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The Esteem Team
Co-ordinated care in
the Sandwell Integrated
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Co-ordinated care for people with complex chronic conditions

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Care Mental Health and
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About this research

Age-related chronic and complex medical conditions account for the largest and growing share of health care budgets in all industrialised nations. However, people living with multiple health and social care needs often experience a highly fragmented service leading to sub-optimal care experiences, outcomes and costs. To address this, strategies of care co-ordination have been developed to promote more cost-effective care through integrated services.

For older people in need of both health and social care support, the divisions in the organisation, funding and delivery of care in the United Kingdom (UK) can result in poor user experiences and outcomes. There have been many innovative projects to promote better care co-ordination for older people, but these have often not met their objectives and the failure rate has been high because of poorly designed interventions, difficulties in targeting those most likely to benefit from care co-ordination and the unmet patient needs that improved follow-up can uncover. There is a lack of knowledge about how best to apply care co-ordination tools in practice.

This case study is part of a research project undertaken by The King's Fund and funded by Aetna and the Aetna Foundation in the USA to compare five successful UK-based models of care co-ordination (see Appendix 1 for methods used to collect the study data). The aim of each case study has been to understand the strategies used to deliver care co-ordination effectively; examine barriers and facilitators to successful care co-ordination; isolate key markers for success for the practical application of the tools and techniques of care co-ordination; and to identify lessons in how care co-ordination can best be supported in terms of planning, organisation and leadership.

Further details about this project can be found at: www.kingsfund.org.uk/coordinatedcare

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1 Introduction

The health and social care system in England

The National Health Service (NHS) is responsible for providing health care to the public in the UK. It is publicly funded, mainly through taxation, and services are provided free of charge to all patients in the UK, excluding certain exceptions permitted by Parliament. Since its establishment in 1948, the overarching principle of the NHS has been to ensure that health care is available to all on the basis of need not ability to pay and these responsibilities are formally enshrined in the NHS Constitution (NHS Choices 2013).

Responsibility for health care is devolved to the governments of each of the four constituent countries (England, Scotland, Wales and Northern Ireland). In England, community, mental health and general hospital services are provided by a number of bodies, from statutory NHS organisations to charities, social enterprises and private organisations who provide NHS funded services.

Primary care providers act as the first point of contact for physical and mental health care services. General practitioners (GPs) are local primary care physicians based in GP practices alongside nurses and support staff. They operate as independent businesses paid through a national contract administered in England by NHS England. Dentists, opticians and pharmacists also provide primary care services.

General practice accounts for around 90 per cent of all patient contacts in the NHS and the majority of people are registered with a GP practice (The King's Fund 2011). When specialist treatment is required, patients are referred to hospital or other specialist providers. In this way, general practice acts as the gatekeeper to specialist care. Urgent and emergency care services are available directly through out-of-hours services and hospitals.

Planning and purchasing of NHS services is referred to as commissioning. In England, general hospital services, urgent and emergency care, mental health and community services are commissioned at population level by 211 clinical commissioning groups (CCGs) who hold the majority of the NHS budget (£65 billion in 2012/13). Each CCG is formed from the GP practices in that locality who come together to assess the needs of their population and commission services from NHS or other provider organisations which meet those needs.

NHS England

NHS England is a statutory body which commissions primary care health services (including GPs), public health and prescribed specialist services such as trauma care on a national basis.

In contrast, responsibility for funding (and some provision) of social care services, for example for assisted living at home and long-term care, is held by local government (through local authorities), with users having to pay for services directly and/or gain access through means-testing based on levels on need and ability to pay. Residential and domiciliary care are predominantly privately provided, and there is substantial self-payment. There is also a variety of voluntary sector providers delivering a range of health and social

care services. While there are national rules for residential care costs, home care is subject only to guidelines and there is considerably more variation in the organisation and delivery of domiciliary services at the local level. Direct payments are increasingly being made available to eligible recipients of local authority-funded social care, allowing individuals to control and directly purchase services to meet their own needs.

Alongside the introduction of CCGs in April 2013, responsibility for public health has shifted to the local authorities. Health and wellbeing boards have been established to support dialogue and the development of joint service strategies between the health and social care system. This is underpinned by a statutory duty to work in partnership. Significant emphasis has been placed on encouraging jointly funded and delivered services that promote person-centred care co-ordination as a means to improve the experience of patients and service users and ensure they receive high-quality care.

Primary care mental health services in England

In 2011/12, spending on mental health for all services was £11.16 billion, or 12 per cent of the total NHS budget. The budget covers all psychological, psychiatric and neurological disorders (with the exclusion of psychopharmacological prescriptions in the primary care sector) (The King's Fund 2013).

Mental health services can be separated into three areas:

- NHS England commissions services for people with low-level mental health problems such as mild depression, stress or anxiety; these problems are typically treated in the community, with a high proportion of services provided either free or paid for by the third and independent sector. Primary care mental health provision accounts for less than 10 per cent of mental health spending.
- NHS England also holds the budget for specialist secure inpatient services, ie where patients present a risk to themselves or others.
- Clinical commissioning groups commission core services for people with serious and enduring mental health problems, including neurological and psychiatric disorders such as psychosis, bipolar depression, dementia, Parkinson's and neuro-muscular diseases. More than 90 per cent of these services are provided in secondary care by mental health trusts working in the community. They receive approximately 90 per cent of national mental health spending.

Historically, primary mental health services have not been well co-ordinated with physical health services, especially in primary care, and there has been little recognition of the interaction between physical and mental wellbeing (Naylor *et al* 2012). In addition, underinvestment and lack of capacity have resulted in long waiting lists for access to therapies and fragmented care. Several government initiatives have sought to address these problems. In 2007, the Improved Access to Psychological Therapies (IAPT) initiative was launched to increase mental health service provision and capacity in the primary care sector to provide better access to therapies for people with mild to moderate mental health problems. It provides an additional £700 million until 2014/15 to train 3,600 therapists specialising in cognitive behavioural therapy (Department of Health 2012). In addition to IAPT, GPs are also incentivised

to keep a register of patients with serious mental illnesses (the SMI register) to monitor their status and to invite them for annual check-ups. The current government has also launched the 'No health without mental health' initiative which seeks to:

- improve the mental health of the population through prevention work
- promote recovery from mental health problems and improve quality of life
- improve the physical health of people with mental health problems
- improve patient experience of care
- improve patient safety
- reduce stigma and discrimination.

(Department of Health 2011)

2 The Sandwell Esteem Team

The Sandwell Esteem Team – Summary

Background

The Sandwell Esteem Team is part of the Sandwell Integrated Primary Care Mental Health and Wellbeing Service (the Sandwell Wellbeing Hub). This hub is a holistic primary and community care-based approach to improve social, mental and physical health and wellbeing in the borough of Sandwell. The community is characterised by high levels of poverty and ill health, both physical and mental. The population of the borough is 309,000.

