Introducing the Framework for Community Mental Health Support, Care and Treatment

NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

AND

NHS ENGLAND

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What is the LTP ambition in relation to community MH care for people with SMI?

We will establish new and integrated models of primary and community mental health care to support at least 370,000 adults and older adults per year who have severe mental illnesses by 2023/24, so that they will have greater choice and control over their care, and be supported to live well in their communities.

A new, inclusive generic community-based offer based on redesigning community mental health services in and around Primary Care Networks will include: improved access to psychological therapies, improved physical health care, IPS/employment support, personalised and trauma-informed care, medicines management and support for self-harm and coexisting substance misuse.

This includes maintaining and developing new services for people who have the most complex needs including EIP, 'personality disorder', rehabilitation and adult eating disorders.

Through transforming the model of care and investing in new workforce we will be providing better care for people already receiving mental health support in the community, and increase access to these services over a 10 year period, including testing a new **four-week waiting times standard** for (generic adult and older adult) community mental health teams with a view to future roll-out. **This testing of a potential future standard will form part of testing of the overall new model, in line with a new Community Mental Health Framework, in selected sites from 2019/20 using centrally-allocated funding, over and above new CCG baseline funding for community mental health services from 2019/20.**

As part of improving the overall community offer, we will further increase the number of people with severe mental illnesses receiving **physical health checks** to an additional 110,000 people per year, and support an additional 35,000 people to participate in the **Individual Placement and Support programme** each year by 2023/24.

Background

Community mental health services comprise multi-disciplinary teams offering assessment, treatment and care to adults with mental health problems in their own homes and in the community.

We are developing a **framework** for community mental health services (CMHS). It will:

- span the service user journey
- deliver greater integration with other services that impact on mental health and wellbeing outcomes including primary care, GPs, social care, education, housing and third sector services
- ensure **equality** for all groups of people in relation to service access, experience and outcomes
- be accompanied by **implementation guidance aimed at commissioners and service providers**

Scope (overview)

Population – adults (aged 18+, including older adults, but also considering young people of transition age) with mental health problems, including those with comorbid neurodevelopmental disorders and learning disabilities

Settings – mental health care and support provided in a person's own home and in the community, including in primary care, care homes and home care

Services – span primary and secondary services (including GPs, recovery services, CMHTs, assertive outreach, specialist primary care mental health, voluntary and community sector services etc.) and includes social care

Care and treatment – maps the care, treatment and support delivered by mental health services in the community (including psychological therapies, social care, housing support etc)

Care and treatment processes – NICE-recommended care and other processes that define how care and treatment should be delivered (e.g. assessment of needs, care planning, care coordination, risk assessment, outcome measurement)

Addressing health inequalities – engagement with and focus on identifying and addressing any differentials in relation to service access, outcomes or experiences of any groups (including people with protected characteristics)

Recent history - Generalist vs functional?

- National Service Frameworks created specialist teams (Crisis Resolution and Home Treatment teams/Early Intervention in Psychosis teams; Assertive Outreach teams) and a wider range of functional services have been developed
- IAPT developed specialist therapy services for depression and anxiety
- Clustering & possibility of payment by results led to more specialist/functional teams
- FYFVMH strengthened some specialist community-based services (CRHTT/EIP/IAPT), added some more (perinatal) and didn't mention others (AOT, generic CMHT)
- And all the while… (mostly) generic community mental health teams have picked up the slack with little policy support for c30 years

Why should services change?

- Community MH services are often not responsive and referrals take a long time to get to the right place
  - Teams set up to manage demand/flow into secondary care do not do this well – average wait for assessment teams was 8 weeks in 2016/17 (up from 5 weeks in 2015/16)
  - Most referrals to community mental health teams do not come from primary care (over 20% are inter-team referrals)
  - Referrals between teams lead to people being lost in transition
- Support provided for people with MH problems provided by community mental health services forms only a small part of a person's life and care
  - Less than half of people report that they definitely see their community worker often enough (CQC Community MH Survey 2017)
  - The average number of contacts a person has with any member of a CMHT is 1.4 per month

Why should services change?

