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Health and care working with local communities in Plymouth, Torbay and the rest of the county

Plymouth Community Mental Health Framework

The Journey So Far

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- *The Case For Change*
- *Plymouth Primary Care Mental Health Team*
- *Progress to Date*

PLYMOUTH SOME KEY FACTS

Plymouth is made up of 39 neighbourhoods grouped together to form 20 electoral wards.
Source: Plymouth Report

Life expectancy is
79 for males
82.1 for females
Source: Office for National Statistics (ONS), 2016 to 2018

13% of the population registered (18+) with a GP are recorded as having depression in 2017/18

Plymouth has a current population of 262,100
Source: Office for National Statistics ONS MYE 2019

Plymouth's Life Expectancy Bus Route

Electoral wards just a few miles apart can have life expectancy values varying by years.
Travelling south from Southway, each mile closer to the Waterfront represents 7 months of life expectancy lost.
Travelling west from Plympton Chaddlewood to same point, each mile represents over 1 year of life expectancy lost.

Why Change?

2018

- Our relationship between primary and secondary care was not positive with communication channels somewhat difficult and unhelpful between professionals
- Lack of trust from primary care colleagues towards secondary care recommendation/specialism
- Misunderstanding of each others challenges and a low tolerance of risk in primary care coupled with little trust in 3rd sector providers
- Clear commissioning gaps of service provision leading to people who need support falling between gaps and “bouncing” around the system
- Approx. 40% vacancy rate of substantive GP positions in Plymouth resulting in lack of knowledge of local provision/support

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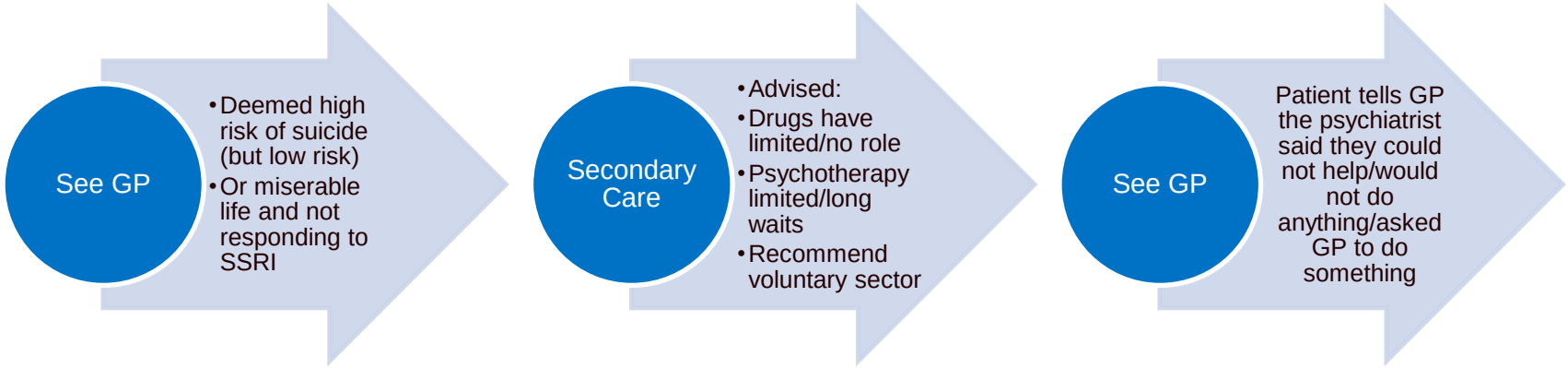
Secondary Care Referrals

- Example of person with diagnosis of personality disorder:



High number of referrals to Community mental health teams resulting in long waits
Poor experience for people using our services
Negative impact on working relationships between primary care and secondary care

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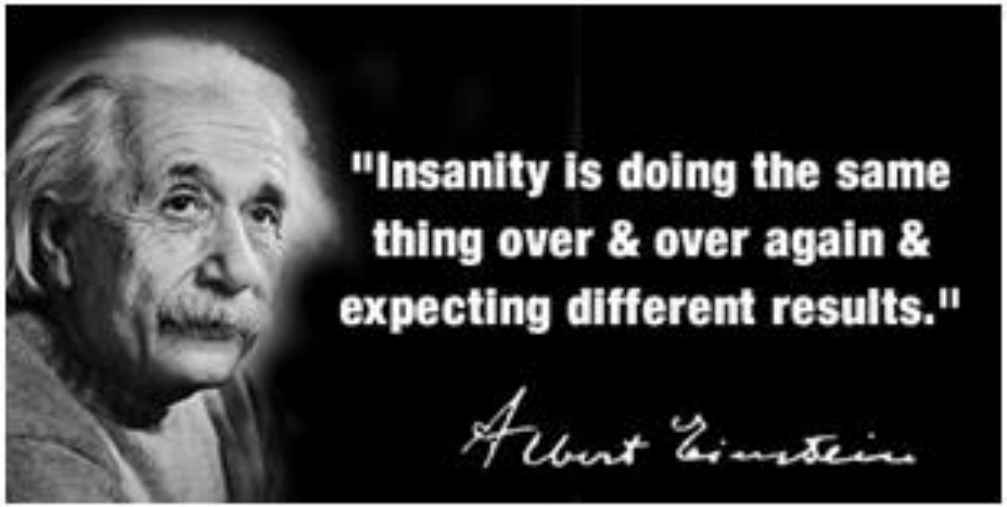