Aims and objectives

The key aim of the Esteem Team is to help people with mild to moderate mental health problems and complex social needs at an early stage to prevent deterioration and admission to secondary care services. It aims to empower patients to take control over their own lives by offering guided therapies and tools for self-help.

Target population

The team targets people on the SMI register and receives referrals from secondary, primary and community care organisations as well as social care and probation services. Patients can also self-refer. The service is open to anyone over the age of 16 who is registered with a Sandwell GP. In 2012, the Esteem Team had a caseload of 168 patients.

Approach to care co-ordination

The team employs six link workers who provide care co-ordination for complex patients. They act as patients' navigators through the health and social care system. They typically have a social worker background and/or personal experience with mental health problems. The Esteem Team can refer patients to a wide variety of statutory and voluntary sector services such as social services, debt advice agencies, substance abuse counselling, therapeutic services and peer support groups. Link workers form close relationships with their patients, building their confidence and self-esteem. They will visit patients at home and accompany them to appointments if required. Link workers will also show patients simple wellbeing interventions such as relaxation techniques, but the main focus of their work is care co-ordination. The Esteem Team's work is not time-limited: patients will be discharged from the service only if the link worker and the clinical co-ordinator agree on discharge using guidelines developed by the service.

Results

A statistical analysis carried out by the commissioner shows significant levels of improvement on a clinical and a wellbeing scoring tool (the Core 10 and Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS), see below). There was also a reduction in the percentage of patients with a diagnosis of clinical depression (see the section on Impact for more detail).

Funding

The hub is mainly funded by the Sandwell and West Birmingham CCG. The cost for the Esteem Team in 2012/13 was £490,349. In 2013/14, the budget is £569,674.

Case study

A male client in his 40s was referred to the Esteem Team by his probation officer. He had a traumatic youth with a history of sexual abuse by his father. Following the breakdown of his marriage, he lost contact with his children and was left heavily in debt as a result of divorce. During the assessment, he confessed to having suicidal thoughts and no hope for the future, despite being in a new supportive relationship. He also displayed agoraphobic tendencies, stating that he would rarely leave the house without his partner, and that he would avoid going into crowded places or socialising with friends. He described being in low mood, having no confidence and low self-esteem. He also suffered from erratic sleep patterns. The patient was diagnosed with depression and anxiety, and he received medication to treat these problems.

Following the assessment, the Esteem Team worker supported the client with one-to-one confidence-building sessions, allowing him to express his thoughts and feelings. He was referred for hypnotherapy and emotional freedom techniques therapy. After six months, the link worker encouraged the client to receive counselling to address the trauma and abuse he experienced in his childhood. The client also agreed to start to tackle his agoraphobia and self-imposed isolation, and the link worker accompanied him to local cafés to re-orientate and slowly integrate socially. He also began writing down his thoughts and feelings, which turned into a narrative of his life story. He would now like to change careers and go back to work. He is volunteering as a befriender in the Sandwell Wellbeing Hub and is in the process of moving home and settling down with his new partner and her children. The Esteem Team worked with him over a 12-month period.

The borough of Sandwell in which the Esteem Team is based is an urbanised metropolitan area with high population density (population 309,000 in June 2011). The city has a culturally diverse population with 34.2 per cent from minority ethnic backgrounds, of which approximately 23 per cent are black, mainly from South East Asia and the Caribbean. It is characterised by deprivation, with high levels of unemployment, ill health and poverty. A former industrial centre, the area has not recovered from the decline and closure of the car and steel production companies in the mid 1980s. It has an unemployment rate of 6.9 per cent compared with a 3.6 per cent unemployment rate for England and 3.9 per cent for the UK (ONS 2013). The area also has low-quality housing stock and significantly higher than average rates of homelessness and alcohol-related admissions to hospital. Physical activity rates among the adult population are the lowest in the country (North-East Public Health Observatory 2013).

Sandwell Integrated Primary Care Mental Health and Wellbeing Service (The Sandwell Wellbeing Hub)

To understand the co-ordination approach of the Esteem Team, it is necessary to briefly describe the approach to care of the Sandwell Wellbeing Hub as a whole. The service aims to provide a holistic mental health and wellbeing service for the population of Sandwell based on a psycho-social model. It uses community assets and the expertise of previous and current service users to co-produce interventions for people with minor to severe mental health problems.

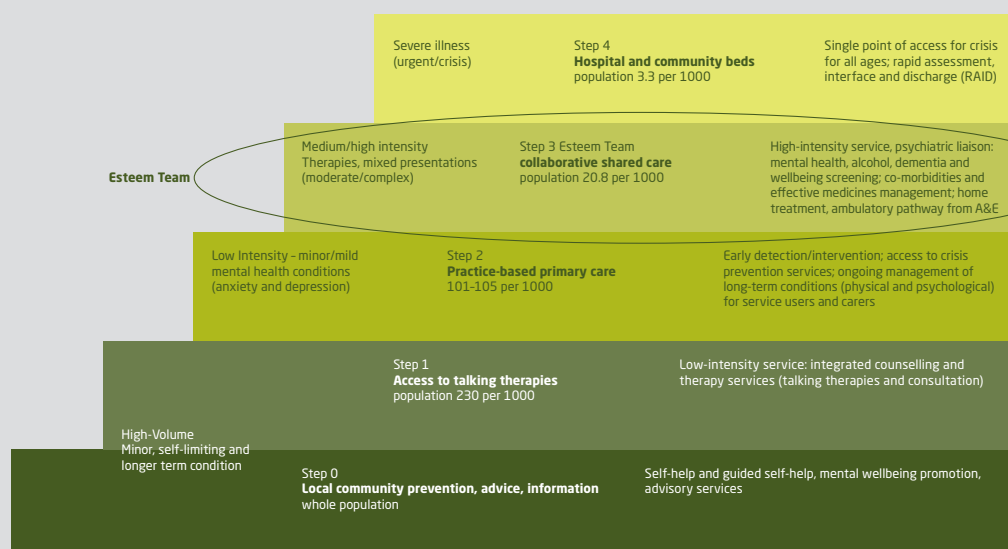
Three core values form the foundation of the Sandwell Wellbeing Hub:

- never turn a patient away
- never discharge a patient if they are not well
- always make sure there is a seamless handover if a patient needs a different service.

