Learning from the Sheffield Primary and Community Mental Health Transformation Programme

The Community Mental Health Framework for Adults and Older Adults (CMHF) aims to deliver "integrated, personalised, place-based and well-coordinated care", by overcoming barriers between Mental health and physical health, betwen health, social care, voluntary, community and social enterprise (VCSE) organisations and local communities, and between primary and secondary care.

The Sheffield Primary and Community Mental Health Transformation Programme is one of 12 early implementer sites testing the CMHF across England.

It was designed to offer care at neighbourhood level, built around new Primary Care Networks (PCNs), strengthening relationships with VCSE organisations, and addressing health inequalities across the city of Sheffield.
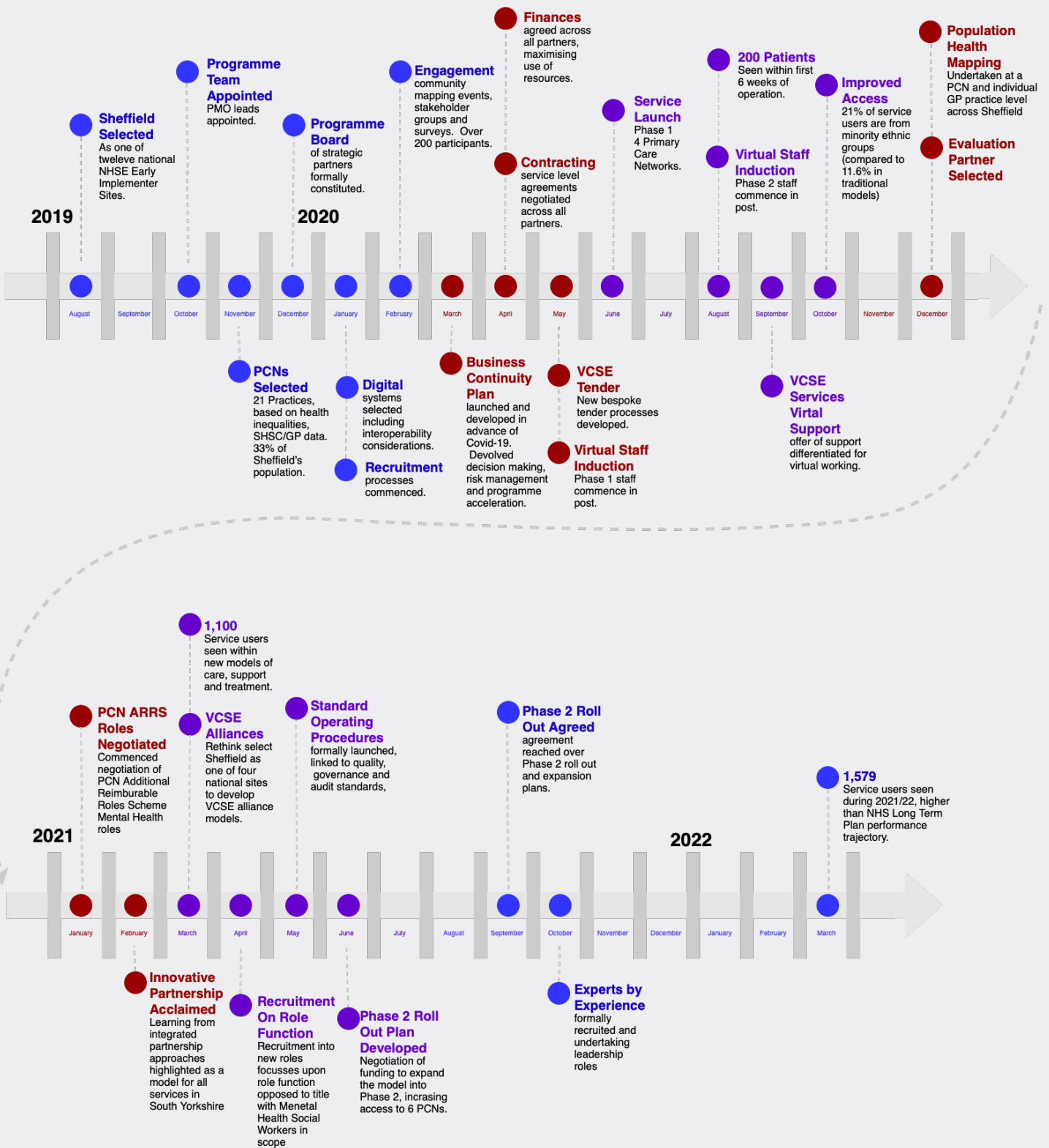
The Sheffield Programme was a partnership between NHS Sheffield Clinical Commissioning Group, Sheffield Health and Social Care NHS Foundation Trust (SHSC), Primary Care Sheffield (PCS), Sheffield City Council and Sheffield Mind, who commissioned 6 further VCSE partners. The Programme was delivered by 36 staff, some in new roles to be tested as part of workforce development. The leadership team included clinical leads and seconded representatives from other Programme partners.

