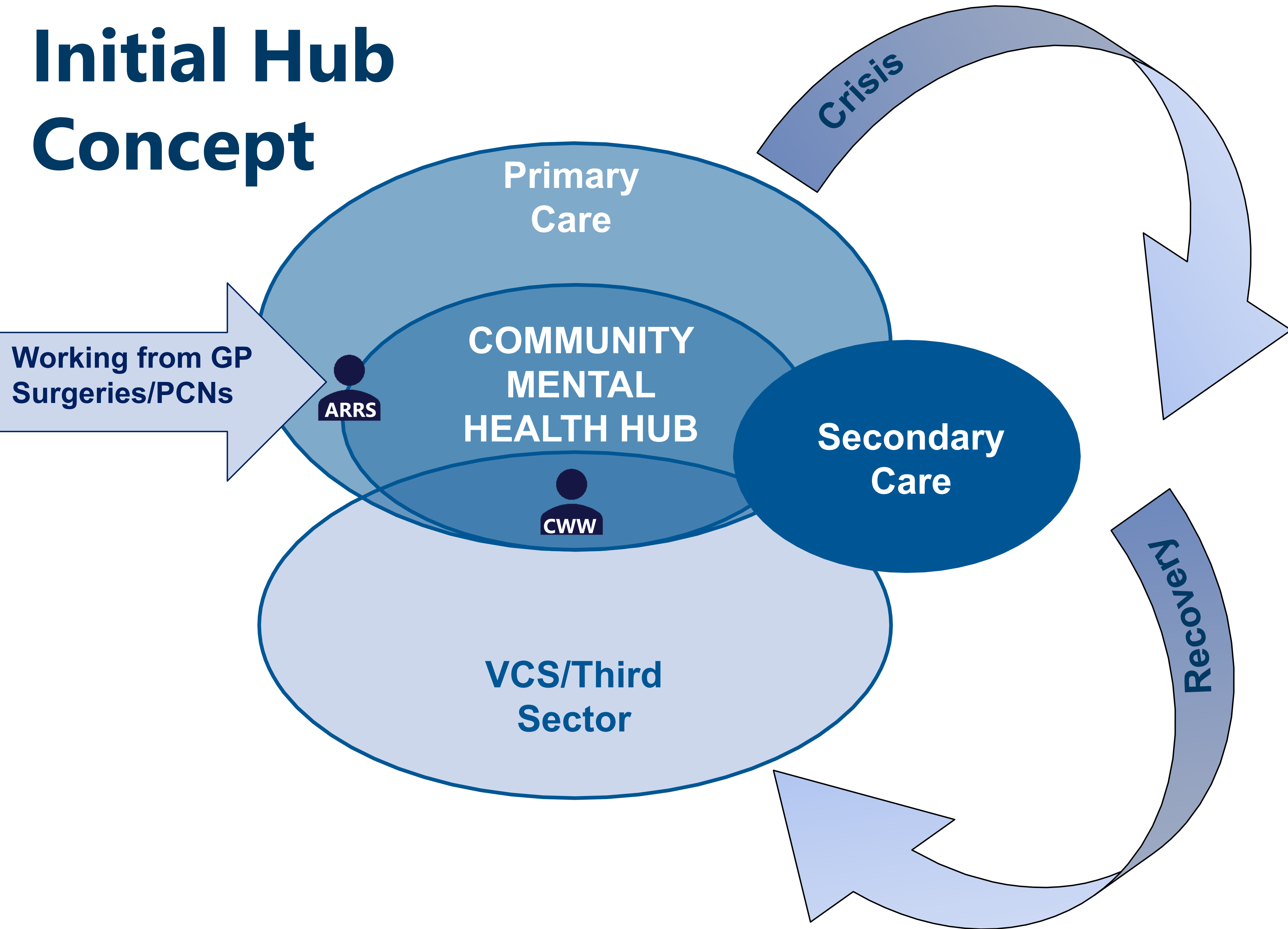
Oxfordshire Community Mental Health Framework

