Redevelopment of Adult Community Mental Health Services

Sheffield LMC

Michelle Fearon, Service Director of Operations & Transformations and Mike Hunter Medical Director, Sheffield Health & Social Care NHS Foundation Trust (SHSCT) attended a meeting of the full LMC on Monday 13 May 2019, to give an update on the redevelopment of adult community mental health services.

An invitation was emailed to all represented Sheffield GPs and 12 GPs attended as observers.

Below is an extract from the approved minutes of the meeting:

Changes to date

- The reconfiguration began 12 months ago and, to date, has resulted in a 'family' of adult community mental health services comprising the introduction of a new service model, a Single Point of Access (SPA), dedicated service provision into early intervention, dedicated home treatment provision and a recovery services model.
- The system was designed based on the prevalence and use of Sheffield's mental health system for adults in the 2 years running up to the reconfiguration.
- The SPA was designed to receive 8000 referrals a year. As of the end of March 2019 9,822 referrals had been received and processed, almost 20% more than had been capacitised to deliver, causing delay in the system.
- One of the most frequent complaints from GPs and other referring agencies is regarding the phone systems / duty system. On average 120 calls per day and 250 duty calls per week are received with 3-4 staff answering those calls. Demand has been significantly higher than the modelling predicted. Unexpected peaks where referrals are 'saved up' and sent in tranches have also been difficult to manage and have a knock on effect.
- On a positive note, the number of people waiting for routine ongoing mental health care has been reduced from 927 to 700 due to the creation of services bridging the gap between what is available in primary and secondary care.
- On average the answered call rate is 78% and compares well with other national services but it was acknowledged that improvement is still needed.
- In terms of managing the challenges a product called UC analytics is being used to analyse volumes & times of calls, resources and responses to peaks in demand. There is now a greater ability to understand demand than previously. Work is in progress to look at how speed of referral / response can be influenced and how to manage demand.
- In addition it is hoped to recruit further administrative and triage support within SPA. However, the work is complex and demanding and attracting staff is often difficult. Further work is ongoing to look at how to retain and support the workforce.

Adult Community Mental Health Recovery Services

- Recovery services are designed to support people with more complex and enduring mental health needs.
- Similarly to SPA:
  - Demand for recovery services has far exceeded the expectations based on demand in the 2 years prior to reconfiguration. This has had significant consequences for services users and the workforce.
  - A deep dive has been carried out on the newly configured service to understand demand.
- As a result, the Care Trust has agreed to some immediate investment in recovery services through increasing the cost improvement target levy to fund this additional capacity. In addition, discussions are ongoing with health and social care commissioners.
- The emphasis is to optimise the service offer for the citizens of Sheffield. However, there are still challenges to overcome before there is a fully funded mental health system in Sheffield.

Future Strategic Direction

- It was noted that the consequences of 10 or more years of austerity on Sheffield as a relatively poor northern city has had a significant impact on people's lives and, therefore, also their mental health.
- The Care Trust has a good 10 year plan and the national team has secured funding that would be new recurrent funding for mental health. Over the course of the 10 years this would be £26m for Sheffield.
- Mike proposed the emphasis should be to work with Neighbourhoods and the new PCN Clinical Directors to scope and define a properly funded and resourced primary care mental health service. It was argued that a secondary care setting was inappropriate for the typical cases presenting at the SPA such as bipolar, ADHD, depression and concerns relating to poverty / unemployment. Many referrals are received from GPs indicating that primary care has run out of options. However, the mental health specialist services do not currently have an alternative comprehensive offer.
- It was hoped that the funding and focus on more specialist community mental health services in the 10 year plan for people with more complex or severe mental illness will result in improvements in service delivery.
- Two pilots had already been carried out with Neighbourhoods in high referring areas looking at different ways of working that had had success in reducing the number of referrals.
- In a year's time the aim was to ensure referrals were more timely and the referral process more seamless, with the issue where patients fall between inclusion / exclusion criteria for a number of specialist services being addressed, and the patient experience of care more consistent in terms of quality.

