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Adult Mental Health Services – Shropshire, Telford & Wrekin

23rd September 2024

MPFT

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Location of Services

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Shropshire, Telford and Wrekin
Mental Health Services
MPFT Sites where we see our patients

Salop Road, Oswestry and Cottage Hospital, Market Drayton

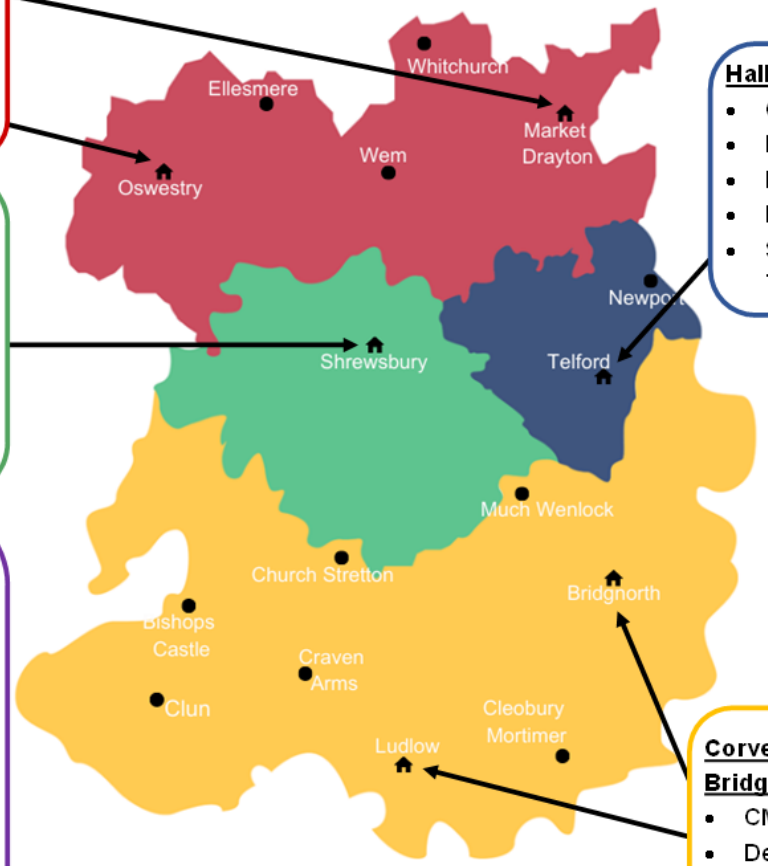
- CMH North Shropshire
- Dementia Shropshire, Telford and Wrekin
- Shropshire, Telford and Wrekin Talking Therapies

Severnfields, Shrewsbury

- CMH Shrewsbury East
- CMH Shrewsbury West and Rural
- Dementia Shropshire, Telford and Wrekin
- Intensive Life Skills
- Early Intervention
- Shropshire, Telford and Wrekin Talking Therapies

Adhoc places where we see patients:

- A&E
- Patient homes
- GP Practices
- Libraries
- MIND
- Outdoor spaces – community gardens, walks
- Nursing Homes
- Community/Day Centres
- Coffee Shops/Cafés
- Supermarkets
- Leisure facilities
- TACT/Branches



Hall Court, Telford

- CMH Telford and Wrekin
- Dementia Shropshire, Telford and Wrekin
- Intensive Life Skills
- Early Intervention
- Shropshire, Telford and Wrekin Talking Therapies

Corve Street, Ludlow and Northgate House, Bridgnorth

- CMH South Shropshire
- Dementia Shropshire, Telford and Wrekin
- Shropshire, Telford and Wrekin Talking Therapies

Tackling Rurality

- Service provision across the county at MPFT bases.
- Additional ad hoc spaces are utilised to provide care closer to home/in reach including Crisis Cafes.
- SMI Physical Health pathway use Whzam boxes to undertake health assessments in convenient places for service users.
- The availability of suitable buildings for service delivery remains a challenge and further partnership work is required.
- Digital – Voluntary Community Social Enterprise organisations were awarded grants to improve digital engagement for service users of adult mental health services, allowing them to access their personal health records, view care plans and complete patient reported outcome measures.

Transport

- Linked to rurality across Shropshire, lack of public transport infrastructure can mean a barrier to accessing services.

- Where services need to see patients in the place they call home, the time spent travelling impacts on the number of service users who can be seen.

- One solution is the introduction of RiO Consultation, a programme that allow you a video consultation, instead of travelling to a hospital or clinic.

Home Treatment

- The table below shows the number of booked appointments with patients in the place they call home from April 2024 onwards.
- This equates to 29% of all booked appointments for CMH, ILS, EIP and Crisis teams.