We were referring patients repeatedly expecting them to be fixed…. And they got bounced /signposted

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What Did We Do?

- **June 2018 – April 2019** consultation and engagement
- Previous link-working had resulted in transfer of mental health work, not integration, massive caseloads, staff burnout and vacancy
- It didn't work so we went back to our silos

- This time we wanted to do it differently using past learning from link-working
- We decided to integrate, co-designed with key-stakeholders
- Every contact a learning opportunity for all of us
- Doors open both ways!
- It was a risk so regular meetings and tweaking the pathway so a pilot first

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- **April 2019** implementing and embedding change:
- Reduced CMHTs from 4 smaller to 2 larger CMHTs
- Consistency of threshold and treatment offer
- This created a small resource (9 clinical staff) to create Primary Care Mental Health Team to work alongside primary care
- Work commenced with Pathfields (a group of GP surgeries working together/primary care network) and gradually rolled out
- PCMHT manage totality of consult unless they feel psychiatrist/GP advice is needed
- Consultant psychiatrist available for advice on all patients of surgeries
- Shared IT

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Understanding the problem

- We sat together in the surgery in shared hub taking calls next to each other
- We identified efficiencies of primary care approach
- Differences in approach to calls, more structure from PCMHT. GPs trained to just listen. Psychological vomiting/no change
- Primary care now confident that we understood their issues
- Primary care were not concerned about people with severe mental illness
- They were concerned about people with difficult lives who were stuck and feeling chronically suicidal. This caused a lot of GP stress although risks were low. GPs felt pressurised to solve the problems for the patient.
- Over-medicalisation of life problems, phoning doctor after an argument with someone. Often limited social support/ friends/family.

Initial Feedback

- This approach was well received by primary care colleagues although regular meetings needed to iron out niggles
- Moving into primary care was stressful for some staff so time invested from managers to support changes
- Improved working relationships
- Significant reduction in referrals to CMHT
- Routine referrals became clinical enquiries with a range of possible outcomes (voluntary sector, CMHT (rarely), back to GP with advice, PCMHT intervention)

Asset-based community development

- Builds on what the community has (not trying to fill the needs)
- Maps the assets of the community/ other providers
- Co-produced
- Place-based (variations between different communities and PCNs)
- Flex round your community
- Relational (including community resources) how can we work together to support the person
- Awareness of capacity and demand of system
- Flexibility to tailor offers made depending on where the system has capacity
- Working inclusively

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- Community Mental Health Framework published by NHSE Oct 2019

- Oct 2019 – July 2021 planning Devon CMHF model and submissions to NHSE

- July 2021: Mobilisation of CMHF introduced which will build on the work that Livewell have already started

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CMHF 6 Key Aims

1. Promote mental and physical health, and prevent ill health.
2. Treat mental health problems effectively through evidence-based psychological and/or pharmacological
3. Improve quality of life, including supporting individuals to contribute to and participate in their communities
4. Maximise continuity of care
5. Work collaboratively across statutory and non-statutory commissioners and providers within a local health and care system to address health inequalities and social determinants of mental ill health.
6. Build a model of care based on inclusivity

Community Mental Health Framework

Self Care: At the centre of our core model is the person and their capacity to care for and help themselves.

Personal Community: When a person has a problem, the first people they turn to are those in their personal network- their family, friends, colleagues and online network

Community: People exist in a communities, a persons community will include the people and places where they contact others, at the school gate, in their place of work, through community events, hobbies and interests etc

Community Based Health and Social Care: Within communities, but not often part of our daily lives are a range of community based health and social care offers which aim to help us when we are unwell.

