

'Fair Horizons': a person-centred, non-discriminatory model of mental healthcare delivery[†]

Chris Fear,¹ Mark Scheepers,¹ Martin Ansell,¹ Rosemary Richards,¹ Paul Winterbottom¹

The Psychiatrist (2012), 36, 25–30, doi: 10.1192/pb.bp.110.032417

¹The Together NHS Foundation Trust, Gloucester, UK

Correspondence to Chris Fear (chris.fear@glos.nhs.uk)

First received 23 Sep 2010, final revision 10 Apr 2011, accepted 31 May 2011

Aims and method Service access is currently determined primarily by age and intellectual function and, unwittingly, is discriminatory. Our aim is to develop a novel, person-centred, non-discriminatory model of mental healthcare delivery. We sought the views of people who use services, carers, commissioners and local politicians.

Results The model represents a major change programme that commenced in September 2011.

Clinical implications By integrating specialist mental health services, with a single access point, and mapping of care to the person's needs, rather than their circumstances we hope to have developed a greatly improved and fairer service. A similar model could be adopted in other locations nationally.

Declaration of interest None.

Introduction

We have seen unprecedented growth in the range and specialism of mental health services for people aged between 18 and 65 ('adults of working age') over the last 10 years. This has widened the gap in service provision between adults of working age and children, the over 65s and people with intellectual disabilities (referred to as people with learning disabilities by UK health services). The Royal College of Psychiatrists recognises that this approach discriminates against the over 65s¹ and notes in its recent report on the future of UK psychiatry: 'service redesign and development for older people should ensure that people over 65 have equitable access to the range of mental health services and that these services are age-appropriate and non-discriminatory'.² Sadly it fails to recognise that people with intellectual disabilities lack equitable access to both specialist functional services and dementia services that are average to over 65s.

The 2007 MENCAP campaign, *Death by Indifference*, and resultant inquiries into healthcare for people with intellectual disabilities were published as *Healthcare for All*³ and *Six Lives*.⁴ They highlight failures in promoting equitable access to care for this vulnerable group. People with intellectual disabilities are 58 times more likely to die before the age of 50; those with Down syndrome are at greater risk of developing Alzheimer's disease; schizophrenia is 3 times as prevalent; and 'challenging behaviour' occurs in 15% of this population. This 'double discrimination' is exemplified in our own College's exclusion of people with intellectual disabilities from the remit of a group

exploring the future development of UK mental health services.

Achieving the ten recommendations of *Healthcare for All* requires that mental health providers consider integrating care for people with intellectual disabilities into their mainstream mental health provision. Additionally, extension of working life has invalidated the concept of 'adults of working age', whereas younger adults who are physically frail or have an organic mental illness may be better served by clinicians with experience in working with older adults. Many early intervention in psychosis services see patients from age 14; some child and adolescent mental health service (CAMHS) patients require transition to adult services at some arbitrary point between the ages of 16 and 18. Further work is needed to allow care and transition to be person centred rather than age focused.

Clinical experience suggests that many people with borderline or mild intellectual disabilities already have their mental health needs delivered by teams working primarily with adults of working age. There have been no systematic studies of outcomes in this group but, intuitively, outcomes are likely to improve if intellectual disabilities expertise is available to support those providing their care. Incorporating this expertise into community teams will allow them to manage the functional mental health needs of the majority of people with intellectual disabilities. Specialist teams for more severe intellectual disabilities, for CAMHS-specific mental health needs, for organic mental health problems, etc., are thereby freed to become truly specialist.

The development of a novel, patient-centred, equitable and non-discriminatory local service model was undertaken by clinical and service directors over a period of 3 years, commencing 2007. The name 'Fair Horizons' was coined as a

[†]See commentary, pp. 30–31, this issue.

