East London NHS Foundation Trust

Community Mental Health Transformation in City & Hackney

Overview and Scrutiny Committee

January 2020

We care We respect We are inclusive

Our starting point - Mental Health in the Neighbourhoods

- Co- produce a model for mental health in the neighbourhoods, taking a population health approach – to secure transformation funding and inform the new Community Alliance contract in 2020, taking a population health and partnership approach
- The community transformation work in City & Hackney builds on the Mental Mealth in Neighbourhoods project., part of the City & Hackney Neighbourhood programme, which started in 2018.
- The Mental Health in the Neighbourhoods project aims to develop a model, and test out through a number of pilots some ideas, for how mental health services can be delivered in Neighbourhoods, responding to what matters to services users, carers, residents, staff and partner organisations.
- The intention is to work with residents to develop healthy Neighbourhoods, and to provide services and support in a much more integrated way with physical health, social care, voluntary services and wider statutory services.
- It is taking a population health approach, looking at the strengths and needs of people with a range of mental health conditions: severe mental illness (SMI), common mental health disorders, mental well-being, dementia, personality disorder, learning disabilities, autism, CAMHs and substance misuse/alcohol

What were the key concerns & ideas people identified for the model?

How we found out

- Focused groups, case study seminars, service user and staff interviews and surveys, meetings with partners

Concerns

- Loneliness and social connections; money worries, employment and housing; and physical health
- A strong message from the seminars and focus groups is that our approach to creating and maintaining good health in Neighbourhoods is more about supporting people live happy, healthy, independent and connected lives in their communities than it is about diagnosis, treatment or services.

Ideas

- Focus on life triggers and wider determinants of health
- Develop a Neighbourhood support pathway and multi-disciplinary (MDT) approach for people who are not engaging with services and could be vulnerable and partner with the voluntary sector to better support people with activities and connections
- Mapping the mental health assets and promoting more signposting to these, so that people can be better supported and connected in their Neighbourhoods
- Better integrated care, with effective multi-disciplinary team working and care plans
- Developing existing roles in the public sector to have more of a focus on supporting people with mental health conditions
- Expanding the peer support worker role to work in Neighbourhoods
- Creating hubs in Neighbourhoods for mental and physical wellbeing

Neighbourhood Pilots

Pilots underway or about to start in some Neighbourhoods, including:

- A pilot with the Barton House practice in the Clissold Park Neighbourhood that is identifying the people with SMI who have not attended for a physical health check in the last year to see what support they might want
- Exploring the potential to set up a satellite recovery cafe in a Neighbourhood with a local community group and voluntary sector partners
- Forming a cycling club for people with SMI and their carers in the Hackney Marshes Neighbourhood to address loneliness and physical health concerns
- Developing a community hub with the voluntary sector at Liberty Hall
- Developing new roles to be tested in the Neighbourhoods including:
  - a joint adult community psychiatric nurse/practice nurse role
  - a joint GP/psychiatrist role
  - a step-down nurse for the CAMHs ADHD service
  - a paediatric liaison nurse in GP practices

TAKING THE MODEL FORWARD – THE COMMUNITY TRANSFORMATION PROGRAMME

- In July we had the opportunity to bid for NHSE funding for community mental health services transformation
- Aim of the programme is to provide more support to people with serious mental illness (SMI) in primary care and their Neighbourhood, with greater focus on social connections and wider determinants of health
- We were well placed to secure funding as the transformation programme builds on our existing primary mental health care service and also our Neighbourhoods work
- The Neighbourhoods ideas and model were the focus of the bid
- One of 12 Trusts in England selected by NHS England to be a pilot for community mental health transformation
- Awarded just over £1m in City & Hackney for 18 month pilot, starting September 2019
- Tower Hamlets and Newham also awarded funding
- We are now implementing the bid
- And also continuing with the wider Neighbourhoods model development to inform the community contract - the bid is about adult SMI and personality disorder services, whereas the Neighbourhoods model is taking a wider population approach

