LONDON BOROUGH OF CAMDEN	WARDS: All

REPORT TITLE
Health and Care System Transformation: Core Community Mental Health Teams

REPORT OF
Camden Division Managing Director, Camden and Islington Mental Health Foundation Trust

FOR SUBMISSION TO Health and Wellbeing Board	DATE 20th September 2023

SUMMARY OF REPORT

This report provides an overview of the progress in embedding Core Teams in Camden since July 2021. Core Teams operate as multi-disciplinary teams consisting of staff from the NHS, adult social care and voluntary sector. They aim to provide preventative, accessible, holistic support within local primary care network and neighbourhoods for people with mental health needs.

The teams have focused on building relationships with partners and local communities and establishing processes to meet a diverse range of needs. We have introduced a new care planning tool, DIALOG+ as a framework for our individual work, and have established internal group support as well as ongoing workshops and drop in spaces in partnership with community providers.

Our early data indicates that we are providing timely support to a large number of local residents and reducing the need for referrals to secondary care services.

We are building a learning framework to ensure we adapt the work of Core Teams in response to feedback, data and our own observations on emerging needs. This approach has also provided us with valuable experience and learning to take into the Integrated Neighbourhood Teams which we are developing with partners. Some of these insights are shared in this report.

Local Government Act 1972 – Access to Information

No documents that require listing have been used in the preparation of this report.

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RECOMMENDATIONS

1. The Health and Wellbeing Board is asked to note the contents of the report

Signed: 

Alice Langley
Managing Director - Camden Division
Camden & Islington NHS Foundation Trust

Date: 7th September 2023

1. Purpose of Report (and Reason for Urgency)

1.1. This report provides the Board with an overview of the progress on embedding Mental Health Core Teams in Camden. Core Teams are aligned to Primary Care Networks and Neighbourhoods and aim to provide flexible, person-centred community-based support for people experiencing a range of mental health issues. The teams represent a local response to the overarching vision of Mental Health Transformation articulated in the national guidance document, The Community Mental Health Framework 2019 which supports the NHS Long Term Plan.

1.2. The model represents a shift in focus to the health and wellbeing of the population, with a greater emphasis on prevention, addressing health inequalities and recovery. The aim is for people's mental health, physical health and social determinants of health to be seen and addressed holistically. The Core Team model is an evolution of the previous Primary Care Mental Health Network which was a Camden wide service aligned to GP practices.

1.3. The first Core Team was established in July 2021 in Kentish Town with the South and North West Teams launching a year later. The ambition of the teams is to provide a whole person approach, including supporting people to develop friendships and connections in their local community and providing physical health support alongside social work, psychological and psychiatric interventions. There is a strong intention for the teams to integrate within communities and to recognise and address specific health needs of local populations. In order to support this, the teams are built around partnerships, with staff from health, social and the voluntary sector coming together as one, with a single point of access.

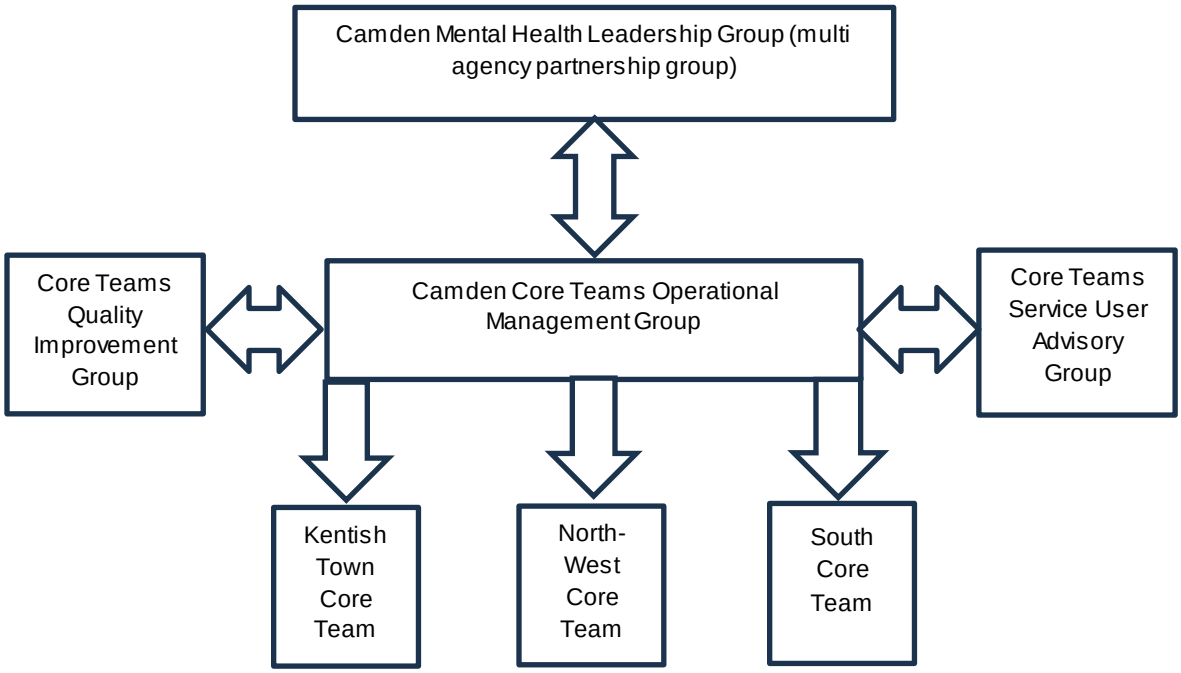
1.4. Alongside a preventative approach, our model is also designed to deliver anticipatory and early intervention support, flexibly and responsively. We recognise that a one size fits all approach does not work for anyone and therefore through integrating a range of disciplines within one team, the service aims to be able to adapt to individual needs in a way that feels meaningful to each person who accesses the service.