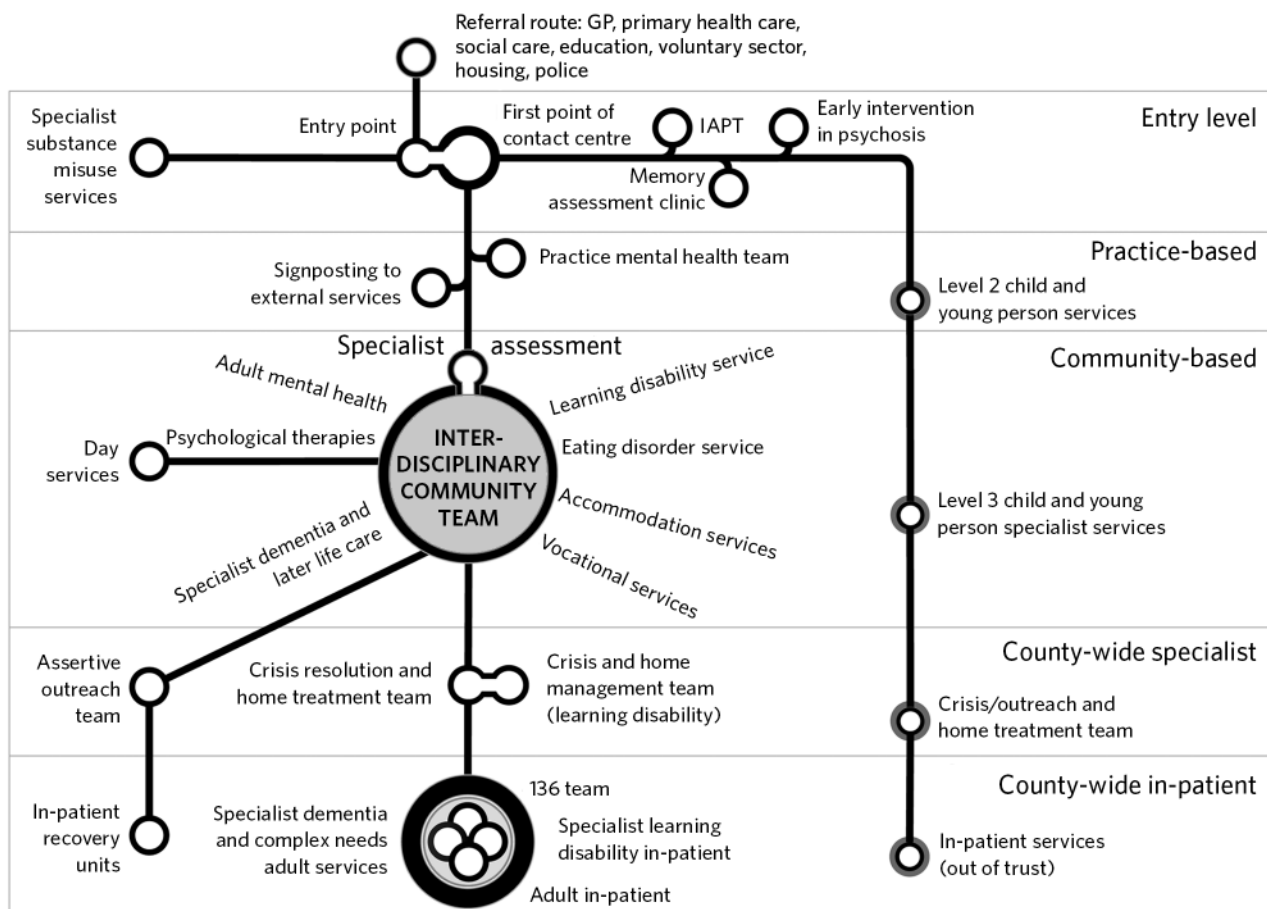


Fig 1 Fair Horizons organisational model. IAPT, Improving Access to Psychological Therapies; GP, general practitioner.

link to the Department of Health's 2009 strategy *New Horizons*⁵ prescribing the then perceived future direction of the National Health Service (NHS). The Fair Horizons model (Fig. 1) has subsequently followed the usual process of change management, seeking views of people who use services, carers, commissioners and local politicians and gaining strong support for the face validity of the proposals. Implementation of this model is now at an advanced stage with the business plan agreed by the Trust board and commissioners, and the reconfiguration of teams ongoing from September 2011, with appointment of management posts and finalising of care pathways to support clustering data.