BACKGROUND AND CASE FOR COMMUNITY MENTAL HEALTH SERVICES TRANSFORMATION

NATIONAL COMMUNITY MENTAL HEALTH FRAMEWORK

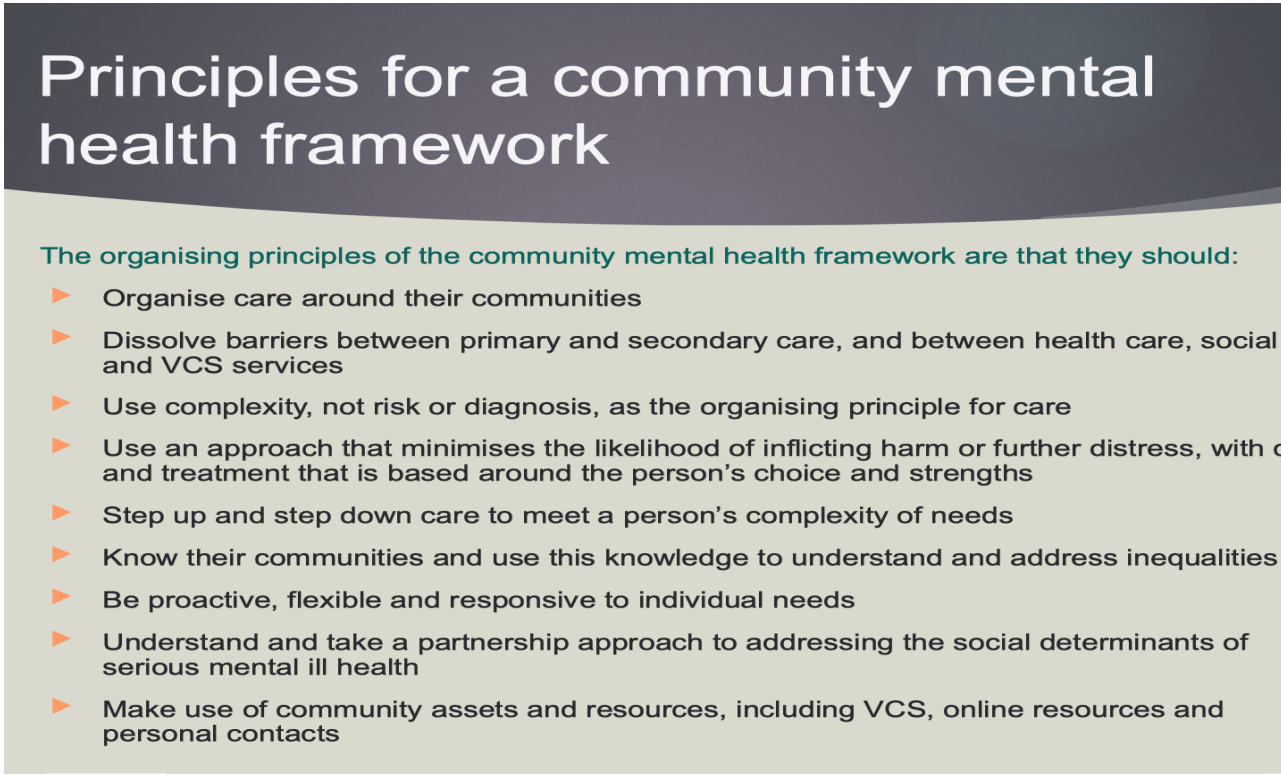
The case for community mental health transformation was made recently in the new national community mental health framework

Developed by National Collaborating Centre for Mental Health & NHS England

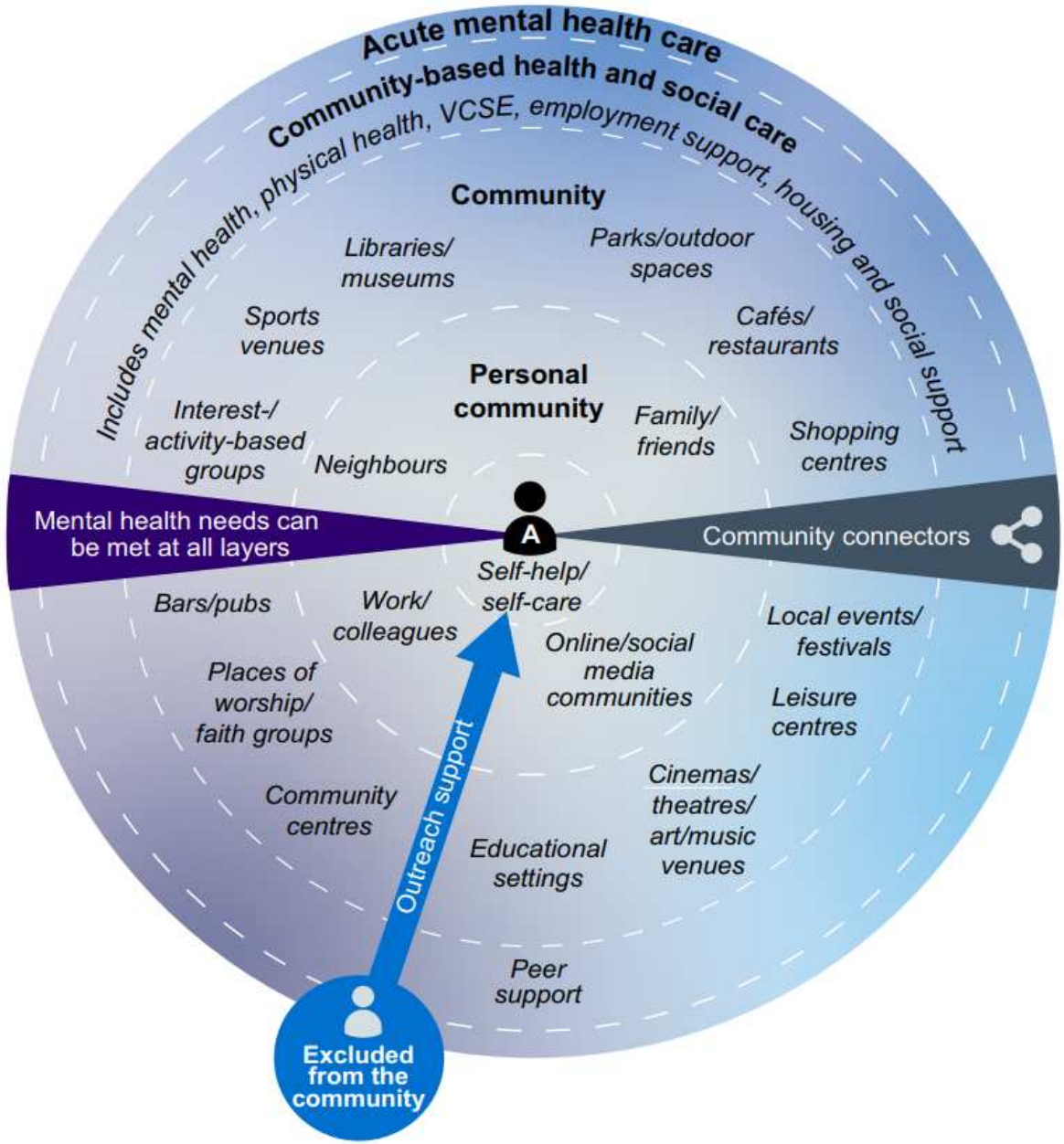
Recognised that in last 20 years mental health policy has focused on developing specialist and functional teams e.g. crisis, home treatment and early intervention etc