The Sheffield Programme was initially tested across 4 PCNs in Sheffield, representing one third of the city's population and directly employed 36 staff. The PCNs sites were selected based on inequalities (socio-economic deprivation and ethnic minority populations) and degree of mental health need.

In total, 2,692 referrals were made into the Programme. The vast majority of the referrals were people of working age (18-65) with only 3.6% over 65; around 60% of people referred were female, and around 20% of those referred were of minority ethnic backgrounds.

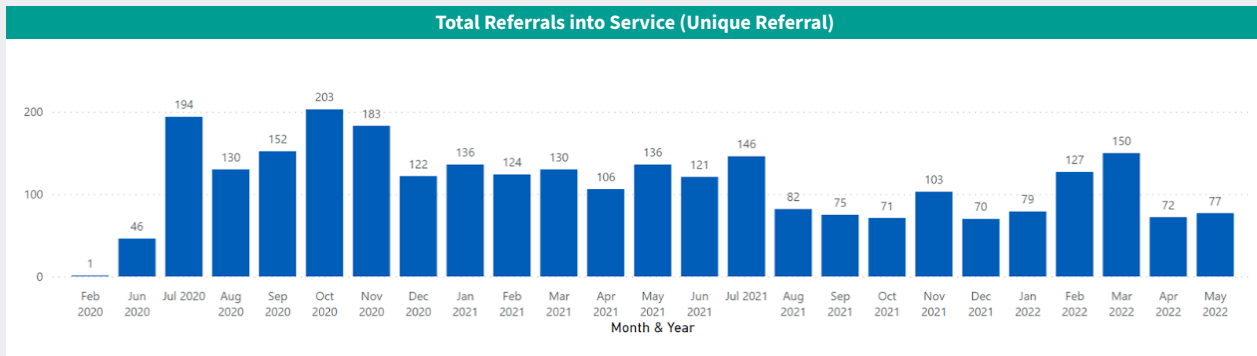
Programme Staff (36)
- Mental Health Practitioner (5)
- Clinical Associate Psychologist (10)
- Psychological therapists (5)
- Community connector (4)
- Health Coach (3)
- Occupational therapist (1)
- Pharmacist (1)
- Leadership team (7)

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Programme Timeline 2019-2022

Sheffield Selected
As one of twelve national NHSE Early Implementer Sites.

Programme Team Appointed
PMO leads appointed.

Programme Board
of strategic partners formally constituted.

Engagement
community mapping events, stakeholder groups and surveys. Over 200 participants.

Finances
agreed across all partners, maximising use of resources.

Contracting
service level agreements negotiated across all partners.

Service Launch
Phase 1 4 Primary Care Networks.

200 Patients
Seen within first 6 weeks of operation.

Virtual Staff Induction
Phase 2 staff commence in post.

Improved Access
21% of service users are from minority ethnic groups (compared to 11.6% in traditional models)

Population Health Mapping
Undertaken at a PCN and individual GP practice level across Sheffield

Evaluation Partner Selected

2019

August | September | October | November | December | January | February | March | April | May | June | July | August | September | October | November | December

2020

PCNs Selected
21 Practices, based on health inequalities, SHSC/GP data. 33% of Sheffield's population.

Digital
systems selected including interoperability considerations.

Recruitment
processes commenced.

Business Continuity Plan
launched and developed in advance of Covid-19. Devolved decision making, risk management and programme acceleration.

VCSE Tender
New bespoke tender processes developed.

Virtual Staff Induction
Phase 1 staff commence in post.

VCSE Services Virtal Support
offer of support differentiated for virtual working.

1,100
Service users seen within new models of care, support and treatment.

PCN ARRS Roles Negotiated
Commenced negotiation of PCN Additional Reimburable Roles Scheme Mental Health roles

VCSE Alliances
Rethink select Sheffield as one of four national sites to develop VCSE alliance models.

Standard Operating Procedures
formally launched, linked to quality, governance and audit standards,

Phase 2 Roll Out Agreed
agreement reached over Phase 2 roll out and expansion plans.

