

Lead Member Briefing – Southwark Community Mental Health Transformation– Update

Summary:

- 1.1 The Community Mental Health Transformation (CMHT) programme has been made a priority and is a key element of the NHS Long Term Plan. The transformation includes a significant shift away from the previous Care Programme Approach and allow a more person centred, flexible approach to mental healthcare. NHSE has committed to funding the programme for 3 years to improve community based mental health services.
- 1.2 The programme has a clear outcomes framework underpinned by the principles of addressing inequalities, service user experience, and workforce & staff experience across the 5 key goals:
 - Anticipatory and preventative care available from a number of settings
 - Simplified, timely access to appropriate care.
 - Continuous seamless and person-centred care
 - Support to achieve and contribute to a wider range of goals.
 - Improved mental and physical health and reduction in mortality.
- 1.3 Through the whole of the CMHT programme we expect to improve access to care for Southwark residents. Taking a ‘no wrong door’ and ‘simple points of access’ approach will simplify the system from the patient perspective and improve their experience. Additional work is being done to decrease the rate of unsuccessful referrals between health and wellbeing professionals and to improve the experience for patients transitioning between primary and secondary care.

Key Information:

Background

- 2.1 Community mental health services is an umbrella term for the NHS and VCS provided mental health and wellbeing services for adults which take place in their homes or communities. Using the new ICS model and working with PCNs, this transformation programme seeks to move towards place-based multidisciplinary services while addressing the historic issues of inequality in access, experience and outcome for patients. The Community Mental Health Transformation (CMHT) programme has been made a priority and is a key element of the NHS Long Term Plan. The transformation includes a significant shift away from the previous Care Programme Approach and allow a more person centred, flexible approach to mental healthcare.
- 2.2 NHSE has committed to funding the programme for 3 years to improve community based mental health services. In Southwark this programme has been informed by:
 - NHSE National guidance and roadmap
 - SEL ICS ‘core offer’ for community mental health
 - Southwark Mental Health & Wellbeing Strategy
 - Local engagement; services users & carers, communities, health and care workers

- 2.3 South London and Maudsley NHS Foundation Trust (SLaM), as the lead provider of mental health services in Southwark, has been the lead for this programme. SLaM has worked closely with key partners across the system including Partnership Southwark, North and South Southwark PCNs, the GP federations for North and South Southwark PCNs (Quay Health Solutions and Improving Health Ltd.), South London Listens and the local VCS.
- 2.4 This briefing focuses on the progress of the programme and patient access in response to queries raised by the Elected Member for Health and Wellbeing.

The Transformation Programme

- 3.1 The programme has a clear outcomes framework underpinned by the principles of addressing inequalities, service user experience, and workforce & staff experience across the 5 key goals:
- Anticipatory and preventative care available from a number of settings
 - Simplified, timely access to appropriate care.
 - Continuous seamless and person-centred care
 - Support to achieve and contribute to a wider range of goals.
 - Improved mental and physical health and reduction in mortality.
- 3.2 The programme covers a core offer for residents with SMI (Severe Mental Illness), the interface between Primary and Secondary Care, and Primary Care and community-based support.

