**Meeting:** Adult Social Care, Health and Wellbeing Sub-committee

**Date:** 5th July 2018

**Title:** Mental Health Service Report


| | | |
|---|---|---|
| **Author:** | Suzanne Barton<br>Head of Commissioning & Quality Assurance<br>Northumberland, Tyne & Wear Foundation Trust. | Tel: 0191 246 6856 (ext. 66856) |
| | Edited by Janet Arris<br>Commissioning Manager<br>North Tyneside CCG | Tel: 0191 2931175 |


**Wards affected:** All wards

## 1. Purpose of Report

The purpose of the report is to provide the committee with an overview of mental health services provided to North Tyneside Residents by Northumberland, Tyne & Wear Mental Health Foundation Trust.

## 2. Recommendations

It is recommended that the committee note the contents of this report

## 3. Details

- The attached report describes an overview of Adult urgent and Emergency care pathway
- Adult mental health community pathways
- S12 doctors
- Access to inpatient beds
- Eating disorder service provision – Adults and young people
- New Care Models

## 4. Appendices

Appendix 1, titled North Tyneside Overview and Scrutiny Committee Mental Health Service Report

## 5. Background Information

The following documents have been used in the compilation of this report and may be inspected at the offices of the author.

Northumberland, Tyne and Wear NHS Foundation Trust

**North Tyneside Overview and Scrutiny Committee**
**Mental Health Service Report**

This report has been written to provide information and an update on a number of areas relating to mental health. This paper will be supported by a presentation to be delivered at the meeting on the 5th July 2018.

Areas covered by this report:

- Adult urgent and Emergency care pathway
- Adult mental health community pathways
- S12 doctors
- Access to inpatient beds
- Eating disorder service provision – Adults and young people

## Adult Urgent & Emergency Care Pathway

### Psychiatric Liaison Services

The Psychiatric liaison services in Northumberland and North Tyneside are based at Northumberland specialist emergency care hospital (NSECH) in Cramlington. The service covers 1 ED department and 10 community hospitals across Northumberland and North Tyneside with a total of 1007 beds. The team has achieved PLAN accreditation and have recently applied for re accreditation. The team provides a 24 hour per day service to NSECH, Wansbeck district hospital and North Tyneside general hospital.

The team is commissioned to provide a 1 hour response to the emergency department and a 24 hour response to urgent referrals made by the acute inpatient wards. The team accepts referrals for any patient over 16 who require advice, support, assessment and potential treatment for any mental health related issue. There is no exclusion criteria. Patients who are over 65 and are at North Tyneside General Hospital will be seen by North Tyneside Psychiatric Old Age Service who are part of Northumbria Healthcare Trust.

On receipt of a referral an initial contact will be made to determine the immediate plan dependant on the person's presentation, need for immediate physical health care and risk. If appropriate a full bio psycho social assessment will be conducted at that point otherwise a plan will be agreed as to when assessment may take place.

The outcome of assessment maybe discharge back to primary care services, referral on to another appropriate service or signposting to the relevant support the plan will be communicated with other services involved with the patient including the acute trust.

Historically the team was a 9-5 service, in June 2016 a 24 hour service pilot commenced and the service has remained in place providing 24 hour care since. However commissioning arrangements meant that the 24hr part of the service was funded on a non-recurring basis. In March 2017 the team recruited a number of staff against the successful bid for development monies to provide a CORE 24 service. The 24 h r service has been functional since then and has proved to be integral to managing the flow within the Emergency department and the Wards. The service ensures that patients experiencing mental health difficulties attending NSECH are seen in a timely way by staff trained to assess their needs. In May 2018 recurrent funding was agreed securing the provision of service and allowing for planned developments to progress.

Plans for development of the teams include the provision of outpatient follow up for patients who have had an episode of self-harm and for patients with a recent delirium.

**Crisis Resolution and Home Treatment Team**

The North Tyneside Crisis Resolution and Home Treatment (CRHT) function has been amalgamated with the Newcastle function as one team since 2000. The team functions 24 hour per day and 365 days per year. The aim of the team is to provide an effective, safe alternative to hospital admission for those individuals who present with high and complex level of mental health need. This is carried out by the team conducting crisis assessments and providing intensive home based treatment interventions as an effective and safe alternative to hospital admission. The CRHT was one of the first teams in the country to achieved HTAS Accreditation (Royal College of Psychiatrist Home Treatment Accreditation Scheme) and has continued to maintain those standards.

