DWMHT Personalisation and Pathways review

FINAL REPORT (amended post-comments)

20 January 2015
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Acknowledgments
Thank you to everyone who has shared their views, experiences and time
with this review. This included people with experience of using mental health
services, family members and carers, representatives and staff from Voluntary &
Community Sector organisations, and staff, managers and senior leaders
across all five partner organisations.

We are also grateful to the staff of all five partners who responded to our
requests for a wide range of information, without which we would not have
been able to undertake this review.
1. Introduction

The National Development Team for Inclusion (NDTi) was commissioned by Dudley Metropolitan Borough Council, Walsall Council, Dudley CCG, Walsall CCG and Dudley and Walsall Mental Health Partnership NHS Trust to review and assess the extent to which the local mental health service system – particularly focusing on its pathways and personalisation — is ‘fit for purpose’ to support the outcomes people with mental health problems across Dudley and Walsall want.

A number of concerns had been highlighted regarding mental health services across Dudley and Walsall. These concerns reflect a variety of different, though inter-linked issues, including a keen focus on medical aspects of mental health rather than wider social and community-based approaches, a risk-averse culture, a lack of engagement regarding personalised approaches, and reliance on traditional service models. Further issues affecting delivery of mental health services across Dudley and Walsall were captured in the CQC’s quality inspection report of May 2014.

The circumstances across Dudley and Walsall are by no means unusual in the provision of mental health services across England. The extent, though, to which there is an appetite to consider different ways of doing things – using, for example, the opportunities presented by the Care Act, Personal Health Budgets and Integrated Personal Commissioning and the new mental health payment system, as well as the overarching agenda of Personalisation – may not be as well developed across Dudley and Walsall as it is elsewhere.

Using bespoke tools to consider pathways of people who use mental health services and the framework of Paths to Personalisation in Mental Health this report presents the findings of the review, including the essential areas where work is needed if positive outcomes are to be achieved for local people.

1 Note: whenever the report refers to “personalisation” it means “personalisation for people with mental health problems” unless explicitly stated otherwise.
2 http://www.cqc.org.uk/sites/default/files/new_reports/AAAA0588.pdf Please note that this review is not designed as a direct response to the CQC’s findings.
1.1. Overview of the report

This review is split into five further sections.

In Section 2 we provide the background and context to this work, and in Section 3 outline the methods used to complete this work. Section 4 presents the findings of our analysis of mental health pathways across Dudley and Walsall, including an in-depth view of psychiatric liaison, whilst Section 5 shares our findings regarding personalisation. In Section 6 we have made a number of recommendations regarding what we think needs to happen to address the findings of Sections 4 and 5.
2. Background and local context

Personalisation in mental health has been a feature across Dudley and Walsall since 2011.

Figure 1 below shows the uptake of Self-Directed Support across England in 2013/14 for different client groups\(^4\), including that 24% of people aged 18-64 with mental health problems have Self-Directed Support.

**Figure 1: Uptake of Self-Directed Support in England, 2013/14**

![Image of Figure 1](image)

Table 1 below presents equivalent figures for Dudley, Walsall, the West Midlands and England. It shows Dudley and Walsall’s uptake of Self-Directed Support for all client groups to be about the same as the West Midlands and England, but that the uptake of both Direct Payments and Personal Budgets is significantly higher than regional and national averages for people with mental health problems.

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Table 1: Comparing Self-Directed Support and other outcome measures in Dudley and Walsall and other areas

<table>
<thead>
<tr>
<th></th>
<th>% All people receiving SDS(^5)</th>
<th>% MH users on Direct Payment(^6)</th>
<th>% MH users on Direct Payment or Personal Budget(^7)</th>
<th>CPA Adults aged 18-69 in paid employment(^8)</th>
<th>CPA Adults aged 18-69 in stable accomm(^9)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dudley</td>
<td>63.5%</td>
<td>30.8%</td>
<td>69.2%</td>
<td>3.6%</td>
<td>30.0%</td>
</tr>
<tr>
<td>Walsall</td>
<td>59.8%</td>
<td>15.4%</td>
<td>23.1%</td>
<td>5.5%</td>
<td>41.4%</td>
</tr>
<tr>
<td>West Midlands average</td>
<td>51.1%</td>
<td>9.3%</td>
<td>17.1%</td>
<td>11.5%</td>
<td>60.3%</td>
</tr>
<tr>
<td>England avg</td>
<td>61.9%</td>
<td>8.1%</td>
<td>21.1%</td>
<td>8.8%</td>
<td>58.5%</td>
</tr>
</tbody>
</table>

The rate of people on the Care Programme Approach in employment or stable accommodation across Dudley and Walsall, though, is significantly below both regional and national averages.

Oversight of the mental health system across Dudley and Walsall is broadly achieved through the following stated governance arrangements:

- The relationship between Dudley and Walsall Councils and DWMHT is formally governed by the Section 75 agreement between the two partners, overseen through both a Partnership Board and a Partnership Operations Group (POG). The Senior Management of DWMHT meets at Management Executive Team (MExT) meetings.

- The Personalisation Implementation Group (PIG) provides governance of the Mental Health Personalisation Implementation Action Plan, comprising

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\(^7\) See footnote 5.

\(^8\) See footnote 6.

\(^9\) Ibid.
four workstreams aligned with Making It Real. The Action Plan states that PIG “will have a membership that spans both health and social care and will include people who use services and carers” and that it reports into both health and social care board structures. The plan states the Head of Social Care has “overall responsibility for the management of the implementation process”.

- User and some other stakeholder engagement with regard to personalisation happens primarily through Making it Real Dudley.
3. Method

The review was completed within the overall framework of Paths to Personalisation in Mental Health. This framework, which was co-produced with users and practitioners for the Department of Health, enables us to review and assess the extent to which a local mental health local service system is delivering personalisation.

The framework comprises the following 10 areas:

1. Person centred systems and approaches – do processes, systems, practice and culture exist to ensure this happens as a matter of routine? Operation of panel? Particular focus on integration and whether this is supported by systems, processes and approaches

2. Creative commissioning – does the system and culture facilitate creative new options, utilising community resources, or is it stuck with traditional provision and relationships? Is management data used appropriately? Is commissioning in line with what data suggests?

3. Information and advice to support risk enablement and recovery – do people have the information they need to take control of their lives and services?

4. Partnerships for inclusion – are the right partners involved to enable all possible resources to be accessed and utilised?

5. Support for managing PBs – are people enabled to use their budgets effectively or are they deterred by a lack of appropriate support?

6. Prevention and early intervention – is personalisation being utilised as a way of preventing increased mental ill-health?

7. Support for carers – are families and carers engaged with the personalisation agenda and if so how, or is it seen by them as an unwelcome threat?

8. Good leadership for all – at all levels (management, front line staff, people who use services) is there an understanding and commitment to the change agenda?
9. Fair access and equality – does the system enable all people to benefit from new ways of working or are some groups or conditions effectively excluded?

10. Workforce and organisational development – is the workforce ready for transformation and personalisation and do systems support this to happen? What training do people receive?

Three key elements of work have informed this report:

1. Documentation review and observation
2. Pathways and data analysis
3. Engagement

Key Lines of Enquiry were created to ensure consistency across each of these elements of the work. They drew on the framework of Paths to Personalisation in Mental Health and are included in full at Annex 1. In summary they were:

1. What values and principles underpin mental health care and support across Dudley and Walsall?
2. To what extent is personalisation embedded across mental health care and support across Dudley and Walsall?
3. What is Dudley and Walsall’s preparedness for the future with regard to personalised mental health support?

More detail on how we completed each element of work is provided below.

3.1. Documentation review and observation

We received a total of 65 policies, procedures, service specifications and other documents in place within the Trust and jointly with council partners. Of these, 47 were comprehensively reviewed to garner how well they reflected personalisation and the extent to which a model of care structured around recovery, optimism and hope was reflected in the policy framework.

The full list of documents received and reviewed is contained in Annex 2.