BACKGROUND

- The Community Mental Health Framework is a NHSE transformation project with funding provided over 3 years. **2021/2022 – 2023/2024**
- CMHF is an opportunity to improve the health and wellbeing of people with significant mental health conditions
- The aim of the CMHF is for care to be closer to home, when and where patients need it.
- *'**This Framework locates community mental health services in the centre of the community, as the central pillar of mental health care, allowing all other services in the mental health care system to function more effectively'.***
- NHSE instructed mental health providers to make it easier for the public to access mental health advice and support, aligning with the 'Health on the High Street' agenda, which puts health service provision on the high street in vacant properties to increase accessibility of these services.
- Initially Oxfordshire's plan had been to base the PCMHTs in existing Primary Care premises rather than within existing mental health estate, but no GP practice had the space to accommodate the Keystone Teams. Our Partners were also approached, and likewise they did not have capacity for the teams.

Initial Hub Concept



CWW = Community Wellbeing Workers Including: MIND embedded navigators, Elmore, Age UK etc.

ARRS = Additional Roles Reimbursement Scheme Mental Health Practitioner

Background cont…

- For many years patients, carers, clinicians (across primary and secondary care) had reported a significant gap in services for people with a SMI, barriers to accessing services, long waits for specialist interventions, lack of capacity and training for secondary care professionals to provide evidenced based interventions, clinicians ‘firefighting’ due to a lack of appropriate Crisis Provision, and a void of individualised interventions for people when discharged from Secondary MH services.
- We repeatedly saw this through complaints, patient and carer feedback, front-line clinicians, GPs. Patients and Carers reported that they often got to crisis point before they were accepted back into mental health services, and the lack of early intervention in relapse impacted on flow across Mental Health Services.
- There were repeated complaints about patients being ‘bounced’ between services and long waits with no support during these waits if they reached the appropriate service. This led to a lack of trust in mental health services and risks for patients increasing during this time.

Why change?

We recognised the need for a different, more joined up approach, across all support providers, with staff from across the NHS, social care and the third sector working together to:

- improve access and remove barriers to care
- improve local services
- reduce health inequalities
- prevent unwarranted variation in care.

We wanted people with mental health problems to be active participants in accessing mental health care, so they could:

- access mental health care and support where and when they needed it
- manage their condition, or move towards individualised recovery, on their own terms
- contribute to and be participants in their community.

Feedback about Oxfordshire's services 2021

Long waiting lists with gaps between primary and secondary care

Barriers to getting the right treatment especially with co-existing conditions

Too much city centric provision and not enough county-wide access to services

Current pathways are confusing and complex

Outcomes and services for people are variable with inequalities in access

Thresholds and criteria for services differ confusingly

Lack of tailored provision for older adults including the younger older adults

Cliff edges after interventions

Development of the model

- The model in Oxfordshire was co-produced in partnership with representatives across the system. Workshops, focus groups, and engagement events were held with all stakeholders including partner organisations (across Primary/Secondary/Third/Voluntary/Acute/Local Government sectors and CCG), staff, patients, and carers to develop the hub model in Oxfordshire.

- The purpose of the CMHF Programme was to deliver radical change in the design of community mental health care for adults and older adults. This would be achieved by moving towards joined up care, designed using a whole population approach, whilst establishing a revitalised purpose and identity for community mental health services.

- People would be supported to live well, to maximise their individual skills, and to be aware and make use of the resources and assets available to them as they wish.

- This new approach of locally based mental health support, care and treatment for adults and older adults which is situated and provided in the community.

Partnership and Co-Production

In Oxfordshire we knew that to develop a successful framework for delivering good mental health support, care and treatment in the community we must work in co-production with our partners across all sectors, experts by experience, patients and carers.

Successful integration of primary and community mental health support also relied on active partnership working.

In Oxfordshire the Community Mental Health Framework programme was led in partnership by Oxford Health Foundation Trust, Commissioners (was OCCG), Primary Care Networks (PCNs), the Oxfordshire Mental Health Partnership & Age UK.