	Number of appointments
Attended	7890
Cancelled by Member of Staff	854
Cancelled by Patient	269
DNA	487

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System Capacity

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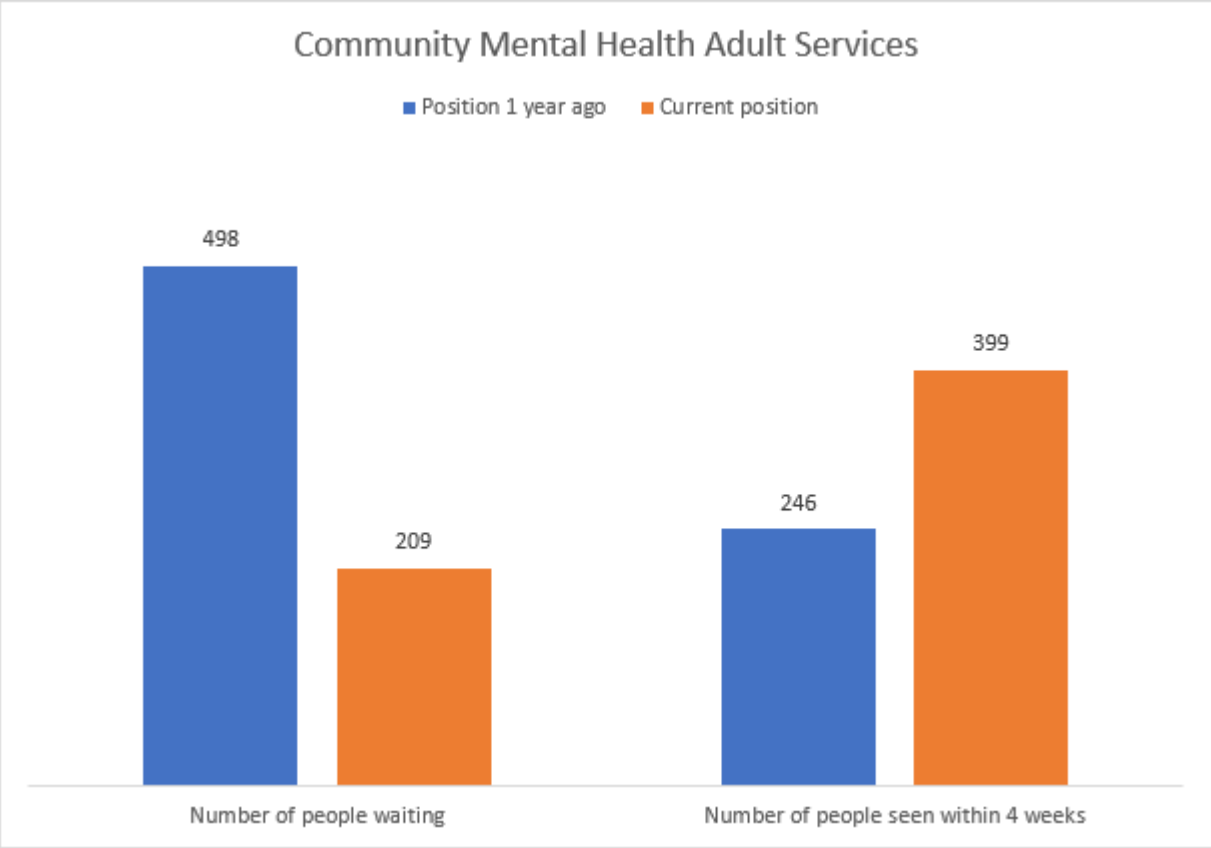
Community Mental Health Teams