We also observed a total of 10 meetings as follows:

• Two meetings of the Personalisation Implementation Group
• Two meetings of the Partnership Operations Group (one including an update by the review team)
• One meeting of the Partnership Board (including a presentation by the review team)
• One meeting of Management Executive Team (primarily to present an update by the review team)
• Two meetings of Dudley Panel
• Two meetings of Walsall Panel.

3.2. Pathways and data analysis
Using a bespoke data analysis tool we mapped the pathways of how people flow into and out of the Trust’s teams, as well as to understand caseloads and levels of staffing across the Trust against national benchmarks. The scope of this strand of work covered the following: Community Recovery Service, Crisis Resolution/Home Treatment, Early Intervention, Assertive Outreach and a more detailed look at Psychiatric Liaison mental health pathway, from front door, referrals, assessments, planning, service placement, review and discharge

3.3. Engagement
To understand the different experiences and perspectives of a range of stakeholders, including users and their representative organisations, practitioners, managers, senior leaders, commissioners and providers, we:
• Completed a series of 5 small focus group discussions
• Undertook 56 individual interviews with people
• Offered people the opportunity to share experiences with us online.
A full list of the work undertook as part of the engagement phase, including the roles of people we spoke to and their organisation, is contained in Annex 4.

We now turn to the first set of findings from this review, regarding local care pathways across Dudley and Walsall.
4. Pathways findings

The aim of this element of the review was to analyse data to understand the pathways of how people flow into and out of the Trust’s teams, as well as to understand caseloads and levels of staffing across the Trust against national benchmarks. The scope of this strand of work covered the following: Community Recovery Service, Crisis Resolution/Home Treatment, Early Intervention, Assertive Outreach and a more detailed look at Psychiatric Liaison\(^{10}\).

**Figure 2: Example flow diagram**

The original aim was to produce a set of flow diagrams for each team, which could also be brought together to look overall at types of teams and the whole

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\(^{10}\) The scope of this element of the work originally also covered Inpatient and IAPT services. Unfortunately, this data was only provided in December 2014 and so couldn’t be incorporated in this analysis. It will be included in any further data and pathways work – see the recommendations for further details.
service (see Figure 2 – provided for illustrative purposes only). This would not have incorporated any kind of “performance management” but would support discussion to see what they highlighted about pressure points in services and the potential for development.

Unfortunately it has not been possible to complete this work against this original intention since there has been no set of data produced in which we have sufficient confidence.

We explore the reasons for these issues now.

4.1. Data issues

Though colleagues in the Information Team of DWMHT have worked hard to pull the requested information together – in a format we understand may not have been part of the team’s brief, and so work that has been much appreciated – it has not been possible to get to a common and confirmed set of data in which we have full confidence.

We made an initial data request in August 2014, after which we received three sets of data, in September, October and November 2014 respectively. On each occasion we understood the information provided to be the full and complete set of information requested. However, after analysis of each respective set of data we identified anomalies and further questions, which led to further revision.

Other challenges beyond providing consistent data have included:

- Comparison with Partnership Performance Indicators (PPI) paper items. When the data provided for this review was compared with the data present in the PPI paper some of the data did not seem to match. It is possible this might be due to “different activities” that are or aren’t included, and so were advised to disregard the PPI data for this analysis.

- There were confused messages about which data was or was not available. For example, the first set of data showed the Crisis Resolution/Home Treatment teams discharged considerably more people than they have had referred to them (in Walsall by a factor of 10). The same was true of CRS. We raised this and were told that this is what is being recorded by the teams. However, the third data submission gave completely different referral numbers and it remains unclear why data “being recorded” was then found to be different later on.
• It has been impossible to reconcile data for the pathways in and out of teams from the data provided at all stages. For example, acute inpatient services show over 800 people referred to them after gatekeeping by CR/HT, whilst the CR/HT data shows referrals for just over 400 people to the acute inpatient service. These numbers should be the same. We are told that the difference is due to service change, but to date we have not been able to get even approximately accurate data for any quarters.

• An associated area of note is that adult outpatients seem to have a total caseload of up to twice the size of all the Trust teams which have been the focus on this review added together. One of the medical staff (or perhaps a small team) has over 500 outpatients on their caseload, and 12 further medical staff have over 300. It has been suggested that these caseloads await cleansing. After our questions the outpatient data was put into the CRS team data in the second data set, but was removed then again in the third.

• The first and second sets of data we were sent included client confidential information. The formal data breach protocol was triggered and subsequently satisfactorily addressed, with all confidential data appropriately destroyed.

Having highlighted the issues faced in data collection, we now turn to what analysis we feel we can draw from the work completed.

4.2. Pathways data: high-level view

Reviewing the team data supplied suggests none of the teams experienced a steady increase in demand over the year, except potentially Psychiatric Liaison in Dudley. This is against national reports of significantly increasing demand for mental health services across the whole of England.

However, the Health and Social Care Information Centre Mental Health Annual Report for 2013/14 shows a 9% increase in demand in Dudley & Walsall Trust between 2011/2012 and 2012/13, and a further 9% increase between 2012/13 and 2013/14\textsuperscript{11}. The same data set shows that between 2011/12 and 2012/13 there has been a 5% rise in adult admissions.

We would therefore conclude that there probably is increasing demand for mental health services in Dudley and Walsall, but are not clear why this is

only shown on one of the sets of team data. It may be that this pressure is being transferred to other parts of the system, for example we note the very high caseloads in psychiatric outpatients.

4.3. Crisis Resolution / High Treatment

In Dudley and Walsall there are a high percentage of referrals to Crisis Resolution / Home Treatment from A&E and secondary specialist care and discharges which are for admissions to hospital. This reflects the acute care services model. The Dudley team seems to have a significantly higher level of discharges to hospital than Walsall.

The low level of referral from GPs and the fact that 10% of people are discharged back to GPs is notable and indicates a difficulty in the overall pathway from and to primary care.

The Dudley caseload is 3.6 people per 10,000 weighted population and the Walsall caseload is 3.4 per 10,000 weighted population while the national average is 5 per 10,000 weighted population. This probably reflects the service model.

When CR/HT was initially developed in the National Service Framework it was intended that they should not work in A&E. Service models will and should develop over time and take account of local conditions; the question is whether these services have the capacity to do this work in addition to fulfilling the original function of supporting primary care, diverting people who would otherwise be admitted to a mental health unit and enabling the earlier discharge of people from mental health inpatient beds. The data available would suggest these teams function largely in support of the acute services model.

It is not possible to identify from the data response times for the crisis service to visit someone at home, nor the degree to which the team is able to support the early discharge of people from acute mental health beds.

4.4. Community Recovery Services

Because of both data issues and the degree of service change we have found it most difficult to map pathways into and out of the Community Recovery Services. For example (and repeating findings from CR/HT) more people seems to be referred from EASs to CRSs than the number of people received by CRSs from EASs.
Overall, the data suggests that many people move around different services delivered by the Trust rather than being discharged back to their GP with treatment completed. Our analysis showed that on discharge, 55% of people went from Dudley South CRS to other trust services, the majority going to medical outpatients. The figure for people from Dudley North going to other Trust services was 45%, and for Walsall South going to other services was 42%. In comparison 13% were discharged from Dudley South CRS to their GP, and 5% from Dudley North to their GP.

However, we also found the following:

- The data appears to show that across all the CRSs the most common pathway in is through CMHTs and consultants. We understand that the term “CMHTs” refers to any/all other Trust MH teams. During the period reflected here the service was moving to a model of EAS assessment and referral on, but there are almost no referrals identified as from the EAS so it is hard to understand this.

- Benchmarking against national data suggests that, against the caseload per 10,000 weighted population, all the CRSs are lower than the national average for CMHTs. However the CRS model of working is different so this benchmark may not be applicable.