The Programme Aimed to:

- Promote mental and physical health and prevent ill health.
- Treat mental health problems effectively through evidence-based psychological and/ or pharmacological approaches that maximise benefits and minimise the likelihood of inflicting harm, and use a collaborative approach that:
- builds on strengths and supports choice;
- is underpinned by a single care plan accessible to all involved in the person's care.
- Improve quality of life, including supporting individuals to contribute to and participate in their communities as fully as possible, connect with meaningful activities, and create or fulfil hopes and aspirations in line with their individual wishes.
- Maximise continuity of care and ensure no "cliff-edge" of lost care and support by moving away from a system based on referrals, arbitrary thresholds, unsupported transitions and discharge to little or no support. Instead, move towards a flexible system that proactively responds to ongoing care needs.
- Work collaboratively across statutory and non-statutory commissioners and providers within a local health and care system to address health inequalities and social determinants of mental ill health.
- Build a model of care based on inclusivity, particularly for people with coexisting needs, with the highest levels of complexity and who experience marginalisation.
- Establish new integrated diagnostic pathways to be delivered through integrated teams based in primary care and locally accessible Hubs in the community. This will allow patients to access and flow through services with no wrong door in or out.

Oxfordshire Hubs ‘Health on the High Street

- Early intervention for people presenting for the first time and those with an existing diagnosis with signs of relapse, or advice/ reviews including support with physical health.
- Offering a welcoming and non-stigmatised outward facing façade with a social enterprise offer alongside mental health and wellbeing support services.
- Social Enterprise - to employ people with lived experience of SMI into a variety of roles and encourage volunteers to work alongside our PCMHT in offering advice and guidance to those coming into the building.
- A local point of access for all, non-emergency, mental health referrals
- Trusted assessment following triage, leading to self-help advice, signposting to Third/Voluntary sector, short term intervention from the KMHT, direct referral into Enhanced MH teams without the need for further triage or repeated assessment
- Truly integrated partnership working at a community level.
- One Stop Shop offering clinics on housing, benefits, Drug & Alcohol services, as well as health and wellbeing services
- Fully integrated MH provision at a local level, tailored to the SMI & socioeconomic needs of the local community.
- Potential for Mental Health support by day and local community groups by night

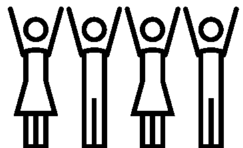
Community Mental Health Framework - Oxfordshire

NHS Oxford Health NHS Foundation Trust
Keystone Mental Health & Wellbeing Hub

Vision

To provide integrated, multi-agency care to adults with complex and serious mental illness in a way which is **proactive**, **personalised** & considers the needs of patients.

A service which works **collaboratively with primary care** and draws upon the **expertise** and **assets of the community** to enable effective, **accessible care** & **communication** across the whole system.



Co produced with patients, experts by experience

Principles for Delivery

No wrong front Door

Care Organised around communities, addressing inequalities and social determinants of serious mental illness

Co-Production

An evidence Based holistic partnership approach reducing unnecessary duplication or escalation

No artificial thresholds between Primary and Secondary care.

Specific focus on pathways for those with Eating Disorders, Personality Disorder and Complex psychosis

Reducing stigma

Fully integrated mental health provision at local level, tailored to people experiencing SMI & the health & wellbeing needs of the local community

Keystone Mental Health and wellbeing Hubs

https://youtu.be/g1WKA41aTYg

Current Situation

- 5 Keystone MH and Wellbeing Hubs open on the high street, Banbury, Kidlington, Oxford City, Abingdon and Wantage.
- 8 Keystone MH Teams (KMHTs) fully functioning – Abingdon, Banbury, Blackbird Leys/ City East, North City and NE Oxon and Wantage/ Didcot/ Farringdon ,Wallingford/Henley/Thame, Witney
- Witney KMHT based in Branch Trust in Chipping Norton every Friday
- Volunteers have started to support manning the front of house in some of the Keystone Hubs.
- OCA (Oxford Community Action)café as front of house for the Cowley Road Keystone Hub.
- Personality Disorder pathway embedded, Elmore Personality Disorder Intervention workers(PDI) in place
- Eating Disorder Pathway commencing SWEDA workers in place
- Continued partnership with Sport in Mind to increase provision across Oxon.
- Partnership with Bipolar UK to run self-management courses for those with bipolar across Oxon and ongoing Peer support groups.
- Self-referrals beginning to be accepted

Ongoing Challenges

- Recruitment
- Demand for Structured Psychological Support (SPS) for people with Personality disorder provided by Elmore PDI workers
- Increasing referrals and assessment leading to lack of capacity to provide timely responses as expected in some KMHTs
- Accommodation for the Wallingford/Henley/Thame and Witney Keystone Hubs.
- Manning front door, - ‘walk ins’ -aim for the front doors to always be open to public.
- Offer to social enterprises to use the ‘front of house’ space in the Hubs
- Use of the group room space in the Hub to local community groups, voluntary sector and statutory organisations to see people around issues which impact on MH
- ARRs(specialist Mental Health Workers) not all PCNs have adopted this offer to have staff embedded in the GPs surgeries, and some have chosen after a year to end contracts.