Interviewees emphasised the influence of these values on the culture of the hub. Once a patient is referred into the hub, they are seen as the responsibility of all team members involved in their care, and they ensure that patients are not left alone. If a particular approach does not work, for example, cognitive behavioural therapy, other alternatives will be explored and arranged. This makes sure people are not left without a service. The Sandwell team calls this approach the 'warm hands on, warm hands off' approach.

As seen in Figure 1 below, the hub provides services at all levels of mental health and wellbeing promotion, from prevention (step 0) to crisis management (step 4). The Esteem Team takes on those patients requiring step 3 interventions whose cases are complicated by social and medical problems that can benefit from the care co-ordination approach. The Esteem Team can access all services at levels 0–3, and can refer to crisis services at level 4 if the patient deteriorates. A full description of the services available at steps 0–2 is included in Appendix 2.

Figure 1: The Sandwell Wellbeing Hub



The patient group

Patients and service users

All patients served by the Esteem Team have clinical mental health problems and are therefore referred to as patients. We define service users as people who have sub-clinical problems or have made a full recovery but still benefit from the lower-level intervention services on offer in the Sandwell Wellbeing Hub. As this case study focuses on the Esteem Team, the term patient is used to ensure consistency and to distinguish between the two groups.

Any patient over the age of 16 and registered with a Sandwell GP is eligible for the service. The Esteem Team accepts referrals from multiple sources who have identified complex cases and actively targets people on the SMI register. The team will contact patients on the register proactively, phoning to inform them about the help they can offer and what steps they could take (eg, initial assessment). Patients come from all ethnicities and socio-demographic backgrounds, although the majority of patients come from deprived circumstances, reflecting the poor economic profile of the borough. In 2012, the Esteem Team had a caseload of 168 people.

Patients suffer from depression and anxiety, with additional complex social and/or medical problems exacerbating their condition and preventing recovery. Issues include unemployment, debt, substance abuse, relationship breakdowns, domestic violence, poor housing and living circumstances, long-term illnesses or chronic diseases. A typical example is that of a man with a relatively small level of debt who suffered from depression. The debt caused the patient high levels of distress and he wanted to be admitted to the mental health hospital to avoid having to address the issue. A link worker arranged for a repayment plan with the creditors and referred the patient to counselling services. This intervention helped to avoid the admission and a deterioration of the situation.

Funding

The service is funded by the Sandwell and West Birmingham CCG, with some additional resources from voluntary organisations and the local council, the Metropolitan Borough of Sandwell. The budget allocated to Sandwell for mental health is £60 million, of which 93 per cent is spent on secondary care mental health. The cost for the Esteem Team in 2012/13 was £490,349, covering salaries of team members (care co-ordinators and team administrator), GP session input, and counselling services. In 2013/14, this will be increased to £569,674 to expand the team.

Programme history

In 2006, the local commissioning body (Sandwell Primary Care Trust, now Sandwell and West Birmingham CCG) ran a series of workshops targeted at people with mental health problems and their carers to assess if their needs were being met. The workshops were triggered by the high number of patients on the SMI register who did not improve and were not discharged from the

service. An analysis of the data showed that nearly half of the patients on the register did not have any contact with primary or secondary care services, so their mental and physical health status was unknown. This analysis also showed that conversely patients who used accident and emergency (A&E) and acute services frequently had little or no contact with mental health services, and their mental health needs remained unattended.

The workshops uncovered high levels of dissatisfaction among both GPs and service users, with little or no improvement of patients' mental wellbeing and high levels of co-morbidities and untreated physical illness. Mental health provision in Sandwell, especially in primary care, was perceived as poor, with people experiencing fragmented services and long waiting times.

The workshops led to a concerted effort by local commissioners and the local GP lead on mental health to engage primary care services to address these issues, and to work with patients and service users to redesign services. This was facilitated by the long-term support from the commissioning body, allowing the service to grow slowly and evolve over time. The timeline below describes the development of the service.

Timeline

2007: Development of primary care mental health and wellbeing model building on existing assets due to lack of local funding; utilisation of existing community services, such as libraries, community centres, and the community and primary care workforce to run community-based mental wellbeing groups and therapies.

2008: Local commissioning body uses Improving Access to Psychological Therapies (IAPT) programme funds earmarked for community development workers and graduate workers to develop the service, which grew incrementally.

2009: 20 per cent of GPs in Sandwell complete an advanced diploma in mental health in line with the target to increase buy-in from all primary care providers.

2010: Further (national) investment through the IAPT results in the low-intensity service (steps 0–2) being run by the voluntary sector and the high-intensity services being run by secondary care services (step 3 and 4). The commissioning body provides additional investments such as advice on welfare and social benefits, return-to-work programmes, spiritual advice for wellbeing, and a range of therapy and low-level interventions.

2011: Creation of the Esteem team service to meet the needs of people with complex problems, partnering with maternal health, criminal justice, children and social services, as well as drugs and alcohol providers. The team runs as a pilot project for 18 months ending in February 2013.

2012: Roll-out of Certificate in Primary Care Mental Health and Wellbeing for primary care and acute staff to increase skills and awareness among staff not directly affiliated with the Sandwell Wellbeing Hub.

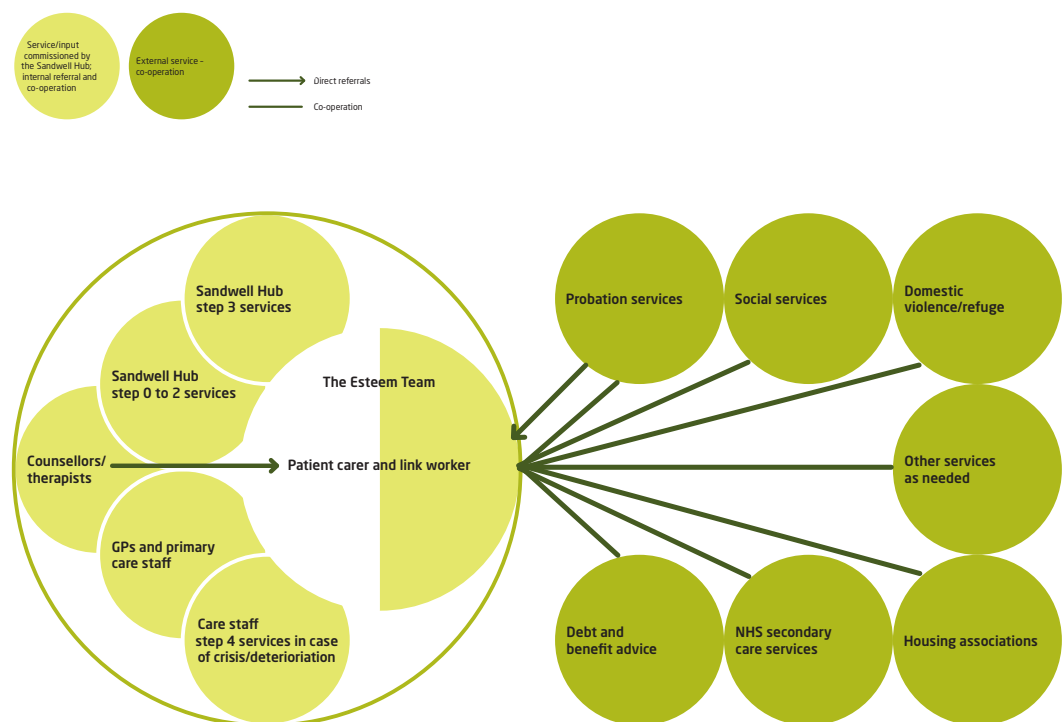
May 2013: The Esteem Team undergoes restructure after evaluation of the pilot period. Reorganisation is completed in June 2013.

