NOW YOU'RE TALKING...

NHS
County Durham and Tees Valley
Mental health and learning disability partnership

County Durham Care Partnership

Evaluating the Community Mental Health Transformation in County Durham

December 2023

Working together to help keep the people of County Durham happy, healthy and at home

Durham County Council

NHS

What were we trying to achieve?

County Durham Care Partnership

Huddles – no wrong door and can do attitude, replaces traditional "referral" processes

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Getting Early Help

- Local community support
- County Durham Together Hubs
- Libraries/ leisure centres
- Parks/ recreation
- Education
- Places of worship
- Work/Colleagues
- Social Media
- Family/Friends
- **Primary Care**
- Online support/ self help
- Social Prescribing
- Local Early Help Services (eg VCSE)

Getting Help

PCN Community Mental Health Hub

NO WRONG DOOR; NEEDS-LED SUPPORT

- 4 week max wait
- System huddles mean no referrals – transfer between members of the hub based on need

Needs led interventions:
Brief treatment & longer term care;
Psychologically & trauma informed approaches;
Governed Psychological Therapies; Social Care interventions; peer support; named workers follow through journey

Step up/down

Getting More Help

Integrated Treatment and Intervention Services

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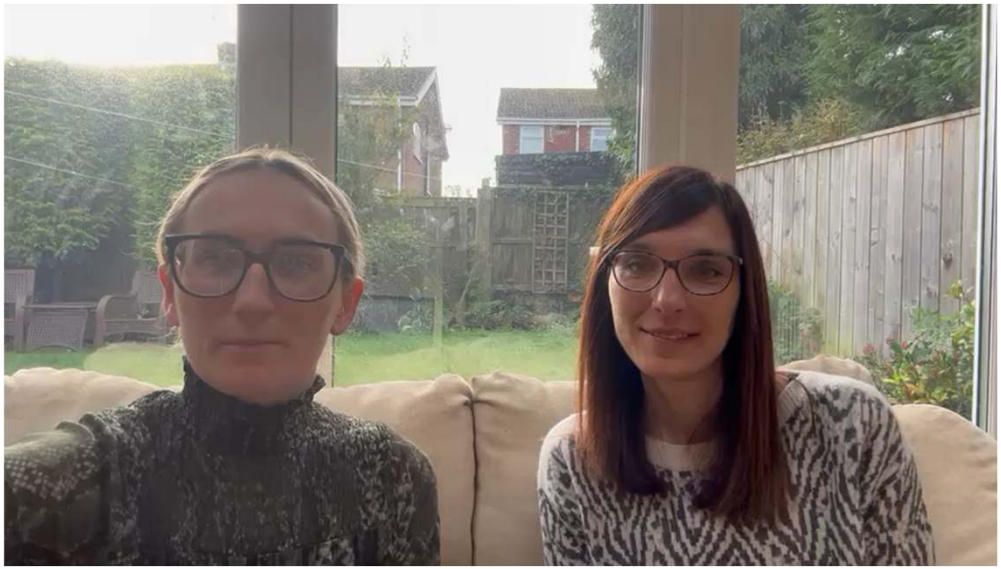
Co-Production



- 2 strategic leads (peer support and lived experience)
- 5 locality LE leads
- 13 Peer Support workers (joint TEWV/VCSE)
- Strong engagement in County and local Steering Groups – definite culture shift in attitudes of 'professionals'

👍	Great support from local organizations
👍	Through building relationships with people and listening to their stories the voice of lived experience become more apparent within CMHT work.
👍	Open and positive attitude from people who are experiencing difficulties with/when accessing services.
👎	Co-production still to be embedded. 'Lived Experience' workshops are the step towards co-production, however looking at co-production ladder we are at the engaging / consulting level.
⚠	Support needed to develop consistent approaches to holding/sharing/safeguarding personal information
	Consistent approaches to incentivisation/reimbursement/appreciation ideas across the system are needed
	Talking to various groups, individuals bring complex stories, issues, and we need to create the environment which allows addressing these in a co-production approach.
	Terms and references needed for local Steering Groups within which the mechanism for co-production to be considered.

How did we use transformation resources?

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INVESTMENT OVER 3 YEAR PROGRAMME

£300,250 *Complex Emotional Needs*

Structured Clinical Management (previously funded); Substance Misuse Peer Mentors; Distress Brief Intervention; Animation

£1,666,326 *Community Rehabilitation*

TEWV and VCSE investment to expand community rehabilitation team

£78,090 *Adult Eating Disorders*

FREED Champion; Provider Collaborative supported VCSE capacity

£5,194,065 *Core Model*

- Population Health Management
- Lived Experience and Peer Support roles
- Pharmacist capacity
- Referral Co-ordination and Community Navigation
- Community Resilience Team
- Older People's Social Isolation project
- MH Housing and Accommodation Strategy
- Programme support and Workforce Project post
- Destination Fund (non recurrent)
- ARRS workers (ICB contribution)

54% VCSE

44% NHS

2% other (inc DCC)

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NHS

What's in place now?

