Bath & North East Somerset Council

NHS
Bath and North East Somerset
Clinical Commissioning Group

How can we improve coordination across mental, physical, social and wellbeing services in the community?

Workshop engagement report
June 2018

In June 2018, we held a workshop and evening drop-in event to give people an opportunity to share their views on how we can improve coordination across mental, physical, social and wellbeing services in the community.

We invited people who use services, those who care for them, those who deliver the services and the wider public to attend these events, and 32 people attended:

- Seven people who use services, carers and members of the public
- 25 professionals/providers of mental health services

Summary

Attendees were given an overview of the community mental health services review, including a summary of the scope of the services that were being considered within the programme, as well as information about what people have told us works well and what people would like to see change.

A sub-group focusing specifically on how we can co-ordinate mental and physical health services, including through future Care Co-ordination hubs, were asked to consider a number of questions:

1. What do we mean by care co-ordination?
2. How well does care coordination work at the moment for people with a mental health issue?
3. What would work well for people in future in models for integrating mental health in care co-ordination?
4. Considering some potential options for incorporating mental health into a care co-ordination hub, what are the strengths and weakness of each option?
5. Are any of the options likely to improve on the current approach?
6. Are there other options or ideas you would like to see happening for care/ service coordination?
7. How would you like care to be coordinated for you between your mental and physical health? If you see someone about your physical health, would you like people to ask about your mental health too?

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What people told us

What do we mean by care co-ordination?

During the first part of the session, the whole group talked about what we mean by the term care 'co-ordination', exploring the differences between the use of the term in some parts of mental health services, and its use here to describe an approach of wrap-around care – where a hub co-ordinates both the mental and physical health needs of individuals.

Three possible options for a hub model were outlined (see Appendix 1) and the group looked at some case studies of people who might potentially use a hub (see Appendix 2).

There was then group work discussion which focused on the following areas:

What would work well for people in future in models for integrating mental health in care co-ordination?

The following issues were raised by attendees:

- Why not start with GP (or Primary Care Liason Service (PCLS)?)
- Need to differentiate needs of people needing secondary services
- Assessment by phone would not be as good as face-to-face
- How can Adverse Childhood Experiences (ACE) and Trauma Informed Care (TIC) be built into our thinking?
- Police control room triage is a good model to identify both mental health needs and wider needs
- Need to ensure that person gets to right help at right time
- How will sensory disabilities (e.g. deafness) be dealt with by the single point of access?
- Thresholds too high for mental health services – there should be something before PCLS

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Considering some potential options for incorporating mental health into a care co-ordination hub, what are the strengths and weakness of each option?

- Information as appropriate – not giving all the details.
- Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) should be involved at triage stage, to help reduce inappropriate referrals. But it's also important to ensure that a person is guided to the service best paced to support them. If they need mental health support, then they should be transferred to AWP, but ensure linking back into wider network for other issues such as physical health specialist services and social care.
- Enable more creative working across physical health and mental health e.g. shared packages of care. Avoid funding battles.
- Crisis issues are not further delayed through call centre model.
- Whichever option, make sure specialist skills are not diluted.
- Caution around 'Jack of all trades' approach.
- Important that primary need is identified effectively.
- Joint assessments where appropriate.
- Better awareness of mental health/physical health between professionals.
- Caution around 'impersonal' call centre, as could prevent service user/carer engaging.
- Guide a person through available options for support.
- Information across systems to support better care and who is involved.
- Technologies to help advise people in the hub.
- Technology can be a barrier for some – e.g. due to lack of access to internet. But can be good for others e.g. people who are working.
- Mental Health nurses in practices in some areas – this would fit with Option 1.
- Signposting – how to access a service. Haven't seen someone at an early stage.
- Less of a culture of entitlement in B&NES.
- Should have someone in hub with specialist mental health knowledge who could do whole cycle.
- Barriers to making first phone call – important not to add to these/exacerbate.
- Ongoing, rolling assessment.
- People not necessarily presenting with mental health needs.
- If mental health community services come in to Care Co-ordination Centre, this could separate it from inpatient mental health services, which could cause risk.
- Risk of duplication at the moment – more collaborative working would help – problem of using different IT systems at the moment – solution = Integrated Care Record (ICR).
- Shared record would need to be held by the hub.
- There are opportunities to improve the current processes.

