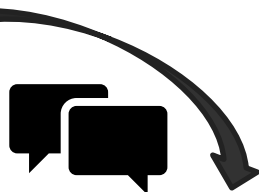
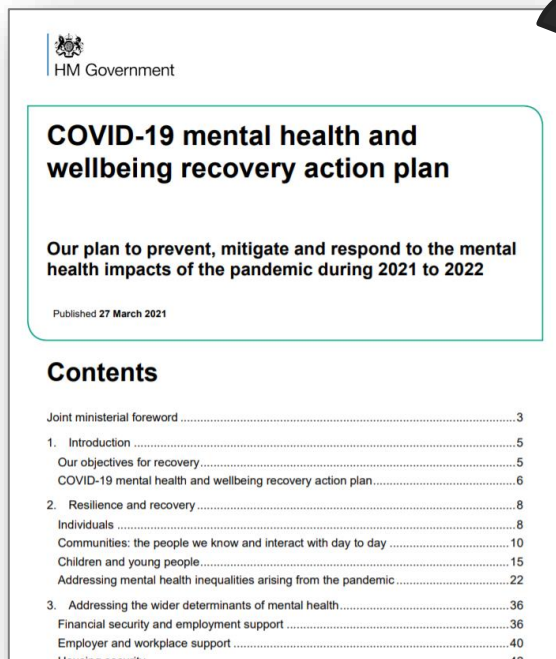


# Mental Health Recovery: Primary Care & MH

## June HWBB

# DHSC Mental Health Recovery action plan



## Serious mental illnesses

Individuals living with serious mental illnesses often face the greatest challenges with their mental health, and have reported more acute difficulties during the pandemic. The roadmap out of lockdown is for many a very welcome step back toward normality, but may well present challenges for those living with a severe mental illness and navigating further changes to life and routine. We also know that this group are at greater risk of poor physical health and have a higher premature mortality rate than the general population. In the context of COVID-19, we have worked across the NHS, public health and the voluntary and community sector to support the psychological and social needs of this group during this time, and most recently to support equitable uptake of the COVID-19 vaccine.

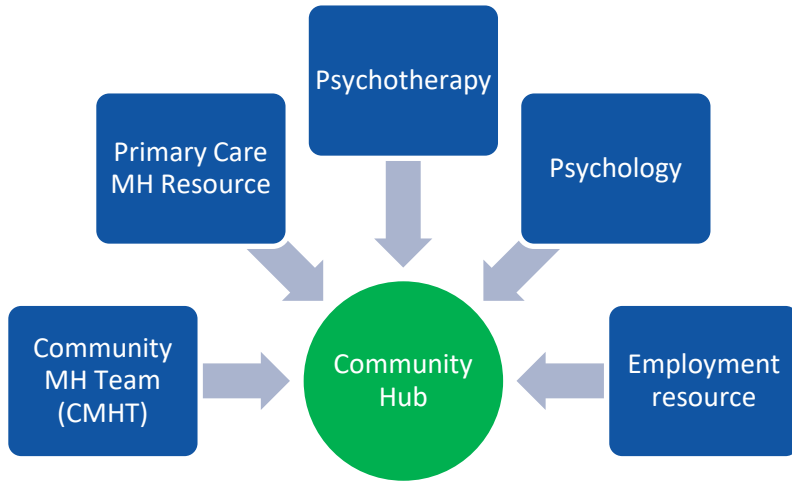
Holistic and joined up support for this group will continue to be a priority area for action during the coming year and beyond.

In particular, the implementation of the modernised [Community Mental Health Framework](#) presents a real opportunity for local systems to come together and consider the psychosocial needs of this group in the round. These new and integrated models of care move away from siloed, hard-to-reach services towards joined up care across primary and secondary health care, social care, the voluntary and community sector, and housing to support individuals with long term and severe mental illnesses to stay well and recover in the community. On top of planned investment, these transformation plans will benefit from additional funding in 2021 to 2022 to go further, faster.