- In Walsall North CRS GPs account for 20% of all referrals to the CRS, higher than any other CRS. 45% of people leave Walsall North CRS with their treatment completed – a rate much higher than the other teams. This team also seems to have a shorter length of stay than the other CRS teams, for reasons we weren’t able to ascertain. In Walsall South CRS 40% of the pathways out are to other DWMHT services, whilst 25% return to their GP’s care.

4.5. Early Intervention

In both teams the average length of stay is low for an Early Intervention service – around 140 days. The published aim is for people to remain engaged with the service for 3 years.

The national average caseload is 5 per 10,000 weighted population. The current caseload in Dudley is very close to the national average, with 4.6 cases per 10,000 weighted population; the Walsall caseload is somewhat below the national average, with 3.9 cases per 10,000 weighted population. This would suggest that while the teams are identifying people needing an EI service they are not offering them support over a full three-year period. This
would therefore suggest that more young people with a first episode of psychosis would relapse and may need to be admitted to a hospital.

In both Walsall and Dudley around 20% of all discharges are recorded as inappropriate referrals. This may be a data recording issue, but if accurate would merit work to clarify and confirm referral criteria to reduce inappropriate referral.

The pathways in to the service data suggest that only 10% of people are referred from EAS, but the large majority come from other Trust services. It suggests people are being referred to other Trust services before they get to EI. If this is accurate improved identification at the first point of entry would reduce multiple assessments before a person arrives at the appropriate services to meet their needs.

The data suggests nobody is identified as moving from the Walsall EI team to hospital. If this is accurate it reflects very positively on the service provision.

4.6. Early Access Services

Over the year the number of new referrals to EAS looks stable. If the main function is to act as a first point of contact and gate keeping service it would appear to be functioning well.

4.7. Psychiatric Liaison

Below we provide a more detailed analysis of Psychiatric Liaison in Dudley and Walsall. This reflects the provenance of the pathways element of this review: in developing the scope for this work, the opportunity was taken to broaden a piece of pathways analysis work originally intended to cover only Psychiatric Liaison in Walsall to a more general approach across all relevant teams in Dudley and Walsall. This more detailed section is therefore included to seek to meet one of the partner's (Walsall CCG) original intentions.

Objectives of psychiatric liaisons services

There are two main objectives of psychiatric liaison services, which every service will meet to a different degree and, depending on the mix of services and client focus, will deliver different outcomes. The two possible foci are:

• Improving service quality – this will include redirecting patient to more appropriate services, improving patient flow, supporting staff
• Reducing costs – his will include avoiding admissions or reducing the length of stay in hospital.

Target client groups or clinical areas

There is a range of different user groups who might be the focus of psychiatric liaison; depending on the user groups concentrated on there are associated different levels of potential cost saving and quality improvement. These groups and services and not mutually exclusive, but include:

• Older adults in acute hospital beds. This is the area where evidence is strongest both for cost saving and for improving service quality and user satisfaction.

• Working age adults in acute hospitals. There is limited evidence for cost saving and quality improvement with this group as they are a minority of acute bed users. However targeted input to those with complex needs may be clinically and cost effective.

• Children and Adolescents. Whilst the number of young people in acute hospital beds is low, support to them may reduce life time needs and deliver long term saving.

• Emergency departments. This area is important in terms of supporting people in crisis and making the services run effectively, but there is limited evidence around effectiveness and cost reduction. There is some evidence of savings from brief interventions to people with alcohol abuse problems, and work on identifying and focussing on frequent attenders.

• People known to mental health services. There is an immediate response role here, potentially signposting people back into mental health services. Liaison supports effective cross-service functioning but there is limited evidence of reduced costs.

• Acute hospital staff training. There is some evidence that the most effective impact of a psychiatric liaison service is through the training and onsite support to acute staff. This is a crucial element of any liaison service.

• People with Long Term Conditions. Outside acute hospital settings there is growing evidence that people with a long-term physical health problem who have a concurrent mental health problem are more likely to suffer further physical health problems. There is evidence that treatment can reduce costs and improve people’s lives.
Medically Unexplained Symptoms. Throughout the NHS, from the GP to consultant clinics, there is a strikingly high rate of medically unexplained symptoms. Where there appears to be no underlying medical problem there are small-scale projects which appear to show that after a psychological intervention the amount of medical care required can be reduced.

Service description and activity levels of psychiatric liaison in Walsall and Dudley

**Table 2: Psychiatric Liaison in Walsall and Dudley – service description and activity levels**

<table>
<thead>
<tr>
<th></th>
<th>Walsall</th>
<th>Dudley</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SERVICE DESCRIPTION</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hours of operation</td>
<td>8am - 11pm, 7 days a week. Outside these hours requests go to the Crisis Resolution/Home Treatment service</td>
<td>24 hours a day, 7 days a week. Works alongside the Crisis Team</td>
</tr>
<tr>
<td>Staffing</td>
<td>4 wte nurses</td>
<td>6 wte nurses</td>
</tr>
<tr>
<td>Clinical focus</td>
<td>Accident and Emergency Department</td>
<td>Accident and Emergency Department</td>
</tr>
<tr>
<td>Base</td>
<td>Dorothy Patterson Hospital</td>
<td>Russell Hall Hospital</td>
</tr>
<tr>
<td><strong>ACTIVITY LEVELS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current caseload</td>
<td>14</td>
<td>160</td>
</tr>
<tr>
<td>New referrals (annual)</td>
<td>1060</td>
<td>1293</td>
</tr>
<tr>
<td>Assessments (annual)</td>
<td>666</td>
<td>827</td>
</tr>
<tr>
<td>Discharges</td>
<td>779</td>
<td>1227</td>
</tr>
<tr>
<td>Pathways in</td>
<td>• 53% A&amp;E</td>
<td>• 91% A&amp;E</td>
</tr>
<tr>
<td></td>
<td>• 36% other secondary care speciality</td>
<td>• 8% other secondary care speciality</td>
</tr>
<tr>
<td></td>
<td>• 9% Primary Healthcare</td>
<td></td>
</tr>
<tr>
<td>Pathways out</td>
<td>• 23% Assessed, treatment not indicated</td>
<td>• 39% Discharged to GP</td>
</tr>
<tr>
<td></td>
<td>• 16% Discharged to GP</td>
<td>• 12% to CRHT</td>
</tr>
<tr>
<td></td>
<td>• 13% to CRHT</td>
<td>• 12% treatment completed</td>
</tr>
<tr>
<td></td>
<td>• 9% to other agency</td>
<td>• 8% Admitted to hospital</td>
</tr>
<tr>
<td></td>
<td>• 6% to a Walsall CRS</td>
<td>• 7% to a Dudley CRS</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 5% to other agency</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 2% Assessed, treatment not indicated</td>
</tr>
</tbody>
</table>
Table 2 presents a service description and activity levels of the psychiatric liaison services in Walsall and Dudley respectively.

It shows that, in Dudley, the main discharge pathways are to the GP, followed by Crisis Resolution/Home Treatment, and treatment completed. Eight per cent of the service users are admitted to hospital.

In Walsall a third of referrals are from secondary care specialists, presumably within the acute hospital. Almost a quarter of people are discharged with no treatment indicated. If this is accurate there could be major benefits for developing and clarifying the referral criteria to reduce this demand, such benefits including reducing staff time on such assessments. The discharge to GP data could also be further investigated to verify its accuracy and to consider how GPs are supported to receive people from psychiatric liaison services.

There is no data to enable an analysis of the different potential areas of liaison activity, such as supporting older people on hospital wards, acute staff training, working with people with Long Term Conditions or Medically Unexplained Symptoms.

There are uncertainties about the robustness of this data, especially with respect to service change and how it has affected the differences found in referral pathways. However the general picture of assessment, discharges and pathways seems similar to A&E-focused liaison services across England. Such services will support patient in times of crisis, signpost people into mental health services, and support and enable pathways within the A&E department. They will not carry out significant work with inpatients.

**Options for psychiatric liaison development**

If there was potential for development within the current service model the following should be considered:

- Whether there were ways to increase therapeutic inputs in the A&E department, including the work on reducing harmful drinking, managing emotions
- Further developing training and support for acute hospital staff.