1.5. The report is being presented to update the Board on this significant local development and seek comments and approval on the direction of the work and its potential impact on the evolving Integrated Neighbourhood Teams.

2. Progress on embedding core MH teams in Kentish Town and elsewhere

2.1. We have established policies and procedures to govern the work, including an Operational Policy and Partnership Agreements with Voluntary Sector providers.

2.2. We have established a governance structure to support the work of Core Teams. The main framework is outlined below. There are additional groups and meetings, which support the work, including daily Multi-Disciplinary Team meetings, Continuing Professional Development forums and discipline specific groups.



2.3. We have more than doubled our staffing from the previous Primary Care Mental Health Network Service to a total of eighty staff from various disciplines working across the three Core Teams. These include Psychologists, Psychiatrists, Social Workers, Population Health Nurses, Peer Coaches, and Community Development Workers, Employment Support Workers, Social Prescribers, and Support Workers from the Voluntary Sector. Recruitment processes have included shared interview panels of Statutory and Voluntary Sector providers.

2.4. We have embedded additional specialist workers in the teams, including psychologists who work with 18–25-year-olds in partnership with local community groups such as The Hive. We have also recruited a specialist eating disorder staff member in response to the growing need for early intervention in this area.

2.5. The number of referrals to Core Teams has steadily been increasing over the last twelve months, and we are expecting this to continue. We are now providing a service to almost three times as many people as we were in the former Primary Care Mental Health Network prior to the pandemic. Additionally, the length of support offered has significantly increased. The former service was based on a brief assessment model, with minimum follow up. Core Teams now provide a range of options where the service offered to people is typically in the region of three months, involving staff from various disciplines alongside community providers.

2.6. We have introduced a holistic care planning tool, DIALOG+ to replace the Care Programme Approach (CPA). This new tool is designed to support a relationship where staff and service users create a plan together which focuses more strongly on personal perspectives on wellbeing. This includes a service user reported outcome measure which captures the individuals view of progress in the areas that matter most to them. We aim to complete this plan with all people accessing our service and for this to be taken with them as they move on and access other support. To date we have completed over 500 plans.

2.7. We have a strong aspiration for holistic health planning to continue to be integrated within our work with GPs. They are also rapidly adopting DIALOG+ which has helped support our joint work. Additionally, we have established in- reach to all GP practices, supporting people identified as having significant mental health needs, to have physical health checks and health advice in a convenient location. In addition to this we support GPs as part of their multi-disciplinary discussions and offer clinical advice and shared consultations alongside links to social support for patients through embedded social prescribing and peer work. We are also starting to explore developing community groups with some practices, such as a cycling club with the Caversham in Kentish Town. This supports our joint aspiration to support wellbeing through improved physical health and developing friendships.

2.8. Relationships have been established with a range of community partners, where we have created groups and delivered workshops. These have included Castlehaven, Kentish Town Community Centre, West Hampstead Neighbourhood Association, UCL Students Union, and Kentish Town City Farm. In total we have worked with over twenty local community groups and organisations and continue to build on these relationships and forge new collaborations.