- Outcomes and services for people are variable and demonstrate inequalities
  - Increased formal admissions and lack of knowledge about outcomes for people with SMI
  - Less than half of people on caseloads were offered non-pharmacological treatments in the last 12 months
  - Older people face exclusions from different services with no coherent pathways particularly when they have complex co-morbidities
  - People from black and some other minority ethnic backgrounds are detained under the MHA at higher rates than the white population
  - Black people more likely to access mental healthcare via A&E or CJS, less likely to access via primary care referral
  - People with complex MH problems often associated with a diagnosis of personality disorder often have no clear pathway to access care
  - No policy interventions have reduced the 15-20 year mortality gap between those with a serious mental illness and the rest of the population

What are we proposing?

A **radical change** in the approach towards the delivery of community mental health care (NHS – both primary and secondary care, social care, VCS, public health, communities):

- Integration of community-based services into a network of health and social care services for adults and older adults, from less complex to complex mental health needs (this does not mean ageless services)
- Primary care being enabled to provide a broader range of services in the community that integrate primary, community, social and acute care services, and bring together physical and mental health care
  - Organised at the local community level for a population of around 30,000 - 50,000 people (approximately 5 to 12 GP surgeries). Most people will receive treatment here
  - Linked closely with wider community services (populations typically of 150,000 to 200,000) that focus on more complex needs where services are provided by specialist multidisciplinary mental health teams
  - Local needs, local geography and specialist services arrangements may contribute to variation in population size

Place-based systems of care
(Kings Fund, 2015)

- "providers of services should establish place-based 'systems of care' in which they work together to improve health and care for the populations they serve. This means organisations collaborating to manage the common resources available to them".
- The proposed Community Framework applies this model to the delivery of community mental health care.
- In this case providers include VCSs, the local authority and other providers of social care, as well as statutory primary and secondary healthcare providers, recovery colleges and care homes and home care.

The new model

- Development of an **integrated core community mental health network** which brings together the extensive mental health support and treatment:
  - 1) currently provided in **primary care** for people with less complex and complex needs; and
  - 2) provided by current **secondary care** community mental health teams
- This model of care replaces the current models for delivery of care (where care is delivered separately from primary care or secondary care) through integrating mental health, physical health and social care
- Teams will be multidisciplinary, with strong links with crisis teams (which may be provided at a wider community level) and other services such as inpatient care, residential and liaison mental health services in emergency departments

A core community mental health network

- The central functions of a core community mental health network will be to effectively treat, care for and support people with the full range of mental health problems in a community setting. This will involve:
  - Assessment and advice
  - Interventions
  - Community support (carers, voluntary and community sector services etc)
  - Care management
  - Specific psychological, pharmacological and social interventions
- The specific make-up of each network or team will be subject to local determination, based on the particular needs of a geographic area or population
- Networks will have common pathways for specific needs or problems, agreed protocols for the delivery of care, shared protocols for the management of specific problems, and reduction in multiple points of access

Principles for a community mental health framework

- The organising principles of the community mental health framework are that they should:
  - Organise care around their communities
  - Dissolve barriers between primary and secondary care, and between health care, social care and VCS services
  - Step up and step down care to meet a person's complexity of needs
  - Know their communities and use this knowledge to understand and address inequalities
  - Be proactive, flexible and responsive to individual needs
  - Understand and take a partnership approach to addressing the social determinants of serious mental ill health
  - Make use of community assets and resources, including VCS, online resources and personal contacts

What does that mean for services?

- Care largely organised around local communities and built around clusters of GP practices – Federations, Primary Care Networks, NAPC 'Primary Care Home' models

Local community = a population of about **50,000** people

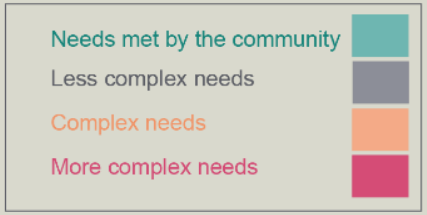
Services for **less complex** and **complex needs** at a local community level

Wider community = several local communities, to a total population of **250,000+** people

Specialist services for **more complex needs** are delivered to the wider community population

* Local communities 1–5 represent population sizes and complexity of needs, not geographical location.