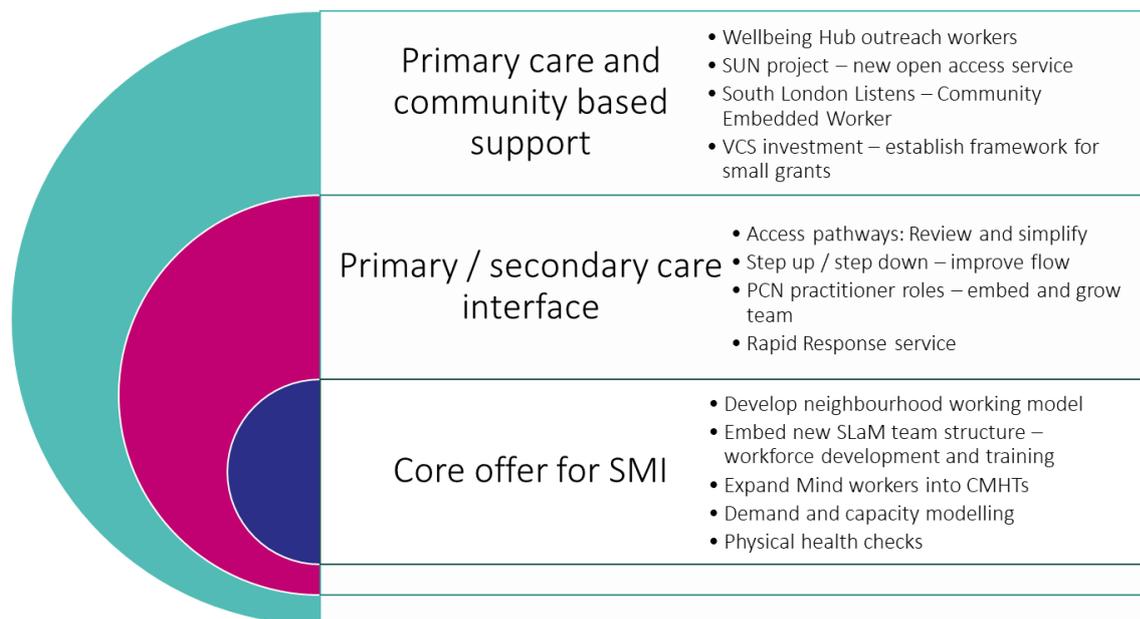


Figure 1: CMHT Programme Scope

- 3.3 The programme is funded from 2019/20 through to 2023/24 to support the year-on-year development of the programme in line with the Roadmap¹ developed by NHSE. The framework has been designed to allow localities to self-assess and design a programme based on their current position, local strengths and needs. Using this tool, the Southwark CMHT Programme Team have developed a milestone plan which has guided the transformation within the borough.

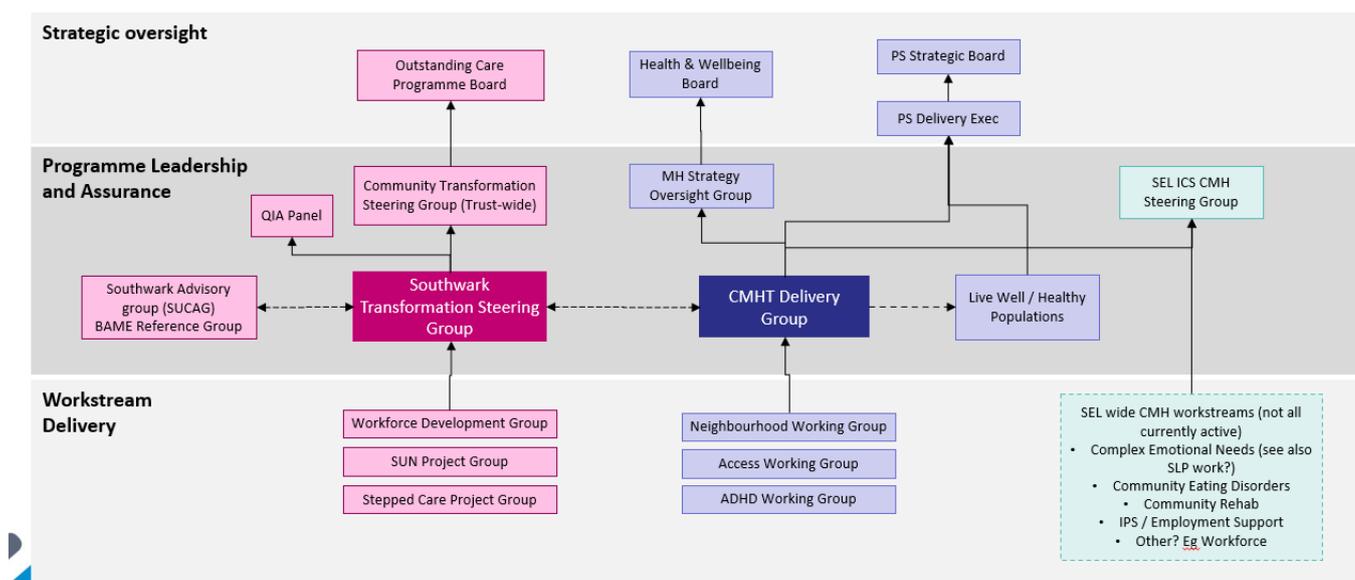
¹ Appendix 1 CMH Transformation Roadmap Priorities by 2023/24