Fair Horizons is formulated from existing services, takes into consideration the framework of *New Horizons*,⁵ it does not rely on new investment and is compatible with *Liberating the NHS*⁶ and *Looking Ahead*.² It embraces the principles of the Mental Health Network's briefing,⁷ using novel approaches to care pathways and clinician/manager collaboration to drive down costs and improve quality. It is underpinned by principles described in the recent publication from The King's Fund: *Mental Health and the Productivity Challenge*.⁸ We understand that similar models are currently being developed, independently, by at least three UK foundation trusts, based upon the intuitive analysis of how mental health services could best provide excellent care within National priorities and agendas

(S. Shrubbs, Director of Mental Health Network, NHS Confederation, personal communication, 2010).

Gloucestershire covers 1000 square miles and has a population of around 600 000; projected to rise to 623 000 by 2016 with increases in over 65s and a slight decrease in school-age children.⁹ The county has a mixture of urban and rural communities and also has a mixed-economic demographic with areas of wealth as well as deprivation. The mental health population has been estimated at 193 541 with approximately 19 212 with a diagnosis of psychosis, 13 471 with personality disorder and the rest comprising the spectrum of depression and anxiety disorders.

The 'Fair Horizons' model for integrated mental healthcare

The national service framework driven 'functionalisation' of teams in adults of working age produced more teams, more barriers and greater fragmentation of services. By contrast, integrated mental healthcare is fundamentally 'person-centred', with a single point of entry and assessments that are front-loaded with experienced staff able to assign a patient to the most appropriate care pathway for their needs. Reasonable adjustments allow extension to the under 18s, over 65s and people with intellectual disabilities, supporting self-determination and the pursuit of personal goals by reducing potential barriers.

The interdisciplinary team

*New Ways of Working*¹⁰ introduced the idea of ‘capable teams’, with skill mixes tailored to their patient groups and workload. Such teams function in ‘capable environments’. A policy of social inclusion affords equitable access to generic primary and secondary healthcare provision, including mental health services, and supports primary care in mental health promotion and illness prevention.

The basis of care within Fair Horizons is a ‘one-stop shop’, providing the majority of mental health needs and supported by specialist tertiary teams. The core of adults-of-working-age services has been the multidisciplinary community mental health team (CMHT). Fair Horizons extends CMHTs to provide care across all subspecialties. We have called such teams interdisciplinary teams. Multidisciplinary teams comprise multiple professions working in one silo of service (adults of working age, older people, children, learning disability, addiction), whereas interdisciplinary teams are integrated multi-agency multiprofessional teams that work in and across silos.

An interdisciplinary team consists of practitioners from different professions and subspecialties who share a common catchment population and common patient care goals and who have joint responsibility for complementary tasks. The team is actively interdependent, working generically on individuals’ health needs and receiving support and advice from specialists where needed. These specialists maintain their skills through membership of tertiary specialist teams but have work plans to provide sessions to the interdisciplinary team. The model is person centred in that staff seek actively to contribute their specialist skills to the shared management of an individual. It moves the current difficulty that intellectual disabilities specialists face of trying to manage dementia in a person with Down syndrome outside of their competencies, to a situation in which the active assistance of older people’s mental health service specialists can be assured.

This departure from established patterns of working demands investment in training to provide staff with competencies and a culture that allows them to meet the needs of people who use the service. Training is facilitated through specialist input, encouraging staff to develop a wider and more eclectic understanding of mental healthcare provision. There is no expectation of working beyond competencies or that staff will move entirely from the patient population they currently support. Rather, there will be potential to offer their expertise to all patients. Such wholesale change of established practice is likely to be as challenging to organisations as to staff, but is entirely consistent with the Royal College of Psychiatrists’ concept of ‘capable environments’: ‘To improve services for people who present behavioural challenges and to enable them to remain in their own homes and communities requires the creation and support of capable environments. Competency-based training and professional support is required for all carers together with the promotion of creative solutions to the challenges faced’.¹¹

