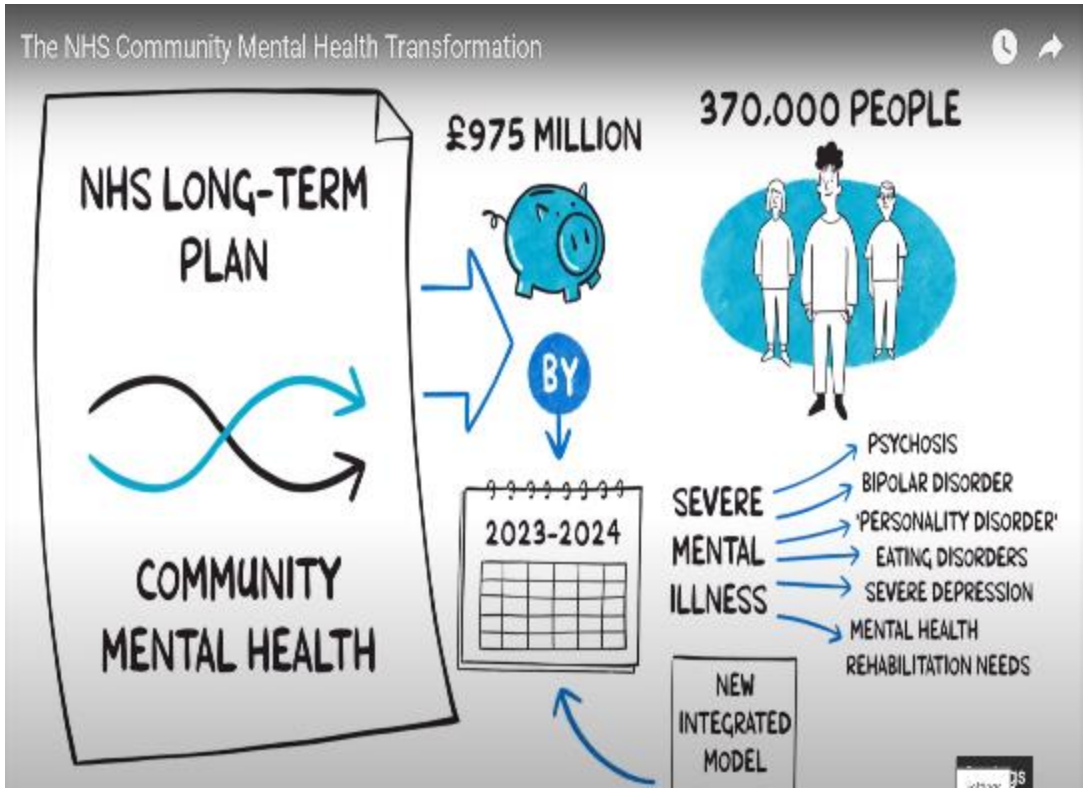
Working collectively to transform the mental health system

Darlington Health and Housing Scrutiny Committee

April 2024

Reminder of core aims of Community Transformation

- To deliver a new mental health community-based offer which allows for collaborative pathways across the system it operates within.
- Create a **core mental health service** which is aligned with **primary care networks and voluntary sector organisations**
- Ensure services are **accessible** to the community it serves and **inclusive of population need.**
- Allow the individual seeking advice and support the right care, at the right time in the right place and in doing so **ensure timely access to care**



Progress since December 2022

COMMUNITY TRANSFORMATION NHS ENGLAND: DARLINGTON

Community Transformation

Our vision:

- Integrated services delivering collaborative pathways which meet the needs of the local population
- Empowering individuals to choose and manage their own personalised recovery, as experts in their own mental health (informed by social, cultural and ethnic needs)

Get advice & keep well

Local community support

Get help

Primary Care Network Mental Health Team
Based in GP surgeries

Community Hub
Senior clinical staff including peers and Care Navigators
Co-located with Voluntary Care Sector and Local Authority

Physical health
Review offer/ medication

Get more help

Treatment and Intervention Services
One team per locality

Supported by Care Navigators

CITO recording

Principles:

- We accept each other's assessments
- We do not refuse a referral
- There is no wrong door to Get Help
- Patients are not "discharged" by services

Primary Care Network Mental Health Team

MDT input across both as a shared resource

COMMENCED February 2023

Community Hub

- Triage and assessment
- Medication reviews
- Interventions:
- Graded Exposure
- Anxiety Management
- Hearing Voices
- Life line work
- Stress Vulnerability
- Sleep Hygiene
- CBT
- Clinics
- Physical wellbeing checks
- Signposting and navigating
- Interface with PCN workforce
- ASD/ ADHD assessment
- Peer support

Treatment and Intervention Services

- Complex presentation and prescribing
- Risk Management
- ASD/ADHD complex needs
- Governed therapies
- Intense/high frequency /complex referrals
- Physical wellbeing checks
- Interface with PCN workforce
- Peer support

Access, Affective and Psychosis teams Re-reconfigured into the hub and treatment teams

Tees Valley Primary Care Mental Health Services

Rationale / need 	• Thresholds to enter into secondary care services are high • Care should be accessible at first point of entry via the GP • NHSE mandate: improvement letter states inclusion of a joint approach to funding Mental Health practitioners on a 50/50 basis via the Additional Roles Reimbursement Scheme under the PCN directed service contract (DES)
Model development	Introduction of a mental health workforce which operates as an integrated part of the primary care network

Proposed Impact:

- reduced referrals into secondary care
- improve access for patients with the positive benefit this will have on carers, staff and stakeholders

Model Development/Workforce

ANP

12, 20 min appt per day

Patients who have a Severe Mental Illness (SMI) and or personality and relational disorders

Too complex for IAPT, would not meet the threshold for TEWV

Allow for assessment, complex medication reviews, short term intervention/stabilisation work/exploring where a patient may benefit from support within our local VCS services (right care, right place)

MHWP

Longer, more flexible appointments for place of appt

Use of Dialogue & ReQol as Patient Recorded Outcome Measures (PROM) – helps with care planning and longer term recovery focused work.

