Cheshire and Wirral Partnership NHS Foundation Trust (CWP)

Long term Impact

Within CWP, the intense community offer for patients with complex mental health difficulties was insufficient with a heavy reliance on in-patient care. There were growing numbers of people in out of area long stay environments, significant numbers of people who were clinically ready for discharge in acute and rehabilitation wards and 'over-commissioning' of support packages to fill gaps in a robust clinical offer. There was room for improvement in quality and experience of care; status quo wasn't financially sustainable.

We liaised/collaborated with a range of stakeholders including experts by experience, families, ICB, CMHTs and LA to develop a community rehabilitation service.

We aimed to develop a service that met the needs of the local population and achieved the triple aim of improving quality of care, patient experience, and value for money. There was a clear expectation that the service will improve sustainability of support for this patient group.

Cheshire and Wirral Partnership NHS Foundation Trust (CWP) provides mental health, learning disabilities, and community services to a population of approximately 1.2 million people across Cheshire and Wirral. The Trust serves both urban and rural communities, delivering care to children, adults, and older adults with a focus on improving mental health, well-being, and supporting individuals with complex needs. CWP is dedicated to delivering high-quality, patient-centred care in collaboration with other healthcare providers and local organizations.

Within Cheshire and Wirral communities, we struggled with increasing use of out of area rehabilitation provision (>50 patients), high proportion of patients staying in acute care for >60 days (14% of total bed usage) and gaps in the community offer for individuals presenting with high complexities.

We had two specific challenges. Firstly, while there was national / regional evidence for 'diagnosis specific' services, this did not meet local need. Secondly, while there was consensus on the clinical need for such a service, we could not get the commitment for funding.

We developed an intensive community rehabilitation service to focus on a patient group who (national and locally) spend prolonged periods of time in hospital (either longer stay rehabilitation wards or acute), struggle to sustain community living and whom services have often struggled to engage. They tend to be largely discharged to restrictive environments and outcomes tend to be unknown at best and are often poor.

We presented a business case to the ICB and our NHS Trust that providing tailored, intensive and recovery focussed interventions would allow for these individuals to live more independently in the community and lead more fulfilling lives.

It was agreed that the service would be spot funded with clear targets to able to demonstrate 'proof of concept'. We gradually built the team and service up over the last four years.

The service was developed in an environment where in: -

- the system was facing significant financial pressures and there was limited appetite for any new investment.
- there was substantial flux in commissioning (CCG to ICB).
- There was scepticism about whether these patients could ever live in the community.
- There was resistance from other community teams about complex patients being brought back into locality.

The tenacity and passion of a small group of clinicians, managers and finance colleagues kept the project going. It took over 2 years of discussions, modelling, papers and presentations for the initial funding to be agreed.

Since then, the service has grown from strength to strength, and the service has stayed true to the cause – a clinically led service which is outcome focussed and intervention driven. At the heart of it is the passion to support people with complex lives to live fulfilling lives in the community. The clinical model remains iterative and has further developed as we have learnt about what works and what doesn't. The service has consistently demonstrated that good quality care which is truly person centred and collaborative is often more cost effective than the alternative.

MhIST provide intensive rehabilitation for individuals in the community and work with people for around 1-2 years. The team identify individualised goals, and the interventions delivered are outcome focussed aimed at integrating people back into their communities and reducing service utilisation.

The aims of the service include: - To maximise people's independence, quality of life, autonomy and enhance community integration, to eliminate rehabilitation out-of-area placements other than in exceptional circumstance and to get better value for money.

The team performs 2 main functions: -

1. Direct care (Tertiary prevention)

The team support individuals who have often spent considerable time in hospitals. We work in collaboration with individuals' and their networks to tailor interventions aimed at supporting the 'whole person' with a particular focus on developing hope, improving engagement, and building connections within local communities. There is a targeted focus on improving physical health activity. The MDT includes healthy lifestyle coaches who lead on supporting people improve physical activity and promote healthy diets.

2. In direct support (Secondary prevention)

- MhIST provides weekly 'in-reach' to acute wards to facilitate discharge and improve transitions into the community. A key role is to provide advice, consultation, coaching and mentoring.

- MhIST work closely with third sector providers to give advice about patient care and to deliver training and coaching.

- We have worked in collaboration with a local university develop a bespoke training package to support teams (both NHS and non-NHS) to take a person-centred approach based on developing strong therapeutic relationships.

In addition, the team has contributed to a few initiatives to support wider system change: -

- Development of a Housing strategy for the Cheshire and Wirral communities

- A housing initiative with a housing association in collaboration with the ICB to support people with high levels of complexity in the community.

