiatrist.

Triage takes the form of one or a number of the following methods;

• a paper triage based on the referral received,

• a telephone triage with the referring GP,

• A multi-disciplinary team discussion

6.6 Steps 4-5

Over the past 12 months the Trust, as a first phase, has been developing its stepped care service model with particular focus on Steps 1-3 as per the Board’s commissioning requirements. The implementation of step 1-3 services will facilitate the next phase which is to review and modernise the elective community mental health services for steps 4 and 5.

Over the coming 18 months the Trust proposes the following as part of its development plan for step 4 and 5 elective community mental health services:

• With the introduction of step 1-3 services i.e. the Primary Mental Health Care Service, the evidence base suggests that there will be a reduced demand upon step 4 and 5 services –Support and Recovery and Specialist Mental Health Services. The next 6 to 12 months will therefore more accurately reflect the demand for step 4 and 5 services within the framework of a stepped care model. The Trust proposes to then complete a demand and capacity analysis for step 4 and 5 services.

• The development of the Primary Mental Health Care service alongside the development at step 4 of two new Mental Health Resource Centers, one in Dungannon and one on the Bluestone site, Craigavon, has enabled work to commence on integrated care pathways. For example, considering the care pathway for a patient with moderate depression that is
admitted to the in-patient unit or home treatment, and on discharge requires psychological intervention.

- The continued implementation and roll out audit of the Discharge Guidance January 2009, with particular emphasis on the requirement for early follow up on discharge will have implications on capacity requirements for step 4 elective community mental health services. This work will form part of the demand and capacity exercise to be carried out. It will also encompass the “Card as you leave scheme” following acute admission in line with PfA target on continuing care.

- The Recovery and Support Work Package of the “Change in Mind” Project is working on a number of projects that will inform the Trust’s service model for steps 4 and 5. One such piece of work is the development and implementation of a “Shared Management Model”. This model looks at care protocols being developed between Support and Recovery Services and Primary Care, specifically for people who have severe mental illness but who are currently well. This will allow the Trust to explore the introduction of New Ways of Working and skills mix, specifically in relation to new posts such as Support, Time and Recovery Workers, band 3 and band 4 staff. It will also look at enhancing a link worker role between Support and Recovery services and Primary Care. This links with another piece of work currently being undertaken which is the development a recovery based model of support for people who have long term mental health needs in the Southern Area. This work is particularly focusing on the introduction of well-being and recovery action plans [WRAP’s]. This work is clearly aligned to other work within the Mental Health Division pertaining to the development of advice, information and advocacy services; social inclusion; and user/carer engagement.

- In implementing a recovery model of service delivery, the Trust plans to undertake a pilot baseline assessment of nominated services orientation towards recovery focused approaches using a validated tool e.g. DREEM [Developing Recovery Enhanced Environments Measure]

- As part of the Trust’s Delivery Plan 08/09 a number of targets in mental health are outlined;
- Strengthen Personality Disorder services by establishing, by 31 March 2010, a suitably skilled multidisciplinary Team in each Trust, and further developing such services by 31 March 2011

- PSA 6.2: By 2011, ensure a 10% reduction in the number of long-stay patients in mental health hospitals and the related Ministerial target: on Resettlement – Trusts should, by March 2009, resettle 30 patients from hospital to appropriate places in the community compared to the March 2006 total (and a further 60 by March 2011) The stepped care model proposed will take cognisance of these service targets and ensure that the service model will be fit for purpose. Development of step 4 and 5 services will also focus on a service delivery model which will support the achievement of these targets. E.g. a dedicated service/team to aid resettlement of patients from continuing care facilities to supported living arrangements.

  - To support the development of a stepped care model the Trust has implemented management structures which will support service function and the model i.e. there are three pillars of mental health services, Primary Mental health Care, Acute, and Support and Recovery. The realignment of Consultant Psychiatrists to reflect the service functions has also occurred in that there are Consultants now designated to the Primary Mental Health Care Service and to the Support and Recovery/Acute Services.