2.9. We have worked in partnership with other Community Development Teams, for example Mind in Camden's Cultural Advocacy Project to co-deliver information and listening sessions. Recently we have been working in partnership with London Mosaic to improve the reception area in our Kentish Town Core Team base. Service Users have been working alongside Peer Coaches and London Mosaic at Kentish Town Community Centre to design and build mosaics to be hung in the entrance as a welcome for new people coming to the service. Alongside this, Peer Coaches have approached local artists for work to display in the waiting area and have received an enthusiastic response.

2.10. Our community development work is a focus of our practice for the whole staff team. Alongside this, we have specific Community Development Workers in each Core Team to act as champions for the work and to work alongside other neighbourhood champions and teams. In addition to facilitating workshops and groups in community settings, our intention is to position ourselves where we will meet people who may be in need but find it harder to access our service, for example, in foodbanks and in organisations

who represent marginalised communities. We are developing our monitoring to help inform us of where need may be greatest and who we need to focus on reaching. Our response to this is to work with other organisation in collaboration, so we are combining rather than duplicating our efforts.

3. Lessons learnt so far

3.1. We have been developing and refining processes to capture key activity, outcome and experience measures. These include being able to report on:

3.2. The number of people receiving two or more contacts over a twelve-month period. This helps us measure how well people are engaging with the service and receiving more than an initial assessment. So far early data indicates that over 80% of people who have had a first appointment have more than one contact with the majority having more than two appointments.

3.3. The length of wait between referral to a first appointment helps us measure whether people are receiving timely support. We have a target of a maximum of a four week wait from referral to meaningful intervention. Whilst the majority of people are seen within this timeframe, we are aware that this has not been the case for everyone. Therefore, we are actively working on refining our processes through a quality improvement approach to ensure that everyone receives support within our target time period.

3.4. Referrals to intensive services, which is an important measure as it means that more people are supported closer to home and intensive team resources are preserved for those in need of this specific support. Between 2019 and 2023, referrals to specialist, intensive services have reduced by approximately 50%. This is an important measure as it means that more people are supported closer to home and specialist team resources are preserved for those in need of an intensive service.

3.5. We have secured specific input from the Voluntary Sector to develop a learning outcomes framework which integrates qualitative feedback from services users, staff and stakeholders to evidence how the service changes and adapts over time to meet needs, alongside quantitative outcome measures including DIALOG+, physical health measures, health inequalities measures and other population health indicators. This is in its early phases of its formal development. However, Core Teams have already demonstrated an approach to growth which reflects the changing landscape. For example:

3.6. We have worked alongside the council to develop a business case for embedding Housing Officers in Core Teams in response to staff and service user feedback on the critical nature of this support being offered as part of an early intervention service. This has also been informed by our review of information gained from DIALOG+ care plans which has indicated a high number of people unsatisfied with their housing situation. We have been developing the way we use data from DIALOG+ to inform how we respond to emerging need responsively and target resources effectively.

3.7. We are also exploring adapting our social prescribing offer to reflect changes in services. When this was originally commissioned, it was the only support of this nature in our Primary Care Mental Health Network. Since then, we have increased our 1:1 social support offer through the recruitment of Support and Connect (Voluntary Sector input) and Peer Coaching staff which effectively represents a twelve-fold increase in this type of support being available in primary care facing mental health services. We can now see the merits of focusing social prescribing more intentionally at the front door of our service to support with people landing well into our service and linking at an early stage to other local support.

3.8. It has taken time to see the development of a fully integrated multi-disciplinary team approach as we have been embedding a wide range of new staff from different sectors into new teams. These teams had a foundation of established practice from the former Primary Care Mental Health Network service, so some staff found it harder to transition from what they were used to into new ways of working. However, staff are increasingly positive about transforming our approach as they start to see the benefits of an integrated team practice. Two examples of this are outlined below (names have been changed to protect anonymity):

3.9. Joyce, a 64-year-old Irish woman with a long history of depression, was referred to our service by her GP for a physical health check with one of our Population Health Nurses. In her consultation, Joyce described how her depression had become worse in the last few months since her dog had passed away. She lived alone and her dog had been the reason for her to get out each day. Since then, she found herself staying in bed longer, sometimes for most of the day and binge eating to comfort herself. Her nurse was able to offer some advice and a follow up session on healthy eating and strategies to regulate mealtimes. Additionally, Joyce was also linked to a Peer Coach in the team, who shared her interest in animals and was able to meet with her in a café near her flat. The peer coach was able to empathise with Joyce's experience of losing a pet and some of the challenges of living with depression. Over the course of eight weeks, the Peer Coach was able to support Joyce to find new reasons to go out. She shared walks with her on Hampstead Health and discussed things that Joyce had previously enjoyed doing. The Peer Coach went with her to meet staff at two community centres, where she was able to join a bridge group and a local history walking club.