While community mental health teams have picked up the slack with little investment or policy attention

This has left a legacy nationally of increasing waiting times, heavy caseloads, service users saying they need more frequent support and poor access for GPs in some places

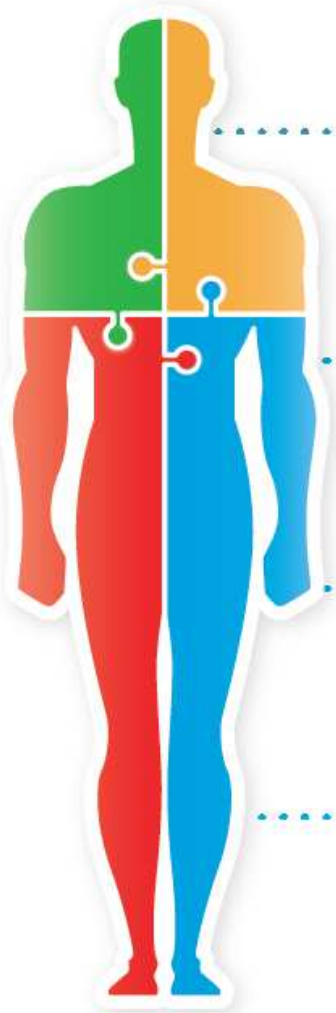


eloping neighbourhood models for mental health



nections between health and social circumstances

HEALTH



SMOKING (low income group)

Tower Hamlets	20% (45%)
Hackney	15% (22%)
Newham	18% (25%)
London/England	13% (3%)

OBESITY

Tower Hamlets	42%
Hackney	40%
Newham	43%
London/England	37%

CANCER SCREENING

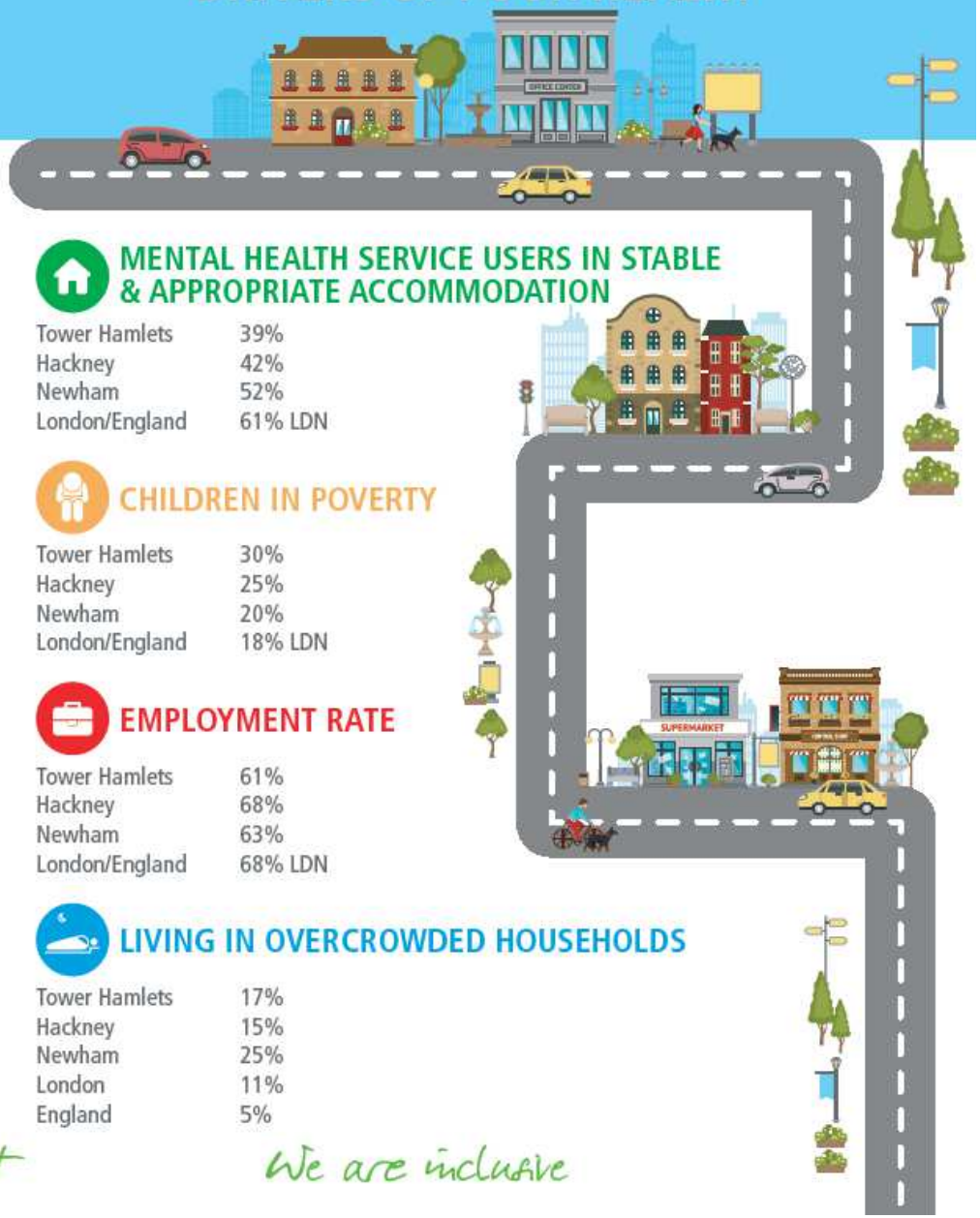
Tower Hamlets	42-73%
Hackney	45-73%
Newham	46-64%