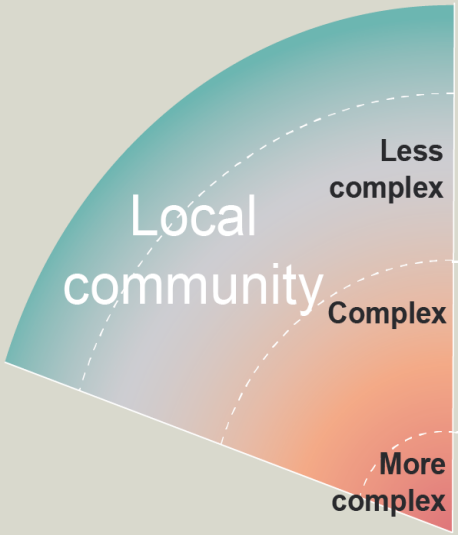
Public health-provided services are out of scope.



Complexity

- Complexity is cumulative, it is influenced by the following factors:
  - nature, duration and severity of mental health problems (including neurodevelopmental disorders)
  - nature, duration and severity of co-existing mental and physical health problems
  - availability and quality of personal and social support
  - ability to meet basic needs such as accommodation, fuel etc.
  - associated functional impairment
  - effectiveness and experiences of current or past treatment and support
  - cultural or societal factors that impact help-seeking behaviours
  - service difficulties in engaging with people, or existing access barriers.

Functions of care delivery across different levels of complexity



Services for more complex needs serve multiple local communities across the wider community

Person*	Example functions	Examples of teams and services**
Ashik Louise Dave	• Brief psychological intervention • Care coordination and medication management	• Peer support programmes • IAPT • Community support groups • Primary care, with oversight from community mental health service
Diane Kyle Carol	• Community support group • Crisis intervention • Specialist intervention for depression or psychosis • Support with housing	• Coordinated multi-professional input • Specialist provision (crisis or disorder-based services) • Community employment and housing programmes
Frank Mei-Lin	• Long-term community-based social support • Long-term coordination and support • Supported housing • Mental health social workers • Assertive outreach function	• Intensive long-term community support team • Specific integrated mental health and physical health teams • Specialist provision for less-frequently occurring disorders (for example, eating disorder services)

* See Figure 2 for more information on each person's needs.

** Services providing functions will differ depending on local models

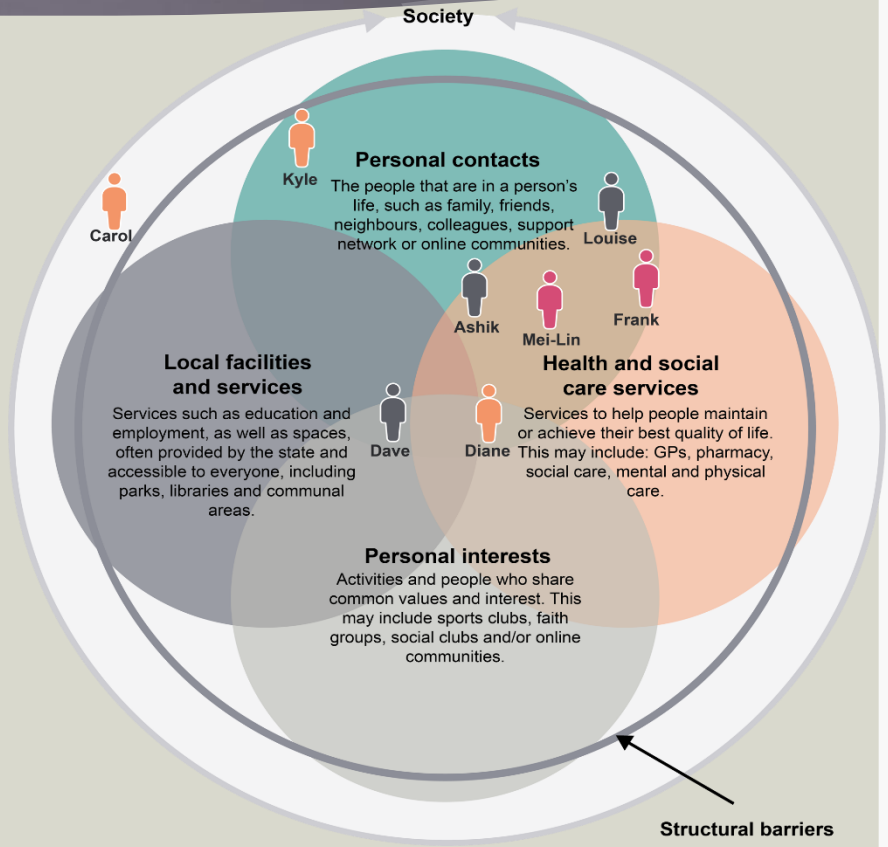
Maximising the use of resources in the community

