The Community Mental Health Framework for Adults and Older Adults - May 2020

This is a brief summary on what to consider when developing a proposal for transforming community mental health care provision based on the guidance below


(there is no implementation guidance yet)

Background

Community mental health services have long played a crucial yet under-recognised role

This focus on community mental health services transformation is seen as being an opportunity to achieve radical change in the design

The intention is still for all STPs / ICSs in England to submit proposals for the new models of community mental health care. This is seen in this COVID time as a CRITICAL area to improve.

Money will be allocated around June 2021 for the models and will be the first of 3 years of funding

Steps for submitting proposals consist of:

Formal communications to confirm revised timeline and process through e.g. a national webinar, likely during summer 2020

Release of online resources and guidance to support planning and proposal development process

First drafts of proposals submitted via regional teams for review

Feedback process

Confirmations

First allocations of money released – likely in June 2021

The guidance says that implementing this new framework for Community mental health care will:

- Break down the current barriers between: (1) mental health and physical health, (2) health, social care, voluntary, community and social enterprise (VCSE) organisations and local communities, and (3) primary and secondary care, to deliver integrated, personalised, place-based and well coordinated care.
- There will be less administration and bureaucracy because within an integrated system there will be fewer referrals.
- People with mental health problems will have fewer assessments, will not be required to repeat their histories, and will not fall through the gap between services. Moreover, they will be supported to live as well as possible in their communities
- It will enable partnerships to be built across health and social care.
• It should result in more time in direct contact with service users, which will comprise joined-up, ongoing, personalised care and support, and access to the right care at the right time for them and for their families and carers, including freeing up time to deliver evidence-based care such as psychological therapies

• For the primary care workforce, there will also be significant benefits. They will be better supported to care for people with mental health problems, increasing their skills and knowledge, and better able to access expert mental health clinical advice rapidly or even immediately. Their referrals will not be rejected and they will not have to wait for responses from mental health services. Fewer primary care appointments will be needed by people seeking mental health support and there will also be fewer people who attend GP practices frequently with unmet mental health needs.

Six aims of the new framework for Community mental health care provision:

1. Promote mental and physical health and prevent ill health.

2. 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; and - is underpinned by a single care plan accessible to all involved in the person’s care.

3. 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.

4. Maximise continuity of care, move towards a flexible system that proactively responds to ongoing care needs.

5. 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.

6. Build a model of care based on inclusivity, particularly for people with coexisting needs, with the highest levels of complexity and who experience marginalisation.

The Framework for Community mental health care provision wants to avoid

Exclusions based on a person’s diagnosis or level of complexity

Unnecessary repeat assessments and referrals

People having “cliff-edge” of lost care and support, arbitrary thresholds, unsupported transitions and discharge to little or no support.
Points to consider when developing a place-based model of community mental health care proposal

1. Define the population group served and the boundaries of the system.

2. Identify the right partners and services that need to be involved.

Representation should include: • CCGs • local authorities, including: - social services - drug and alcohol services - education - housing and employment - public health • mental health services • physical health services • primary care, including Primary Care Network representatives • service users and carers • VCSE organisations.

3. Develop a shared vision and objectives reflecting the local context and the needs and wants of the public.

One way of achieving this is through multiyear alliance contracting. An overarching contract across organisations means that each member organisation is contractually mandated to achieve the same objectives.

4. Develop an appropriate governance structure for the system of care, which must meaningfully involve patients and the public in decision-making.

5. Identify the right leaders to be involved in managing the system and develop a new form of system leadership.

6. Agree how conflicts will be resolved and what will happen when people fail to play by the agreed rules of the system.

7. Develop a sustainable financing model for the system across three different levels:

- the combined resources available to achieve the aims of the system
- the way that these resources will flow down to providers
- how these resources are allocated between providers and the way that costs, risks and rewards will be shared.

8. Create a dedicated team to manage the work of the system.

9. Develop ‘systems within systems’ to focus on different parts of the group’s objectives.

10. Develop a single set of measures to understand progress and use for improvement.

When introducing outcome measures, consider:

- the rationale (why outcomes are being collected and in what context)
- the opportunity cost (balancing the value of the data against the time taken to collect it)
- whether the measure is at the individual, service or system level. STPs/ICSs should also consider integrated, system level outcomes and indicators that are meaningful to the range of provider.