If there was potential for development of broader psychiatric liaison services beyond the current service model the following should be considered:
• Enhancing cost benefits by developing a very strong focus on older adults, and enabling them to leave hospital earlier

• A focus on children and adolescents in the acute hospital setting

• The development of services for people with Long Term Conditions

• A broadening of the professional base of the service.

This would need to include enhanced information collection such as\(^\text{12}\):

• Inputs/structure, such as:
  
  o Availability of adequate accommodation on the hospital site

  o Availability of suitable facilities for patient assessment in the emergency department and all wards

  o Access to the information systems of the general hospital and local mental health services

  o Suitable arrangements for referrals, e.g. single point of access

  o Availability of suitable mechanisms for clinical supervision and governance

• Activities/outputs, such as:
  
  o Response times, separately for routine, urgent and emergency referrals

  o Numbers of patients seen, separately for major age and diagnostic groupings

  o Proportion of patients aged 65+ with dementia having a review of psychotropic medication

  o Proportion of patients with alcohol problems given a brief intervention for alcohol misuse

  o Proportion of patients attending A&E for self-harm receiving a psychosocial assessment

  o Numbers of general hospital staff attending mental health training sessions

\(^{12}\) This list derived from “Outcomes and performance in liaison psychiatry” (2014), Matt Fossey & Michael Parsonage, Centre for Mental Health. Available online: http://www.centreformentalhealth.org.uk/pdfs/Outcomes_and_perf_in_LP.pdf
• Reductions in length of stay among patients with a mental health diagnosis

• Reductions in readmission rates among patients with a mental health diagnosis

• Reductions in numbers of discharges to institutional care among patients with a mental health diagnosis

• Reductions in numbers of frequent attenders at A&E

• Reductions in numbers of serious untoward incidents

• Reductions in numbers of mental health-related A&E waiting time breaches.

• Outcomes, such as:

  • Improvements in health and well-being, based on appropriate generic and/or condition specific outcome measures

  • Improvements in patient satisfaction

  • Improvements in family/carer satisfaction

  • Improvements in referrer satisfaction.
5. Personalisation findings

We now turn to the findings of the review with regard to personalisation.

As noted in Section 3, we undertook a review of policies and documentation, observations of various key governance and decision-making mechanisms and nearly 60 interviews with a wide range of stakeholders in order to review and assess the extent to which local mental health local service system is delivering personalisation.

The results of this work are presented and discussed below, and are arranged according to the 3 Key Lines of Enquiry highlighted in Section 3 and Annex 1, namely:

1. What values and principles underpin mental health care and support across Dudley and Walsall?
2. To what extent is personalisation embedded across mental health care and support across Dudley and Walsall?
3. What is Dudley and Walsall’s preparedness for the future with regard to personalised mental health support?

5.1. Underpinning values and principles

It was widely accepted that there was little momentum for personalisation in the “early” days of 2011 and 2012, resulting in personalisation in mental health being “left behind” progress for other client groups. There has been an increase in activity regarding personalisation over the last 18 months, and especially in the last 6 months. It is beginning to be talked of as “business as usual” rather than something exceptional or separate.

The document review showed that personalisation is referenced and, to some extent, articulated in a reasonable proportion of policies.

For example ‘My Support Plan’ is well structured, positively focused and offers an enabling care planning structure. After the initial administrative questions, on page 3 it starts by asking the user to consider: ‘What is important to me?’ and ‘What is good in my life?’ These are really simple, effective and
individually-focused and positively biased questions, which create a focus on the individual, their lives and their aspirations.

Furthermore, documentation suggests it is often understood that personalisation is clearly related to the recovery model in mental health. For example, Community Recovery Services, operational policy has some clear statements about the aims and objectives of the services that echo principles of personalisation and recovery:

The team aims to help people set and achieve their goals and ambitions by providing information, support and encouragement within their own community.

Objectives about service provision include:

- A person centred, recovery focused, socially inclusive approach
- A sensitive and responsive approach to service users’ cultural, religious and gender needs

There are many places where opportunities for talking about personalisation and recovery, including optimism and hope, are missed.

For example, the Transition Protocol from Child & Adolescent Mental Health Services to Adult Mental Health Services states:

It is the task of services to ensure that the transition process and the change in services run smoothly. It is recommended that multi-agency transition planning for young people, is key to providing high quality transition services. Within this, individual disciplines should have clear, good practice protocols for the management of young people’s health during the transfer to adult care.

Whist this is of course correct, the point of transition for a young person presents no better nor more important time to focus on the individual. The protocol could therefore describe that transition is the key point to work with the young person to find out what they want to achieve, not just for their care and support but for their aspirations regarding work, education, where to live, and their cultural life and leisure, as well as what might be needed to achieve this.

All the protocols are necessary and need to describe the practicalities of admission, processes and the role of different parties in it. However, for personalisation and recovery to be embedded in a whole way of working, all documents need to create opportunities to reflect people’s aims and aspirations.
More generally, the language of “patient” is prevalent within the Trust, including social care staff. This is inconsistent with personalised care and support and is indicative of a medical model, deficit-based approach rather than a social model, asset-based approach.

It had been suggested that personalisation is perceived within the Trust as “only a social care issue”. We found little evidence of this view. Personalisation is clearly identified as something that staff with either social care or health backgrounds are responsible for. Nor did we find evidence that staff from one discipline were working in a more personalised way than another discipline: there was equally good and poor practice with regard to personalisation amongst health and social care staff. The only relevant observation to this question is that there appears to be less opportunity for social care staff to progress within the Trust: we understand all Heads are from health backgrounds.

5.2. To what extent is personalisation embedded?

In this section we consider the practical extent to which personalisation is embedded. We do this by considering specific issues that were highlighted through the review process. Some findings belong to several different areas; in this case we have included them under the most relevant heading.

Information

Sources of information for users or staff is a perpetual issue in personalisation: there can never be enough information. Within DWMHT, the personalisation pages on the intranet that have been recently developed, and summarised in a Wednesday Wire dedicated to personalisation, are good. They contain suitable information about principles and practicalities in a place that staff will regularly see them. It will be important to recognise that producing this information is a starting point and not an end point: the pages need to be continually added to. Additions should include example documentation of what is good / poor practice.

A key addition will be of “good news” stories, sharing examples of the difference personalisation has made to users and staff. Such examples across Dudley and Walsall do exist, but the opportunity to capture and share

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13 Recognising this, Think Local Act Personal has produced a considerable series of resources on information and guidance aimed at a variety of stakeholders – see: http://www.thinklocalactpersonal.org.uk/Latest/Resource/?cid=9553
them has been missed. A further benefit of sharing such stories be of helping to understand if personalisation is working well.

Another missed opportunity was the process for creating these information resources. This provided an ideal chance to engage both users and wider stakeholders, including voluntary and community sector organisations, to shape and inform the resources. Whilst the quality of the information is still good, it could have been enhanced through such engagement, as well as provided a good chance to build relationships around practical work to support personalisation.

**Staff practice**

In any organisation it is to be expected there will be a range of quality in practice. This range was present across Dudley and Walsall, but we also identified that some basics are not being done more than would be expected. This particularly included assessment: examples included CPA assessments including only the name of the user and a signature with no other information. Providers noted that they had to pick up basics in assessment work that wasn’t being done much more than they would expect. The quality of support planning and reviews also followed this pattern. Irrespective of the personalisation agenda, this is a worry.

(Under the Panel section later we discuss the paperwork, particularly the SDAQ and MAF2, associated with personalisation and how they do not create the best opportunity for good personalisation practice.)

We heard that supervision from managers does not always address these practice issues. For example, we heard that work has been done to identify staff who would benefit from additional support in, for example, presenting at Panel, but did not identify any clear action taken to provide this support.

Nor is support or promotion as generally available as it could be for personalisation. Within teams there don’t appear to be individual personalisation champions. Opportunities to promote personalisation through, for example, Heads meetings or the Social Care Forum, have not been exploited as well as they could be.