Personalised care: social prescribing and community connections

Social prescribing connects people to community groups and services, through the support of 'link workers' who:

- take referrals from local agencies
- can give people time
- co-produce a plan to meet the person's wellbeing needs, based on what is important to them

Social prescribing is an umbrella term and is sometimes referred to as community connection, care navigation or other names. The core purpose is the same – to ensure that a person can access the range of resources that are available to them in their communities to keep them well.



Care planning and the Care Programme Approach

- Core elements and purpose of the CPA are sound and remain important and relevant
  - But it has often become an admin process, burdensome, meaningless to service users and not aligned with a personalised approach to care; there is significant variation in how MH Trusts apply the CPA
  - It also creates a divide between those on CPA and not on CPA, in terms of what they can expect, and what a service is required to report on to national bodies
- **This proposed model aims to subsume the CPA. Under the proposed model, every person who requires support, care and treatment in the community should have a care plan, based on good assessment**
  - The level of assessment, planning and coordination of care required will vary, depending on the complexity of a person's needs
  - Care plans will be co-produced, based on reviews and outcomes, and aligned to people's rights under the Care Act
  - The intensity of each element will vary, but everyone should have an expectation that they will receive this
- Assessments and care plans should be single across heath and social care, accessible across different settings and digitised where possible

Outcomes and quality measures

- Quality measures will help support local areas set standards for what mental health care should be provided in the community and how care should be delivered within the framework
- Outcomes should be collected across the following areas:
  - Outcomes for the person
  - Knowing, being a part of, and being responsive to the community
  - Effective working relationships with other services
  - Access
  - Building relationships with people and helping them take care of their own mental health
  - Assessments
  - Staffing
  - Families, carers, support network
  - Continuity of care
  - Joint working
  - Care planning
  - Physical health
  - Interventions
  - Reviews
  - Advocacy
  - Safety
  - Coproduced service planning, development and evaluation

Commissioning and governance

- The core community mental health networks will require agreed governance structures for their effective operation including the development of systems to support the integration of primary care, secondary mental health care, social care, and voluntary and community services
- Governance bodies will be established in each local community and in the wider community, comprising senior staff from each relevant service

How is the proposed model different from the current model of care?

- A shift towards **integrated delivery of care** across mental health, physical health and social care based in local communities means care will be **more responsive and less fragmented** also enabling MH clinical expertise to reach in to primary care and provide additional expertise and support
- Ability to **step care up and down based on need and complexity** and ensure those no longer in need of more intensive support will still receive a level of ongoing care and support
- Increased delivery of **evidence based interventions** such as psychological therapies, trauma informed care, physical health care and employment support in the community
- Making more **effective use of community assets and resources**, including housing, debt advice, employment services
- Meeting the needs of people in integrated core community mental health networks enables **more effective use of existing resources** and less reliance on hospitals and crisis services
- More **efficient links** with specialist mental health services that may be delivered within the wider community

5 million people in the SW

1 million people in Devon

DPT NCM & Tier 4

DPT MBU, PICU, Secure, Rehab, Community Forensic, Community Eating, ECRS, IPP

500k UHP

500k RD&E

DPT Core 24 Liaison Psych

LivewellSW Liaison Wards CRHT

Liaison, Wards, CRHT

Liaison, Wards, CHRT

Wards, CRHT

5 localities of 200K

20 Neighbourhoods of 50K

LW 3 CMHTS

DPT 17 CMHTS

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UCL

NCCMH

Specialist Mental Health Commissioning

5 million people in the SW — DPT NCM & Tier 4

1 million people in Devon — IPP ECRS

Specialist Wards: MBU, PICU, Secure, Rehab,

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Liaison Psych

DPT Wards CRHT

Liaison, Wards, CRHT

Liaison, Wards, CHRT

Wards, CRHT

?

5 localities of 200K

Ten specialist community MH teams: Forensic, Eating, ECRS, Transition, CAMHS, OPMH, ID, VHI, HI, PD, Recovery

20 Neighbourhoods of 50K

20 Integrated Care Teams

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