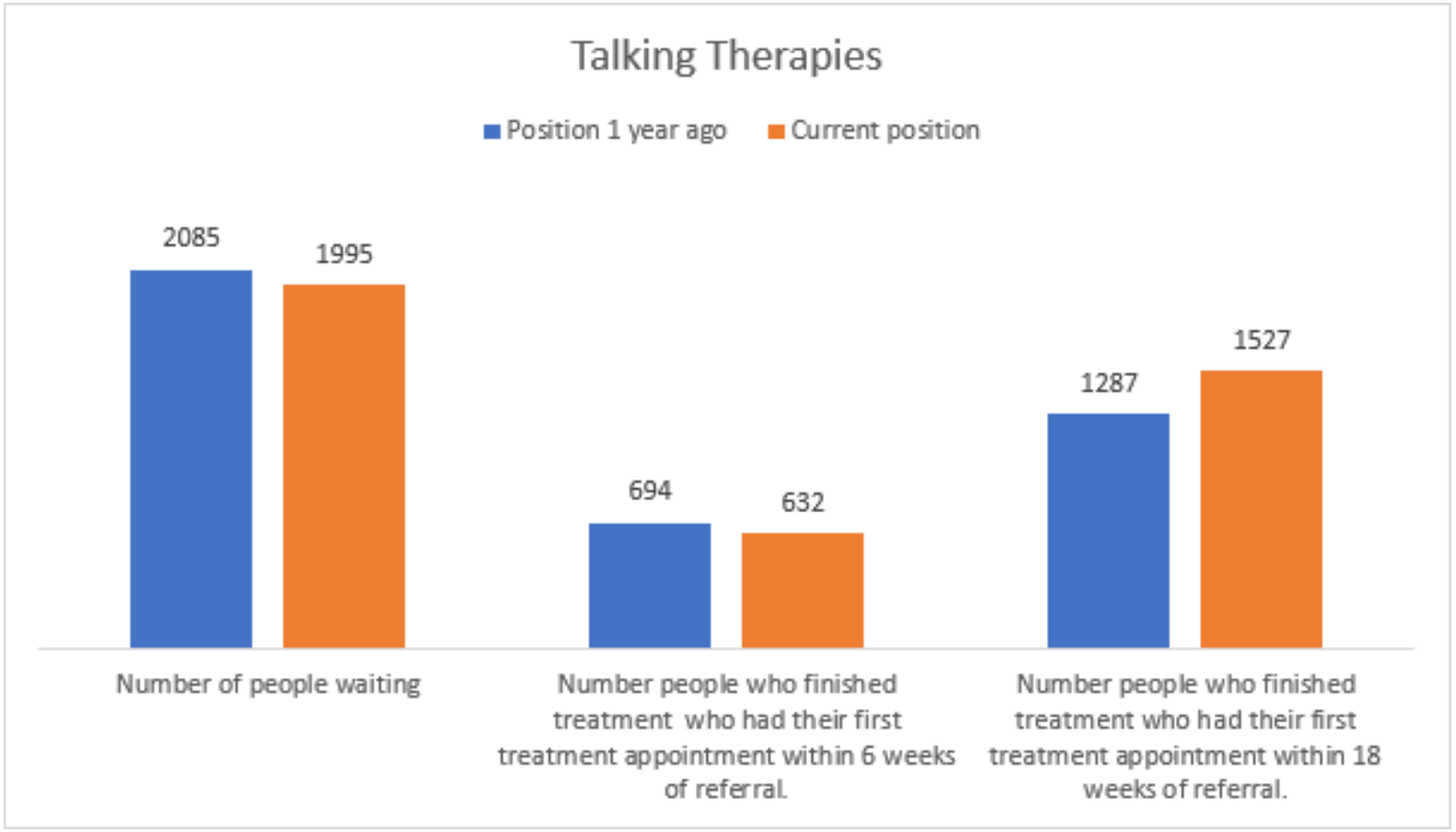


118 additional service users were seen outside of the 4-week target.

The average wait for those seen is currently 3.14 weeks.