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Core model

- System branding – "Now You're Talking…."
- Single point of access for additional support – Durham Mental Wellbeing Alliance or Gateway in Sedgefield
  - Rapid contact (24-48 hours)
  - Single assessment of need
  - Daily decision making
  - Supported by multi agency huddles for step up/down/across
  - "Business Card" to support self-navigation
- Community Navigation and local link worker networks
- Enhanced capacity within practices (GP Aligned plus First Contact Practitioners)
- Increased joint working between AMH and OP services (based on need, rather than age)

Dedicated Focus Areas

What's in place now?

- Significantly enhanced offer for people with complex emotional needs:
  - Structured Clinical Management
  - Distress Brief Intervention
  - Family/Carer Psychoeducation Model
  - Peer Mentors
  - Animation
- Still more to do to ensure the whole systems works in a trauma-informed way
- Community Rehab
  - Multi agency enhanced model
  - Significantly increased activity
  - Social Rehab model
- Eating Disorders:
  - FREED embedded
  - VCSE offer enhanced and strong lived experience involvement (working with Provider Collaborative

What's in place now?

County Durham Care Partnership

Other areas of focus

CYP

- 14-25 Preparing for Adulthood Group re-established and initial mapping work completed
- CYP MH Early Intervention Hub (11-25 yrs) bid submitted
- Alignment with CYP Integration work, including Family Hubs and Consett Pilot

Older People

- Joint Age UK/TEWV social isolation offer
- Better access to GP Aligned, First Contact Practitioners, NHS Talking Therapies and wider community services

Physical Health

- Improving joint working with adult teams
- Achieved national targets for SMI Physical Health Checks
- Focused work within primary care based on PHM profiles (eg type 2 diabetes weight management and SMI, smoking cessation and SMI)

HEADLINE ACTIVITY AND PERFORMANCE CHANGES (Countywide)

Average 26% monthly increase in referrals to Durham MWB Alliance with contact remaining within 48 hours

Number of people signposted to system services rather than referred to secondary care increased 8 fold

GP Aligned – 5222 referrals in 2023/24 (to Q3) with only 14.8% stepping up to secondary care

22,560 people seen in past 12 months by First Contact Practitioners with majority (95+%) having needs met in primary care or through signposting to community offers

Community Navigation met 72.5% of people's needs when referred to them, with 94% receiving support within 1 week

Access "waiting" caseload (excl. neuro) has halved and waiting times for assessment reduced from approx. 6 weeks to approx. 2 weeks on average

SMI physical health checks exceeding 60%

More men accessing help – access up from 32% referrals for males to 47%

FREED and EIP exceeding targets for young people presenting with first episode eating disorders or psychosis/at risk mental states

423 people 2+ contacts from Community Rehab in past 12 months = 480 referrals (projected) in 23/24 and 4521 contacts (256% increase)

More under 70s accessing support (22% access now over 50 yrs) and significant increase in those accessing early support through Age UK

Almost 35% increase in the number of over 65s accessing NHS Talking Therapies

Over 100 staff accessed 2 day SCM training and over 250 accessed DBI level 1 training

SCM:

- 30 people (40%) had hospital admissions prior to SCM vs to 2 (3%) after SCM
- ALoS pre SCM 20 days vs 13.5 days after SCM

Community Peer Mentors

- 91% increase in MH referrals now skill set available
- 155 people High Impact Users of police: 87.6% demand reduction saving 20,260 staff hours

TOPIC: SYSTEM FEEDBACK TO HEALTHWATCH ON PROGRESS TO DATE

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People using services before and since transformation have said:

What's working well?

- 89% felt support offered in the last 4 months met all or some of their needs
- 68% said it was easy to get the support they needed
- 64% knew where to go to get the support they needed
- 80% felt able to explain what they wanted
- 73% felt their needs were listened to

What do we need to do more work on?

- 50% found it wasn't as quick a process as they would want to get the help they needed
- 48% felt they didn't have choice over the services that could support them
- 48% had to explain their story more than once to get the support they needed
- 42% had to speak to more than 1 person to get referred to all the services needed to support them

Staff and teams have said:

What's working well?

Service provider response

- 50% of providers had used the Single Point of Access → 39% found it was quicker → 50% felt it helped meet the needs of the service user
- Communication between services → 80% said communication had improved → 19% felt there was no improvement
- Knowledge of other services → 95% said knowledge had improved → Knowledge increased a great deal for 19%

Huddles

- 64% taken a referral to a huddle
- 79% found referring within a huddle easy
- 71% received a referral in a huddle
- 92% found huddles to be as expected
- 85% felt they received the right information
- 86% able to refer to the right services to meet the needs of the client

What do we need to do more work on?

- Time to attend huddles consistently
- Making sure the right people are attending the huddles
- Promotion and communication of new models/process needs more work
- Lack of capacity in community mental health teams is a barrier to stepping up
- In some places, still feels like there is a divide in the system
- Complex, long referral forms still being used in some places mean people have to repeat their story
- Need to continue to ensure that there is a person centred approach with the service user at the heart of all decisions

ACHIEVEMENTS, CHALLENGES AND RISKS

What are we most proud of?

