Camden and Islington
NHS Foundation Trust

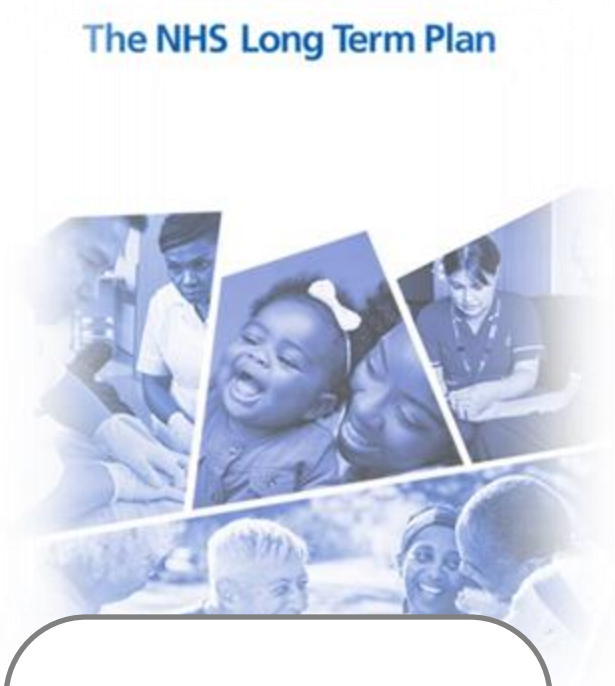
Camden and Islington Suicide Prevention Partnership Meeting

Tuesday 27th September 2022

Your partner in care & improvement

Policy Context: NHS Long Term Plan and The Community Mental Health Framework for Adults & Older Adults

"Joined-up services and improved information sharing will give adults and older adults greater choice and control over their care, and support them to live well in their communities"



How this will work:

Organisations in a local area work more closely together to manage the resources available to them

A joined-up service across mental health, physical health and social care

"focus on people living in their communities with a range of long-term severe mental illnesses, and a new focus on people whose needs are deemed too severe for IAPT services but not severe enough to meet secondary care "thresholds"

NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

NHS

The Community Mental Health Framework for Adults and Older Adults

Interventions readily available and accessible at the location most appropriate to someone's needs

Integrated NHS & VCS partnership models

The Vision: The End Goal in 2023 - 2024

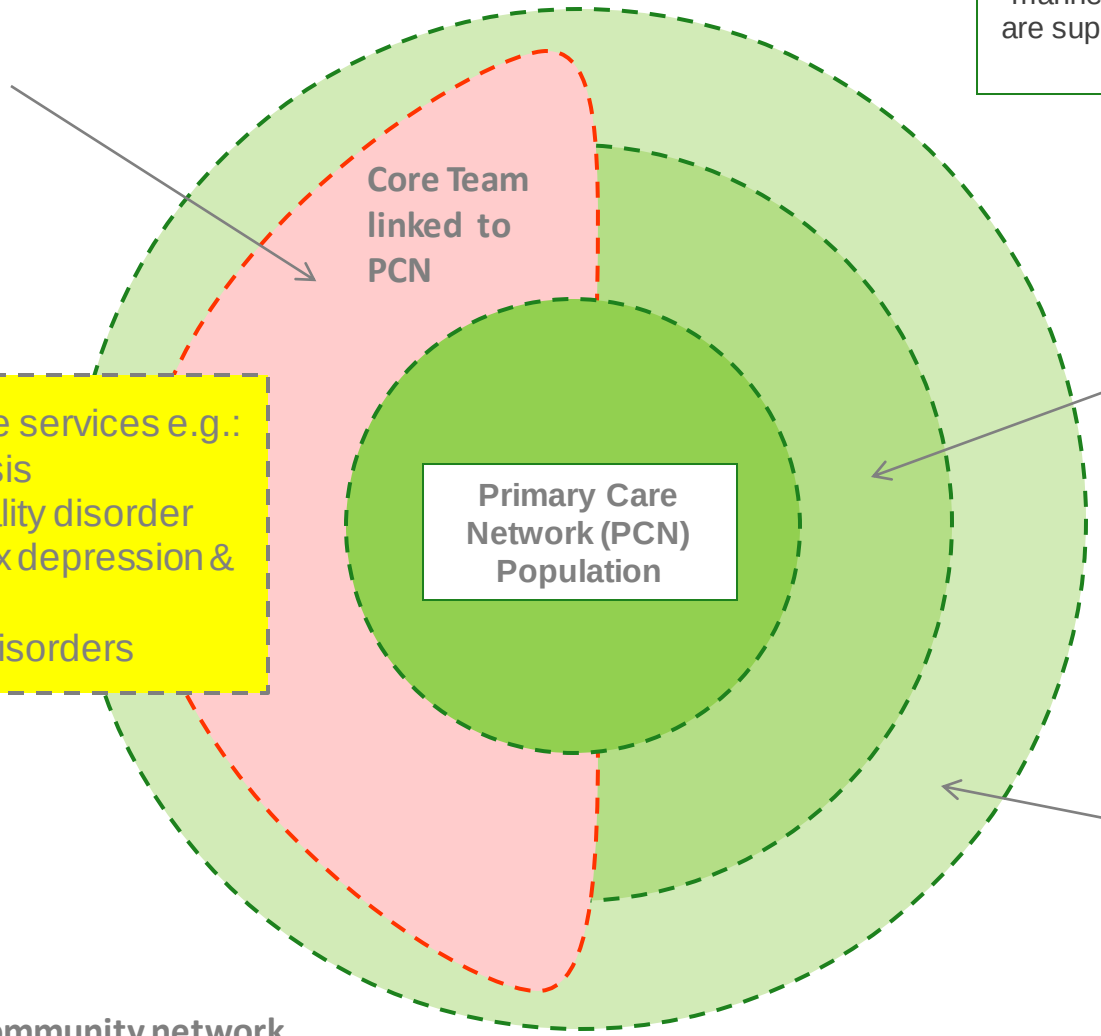
- Core integrated teams wrapped around PCNs,
- Community services for PD, ED and community rehab are developed,
- Other more intensive/specialist services are sufficiently expanded (e.g. EIP),
- The minimum outputs (community team activity, IPS, EIP and physical health checks) are delivered
- Expected outcomes including around inequalities are defined and measurements put in place
- A whole life course approach to services are adopted taking into consideration the differing needs of transitioning young adults, adults and older adults,
- A core offer developed across North Central London but geographies will shape their model based on their needs