CARDIOVASCULAR DISEASE

Tower Hamlets	94/ 100,000
Hackney	93/ 100,000
Newham	95/ 100,000
London/England	70/ 100,000

(PHE Fingertips 2019)

DRIVERS OF POOR HEALTH



MENTAL HEALTH SERVICE USERS IN STABLE & APPROPRIATE ACCOMMODATION

Tower Hamlets	39%
Hackney	42%
Newham	52%
London/England	61% LDN

CHILDREN IN POVERTY

Tower Hamlets	30%
Hackney	25%
Newham	20%
London/England	18% LDN

EMPLOYMENT RATE

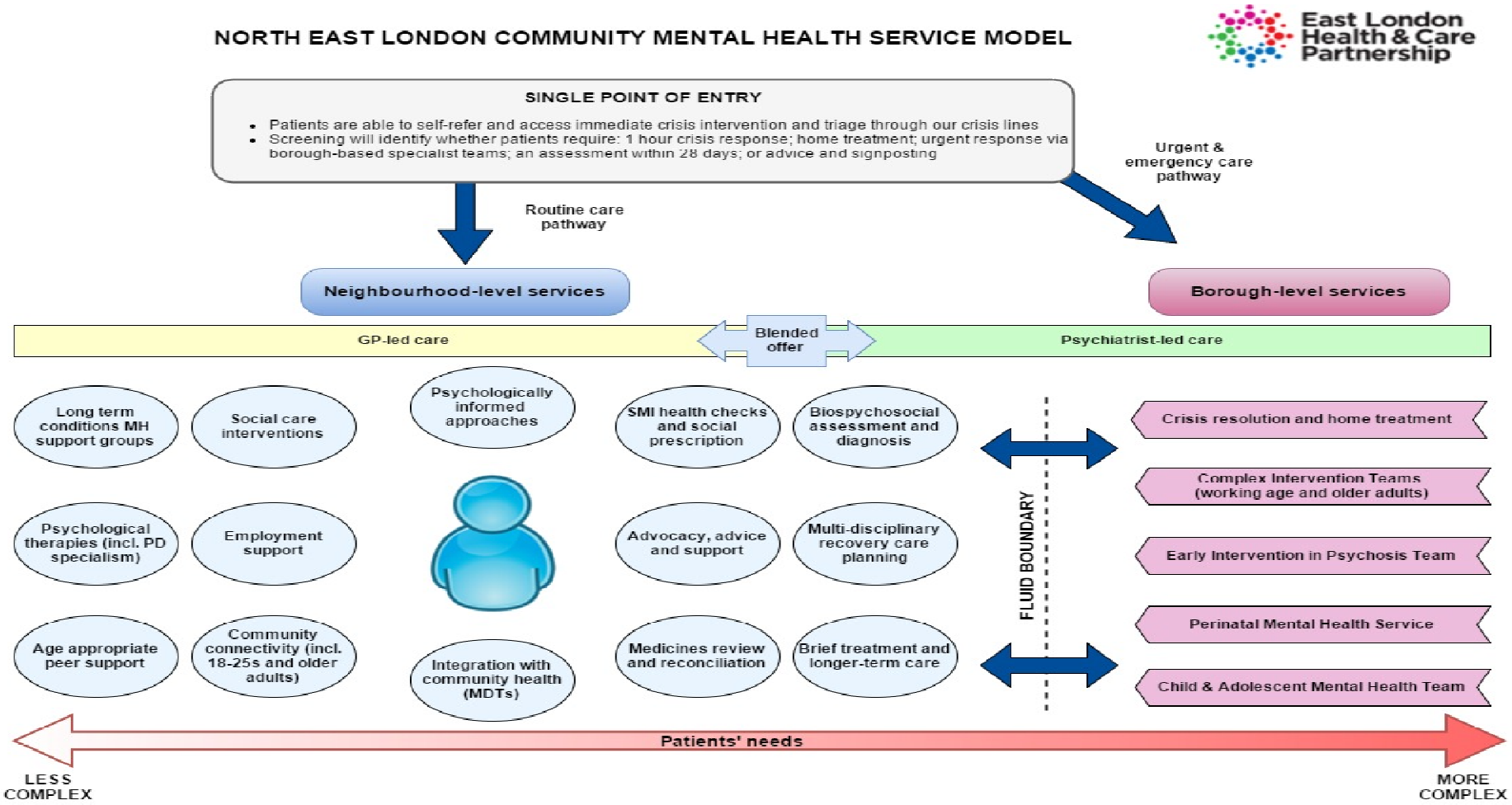
Tower Hamlets	61%
Hackney	68%
Newham	63%
London/England	68% LDN

LIVING IN OVERCROWDED HOUSEHOLDS

Tower Hamlets	17%
Hackney	15%
Newham	25%
London	11%
England	5%

We care We respect We are inclusive

Our model on a page



Posts

Neighbourhood mental health teams

1 x band 7 EPC Worker

4 x band 3 support worker/peer support worker

Voluntary sector

8 band 5 equivalent community connectors employed via the voluntary sector

Personality Disorder

2 x band 7 psychologist
2 x band 5 associate psychologists (apprentices – start in Sept 20)

What we have to deliver
Key features of the model: neighbourhoods & populations

- **Neighbourhood ethos**
  - Working in the 8 neighbourhoods/primary care networks (PCNs)
  - Focused on the wider determinants of health and life triggers – community connectors role
  - Asset/strengths based
  - Strengthening and connecting communities
  - Population health- integrated care approach