**Access**

The team provides open access for urgent referrals and will accept referrals from individuals, professionals and family/friends as long as the referral is made with the consent of the individual being referred. Due to the urgency of need, all referrals are made directly to the team via telephone. Referrals are accepted for adults from 16 to 65. Adults over the age of 65 who are already active to NTW adult community mental health service are able to access the team. Services for older adults are provided by Northumbria Healthcare NHS Foundation Trust.

It has not been possible to develop a dedicated single point of access for North Tyneside however in an attempt to improve access all urgent referrals are routed via the Northumberland Initial Response Team which provides a call-handler function enabling calls to be directed to the triage nurse whilst more general enquiries are able to be dealt with by the call handler. All referrals are triaged by a senior clinician which enables referrals to be safely prioritised based on risk and where necessary signposted to other services.

**Assessment**

The team aims to conduct assessments within 4 hours of referral however will respond to the needs and wishes of the individual. A crisis assessment is completed with the individual and wherever possible and appropriate to do so this process will include family/friends. The outcome of the referral will generally be one of the following:

- Admission to hospital
- Offer of a period of intensive home based treatment
- Signposted/referred to other services
- GP follow-up

**Home Treatment**

The team offers individualised packages of care which include review by a Consultant Psychiatrist; daily contact with the team up to several times per day depending on need; support to take medications; support with activities of daily living; brief psychological interventions; support in accessing appropriate help to address any social issues; access to the team via telephone 24-hours per day; carer support with 24-hour access to the team.

**Transfer/discharge**

Service users remain with the team until the crisis has resolved and it is safe and appropriate for them to move onto or back to their usual care pathway. This can be from a matter of days to a couple of months depending on level/complexity of need. The team actively supports service users in engaging with social and voluntary support agencies to enable them to access longer term support. The team works closely with the Community Treatment Teams to ensure smooth and safe transfer of care.

**Team feedback**

The team consistently receives very positive feedback from service users and families who have been in receipt of a service from the team however criticism of the team is that it is difficult to be accepted for home treatment. Some of this relates to expectations of the public to be able to access services immediately regardless of level of need and some relates to delays in accessing other services throughout the pathway. Professionals have expressed concern regarding the delay in accessing triaging clinician when making a referral due to the levels of demand on the service.

**Street Triage**

Street Triage is a jointly provided service between NTWFT and Northumbria Police and was set up in recognition that some people were being inappropriately detained under S136 of the Mental Health Act by police officers. S136 allows police officers to detain an individual who they find in a place that is not their home and are felt to be at risk to themselves or others due experiencing mental ill-health. This allows the individual to be transported to a place of safety and an assessment of their mental health to be completed. The team is made up of mental health nurses and police officers. Only police officers can refer to the team. Street Triage will offer advice to the police officer in relation to whether it is necessary to apply their powers of detention and where required will conduct a face-to-face triage to enable the individual to be effectively signposted/referred to the help that they need. Since the introduction of Street Triage the number of inappropriate detentions has reduced by over 60%. The team is increasingly becoming involved in supporting the police in conducting welfare checks and mental health act assessments.

**Adult Mental Health Community Pathways -**

The Community Treatment Team (CTT) is a secondary care mental health service for adults over 18 years of age based at the Oxford Centre in Longbenton. However, there are also satellite bases at North Shields and Whitley Bay. NTW accepts referrals to the service from GP's, other health professionals and social services.

The Community Treatment Team provides assessment and treatment for people who are experiencing difficulties with their mental health.

The team is made up of a number of health care professionals including:

- Consultant Psychiatrists
- Psychologists/Psychological Therapists
- Registered Mental Health Nurses (Community Psychiatric Nurse)
- Occupational Therapists
- Support Workers
- Peer Support Workers
- Junior Doctors
- Local Authority Social Workers

The clinical staff team are largely allocated to a clinical pathway and work with service users who present with difficulties from a Psychosis or Non-Psychosis perspective. The clinical team is supported by an admin team that works across both pathways. Within the Pathways there are also some sub functions which support the wider delivery and accommodate some of the specialist need. The pathways and sub functions include;

**Psychosis Pathway and EIP**
This pathway works with people who have complex mental health difficulties that are impacting on their ability to: regulate their emotions, maintain relationships both within their own life but also with professionals and are often at high risk of harm to themselves. As a consequence, life can feel chaotic and unpredictable for the person and those around them. This pathway offers a structured approach to support the person to engage and learn to work with the distressing thoughts and feelings to achieve their goals. The service specifically provides clinicians who are trained to work with Early Intervention Psychosis (EIP) for first episode presentations. This service works with service users from 14 to 35, however, for young people from 14-18, the clinicians will work alongside clinicians from the CAMHS service.