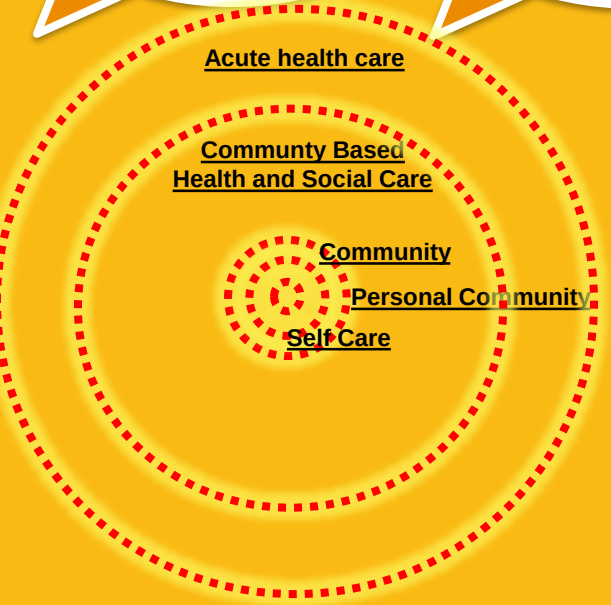
Acute Health Care: within our wider communities we have a more specialist range of health, social care and other community services which help us when our needs are more urgent and acute.

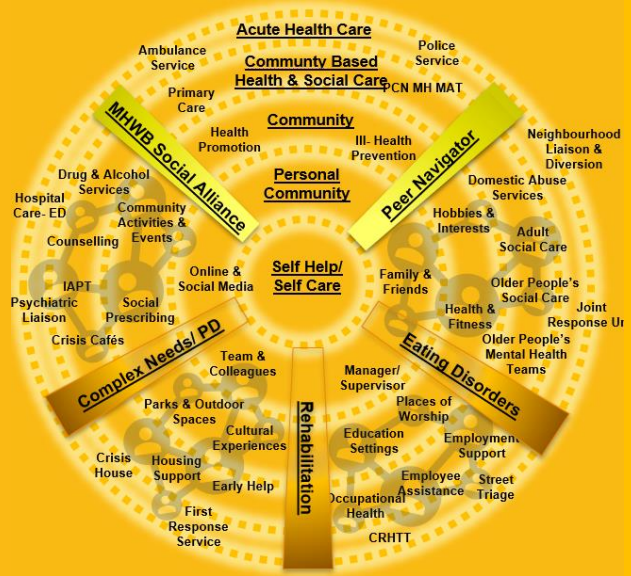
Our Model: What it means for people

I am severely unwell. I can't keep myself safe. I've withdrawn from my friends and family. Community Services and Acute/ Emergency service need to keep me safe.

Support, care and treatment help me meet my biopsychosocial needs We look at my strengths and my needs and spot the gaps in my networks

My support, care and treatment helps me to develop and sustain long term connections which will help me self care, get support from my personal network and connect me to my community.





Integration and co-ordination across the rings and sectors

Balanced rings reflected in commissioning, care planning and support, care and treatment.

Building self, personal network and community capacity

Rings are not solid, they are permeable allowing connection and support to move between

Built on CMHT foundations, building Mental Health Social Alliance offer.

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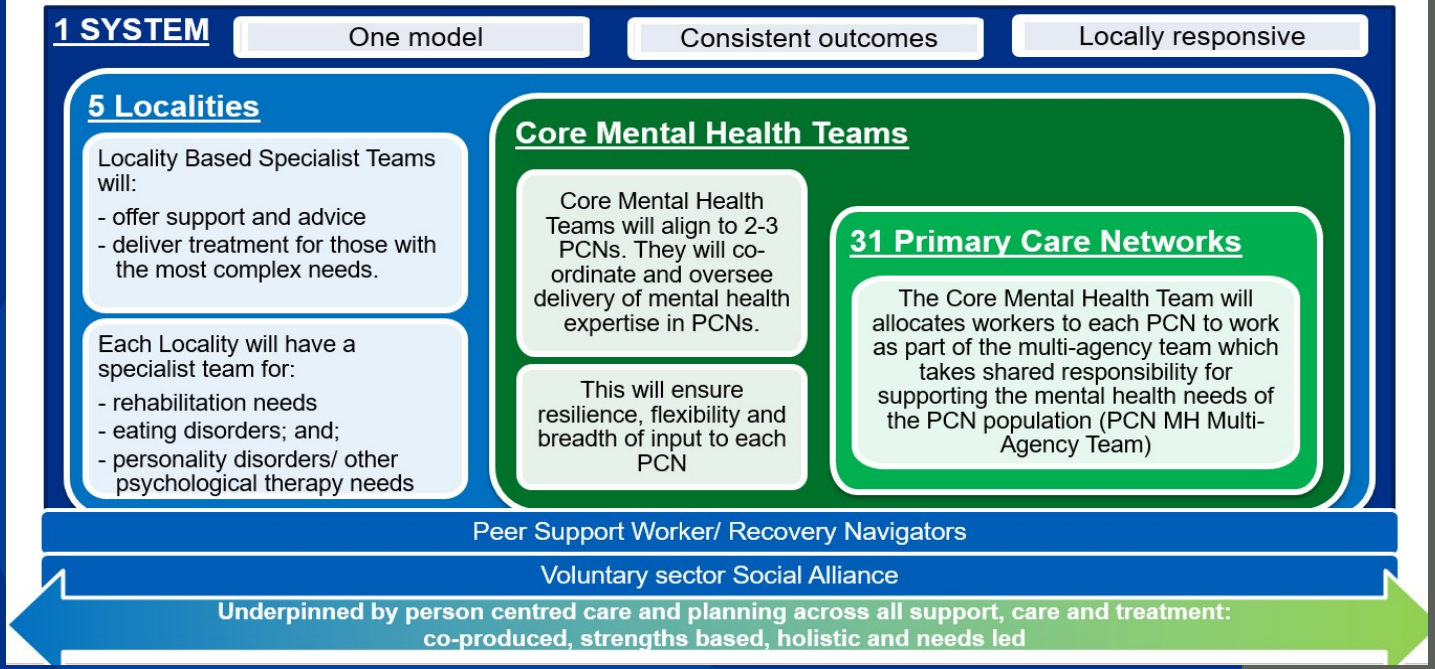
Our Model: Components