  - A mapping exercise aimed at identifying those Voluntary/Community and independent sector service providers who deliver at steps 4 and 5 is also being undertaken.

7 CONCLUSION

Over the course of the past year the Trust, through the “Change in Mind” Project, has developed a clear proposal for the implementation of steps 1-3 of a stepped care model. As a continuation of this work the Trust has mapped out in section 6.7 how it plans to further develop and implement it’s proposal for steps 4 and 5 elective community mental health services. This is work in progress and the Trust would welcome working in collaboration with the newly established Regional Health and
Social Care Board in bringing it’s vision of a stepped care model for mental health services to fruition.
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Management of Long-term Conditions (Mental/Physical)

STEP 0
Early Intervention Services
Local Community
Mental Health Promotion

Healthy Living within the Community
Person Accessing Primary Care
Specialist Mental Health Services

General Practice
Primary Care Treatment

Primary Mental health Care Services and Crises Response
- Choose and Book
- Triage and onward referral
- Clinical Assessment
- Treatment

STEP 1 AND 2
Primary Care
- Health and Social Care services for common Mental Health Problems e.g. depression, anxiety
- Agreed Protocols for serious mental illness

STEP 2 AND 3
Screening and Assessment Service
- Single point of access
- Expert standardised assessment
- Signposting
- Choice
- Access Management

STEP 4
Secondary Care
Health & Social Care for serious common MH problems e.g. depression
Health & Social Care for severe mental illness e.g. schizophrenia, psychotic depression

STEP 5
Tertiary Services
Forensic, Eating Disorders, Addiction Services

Discharge

APPENDIX 1
7.1.1 STAFFING CALCULATIONS

Demand & Capacity Analysis – Primary Mental Health Care Service

Projected Demand in 08/09

Services To Be Included in Primary Mental Health Care

In order to determine the number of clinical staff required to support Mental Health Services across the Trust, it has been necessary to examine demand facing the service. In the new service model the Primary Care Mental Health Service will be facing the following demands:

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<th>Service</th>
<th>Actual Demand 07/08- New Referrals</th>
<th>Projected 10% Increase for 08/09-</th>
<th>Projected 15% Increase 08/09</th>
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<tr>
<td>Elective CMHT</td>
<td>1896</td>
<td>2086</td>
<td>2180</td>
</tr>
<tr>
<td>Cognitive Behavioural Therapy</td>
<td>196 (accepted into treatment)</td>
<td>216</td>
<td>225</td>
</tr>
<tr>
<td>Primary Care Counselling</td>
<td>508</td>
<td>559</td>
<td>584</td>
</tr>
<tr>
<td>Psychology</td>
<td>364</td>
<td>400</td>
<td>419</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>2964</strong></td>
<td><strong>3261</strong></td>
<td><strong>3408</strong></td>
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Existing Consultant Demand has been examined to determine how this should be worked into the new service model. As there is currently some anecdotal evidence to suggest that a level of duplication exists within the Mental Health Services, an audit of caseloads with Consultants has indicated the following;

- 1/3 of patients would be assessed at the Out-Patient Clinic and discharged back to the G.P with recommendations for treatment;
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- 1/3 of patients would be co-worked with CMHT staff: future primary mental health care team or support and recovery teams
- 1/3 would remain on Consultant caseload for Outpatient review.

<table>
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<tr>
<th>Service</th>
<th>Actual Demand 07/08</th>
<th>Projected 10% Increase</th>
<th>Projected 15% Increase</th>
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<tr>
<td>Consultant Psychiatrists</td>
<td>2714</td>
<td>2985</td>
<td>3121</td>
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**Future Service Model**

As part of new service model all new patients will be referred centrally and triaged by senior mental health care professionals. Based on the above information the following details how Consultants referrals will be managed in the future.

**Group 1**
- 1/3 of patients would be assessed by a PMHC Practitioner and either discharged back to G.P with recommendations for treatment, stepped down for step 2 practitioner input or signposted to other appropriate services = PMHC Practitioner New Patient assessment. Calculated into PMHC calculations below = 905 patients.