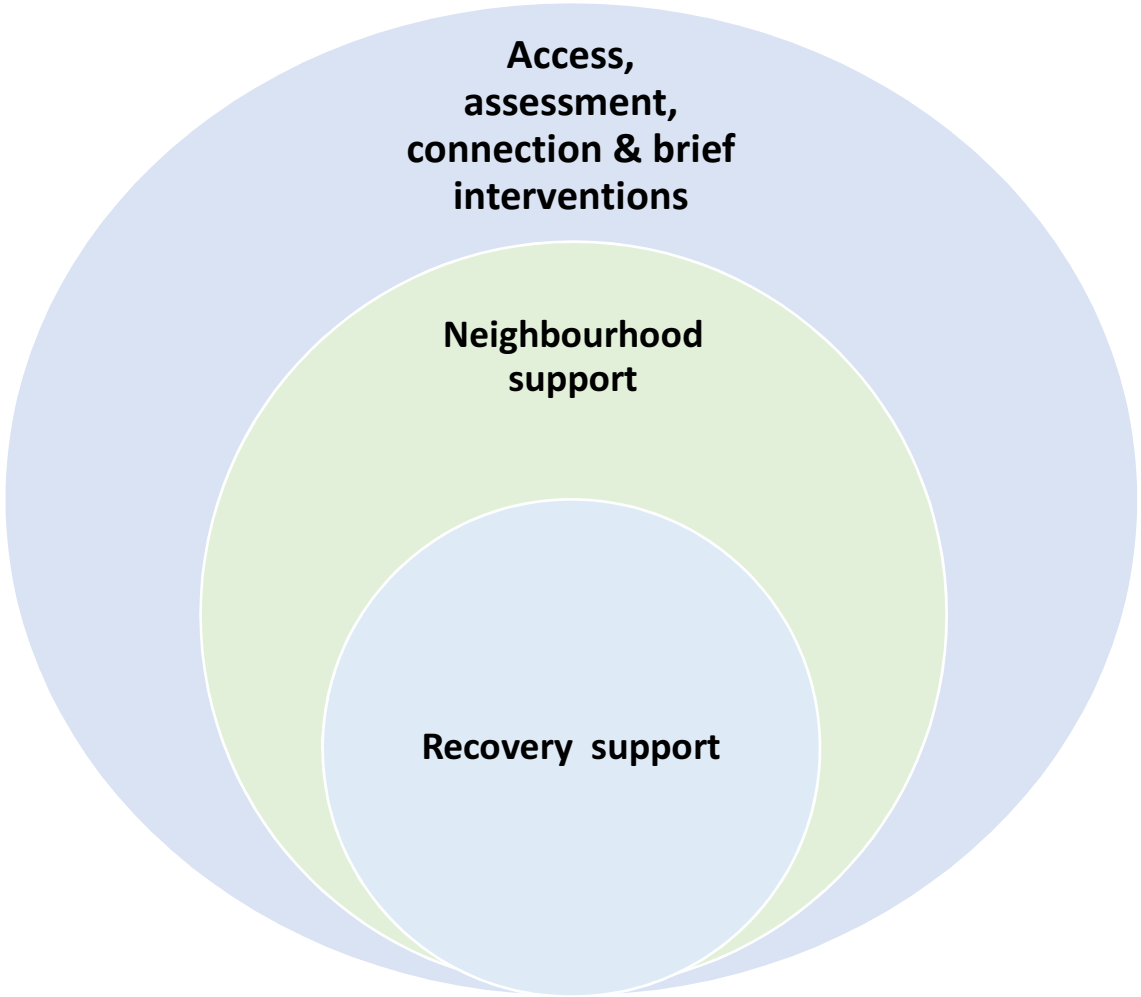
- **Supporting 3 main groups of people**
  1. Those needing more support who are already managed in primary care – step up
  2. People seen in outpatients and not care co-ordinated in recovery teams
  3. People not engaging – the worry list

- **Plus a focus on**
  - Personality disorders: Working with CYP services to identify people with emerging problems. Trauma approach.
  - Transition (18-25): Developing young adult (YA) or transition specialists within the specialist community teams at place-level. PCN teams will contain YA specialist posts to lead on assessment , support planning and peer support for 18-25s.
  - Older adults: initially retain a specialist place-based CMHT for older adults but with fluid transitions with PCN teams and consider the case for further integration of CMHTOP support into PCN MH Teams
  - Eating disorders: neighbourhood based groups

Key features: team and place

- **The blended neighbourhood team**
  1. MH: assessment & referrals, brief interventions, primary care liaison, enhanced primary care, psychology, MH pharmacy +++
  2. Voluntary sector: community connectors
  3. PCN: community pharmacy, physiotherapy, paramedics, associate physicians, GPs, practice nurses, social prescribers
- **First layer of the development of a wider neighbourhood team**
  - Community/district nurses and physical health therapists, social workers, well-being practitioners, volunteers
  - Neighbourhoods programme about to start an anticipatory care MDT pilot in Clissold Park neighbourhood
- **Place focus**
  - Appointments/clinics will be offered in PCN settings
  - Look to create hubs in neighbourhoods – non institutional feel
  - Connect to a wide range of community activities, resources, leaders and places – via community connectors
  - Promote good mental well-being, breaking down stigma & loneliness
  - More opportunities for local people and people with lived experience

Circles of support



Starting point: Hackney Marshes PCN Pilot

- Currently scoping and designing the pilot
- Data analysis phase – looking at caseloads and deep dive in to the ‘worry list’
- Will test out blended team approach
- Test of community connector role
- MDT working
- Test the ‘attachment’ focus group
- Focus groups for GPs about personality disorder
- Start testing in early spring 2020
- Dr Ian Burrows supporting from GP Confederation