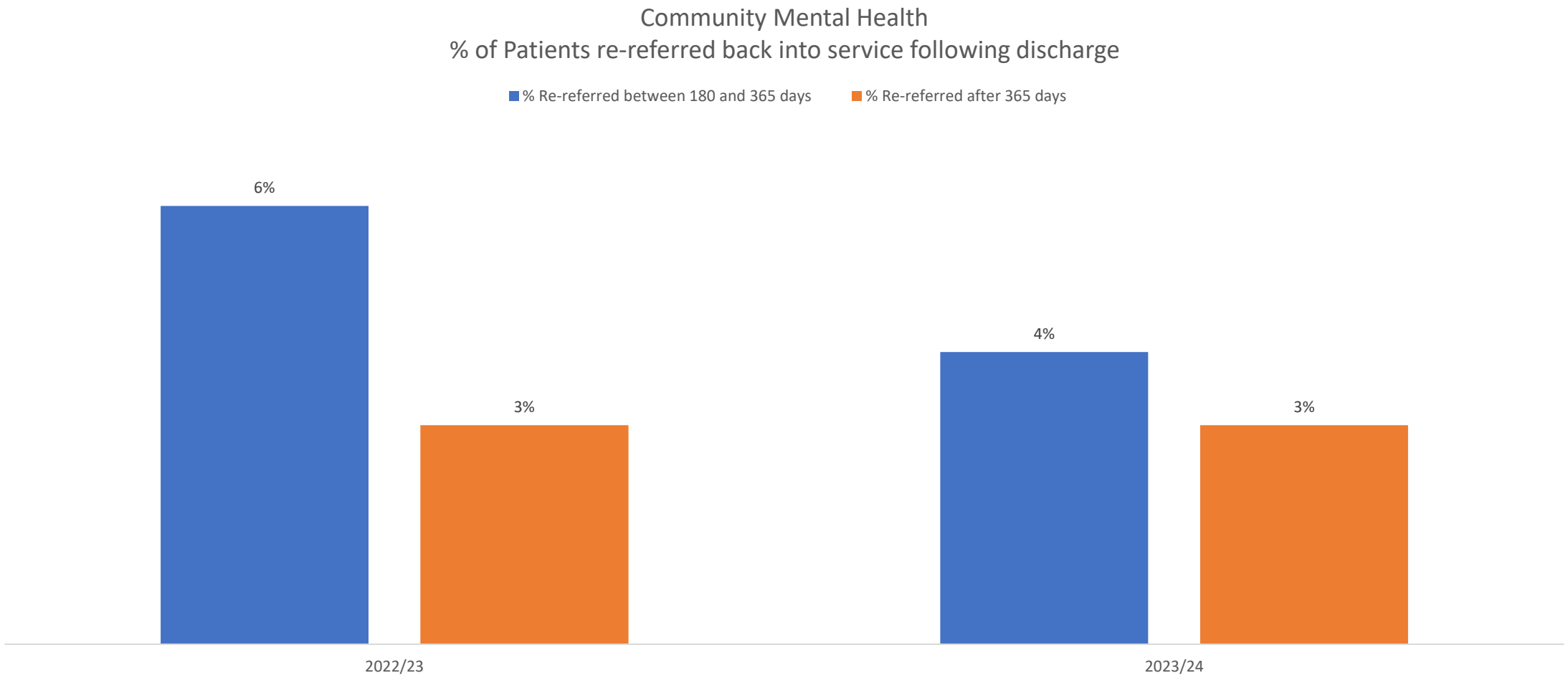
The median wait is currently 2 weeks
And the maximum wait within the last 12 months was 16 weeks.

NHS Talking Therapies



In order to ensure the service was following the national guidance on when the person enters treatment, the service agreed with commissioners to change the 'assessment and treatment' option on IAPTUs to assessment only. This meant the waiting times reported by the system would be accurate and there is now no hidden waits. Since the coding change no one enters treatment before they get the first proper treatment session.

Outcomes/Referrals



Veterans

- The Veterans Mental Health Service is a specialised support service covering the Shropshire Telford & Wrekin area, primarily focused on offering advice and information to healthcare staff who are supporting Veterans or Reservists with mental health needs. Operated by a single staff member working one or two days per week, the service provides guidance to ensure that Veterans and Reservists receive appropriate mental health care. In more complex cases, joint assessments may be conducted with staff, and in certain circumstances, short-term, direct support may be provided by adding a Veteran to the caseload. The service is designed to complement existing care and ensure specialised attention to the unique mental health needs of those who have served.

Recovery

- For people with an enduring Serious Mental Illness, each recovery journey will look different. Most will experience exacerbations throughout their lives.

Community Mental Health Rehabilitation Pathway

- Continued development of this pathway to provide a more integrated and comprehensive approach to mental health rehabilitation, reducing reliance on Out of Area placements and improving outcomes for individuals with complex psychosis or serious mental health problems. Supporting service users in achieving sustained community living.

Recovery

Recovery is
"a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness"
Antony (1993)

Recovery as a natural healing response – most people get better from most things, most of the time

Clinical recovery – recovery from symptoms and difficulties in response to effective, evidence-based, care and treatment

Personal recovery – recovery of a valued pattern of life and living, connectedness and interdependence with others, with or without ongoing symptoms and difficulties. This is linked to an active personal commitment to working on recovery

The Recovery Movement - a values-led collaborative endeavour of people in recovery, practitioners and many others, working to develop and transform mental health care and treatment

Recovery oriented approaches and services – the overall pattern of care, support and professional practice based on learning 'what works' from people in recovery conducted by staff with appropriate qualities and skills in recovery-supportive systems