1,579
Service users seen during 2021/22, higher than NHS Long Term Plan performance trajectory.

2021

January | February | March | April | May | June | July | August | September | October | November | December | January | February | March

2022

Innovative Partnership Acclaimed
Learning from integrated partnership approaches highlighted as a model for all services in South Yorkshire

Recruitment On Role Function
Recruitment into new roles focusses upon role function opposed to title with Menetal Health Social Workers in scope

Phase 2 Roll Out Plan Developed
Negotiation of funding to expand the model into Phase 2, incrasing access to 6 PCNs.

Experts by Experience
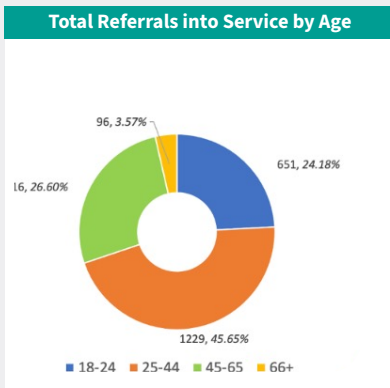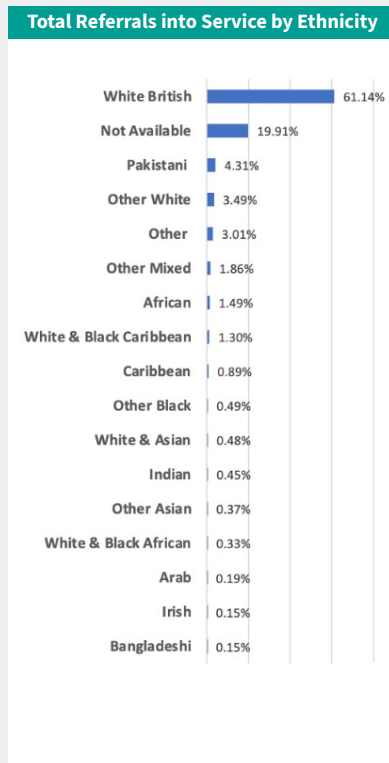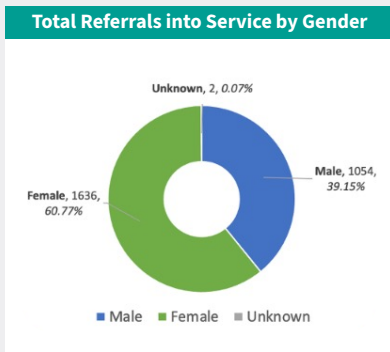formally recruited and undertaking leadership roles

Key:

● Denotes non-Covid restrictions in effect

● Denotes times of UK National Covid lockdowns

● Denotes times where social distancing/tiering was in effect in response to Covid

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Referrals into Service by Month (16 Jun 2020-31 May 2022)

Total Referrals into Service (Unique Referral)

Month & Year	Value
Feb 2020	1
Jun 2020	46
Jul 2020	194
Aug 2020	130
Sep 2020	152
Oct 2020	203
Nov 2020	183
Dec 2020	122
Jan 2021	136
Feb 2021	124
Mar 2021	130
Apr 2021	106
May 2021	136
Jun 2021	121
Jul 2021	146
Aug 2021	82
Sep 2021	75
Oct 2021	71
Nov 2021	103
Dec 2021	70
Jan 2022	79
Feb 2022	127
Mar 2022	150
Apr 2022	72
May 2022	77

Total Referrals into Programme (by Gender, Age and Ethnicity) Jun 2020-May 2022

Total Referrals into Service by Gender

- Male, 1054, 39.15%
- Female, 1636, 60.77%
- Unknown, 2, 0.07%

Total Referrals into Service by Ethnicity

Ethnicity	Percentage
White British	61.14%
Not Available	19.91%
Pakistani	4.31%
Other White	3.49%
Other	3.01%
Other Mixed	1.86%
African	1.49%
White & Black Caribbean	1.30%
Caribbean	0.89%
Other Black	0.49%
White & Asian	0.48%
Indian	0.45%
Other Asian	0.37%
White & Black African	0.33%
Arab	0.19%
Irish	0.15%
Bangladeshi	0.15%

Total Referrals into Service by Age

- 18-24: 651, 24.18%
- 25-44: 1229, 45.65%
- 45-65: ...6, 26.60%
- 66+: 96, 3.57%

A team from the University of Sheffield were selected to evaluate the Sheffield Programme and spent 16 months studying the Programme. Their report focused on 7 key themes.