**Non Psychosis Pathway**
This pathway provides assessment and evidence based time limited interventions for people who have complex mental health difficulties that are significantly impacting on daily life. This would include mood disorders, anxiety disorders, trauma related conditions, and other severe emotional difficulties.

**Step up**
The Step Up function will provide Community Treatment Teams (CTTS) with the flexibility to increase the intensity of treatment to service users requiring an enhanced level of care, over and above that which can be provided via planned CTT work. This benefits the service user by allowing them to access a higher intensity of care at critical points in their pathway to recovery. It also benefits CTT clinicians who can access the step-up resource when additional therapeutic clinical intervention is required and enable the CTT clinician to continue to focus on their planned care contact with other service users and clinical commitments. This resource which has been created as a function provides the capacity and flexibility to respond to increased level of need in relapsing and recently admitted or discharged service users. This is not however, a crisis service but this provision can have a positive impact on preventing situations escalating, requiring then the need for the crisis service.

**Physical Health Clinicians**
Regular assessment of the physical health needs and lifestyles of service users within all pathways is important but particularly for those with psychotic disorders requiring the prescribing of particular drugs that can have an impact on physical health. The staff provide appropriate follow up and monitoring of physical health and liaise with Primary Care where possible.

**Mental Health Carer Support Pathway**
Following team assessment and throughout the episode of care, any needs identified by the service users carer will be considered and an appropriate plan agreed as to how best these should be managed. Using the NTW Getting to Know You (GTKY) Framework, this allows the carer to explore their perspective on their carer role and for the worker to provide information that may increase their awareness and understanding of the difficulties their family member may have. In addition this the process enables staff to appropriately signpost the carer to other opportunities to receive carer support i.e. The North Tyneside Carers Centre or a statutory carers assessment via the Local Authority.

**Referral and Allocation Process**
The CTT receives referrals direct to the team, largely by letter or secure email. The referrals are triaged daily by the triage team which consists of a medic, clinical lead and a senior clinician/care coordinator. This process is supported by an administrator. Should it be considered that the CTT is not the most appropriate service to meet the person's needs, or the team require additional information to support the triage, this is communicated with the referrer.

Once allocated for assessment this is arranged by the administrator, largely by telephone with the person to increase their choice and reduce DNA's and the person is then booked into an assessment clinic. A confirmation appointment letter is sent to the person and this is communicated to the respective clinician undertaking the appointment. The assessment appointments are largely dual supported by a nurse and a doctor. Following the assessment, the assessment findings, risk formulation and outcome plan is agreed between the clinician, doctor and the service user and this is communicated in writing to the referrer. If the outcome is to offer ongoing interventions, this will be agreed collaboratively with the service user.

**Enhanced needs**
Patients who have enhanced needs and require care coordination will be allocated a care coordinator via the appropriate Pathway Clinical Lead. We will aim to do this within 72 hours. Once all documentation has been completed with a clear plan and rationale assessors will notify the Clinical Lead or deputy on the day of assessment. Continuing medical responsibility for these patients will be with the Consultant covering the relevant sector regardless of pathway.

**Standard care / Non CPA**
Patients who require standard care under non CPA with a Medic who will be the lead professional for a period of time will be transferred to the relevant sector Consultant.

Patients who require standard care from a CPN/OT/SW who will act as lead professional under non CPA will be allocated via the appropriate Pathway Clinical Lead. We will aim to do this within 72 hours. On the day of assessment once all documentation has been completed with a clear plan and rationale assessors will notify the Clinical Lead or deputy

If these patients require medical input this will lie with the relevant sector Consultant.

**Interventions**
The service offers a range of therapeutic interventions from trained practitioners who can deliver one to one or group interventions. The initial focus of the relationship between the clinician and the service user is to complete a 5 P's formulation which can help the person and the worker better understand how that persons specific illness is impacting on their lives and to consider their

strengths and areas of challenge that may require some attentions as part of the goal setting and intervention plan agreed.

In addition, the pharmacological interventions offered are also monitored by the team and appropriate advice on symptom and side effect management, as appropriate.

**Waiting list Management**
The Team and Clinical manager monitor closely referral activity and make necessary adjustment to workload to manage any increase in demand or spare clinical capacity. This includes emphasising to clinicians and service users the importance of clear goals and monitoring arrangements to assist with discharge planning from the outset. The service is currently managing the referral demand very well with the longest wait for assessment being 4-6 weeks.