- Links to Wellbeing Options website, and give people hard copies, as can't rely solely on online. Online and leaflet 'bank' to mirror structure of hub.
- Collating information.

One group considered the case studies shared earlier in the session and how a care co-ordination hub could work for those people:

Millie – how would she know how to access things? Currently she would go to the diabetic nurse and might stay with them signposting to services. In the future, would the diabetic nurse refer to the hub?

Richard – therapies team – GP could refer. If there was an online app with a questionnaire to complete by the person themselves, would they do it? Motivation? Literacy rates low in armed forces leavers. Resettlement package from army – now includes early service users. Mental Health issues from childhood possible – TILS service. Help for Heroes regional rehab centre – do GPs know about that? Could hub have that? From GP? Could be a specialist veteran mental health person in the hub. If Richard has come directly to the hub should he go to secondary services? Could hub provide advice/guidance to e.g. GP.

Jenny – Wellbeing college – if presents as e.g. smoking – should the care co-ordination centre step back and look at her holistic needs? Rural areas – things held in centre of Bath. But – use of Village Agents? Connecting hub and Village Agents etc. to each other. Hub would be great for Jenny.

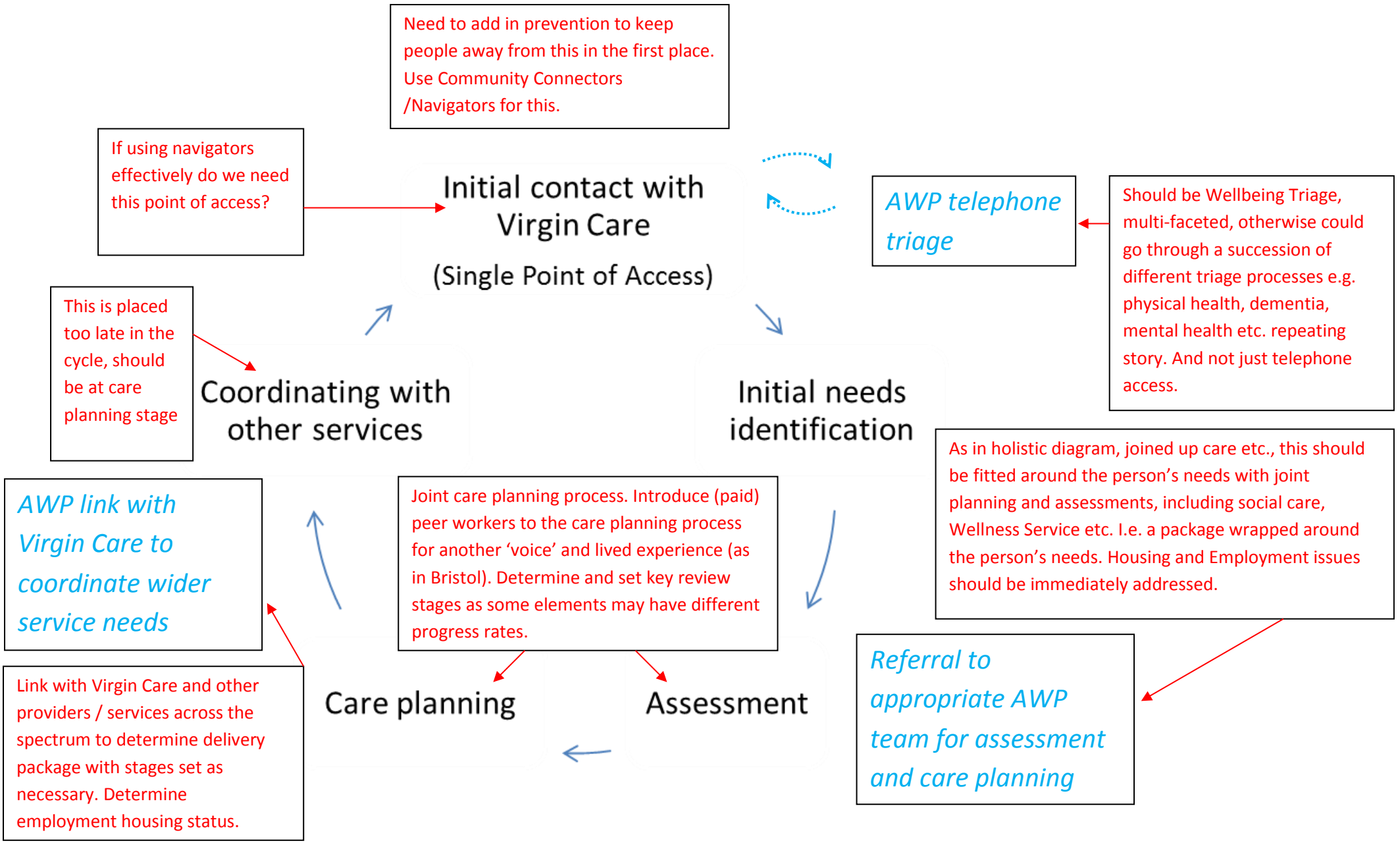
George – who would go to the hub? Long-term condition link to depression. Need for triage person in the hub. Need for management of complex medications.