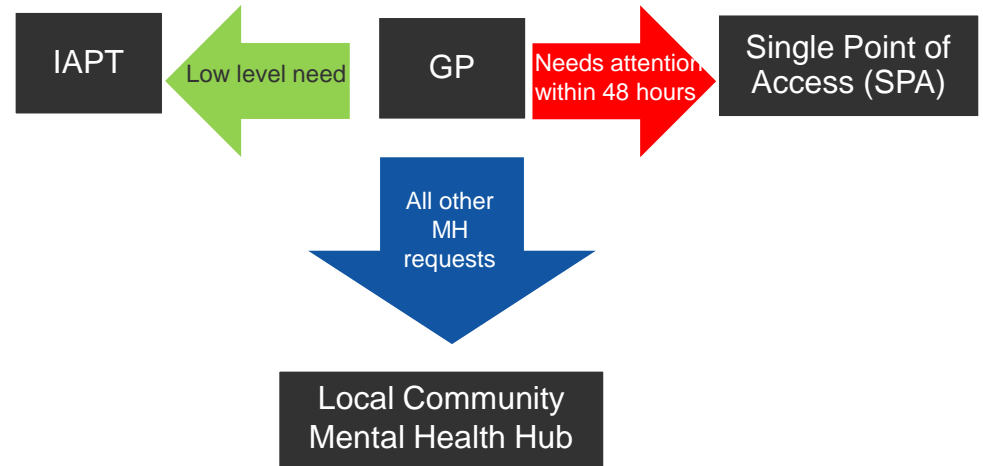
Need to fully embed/accelerate delivery of new integrated primary-community MH hub model: *'Community Living Well+' (RBKC) or Community MH Hub (Westminster)*

# 10 Principles of new Community Hub Model

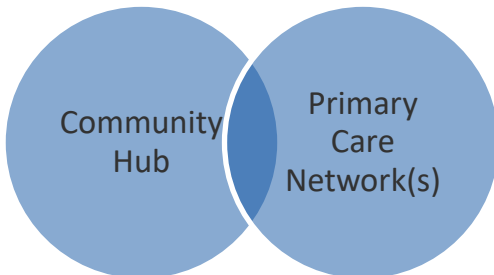
## 1) All resource, where possible, in the hub



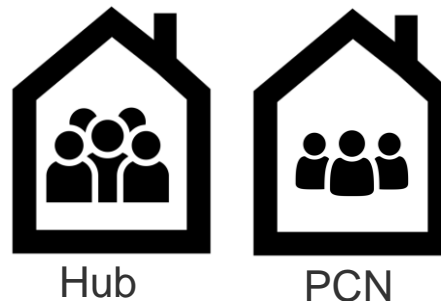
## 2) Separate 48 hour urgent referral route