Organisational structure

The Esteem Team is the result of patient feedback and demand analysis. Its structure, the process of care co-ordination in the service and the wide variety of external organisations it co-operates with are the result of co-production by the Sandwell Wellbeing Hub and patients and service users, a key feature of all services in the hub.

Figure 2 shows the interaction between the Esteem Team, organisations and services commissioned by the Sandwell Wellbeing Hub, and external organisations with which the Esteem Team has built relationships to help their patients.

Figure 2: The interaction between the Esteem Team and external organisations



As described above, the Esteem Team can access all services commissioned by the hub. Co-operation with external services is on a case-by-case basis. The team has worked extensively with external organisations to ensure awareness and stability of the liaison and referral process.

Team composition

The Esteem Team consists of five link workers who co-ordinate care. A sixth link worker with sign language specialisation for deaf and hearing impaired people provides input as and when required. Link workers have a clinical or social worker background, and most will have either experienced mental health problems themselves or cared for a family member or friend with mental health issues. Initially, the team also employed two 'gateway' workers to carry out the first assessment of the patient and to decide if the Esteem Team was suitable for them. However, their role was not sufficiently defined and differentiated from that of the link worker, leading to duplication and confusion

in responsibilities. As part of the team review (see timeline above), the gateway worker role has been abolished. The link workers are managed by a clinical co-ordinator and support manager, who split the role between clinical work and managerial oversight. A clinical supervisor is also based in the administration centre, which receives and co-ordinates referrals to support the process and prioritise cases. The team have input from a dedicated local GP who provides medical oversight.

A Maternal Mental Health Team is part of the Esteem Team and employs a further three link workers and two counsellors who provide dedicated specialist services to parents with mental health issues as a result of impending or recent childbirth, and additional social and/or health problems. Two South Asian workers funded by the voluntary sector also work on the team to support roll-out among the South Asian Community. The two teams are co-located and co-operate on a case-by-case basis, but they do not hold joint team meetings.

3 The process of care co-ordination

Referrals

Patients come from two different referral sources:

- the Esteem Team proactively targets people on the SMI register (see introduction) who have not been in touch with counselling or social services, and whose status is unknown
- patients can be referred by GPs, social services, probation services, some voluntary sector counselling organisations, and primary health care workers working in a walk-in centre, midwives and counsellors. Patients can also self-refer, although this is relatively rare.

Referrers can approach the Esteem Team directly, although most refer a patient through the administrative centre of the Sandwell Wellbeing Hub, which then passes the cases on to the Esteem Team.

Initially, there were no formalised referral criteria for the Esteem Team. This led to some inappropriate referrals, for example, sending people in acute crisis to the team rather than to emergency services. These inappropriate referrals stretched the team's capacity and led to the change of governance and management describe above. Patients now receive a whole person assessment using an emotional needs audit tool, as well as an assessment of their physiological and social needs. Physical needs are assessed by the GP. If a patient's needs are not complex, they are referred to the services on step 0–2 or to counselling.

The list of referrers is constantly evolving as the hub responds to input from patients. Team members as well as commissioners work extensively with community and primary care organisations to increase awareness of the Sandwell Wellbeing Hub and the Esteem Team. For example, a link worker from the maternal mental health team works with health visitors, nurses and midwives to make them aware of the service and to explain the value of referring expectant or new parents with signs of mental health problems. Other links have been established with social workers and the wider GP community in the area. A monthly meeting of a primary care mental health steering group organised by the Sandwell CCG and with 12 GP members keeps GPs updated about available services and engages them in the service.

Care planning and care co-ordination

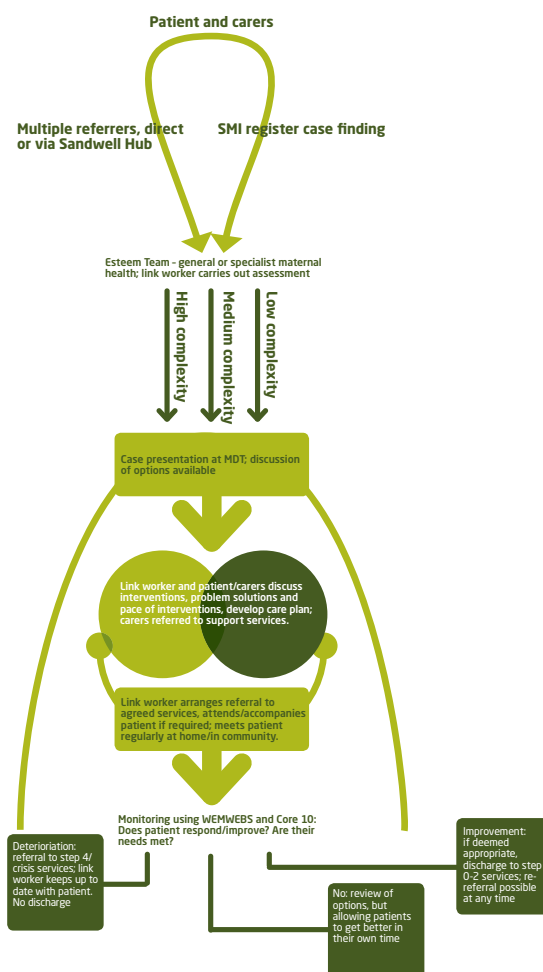
When somebody is upset you will have to do their thinking for them.

(Senior therapist)

It is important to note that the Esteem Team delivers only low-level interventions such as introducing the patient to relaxation techniques and self-help tools. Their main role is to act as care co-ordinators and navigators. They build strong relationships with the patient, their families and care-givers, gaining their trust and meeting them regularly at their homes or in the community to listen to any issues they may have and to actively work with patients to jointly find solutions. Figure 3 illustrates the care pathway.