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New resources to aid transition

Over £15 million additional funds to Devon mental health over a three year period expedited to 18 months by Devon ICS.

20 – 22% of new funds identified for VCSE

- Develop and strengthen community assets to work with people with mental health needs
- Reduce loneliness and isolation particularly in OPMH
- Reducing digital exclusion and digital solutions to support access to services
- Utilising new roles to support range of care e.g. Rehab Recovery Navigators
- Offer therapeutic interventions (too complex for IAPT not complex enough for core mental health services)

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New resources to aid transition

92.6 WTE new roles within provider trusts (DPT and Livewell)

- 48 wte in core team (38)
- 21 in Rehab (15.6)
- 16 wte Personality disorder (9)
- 8 wte eating disorders (6)

Opportunities with participating PCNs to enhance mental health provision further through **Additional Roles Reimbursement Scheme (ARRS).**

PCN level data being pulled together to support role planning to address unmet needs - identified by bounced referrals and low priority individuals waiting – Up to 24 additional roles for DPT footprint

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What does this mean?

- Providing services that are based around individuals whole-life needs, not just their mental health needs. This includes access to psychological therapies, improved physical health care, employment support and support for coexisting substance use.
- A one-team approach between health and social care aligned with primary care networks to maximise continuity of care. There should be no “wrong door” for service users to access the support they need and support should be able to be stepped up or down as required without referrals and repeated assessments.
- Services that are as close-to-home as possible, ensuring that individuals are able to participate in their communities, and they are shaped to meet the needs of local communities
- Addressing inequalities in mental health care
- Co-production and co-design with people who have lived experience and carers. People should be enabled as active participants of their treatment.
- Consistent services and standards of quality across the county