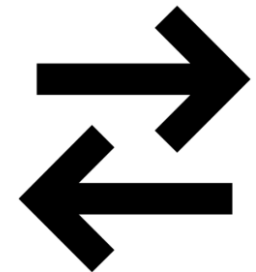
## 3) Community hubs aligned to PCNs



## 4) Regular Hub and PCN catch ups



## 5) Less focus on caseloads more on flow

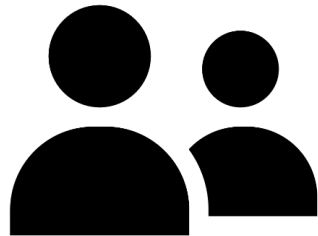


# 10 Principles of new Community Hub Model

## 6) Daily Senior Triage meeting



7) DIALOG+ to be used to inform every assessment



8) Every person to have a named worker

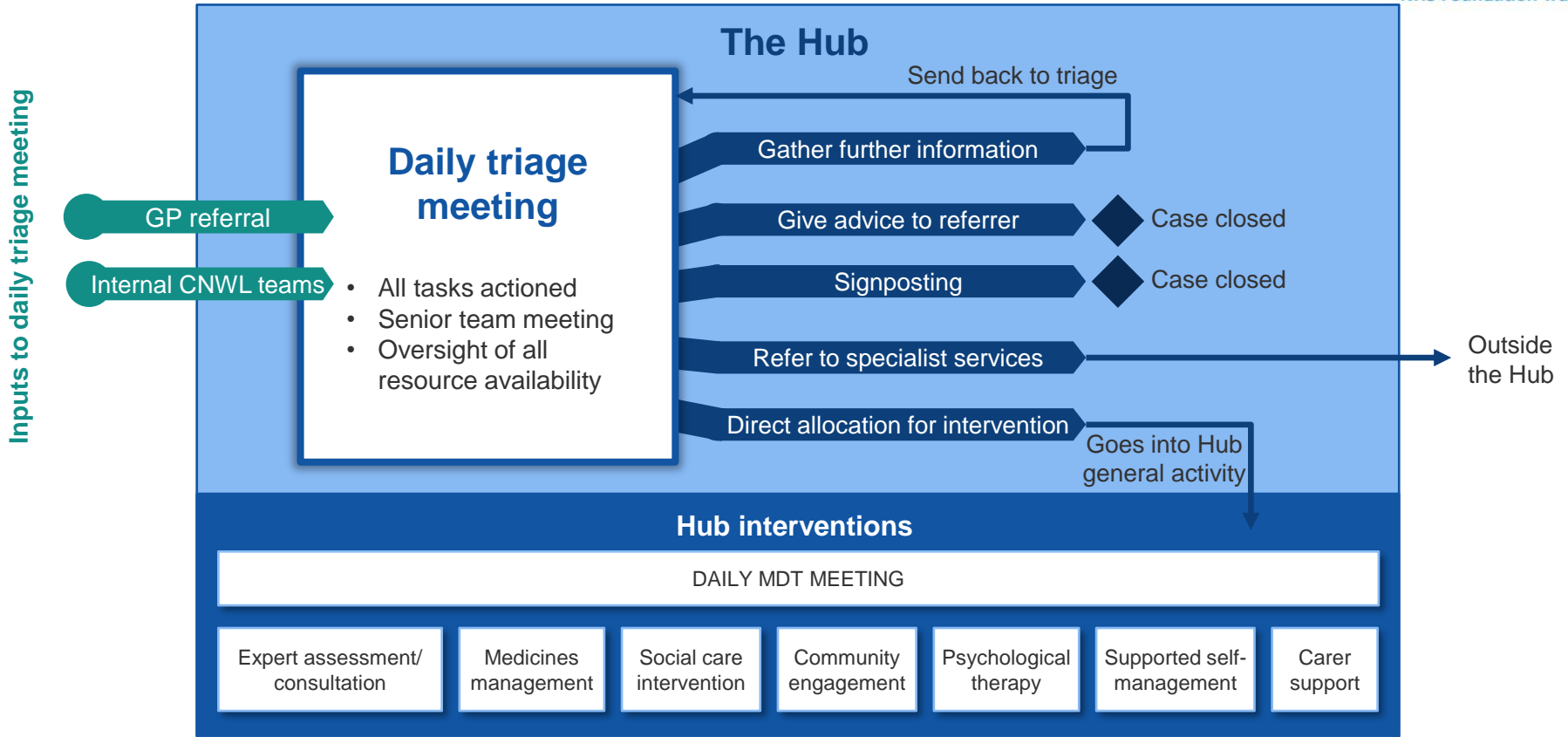


9) Delivery of intervention based care not generic care coordination



10) Every member of staff dedicated to supporting the physical health needs of their service users

# Overall Delivery model



## Underpinning principles

-   
 Physical health with mental health
-   
 Minimise bureaucracy
-   
 Working as One Team
-   
 Shared responsibility for patients and resource
-   
 Optimises use of community based resources
-   
 Active intervention with clear outcome
-   
 Preparing for end of intervention rather than discharge