**Access to Inpatient Beds and Enhanced Bed Management (EBM)**
North Tyneside CRHT provides a gatekeeping function for inpatient admission beds. When it is identified that a bed is required, it is sought from the Enhanced Bed Management team. EBM was launched due to the increasing demand on inpatient services and to avoid delays in admissions.

Enhanced Bed Management services became operational on April 1st 2018 and provide an efficient patient flow service in and out of NTW inpatient beds. The service operates 7 days a week from 8am – 8pm. The team is multidisciplinary and its purpose is to ensure NTW patient flow issues are addressed from one team/base thus ensuring prompt access and egress from inpatient beds.

A programme of work is ongoing to ensure all delays are prevented for efficient bed stock management and to ensure we have the right patient, in the right bed, at the right time.

Out of hours Bed Management is the responsibility of the Night Site Coordinators – EBM ensure all bed movement actions are planned during office hours.

**Mental Health Act Assessments & s12 Doctors**
When someone requires an assessment under the Mental Health Act, NTWFT are required to provide a suitably qualified (S12 approved) Doctor to complete the first recommendation for the section. During office hours this would usually be the Consultant Psychiatrist involved in the individual's care or one of the community consultants. Where the individual is not already known to NTWFT services, then the assessment is conducted by a Consultant Psychiatrist from the CRHT.

A second S12 Doctor is also required as part of the assessment. This would not usually be another NTWFT Doctor and preferably the person should have some knowledge of the patient. There has been an increase in the mental health act assessments and detentions nationally and this is reflected within North Tyneside.
Identifying the second opinion doctor is usually the responsibility of AMHP but some LAs (such as NTC) are not comfortable with this and the responsibility then falls on the first doctor to find another doctor for a second opinion.

The second opinion is a fee paying service and doctors are not obliged to participate in providing this service.

This combined with a national shortage of Consultant Psychiatrists and changes to GP working practices means that it has become increasingly difficult to obtain the second Doctor. This has led to some significant delays in assessments taking place. We have been working closely with North Tyneside Local Authority and those Doctors who make themselves available for this work to attempt to facilitate these assessments as quickly as possible. NTW is working with the CCG and Local authority to seek a local resolution to this issue for the future

**Inpatient Services**

The main Inpatient services for North Tyneside residents are provided at St Georges Park Hospital; a purpose built modern mental health facility. It provides care within the specialism of Adult Acute (Urgent Care) psychiatry, Adult Rehabilitation services and Older Peoples Services.

**Adult Acute Assessment & Treatment**

The acute admission wards provide safe therapeutic hospital environments to individuals who present with critical levels of mental health need. Ward teams are predominantly made up of nursing staff with dedicated medical input and sessional input from occupational therapy, pharmacy, exercise therapy and psychology staff. We aim to offer a safe, therapeutic and effective inpatient experience based around the needs of individuals, their families and their carers.
The acute admission wards work towards a recovery based model and use NICE guidelines to inform best practice.

There are three acute wards within St Georges Park; Alnmouth Ward, Embleton Ward and Warkworth Ward. Each ward has 19 beds and provide accommodation for single gender patients with Alnmouth providing care for female patients.

In order to improve accessibility to the wards both Warkworth and Embleton are able to increase capacity for male patients. The wards can increase bed availability to 23 and 21 respectively.

**Aims and objectives of service**

The main aim of acute inpatient care Services is to provide specialist mental health advice, support, assessment and treatment within the least restrictive environment possible and within the shortest possible time span helping individuals to reach a point of recovery that will enable them to move through the pathway into community services, rehabilitation, primary care or other mainstream services.

**Service description/care pathway**

The wards provide a service for working age adults who have become acutely unwell and require urgent specialist help from appropriately skilled mental health practitioners. Admission is considered where circumstances or acute care needs mean Service Users cannot be treated or supported appropriately in a less restrictive setting. Service Users can also be admitted under the Mental Health Act when their care needs require safe therapeutic management and treatment in an in-patient setting. Service Users once admitted require high levels of observation, assessment or intensive treatment on a 24-hour basis.

A range of specialist multi-disciplinary assessments compliment the core assessment of need. Care co-ordination is the vehicle for care delivery and facilitates a collaborative multi-disciplinary assessment, individualised care planning, carers' assessment and treatment programmes.

**Admission and Discharge**
Admission to the acute inpatient wards is determined on the basis of need and the level of risk assessed by the CRHT or via an assessment under the Mental Health Act. The NTW Bed Management Service facilitates admissions from authorised gate keepers (e.g. CRHT or MHA assessment) and manages transfers within the pathway and between pathways.