Dementia Services

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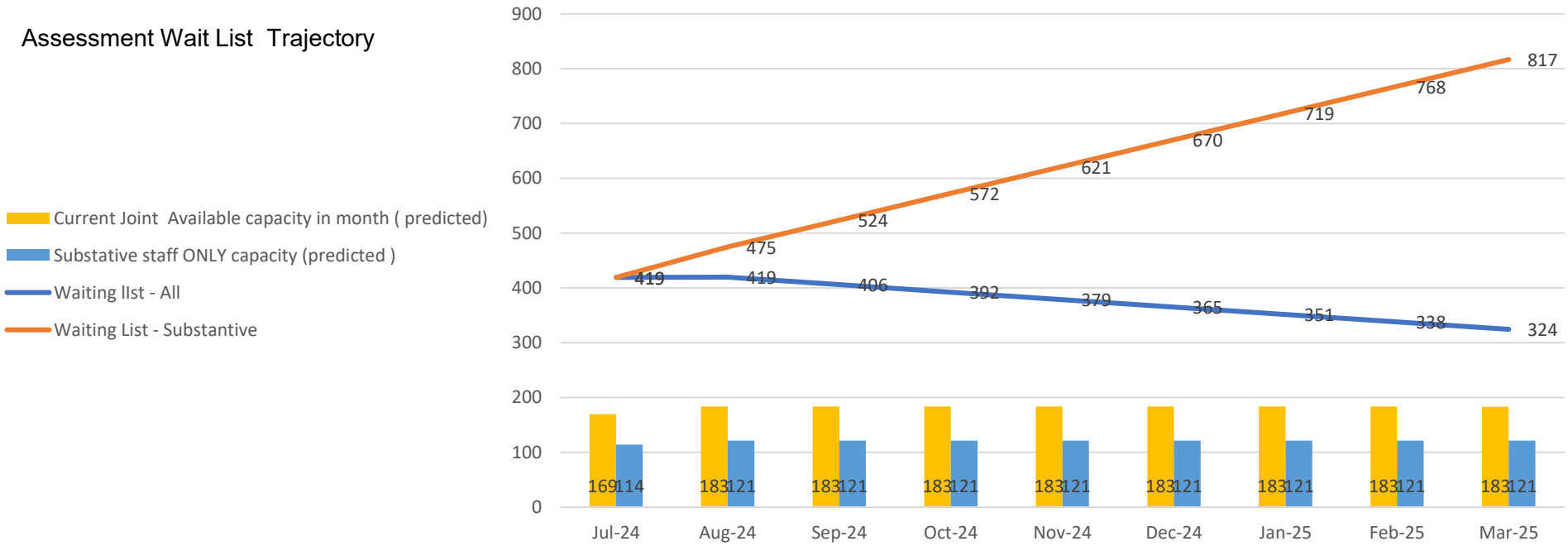
Between 2017 and 2035 the number of people aged 65+ with dementia is expected to increase by 80% in STW. In addition, those people who are aged 65+ unable to manage at least one activity on their own is projected to increase by 63%. Therefore, demand for services is shifting with greater need for services to support frailer people. We are starting to see these challenges impacting on our dementia service, with the service struggling to deliver on our expected waiting times for assessment, home treatment and 12 monthly reviews. With demand now outstripping capacity to deliver on assessments to support the system DDR rate as shown below.

Dementia diagnosis rates rises predicted (NHSE)

Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8
2024	2025	2026	2027	2028	2029	2034	2039
2,481	2,541	2,607	2,677	2,751	2,826	3,179	3,427



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Learning

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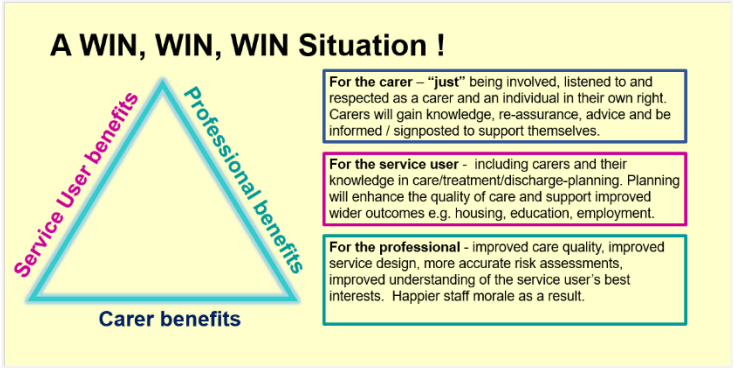
Patient Stories- PALS and Experience

- Patient experience can be defined as what receiving care feels like for our patients, carers and families and how it makes them feel. It is a key element in measuring quality, care and driving improvement throughout the Trust, ensuring that anyone who uses our service, feels listened too and that their feedback and voice are truly 'heard'.
- As patient stories can be positive, negative, or a combination of both, by listening and having one-to-one conversations, we are able to capture the everyday experiences of the very people who use the services across the Trust.
- With consent, after completing a patient story feedback is shared via a report, this will also identify any themes and themes.
- Improving patient experience is about working with the patients who use our services, to make our services better. Patient feedback allows us to identify the incredibly positive aspects of patient experience as well as the areas identified for improvement. This feedback allows us to then evolve patient care to meet the changing needs of our patients on an ongoing basis.
- Patient experience stories can be collected in a number of different ways, including via telephone, face-to-face or via online platforms. By speaking directly with our patients, carers and relatives we can have meaningful and direct conversations about the things that really matter and are important to each and every person.
- Where improvements are identified, we develop a 'you said-we-did' outcome analysis. This allows us to show what we are learnt from our patients and how we are proactively using the feedback to drive improvement throughout the services.
- Patient stories allow us to capture incredibly rich, narrative feedback from our patients and families, allowing us to learn from their experience in a way that embraces improvement as a way of refining our services into the future.