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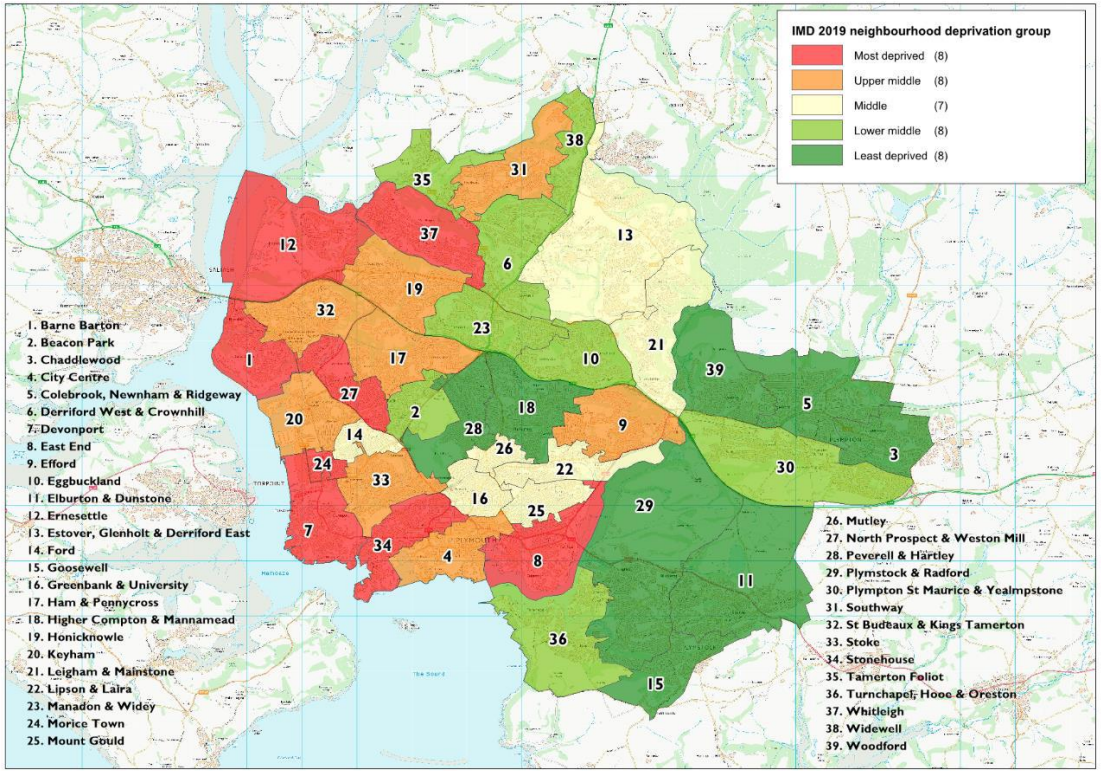
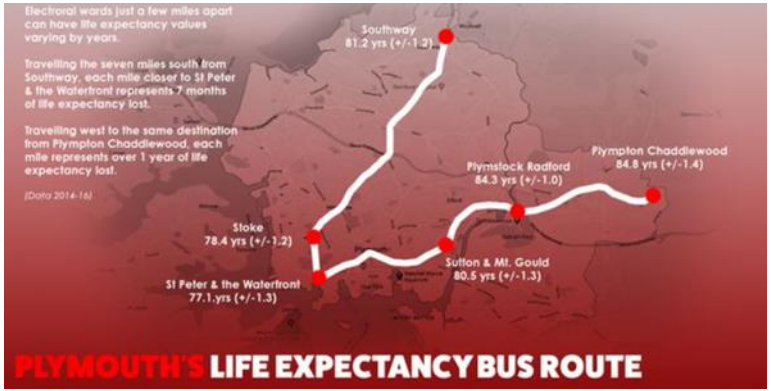
Understanding Our Local Population



Multi-Agency Teams and Core Services at neighbourhood level formed around PCNs – *consistency not uniformity*



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Core Services

- **Core mental health services** which will include a lower level offer (Primary Care Mental Health Team) and an enhanced offer (Community Mental Health Teams)
- Take a collective responsibility to finding solutions for individuals whose needs aren't easily met by current support or treatment offers

- Dedicated services for specific needs are being further developed:
    - eating disorder services
    - services for people with personality disorder and complex lives
    - SORT (specialist outreach recovery team) for people with rehabilitation and recovery needs

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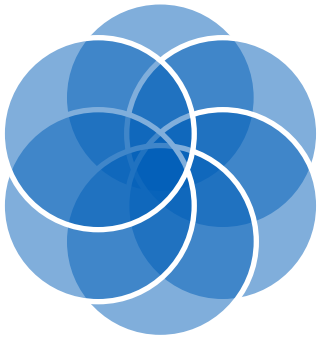
Focus of the alliance consistency not uniformity

The role of the Alliance within the CMHF

Develop & strengthen community assets to work with people with mental health needs

Reducing digital exclusion and digital solutions to support access to services



Reduce loneliness & isolation, particularly OPMH

Utilising new roles to support range of care e.g. Rehab Recovery Navigators

Offer therapeutic interventions (too complex for IAPT not complex enough for step 4 psychological therapies)

Person-centred care with an MDT approach

Additional service areas

- Counselling
- Bereavement Support
- Employment Support
- Crisis Café's

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Focus of CMHF and VCSE/I Alliance

Severe Mental Illness

psychosis

mental health rehabilitation needs

bipolar disorder

severe depression

personality disorder diagnosis,

eating disorders

– some of which may be co-existing with other conditions such as frailty, cognitive impairment, neurodevelopmental conditions or substance use.