Discharge is also determined on the basis of need with recognition that care should be facilitated within the least restrictive environment. Each ward has an identified Discharge Facilitator who assists with all aspects of the discharge pathway and may facilitate timely discharge to CRHT or CTT in collaboration with the multi-disciplinary team, Service Users and their carers.

**Rehabilitation Wards**
The purpose of mental health rehabilitation services is to provide specialist assessment, treatment and interventions to enable the recovery of people whose complex needs cannot be met by general adult mental health services. Rehabilitation services focus on addressing and minimising symptoms and functional impairment and supporting people to achieve as much autonomy and independence as possible. In order to do this a graduated approach is required, supported by a care pathway that provides a range of treatment and support settings to facilitate and enable recovery on an individualised basis' (Royal College of Psychiatrists, 2009).

In line with the Royal College of Psychiatrist's (2009) recommendations, NTW has developed a care pathway providing a range of treatment and support settings to facilitate and enable recovery on an individualised basis. The model of care pathway includes: High Dependency Rehabilitation Units, Step Down/ Move on and Complex Care units. A step-down in intensity of care aims to deliver the appropriate care pathway for service users who require slow stream rehabilitation, where small key steps are identified and achieved from transfer/admission through to discharge. Following the CQC's inspection in 2016, our rehabilitation services across the organisation were rated as outstanding which puts NTW at the national forefront of providing rehabilitative care.

People who do not recover quickly on acute admission wards are referred to rehabilitation services. Most have a diagnosis of schizophrenia (Killaspy *et al*, 2008) and are referred at the point when it has become clear they have not responded adequately to usual treatment (NICE 2002; 2009) and cannot be discharged home (Holloway, 2005).

Craig *et al*, 2004 and Killaspy *et al*, 2006 identify that despite major investment in community based mental health services a proportion of service users have such complex needs, they continue to require lengthy hospital admission and high levels of support. Service users within the rehabilitation care pathway often require small and sensitive steps towards their recovery and discharge.

**Newton Ward – HDU (Male; 18 beds)**
Patients who need the facilities of our HDU will be highly symptomatic, have several or severe co morbid conditions, significant risk histories and a high proportion will be detained and have "challenging behaviors." Often they will have had forensic admissions or spent periods of time in psychiatric intensive care units. The focus is on thorough ongoing assessment, medication, engagement, supporting clients in managing their behavior and re engaging with families and communities.

Patients on the ward will often require a high level of support and supervision to maintain their safety. Risk management within the HDU is provided by a controlled entry and exit within an emphasis on the implementation of relational skills, appropriate boundary setting and environmental management.

**Kinnersley Ward – Complex Care (Mixed Gender; 21 beds)**
Complex care's key focus is providing a service for people experiencing psychosis who have multiple areas of need associated with their condition. They are likely to have treatment resistant symptoms of psychosis (persistent psychotic symptoms) as well as debilitating negative symptoms such as social isolation and withdrawal; motivation and problems with engagement.

This population group will have the propensity for significant co-morbidity including physical ill-health. Co-morbidity may also include Autistic Spectrum Difficulties (ASD), mild Learning Disability (LD), substance misuse issues, personality disorder (PD) and behaviors which are challenging and associated clinical risk. Challenging behavior will not be of a severity to warrant admission to High Dependency Rehabilitation provision or prolonged intensive, observation levels**.**

Delayed recovery may be due to treatment resistance, cognitive impairment, severe negative symptoms, substance misuse and challenging behavior (Wykes & Dunn, 1992; Wykes *et al*, 1992; Meltzer, 1997; Holloway, 2005; Killaspy *et al*, 2008). A relapsing and remitting course of illness with associated risks of suicide, self-neglect and harm to others increases the vulnerability of this client group. This is a "low volume, high need" group.

The recovery approach is fundamental to the Model of Care for people with mental illness, prioritising interventions and treatment and aiming for optimum recovery for each individual. However, given the complex needs of service users within this pathway, it is anticipated the degree of need at discharge will continue to be significant and eventual discharge would typically be to supported community accommodation (residential care or nursing home environments). They are less likely to be able to manage their own tenancy or independent living.

All service users will have clear goals for intervention, a strategy to promote recovery and a discharge pathway to supported community living. The aim is for each person to stay within the service for the optimum period, maximising individual recovery. The person's needs for treatment and intervention are comprehensively assessed and plans for treatment and intervention are put in place. Attention is primarily given to those needs which require intervention in hospital.

**Bluebell Court – Moving On Care (Mixed Gender; 15 beds)**
Our 'Move On' inpatient rehabilitation service provides 24hr hospital care within specialist accommodation. Bluebell Court provides self-contained single person flats to facilitate maximum independence. Service Users within the moving on service are coming to the end of their hospital journey and aim for discharge into supported or independent living. The service has open access and egress for service users and may accommodate those detained under the Mental Health Act.