Why will people go to the hub? What would change that? Telephone services in particular can be off-putting – e.g. NHS111.

Several groups considered the different options for hubs, and made comments on these:

Option One	Option Two	Option Three
➢ Increased stigma due to handover ➢ Delay in access to other services ➢ Not holistic ➢ Repeating their story ➢ Slipping through net ➢ Making people "fit into boxes" ➢ Working very separately ➢ Lack of care co-ordination in primary services ➢ Feeling of "being passed from pillar to post" mars initial relationship ➢ Delay from primary to secondary services	➢ Someone with expertise at triage stage ➢ If triage is not face-to-face – increased risk ➢ Additional step for people who use services ➢ Potentially better work with Virgin Care colleagues ➢ Expertise at triage stage could improve signposting to services	➢ Disjointed model ➢ Disjointed experience for people who use services/carers ➢ Repeating their story ➢ Co-ordination with Virgin Care is late in process

Option 3: Mental health embedded and makes use of wider care coordination staff



Are there other options or ideas you would like to see happening for care/ service coordination?

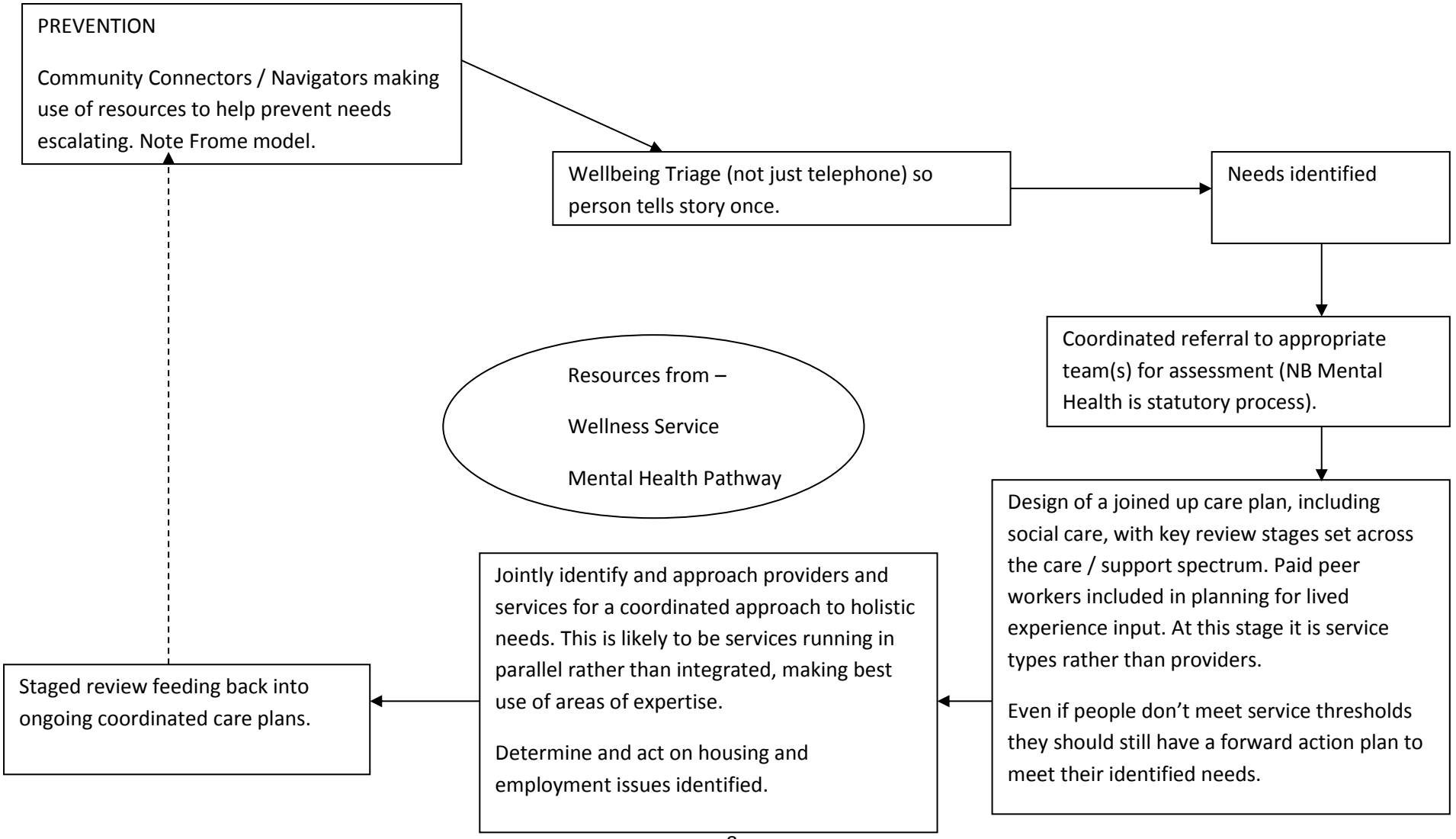
One group developed their own fourth option which centred around a single point of access to the hub. In this model, key elements identified were:

- Information available
- Apps for young people for access
- No hand offs
- No barriers to referral
- Signposting
- Quick access, but not geographically wed to a particular hub
- GPs involved
- Balance of professionals and third sector reps
- Home visits
- Phone line
- Appropriate and timely expertise
- Range of options for assessment including self-assessment and face to face
- Advocacy
- Triage
- Evening opening times
- Navigator role – stays with person
- Physical hub people can go to
- Surrounding and enabling all this, the group identified the importance of trust, shared values, shared vision, culture change and honesty

