

Bexley Locality Team Overview

The service model is a locality based pathway of care which offers a range of services for adults comprised of:

- **Primary Care Plus (PCP)** pathway which is the direct link between primary and secondary care services and focuses on tele-triage, providing direct advice and support to GPs and directing service users to the pathway that will specifically meet their needs.
- The **ADAPT** Pathway which provides focused, therapeutic interventions to adults residing within the respective Boroughs who require care and treatment for **Anxiety, Depression, Affective disorders, Personality disorders and Trauma**
- **Intensive Case Management for Psychosis (ICMp)** pathway which provides care and treatment for service users who are diagnosed with schizophrenia or bi-polar disorder.

Primary Care Plus (PCP) Pathway

Aims of the service

Primary Care Plus (PCP) will provide a specialist mental health liaison service to primary care. It has four core aims:

1. Assessments & referrals management

- PCP will provide a single point of access for all referrals to Oxleas Mental Health Services from primary care.
- Urgent referrals will be telephone triaged within 24 hours, and if needed will receive a same day face to face assessment from our crisis service. Routine referrals will be triaged within 2 weeks.
- New referrals will then be directed to the appropriate treatment pathway (psychosis, ADAPT, Early Intervention) to have their full assessment and treatment.

2. Relapse prevention & shared care

- For people who have previously been under Oxleas' services, PCP aims to support primary care to assist patients maintain their remission and help them develop good self-management skills.
- PCP will have a link psychiatrist and multidisciplinary team for every GP practice, who provide liaison support between primary and secondary care.
- PCP psychiatrists will support GPs to manage complex medication regimens, and provide advice and oversight for issues such as off-license prescribing, monitoring, and input into the updating of shared care prescribing guidelines.
- PCP psychologists will be able to offer systemic consultations for people who are not willing or able to access treatment pathways (for example for personality disorder), and help formulate a care plan for that person.

3. Health promotion

- PCP will promote physical health by offering a range of brief interventions
- PCP will promote functional recovery and mental wellbeing by offering occupational therapy led social inclusion work

4. Education, training & consultation

- PCP will provide regular teaching to borough wide GP training events.
- The PCP will deliver training to practice nurses and will provide bespoke training based on identified need e.g. master classes for mental health leads.
- PCP will provide training opportunities for foundation trainees and GPVTS trainees.

PCP Extended Opening Hours

- The PCP will map onto GP opening hours of 09:00 – 20:00. This service will be operational from Monday 16th November 2015. The contact telephone number for GP's between the hours of 17:00 – 20:00 is: **02038611170**.

Criteria for Transferring service users back to Primary care

Service Users should be considered for transfer back to their GP if the following apply:

- a) Those in remission, or with stable well controlled symptoms [The PANSS in RIO could be used to measure this];
- b) Those who have had a minimum of 12 months since their last admission;
- c) Those on a stable medication regimen which their GP can prescribe [clozapine is excluded];
- d) Those who have been collecting their medication/attending for their depot reliably from their GP for minimum of 3 months prior to transfer back to their GP;
- e) Those who have sufficient knowledge and understanding into their condition and are willing to continue long term treatment and self-management;
- f) Those who have been offered and either completed or declined NICE concordant psychological therapies/other relevant groups;
- g) Those who have made a functional recovery/have reached a stable plateau in progress;
- h) Those who are in work/volunteering/education/meaningful activities;
- i) Those who have stable inhabitable accommodation;
- j) Those who have a family member/friend/other contact person who they would be willing to have as a point of contact and a person who can help them seek help if needed in the future;
- k) Those who have completed self-management skills training/been able to develop their own and have this documented in a wellbeing plan and have tested this out;
- l) Those who have left the area.

GPs should use the GP Quality Alert systems for reporting any issues and difficulties they are experiencing with the service.

ADAPT Pathway

The ADAPT pathway will offer a flexible service to service users presenting with complex presentations (excluding Psychosis or Bi-polar disorder) who currently require secondary mental health care. Presenting problems will include Anxiety, Depression, Personality Disorder and Trauma. Referrals to ADAPT may come from Primary Care Plus via triage, from the Wards, Crisis or Day Treatment Teams, EIP teams (following clarification of diagnosis), Forensic services or as a result of Out of Area transfers.

Assessment within ADAPT Pathway

The Multi-disciplinary team (MDT) for ADAPT consists of psychiatrists, social workers, occupational therapists, clinical psychologists, psychiatric nurses, employment advisors, support worker staff and lived experience practitioners with the support of administrative roles.

Following Triage within PCP, those service users considered to need input from ADAPT will be booked into an Assessment Clinic. This assessment should take place within 10 working days by an experienced clinician with the appropriate skill set and competency to ensure good quality formulation and care planning.

Core Interventions

Following assessment service users will subsequently be offered prompt access to low intensity or “core interventions” delivered by one or more members of the MDT. These “core interventions” will be focused and time limited and may either lead to further specialist interventions within ADAPT or transfer back to primary care upon completion.

Core interventions will include psycho-education, safety planning, problem solving, supported self-management skills (including support by lived experience practitioners, social prescribing, employment support, low intensity Cognitive Behavioural Therapy (CBT).

The intensive case management function within the ADAPT service (for those service users with more complex, enduring needs and associated risks) will offer co – ordinated care via CPA to those needing multiple specialist interventions delivered concurrently by different members of the ADAPT multi – disciplinary team.

ADAPT Inclusion Criteria

- Adults aged 18 or over who are resident in the London Boroughs of BBG and also have a GP located in the borough.
- People with complex presentations of anxiety, depression, personality disorder and trauma which are severe or enduring and which significantly impair normal functioning/independence or where first line treatments within primary care or IAPT services have not provided therapeutic benefit.
- People where there is significant risk to self, to others or of self-neglect.
- People who have a mild identified learning disability and are also experiencing significant enduring mental health difficulties.
- People who are over 17 years old and have identified on-going secondary care needs.

Intensive Case Management for Psychosis (ICMp) Pathway

The ICMp provides a flexible service to all adults within the psychosis clusters who currently require secondary community mental health care in the locality. It therefore includes all those diagnosed with bipolar disorder as well as the various psychotic conditions.

Referrals will come from:

- Psychiatric inpatient wards - acute and rehabilitation services
- EIP once an episode of commissioned care is complete and there is an identified on-going need
- Home Treatment Teams
- PCP via triage
- ADAPT, occasionally as a result of re-diagnosis or changing needs
- Transfers from out of area
- Service users discharged from inpatient forensic wards into the community and also service users being transferred from community forensic teams to adult mental health teams.

Inclusion Criteria:

- Adults with a diagnosis of psychosis
- Adults with a diagnosis of bipolar disorder
- Adults who are 18 years and over and;
- Adults who may have difficulties in engaging with services;
- Adults who may have a forensic history
- Adults who may have a history of repeated failed community placements;
- Adults who may have symptoms poorly controlled by medication;
- Adults who have high levels of disability associated with their mental illness affecting their ability to manage daily living skills e.g. budgeting, routine, diet, problem-solving;
- Adults who may have limited or non-existent positive social relationships and supportive networks
- Adults who may have profound difficulties in family and social relationships or severe difficulties with living skills and would benefit from intensive community support.

Oxleas Adult Community Mental Health Service: Bexley Locality Team Overview

Bexley Locality			
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This information and further information for GP's about Adult Community Mental Health Services in Bexley is available on the dedicated GP web page on the Trust's website:

<http://oxleas.nhs.uk/bexley-gp>