The team was initially spot purchased but after 3 years of working collaboratively with the ICB and other partners which included sharing outcome data on a 2 monthly basis, the ICB agreed to move to a 'contracted service' for 75 patients. We continue to work closely with the ICB and are exploring benefits using the principles of the approach and clinical model to develop other services.

Testimonial from Finance Lead Cheshire Contract, CWP

"Working in finance within the NHS more than once I have had a conversation with a service lead about the next self-funding quality patient initiative, they wish to pursue but generally these schemes never get very far. From the outset, the initial finances for the Mental Health Intensive Support Team were fundamentally strong as was the passion and drive to do this …… which became contagious for all those involved to ensure this service became operational. I think it's fair to say a lot of my peers looked at the initial financial modelling with some scepticism, however, time

has given birth to the truth with the financial benefits only being overshadowed by the incredible patient stories I am fortunate to hear. This sort of scheme keeps the passion going within all those involved and allows us to know why we need to continue, to do, what we do, to help people, to live better lives".

Currently, the team provide direct care to 72 patients. 94% of these patients were in a hospital setting when referred and now 61% are living independently (or with family) and 33% are in supported living.

70% of these patients haven't had an admission since being with MhIST.

In the first three years MhIST have discharged 16 patients. Below are some outcomes of these patients: -

Percentage of people detained

When they come into the service: - 62.5%

When discharged from MhIST - 18.8%

Accommodation

When they come into the service

Hospital - 93.7%

Independent - 6.25%

When discharged from MhIST

Independent / living with family or friends - 62.25%

Supported Living - 25%

Nursing Home / Residential - 12.5%

Hospital - 6%

Discharge team on leaving MhIST

Primary Care - 25%

Consultant Only Care - 25%

CMHT - 50%

Bed usage

Percentage of patients admitted during MhIST – 27%

Percentage of patients admitted following discharge from MhIST – 12.5 %

PROMS/PREMS

DIALOG (a self-reported quality of life measure) 75% Improved

HONOS (a clinician rated measure of severity of illness) - 85% Improved

Employment

Pre-MhIST: On discharge from MhIST - 0%:25%

Out of area placements

Pre-MhIST = >50 (total)

Current (total) = 34

Rehabilitation = 8

PD pathway =18

ABI = 6

Others specialised pathways = 2

Some qualitative outcomes

One of the key interventions that the team deliver is Open dialogue - A family intervention that helps reduce hierarchy and empowers individuals and their families. We collated feedback about this – the general themes included feeling better understood, improvement in communication and engagement, being able to have open and honest discussions and overall improvement in quality of life. 83% of patients agreed that it helped them feel better supported by those involved in their care. 83% agreed that this improved communication and honesty within their social network.

Financial outcomes

When the team were initially commissioned, we were keen to demonstrate that investing in getting the right support for people even those with complex needs can improve the quality of life for individuals and will result in system savings. The team have successfully demonstrated the sustainability of this model of care. The team have now been commissioned on a recurrent basis with savings to the wider system.

From a financial viewpoint, the success of the service is substantial. As evidenced through a rigorous gatekeeping process, the cost of alternative care if this service did not exist, averages at £2,849 per patient per week. The cost of MHIST is £1,205 per patient per week and therefore a 58% cost saving. The service is now commissioned to provide support to 75 patients at one time, resulting in a cost benefit to the Cheshire and Merseyside Health System in excess of £6.4million per annum and improves sustainability of wider mental health services and the wider system

We are planning to continue working with the ICB and also LA commissioners to explore expanding the service and use a similar model to set up other services.

Some feedback we have had from different stakeholders: -

Feedback received from a provider: -

"Your team were very efficient and a great help to us sorting out the client's medication. We were very impressed with your team's professionalism. It is really appreciated how quickly it was dealt with. We feel your team should be recognised for their great work, and …just wanted to say how lovely it has been to work with you guys!"

We have been fortunate to be a part of the journey of some amazing people who have shared their personal stories about their progress and the value the service has added. A few are shared below:-

From a service user: -

"The team was really inclusive and really got to know me as a person. The approach made a difference in relation to the trust and inclusion making me feel empowered"

From a family member (Mum): -

"As I write X is upstairs engaged in her course. I can hear her chatting away to her tutors and fellow students. I still have to pinch myself that she is not only at home but also doing all these wonderful things!"

From a supported housing provider: -

"Really positive. The staff visited weekly, they were really helpful and informative. If we ever needed anything they were happy to help and support."