**<u>Older Peoples Wards</u>**
There are two Older Peoples Wards at St Georges Park. Hauxley Ward provides 15 mixed gender beds for service users with a functional illness. Woodhorn Ward provides 12 mixed gender beds for service users with an Organic (Dementia) illness. Service users are predominantly over 65 years of age.

**Hauxley Ward**
The functional in-patient service aims to offer a timely and appropriate admission to hospital for the purpose of assessment and treatment for individuals generally over the age of 65 with a mental health need where such assessment and treatment cannot be managed effectively in the community.

The key aims of functional in-patient admission are to:

- Provide person centred admission for complex mental health needs
- Provide a comprehensive multi-disciplinary assessment
- Formulate a diagnosis, plan of treatment, and aftercare-plan.
- Provide a range of appropriate therapeutic interventions
- Consideration will be given to co-morbidities
- Facilitate early discharge and follow up
- Facilitate transfer to appropriate care settings
- Promote mental health well being
- Prevent avoidable deterioration in mental health
- Facilitate timely access to a range of services on discharge
- Provide information relevant to individuals' needs and abilities
- Involve service users and carers in the decision making process to enable them to make realistic choices about their treatment and care.

**Woodhorn Ward**
The organic in-patient service aims to offer a timely and appropriate admission to hospital for the purpose of assessment and treatment for individuals regardless of age with a progressive organic (dementia) mental health need where such assessment and treatment cannot be managed effectively in the community.
Hospital continuing care may be offered where such interventions cannot be managed effectively in the community and where alternative accommodation/ care packages are unsustainable
The key aims of in patient continuing care are to:

- Provide a hospital in patient stay for people with complex mental health needs
- Provide ongoing multi-disciplinary assessment
- Formulate a diagnosis, plan of treatment, and aftercare-plan.
- Provide a range of appropriate therapeutic interventions
- Consideration will be given to co-morbidities
- Facilitate appropriate and timely discharge and follow up
- Facilitate transfer to appropriate care settings
- Promote mental health well being
- Prevent avoidable deterioration in mental health
- Provide information relevant to individuals' needs and abilities
- Involve service users and carers in the decision making process to enable them to make realistic choices about their treatment and care.

.

All inpatient wards at St Georges Park have dedicated multi-disciplinary teams working with our service users. These teams are comprised of a number of different specialties including – nurses, psychiatrists, occupational therapists, exercise therapists, physiotherapists, psychologists, art therapists and chaplaincy.

## Eating Disorder Service Provision

### Adult Service –

### The Richardson Eating Disorder Service (REDS)

REDS is a specialist tertiary eating disorder service for adults that offers a limited number of day patient places and a small number of inpatient beds.

### Referral to REDS

Referral to REDS is via secondary mental health services, and all patients have a care co-ordinator outside of REDS. The service treats adults suffering from moderate to severe eating disorders whose needs cannot be met by primary or secondary mental health services or the third sector.
When the referral is not suitable for REDS it is redirected to the most appropriate service, or a discussion is had with the referrer. When REDS accepts the referral the patient is allocated to the waiting list for assessment. Currently all assessments are conducted within the 18 week standard, and are prioritized according to urgency based on health needs.

REDS is a very small service for the most severely unwell patients, and consequently is able to offer a very limited range of interventions:

1. Day patient treatment
2. Referral for inpatient treatment
3. Support and consultation for patients with eating disorders who are admitted to medical or general psychiatric wards.

### Day Service treatment

REDS is commissioned to provide 50 day patient sessions per week. There is significantly more need than places, and consequently the REDS Day Service has accrued a waiting list of approximately 4 months from referral to treatment.
When treated by the REDS Day Service patients are offered and encouraged to engage with a comprehensive package of care. This care package consists of an individual care plan comprising the following:

- Medical monitoring (weight, bloods, ECG), guidance on prescribing for physical and mental health difficulties.
- Dietetic interventions focussed on improving health and restoring weight safely to a normal level when appropriate.
- Structured support surrounding meals, meal preparation, and post-meal support.
- Nursing interventions to help the patient move forwards with their health.
- Psychological interventions. Patients are encouraged to access both individual therapy and the group therapy programme. Interventions are NICE concordant and there are plans being progressed for REDS to become concordant with the update of NICE (2017).