KMHT Staff

In the KMHT there are:

- Team manager (OH)
- Band 7 qualified clinician(nurse or OT) (OH)
- Band 6 qualified clinicians (nurse or OT) (OH)
- Psychologists(cross covering patches) (OH)
- Assistant psychologists (OH)
- Peer support workers (lived experience) (OH)
- Personality Disorder Intervention (PDI) workers - Elmore
- Wellbeing and Options Workers – Oxfordshire Mind
- Eating Disorder support workers – Southwest Eating Disorder Association (SWEDA)
- Individual Placement Support (IPS) workers (OH)
- Administrators
- Volunteer workers
- Consultant Psychiatrists in advisory roles

FEEDBACK

Re peer support worker *"never met such a comprehensive team"* and *"you give me hope."*

X said the Hub is helping him rebuild trust with mental health professionals

It's was nice to be treated like a human and not someone on a piece of paper.

' I do appreciate everything you do, you understand me more than any professional help I've had over the years and I feel a little light pressing through a dark tunnel I've been in for many years, and not knowing what to do than end myself constantly.'

"Fastest support I have ever received"

Location – its great, you can pop into town, and it is a central location and works well.

First time trauma has actually been **recognised** from a MH service. Other services are not trauma informed

"Many conversations and comments made and shared with the intervention will stick with me for the rest of my life. Whenever difficult times come up I often use the techniques and thoughts learned in this intervention to lessen the difficulty or at least think in a less negative way.

I thought it was fantastic, it was easier to access compared to other services. Once I got the courage to come through the door everyone was so friendly

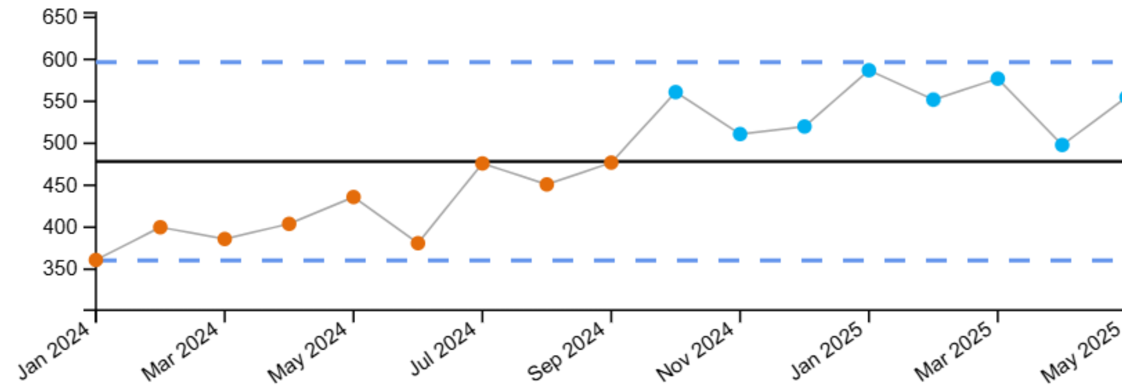
I wish I could have received this support years ago when my trauma happened.