**Group 2**
- 1/3 of patients would be assessed by the PMHC Consultant and co-worked with Primary Mental Health Care Practitioner. These patients are likely to be Step 3 patients, who will therefore have on average 3 treatment slots with the Consultant and 12 treatment slots with the Primary Mental Health Care Practitioner. Treatment for these patients would be split = calculated into both Consultant treatment figures and PMHC treatment figures, see below = 904 patients.***

**Group 3**
- 1/3 of patients would be assessed and reviewed by the PMHC Consultant only = 905 patients.
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Primary Mental Health Care Consultant Demand

Group 2 & Group 3
ASSESSMENT
1809 x 60 mins = 108540/60 mins = 1809 hours

Group 2 (Consultant Only – (Remaining Treatment included in PMHC Practitioners figures))
TREATMENT
904 x 20 mins x 3 sessions = 54240/60 mins = 904 hours

Group 3
TREATMENT
904 x 20 mins x 6 sessions = 108480/60 mins = 1808 hours

TOTAL ASSESSMENT & TREATMENT
1809 + 904 + 1808 = 4521 Consultant Hours

Remaining Primary Mental Health Care Demand = 3869 referrals

Rationale
3869 total referrals = Actual Demand 07/08 for Primary Mental Health Care Services, (identified above, 2964), plus the 1/3 of actual Consultant demand for 07/08 figures, identified above as 905 patients. The rationale for the use of demand into the overall service based on 07/08 data is to move toward the balancing of the anecdotal duplication which apparently exists within the system.

ASSESSMENT
3869 x 90 mins = 348210/60 = 5804 hours

TREATMENT
Step 2 Intervention (20%)
774 x 8 sessions x 60 mins = 371520/60 = 6192 hours

Step 3 Intervention (Moderate Mental Health Problems – 65%)
2515 x 12 sessions x 60 mins = 1810800/60 = 30180 hours
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**Step 3 Intervention Moderate MHP – Co-worked with PMHC Consultant)**

904 x 12 sessions x 60 mins = \( \frac{650880}{60} = 10848 \) hours (patients co-worked with Consultant).

**Step 2/3 Intervention (Group Work – 15%)**

Pre/Post Group Session

580 x 60 mins x 2 sessions = \( \frac{69600}{60} = 1160 \) hours

**Group Sessions**

580/10 = 58 groups x 120 mins x 2 practitioners x 10 sessions = \( \frac{139200}{60} = 2320 \) hours

Total Treatment Hours = 6192 + 30180 + 10848 + 1160 + 2320 = 50700 hours

**8 Centralised Triage Function**

As the Mental Health Services have now been centralized, all referrals are received at this point. Senior practitioners are required on-site to triage the referrals appropriately to the relevant mental health care professional, liaise with booking centre staff, GP’s etc. The professional requirement for the triage function is as follows;

Total PMHC Demand 07/08 = 5678 referrals x 45 mins = \( \frac{255510}{60} = 4259 \) hours

**Total Triage + Assessment + Treatment = 4259 + 7613 + 53412 = 65284 hours**

**Introduction of the role of Mental Health Link Worker**

To support the introduction of the Stepped Care Model, the Trust proposes to ring fence dedicated time for G.P.’s with named Primary Mental Health Care Practitioners, as part of the link worker function. This will ensure G.P.’s have access to practitioners at an agreed time, within their practice to discuss pathways for patients...
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who may be suitable for on-ward referral. It is envisaged that PMHC practitioners, will carry out the Link Worker for a number of practices, determined by geographical proximity and population size. The dedicated time required to facilitate this is detailed below;

1 session = 4 hours
22 sessions are required per week, (based on number of practices across SHSCT. Practices are grouped dependant upon population size and geographical proximity)

22 x 4 = 88 hours per week x 42 wks = 3696 hours.