- Occupational Therapy assessment and interventions, to support patients to live as independently and as meaningfully as possible given any health limitations.
- Individual patient care and the service as a whole are monitored and evaluated formally, supported by the Assistant Psychologist working with the Consultant Clinical Psychologist.

**Inpatient treatment**

Tees, Esk and Wear Valleys NHS Foundation Trust hold the regional contract for adult inpatient treatment for eating disorders. Patients are referred to TEWV, and the Liaison Nurse from TEWV arranges bed allocation according to need. Whenever possible, patients are admitted as near to home as possible. Due to there being only five beds in Newcastle, and 15 hosted by TEWV in Darlington, the majority of patients are admitted to Darlington. Occasionally it becomes necessary to source a bed out of area. When this occurs the most commonly used unit is The Priory Hospital in Glasgow due to bed availability. Due to the number of patients requiring inpatient admission, there is usually a wait to access a bed. TEWV bed managers allocate patients according to priority as set by TEWV. The wait for beds is within 18 weeks. For urgent and priority cases beds are sourced sooner than 18 weeks, according to need.

Once a patient is allocated by TEWV for admission to Ward 31A at the RVI where the local beds are based, the programme of treatment is very similar to that provided by the Day Service:

- Medical monitoring (weight, bloods, ECG),
- Psychiatric assessment and treatment (e.g. psychotropic prescribing)
- Dietetic interventions focussed on improving health and restoring weight to a normal level when appropriate
- Structured support surrounding meals, meal preparation, and post-meal support.
- Nursing interventions to help the patient move forwards with their health.
- Psychological interventions, individual and group. Patients are encouraged to access both individual therapy and the group therapy programme.
- OT assessment and interventions, to support patients to live as independently and as meaningfully as possible given any health limitations.
- Individual patient care and the service as a whole are monitored and evaluated formally, supported by the Assistant Psychologist working with the Consultant Clinical Psychologist.

In addition to the above, the following are also provided that are not provided by the Day Service:

- Nasogastric refeeding when necessary
- Treatment under the Mental Health Act when necessary

**General standards**

REDS is staffed by expert appropriately trained staff, e.g. psychological services staff hold a relevant therapy qualification and obtain suitable skilled supervision. There is dedicated psychiatric and medical cover. REDS/NTW is committed to New Ways of Working – the Consultant Clinical Psychologist works closely with the psychiatry team in providing treatment under the Mental Health Act and leadership to the overall service.

REDS works closely with our partner providers of adult eating disorder services in TEWV. Consequently, services provided by the two Trusts are comparable in content. TEWV hosts more day patient places (10 per session as opposed to NTW's five), and more inpatient beds (15 as opposed to NTW's five). In addition, TEWV has a Community Eating Disorder Team funded by local CCGs. This is

the most significant difference between NTW and TEWV adult eating disorder services and represents a disparity in provision of care and treatment.

**Gaps in service delivery**

The feedback consistently obtained from patients is that once accessed, the eating disorder service was good or excellent. However, many patients report difficulty accessing an appropriate skilled eating disorder service within NTW. There is a significant gap in care provision in that NTW is not commissioned to host a community eating disorder service. Therefore, whilst patients wait to be treated in the inpatient or day patient services, they are either 'scaffolded' by REDS or are held by the general Community Mental Health Team which is not skilled in providing interventions for people suffering from moderate to severe eating disorders. Also, once patients are discharged from inpatient units there is now a considerable wait for the same patient to access the Day Patient programme. This is because demand outstrips supply. Demonstrating cause and effect is difficult, but the absence of a community eating disorder service means that patients will be more ill by the time they access day patient or inpatient services. The lack of capacity in the Day Service means that early discharges may not be supported. And the absence of a community eating disorder service almost certainly contributes towards some patients relapsing and requiring further intensive treatment following discharge from either the Day Service, inpatient admission, or both.

**Children and Young people's service -**

**Eating Disorders**

North Tyneside CAMHS is commissioned by North Tyneside CCG and is provided by Northumbria Healthcare Trust to provide care for young people presenting with eating disorders.

Due to the serious nature of eating disorders if it is apparent from the referral to CAMHS that the young person is likely to have an eating disorder the referral is immediately (same day as referral received) directed to the eating disorder team and an appointment for an initial assessment is arranged. Most of the referrals for eating disorder patients are made by GPs, but the team are working towards self-referral especially for this patient group. Some referrals may arise from open CAMHS cases where eating problems may have developed following referral for another mental health problem.