In scope

- Working age adults and older adults;
- Young adults 18 to 25 (inc support from 17 years)
- Co-existing substance use
- co-existing neurodevelopmental conditions, and co-existing cognitive
- Co-existing dementia
- People transitioning back into their local communities (e.g. from the criminal justice system, from out-of-area care, or people who have experienced homelessness /rough sleeping
- People who self-harm

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PCMHT team now

- Team manager band 7 nurse
- Team practice lead band 7 nurse
- 8 x band 6 nurses
- 1 x band 6 occupational therapist
- 1 x band 6 social worker
- 2 x band 5 nurses
- 2 x band 3 support worker
- 4 x band 3 peer support worker
- 1 volunteer befriender
- 1 x band 3 group care co-ordinator
- 1 band 3 and 1 band 2 administrator
- 1 x preceptor nurse

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The current offer

- Triage – Risk Assessments and Signposting
- Assessments- Qualified
- Emotional Intelligence Group – Qualified
- Understanding Recovery Group – Support Workers
- Personal Recovery Group – Support Workers
- 1:1 Interventions by Qualified – Psychoeducation, Emotional Intelligence (only if cannot attend a group due to mobility issues or criminal conviction).

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- 1:1 Intervention by Support Workers – Anxiety Management (if due to risk cannot attend Options for CBT)
- Exposure Work
- Personal Recovery Plan – If unable to attend groups due to mobility issues or criminal conviction).
- Support to 3rd Party Agencies.
- MAT Meetings – ARRS workers will be chairing the meetings these will be commencing in July 2022.

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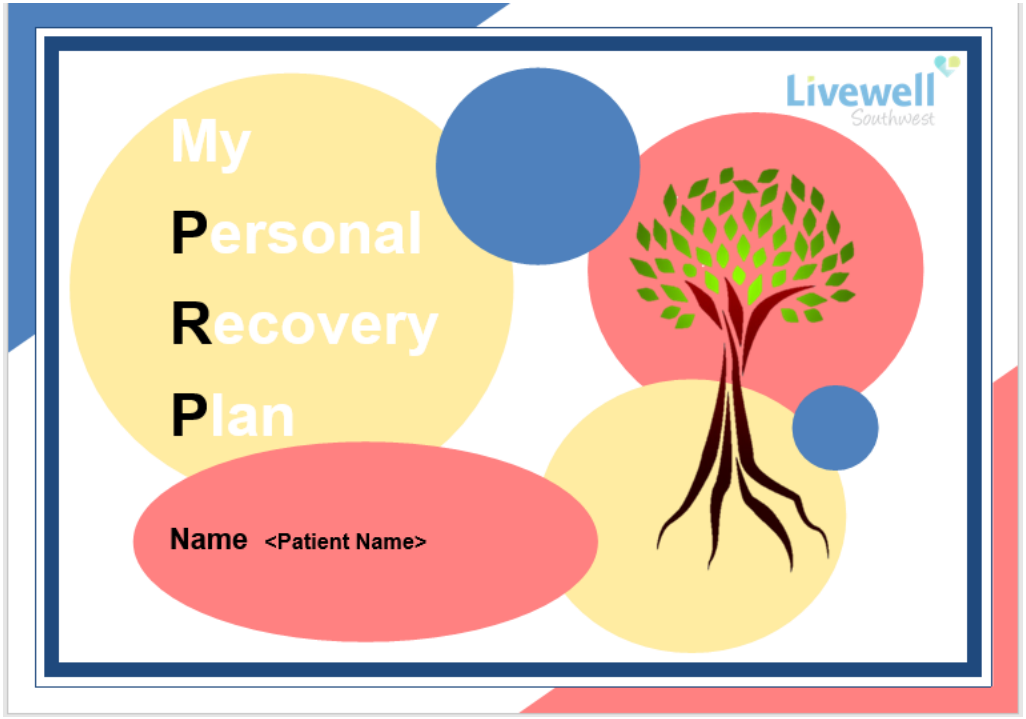
Supported by

- Lean methodology for paperwork (with senior management to streamline process)