Early progress

- Central team support
- PCN pilot underway in Hackney Marshes
- Resident, partner and staff briefing e.g. meeting with Healthwatch
- Co-production discussions with Recovery College
- Staff engagement and model design- clinical leaders and manager meeting on 17 September and 17 December
- Voluntary sector engagement meeting on 25 September
- Discussions with GP Confederation - focus on Hackney Marshes neighbourhood & support from PCN Clinical Director
- Local project board formed and meets monthly – Beverley Gachette and Tessa Coles from LBH.
- Montly update meeting with Ian Tweedie from City of London
- Modelling activity
- Personality disorder design work underway – focus groups and case study seminar
- Recruitment underway

Appendix

s of increased focus

Adults with a diagnosis of personality disorder

- Much clearer PD / complex trauma pathway, with significant additional clinical and non-clinical staff working as part of a PD specific offer to PCN populations
- Our pathway will include locally delivered support networks led and delivered by people with PD – service user networks will provide peer support, increase participation, connection to community, and thereby reduce social isolation

Adults at risk of developing an eating disorder

- We will develop a pre-diagnostic service (focused on pre-ICD 10 Eating Disorder diagnostic threshold patients and the mild end of the spectrum) to complement the existing services in our patch
- The service will be co-developed with experts by experience, and we anticipate their input into the delivery of the service through opportunities such as being group co-facilitators

Young adults (18-25)

- We will build on the good practice in existing transitions planning between CAMHS and adult MH services (particularly EIP Teams) by developing young adult (YA) or transition specialists within the specialist community teams at place-level
- PCN teams will contain YA specialist posts to lead on assessment, support planning and peer support for 18-25s; and support will be offered at locations that are most meaningful to the service user e.g. university campuses, youth hubs
- We will actively promote opportunities for YAs to pursue careers in MH; establishing a pathway for Peer Support Workers to take up paid Community Connector or other non-qualified roles within our staffing structures

Working age adults

- Our Community Connectors, Support Workers and Peer Support Workers will flex between those whose needs are reducing; and those whose needs are increasing. This approach will particularly benefit people who struggle to navigate VCS and universal services on their own
- We will co-design intuitive pathways to employment from both within the PCN teams and our place-based specialist teams. These pathways will incorporate third sector, council and DWP funded support for adult training and education

Older adults

- Where there is a care home within the PCN, the PCN MH Team will provide MH consultancy support to the home, as part of the more general PCN MDT offer
- There will be Community Connectors with a specific brief to support older adults to connect with opportunities available in local community settings
- Our PCN teams as part of the broader PCN MDT will proactively engage with paid and unpaid carers, and will be trained on how to manage expectations, and hold difficult conversations

Key features: Neighbourhood mental health pathway

- Healthy life styles pathways
- People to have annual SMI check by 2020 (Currently at 75%)
- Focus on wider determinants of health – supported by community connectors
- Community connectors (band 5 equivalent): assessment, brief interventions, group work, care navigation, social prescribing+++, partnership work and liaison with communities, connection into community activities
- Support for people with personality disorders & complex PTSD– embedding a trauma led approach
- Neighbourhood based OT, arts therpaies, psychology and psychotherapy support including group work
- Pharmacy input – medication reviews, comorbidities with physical health/medications, GP/community pharmacy liaison, and training, audits, sourcing replacement meds when certain meds no longer manufactured
- Staff will have skills/experience in substance misuse
- More SUN groups
- More peer worker support – via accredited peer support course in ELFT
- Carer support
- Parental mental health support
- Fluid approach across to recovery pathway
- Support people who have to date been seen in outpatients in recovery teams
- More medical time available - as outpatients is scaled down
- Some functions will need to move across from recovery teams e.g. FACT, urgent assessment, Duty
- Offer must match and preferably exceed current recovery pathway outpatient offer
- Support people for up to 2 years (to be debated)

East London Community Mental Health Transformation - Complexity-led Care Model

Workforce

- GP
- Practice Nurse
- Social Prescribing Link-Workers
- Community Connectors
- Neighbourhood Link Workers
- Other Support Worker
- Local Authority Advisor (housing, drug & alcohol, benefits etc.)

Intervention

- Psychological therapies
- Psychoeducation or condition-specific groups
- Signposting / brief support to access universal services (libraries, leisure centres etc.)
- Signposting / brief support to access VCSEs and community groups
- Advice and information

Care process

- Referral to non-registered team member for brief assessment & intervention
- Annual physical health check (SMI, LD, LTCs)
- GP care / health action plans and reviews (dementia, LD)
- PCN MDTs & residential / nursing care homes MDTs

Identification by a service / MDT / **referral**

Biopsychosocial **assessment** by qualified person within 28 days

Personalised **care planning process** - uni-professional where complexity is less, or multi-professional where complexity is higher (PCN team)

Care plan reviews – frequency determined by need, risk, multi-agency involvement, carer & service user preferences

Outcomes review and determination of on-going needs - step up to higher intensity team, continue, reduce intensity (PCN MDT decision?)