North Tyneside CCG also commission an intensive eating disorder service (EDICT) in conjunction with Newcastle and Northumberland CCGs. This service is a community based service operating 5 days a week to meet the needs of those with more severe or complex eating disorders. A referral is made to this service from North Tyneside CAMHS if a young person's condition is deteriorating or not improving at a satisfactory rate and a more intensive community treatment is required. EDICT offers similar interventions but can offer more frequent appointments and have a wider multi-disciplinary team.

The EDICT service works with those aged up to 18 years and aims to identify young people as early as possible in the development of their illness and to support them and their family to recover. For those in the most severe need the service will provide a level of intensive home based treatment and will work to prevent admission to inpatient services where possible. Where a young person is admitted, the service will work to support their discharge and return home at the earliest opportunity.

When a young person requires an inpatient bed this is provided regionally at Evergreen which is a specialist eating disorder inpatient unit based in Middlesbrough. Due to a national shortage of

beds/high demand for beds, young people do at times have to be admitted to Scotland or further south which creates isolation from families, their peer group and their community.

In 2016 NHS England publish the access and waiting time standard for children and young people with an eating disorder. This requires those in most urgent need to be in treatment within a week of referral and those who are less urgent to be in receipt of treatment in 4 weeks. This standard also provided within it an identified service model and staffing configuration to support delivery of the waiting times. The service has been reviewing current provision against the preferred model in the paper and is embarking on work with the CCGs to develop this further in line with the 5YFVMH requirements.

**Intensive Community Treatment Service (ICTS)**

North Tyneside CCG in collaboration with Newcastle and Northumberland CCG commission ICTS. This service works with young people up to age 18 years who are in crisis or whose needs cannot be adequately met by the children's and young people's community mental health team.
The service operates 7 days a week with provision into the evening although not overnight.

The service will see young people admitted to the acute services who are deemed to be a risk to themselves or others and will provide intensive home based treatment where necessary in order to minimise risk or to prevent admission to an inpatient bed.

Where an inpatient service is required, ICTS will support and facilitate the admission, remain involved with the young person and their family during their time in the inpatient service and will support and facilitate a timely discharge.

The service works closely with the community mental health service providing support, advice and consultation as well as direct intervention where needed.

When the service is not available there is a more traditional medical on call rota available to support those in most urgent need.

**Gaps/challenges in service provision**

- It has not been possible to provide a dedicated single point of access and the current point of access which covers North Tyneside, Newcastle and Northumberland is often in high demand. Improved access has been provided by routing calls via Northumberland IRT.
- There is no CRHT service for people over the age of 65 in North Tyneside unless they are already open to adult mental health services. There has been some discussions in relation to this role being provided by NTWFT however it is not currently possible due to not having the required expertise within the current urgent care pathway within NTWFT. Discussions are ongoing between CCG, NTWFT and NHFT
- North Tyneside does not have a locality based dedicated CRHT however the joint team have been functioning well for many years and allows flexibility to respond to peaks in demand in both areas.
- Shortage of S12 Doctors are sometimes leading to significant delays in mental health act assessments
- The lack of an adult community eating disorder service is impacting on pressure in the existing services and may be impacting directly on patient care

- The Adult inpatient eating disorder beds commissioned by NHSE are coordinated by TEWV. Due to having only 5 beds in the local area there is a potential for North Tyneside service users to be placed out of area when specialist eating disorder inpatient provision is required.
- Eating disorder services for young people are limited in not being able to provide preventative or early intervention programmes to minimise those requiring intensive or inpatient care. Work has now started in relation to this both in North Tyneside and in conjunction with partners through the New Care Models approach.

**New Care Models – What are they?**

Part of NHS England's 'Five Year Forward View for Mental Health. This is an opportunity for secondary mental health providers (in relation to North Tyneside this is NTW) to take responsibility for tertiary commissioning budgets (previously held by Specialised Commissioning NHS England) and demonstrate ability to innovate and transform services in the best interests of service users and their families.

The principles of New Care Models are as follows

- Reduce reliance on inpatient beds
- Reduce length of stay
- Provide Care closer to home
- Reduce out of area placements

Alongside this change to tertiary commissioning there are also other influencing that are affecting the number of mental health and learning disability beds available in North East England. These are

**Tier 4 Service Review**

NHS England carried out a review of the distribution of CAMHS beds across the country. Consequently the North East of England is expected to reduce its bed base.

**Transforming Care**

The aim is for fewer people with learning disabilities and/or autism to be admitted into hospital for their care. This means the closer of hospital beds across England. Alongside the closer of beds is the development of enhanced community provision. If people do need to go into hospital they are able to access a bed close to where they live.

New Care Models has no additional funding. Monies released from bed/ward closures and sending patients "out of area" can be used to enhance community provision.