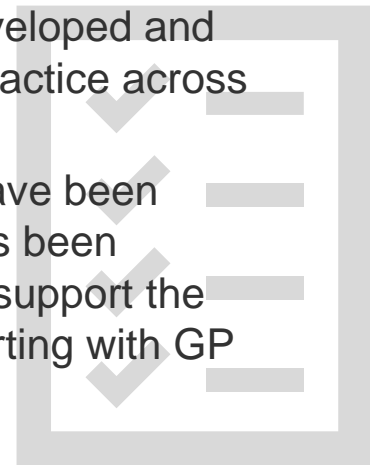


# How will this improve services?

- No primary, secondary care divide - conversations and tasks, not referrals
- No thresholds
- Rapid communication to patient and referrer following triage
- Shared ownership of resource utilisation
- More intervention than assessment – defined, shorter, outcome informed episodes of care
- Redefining discharge - no cliff edges
- Increased confidence of primary care clinicians through regular contact with mental health colleagues and MDT support
- Enhanced offer incorporating 3rd sector, social care and new innovative roles
- **Enhanced patient experience, referrer experience, staff experience**

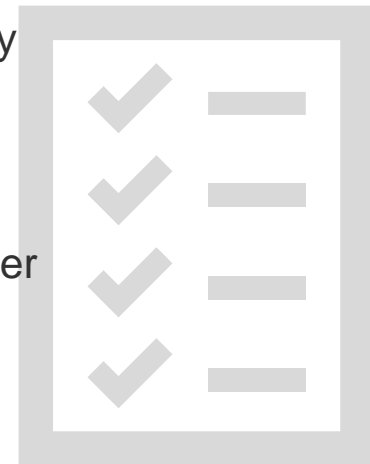
# Where are we on implementation in Westminster?

- New integrated, population based community mental health hubs went live in September 2020
- Regular review and tweaking of the model of delivery with significant positive improvements in the triage model and integrated working within the teams across professions
- Continual effort to ensure that the social care agenda is being delivered in the hubs at all areas of the new pathway e.g. identifying and addressing social care needs at the earliest stage (triage) and ensuring service users receive the required assessments and care that is care act compliant throughout their recovery journey
- Currently undertaking a review against the SOP. Action plans will be developed and led locally to address areas of improvement using learning from good practice across teams
- Mental Health Additional Role Reimbursement Scheme (ARRS) roles have been agreed for each of the four PCNs in Central London. Job description has been agreed with PCN directors and will be out to advert ASAP. This role will support the triage function of the new hubs in addition to working closely and supporting with GP practices in the aligned PCNs



# Where are we on implementation in K&C?

- SOP drafted being finalised
- Final detail around staffing and process being added to the triage functions of each hub
- Comms and engagement group formed with reps from CNWL, CLW and LA – Comms strategy developed and outputs and timeframes defined
- Systems and IT group formed to deliver data migration of cases into the integrated hub teams as well as IT support, phonelines, emails that will need to be set up to ensure a fluid pathway
- Both Primary and secondary care staff combined and aligned to PCNs
- Training package for all staff being developed and will be delivered – July – September
- Social Care T&F group restarted to ensure Social Care agenda being delivered in the new teams
- PCN introductory engagement sessions with lead consultant and manager from each PCN
- Recruitment to new roles both in CNWL and newly expanded 3<sup>rd</sup> sector contracts underway





# Further detail RBKC: Old Structures

K&C South  
CMHT

K&C North  
CMHT

QPP CMHT

PCLN

Step 4

# New Structures

## Covering borough of K&C

### K&C South Hub

Brompton  
PCN

K&C South  
PCN

### K&C North Hub

Neohealth  
PCN

WestHill &  
Inclusive  
K&C PCN

### QPP Hub

WestHill &  
Inclusive  
QPP PCN

Covering borough  
of Westminster

# GP referral pathway

Patient  
presents at  
GP with  
MH need

Needs attention within 48 hours

Single  
Point of  
Access

★ Takes self referrals

# COMMUNITY LIVING WELL+

★ IAPT

Local Community Mental  
Health Hubs

★ Wellbeing Services

- Peer Support
- Navigators
- Employment Support

Please note there will be strong links between IAPT, SPA, Community Hubs and Wellbeing Services all of which will take and receive referrals from each other and work in an integrated way to deliver care for the local population of K&C and QPP