Practice-based care: ‘access and maintenance’

Lord Darzi’s aspiration was to place primary care at the forefront of improving NHS provision: ‘We will re-invigorate practice-based commissioning and give greater freedoms and support to high performing GP practices to develop new services for their patients, working with other primary and community clinicians’.¹² This has been re-affirmed by *Liberating the NHS*,⁶ which prescribes the abolition of primary care trusts in favour of general practitioner (GP) commissioning consortia, by 2012. The starting point for non-discriminatory services is the active registration of people who use mental health services and people with intellectual disabilities with a GP, the coordination and management of their general health needs in primary care and equitable access to secondary care.

Improving Access to Psychological Therapies (IAPT)¹³ is the first initiative to support the tenets of *Healthcare for All*:³ it is available to all adults, regardless of age or intellectual ability. We have set this standard for future access to mental healthcare at the heart of Fair Horizons. Avoidance of the need for complex triage services or assessment teams requires a fully integrated specialist mental health service, providing a single point of access to specialist care for all.

The focus of existing primary care mental health teams changes to the support of people whose long-term needs no longer require specialist secondary care. Fair Horizons provides for a ‘practice-based mental health team’: specialist staff based in primary care with population-based case-loads of defined general practice/s who support primary care teams to manage chronic mental health problems, intellectual disabilities or dementia. They facilitate general healthcare and prompt access to secondary care in the event of deterioration for a case-load held by the GP. This supports social inclusion in healthcare and provides a pathway to urgent specialist review in case of relapse.

Secondary care (community): ‘the interdisciplinary team’

The first recommendation in *Looking Ahead* is that ‘The relationship between community teams and specialist teams should be examined with a view to rebalancing their roles, and the model of an enlarged CMHT should be further explored’.¹² As CMHTs were to ‘traditional’ mental health services, so interdisciplinary teams represent the basic building blocks of Fair Horizons. Interdisciplinary teams are community teams serving defined catchment areas but providing assessment and management for all people with mental health problems. The teams are both multidisciplinary and interdisciplinary, allowing them to respond to mental health problems across a range of ages and disabilities.

In Gloucestershire, locality hubs, with around 150 clinicians, across subspecialties, will work collaboratively in subteams addressing particular payment-by-results patient clusters. Support from clinicians working in specialist tertiary teams (e.g. dementia, addiction, specialist intellectual disabilities) will be work-planned into the hub teams to maintain specialist skills. An average 800 contacts

per year per clinician (i.e. 20 weekly, 40-week clinical year) accommodates at least 40 000 contacts per year, per hub. The 31 269 clinical contacts in 2009/2010 were adjusted for data variance, expected growth, new referral system, clinician care pathway leadership work, reasonable adjustment for people with intellectual disabilities accessing 'mainstream' specialist services and internal training, giving total estimated annual contacts for the entire service of 39 416. This basic hub model can adapt to the range of urban, suburban and rural settings that comprise Gloucestershire. We believe it can be adapted, in units of around 150 staff, to any setting nationally.

Assessment

Around 30 000 new referrals are received by ²gether Trust (adults of working age, older people's mental health, intellectual disabilities, CAMHS and addiction) annually. There is no uniform process for managing these referrals and an individual may pass through duplicated 'assessments' by successive teams, particularly when their needs fall between services. Existing subspecialty teams may be unable to provide comprehensive support, but collaboration with colleagues in other subspecialty teams is complicated by service structure.

All Fair Horizons referrals come to a first point of contact centre. Their details are captured on the electronic records system and algorithms are used to assign them to an appropriate part of the service. This could be IAPT, partner agencies, crisis teams or an assessment component of the interdisciplinary team. Capturing patients' data at referral allows them to be linked to a team and care coordinator at every point: people cannot become 'lost' or fall between teams. The contact centre's work is primarily administrative, with clinician advice on referrals that do not fit into their algorithms. The duty consultant psychiatrist provides advice to GPs or on management of referrals that fall outside established protocols. Most referrals are received between 07.00 and 19.00 h, fewer from 19.00 to 23.00 h, and virtually none after 23.00 h, when the contact number becomes a crisis number. Four administrative staff can deal with the 30 000 referrals at less than 2 per hour allowing time to manage telephone enquiries.