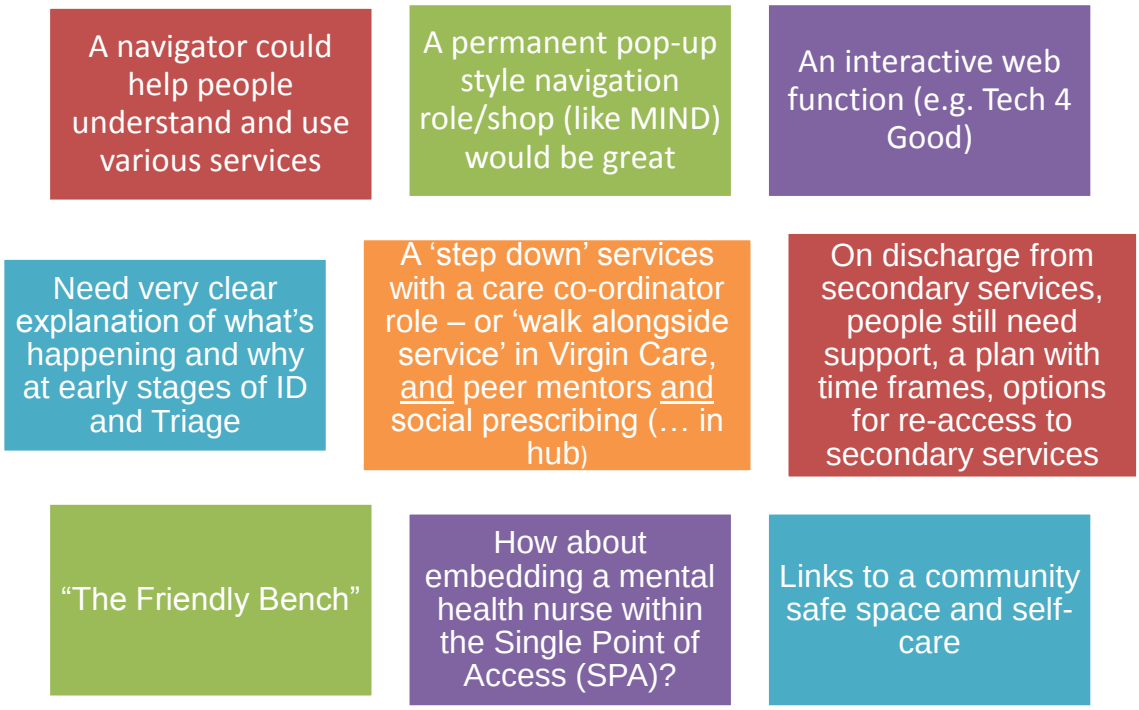
Another group developed a variant on option 3, which can be found on the next page:

Revised Option 3

Mental health embedded and makes use of wider care coordination staff



Attendees also came up with some creative ideas for a hub:



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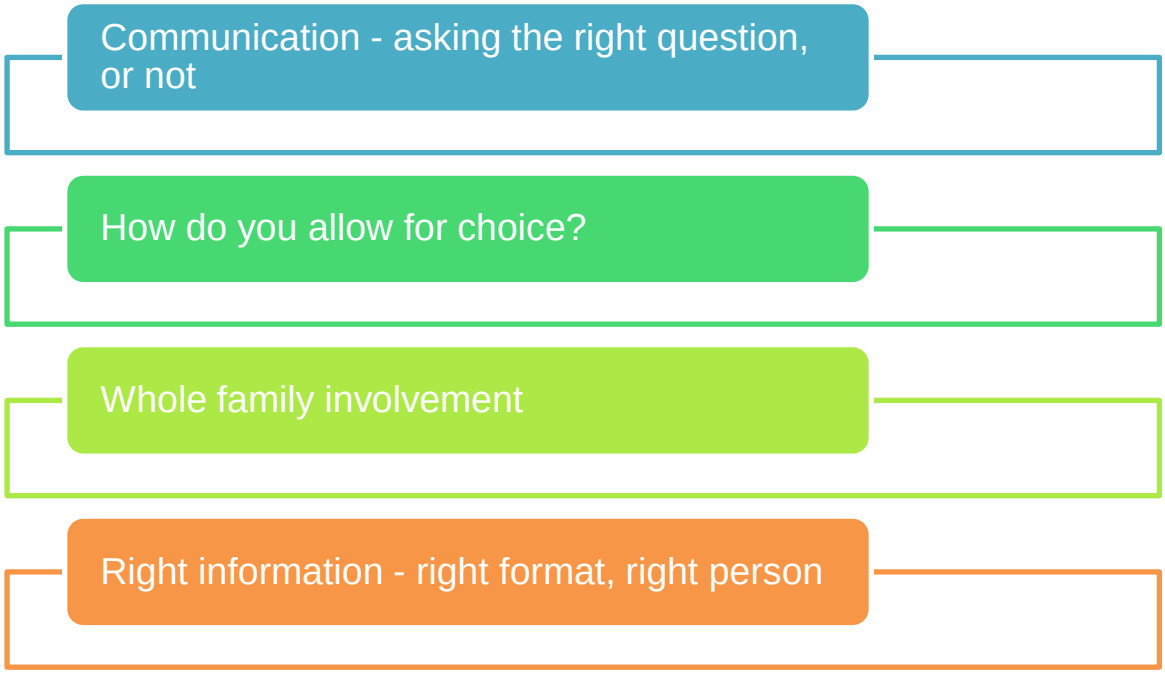
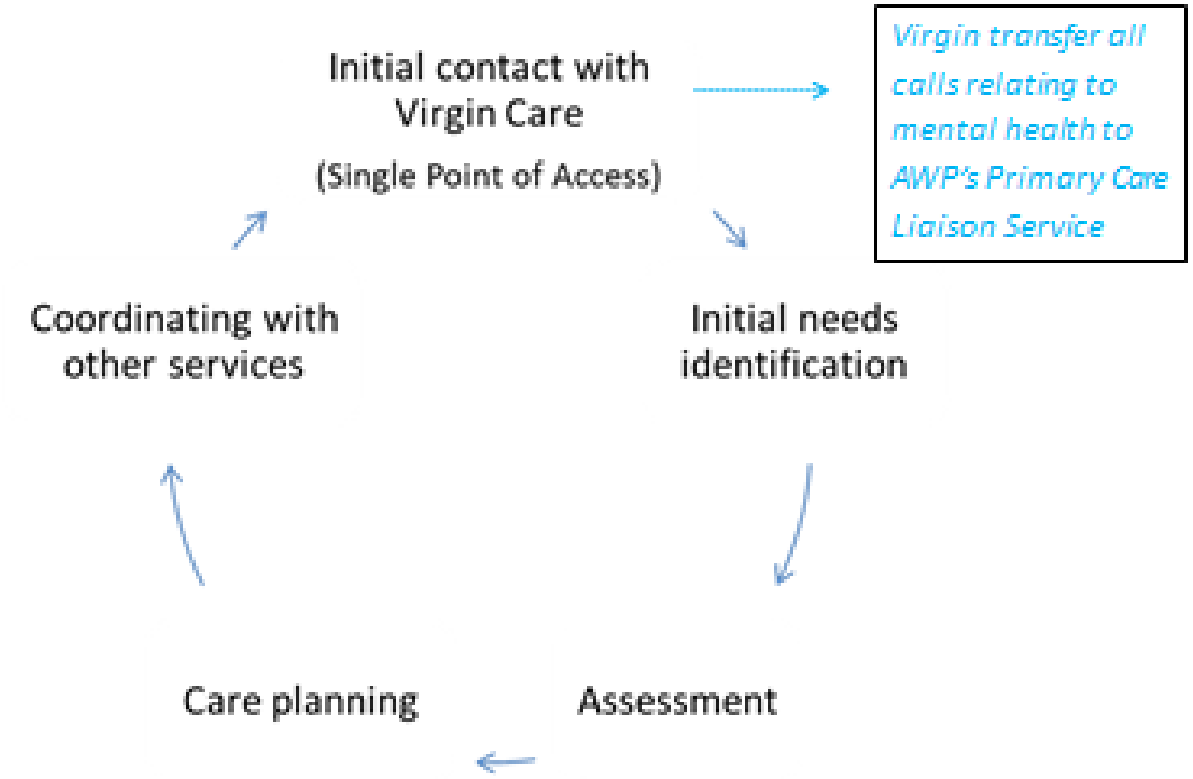