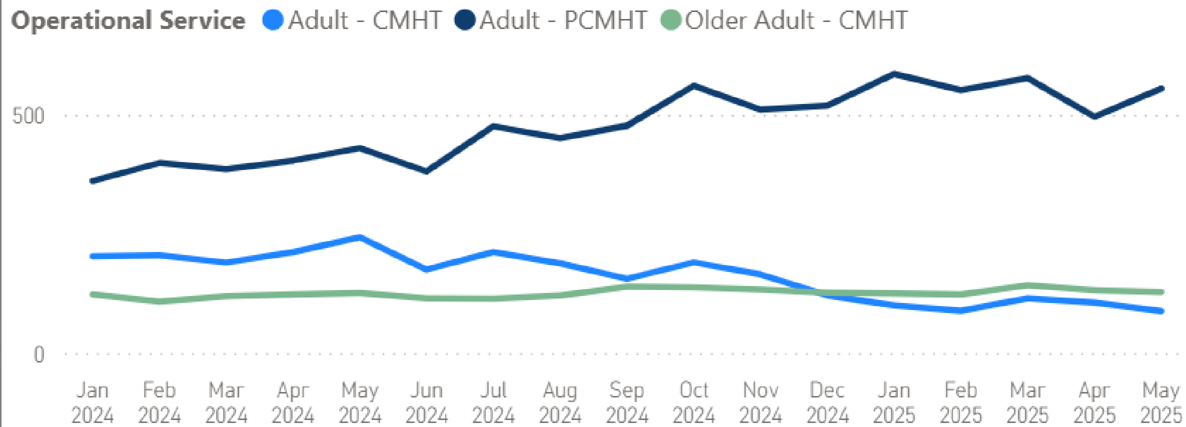
All the days were darker before I came to the Hub, now the days are brighter, and I feel content. I also do not feel as vulnerable.

Outcome based measures

- Patient reported Outcome measures(PROMs) are being used within the Hubs. This consists of using questionnaires, talking with patients regarding their responses, and care planning around these, whilst monitoring the impact of interventions and care. People are sent a link via email or text to complete the PROMs online on a website called True Colours. Alternatively, these can be completed during the appointments.
- Questionnaires are:
- DIALOG scale
- Recovering Quality of Life Scale(ReQol-10)
- Goal Bases Outcomes (GBOs)