The King’s Fund has further details on the ten design principles
Key points to consider in developing your proposals for community mental health care provision for older people

It should be built around existing GP practices, neighbourhoods and community hubs – elements that make up the new Primary Care Networks. The configuration of each team will be determined by each local area, based on its population’s needs.

The involvement of service users, families and carers is critical in the co-design and co-delivery of new local approaches.

It should also include intensive and assertive support, long term care, and support for those who may be at risk of exclusion from their community, including:

- people leaving the criminal justice system or people with multiple vulnerabilities frequently in contact with the police
- rough sleepers
- socially excluded people
- those with very complex needs, such as people with disabling psychotic disorders or people with disabling complex mental health difficulties associated with a diagnosis of “personality disorder”.

Consider how your proposal is responding to the impact of and needs caused / exacerbated by the pandemic, in which older people are particularly impacted.

Consider how your proposal links with the Ageing Well and frailty integrated local workstream.

Assessment process

People need to be able to have a good-quality assessment at whatever point they present. In this Framework, there will be a “no wrong door” approach to accessing care. People with the full range of mental health problems will be able to access support, care and treatment in a timely manner and from wherever they seek it, whether from their GP, from a community service, through online self-

It relies on communication and respect between professionals from different backgrounds and settings – and a mutual understanding about the approach to assessment. Assessment can be undertaken by different members of the core community mental health service at the point at which a person seeks access, though staff must be suitably qualified. It will vary according to the needs of the individual and the complexity of their problem(s).

Assessment can be a relatively brief initial contact in which an understanding of the person’s current problems and a shared view of an intervention have been developed and agreed with them.

Coordinating and planning care

Every person who requires support, care and treatment in the community should have a co-produced and personalised care plan that takes into account all of their needs, as well as their rights under the Care Act, and Section 117 of the Mental Health Act when required.

The level of planning and coordination of care will vary, depending on the complexity of their needs.

People with more complex problems, who may require interventions from multiple professionals, will have one person responsible for coordinating care and treatment. This coordination role can be
provided by workers from different professional backgrounds whilst facilitating greater role for carers

The care plan will include timescales for review, which should be discussed and agreed with the person and those involved in their care at the outset.

Interventions

In a place-based integrated service, available interventions should include access to psychological therapies, improved physical health care, employment support, personalised and trauma-informed care, a medicines management and support for self-harm and co-occurring drug or alcohol-use disorders.

Interventions for mental health problems need to be readily available and accessible at the location most appropriate to people’s needs

The intervention itself may comprise a simple, short advice session that enables the person to obtain help for themselves, or perhaps no further help will be required. Digital technologies, such as mobile applications, may be used.

Care can be stepped up where or when more specialist care is required, and stepped down, in a flexible manner without the need for cumbersome referrals and repeated assessments People with the highest levels of need and complexity will have a coordinated and assertive community response

There need to be effective links with community assets to support and enable people to become more embedded within their community and to use these assets to support their mental health.

Care will build on existing skills and expertise however, a specific “community connector” or “social prescribing link worker” role might need to be created (or the functions of that role carried out by, for example, peer support workers, recovery coaches or care coordinators).

Part of everyone’s role is to work with their community.

Workforce

While this list is not exhaustive, key roles in local place-based, multidisciplinary services could include:

- administrative staff
- clinical psychologists
- mental health nurses
- mental health pharmacists
- occupational therapists
- primary care staff
- psychiatrists
- psychological therapists
- social workers and other local authority workers (for example, housing support workers and debt advisors)

Services should also make full use of newer roles, including:
- community connectors/social prescribing link workers
- paid peer support workers/experts by experience.
  Having a collaborative and integrated approach to delivering care also means that skills and competences can be shared across multiple disciplines.

There are some early implementer sites which are listed below
Cambridgeshire and Peterborough STP
Cheshire and Merseyside STP
Frimley Health and Care ICS
Herefordshire and Worcestershire STP
Hertfordshire and West Essex STP
Humber, Coast and Vale Health and Care Partnership
Lincolnshire STP
North East London STP
North West London STP
Somerset STP
South Yorkshire and Bassetlaw ICS
Surrey Heartlands Health and Care Partnership