Assessments are booked into the assessment clinic of the interdisciplinary team, front-loaded with senior clinicians to diagnose and assign individuals to a payment-by-results cluster.¹⁴ Early access to senior clinicians with an understanding of diagnosis and management is expected to optimise outcomes.^{2,6,8}

'Capable environments'

Crisis resolution and home treatment teams (CRHTT) are also supported from specialist intellectual disabilities, CAMHS and older people's mental health services to deliver patient-centred care. Definitions of 'crisis' extend to include behaviour that challenges, dementia and vulnerable people with intellectual disabilities with complex needs. Existing challenging behaviour or dementia support services are integrated with CRHTT allowing 24-hour support in the community and preventing inappropriate hospitalisation.

Tertiary specialist services (countywide)

Fair Horizons provides for generic, inclusive and non-discriminatory care from adolescence to grave through primary care and interdisciplinary secondary care teams staffed and trained to provide basic mental health and intellectual disabilities interventions. Nevertheless, a need remains for highly specialist tertiary teams to provide for individuals whose care is beyond the remit of standard mental healthcare. These include CAMHS and specialist intellectual disabilities and dementia services. Although apparently reflective of existing subspecialty 'silos', patients reach these teams, based upon a needs assessment, through non-discriminatory services by a similar route to that of a person who has had a stroke reaches specialist neurology via primary care and general medicine. Other tertiary teams may provide for specialist eating disorders, maternal mental health, etc. Integrated assertive outreach teams follow the same profile of patients as the other interdisciplinary teams, and will need to be 'capable'.

In-patient provision

Current configurations for in-patients continue. Access for people with intellectual disabilities and older people's mental health service is based upon assessment of need indicating the optimal environment for the individual. Some specialist in-patient provision for children, people with intellectual disabilities and organic mental disorders will be required.

Capable dementia services

Tertiary teams for complex and presenile dementia, specialist memory services based in secondary care, including provision for people with intellectual disabilities with specialist intellectual disabilities services working alongside colleagues in older people's mental health services, together with community dementia nurses based in primary care and linking to third-sector dementia advisors ensure high-quality, non-discriminatory interventions along the care pathway and are fully compatible with the National Dementia Strategy.¹⁵

Children's services

In light of the 'Baby P' inquiry,¹⁶ the future provision of CAMHS is difficult to predict.¹⁷ Fair Horizons proposes that services for children continue to be subject to specialist provision integrated with other mental health services only from adolescence, where care can realistically be provided within interdisciplinary teams. This is compatible with the choice and partnership approach and tiered services, allowing children to be children first, with partnership or segmented clinics where specialist skills improve patient outcomes. The integrated service structure reduces the trend for children with intellectual disability to fall between services.

Work planning

Job planning allows consultants to allocate time between clinical and administrative activities with annual review and incorporation of personal development objectives. Fair Horizons includes all staff, whose work plans allocate time to each component of the service. Specialist competencies are maintained through working within specialist tertiary teams, with sessions available to interdisciplinary teams. They are agreed with professional leads and line managers, ensuring maintenance of clinical competencies (e.g. an older people's mental health services specialist might work 3 days with a tertiary team and 2 days in an interdisciplinary team). Work plans facilitate team accounts with a locality workforce needs-responsive to the requirements of commissioning clusters. Being located together at the same team base maximises interdisciplinary working.

Financial implications

Maintaining services in the current financial climate means that: 'service redesign is the key, clinical leaders and managers need to be prepared to take this forward together'.⁷ Fair Horizons anticipates the following:

- assessment by senior clinicians avoids waste in allocating individuals to care pathways;
- IAPT manages people with mild depression/anxiety;
- interdisciplinary teams/tertiary teams are located together with work-planned sessions across teams and cost-effective delivery of training;
- CRHTT gate-keep in-patient facilities for the whole service;
- capital outlay for estates is reduced, with larger teams sharing offices;
- human resources and finance are devolved to localities, improving responsiveness to local needs;
- information technology advances and mobile working prevent clinicians from being 'desk bound', optimising office space;
- administrative support is optimised in larger teams;
- set-up cost for the first point of contact centre is recouped early.