Oxon Keystone Hubs Data for Health Improvement Partnership Board



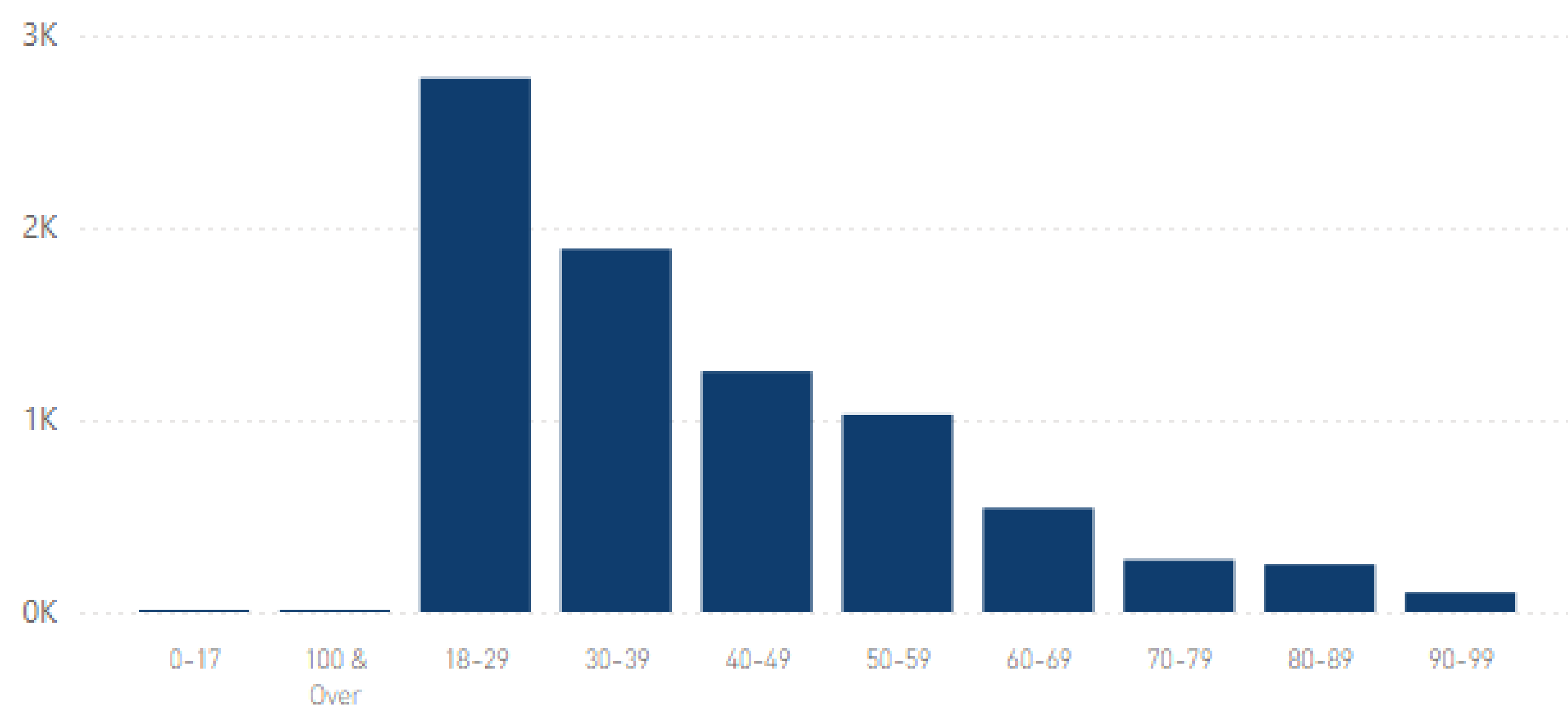


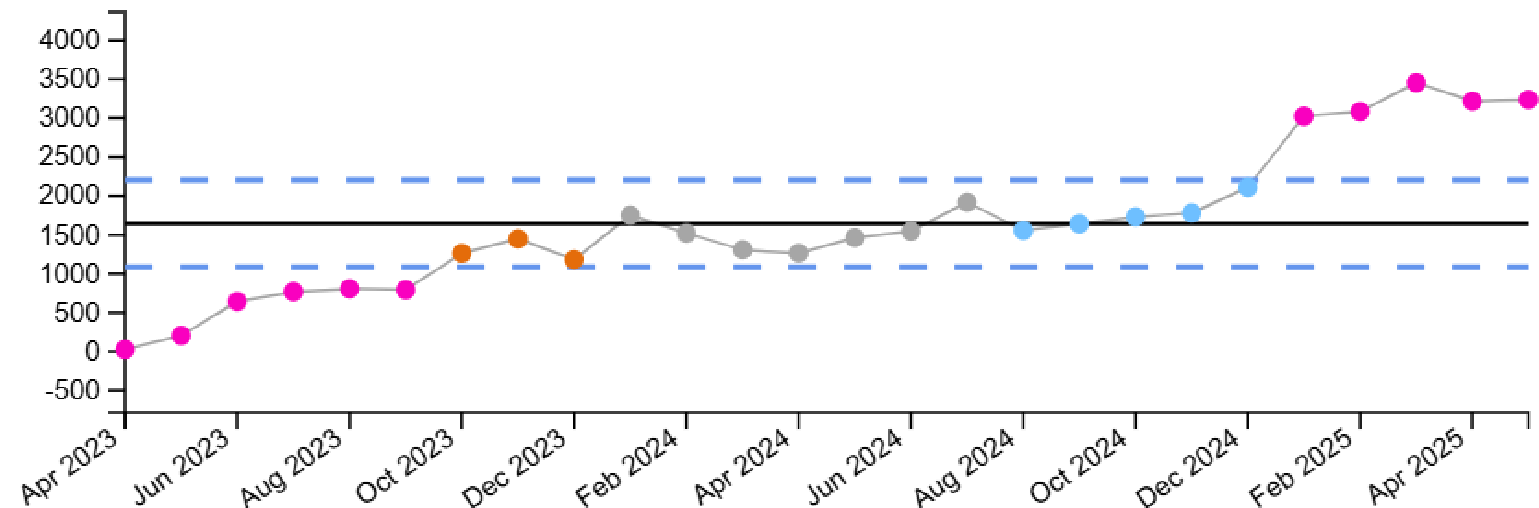
KMHT Activity

Referrals received and discharged referrals:

- 8,133 referrals received
- 8,077 discharged referrals
- 67 Days Average LOS of discharges

KMHT DATA Cont ...





Thank You

Any Questions?