Despite this, there is an appetite amongst staff for personalisation to be done well. This extends to staff beyond the Trust, for example, people who manage local mental health day services. Rather than personalisation being something “done to them”, staff want the opportunity to engage with and shape how personalisation works across Dudley and Walsall.

**Staff training and support**
Training on personalisation was made available when it was first introduced. This focused primarily on the practicalities and paperwork of personalisation rather than its principles and values. The training that was offered was not sufficient to cover everything needed for the successful introduction and embedding of personalisation; nor has there been sufficient follow-up or further training made available. The effects of this are felt now, for example at Panel.

Regular and ongoing training is available for wider social care staff working in their respective local authorities. This is rarely made available for staff working within the Trust. More coordination between Learning & Development teams in the Trust and Local Authorities should be in place so available training resources that are in place are available for everyone. Training-needs analysis to underpin future training should actively involve practitioners and look across organisational boundaries.

Beyond formal training, neither practitioners nor team managers get the regular ongoing support they need to successfully embed and enable personalisation.

Sources of support are available in principle, such as through the Personalisation Implementation Team Manager in Dudley; 1:1 support is also available through the Personalisation Manager in Dudley and the commissioning team in Walsall. This includes providing drop-in sessions for practitioners and being a source of advice for practitioners and managers alike, alongside leading some of the strands of work for the Personalisation Implementation Group. In practice, the effectiveness of this role is diluted by other demands made of it, including being asked to deputise as Panel chair in Dudley, supporting people to prepare for Panel, and being involved in commissioning work.

Similar support is provided informally in Walsall through the role of the Commissioning Development Officer (Mental Health). This effectively provides the basic support and help to practitioners that should be provided through supervision and management. It is not sustainable practice for such support to be provided through one individual.

Whilst the review was being undertaken a new role to support personalisation within the Trust was advertised. Though a sign of commitment to personalisation, this reaffirms the idea of personalisation as something separate rather than business as usual. On a practical level it also introduces overlap, and so a lack of clarity, with the existing support role noted above.

Panel – Dudley
Dudley Panel is owned in practice by the Trust (it is chaired by the Head of Social Care MH) and, increasingly, the CCG.

There is no shared understanding between practitioners, team managers or Panel members as to the purpose of Dudley Panel. It is most typically seen as a financial control, with discussion focused on costs and hours of care, and rarely as a mechanism by which to explore creative, personalised ways of meeting user outcomes.

The membership of Dudley Panel doesn’t currently appear to be right. For example, there is irregular representation of commissioning from Dudley MBC. The effect of this is that Dudley MBC commissioners receive recommendations from Dudley Panel rather than being directly involved and, as a result, the location of decision-making power is unclear. Dudley Panel really only makes recommendations, though in practice the majority of its recommendations are accepted without challenge, either from a practice or financial point of view.

Conversely, the Trust’s Acute Services team is represented at Panel. Though this is useful in terms of understanding some user’s histories, it can tend to bring a clinical perspective to Dudley Panel motivated at least in part by ensuring people aren’t admitted to acute services.

Finally, Team Managers or Heads of Service don’t appear to regularly attend Dudley Panel apart from in exceptional circumstances, such as when it was perceived there was consideration of “risk” in decision making. Reflecting the points made under Staff Practice, Dudley Panel has become de facto supervision.

Dudley CCG is now represented at Dudley Panel through the Placements & Recovery Manager. This role has provided a positive, expert and respected addition to Dudley Panel’s practice and approach.

Staff representatives have highlighted – both previously to commissioners and the Trust, as well as to us – how difficult the process and tone of Dudley Panel is. Our two Dudley Panel observations support the view that Dudley Panel appears to have an adversarial tone; it was described on more than one occasion as a “battle” and as a source of additional stress and pressure. This has the effect of undermining or questioning practitioner capability or judgment. The tone and practice of Dudley Panel also occasionally impacted on decision-making: on at least one occasion we noted valuable (social work) expertise was not taken into account because of the nature of the discussion. It is clear there is little trust in the Dudley Panel process and how its purpose is discharged, and so it has a poor reputation.
Our conclusion is that Dudley Panel is a symptom, not a cause. That is, the issues we are highlighting in this report – such as information, assessment practice and tools, insufficient training, support and supervision, limited market development etc. – are what leads to the problems of Dudley Panel, rather than Dudley Panel being the cause of its own issues. These circumstances are then exacerbated by the tone in which Dudley Panel is conducted, and by the current circumstances of the assertive review process for some users in Dudley.

**Panel – Walsall**

Walsall Panel is fundamentally owned by Walsall Council. This is especially articulated through the role of Head of Service (Mental Health) who acts a conduit for strategy into practice and vice versa, thus providing good leadership.

Walsall Panel has become a vehicle through which users, practitioners and managers can challenge the use of traditional services. We observed several person-centred discussions in which people using traditional care had been supported and enabled to think about different ways of meeting their needs. Practitioners talked of “working from the outcome backwards” rather than starting with need or what support was available.

The Panel process in Walsall hasn’t always been like this: historically it had played the part of team managers and provide supervision and support. Some practitioners reported that the process of Panel was still not an enjoyable experience. Overall, though, Walsall Panel has developed an explicit learning role over time that coaches practitioners to work in more personalised ways.

Whilst the purpose of Walsall Panel isn’t absolutely explicit, it balances person-centred approaches with financial reality. We observed occasions on which it was understood that slightly more financial support in the short-term can support someone’s recovery in the longer-term, monitored through appropriate review.

**Panel – both**

The tools that underpin the Panel processes in Dudley and Walsall – namely the Self-Directed Assessment Questionnaire (SDAQ) and My Assessment Form 2 (MAF2) – are both blunt tools that are not well suited to reflect the needs of people with mental health problems. Both have been adapted from assessment forms for other client groups and consequently have a focus on physical needs. Practitioners, especially in Dudley, are clearly frustrated with the inappropriateness of the paperwork.
(Work in Walsall and Dudley is being done to make the assessment form more appropriate for people with mental health problems. This is welcome, and a good opportunity to involve users and practitioners in this process, as well as commissioners.)

The use of “I statements” is superficial and rarely appears to reflect the actual stated wishes of people who use services. They are very close to a tick-box exercise. We observed one situation in which a request wasn’t to be signed off by Panel until the practitioner had changed the grammar of the assessment from their own words describing the client’s needs to “I” statements. At no point was it suggested the actual wishes and words of the client should be recorded. More generally there appears to be little user involvement in creating support plans; this perhaps reflects users sometimes being happy about receiving any kind of support.

It is clear that personalisation is equated to the Panel process too much at the moment: people are fixated on Panel. In an effective, personalised approach, the vast majority of personalisation happens outside any Panel process.

**Personal Budgets**

In many areas personalisation is equated to Personal Budgets. Across Dudley and Walsall there isn’t too much of an explicit focus on the payment mechanism, which is welcome.

In Dudley, the current lack of diversity in the mental health market means that Individual Service Funds\(^\text{14}\) are a practical solution that will help explore costs and quality.

**Market development**

Explicit work on market development in Walsall has helped with step-down arrangements for people with mental health problems. This has included bridging the gap between high-level and community-based supports by working with existing providers to adapt their current offer and have included, for example, introducing housing with support approaches. There are clear examples of de-commissioning traditional day services in Walsall.

The joint commissioning arrangements in Walsall are a strength that supports person-centred approaches.

The equivalent market development work\(^\text{15}\) is not currently as well developed in practice in Dudley; a clear Market Position Statement for mental health,\(^\text{23}\)

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\(^{14}\) Information about Individual Service Funds for homecare can be found here: [http://www.thinklocalactpersonal.org.uk/Browse/marketdevelopment/servicefunds/?parent=86&child=9437](http://www.thinklocalactpersonal.org.uk/Browse/marketdevelopment/servicefunds/?parent=86&child=9437)

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however, sets a clear direction of travel. More commissioning resource, focused specifically on mental health, may help bridge intent with practice.