Triangle of Care



The **Triangle of Care** is a therapeutic alliance between carers, service users and professionals, aiming to promote safety and recovery and to sustain wellbeing in mental and physical health by including and supporting un-paid carers.

The Triangle of Care membership scheme enables the Trust to benchmark services against the required standards and demonstrate how the principles are embedded. This is achieved via a three-stage process for trusts who commit to self-assessing their existing services. We have already achieved level 1 accreditation through evidencing the progress of our mental health in-patient carer engagement work streams. The Trust is striving to achieve the next two by working with community teams and physical health services.

The self-assessment tool comprises of six standards:
Standard 1: Carers and the essential role they play are identified at first contact or as soon as possible thereafter
Standard 2: Staff are 'carer aware' and trained in carer engagement strategies
Standard 3: Policy and practice protocols regarding confidentiality and sharing information are in place
Standard 4: Defined posts responsible for carers are in place.
Standard 5: A carer introduction to the service and staff is available, with a relevant range of information across the care pathway.
Standard 6: A range of carer support services is available

Following the completion of the self-assessment tools services hold an Overview & Scrutiny Panel. The panel acts as a 'critical friend' to review and analyse the findings and share best practice across teams. Carers are invited to be part of the panel and it is an effective way of monitoring service delivery and performance against the overall action plan.

Triangle of Care continued

Examples of how services have developed the six standards and improved carer engagement:

Information for Carers and Families: a co-produced carer information pack that is given to carers at the earliest opportunity. The pack contains information about the trust, the service, and signposts carers to community organisations and dedicated carer services

Defining Carer Leads: services have identified ‘carer champions’ who are a named point of contact for staff, service users and carers. They promote carer engagement within the team and keeps carer resources up to date.

Engaging with Carers Training: is co-produced and co-delivered by carers. Staff can access this training as an e-learning package or face to face sessions.

Terminology explained

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Participation	Involvement	Coproduction	Lived Experience	Lived Experience Practice
"Everything that enables people to influence the decisions and get involved in the actions that affect their lives. [...] It includes but goes beyond public policy decisions by including initiatives from outside that arena, such as community-led initiatives. It includes action as well as political influence. It also encompasses the need for governance systems and organisational structures to change to allow for effective participation" - INVOLVE	"involving patients, clients, users and carers in planning, developing, and delivering healthcare services to improve quality, patient experience and outcomes through shared decision-making and recognition of lived experience expertise	"advocates for a different relationship between people and communities and the services they use, in part, as a way of moving beyond what some see as 'tokenistic' efforts at engaging people to more meaningful forms of involvement and equitable power relations. The term was originally linked to work with the disability and mental health rights movements, as well as participatory democracy. [...]. [It] is a way of working that places the input from people using services on an equal footing with those who work in the system."- The King's Fund	Lived experience as a concept is about understanding people's interactions with services from their perspective and the meanings they derive from those experiences and interactions. People with lived experience bring a different perspective to health and care policy, service design and delivery"- Loreen Chikwira via The King's Fund	An experientially focused practice undertaken by someone with their own lived experience who also holds additional skills, competencies and expertise. In health, lived experience practice (LXP) can be applied within clinical contexts (as in peer support work), educational contexts (as in peer trainers and tutors in a W&RC), to Continuous improvement or safety focused work (as in Patient Safety Partners) or strategic spaces, as in many lived experience leadership roles. As a general rule of thumb, we can consider LXP to be about moving away from working primarily with our own story and instead working to elevate collective stories and perspectives to improve experience.

Peer Support and Lived experience Practice

Strengths based

Recovery-focused

Progressive

Inclusive / Community facing

Safe / boundaried

Mutuality

Reciprocity

Non-directive

Peer Support and Lived Experience Practice

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- Own personal lived experience of recovery and of accessing mental health services and able to safely share lived experiences with people who use our services, their loved ones and their colleagues/team

- Through sharing wisdom from their own experiences, peer support workers will inspire hope and belief that recovery is possible in others.