Questions / Feedback

- Numbers of mental health cases presenting at GP surgeries were unprecedented and many felt overwhelmed by the complex nature of the cases, lack of experience / familiarity with medication, lack of options available and inadequate communication between services.
- Delays within IAPT were becoming a major barrier to patient care. In addition patients no longer needing specialist input sent to IAPT are often turned away by IAPT, being deemed unsuitable for their service. It was argued this demonstrates a significant disjunction between what secondary care thinks IAPT does and what IAPT is willing to do, and should not be the responsibility of the GP to resolve. Michelle understood the frustration and explained that despite being run by the same Trust, as a nationally commissioned service, IAPT had clear fidelity to a model with strict referral criteria and that the service could not receive referrals from secondary care. The Clinical Director for IAPT had recently been tasked to find a solution. Michelle also informed attendees that there has been a 40% increase in demand by individuals seen by crisis and liaison services.
- The lack of response or not receiving letters from mental health services in a timely manner was particularly frustrating.
- The majority felt positive regarding a Neighbourhood community based model, but were concerned that resources, lack of support / education and the historical poor communication between primary and secondary care might be barriers. Mike acknowledged that relationships were of prime importance to any successful model and that he was determined to work creatively with Neighbourhoods in order to address the challenges.
- Patients referred by GPs for possible personality disorder are often seen by a clinician that is not a psychiatrist and, therefore, sent to IAPT for further consultation rather than being diagnosed. In addition questions / letters asked by GPs on referral often do not appear to have been read and come back unanswered, making ongoing management of a patient 'returned' to primary care more difficult for the GP who may be unfamiliar with the condition. Mike felt this was partly due to historical 'anti-psychiatry' attitudes in Sheffield and that communication / feedback for the GP had previously been underestimated. Future models would try to address this.
- Instances of the Eating Disorder Service refusing to take patients with complex conditions were exacerbated by the service currently being without a consultant. Michelle advised that another consultant should be providing cover and offered to follow this up.
- The statistics relating to percentage of calls answered within the slides did not tally with GP experience, many having to wait on hold or being put through to voicemail, even when selecting the option for 'urgent'. Mike explained that improvements in telephone systems were ongoing but had not progressed as quickly as hoped. To date it had not proved possible to purchase a system that both collected the desired data but also met the necessary clinical governance standards. Recently there had been a renewed drive to progress this.

- Assessment reports are lengthy but have limited valuable clinical information for GPs, often having no clear conclusion / care plan and no job title attached to the signature, making it unclear who has assessed the patient. Mike and Michelle agreed that this was unacceptable, advising that a nurse consultant had been tasked with examining the quality of triage and assessments.
- University practices struggling with a high number of young people with mental health issues and trying to prevent issues like personality disorder escalating at an early stage found it particularly difficult to support students with the 6 month wait / delays with STEP for the understanding personality disorder group. This is exacerbated by the lack of continuity in engagement as a result of lengthy holiday periods when students relocate. Mike agreed, adding that the evidence based interventions for mentally unstable personality traits are Dialectical Behavioural Therapy (DBT) and mentalisation psychotherapy which were available in Sheffield but very much specialist therapeutic services and hence waits were significant. A possible solution might be to look at an expansion of the IAPT function using the existing infrastructure, introducing a greater number of therapists and a better mix of psychologist, psychotherapist, IAPT therapist etc, and to pilot evidence based treatments at Neighbourhood level. Michelle advised that the work with the practice pilots had looked at students in particular, recognising them as a transient group.
- The transfer from CAMHS into adult services was of concern and it was noted that there had been some tragic deaths. Mike advised that there was now an interim solution in the form of a declaration of intent between the two organisations to try to cover that gap. Sheffield CCG was looking at a business case for a more sustainable solution.
- A current pilot using an emotional wellbeing worker employed in a Neighbourhood model had reduced GP workload. GPs often have insufficient capacity for regular appointments for mental health patients. This type of pilot had been proved nationally and, in this particular example, the wellbeing worker had managed to engage patients in therapeutic intervention when they had previously failed to engage with IAPT. The Care Trust was asked to consider funding for continuation of the pilot and other similar schemes. Mike agreed with the arguments advising that similar conversations had already taken place with the CCG and he would be keen to look at the possibilities at Neighbourhood level.

Mark Durling thanked the speakers and observers for their time and contribution and remarked he would like to invite the speakers back at an appropriate interval. Bullet points of the meeting would be shared with all attendees when available.

Mike stressed that if GPs encounter circumstances where the spirit of partnership and working together creatively to crack complex issues is not forthcoming, he should be contacted directly for assistance. It was agreed that his and Michelle's contact details would be circulated via an LMC newsletter:

Michelle Fearon michelle.fearon@shsc.nhs.uk
Mike Hunter mike.hunter@shsc.nhs.uk