



Halton & St Helens
Voluntary and Community Action



Mersey Care
NHS Foundation Trust

Integrated offer to provide Social Need Support for Community Mental Health Patients

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Overview

- To support the NHS Long Term Plan for Mental Health, trusts can bid for Community Mental Health transformation funding
- The funding was for mental health in adults and older adults (not dementia care)
- Focus on severe and enduring mental illness and those with complex needs and their carers
- In February 2021, CVS network hosted a workshop consisting of 30 local groups and organisations across the four places.

Improved Community Mental Health Care



NHS MH
Trusts

VCSFE
providers

VCFSE Governance

one
KNOWSLEY



Warrington
VoluntaryAction

LCVS
TOGETHER
FOR LIVERPOOL
FOR GOOD

Sefton CVS
Supporting Local Communities

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Alliance Group

- Meets Quarterly
- Forward thinking Agenda items
- Strategic Priorities
- State of the Sector
- Barriers/ Challenges to delivery
- Summary of other meetings

Operational Group

- Meets every month
- Relationship Building
- Vignettes/ Good News Stories
- Operational Issues
- Shared Training

Contract Meeting

- Meets every month
- Formal Standard Quality Assurance Agenda/Contracts

Halton Care Navigators

2 x Mental Health Care Navigators supporting patients with SMI and complex needs



Hosted by VCA, embedded in secondary care community teams and in-patient units

Health Care Navigator Team have received 179 referrals including:

Reducing anxiety and social isolation increasing activities in the community, increased learning, engaging in volunteering

Discharged 65% of referrals engaged with over 40 different activities

Worked closely with referring teams to improve communication, quality of information and reduce inappropriate referrals

Halton Care Navigators

Performance and Activity Reports



Indicator	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Total
[HVA1] Number of referrals received	4	21	14	13	11	5	12	9	6	95
[HVA2] Number of F2F contacts	16	13	9	6	6	3	7	3	2	65
[HVA3] Number of Non-F2F contacts	24	34	23	23	20	6	27	8	17	182

Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Total
8	4	5	9	6	12	7	16	5	99
13	12	4	0	1	14	7	12	1	76
42	16	9	6	0	27	17	30	4	203

Contract Requirements: The service will support safer transitions and community engagement both in Inpatient and Community settings. There will be two Care Navigators for each Borough. With a range of populations of between 88,000 and 209,547 for each Borough and many wards according to council Websites. This role has the potential to further enhance each Boroughs population's current mental health services through a joined-up partnership working approach.

Since the team have had access to Rio the data pulling through our systems is as below:

Indicator	Feb-24	Mar-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Total
[HSH1] Number of referrals received	1	1	1	1	1	1	11	11	19	4	51
[HSH2] Number of F2F contacts									50	57	107
[HSH3] Number of Non-F2F contacts								1	31	38	70
[HSH4] Number of meetings achieved								1	81	95	177

Service User Stories

Background of patient/ reason for referral:

- Suicidal ideations (thoughts of hanging herself) and overdoses
- Isolating at home as signed off work due to being unwell
- Feels unsupported by work, too anxious to go outside, lacks motivation, disinterested, loss of confidence and gets overwhelmed easily

Intervention/ support received

- Referral to Care Navigator for introduction to services/ cafe
- Regular telephone contact and weekly meets at the community café
- Using Motivational Interviewing and Graded exposure to support

Outcome

- Going to the community café on her own, attended classes
- Linking in with IPS to look at getting a different job that will support her
- Registered with volunteer centre and exploring volunteering/ peer support
- Active role as a grandparent, feels a lot better than she did.



Service User Stories

Background of patient/ reason for referral:

- Deaf client referred from Brooker centre, who has mental health problems
- Feeling isolated and lonely, especially through communication barriers
- Safeguarding issues, social needs and demonstrably vulnerable

Intervention/ support received

- Accompanied to Weaver Arts Centre at Grangeway Community Centre
- Helped communication with sign language cards and BSL tools
- Linking with Deafness Resource Centre to support social needs

Outcome

- Socially connected with arts groups who greet her in BSL
- Managed safeguarding issue with appropriate support from agencies
- Enabled improvements to the home for security and accessibility
- Feeling more confident and connected, improved wellbeing, reduced low mood and depressive episodes



Service User Feedback

“Shirley is my Care Navigator and has been helping and supporting me. She has helped me re-connect with people.”

“She is/ has been an absolute angel to me, she listens, advises and never judges me. Without her in my life I wouldn’t want to have carried on living. She has encouraged me to focus on what is important. She’s amazing and I wouldn’t be here without her”

“The Mental Health Care Navigator, supported and encouraged me through every step of the process. I felt valued and validated. Through talking with her, she instantly knew my strengths and where best to apply them, by tailoring her service to my needs”

“Without the help of Fran and the service, I believe I would still be lying in that bed with no purpose and no reason to leave my flat.”

Challenges Identified

- Access to information
- Ongoing maintaining/ referrals to VCSFE
- Training for VCSFE- addressed through training programme
- Data flow – ongoing access to Rio now addressed and services have access
- Access back to services when stepped down
- Timely discharge from VCSFE
- Managing expectations of patients/ service users





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Questions

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