- Its making a difference – to people needing support and to staff
- Cross sector collaboration and understanding of each other's roles
- increasingly influential role of people with lived experience – which is demonstrably changing culture and approach across system
- Achieving a single point of access in each local area
- The role the VCSE have played and our ability to embrace their passion to change, adapt and help
- Tangible movement towards needs-led, multi disciplinary and multi agency services
- Person centred approach – coming together of all providers to really put the person at the centre of support
- Delivering such a complex system change within a relatively short timescale
- Visible change to how services are working together, and how people are talking differently
- Significant successes of some of the smaller projects – huge impact for relatively modest resource

What are the biggest challenges, gaps and risks?

- Getting the communication of a simplified, new pathway/model right across so many services, partners and communities
- Increased psychological interventions and other wider system workforce developments
- Data sharing and interoperability
- Commissioning and contracting supporting model capacity/sustainability and continued future growth, including admin support for hubs
- Loss of momentum when the "formal" national programme ends
- Capacity and data to support ongoing evaluation of the overall impact in the medium and longer term
- In shifting our focus to more of a preventative/early intervention approach, ensuring we are still able to meet the needs of those with more complex needs
- Embedding a single pathway in each local area to replace multiple access points/teams
- Continuing to reshape the system to remove duplication
- System estates approach to enable model to be delivered through physical bases within local communities

Patient stories

GP Aligned Service:

A 25 year old single male with a history of homelessness and rough sleeping, socially isolated with features of anxiety, depression, poor self-esteem and lacking confidence. He was a regular attender at the GP surgery and was very focused on prescription led solutions often presenting with associated physical complaints. Following assessment we agreed a PsychoSocial approach engaging specialist counselling after he disclosed historic sexual abuse we also engaged one to one support from a local support and recovery agency who enabled him to find secure accommodation and introduced him to the local community resources improving his confidence whist developing positive social networks. As a result he was able to reunite with his children and his quality of life improved. As the counselling progressed his confidence grew and
he was able to secure full time employment, his attendance at the surgery has reduced and he is no longer using anti-depressant medication

"This was my first time ever getting professional help for my mental health and Richard, you were incredible. I had a preconceived opinion – thinking the system was in shambles being the reason I never sought help before – and you quickly proved me wrong. From the very first session you were very sympathetic, patient, understanding and in every way amazing. You didn't hesitate to help with anything I brought to you, pointing me in the right directions if you couldn't help yourself and helped me every step of the way you possibly could, putting a lot of my worries at ease. You never left me wondering what was going to happen, always explained and planned my next steps with me and made sure I was always comfortable. You've helped me in many ways I never thought I'd be able to be helped, and I can't thank you enough for it all. An extremely amazing person that I probably wouldn't be here without. Thank you so, so, much for everything."

Patient stories

Age UK/TEWV Social Isolation Offer:

Man referred by MH Access clinician suffering from anxiety and depression, finding the return to work after COVID very difficult. Chatting to him, it was revealed that he would really like to do something meaningful and helpful. He had considered voluntary work but had been put off by the long application process. He was interested in doing some volunteering as a handyman and after a chat with our Volunteer Coordinator, we put him in touch with her and he was happy to fill in the simplified version of our application form and to receive help with his DBS application.

The client has been able to do something which is useful and valuable. Our organisation has gained a valuable handyman and our clients on the Help at Home waiting list will be able to get help much earlier than expected

Patient stories

Community Navigator:

Client was struggling with symptoms of depression and anxiety and had not left the house in 2 years following a relationship breakdown and loss of business. He wanted to access mental health support but was unsure of who to reach out to. He had lived off savings for the past 2 years and needed support to apply for PIP and UC.

He was discussed in the CLS Huddle and a step across to the GP Aligned Mental Health Team was agreed. The Community Navigator worked with the client over a period of time to apply for Universal Credit and PIP. On advice from the GP Aligned Team, the Community Navigator used an approach similar to graded exposure, to help the client leave the house and access his local community. Client agreed to speak to the Lived Experience Lead of the CLS Transformation – 'He mentioned that he benefits a lot from a support you give him (his words: "Rosie is fantastic"), which was great to hear.'

Patient stories

PCCVO Peer Mentor Service:

Feedback from Male Client Alcohol Misuse: I writing this to say thank you for all your help and support, you came into my life at just the right time. I lost everyone I could actually could turn to for advice, no one ever gave me the answers, help or support I really needed. Look were we started to were we are now yes I fell twice on the way but you were the one I could pick the phone up anytime which actually means a lot. I always thought I was one of the strongest minded people on the planet until I need a shoulder to cry on . I'm so grateful for having you come into my life and I now want to give back to as all I've ever done is try my best to make people happy and also thanks for offering me a bike that meant a lot. You've actually done more than you know mate.