In Dudley, the lack of an explicit Resource Allocation System for mental health is not necessarily a problem. One consequence is that practitioners may tend to choose a provider they are familiar with, rather than identifying outcomes, understanding the resources available, and working backwards from there. This itself may also be exacerbated by two further issues: practitioners may be wary of their role becoming more about cost negotiation with providers eclipsing their role of working with individuals, and not being aware of what is locally available, despite CQC having approximately 30 mental health providers registered in Dudley and the well-developed Dudley Community Information Directory. More work that promotes these resources and awareness of them would be of benefit.

Relationships between commissioners are reasonably well developed on a one-to-one basis. There is not currently a providers’ forum that provides an opportunity for commissioners and providers to collectively discuss issues and solutions regarding personalisation or local mental health provision. Related to this, engagement with the local voluntary and community sector as it relates to mental health is routine.

A welcome development in Dudley is the proposed Recovery Working Group – an initiative from a team manager and social workers themselves, with commissioner input.

**Measurement / outcomes**

There is currently no single measure that indicates if personalisation is meaningfully working across Dudley and Walsall.

People at all levels reflected to us that they don’t easily know what the position is when it comes to personalisation. For example, Partnership Performance Indicator papers routinely provided to Partnership Operations Group (notwithstanding the point about reliability highlighted in Section 4) only refer to activity and process statistics – data driven by CPA requirements. No outcomes data or any indication as to the quality of support people receive is included, nor required by the Section 75 agreements in place. (Some

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15 The de-registering of Wordsley House and St Marks is a form of market shaping, and has had a significant impact on what practitioners have been asked to do and process at Dudley Panel. It was reported to us that there had been relatively poor communications with users of this service as well as with practitioners responsible for undertaking review activities.
measures, such as employment rates and stable accommodation rates, are reported on elsewhere but not included here.)

16 Correspondence indicates that this lack of outcomes-based data was challenged through Partnership Board and a request made that it be addressed, but we have found no evidence that this has been acted on.

5.3. Preparedness for the future

Having considered in detail the extent to which personalisation is embedded across Dudley and Walsall, we now turn to its preparedness for the future. We begin with the current governance arrangements.

Governance arrangements

On paper the current governance arrangements look encouraging: a Personalisation Implementation Group, Partnership Operations Group and Partnership Board suggests oversight of operations, the interface between operations and strategy, and the overall strategic direction of the partnership respectively.

In practice, however, information doesn’t easily flow up or down these chains. Most useful business is transacted bilaterally outside of these arrangements. It is a governance structure that has emerged rather than being planned, with a resulting lack of clarity over purpose. Two further consequences are that decision-making and accountability aren’t always clear.

We turn to discuss PIG and POG in detail.

Personalisation Implementation Group (PIG)

PIG has drifted and become routine. During our observations there was no mention of the reason why it exists or what its terms of reference are. It is perhaps that this has been the case since PIG began.

The focus of PIG is too narrow, despite a good activity plan being in place. Instead of focusing on the requirements of the activity plan and updating them as progress is made, business at PIG appears to be driven more by minutes and matters arising and other issues that have arisen. This is a circumstance exacerbated by a lack of clear ownership of some of the work strands within the activity plan (e.g. commissioning).

The membership of PIG isn’t sufficiently wide. It appears to be based more on who is willing to attend and who has historically attended rather than who

16 It is entirely feasible to find suitable measurements. For example, the Personalisation Outcome Evaluation Tool (POET) specifically explores the difference personalisation makes to various domains of people’s lives. See Annex 5 for more details.
should attend to maximise the chance of personalisation being a success. Despite explicitly stating in the Personalisation Implementation Plan that users and carers will be included at PIG, we have not seen any evidence of such involvement. Similarly, there has been a missed opportunity to include users and their representative organisations, practitioners, managers, all commissioners, provider Heads of Service, commissioners, and providers.

POG

The overall view of relevant interviewees is that POG, whilst having improved over time, has become a (useful) conduit for problem solving, discussion and messaging rather than for devolved decision making or leadership. Similar to PIG, the purpose of POG – what it’s purpose is and what it can/can’t deal with, and especially its responsibilities with regard to personalisation – needs to be clearer.

Recognising that POG has a broader remit, with specific regard to personalisation we observed some occasions on which it was possible for POG to give a clearer steer. The best example was the discussion relating to Care Act Training: POG provided an opportunity for coordination across all partners for training on the Care Act for mental health staff, but this wasn’t clearly pursued. More generally, there had been a recommendation from POG that there be a specific Task & Finish Group on the Care Act, but nothing happened as a result of this and was not, as far as we could see, translated into practical action at PIG. Similar examples were reported on topics like Panel, market development and outcomes measurement.

During our observations we didn’t get a sense that POG holds PIG to account for progress or otherwise on the Personalisation Implementation Plan.

User engagement

There doesn’t appear to be a culture of understanding or valuing meaningful user engagement with regard to mental health and personalisation across Dudley and Walsall. It was rarely mentioned except for purposes of consultation in specific circumstances (such as the future of Woodside Day Centre).

We have noted the missed opportunities to include users in the development of areas such as information. Similarly, the link to Making it Real in Dudley (MIR) isn’t sufficient. There has been limited and inconsistent attendance at MIR, which doesn’t appear to shape or influence work in places like PIG.

Leadership
Nobody could identify clear leadership for personalisation in mental health in Dudley and Walsall. The Section 75 arrangements lead the local authorities to believe it to be picked up by the Trust’s; the Trust has come relatively late to the personalisation agenda, and so it has fallen between the gaps.

The only other possible option for leadership for personalisation in mental health is the Making it Real Board; this is shown above to be relatively ineffective, as well as only structurally applying to Dudley.

The status of leadership regarding personalisation is perhaps best represented by the creation of a specific policy for personalisation. This was produced (rather than co-produced) as a response to a specific request from Dudley MBC in 2012. Since then, it is unclear how this policy has been used as a guiding document for the work of, for example, practitioners, managers or PIG.

The nature of the Section 75 arrangement means there is no natural collective mechanism by which Dudley and Walsall CCGs can contribute easily at any strategic level to the work of the Trust and local authorities. As a result, relationships and mechanisms for coordination can be haphazard or reliant on personal commitment to relationships and working together. A consequence of this is the lack of a clear, collective picture of the overall mental health economy across Dudley and Walsall, including the role personalisation has to play. We therefore see different partners developing their own future strategies for mental health care and support across the area rather than the possibility of a collective vision.

A final point here is that there can occasionally be a lack of joined-up approach between the two local authorities in their dealings with the Trust. Though understandable – given the different environments, histories and populations of Dudley and Walsall – it can lead to an inconsistency which makes it difficult for the Trust to know what to respond to.

**Preparedness for the future**

The points made about **Governance** and **Leadership** above impact on Dudley and Walsall’s ability to deal with future issues.

We have highlighted elsewhere the example of staff preparedness for the Care Act. With the scope of responsibilities also introduced by the additional partners of both Dudley and Walsall CCGs, the range of issues that need to be acted on now or in the near future include Personal Health Budgets, Integrated Personal Commissioning, and the new mental health payment system, as well as new initiatives like mental health waiting times and explicit user choice in health.
The experience of introducing and embedding personalisation provides some clear learning that, if successfully addressed and applied, could considerably help with the roll-out of these future issues, as well as personalisation itself.
6. Recommendations

In this section we make a series of recommendations based on the findings of the review.

When considering these recommendations, two key principles must be kept in mind:

1. These recommendations are not comprehensive: they should be seen as a good suggested starting point, not an end point, and provide strong foundations from which all issues identified in this review can be addressed

2. Responsibility and actions that flow from these recommendations must be collectively owned. Put simply, this means a wide range of people from a wide range of organisations and experiences should work together in partnership. As a minimum, this must include users and their representative organisations, practitioners, managers, senior managers, commissioners (including from the CCGs), providers, and the local voluntary sector.