- 3.4 Although lead by SLaM, the CMHT programme has benefitted from sitting within the Live Well workstream of Partnership Southwark the system wide connections that this provides. Key partners throughout this transformation programme have included:
- Partnership Southwark programme and commissioning teams
 - Primary Care, including Quay Health Solutions and Improving Health Ltd
 - South London Listens
 - Lambeth & Southwark Mind
 - Black Thrive
 - Community Southwark
 - Together for Mental Wellbeing
 - Southwark Wellbeing Hub
- 3.5 The CMHT programme governance structure takes into account the oversight of the SLaM Community Transformation Steering Group (which covers all internal SLaM activity across the Trust) and the Partnership Southwark Delivery Group (which focuses on the Southwark specific elements of the programme) as well as the

Southwark Community Transformation governance

Updated: November 2022

SLaM
Partnership Southwark
SEL ICS



Southeast London ICS CMH Steering Group which covers the ICS wide elements of the programme.

Figure 2: CMHT Governance Chart

3.6 Service users and carers have been engaged with throughout the programme and in a number of ways. Two lived experience representatives attend the monthly CMHT Delivery Group meetings, additional feedback is sought from the Service User & Carer Advisory Group, and targeted, specific engagement with BAME communities has been done in partnership with Black Thrive. We are currently working on plans for further engagement around particular workstreams such as simple points of access and neighbourhood working.

Progress to Date

4.1 2021/22

- SLaM Community Teams Redesign consultation and mobilisation
- Psychological Interventions work to reduce waits and implement Stepped Care model.
- Model and framework developed
- VCS contracts awarded to Mind and Black Thrive
- Developed system-wide governance and decision making – Delivery Group
- PCN mental health practitioner roles created

4.2 2022/23

- SLaM community teams' new structure in place
- PCN MHP team expanded – interviews currently taking place.
- Wellbeing Hub Support Worker roles created. Alternative funding secured.
- Outcomes framework developed.
- Partnership workshops on Neighbourhood Working and Access – working groups established Draft funding proposal for 2023/24 ready.

Access

5.1 Through the whole of the CMHT programme we expect to improve access to care for Southwark residents. Taking a 'no wrong door' and 'simple points of access' approach will simplify the system from the patient perspective and improve their experience. Additional work is being done to decrease the rate of unsuccessful referrals between health and wellbeing professionals and to improve the experience for patients transitioning between primary and secondary care.

5.2 Making better use of data and digital technology: we will provide more convenient access to services and health information for patients, with the new NHS App as a digital 'front door', better access to digital tools and patient records for staff, and improvements to the planning and delivery of services based on the analysis of patient and population data.

5.3 Primary care's health care professionals, Additional Roles Reimbursement Scheme Mental Health Professionals (ARRS MHPs) and Mental Health & Wellbeing (MH&W) team will be working in more flexible and dynamic ways to provide care that's wrapped around our patients in our localities and close to their homes.

Next Steps for 2023/24

Workstream	Objectives	Next steps
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Neighbourhood working	Build on new PCN roles: Develop and test model for integrated neighbourhood working	Working Group established and recruitment well underway. Next: Plan and start Test and Learn – neighbourhood MDT meetings
Simple points of access	Streamline and simplify referral processes. Tackle barriers to access and improve communication	Working Group formed – initial – scoping, review other models, develop, and assess options. Next: Look at referral forms, digital options, SLAM contact options
BME outreach and community development	Address inequalities in access Targeted work with underserved communities	Investing in VCS partnerships and projects Next: Further planning with Black Thrive; link with Healthwatch Southwark work
Data & Outcomes	Develop partnership approach to service evaluation and monitoring against shared outcomes	Not progressing currently: No Business Intelligence / analytics / performance support
New roles and services	Launch SUN project service. Develop and evaluate Rapid Response service Recruit to new transformation roles	Rapid Response launched – 6-month review in Feb. SUN project – mobilising for Q4 launch Most roles recruited to
Physical Health improvement for SMI	People with SMI are offered a comprehensive physical health check and are able to access support for physical health needs as part of a holistic offer of care.	SEL work and LCP Task and Finish group. Using 75k funding recruit 2 band practitioners to deliver SMI health checks
Depot service	To run a pilot with GP practices to administer depot injections.	Confirm volume of resource needed, funding sources, staffing etc.