Figure 3: The care pathway

Sandwell Esteem Team care planning/co-ordination process



Once a patient is referred to the Esteem Team, a link worker carries out an initial assessment as soon as possible (within three days of referral or immediately if the crisis appears to be acute), usually at the patient’s home. The link worker uses tools such as Core 10 and WEMWBS (see Impact section), and takes a case history, listing all issues (clinical or not) that the patient may have. If the link worker identifies an urgent need, they will initiate interventions as required directly after the assessment, for example, contacting social services if there is a housing issue such as overcrowding. The link worker also identifies carers and informs them about services available to them through the Sandwell Wellbeing Hub such as respite, information and peer group support. They ensure they are put on the carers’ register, which triggers an assessment and support process by the local authority and entitles carers to benefit payments.

The Esteem Team meets weekly to discuss new and existing cases. Cases are assigned a colour code of red, amber or green depending on their complexity. They are allocated to a link worker based on expertise and availability. In some cases link workers will take on patients with whom they have had a previous relationship.

Following assessment, the link worker visits the patient, creates an action plan and discusses suitable therapies. The action plan also includes steps to address a patient's social problems. The link worker arranges for referrals to services. If needed, they will accompany patients to appointments, for example, when agoraphobic patients are too afraid to leave the house on their own. Throughout their relationship, the link worker seeks to bolster the patient's confidence and self-esteem by offering them step-by-step actions that the patients can implement at their own pace, creating a sense of achievement. The link worker will also invite the patient to use self-assessment tools to measure their wellbeing and to chart progress. If no progress is made, the action plan is revisited to discuss alternative therapies and services. The emphasis throughout is on empowerment to give patients control over their own lives and to make them more resilient for future crises.

There are no defined care packages, but care co-ordinators seek to provide interventions that can benefit the patient. Patients stay in the esteem service as long as they need support. They will be discharged when the link worker and the clinical co-ordinator feel that they have improved enough to benefit from lower level services (step 0 to 2). Link workers will usually encourage patients to make use of these services early on to include them socially and to put them in touch with other patients in similar situations. In the lower-level interventions, people may never leave the service and continue to attend community support groups. Some get involved as volunteers. A service user network (SUN) created and run by previous patients and service users allows people to keep in touch with each other and acts as a safety net should they experience a relapse. There is a strong ethos of solidarity and of mutual support, as patients have experienced the benefit of peer support during their recovery phase.

It became apparent during the pilot phase that the process of care co-ordination and discharging of patients needed improvement. Link workers were reluctant to discharge patients as they often formed close personal bonds. As practitioners, they also were initially reluctant to tend to organisational and administrative issues.

They don't want to do [paperwork], they want to see their clients, but it's really important to meet as a team, to stop working, because this is what we do in general practice, you can spend your life running around in circles seeing patients; you have to come together, think what we're doing, why are we doing it...

(Local GP)

The reform of the team improved this situation by introducing formalised referral and discharge guidelines. A dedicated administrator for the Esteem Team who schedules and keeps track of meetings and the calendar also helps to keep track of link workers' workload and encourages note-keeping.

The key success factors for the co-ordination are the dedication of the link workers and the relationships they have built with other services. These relationships ensure that any problem a patient may encounter can be addressed.

The interaction of counselling services and the Esteem Team – case study

A female patient was referred to a therapist in an extremely distressed state and at risk of suicide. The patient stated that this distress was caused by her partner who was highly controlling – she had to account for her daily movements. There was also a history of physical abuse. The patient had to hide her attendance at therapy from her partner. The therapist described the patient as lucid without latent psychological problems, so his therapeutic efforts concentrated on treating her suicide risk. After a few therapy sessions, the therapist suggested to the patient that she might be referred to the Esteem Team, which she accepted. The link worker assigned to the case was able to quickly build a rapport with the patient. Together, they developed perspectives and solutions to free her from the tight grip of her partner, such as taking days off work and using the time to socialise, and to plan moving away. Soon after the involvement of the link worker, the patient's Core 10 scores improved and her measure of suicide risk dropped to below the clinical risk threshold for the first time since she had started to receive counselling. The combination of therapy and the input from the link worker increased the patient's confidence to a level where she felt able to leave her partner. The therapist stressed that without the link worker's input, his ability to treat the patient would have been very limited.

(Some details have been changed to protect the patient's identity)

Team culture

The team culture is characterised by a supportive atmosphere and understanding of the pressures arising from team members' work. All members (including the GP) have experience of working with complex patients, either through professional or personal experience. This can be seen in team meetings, where staff express sympathy and encouragement and provide constructive input in the form of practical suggestions and offers of support, although the team administrator will intervene if she believes that team members add too many tasks to their workload.

This supportive and constructive atmosphere is replicated in their relationships with the commissioners and managers. Commissioners meet regularly with the team and are up-to-date with the team's work. Team managers foster independent ideas and support staff in implementing them, adding to the positive team climate,

I came with all these ideas and they [the managers] could have turned round to me and said 'calm down, you don't want to change the service, keep your ideas to yourself', but they didn't and they let me carry on.... It was not only that they said 'yes you can do it' ... they actually provided support and improved on my ideas. I mean food, if you ever need to get nurses to somewhere, offering them meals works really well, so when Linda and Sue said 'if you're going to put training on we'll provide you with food'

(Maternal mental health worker)

Staff turnover is low. At the time of writing, the only team member looking for another position was covering maternity leave.

The positive team climate, the fostering of team and service user participation in the shaping of the service and the high levels of independence are all key to the success of the service. Recruitment practices also contribute – personal or professional experience with mental health problems is valued highly.

Functional integration

The team uses a variety of means to exchange information. The Sandwell Wellbeing Hub, including the Esteem Team, uses Corenet software to capture and manage patient data, and every service staff member (either directly employed by the Sandwell Wellbeing Hub or working for an external provider) can input data. To preserve confidentiality, only the individual teams (and commissioners) can see the information they input. If a patient transfers from one team to another, the accountability for the care of the patient transfers as well, along with access to the relevant information to ensure continuity of care.

Within the Esteem Team, information is exchanged informally via face-to-face conversation, telephone and email. A weekly multidisciplinary meeting is also used to exchange information on patients. GPs can see patients' clinical data, which is put into their system by the commissioners.

Commissioners and GPs have raised issues about the availability of data for the whole of the catchment area population; however, information exchange within the system seems to be working well. The commissioners have made it a priority from the outset to capture patient data to track their wellbeing (see Impact section below for more detail), and worked intensively with counsellors and external service providers to convince them of the advantage of using a unified system. They also demonstrated the feasibility of sensitive data exchange between services by establishing a data sharing agreement with probation services. As one commissioner put it, 'If you can get data sharing between health and probation services, you can get agreements with anyone'.