- With Joyce's agreement she was also offered a medication review to support with regulating her medication, as she disclosed she had been taking her anti-depressants sporadically and inconsistently. The consultant in the team was able to adjust her medication so she needed to take it just once a day rather than three times, so it was easier to remember. She was then encouraged to set an alarm as a reminder and received information of the benefits of taking it consistently as opposed to occasionally.

- Towards the end of the work with the Peer Coach, Joyce expressed her gratitude for the support she had received from the whole team. She said she felt more motivated and had appreciated the different ways she was supported. She also expressed feeling anxious that the support was coming to an end and that she would benefit with more one to one time. In response to this the peer coach introduced her to the mental health charity, Likewise who were able to offer her some further individual support as well as an invitation to a number of groups in their community space, including a gardening group.

3.10. Ike, a thirty-year-old Nigerian man, was referred to our service for a medication review to support with mood swings. In the meeting with the consultant, Ike disclosed that his mood swings had led to him being dismissed from his job in a petrol station six months ago due to a series of arguments with customers. He said as a result of what he had been through he had also fallen out with his brother, who was the person he felt closest to.

- As part of his review the consultant explored with Ike what further help he would like from the team. Ike requested support with his anger and advice to look for work to help him regain his self-respect. He was linked to a psychologist who worked with him on strategies for regulating his emotions and improving his self-esteem. He was also able to explore how to have conversations with his brother, and other family members and friends about his mental health and to think about his needs in relation to them.

- Alongside this, he was linked to an employment worker in the team, to help him consider his options for work. Ike was able to step back and think about work he really wanted to do and was given support to write a CV. He identified he liked being outside and on his own but appreciated the support of being in a team and having a stable income. He thought he would enjoy delivery work and was supported by his worker to look for opportunities and understand the differences in terms and conditions. Following support with applications and interview preparation he secured a part time employed job with a local delivery service.

- In his feedback on the service, Ike said he felt he had a renewed sense of purpose and that he had left his recent past experiences behind him. He said he felt he had learnt new ways of managing his emotions which had helped him not to react in several challenging situations, and that he had started to repair the relationship with his brother.

4. Implications of this work for developing integrated neighbourhood teams

4.1. The work we have undertaken in the development of Core Teams has provided significant groundwork for the development of Integrated Neighbourhood Teams. Our staff teams are now experienced in working in partnership across sectors and as part of a multi-disciplinary team approach and are preparing to bring this experience into these expanded teams.

4.2. We have recognised the value of having a base within a local community which we achieved at an early stage for the Kentish Town Team. We have seen the benefits of being able to be easily in touch with the local and organisations and to be able become identified as a team with a local population. There are more opportunities for conversations with residents, seeing and feeling how the needs of a local community may be developing and keeping in touch more readily with key community stakeholders. Considerable work is being undertaken for Integrated Neighbourhood Teams to secure local bases and we would see this as of significant importance for these new teams to fulfil their potential.

4.3. We have observed that when demand for a new service is high, staff may retreat more into familiar practices in response to this and be less open to new perspectives and ways of working which seek to address causes of demand. We have learnt that a more structured approach to change may be most supportive rather than allowing teams to evolve more organically. The structure of this approach should be co-produced to allow for new ways of working to emerge which feel collaborative. In particular, we have found that it can be a challenge to shift assumptions of how work should happen if it confronts deeply habitual ways of working. Considering how we develop and review processes in Integrated Neighbourhood Teams to give equal weight to non-statutory/clinical voices such as Voluntary Sector and Peer Coaches will be important in developing teams which feel close to the community and aligned to our shared vision.

4.4. We have seen the practical benefits of working across sectors in being able to combine resources. We have noted that in working in embedded partnerships, previous duplication of work and better coordination of support around service users can be achieved. This has been particularly evident with voluntary sector organisations, where service users who may have previously been supported in both statutory and voluntary organisations with limited joint working, have now experienced support being provided by both from one service. Similarly, we have noted the opportunity to combine resources in Integrated Neighbourhood Teams. For example, our Population Health Nurses provide comprehensive physical health checks and if this information is shared more easily within an Integrated Neighbourhood Team there will be no need for this to be repeated by other providers.

5. Finance Comments of the Executive Director Corporate Services

5.1. The Director of Finance has been consulted on the content of this report and has no comment to make.

6. Legal Comments of the Borough Solicitor

6.1. The Borough Solicitor has been consulted and has no comments to add to the report.

7. Environmental Implications

7.1. This update does not have any environmental implications.

REPORT ENDS