- Identification of appropriate service: EIP, Perinatal, HTT, Complex Intervention Team
- Added to place-based service clinical caseload
- Care plan formulation - MDT approach with designated care coordinator

Complexity level

Low complexity

- People with recent onset of symptoms (excl. FEP)
- People 'in remission' or recovery
- People with a single issue or 'problem' they would like support with
- People experiencing loneliness or low mood
- People coming to terms with a physical health condition / diagnosis

Increasing complexity
(not exhaustive lists - level of complexity increases the more of these factors that are present)

Co-ocurring conditions

- People with a disability or complex health condition
- People with 2+ chronic conditions
- People with co-occurring LD, or neurodevelopmental condition
- People with MCI / dementia
- People with addiction problems
- People with physical frailty (elderly)
- People with residual symptoms
- Fluctuating mental capacity

Social circumstances

- People with unstable or poor housing
- People experiencing DSV
- People with immigration issues / no recourse to public funds
- People with caring responsibilities
- People with very limited social networks
- People experiencing stigma due to their sexuality, gender identity etc.
- People with economic & occupational instability

Psychological needs

- People at risk of developing eating disorders or body dysmorphia
- People who are self-harming
- People who have experienced trauma (childhood, emotional etc.)
- People with affective and psychotic disorders
- People experiencing periods of emotional instability
- People who have been bereaved

High complexity

- People experiencing FEP
- People leaving prison/hospital
- People requiring crisis intervention services
- People during the perinatal period with a SMI
- People with disabling, complex mental health conditions
- People requiring assertive, coordinated care
- Rough sleepers

PCN Population

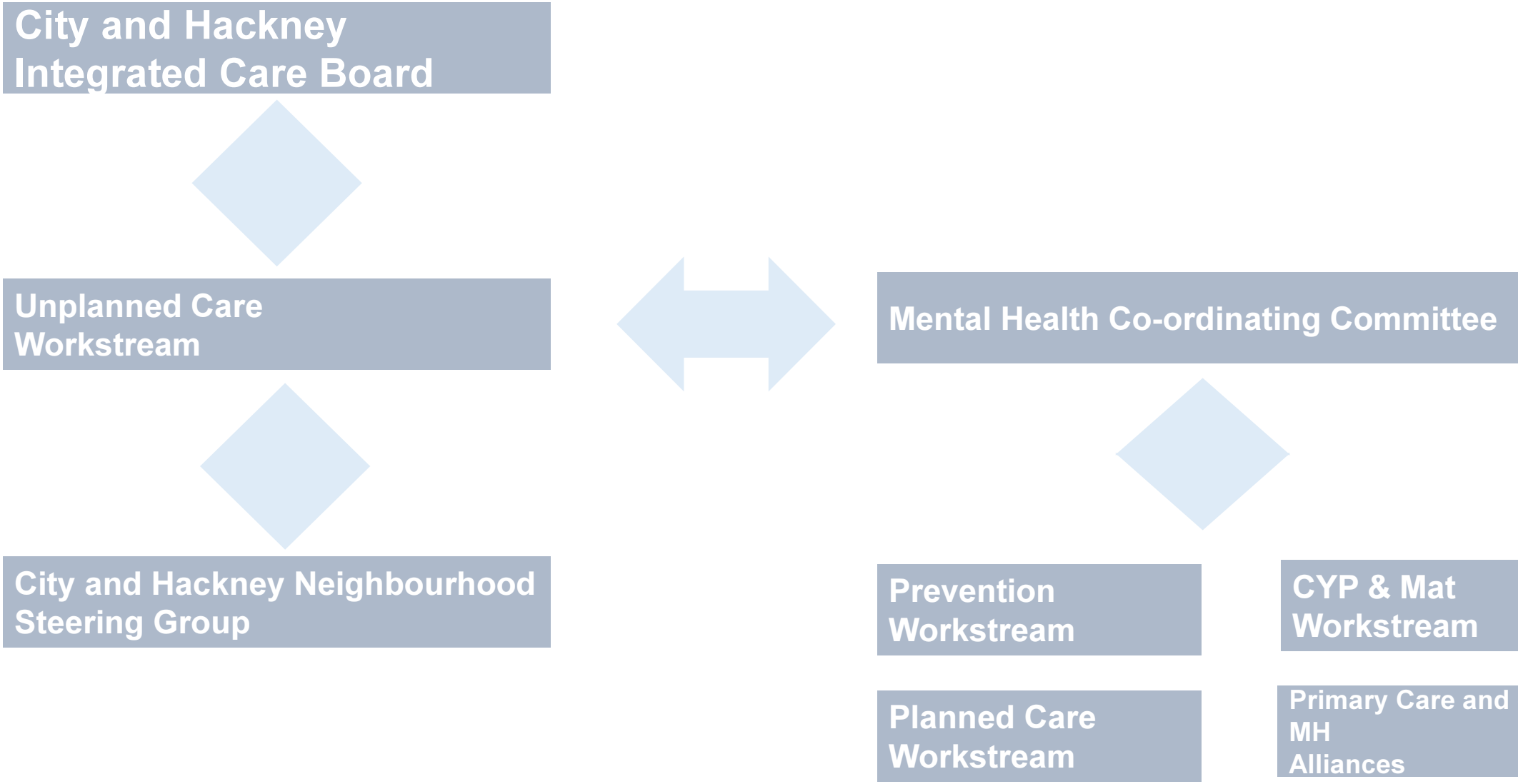
ramme aims - what have we said we want to achieve?

What we're aiming for	Metric / data requirement
Simpler, local front-door for patients with less 'bouncing around' between teams	Reduction in no. referrals between ELFT teams (e.g. ABT, EPC, CRTs, HTT)
	Patient seen within 28 days of 'referral'
	% appointments booked directly via NHS App
	PREM - satisfaction with pathway design
	SYSTEM - clarity around crisis access route and 'routine' access pathway
Person-centred assessment and care planning approach aids recovery and reduces duplication	Reduction in no. separate Care Act Assessments done by LA
	SYSTEM - Reduction in no. separate care plans that patients have
	PROM - Dialog Plus
	PREM - 6-item Patient Experience Measure
	PREM - support given in locations that are meaningful to the service user
More people with MH needs will be in regular, sustained employment	No. people with SMI in employment
	No. people in touch with IAPT services in employment
	No. PSW & Community Connector posts taken up by local people (BME, 18-25s)
People from the different communities we serve have improved access to services	Reduction in no. people from BME communities detained under the MHA
	Increase in % of people from BME communities accessing IAPT
	No. of people from BME communities accessing PCN Team support
	No. of older adults accessing PCN Team support
	No. PCN Team visits to Res/Nursing Homes in PCN geography quarterly
	No. and % of PCN Team staff trained in cultural awareness by NELPPLC