One of the key lessons from the Sandwell service is the value of thinking about data sharing early and ensuring usage of a unified system. The investment pays off for the service as it is able to trace patients' progress and demonstrate impact at the same time.

4 Impact

Given the pilot nature of the Esteem Team, there is little quantitative evidence of its impact. However, statistical analysis of WEMWBS and Core 10 results has shown improvements for patients. Outcomes for the Core 10 measurement tool show an average improvement of 10.2 points for patients in the Esteem Team, and a 10.1 point improvement for WEMWBS. There was also a reduction of 48 per cent in patients in the Esteem Team deemed to be in need of clinical intervention for their mental health problems (clinical cut-off point).

TABLE 1: Pre- and post-scores for WEMWBS and Core 10

	Pre-score (mean)	Post-score (mean)	Change (mean)
WEMWBS	n/a	n/a	10.1
Core 10	16.9	6.7	10.2

Source: Hill 2013 (modified)

Statistical testing on the Core 10 and WEMWBS results using the ANOVA (analysis of variance) method showed that the changes are significant and not random, ie, they can be attributed to the Sandwell Wellbeing Hub interventions (Hill 2013).

TABLE 2: Statistical significance of change in CORE10 and WEMWBS results

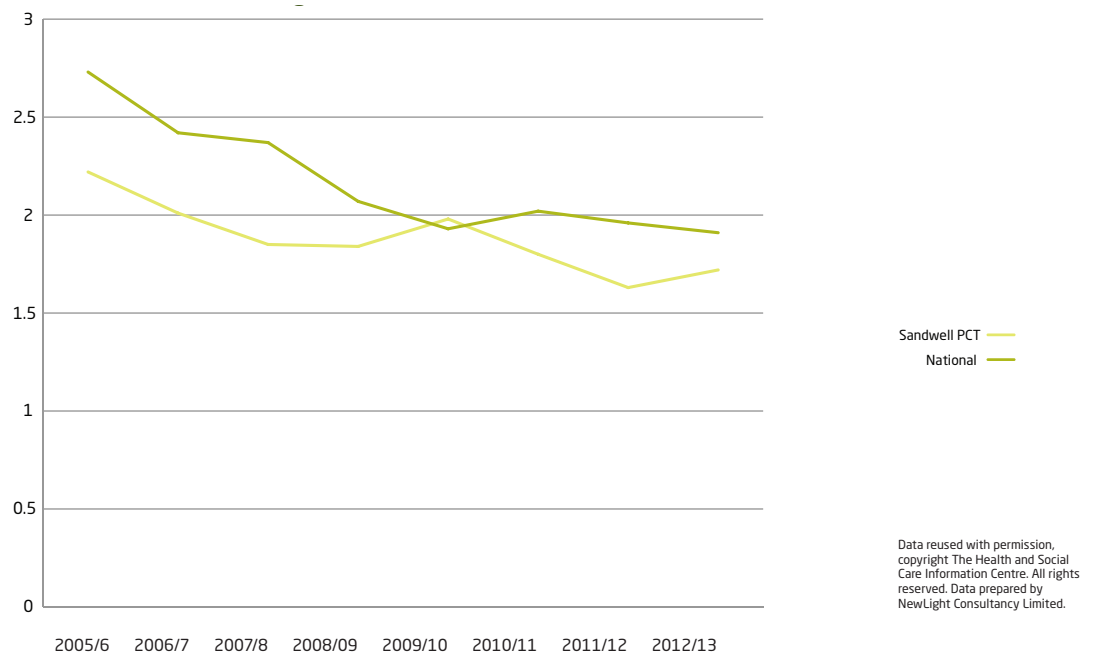
	F-ratio	P value
WEMWBS	8.1	0.0
Core 10	20.3	0.0

Source: Hill 2013 (modified)

A further indication of the positive outcomes achieved by the team is its success in helping people on the SMI register. Following the closure of a secondary care day centre, the team assessed 25 of the 26 patients on the SMI register, offering them interventions based on their needs. All 25 patients have improved and could be discharged from the service and the register. The remaining patient declined contact with the team.

These outcomes are very promising but are limited by relatively small sample sizes. In addition, some of the patients may have also improved without the intervention (regression to the mean). Due to its holistic psycho-social approach, measuring solely quantitative outcomes and outputs may also not capture all the benefits of the intervention. However, there are general trends that suggest that the Sandwell area is improving on standardised measures of mental health: for example, there appears to be a decline in standardised rates of admission per 1,000 population compared with the whole of England (see Figure 4).

Figure 4: Standardised rate of mental health admissions per 1000 population, NHS Sandwell and England



Source: The Health and Social Care information Centre

It is difficult to attribute these trends to the Sandwell Wellbeing Hub, and in the absence of confidence intervals it could be that changes are due to random fluctuations. However, the evidence suggests that a change is occurring in the area.

Core 10 and WEMWBS

Core 10 is an assessment tool to measure outcomes of psychological therapies. It can be used for any therapeutic approach (pan-theoretical) and any mental health problem (pan-diagnostic). It is specifically designed to assess progress after each therapeutic session and can be used for quick assessment and review. It covers 10 items about anxiety, depression, trauma, physical problems, social functioning, and risk to self. It is based on a more extensive tool called Core-OM that includes 34 items and is used to provide more in-depth one off assessments (Core IMS 2013).

WEMWBS

The Warwick-Edinburgh Mental Health and Wellbeing Scale assesses a person's emotional wellbeing using a scale of 14 positively worded items such as 'I have been feeling useful' or 'I have been feeling relaxed' that the person then marks on one of five categories from 'none of the time' to 'all the time'. It was developed by researchers at Edinburgh and Warwick universities. (NHS Scotland 2013).

Patient experience

The Esteem Team collects feedback from patients. The evaluation was not available at the time of writing; however, three former patients who continue to be involved with the Sandwell Hub were interviewed as part of the research. All three emphasised that the service has given them the support that they needed, which they hadn't been able to access before. The strong feeling of never being left alone, being listened to, and being taken seriously all contributed to their positive experience.

A former patient who continues to be involved in the service as a volunteer and in service design describes this experience:

I know that [the team], they're all at the end of a phone. Whereas anywhere else doesn't really offer that. It's just like six weeks [of therapy]: 'There's the door. Bye.' What we wanted is something there so they know there's a safety net....You just want the net there as a safe thing so, if times are hard, we're able to say, 'Come in and we'll help support you'.

Link workers feel that their role in providing link-ups between services to the client is key. It is also the responsibility of link workers to follow up with people if a person fails to attend an assessment or doesn't respond to an invitation for a referral appointment, especially if their morbidity (anxiety, depression) may prevent them from leaving the house or taking the initiative.