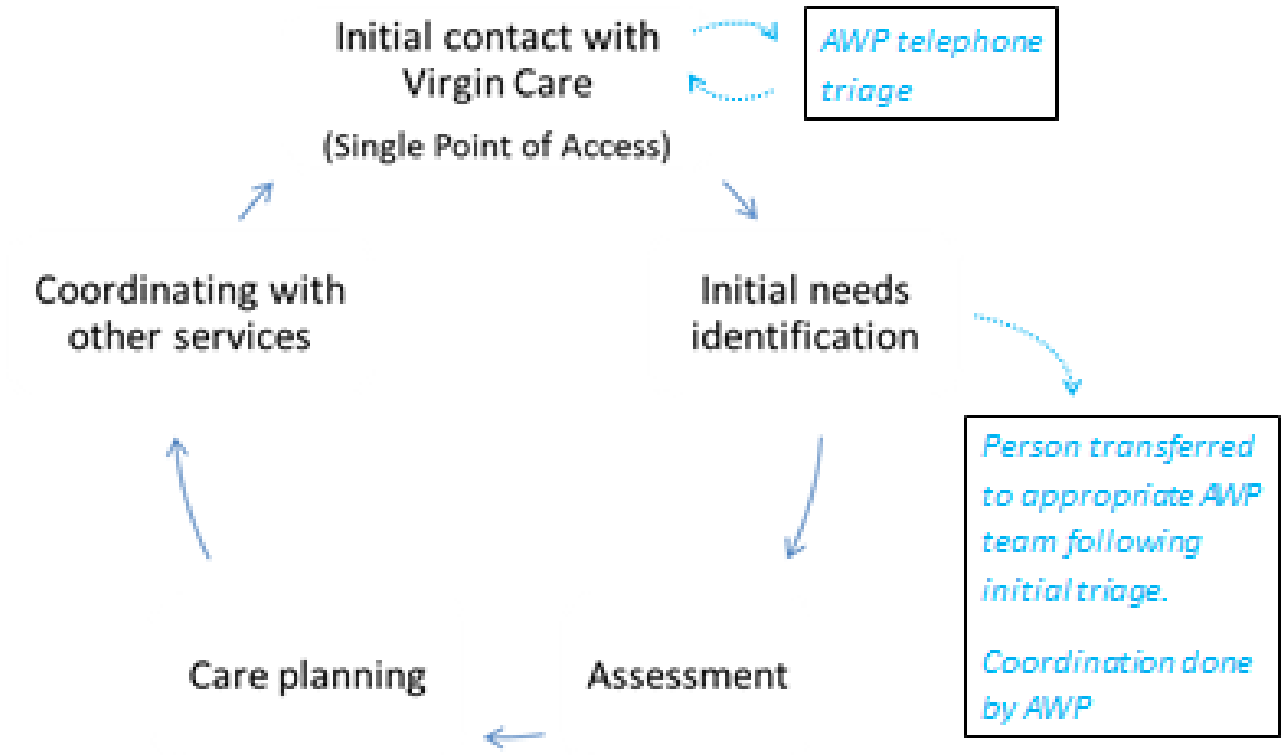
Actions and next steps

The key conclusions reached as a result of this engagement, include:

Option 1: Mental health stays completely separate



Option 2: Mental health staff available at the initial contact point



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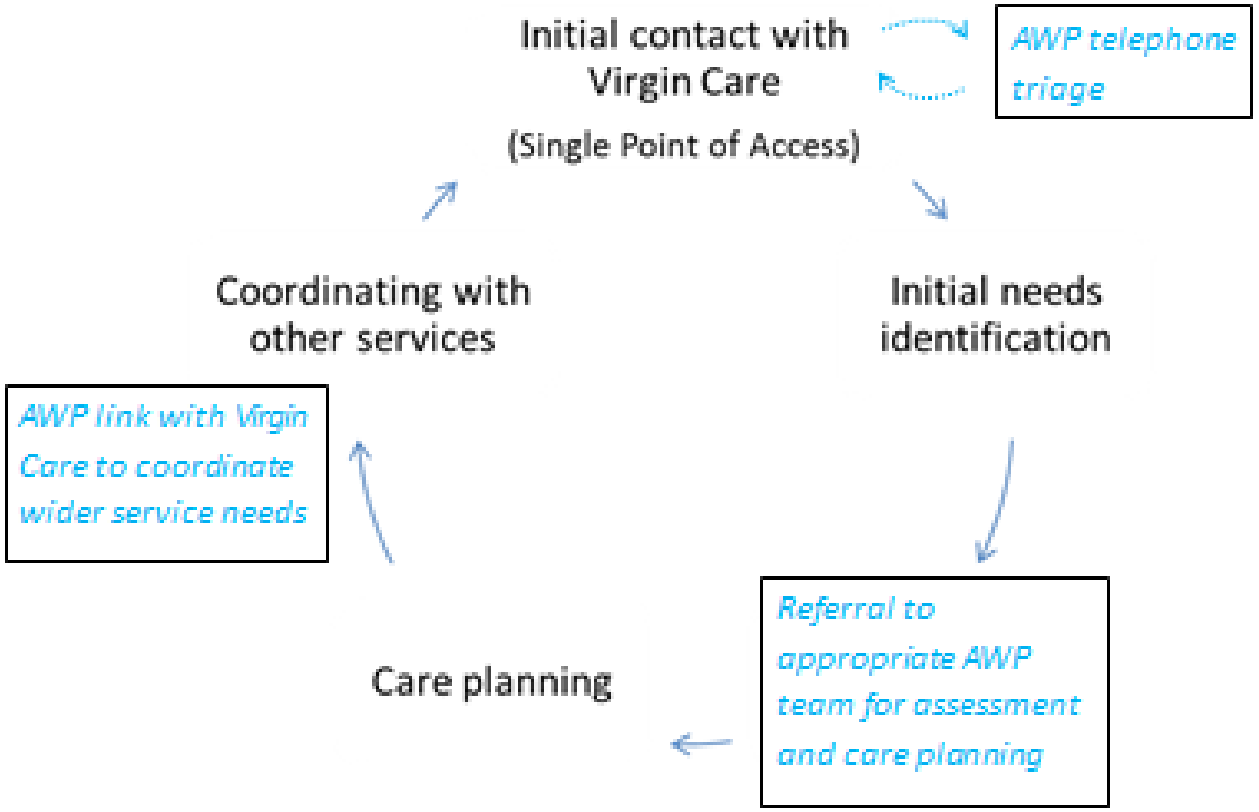

Millie
Millie is an 18 year old girl from Keynsham who sees her GP each year for her diabetes. Her diabetes is not very well controlled. Sometimes she feels down about things and says that she occasionally self-harms and also seems to be drinking alcohol at levels that may be risky in the short term and harmful in the long run.

Richard
Richard is a 37 year old veteran of the armed forces living in Bath. He is physically fit but smokes, is not currently in work, reports having limited social contact and at a recent GP visit it was suggested he may have post-traumatic stress disorder.

Jenny
Jenny is a 41 year old woman from the Chew Valley. Following a conversation with her local work coach it emerges that she had a period of mental illness some years ago and stopped attending appointments with mental health services. She is overweight, smokes and is living in temporary accommodation. Previously she was living in Midsomer Norton which is where her friends and family are.

George
George is a 78 year old man from Radstock who is referred to B&NES community services after seeing his GP. His GP has seen him for some time about his lung condition but George is not always taking his medication, his condition seems worse and his GP also thinks he may have symptoms of depression. He is a carer for his wife and is worried she may be developing dementia.

Ava
Ava is an 83 year old lady who had been living alone in Midsomer Norton and has moderate dementia. Her family have temporarily moved in to support her and have become concerned about her, noticing that she appears to be having distressing visual hallucinations, insomnia and agitation. They want to know what support she might need and advice about care options for the future

Zoe
Zoe is a 26 year old woman from Bath who is 22 weeks pregnant. Her midwife becomes aware that she has been feeling low in mood and stressed, and she has a history of bi bipolar affective disorder. The midwife believes Zoe may not yet be at the point of being eligible for a perinatal service.

Fred
Fred is a 75 year old man with dementia presenting with complex behavioural needs which occurred predominantly in the afternoon and early evening. Fred's wife has been his main carer but now feels she can no longer cope and her own health is beginning to deteriorate.