Appendix 1 CMH Transformation Roadmap Priorities by 2023/24

DRAFT

By 2023/24 - Priorities for Community Mental Health transformation



Dedicated focus⁶

Model development	Care provision	Workforce	Data & outcomes	CEN / 'personality disorder'	Community rehab	Eating disorders
Joint governance with ICB oversight ¹	"Must have" services ³ commissioned at PCN level tailored for SMI ⁷	Recruitment in line with indicative 23/24 MH workforce profile	Record access data from new model (inc. primary, secondary and VCS orgs)	Dedicated function linked to core model: increased access to dedicated function and consultation, support, supervision and training to core model		
Model design coproduced with service users, carers & communities	"Additional" services ⁴ commissioned at PCN level tailored for SMI ⁷	Expand MHP ARRS roles in primary care	Interoperable standards for personalised and co-produced care planning	Embed experts by experience in service development and delivery		
Integration with primary care with access to the model at PCN level ²	Improved access to evidence-based psychological therapies	Staff accessing national training to deliver psychological therapies	Routine collection of PROMs using nationally recommended tools	Development of trauma-specific support, drawing on VCSE provision	Ensure a strong MDT approach ⁵	No barriers to access e.g. BMI or weight thresholds
Commissioning and partnership working with range of VCSE services	No wrong door approach means no rejected referrals recorded	Multi-disciplinary place-based model ⁵ in place	Waiting time measured for CMH services (core & dedicated focus areas)	Co-produced model of care in place to support a diverse group of users	Clear milestones are in place to reduce reliance on inpatient provision	Early intervention model (e.g. FREED) embedded
Integration with Local Authority services	Tailored offer for young adults and older adults	Staff retention and well-being initiatives	Interoperability for activity from primary, secondary and VCSE services		Co-produced care and support planning is undertaken	Clear arrangements in place with primary care for medical monitoring
100% PCN coverage for transformed model	Principles for advancing equalities embedded in care provision	Dedicated resource to support full range of lived experience input	Impact on advancing equalities monitored in routine data collection		Supported housing strategy delivered in partnership with LAs	Support across spectrum of severity and type of ED diagnoses
Shift away from CPA towards personalised care	Support for co-occurring physical needs & substance use	Staff-caseload ratios to deliver high quality care				Joint working with CYP ED services including transitions
Alignment of model with IAPT, CYP & perinatal	Trauma-informed & personalised care approaches	Place-based co-location approaches				Accept self-referrals, VCS referrals and Primary Care referrals.

1. Governance to include commissioners, primary care (inc. PCN leadership), mental and physical health services, local authorities, VCSE, service users and carers
 2. "PCN level" defined as a footprint of typically 30,000 and 50,000 people (this can also be thought of as "sub-place", "localities", or "clusters of wards"). More targeted, intensive and longer-term input for people with more complex needs can be provided at the wider community or "place" level of around 250,000–500,000 people (this can also be thought of as a "PCN-cluster")
 3. Must-have: physical health checks, EIP, employment support, psychological therapies, social prescribing, personalised care planning, care coordination, peer support, outreach for inequalities
 4. Additional: advocacy services, carer support, community assets, culturally competent services, financial advice, housing, social care, support groups, volunteering & education
 5. Should include clinical psychologists; MH nurses; MH pharmacists; occupational therapists; primary care staff; psychiatrists; psychological therapists; social workers; community connectors; paid peer support workers
 6. Systems should have commenced work on 2 of 3 dedicated focus areas in 2021/22, meeting relevant expectations. Where appropriate, aspects of core transformation model should be applied to dedicated focus areas
 7. In this context 'SMI' covers a range of needs and diagnoses, including but not limited to: psychosis, bipolar disorder, 'personality disorder' diagnosis, eating disorders, severe depression and mental health rehabilitation needs – some of which may be co-existing with other conditions such as frailty, cognitive impairment, neurodevelopmental conditions or substance use

■ In place by end of year
■ In progress by end of year
■ Planning underway by end of year