May do joint working with SPLW/VCS

Offering psychologically informed interventions (such as CBT based skills)

SMI Physical Healthcare Practitioner

New development within TEWV

Time split between 50/50 primary care and secondary MH service

Importance of screening (core 20plus5 - national approach to reducing health inequalities)

Kits from NHSE allows for portable screening for patients who may be difficult to reach hard to engage – assertive outreach.

Importance of **intervention** and **making every contact count**

Proposed outcome measurement - benefit of workstream

Time

20 minute appointments enables greater throughput of patients and greater availability of being seen at the earliest opportunity

Number of appointments

56 appointment per week per clinician available as per service level agreement. Flexibility in appointment time outside of 9-5

Individual needs are met at the earliest opportunity

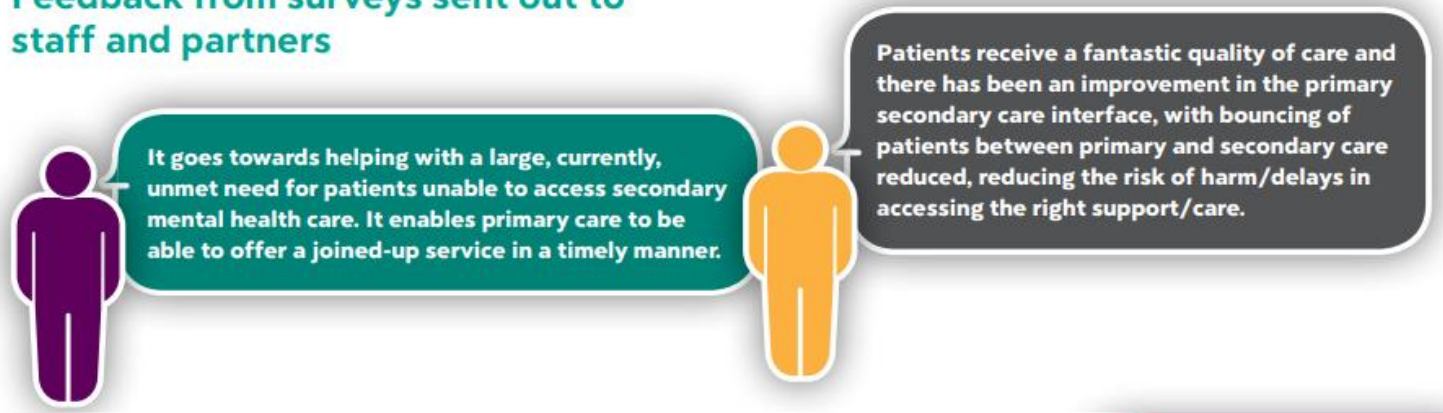
Only 2% of all patients are stepped up into secondary care services (of 41,000 between 2021-2023)

SMI Health Care Checks

National drive for PCNs to meet the ambition of 60% target for all SMI physical healthcare checks, One life Hartlepool are now over 70% since practitioner is in post. Havelock Surgery (pilot) at 80%.

Improved Relationships with Voluntary Care Sector and Primary Care

Feedback from surveys sent out to staff and partners



Feedback from surveys sent out to services users

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Darlington Connect Mental Health & Wellbeing Hub

Funding hosted by the 700 Club

Darlington have created a Community Hub known as Darlington Connect.
Funding covers the building, lease and project management costs for day-to-day coordination and delivery.

Darlington Connect

- A holistic approach to supporting mental health and wellbeing for the people of Darlington
- Opened March 2023 in the high street
- Led by 700 club with a range of VCSE partners – “connecting” the offer
- Approximately 500 appointments per quarter plus informal drop in advice
- Trained support staff delivering the service
- Now includes outreach work – employed development manager
- Development of online directors including: Health, Utilities, Recreation, Clothing & Essentials, Finance, Training & Employment, transport.
- Household support fund
- Accessible toilet
- Soundproof “pods”

Expectations/Impact of the model

- No wrong door – no rejections: *Community Navigator post pivotal to this.*
- Warm transfers of care.
- Pathway simplified: Easier navigation for people who need help and staff
- Holistic offer – people will receive a package of care from TEWV and system partners
- Staff recruitment/ retention and wellbeing
- Earlier access to support/ guidance and interventions
- Waiting times reduced from 6 months to within 28 day target
- Specialist caseload reduced to allow more meaningful therapeutic treatment

Challenges

- Funding
- Unprecedented system pressure
- Specialist Workforce
- Time to transform
- Maintaining momentum
- Funding (such a challenge its worth repeating……)

Thank you for listening. Any questions?

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