6.1. Personalisation recommendations

Our recommendations with regard to personalisation are as follows:

- The Partnership Operations Group (POG) and Partnership Board should be maintained. These governance mechanisms clearly cover areas beyond “just” personalisation. This review provides an external impetus to look at these governance mechanisms afresh and renew them accordingly, especially with regard to their oversight of the personalisation agenda

- The Personalisation Implementation Group (PIG) should be disbanded – A new forum which has the right people and covers the right topics should be created to lead the personalisation agenda across Dudley and Walsall.
• By the right people we mean it should provide a forum for, as a minimum, users and their representative organisations, practitioners, managers, commissioners, providers and the voluntary sector to come together.

• By the right topics, we primarily mean personalisation and the strands of work highlighted below; we also mean the forum should be flexible and relate to other associated agendas, including (but not necessarily limited to) the Care Act, Personal Health Budgets, Integrated Personal Commissioning, and the mental health payment system but talks to Care Act, PHBs, payment system

• The forum should (co-)produce and be responsible for a common action plan. This common plan will include strands of work that relate to a range of issues, including those highlighted within the report (see further recommendations below)

• The forum should ensure responsibility is associated with a key individual for each strand of work within the common action plan

• The forum should be accountable to POG and so Partnership Board, both of whom should include a standing item on its progress against the common action plan.

The common action plan should include work strands at least covering the following issues highlighted in this report:

• Staff support and training, including both local authority and Trust Learning & Development teams to enable this

• A review of assessment practice

• A review of supervision practice

• Developing a clear statement on the purpose and practice of Panel in both Dudley and Walsall that is shared and understood. The membership and expectation of attendance for Dudley Panel should be explicitly reconsidered and updated

• Work in Dudley to help bridge the gap between intent and action in commissioning and market development. This should include ensuring representation of Dudley commissioners on the proposed forum, Dudley Panel and active support for the developing recovery working group

• Exploration of introducing Individual Service Funds
• Continual updates and ongoing dissemination of information regarding personalisation. This should include producing stories and examples of the difference personalisation has made, as well as actively reflecting personalisation and recovery through any policy and document review schedule

• Develop, monitor and publicly report on measures of success for personalisation.

6.2. Pathways recommendations

Having discussed at length in Section 4 the issues regarding this element of the review, we do not necessarily see this part of the work as complete. The key recommendations are therefore as follows:

• Convene a dedicated information group to finish gathering and analysing this information, with representation from the 5 parties to this work

• Share the data with the people who use services, front line staff and local managers to understand if it reflects the work done and to look at any lessons to learn.

• Determine the future information needed across the 5 partners working together that would deliver a comprehensive information service (as distinct to that needed by each party individually).

• Agree the underlying data required for joint working.
Annex 1: Key Lines of Enquiry

As noted in Section 3 there were several distinct elements to this work.

In order to ensure a consistent approach to gathering information across these elements of the work we have drafted the following Key Lines of Enquiry. These are informed by issues identified in developing this piece of work and by the “Paths to Personalisation in Mental Health” framework.

The Key Lines of Enquiry are effectively “What are we seeking to find?” Under the Key Lines of Enquiry we can then develop different review tools for different elements of the work, such as a set of interview questions when speaking with users and staff, i.e. the “how” we will find things out.

Questions for each of the different elements of work were derived from these key lines of enquiry.

Key lines of enquiry

1. What values and principles underpin mental health care and support across Dudley and Walsall
   a. What values, principles and assumptions form the foundations for care and support across Dudley and Walsall (DW)?
   b. To what extent are these consistently understood amongst all relevant stakeholders at all levels across DW?
   c. To what extent are these articulated through appropriate avenues?
   d. To what extent do these influence and inform day-to-day practice at all levels across DW?

2. To what extent is personalisation embedded across mental health care and support across Dudley and Walsall, through:
   a. Do current systems and approaches support personalisation as a matter of routine?
b. Are the right organisations and people involved to shape and drive personalisation across DW?

c. How are decisions made at all levels?

d. How effective is the practice of and support to staff with regard to personalisation?

e. How do the practicalities of a personalised system work for people who use mental health services and the people around them?

f. What outcomes are achieved by people with mental health problems across DW, and how equitable are they?

3. What is Dudley and Walsall’s preparedness for the future with regard to personalised mental health support, through:

a. Understanding the way in which people currently “flow” through the mental health system in DW, the reasons for this and any associated assumptions

b. Exploring the contribution that commissioning and market development makes to current and future provision

c. Considering the extent to which the current system reflects known best and emerging practice elsewhere

d. Understanding the way in which leadership at all levels understands and commits to what may be needed.
### Annex 2: Document review

Below is the list of documents reviewed as part of this work.

<table>
<thead>
<tr>
<th>No.</th>
<th>Document</th>
<th>Owner</th>
<th>Relevant?</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>Care Programme Approach (CPA) Policy</td>
<td>Trust</td>
<td>Yes</td>
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<tr>
<td>2</td>
<td>Community Recovery Service (CRS) Operational Policy</td>
<td>Trust</td>
<td>Yes</td>
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<tr>
<td>3</td>
<td>Confidentiality and Data Protection Policy</td>
<td>Trust</td>
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<td>Conveying mentally disordered patients to hospital</td>
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<tr>
<td>5</td>
<td>Deprivation of Liberty Safeguards Policy</td>
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<td>Early Access Service (EAS) Operational Policy</td>
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<td>Yes</td>
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<td>7</td>
<td>Incident, Near Miss and Serious Incident Reporting Policy</td>
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<td>8</td>
<td>Policy on the Investigation of Lessons from Incidents, Complaints and Claims</td>
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<td>Lone Working Policy</td>
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<td>Managing Allegations against Staff/Volunteers who work with Children/ Vulnerable Adults</td>
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<td>11</td>
<td>Mental Capacity Act Policy</td>
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<td>Mental Health Act (Overarching Policy)</td>
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<td>13</td>
<td>Multi-Agency Operational Policy for Section 136</td>
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<td>14</td>
<td>Risk Management Strategy</td>
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<td>15</td>
<td>Clinical Risk Assessment and Management Policy</td>
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<td>16</td>
<td>Safeguarding Adults Policy</td>
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<td>Safeguarding and promoting the welfare of Children Policy and Procedure</td>
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<td>Section 117 Aftercare</td>
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<td>Transfer &amp; Transition Team (TTT) Operational Policy</td>
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<td>Transition Protocol from CAMHS to Adult Mental Health Services</td>
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<td>Triangle of Care protocol</td>
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<td>22</td>
<td>Whistle Blowing Policy &amp; Procedure</td>
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<td>23</td>
<td>Confidential Reporting Policy</td>
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<td>Employee Improvement &amp; Disciplinary Procedure (Employees)</td>
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<td>Employee Improvement &amp; Disciplinary Procedure (Managers)</td>
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<td>Grievance Policy and Procedures</td>
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<td>Mental Capacity Act – Practice Guidance</td>
<td>DMBC</td>
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<td>28</td>
<td>Performance Review and Development Policy &amp; Procedure</td>
<td>DMBC</td>
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<td>Section 75 Agreement - Dudley</td>
<td>WMBC</td>
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<td>Section 75 Agreement - Walsall</td>
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<td>31</td>
<td>Fair Access to Care FACS</td>
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<td>Support Plan</td>
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<td>33</td>
<td>My Assessment Form Part 1</td>
<td>DMBC</td>
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<td>My Assessment Form Part 2</td>
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<td>Personal Budget through Direct Payment Procedure</td>
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<td>Funding Panel Flowchart</td>
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<td>CPA Assessment</td>
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<td>Panel Application Form</td>
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<td>Capacity Assessment Tool</td>
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<td>Support Information for Resi/Nursing Applications</td>
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<td>Eligibility Criteria</td>
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<td>Benefits Based Contributions – Policy Guide</td>
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<td>Benefits Check Process</td>
<td>WMBC</td>
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<td>Panel Flowchart</td>
<td>WMBC</td>
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<td>46</td>
<td>My Support Plan</td>
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<td>Self-Directed Assessment Questionnaire SDAQ</td>
<td>WMBC</td>
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<td>Placement Panel Checklist</td>
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<td>49</td>
<td>Support Planning Policy</td>
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<td>50-61</td>
<td>DWMHT Service Specifications x 12</td>
<td>CCGs</td>
<td>Yes</td>
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<td>62</td>
<td>DWMHT CQC quality inspection report, May 2014</td>
<td>CQC</td>
<td>Yes</td>
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<td>63</td>
<td>Mental Health Personalisation Implementation Action Plan</td>
<td>All</td>
<td>Yes</td>
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<td>64</td>
<td>Minutes of POG and PIG meetings, 2012/13-2013/14</td>
<td>All</td>
<td>Yes</td>
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<td>65</td>
<td>Dudley mental health Market Position Statement, Feb 2013</td>
<td>DMBC</td>
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Annex 3: Review Phase topic guide

Below is an example of one of the topic guides used throughout the second part of the review. The one below was specifically for staff; other versions were produced for users, commissioners / senior managers and providers.