1. The Programme was successful in reaching marginalised groups and tailoring mental health care to match local need

We found the mental health care provided by the programme was tailored to local needs and was able to reach those in marginalised groups. This was enabled by three main factors: the programme being located within communities, the use of general practices and third sector organisations understanding of local needs, and the flexible way in which care was made accessible and delivered.

The good thing about working locally is, you obviously can focus on the particular concerns in each area, can't you, (…) and, hopefully, the team that can be built around that can be tailored to that need. (Team member)

There's a greater proportion of people from BAME backgrounds who are coming through the primary care transformation. I think it's because they're out there, they're connected with primary care, they're linked properly with local communities. (Trust lead)

2. The Programme benefitted from strong engagement with general practice

It was clear the Programme was strengthened by effective engagement with general practice. This meant the programme better reflected the mental health needs of patients and the pressures experienced in general practice seeking to support these patients.

What we've done is tapped into huge amounts of need that would never have breached the doors of mental health services, but because we're in GP practices,

and because people trust their GPs and they're used to going there for any sort of health need, and GPs have said, "well do you know, actually, we do have someone that you can probably talk to about that now", whereas before they might have said, "oh, no, I'm not going to the City Centre or whatever, I'm not seeing strangers who are going to ask me loads of questions", is we've tapped into a huge amount of unmet need in people who probably were really, really struggling, and who just never shouted up. (Team lead)

3. The Programme faced challenges managing the scale of demand

The scale and complexity of demand presented challenges. Balancing workload across teams was challenging, as was the need to ensure support reflected the local demographics in each PCN. The primary care model of 'GP patient lists' did not fit neatly with the refer-treat-discharge model of secondary care, which presented challenges in how caseloads were managed and how services users and staff understood referrals and discharges.

The nurses are under far too much pressure and it's not okay, it's not sustainable and it's not something that's going to keep them in the job a long time. The heart's there and in the right place but the workload is just completely unreasonable (Team member)

4. The Programme also faced some challenges integrating with secondary and specialist mental health services

The position of the programme separate to other services gave it greater focus. This also meant however that it could be more difficult positioning the Programme within secondary and specialist mental health services. For the programme to be better integrated, clarification and coordination of policies and processes with other providers, and engagement at a senior level is key.

There just needs to be more cohesion. As far as the patients are concerned, we're a mental health service. They don't care if we're primary or secondary care, they've got a need that needs to be satisfied. And pressure of caseloads and things like that is not an excuse not to give somebody care. (Team member)

5. The VCSE partners were Important to the Programme and had the potential to make a greater contribution in the future

The contribution of VCSE providers so far, and the potential for greater contribution, was widely recognised, although challenges and barriers to involvement were also identified. Some VCSE leads would prefer greater involvement in the design of Community Mental Health services and several felt that there was a need to strengthen relationships between VCSE providers and general practices.

It's only recently we've been allowed to go to the multidisciplinary meetings and we don't understand why that wasn't set up at the beginning of the project (…) we were queried and questioned about data protection and about sharing of information (…) which I challenged. Early days, people wouldn't even say the first name of the person and I said, "I can't do this". (Team member)

6. The effectiveness of the Programme relied on the flexibility and innovation of the staff in delivering care

Staff and service users felt strongly that flexibility in the delivery of care was vital in the Programme, with staff feeling empowered to develop innovative solutions to meet users needs, and service users feeling this flexibility valued their own autonomy and choices. Some staff felt this presented certain challenges to consistency of care and innovation should be balanced with evidence-based care.

And I just think that the way that we approach people and the culture that we've adopted within, especially the psychology part of the team, that's something that my clients have commented on to me and says that "I've been through CAMHS, I've talked to my GP of them, this and that, but this is the first time that I've really felt a service has properly listened to what I want and what I need". (Team member)

I think the programme is really, really helpful because not only have you got that support there, but you've got it when you need it, not like if you've got…wanted to see the GP and it's really hard to get appointments. (Service user)

7. All staff identified key challenges in rolling out the the service so that it could be sustainable at scale

As the service expands, sustainability was understood as likely to be a significant challenge. Four key areas were highlighted by staff: how to ensure the service was financially viable when rolled out; how to ensure good staff could be recruited and retained; how to embed the service within the wider health and care system; and how to get useful and appropriate evidence of the impact of the service.

For more information on the Programme, see the video at;
Youtube link: https://youtu.be/VCLcbHSMqWc

For more information on the evaluation, contact Prof. Damian Hodgson, evaluation lead at:
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