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Shared IT

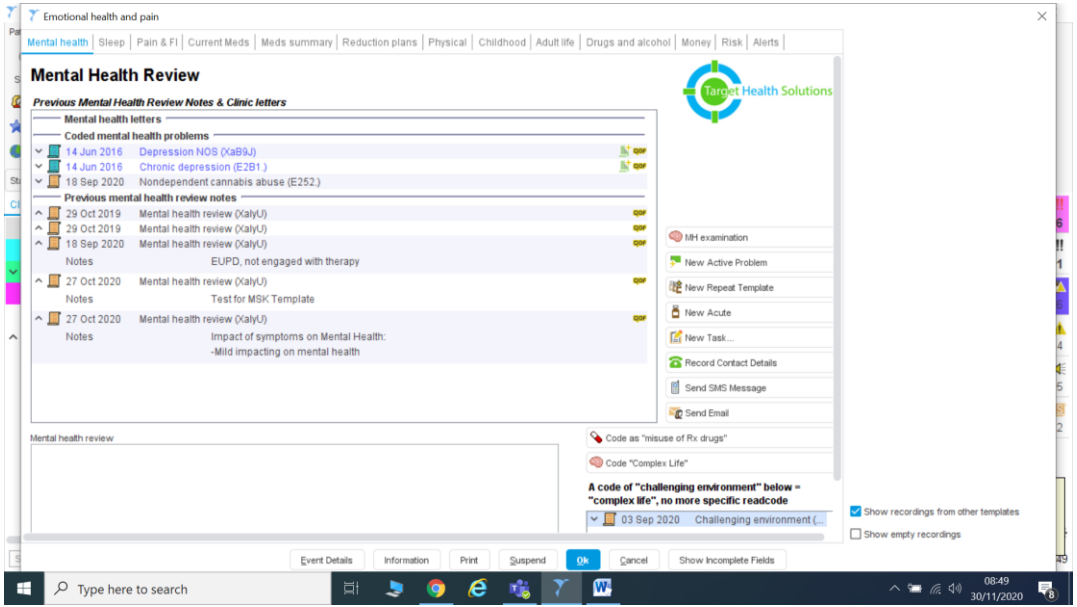
- System one
- We work on the GP IT system when giving advice/PCMHT
- Enables services to all wrap around one hub of information
- Especially useful for complex patients

Tasks

- Urgent referrals follow usual pathways
- Previous routine referrals to CMHT become clinical enquiries and reviewed by psychiatrist. PCMHT also work via task
- GP writes ‘PI see notes’ presses button
- No dictation of referral or admin time
- Prompt reply

Emo template

- Groups together all information relating to emotional health and pain (sugar cube)



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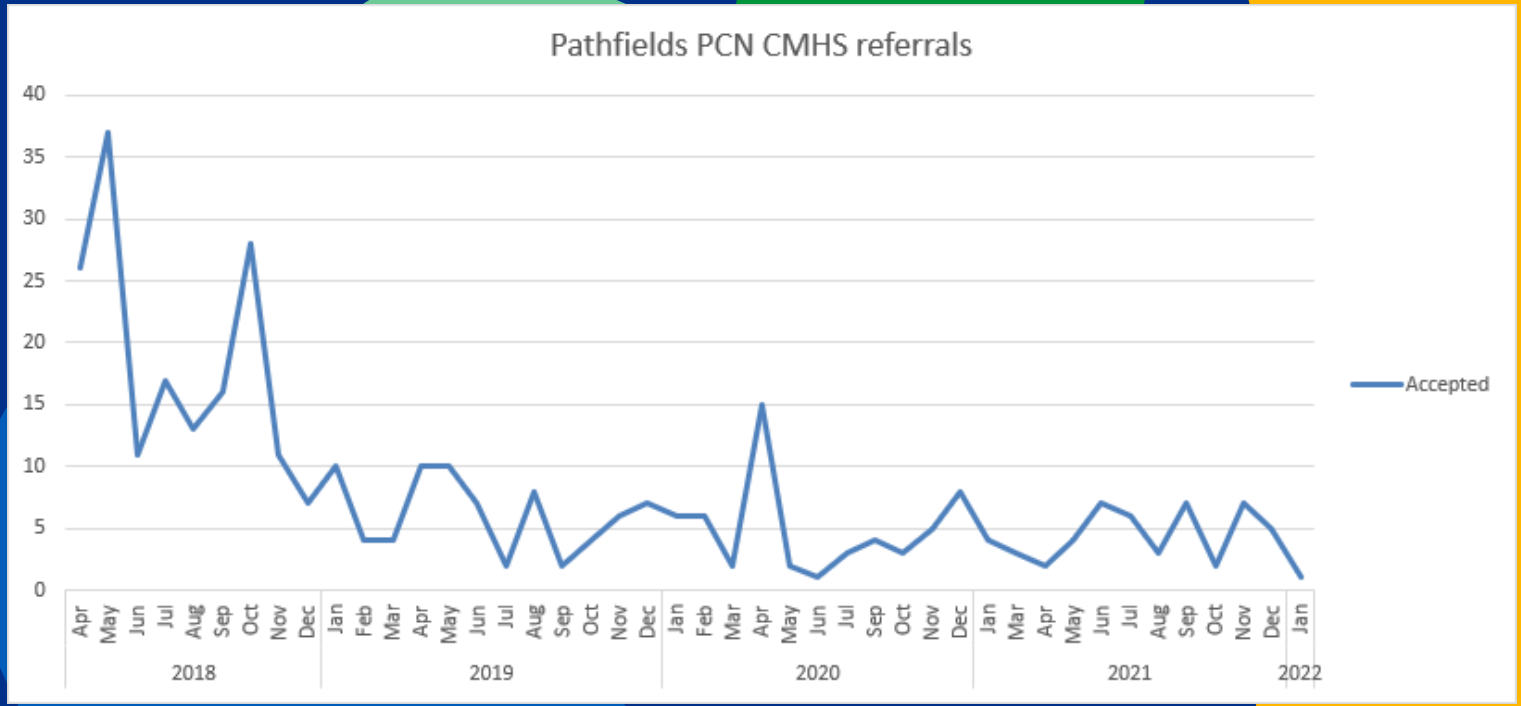
Impact So Far