Key deliverables in the Long Term Plan by 2023/24				
Core model	**Dedicated focus**	**Physical health**	**Employment Support**	**Early intervention in Psychosis**
A new, inclusive generic community-based offer based on redesigning community mental health services in and around Primary Care Network, contributing to 370k minimum access number by 23/24	Improving access and treatment for adults and older adults with a diagnosis of 'personality disorder', in need of mental health rehabilitation and eating disorders, contributing to 370k minimum access number by 23/24	Increasing the number of people with SMI receiving a comprehensive physical health check to a total of 390,000 people per year	Supporting a total of 55,000 people a year to participate in the Individual Placement and Support programme	Maintaining the 60% Early Intervention in Psychosis access standard and ensuring 95% of services achieve Level 3 NICE concordance

Evolving Community Mental Health Model

Seamless and universal offer intensified according to need
Core Community Teams will be the primary healthcare provider (HCP) for red/amber patients with integrated input from RN
RN and GP will be primary healthcare provider (HCP) for green patients with integrated input from Community Teams
Support is 'stepped up' and 'stepped down' in a flexible manner, based on need – instead of being 'discharge' people are supported in the setting most appropriate for their needs at any given time.

Core Community MH Team
Integrated, responsive, personalised - Blended Team of Psychiatrists, Population Health Nurses, Psychology, Social Work, OT, Social Prescribing, Welfare Rights, VCS and Peer Support



Borough or NCL level services for most complex needs

Network of voluntary sector providers
Entry into the voluntary sector is streamlined and support is accessed in a coordinated way, drawing upon the strengths of a range of different but connected organisations

Wider community
The voluntary sector ensures that the individual benefits from the full range of resources available in the borough

Core Team seamlessly embedded in local community network

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Aims of the core teams

A truly integrated service with secondary mental heath, the VCS, primary care, social care and community assets and some physical health provision working together to support the whole population through a combination of prevention, supporting people to stay well and responsiveness to changes in need

The core teams aim to:

- support individuals struggling with their mental health and wellbeing, including people who don't usually engage with services and those isolated or disconnected, to be as connected and as well as possible in their homes and in their communities,
- To take a 'whole person' approach, supporting people with their mental health in the context of the social determinants of wellbeing such as social contact, welfare, physical activity and beyond.
- To utilise the skills and approach of the VCS organisations to ensure everyone introduced to the service feels heard, understood, and treated as a full person