Conclusion

In a few decades, mental health services have escaped the shadow of the asylum and now work to address discrimination and stigmatisation of people who use them. Care has moved from hospital-based services to communities, with functionalisation of teams according to stringent targets. Unfortunately, in defining the role of modern mental health workers and services, we may have inadvertently perpetuated the discriminatory practices we eschew. Rather than being person centred we have allowed ourselves to become age or ability focused.

A modern mental health service must provide high-quality, safe, efficient, cost-effective care. Delivering such services amid financial constraint, demands an innovative, person-centred care focused on outcomes. This can be done effectively through integrating specialist mental health services, with a single access point, and mapping of care

to the person's needs, rather than their circumstances. Additionally, there are opportunities to reduce overheads, increase capacity, drive up quality and enhance the patient experience.

This paper presents a novel model for mental health services, conceived and developed to the point of implementation by senior clinicians in Gloucestershire. Its ideas have pre-empted many of the recommendations made recently by the Royal College of Psychiatrists and Department of Health. Other UK services have struggled with the same ideas and reached similarly novel solutions. The authors would welcome contact from other services and would like to see the College taking a lead in driving forward change for the benefit of the populations we serve. Integrated mental healthcare requires unprecedented cooperation and partnership between all stakeholders. *Liberating the NHS*⁶ through *Looking Ahead*² can turn *Healthcare for All*³ and *New Horizons*⁵ into Fair Horizons.

Acknowledgements

We thank the Chief Executive, Shaun Clee, the Service and Executive Directors of ²gether Foundation NHS Trust for their erudite discussions and critique, and Helen Knowles for her graphics.

About the authors

Chris Fear is a consultant psychiatrist and clinical director for services to adults of working age, ²gether Foundation NHS Trust, Gloucester. **Mark Scheepers** is a consultant psychiatrist and clinical director for services to people with learning disability, ²gether Foundation NHS Trust, Gloucester. **Martin Ansell** is a consultant psychiatrist and clinical director for services to older people, ²gether Foundation NHS Trust, Gloucester. **Rosemary Richards** is a consultant psychiatrist and clinical director for services to children and adolescents, ²gether Foundation NHS Trust, Gloucester. **Paul Winterbottom** is a consultant psychiatrist and medical director, ²gether Foundation NHS Trust, Gloucester.

References

- 1 Anderson D, Banerjee S, Barker A, Connelly P, Junaid O, Series H, et al. *The Need to Tackle Age Discrimination in Mental Health: A Compendium of Evidence*. Faculty of Old Age Psychiatry, Royal College of Psychiatrists, 2009.
- 2 Royal College of Psychiatrists. *Looking Ahead. Future Development of UK Mental Health Services: Recommendations from a Royal College of Psychiatrists' Enquiry* (Occasional Paper OP75). Royal College of Psychiatrists, 2010.
- 3 Department of Health. *Healthcare for All. Report of the Independent Inquiry into Access to Healthcare for People with Learning Disabilities*. Department of Health, 2008.
- 4 Parliamentary and Health Service Ombudsman. *Six Lives: The Provision of Public Services to People with Learning Disabilities*. TSO (The Stationery Office), 2009.
- 5 Department of Health. *New Horizons: Towards a Shared Vision of Mental Health Consultation*. Department of Health, 2009.
- 6 Department of Health. *Equity and Excellence: Liberating the NHS*. Department of Health, 2010.
- 7 Royal College of Psychiatrists, Mental Health Network, NHS Confederation, London School of Economics and Political Science. *Mental Health and the Economic Turndown. National Priorities and NHS Solutions* (Occasional Paper OP70). Royal College of Psychiatrists, 2009.
- 8 Naylor C, Bell A. *Mental Health and the Productivity Challenge. Improving Quality and Value for Money*. The King's Fund, 2010.