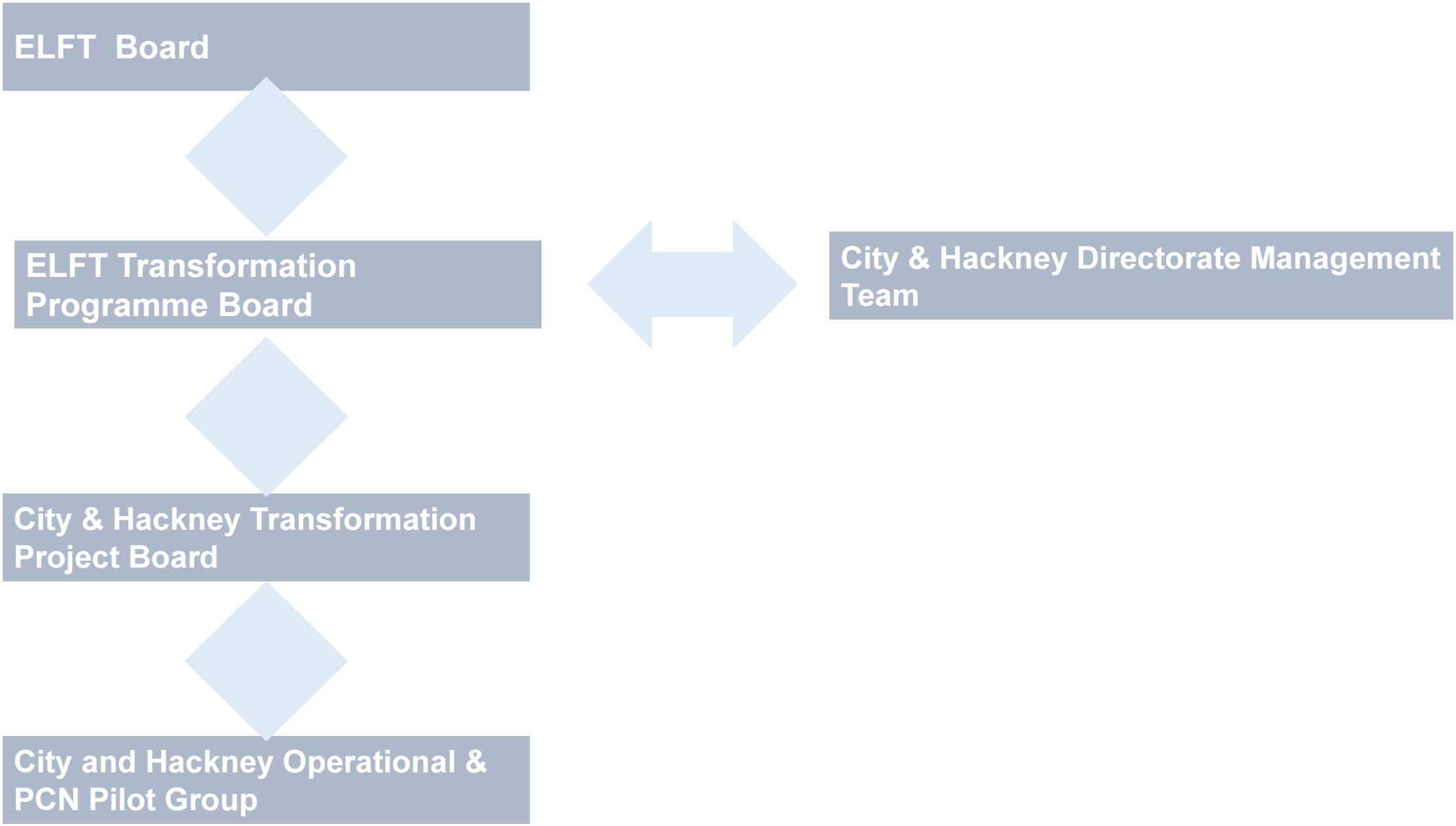
ramme aims - what have we said we want to achieve?

What we're aiming for	Metric / data requirement
Traditional boundaries between primary and secondary care are dissolved (and secondary care is sustainably resourced)	No. and % of patients referred from PCN to borough-based teams remains low
	Reduction in secondary care caseloads
	Spend on secondary care reduced as a % of overall contract value
	Hospital admissions for PCN patients decreases (or does not increase)
	PREM - SUs & carers tell us they feel adequately supported by PCN Teams
People with SMI experience better physical health outcomes and live healthier lifestyles	% SMI register receiving annual phys health check (we said 80% by 2020/21!)
	Reduction in % of people with SMI who smoke
	Reduction in % of people with SMI with BMI over 25
	PROM - Dialog plus
	Increase in no. people with SMI given a social prescription
3 x integration of primary & secondary care; physical health & MH; and health with social care and VCSOs	No. MH awareness training sessions given to wider PCN workforce
	Care plans reflect wider health and social care goals, not just MH recovery goals
	SYSTEM - could we devise a place-based system-wide measure?
Services better meet the needs of people with PD through clearer pathways and trauma-informed approach	No. and % of PCN Team workforce trained in PD
	No. of PD support group sessions and no. service users attending (per PCN)
	No. of Peer Support Workers with PD diagnoses
	PROM - Dialog Plus
	Reduction in A&E attendances for people with PD
	Reduction in use of MH Crisis services (excl. crisis alternatives) for people with PD

Local governance – with partners



Local governance – within ELFT



Further information

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