- Work from a place of shared understanding and equality with both people accessing services and those working within them and striving to ensure that same equality and shared humanity is reflected within the culture of the service.

Professional Lead for Lived Experience Practice

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- Professional leads for lived experience will demonstrate experience of utilising their own lived experience perspectives and insights in a strategic leadership role

- They challenge, support and work in partnership with teams, using personal lived experience, in delivering the strategic direction of the peer recovery working approach

- A lived experience voice in STW senior management group to support us to learn and co-design our services with the ‘patient’ lens.

Peer Support and Lived Experience Practice

- Sharing own lived experience and bringing forward the ‘patient voice’ in teams and MDTs to question, challenge and encourage teams to be recovery-focused, trauma informed and person centred.

- By having a deep, shared understanding of the barriers, challenges and stigma faced peer workers they can offer teams a critical friend approach to improving culture through recovery-focused language and a lens of strengths-based approaches and a belief recovery is possible for anyone.

- The impact of peer workers sharing their lived experiences in MDTs has been noted by operational leads, one example of a peer worker with lived experience of addiction alongside mental health struggles raising awareness and supportive challenge to the MDT that has led to a noticeable difference in using recovery-focused language when discussing people with these struggles and a lens to a co-produced recovery plan.

Using Feedback to Drive Improvement

- The Trust has a Co-Production and Patient Experience strategy. This was developed with service users.
- We use a range of approaches to actively seek and capture feedback from people using services.
- The approaches we use are based on best practice.
- Feedback is shared with people delivering services and they take appropriate local action. We publish action taken as a result of feedback on our website and Quality Account.
- People using services are encouraged to be part of specific quality improvement projects and service redesign projects.
- Trust Board regularly invites people to share their experience of services and any appropriate action is taken.

PSIRF – Patient Safety Incident Review Framework

- Taking learning from sailing and aerospace safety approaches.
- Focus both on learning from good practice and from errors.
- Taking a human factors approach.

- STW Care Group have a weekly incident review meeting where, as a team we decide what learning approach fits best, e.g. an ‘after action review’, a thematic review, or a multidisciplinary team review.
- This is followed by a monthly learning forum when the findings from reviews are brought back for discussion.
- A monthly ‘learning lowdown’ is published and shared widely among staff teams.

Learning from PSIRF

- The importance of documenting decisions made by multidisciplinary teams in individuals' notes
- To make plans when a key worker is on leave for the above to take place on a regular basis and to identify how individuals and their supports can make contact with services
- The importance of good sleep to mental wellbeing
- Supporting service users to access their GP when there are negative stereotypes about substance misuse experienced was increasing
- Inviting other agencies to learning reviews enriches the learning e.g. GP, WMAS, Social Care and Sath
- The importance of safety planning at earliest opportunity
- The importance of meeting with families post incident and throughout a person's care

Friends & Family Tests

- Within the Experience section of the Trust Quality Dashboard from July 2024 the Trustwide F&FT figures remain above the national target of 90% positive response.
- Performance in STW Care Group is lower at 80%. Response rates are discussed as part of routine Care Group governance meetings. A task and finish group was established to improve response rates supported by the corporate team.
- The group is looking at ways to increase opportunities for service users and carers to comment. This is will be bolstered by the introduction of the new electronic system for capturing feedback.

Future – Digital Solution

- To improve service user feedback the Trust needs to utilise technology to reach as many individuals as possible in all areas.
- Feedback from focus groups tells us that using SMS messaging, in conjunction with purpose built analytical software is the best way to obtain and understand what our service users are saying.
- In addition, using digital platforms that facilitate individuals to ‘tell their story’ helps us to understand their experience and provide timely responses to both support the service user and enable learning.
- MPFT has invested in two systems that combine both of these approaches– CIVICA and Care Opinion.
- Utilising the two systems will support with obtaining feedback and data analysis from both stories and feedback combined. It will enable us to really understand what our patients are telling us; highlighting areas of concern, timely and responsively

Future – Care Opinion

- About Care Opinion | Care Opinion

- Care Opinion is a non-profit community interest company that provides an online site where you can share your experience of health or care services and help make them better for everyone.
- It is safe and simple to share a story about care online and see other people's stories too.
- We think that by sharing honest experiences of care, we can improve services for all who use them.

Patient Related Outcome Measures (PROMS)

- The use of PROMS is driven nationally through the Five Year Forward View and the Long Term Plan
- A PROM is a questionnaire that patients complete about their health.
- Benefits of using routine outcome measure:
  - Better understand the impact of an intervention and effectiveness of care over time
  - To guide and inform individual coproduced care planning
  - Improve person centred care
  - Ensure care being delivered meets an individuals need
  - Can help service user feel understood by allowing discussion on issues that are important to them
  - Allow services to reflect on whether they are offering value for money

Mandated PROMS

- ReQoL is a new Patient Reported Outcome Measure (PROM) that has been developed to assess the quality of life for people with different mental health conditions.