Introduction

The National Development Team for Inclusion (NDTi) is working with all key stakeholders in Dudley and Walsall to build a comprehensive and independent picture of the way in which the mental health system across Dudley and Walsall is working for people with mental health problems in their local area.

The work has been commissioned jointly by Dudley MBC, Walsall MBC, Dudley and Walsall Clinical Commissioning Groups and Dudley & Walsall Mental Health Trust and will begin in July 2014. It will run until around December 2014.

Things to cover before interview:

- **Confidentiality** – what we learn will be reported anonymously.

- **You don’t have to share anything you don’t want to** – We will be making notes but if you want us to stop recording at particular points then tell us

- **Respecting for your views** – this is not about testing, or ‘right’ or ‘wrong’ answers, or about criticising or supporting the system, or colleagues. Everyone’s contribution is equally valuable.

- **Safeguarding** – Everything everyone says will be anonymous. We won’t share any personal information with any other organisations except if it is felt that someone is at significant risk of harm or abuse

- If you have something you would like to say in addition and don’t get the chance today please contact us.

Questions

Warm-up
What is your role?
What team are you part of?
How long have you been in this role?
Who are you employed by?
Who are managed by?

1. What values and principles underpin mental health care and support across Dudley and Walsall

What are the main things driving your work at the moment? Where does personalisation fit into this?

What's driving this?
What is the culture that guides this?
Is it short-term or long-term?
How consistent is it with what you want to do?
What support do you get to do your role?
Take me through a typical supervision meeting
What are the main barriers you're experiencing?

2. To what extent is personalisation embedded across mental health care and support across Dudley and Walsall, through:

Take me through the whole process from when you get a new referral

Why does the referral come to you? Consistent? Referral pathway to you / from you
What paperwork?
Eligibility and assessment – across health and social care
Financial assessment – how does this happen
Sign-off / Panel – how does this happen, what is the experience like, how consistent is decision making
Implementation
Review
Where do you go if there’s a problem?

How do you find out about good/creative practice?

What chance do you have to reflect?

Where is the good practice? Why?

Where is the not-so-good practice? Why?

How do you know what is good?

What are you measuring this against?

Prompt questions depending on context and elements of the Paths framework

3. What is Dudley and Walsall’s preparedness for the future with regard to personalised mental health support

We’ve talked about the local system and about personalisation at the moment – both broadly on the demand side. What’s your view on the supply side: what’s the “market” like to support choice and control?

Thinking 10 years away, what do things look like?

What’s different to now?

How do you get there?

Who gets you there?

What’s getting in the way of that?

How much does best/emerging practice drive this?

One thing

If there is one thing you could keep about how things work now, what would it be?

If there is one thing you could change about the system now, what would it be?

If we came back in 12 months time, what difference would you hope your time here today would have made?

Any further comments or questions?
Annex 4: Interviewees in review phase

Below is a list of the roles of people we spoke to and their organisation for the engagement phase of the work. In total we conducted 56 interviews.

All interviews were carried out in confidence, so information is presented in this way in order to maintain anonymity.

**Interviewees, by position**

- Practitioner or team manager – 17
- Senior manager – 16
- Commissioner – 11
- Provider – 4
- Other – 8

**Interviewees, by organisation**

- DWMHT – 24
- Dudley MBC – 9
- Walsall MBC – 11
- Other – 12

**Meetings observed**

In addition to the individual interviews carried out we also observed the following meetings:

- Two meetings of the Personalisation Implementation Group
- Two meetings of the Partnership Operations Group (one including an update by the review team)
- One meeting of the Partnership Board (including a presentation by the review team)
• One meeting of Management Executive Team (primarily to present an update by the review team)

• Two meetings of Dudley Panel

• Two meetings of Walsall Panel.

**Note on user engagement**

At the time of writing (early January 2015) there is outstanding user engagement work to be completed as part of the review.

We are currently working through four key networks to garner information from users and user representatives:

• Mind in Dudley

• Rethink in Dudley

• Support Association for Mental Health

• Making it Real Dudley

We will produce a supplementary note to this report highlighting specific user perspectives in February.
Annex 5: POET survey 2013 – findings for people with mental health problems

Below are the key findings from the POET survey in 2013 for people with mental health problems¹⁷ (the most recent findings available of the kind reported below).

**Process findings**

People with mental health problems (24%) were more likely to get support from someone in the NHS than other groups (people with learning disabilities (8%); people with physical disabilities (8%) and older people (6%)). People with learning disabilities (58%) were more likely to get support from family and friends than other groups (older people (28%); people with physical disabilities (28%) and people with mental health problems (19%))

In terms of the council making it easy for the person to be in control of how their personal budget is spent, there was a trend for people with physical disabilities to be more likely to say the council made this easy (64%) compared to older people (60%), people with learning disabilities (57%) and people with mental health problems (56%). People with mental health problems were more likely to say the council made this difficult (21%) compared to people with learning disabilities (18%), people with physical disabilities (17%) and older people (13%)

**Outcome findings**

- Physical health: People with mental health problems: 63.3% better/much better; 30.8% no difference; 5.9% worse/much worse

- Mental wellbeing: People with mental health problems: 71.0% better/much better; 18.9% no difference; 10.1% worse/much worse

¹⁷ The full findings can be found here: [http://www.thinklocalactpersonal.org.uk/_library/POETNationalReportFINAL.pdf](http://www.thinklocalactpersonal.org.uk/_library/POETNationalReportFINAL.pdf)
• Control over life: People with mental health problems: 63.9% better/much better; 32.0% no difference; 4.1% worse/much worse

• Being independent: People with mental health problems: 70.6% better/much better; 24.7% no difference; 4.7% worse/much worse

• Control over support: People with mental health problems: 72.8% better/much better; 18.3% no difference; 8.9% worse/much worse

• Getting the support you need: People with mental health problems: 65.9% better/much better; 25.7% no difference; 8.4% worse/much worse

• Being supported with dignity: People with mental health problems: 74.3% better/much better; 19.2% no difference; 6.6% worse/much worse

• Feeling safe: People with mental health problems: 65.3% better/much better; 31.1% no difference; 3.6% worse/much worse

• Choosing where to live: People with mental health problems: 33.5% better/much better; 65.9% no difference; 0.6% worse/much worse

• Getting/keeping a job: People with mental health problems: 11.0% better/much better; 85.6% no difference; 3.4% worse/much worse

• Volunteering: People with mental health problems: 18.6% better/much better; 80.8% no difference; 3.4% worse/much worse

• Relationships with family: People with mental health problems: 46.4% better/much better; 49.4% no difference; 4.2% worse/much worse

• Relationships with friends: People with mental health problems: 41.2% better/much better; 56.4% no difference; 2.4% worse/much worse

• Relationships with paid supporters: People with mental health problems: 63.5% better/much better; 32.9% no difference; 3.6% worse/much worse