I think because of how flexible we are, we actually go and take people from their home to appointments and take them back home because a lot of our clients don't like going outside, they've built a prison and that's their home, without bars, so what we do is give them the support to get to their appointments.

(Link worker)

5 Challenges and facilitators

Challenges

Integrating primary, secondary and social services in a deprived area presented the team with challenges and obstacles that needed to be overcome. Some applied to the Sandwell Wellbeing Hub overall, while others were specific to the Esteem Team.

Contextual challenges

One of the major challenges was getting **funding** for the service. As described in the introduction to this report, only a small proportion of mental health funding is spent in the community. The commissioners persuaded their managers and strategic steering groups to use the extra funds available through the IAPT funding stream (see introduction) to invest in community services, rather than solely focusing on diagnosis-based therapies that could not address social problems.

Professional silo thinking also hindered development, as the suggested approach of service delivery in the community and of user involvement in service design was going against the grain of established practice. In addition to convincing health managers, the commissioners also needed to convince the local authority that it was in their interest to co-operate and help with funding for certain posts. Commissioners describe feeling that many local staff had written off Sandwell, meaning there was no faith in the local community's willingness to improve wellbeing.

The service overcame these challenges by engaging intensively with managers, social services and involving service users and patients. The workshops that were run before setting up the Sandwell Wellbeing Hub and the Esteem Team demonstrated to managers the appetite of the community to improve the situation. Their involvement in service design also meant that the community could see practical solutions before the service even started, securing long-term engagement. However, silo thinking also remains an issue in the acute and secondary sector, which is slowing the creation of relationships between the Sandwell Hub and these services.

Continuity of relationships and funding affects all integrated care services, and the Sandwell Hub is no exception. In relation to health, the service is established enough to have the continued support of the CCG. However, recent cuts to social services have put some strategic partnerships under threat, and there is a risk that the cuts may demoralise social workers at a time when austerity is creating additional demands on their resources. While the service continues to work with social services and to fill gaps with its existing budget, there is a risk that a further decrease in social funding will stretch the budget to its limit. The commissioners are exploring avenues to find other sources of funding.

Organisational challenges

A key organisational challenge for the Esteem Team was that of **referrals**. In the absence of formal referral criteria many services (probation, social services, alcohol and substance abuse counselling services) would refer inappropriate

cases to the team. For example, someone with alcohol problems already seen by the alcohol counselling service would be sent to Esteem to help with the drinking problem, leading to duplication and increasing the team's workload without adding value for the patient. The Esteem Team also received referrals of people with acute suicide risks, instead of them being sent to acute services. The team helps in these cases by alerting the appropriate services, but at the expense of prolonging distress for the patients and creating additional work for the team.

Another difficulty was the **lack of differentiation between the roles** of gateway worker and link workers. They were too similar to make a difference to the patient and risked duplication and delay of assessment. In combination with the capacity problems due to inappropriate referrals, this hampered the efficient delivery of care co-ordination.

To overcome both these organisational challenges, the Esteem Team's brief has been reviewed and since June 2013 the team is operating under a new structure. A key learning point here is to review processes and interventions on an ongoing basis and to be prepared to learn from mistakes. In the case of the Esteem Team, early intervention and reaction to problems ensured continuity of service for patients during the restructure of the team.

Facilitators

The **IAPT programme**, while being criticised as being too formulaic in its national approach, has helped to unlock funding for primary care-based services. Without this funding, the service may not have been created, and one commissioner stressed that the flexibility and collaboration of the local IAPT team was integral to the team's success.

The **dedication and vision** of the commissioner and of the local mental health lead GP were mentioned as indispensable to the service and its creation. Their drive helped overcome reservations by clinicians, commissioners, managers and other providers, and staff members described them as key factors for the success of the service.

The **involvement of former service users and patients** from day one in listening exercises that helped to shape the Sandwell Wellbeing Hub is another key feature. It helped to identify the failings of the previous system such as the lack of handover, discharge from services without follow-up, long waiting times and few community-based facilities and services, and enabled the commissioners and service users to co-produce the service that now exists.

6 Key lessons

The aim of this research was to identify key lessons of co-ordinated care approaches that can be applied to different settings and countries. Every case study site has a unique history, which cannot be replicated elsewhere. In Sandwell, the combination of funding availability, a driven and dedicated commissioner and GP mental health lead, and an environment willing to try a new approach to mental health delivery in primary care acted as catalyst for the creation of the Sandwell Wellbeing Hub and the Esteem Team. These circumstances cannot be replicated. However, the underlying principles and values that drove the development of the services can be applied elsewhere.

- *Co-production, patient focus and involvement*
The involvement of patients and service users from the inception of the service, and their continuing input in service design and review, facilitates buy-in and trust-building. Using patients' expertise also contributes to patient-centred service design, a stated aim of the Esteem Team and the Sandwell Wellbeing Hub.
- *Skill mix and staff roles*
The service actively recruits people with personal experience of mental health problems, and the Sandwell Wellbeing Hub employs recovered patients and service users. Staff's first-hand experience of mental health problems contributes to a shared understanding of the issues patients may be facing, and helps to gain their trust.
- *Awareness-raising and relationship-building*
The Esteem Team relies strongly on relationships with other services to offer patients access to a range support services. Relationship-building activities also help to raise awareness of the service to ensure appropriate referrals.
- *Holistic co-ordinated care embedded in a stepped care approach*
The holistic psycho-social approach enables the Esteem Team to tailor care packages to the specific need of patients in a joined-up way. The ability of the team to discharge patients into other services provides additional security to patients, as they remain embedded in the Sandwell Wellbeing Hub system and can quickly be re-referred to the team if their situation deteriorates.

The spirit of solidarity and mutual support that is evident in the service – both in the Esteem Team and in the Hub as a whole – is an intangible asset and a key feature of the service. It underlines the importance of having a joint vision and buy-in from everyone involved – staff, management and patients, or what Meads *et al* (2006) call parity of interest. The difficulties that the Esteem Team experienced through the lack of formal referral criteria underline the importance of clearly defining relationships with external providers. Last but not least, the support of the commissioners that allowed the service to grow and to prove itself over the years – as opposed to demanding immediate impact – should also be considered when designing a similar service.

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Appendix 1 Methodology

The research team used a mixed-methods approach which involved:

- 12 semi-structured qualitative interviews with staff in the Esteem Team, the Sandwell Wellbeing Hub, local GPs, commissioners and external service providers
- observational analysis of a weekly multidisciplinary team meeting and caseload meeting
- content analysis of key documents and impact data provided by the Sandwell Wellbeing Hub and the commissioners.