- The GBO tool is a way of evaluating progress towards goals in clinical work. The GBO compares how far a person feels they have moved towards reaching a goal that they have set for themselves at the beginning of an intervention, on a scale between 0 and 10.

- DIALOG+ is a scale of 11 questions. Patients rate their satisfaction with eight life domains and three treatment aspects on a 7-point scale. DIALOG provides a score for subjective quality of life and a score for treatment satisfaction. It can be used to evaluate treatment on the level of individuals, groups and services.

Patient Knows Best (PKB)

PKB is a secure portal that allows a user to:

- Access appointment information
- Access their care plan
- Access PROMS – this can be done ahead of appointments, notification to be sent by healthcare team
- Shae personal information if they choose to with family, carer, other healthcare professionals
- Access resources added by the healthcare team
- Keep an optional health journal

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Investment in Prevention

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Prevention

- Universal prevention is provided through Local Authorities, targeting the general population to improve their health and wellbeing.

- Targeted prevention is provided by MPFT focussing on those with a severe mental illness to improve not only their mental but also physical health.

Investment in Prevention MPFT

Early Intervention in Psychosis

- The Early Intervention in Psychosis Pathway supports people aged 14 - 65 and their families/carers, who are experiencing – or at risk of experiencing – their first episode of psychosis
- The specialist team offers a broad range of interventions, which are specifically focused on minimising the risk of developing psychosis or aimed at recovery from a first episode of psychosis. Research tells us that when a person receives early treatment and a range of specific interventions (such as medication, talking therapies, and employment/education support), they are less likely to have a hospital admission and more likely to recover. For some people, recovery does not mean that all of their psychotic experiences will go away. A strengths-based approach is used to support people in building resilience and control over their individual challenges to move forward positively from their experiences.

Children and Young People

- All services provided for the children and families supported by BeeU at MPFT are designed to primarily meet the mental health needs of the children and families at a point in time.
- The secondary benefit of these services is building resilience and preventing CYP being unsupported and therefore becoming adults with severe and enduring mental illness.

Investment in Prevention MPFT

VCSE

- The Community Mental Health Framework for Young Adults and Older Adults (CMHF) model means that NHS community mental health services will be developed with community organisations working together in a seamless way, with people who use services at the centre of service provision and much more involved in their own care and support. Providing support to individuals around the wider determinants of health such as housing, financial wellbeing, digital poverty.
- This programme will support voluntary, community, and social enterprise (VCSE) organisations that encourage engagement with and provide training and interactive training materials to secondary care mental health service users. Ensuring partnerships at a grass root level within communities.

Physical Health SMI

- Dedicated clinicians (MPFT) support Primary Care to deliver SMI physical health checks, in support of PHC reviews at both the Primary and Secondary care level (Affinion devices have been distributed across PCN's and Community Mental Health Clinics to improve access and delivery of PH checks
- To provide healthy lifestyle resources and activity
- To use collective intelligence and insight to inform recommendations for the best use of collective resources allocated to NHS Prevention Programmes and Healthcare Inequalities Improvement Initiatives.

Investment in Prevention MPFT

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NHS Talking Therapies

- This service supports people with common mental health problems, such as anxiety and depression.
- Therapists support people to self-manage their symptoms and improve their mental health
- The service supports people with not only new episodes of mild depression but also as a relapse prevention intervention for patients who have had repeated episodes of depression.
- The interventions offered prevent the worsening of symptoms related to common mental health problems.

Mental Health Practitioners

- The overall aim of the Service is to provide a timely and responsive mental health service to the people of Shropshire, Telford and Wrekin who are experiencing any mental health problem that can be treated effectively in primary care – a single point of access for all mental health problems in primary care.
- The Mental Health Practitioner delivers timely access to an integrated, high quality, service users-centred service in primary care that enables people with mental health needs and/or social care problems (regardless of diagnosis) to improve their well-being and functionality, thereby preventing, reducing or delaying the need for more specialist services (either for mental health, physical health or social care needs). Working as part of the integrated primary care team, qualified ARRS staff ensure the mental health and associated social care needs of Service Users is addressed alongside their physical care thereby promoting wellbeing, independence and choice whilst preventing, reducing or delaying the onset of greater need.
- Utilising multi-agency multi disciplinary meetings at a PCN level to ensure the right intervention for people at the right time as a result of the Community Mental health transformation.