Total Triage + Assessment + Treatment + Link Role = 4259 + 7613 + 53412 + 3696 = 68980

PRACTITIONER CAPACITY REQUIRED TO MEET DEMAND

IAPT Guidance on skills mix recommends a 60:40 mix for step 2/step 3 interventions. i.e for mild to moderate common mental health disorders. The following assumptions have been made regarding skills mix of staff at various levels within the stepped care model based on guidance provided by IAPT. A guide on actual face to face hours is detailed below;

<table>
<thead>
<tr>
<th>Skills Mix Required</th>
<th>Actual Face to Face</th>
</tr>
</thead>
<tbody>
<tr>
<td>40% = AFC 5</td>
<td>70/30 = 26.25 hrs x 42 = 1102.50</td>
</tr>
<tr>
<td>60% = AFC6/7</td>
<td>50/50 = 18.75 hrs x 42 = 787.50</td>
</tr>
</tbody>
</table>

Actual Hours Required To Meet The Needs of Service

68980 = Total Hours

40% = 27592/1102.50 = 25.02 WTE (Band 5)
60% = 41388/787.50 = 52.55 WTE (Band 6)

77.5
Locality Breakdown

Armagh & Dungannon
Band 5 = 25.02 x 33% population = 8.25 WTE
Band 6/7 = 52.55 x 33% population = 17.34 WTE

Craigavon & Banbridge
Band 5 = 25.02 x 40% population = 10.00 WTE
Band 6/7 = 52.55 x 40% population = 21.00 WTE

Newry & Mourne
Band 5 = 25.02 x 27% population = 6.75 WTE
Band 6/7 = 52.55 x 27% population = 14.18 WTE

FUTURE SERVICE MODEL - SYNOPSIS

It is imperative to highlight that all calculations are based on actual demand into the service during 07/08. These figures have not been increased due to the perceived level of duplication which may have existed within the system, as earlier indicated. However, the service model identified above will deliver a first class Primary Mental Health Service to patients across the Southern Health & Social Care Trust and will have many additional benefits for patients and G.P’s. Southern Health & Social Care Trust are committed to providing a seamless service for patients who move from primary to secondary care services and therefore the role out of the Link Practitioners is pivotal to the success of the model.

ADMINISTRATION SUPPORT

The administration pools to support the professional staff will be based at the following locations and the WTE required to support these services is calculated on the requirement of having 1.0 WTe administration support at each team base, 52 weeks a year, with additionality to support the operational management function. Staff to support these services will be calculated on the 7 hours admin support per week, per professional team member. This equates to a requirement of 5.5 WTE x AFC Band 3.
Primary Mental Health Care Service – Administration Locations

The Mews, Armagh  
South Tyrone Hospital  
Trasna House, Lurgan  
Daisyhill Hospital, Newry

The table below sets out the recurring funding requirements for this service development.

<table>
<thead>
<tr>
<th>Staff Grade*</th>
<th>WTE</th>
<th>Cost (£)**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Mental Health Care services Co-ordinator Band 8</td>
<td>1.0</td>
<td>61,778</td>
</tr>
<tr>
<td>Primary Mental Health Care Team Leader Band 7</td>
<td>2.0</td>
<td>101,748</td>
</tr>
<tr>
<td>Mental Health Practitioners-CBT, Clinical Psychologist, SW, OT and Mental Health Nursing Band 7</td>
<td>15.0</td>
<td>763,110</td>
</tr>
<tr>
<td>Mental Health Practitioners-Mental Health Nurses, Social Workers and OT Band 6</td>
<td>37.0</td>
<td>1,572,352</td>
</tr>
<tr>
<td>Mental Health Practitioners Nurse, SW, OT, Associate Psychologists Band 5</td>
<td>25.0</td>
<td>857,575</td>
</tr>
<tr>
<td>PMHC Service Admin Support</td>
<td>5.5</td>
<td>133,914</td>
</tr>
</tbody>
</table>
## Staff Grade* | WTE | Cost (£)**
---|---|---
Band 3 | | |
**Overall Total** | 85.5 | 3,490,477

*Staff grades have not been confirmed and will be subject to Agenda for Change banding once job descriptions have been agreed.

**Staff have been costed at the midpoint of the scale (inclusive of employers costs) with addition of 20% goods and services.