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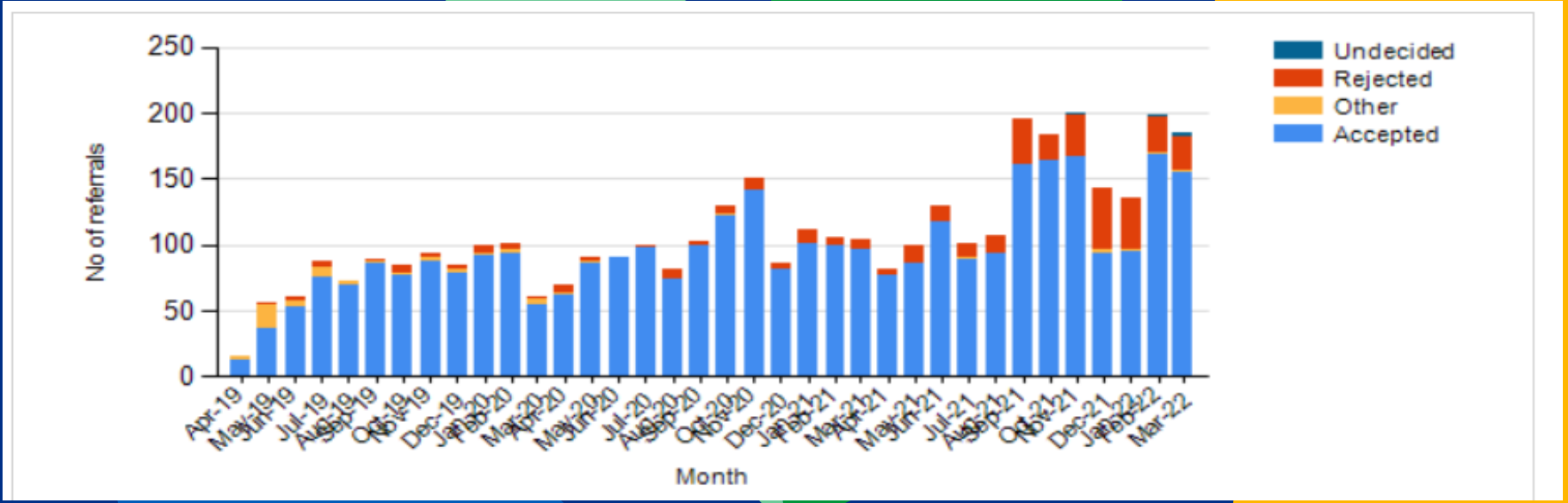

Total referrals to PCMHT: 3892 since April 2019

Total number of people re-referred: 378 people since April 2019

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July 2021 – Feb 2022: 1462 patients have had two or more contacts within the new way of working in CMHF including VCSE and Core Services/Primary Care level

2021 approx. 1000 pieces of advice given by psychiatrists for patients not open to CMHT
CMHT less delivery more consultation

Waiting lists have gone from 15-16weeks for a routine referral to 2 weeks

Feedback from primary care

- I really enjoy working closely with the primary care mental health team. There really is something to be said about working in the same room and getting to know your colleagues. We bounce off each other with ideas and learn from each other every day. It really feels like teamwork managing some of our more challenging patients.

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- Working in a joined up way with our mental health colleagues allows the best possible service for our patients within the budgets we all need to stick to.
- From a quickly received consultant advice straight into the notes to recovery plans for our patients everything is covered.
- As with anything in life working together as a team is always better.

- Totally transformative - we have gone from working in opposition to working alongside each other.

From service users

- Always contacted me when they said they would. YouTube Videos useful to refer back to.

- The professional who dealt with me was non judgemental, listened with compassion and signposted me to other services they felt I would benefit from.

- Content of this course and 1:1 sessions are extremely relevant to me and will be very helpful in the future. Thank you so much for providing this course. It's genuinely life changing.
- I feel so different today in comparison to when we first started the course! Thank you for your amazing work and support!

Any questions?

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