Appendix 2 Services, tools, support and advice

Organisations involved in the Esteem Team

Statutory organisations

A number of **NHS primary care services**, such as counselling, are part of the Sandwell Wellbeing Hub and the Esteem Team. They are employed by the NHS and commissioned by Sandwell CCG. They accept referrals from practitioners working in the Sandwell Wellbeing Hub and the Esteem Team. The service has a total of 33 therapists and counsellors at its disposal, 23 of whom are employed by the NHS and 10 by third sector organisations. Two GPs provide medical input and supervision.

On the commissioning side, the mental health leads of **Sandwell and West Birmingham CCG** provide managerial oversight of budgets and performance and take an active role in the service. They speak regularly to patients and staff in the various services and work flexibly to meet patients' needs by working continuously with local community organisations to fill gaps in service provision.

Sandwell and West Birmingham Acute Trust is the local hospital trust. The hub co-operates with the trust to provide secondary health interventions and on improving acute admission and discharge procedures for patients who are treated in the hub.

Black Country Partnership Foundation Trust is the local mental health trust which employs some of the counsellors and therapists providing services for the Sandwell Wellbeing Hub and the Esteem Team. It also co-operates on more complex cases requiring psychiatric input and inpatient services.

Sandwell Metropolitan Borough Council provides a dedicated welfare advice officer funded by the CCG, and its social workers have developed close working relationships with the Esteem Team.

Staffordshire and West Midlands Probation Trust has developed a partnership with the Esteem Team and can refer recently released prisoners with complex needs to the team.

Third sector providers

There are also a host of third sector organisations commissioned by the CCG to deliver services as part of the Sandwell Wellbeing Hub and to which the Esteem Team can refer clients. Some organisations, such as the Kaleidoscope Plus Group existed long before the inception of the Sandwell service, while others, such as the Service User Network (SUN) were created by the commissioners. Two of these organisations can refer to the Esteem Team and are involved in providing care to the patients:

Swanswell Alcohol and Drugs Services is a national charity seeking to help alcoholics and people who abuse alcohol and drugs by providing advice and surgeries at central locations (both drop-in and by referral). Services are offered on a one-to-one basis.

Kaleidoscope Plus Group (formerly Sandwell Mind) provides mental health self-help and counselling services to the population of Sandwell. The

organisation has disaffiliated itself from the national mental health charity MIND to provide more localised services in Sandwell.

To provide help for carers, the hub works with **Carers UK**, a national organisation locally supported and commissioned by Sandwell Metropolitan Borough Council and Sandwell and West Bromwich CCG. It provides support and respite activities for long-term carers on the carers' register.

Services available at the Sandwell Wellbeing Hub at steps 0–2

Service User Network: Unique people

SUN is a network of former or current service users/patients who, through their own experience, have an insight and understanding of mental health issues. They run user service forums and are key stakeholders in the development and future evolution of the Sandwell service. The service user network also runs a six-week programme called *Flourish* for people recovering from mental health problems. It includes modules on recovery and how to achieve it, education on patients' rights in the mental health system, the use of daily and weekly plans to support a patient's goals, bringing people out of their comfort zone and how to recognise triggers that set off an episode of mental health problems.

Self-help tools and community groups

These self-help tools use existing approaches to self-management and have been adapted to meet local needs in terms of service delivery modes and locations.

The tools include:

- Talking in mind – guided self-help and talking therapy for people experiencing stress, anxiety, panic or low mood/depression.
- Make friends with a book – patients can choose a small reading group in which a facilitator reads out the book, which is then discussed in the group.
- Books on prescription (supported by Sandwell Metropolitan Borough Council, the Sandwell Partnership, Sandwell and West Bromwich CCG) – a GP gives the patient a prescription for a recommended self-help book available from the library, or clients can refer themselves to obtain a copy.
- Just Laugh (Sandwell Wellbeing Hub) – free sessions on breathing and laughter therapy ('laughter yoga') for everyone regardless of age (under 16s have to be accompanied by an adult).
- Family Arty Party (Sandwell Wellbeing Hub) – a five-week course for families to learn how to make art from scrap.
- The Big White Wall – an online safe and anonymous social community network that allows patients and service users to work through their problems.

Confidence and wellbeing team (Health for Living) offers a selection of programmes that aim to support and equip people with a range of tools to manage their own health and wellbeing:

-
- health improvement programmes
 - stress and relaxation workshops
 - food and mood activities
 - internet-based CBT self-help (Fearfighter, Moodcalmer, Living Life to the Full)
 - positive mental training CDs
 - breathing techniques (capnography).

The team also offers a range of wellbeing programmes specially catering for people with long-term conditions, young people between the age of 11–18, and people at risk of redundancy or who have recently been made redundant.

Sandwell Kaleidoscope Community Wellbeing Service provides wellbeing activities based on a 'five ways to wellbeing' model, designed to support people to maintain and/or improve their own sense of wellbeing. It also provides a range of one-to-one therapies, talking therapies service (IAPT, CBT), counselling for life adjustment issues (with special services for Asian or African-Caribbean populations), and complementary therapies. Kaleidoscope also offers volunteering opportunities as a befriender to help people out of isolation and to develop the confidence, social networks and social relationships of people with low-level problems.

It also includes the Sandwell Cancer Care Service, which specifically targets people living with cancer and their family and carers. People need to be referred to this service by a community nurse practitioner, and referrals are assessed to ensure they receive the most appropriate service. They have access to more intense counselling services specifically targeted at cancer patients, and can also be referred to clinical psychologists.

D/deaf counselling services provide counselling for deaf and hearing-impaired people for stress, anxiety, bereavement, and low mood.

Chaplains for Wellbeing gives pastoral and spiritual care for people with emotional or other stress-related problems that are not of clinical significance.

Support and advice services

Welfare rights is a service offering advice on social welfare benefits. The team can also help with debt issues and provide financial advice, either at home or at their community base. Sandwell CCG funds a full-time adviser post in this team who is dedicated to referrals from the Sandwell Wellbeing Hub.

Carer support: There are a range of services available to provide support to carers. The majority of these services are provided by Carers Sandwell. It provides help and guidance for carers to carry out self-assessment on their ability to provide care, run an emergency planning service and a support project and support groups. In addition, it provides guidance on employment and learning services for carers wanting to go back to work, such as educational courses to learn new skills and to get qualifications for carers wanting to return to work. There is also dedicated support for BME carers.

BUDS (Better Understanding of Dementia for Sandwell) provides specialist support for dementia sufferers and their carers.

With the exception of the Cancer Support Services, the services listed here are available to all patients via self-referral or GP referral, and can be accessed through a central call centre with a single phone number.