- 9 Gloucestershire County Council. *Gloucestershire Local Projection 2010. Report of Research & Development Team, Chief Executive's Support Unit*. Gloucestershire County Council, 2010.
- 10 Department of Health. *Mental Health: New Ways of Working for Everyone*. Department of Health, 2007.
- 11 Royal College of Psychiatrists. *Challenging Behaviour: A Unified Approach* (College Report CR144). Royal College of Psychiatrists, 2007.
- 12 Darzi A. *High Quality Care for All: NHS Next Stage Review Final Support*. TSO (The Stationery Office), 2008.
- 13 CSIP Choice & Action Team. *Commissioning a Brighter Future: Improving Access to Psychological Therapies Positive Practice Guide*. TSO (The Stationery Office), 2007.
- 14 Department of Health. *Confirmation Of Payment By Results For 2010–2011. Mental Health Clustering Booklet 2010–2011*. Department of Health, 2010.
- 15 Department of Health. *Living Well with Dementia. A National Dementia Strategy*. Department of Health, 2009.
- 16 The Lord Laming. *The Protection of Children in England: A Progress Report*. TSO (The Stationery Office), 2009.
- 17 Department for Children Schools & Families. *Children's Trusts: Statutory Guidance on Inter-Agency Cooperation to Improve Well-Being Of Children, Young People and their Families*. Department for Children Schools & Families, 2008.

An innovative service but will it work in practice?

Commentary on . . . Fair Horizons[†]

Stephen Patrick Tyrer¹

The Psychiatrist (2012), 36, 30–31, doi: 10.1192/pb.bp.111.036889

¹Newcastle University, Newcastle-upon-Tyne, UK

Correspondence to Stephen Tyrer (s.p.tyrer@ncl.ac.uk)

First received 11 Sep 2011, accepted 26 Sep 2011

Summary This commentary discusses the proposed service, Fair Horizons, a new development designed to ensure comprehensive mental healthcare coverage. Although the aims of the new service are laudable and derive from recent seminal papers on changes in the National Health Service, the proposed initiatives are so far untested and there is uncertainty about how far costs will be reduced under this new system. Success is more likely to result if clinicians are committed to the new service and work harder.

Declaration of interest None.

Despite the recent political furore about the role of general practitioners (GPs) in the implementation of the NHS Reform Bill¹ the influence of GPs is legislated to increase over the coming months. Lord Darzi's preliminary review of the National Health Service (NHS) in England proposed the development of GP-led health centres.² The aim of these centres is to provide services from GPs and consultants, with diagnostic and therapeutic services under one roof. Mental health services are an integral component of this system. The impetus for the development of Fair Horizons, a local non-discriminatory mental health service model in Gloucestershire, may partly have derived from Lord Darzi's review but was more influenced by a government paper *New Horizons: A Shared Vision for Mental Health*, introduced by the then Prime Minister Gordon Brown in 2009.³ A subsequent report from the Royal College of Psychiatrists, *Mental Health and the Economic Downturn*,⁴ resulted in the publication of an Occasional Paper,⁵ and the recommendations indicated in this paper underlie the initiative described.

[†]See Special article, pp. 25–30, this issue.

New service tenets

The proposed development stated in Fair Horizons aims to ensure equitable and comprehensive mental healthcare for all who access the service. In particular, people who have chronic mental health difficulties that no longer require specialist secondary care will be supported by appropriate mental healthcare professionals. This support is proposed to be carried out by what is termed the interdisciplinary community team, essentially an expanded and more comprehensive standard community mental health team. Although the model 'provides for a "practice-based mental health team" . . . based in primary care with population-based case-loads' (p. 30), the interdisciplinary teams will not, as far as I can make out, be necessarily situated in primary care (though many may well be), but will be at the centre of a number of locality hubs that will be placed throughout Gloucestershire. The model ensures that all referrals, from primary care or elsewhere, come to the service via a first-point-of-contact centre. These centres will be staffed by administrative personnel, but all the details of the referral will be recorded on an electronic database