Table Top Discussions – Part 1

Allocated question: Care-coordination

- Variation in provision and funding – Extend to which EIP see ARMS as extended assessments
- Bradford Model
    - Care Navigator plays 'sleeping role', unless issues re risk etc.
    - Bulk of work run by 4 therapists
- Anticipate >35s will increase car-co workload
- CPA
- ? Pull care-coordination resource from EIP

Allocated question: Capacity – Developing ARMS pathway

- Purpose? How design? How to facilitate when already feel like over-capacity?
- Issues of holding mixed case-load
- Extra money? – sometimes just offsets debts
- ARMS Pathway – 3 to 12 months maybe
    - Care co-ordinate – maybe 6 months
    - Mobilising network / ID approx. therapeutic intervention
    - Individual / group / family
- Separate ARMS service – FEP

Allocated question: Capacity – Referral Rates – Demand

- Concern over the number of ARMSp – 1:1 to FEP = demand on stretched services
- Bring IAPT into provide therapy? – Partnership
- How will we manage the increase demand
- Should it be allocated ARMSp staff or EIP staff
- At risk of developing a MH problem

Allocated question: CBT vs CBTp / use of ARMS - ? Existing pathways

- Assessment team for FEP and ARMS
- CAARMS assessment to identify ARMS, also use to identify FEP – better to have over assessment
- ARMS – referral to recovery co-ordinator
    - Psychological therapist can act as co-ordinator in less complicated cases
- Care co-ordinators for complex psychological therapist can get on with therapy – but not on all psychological therapy input needs to dive the change
- Monitoring done by any psychologist using CAALMS to overwork someone is maintaining gains. Monthly for first 6 months – quite intense input
- Capped caseloads for ARMS? No guidance
- Attenuated systems route get most referrals – low level symptoms

Allocated question: Interface with IAPT – Substance

- First encounter with psychologic symptom e.g. voice – referral source but also reluctance to take on
- Some referrals have failed with IAPT – represent in crisis opportunity to pick up sooner

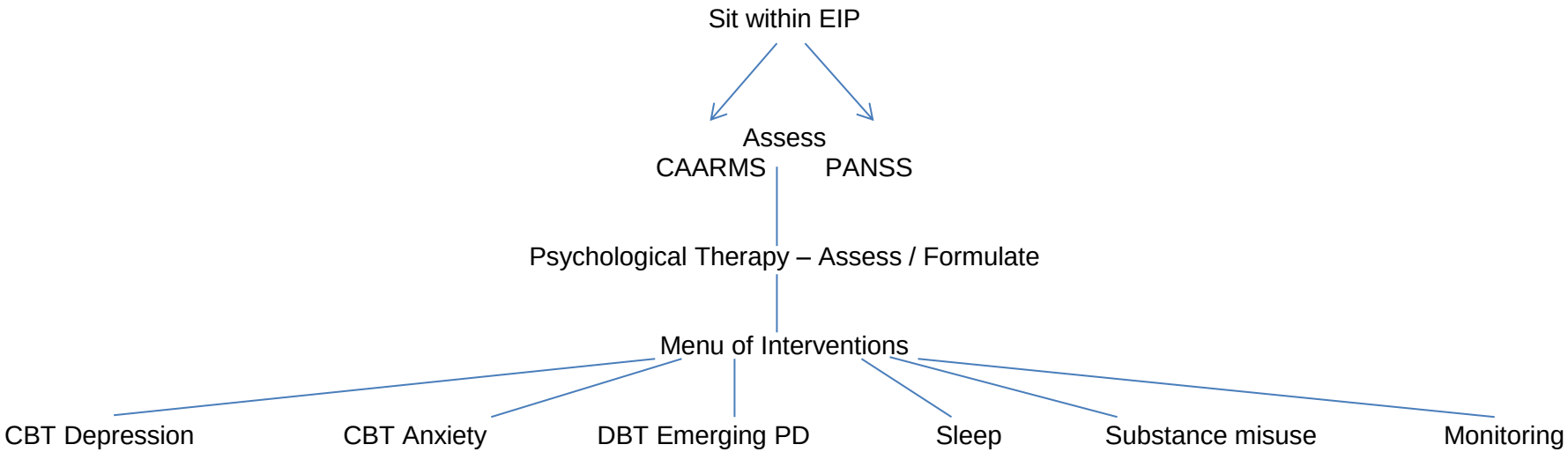
- Waiting list
- Knocking item back – “until one of us agrees” - Negotiation
- Personalities
- Complex individuals are likely to engage with IAPT – less effective follow up
- Group programmes – tend not to be very helpful for follow-up clients
- Transition Panel?

Allocated question: Not Noted

- CAARMS – Help seeking professionals view? Psychotic
- Care co-ordination - ?CPA? – few cases where issues were solely psychological
- Deskilling current practitioners – formally work input is CBT enough – cannot use IAPT
- CAMMS – carrying ARMS already – needs to be connection

Yorkshire and the Humber
Clinical Networks

Table Top Discussions – Part 2



- Can Offer
  - Physical Health
  - Medic / GP
  - Support work
- 3 months / 6 months review – Repeat CAARMS
- Single point of access? Shared between ARMS / EIP
- If integrated, clear delivery of pathways – Clear identity
- Embrace uncertainty
- Protected care-coordinators resource – how much?!
- CBT/CBTp? – Stepped / trend model
- NAViGO - has a pathway at niche <30 or <35 FEP
- Wakefield / SWYFT - taking everybody (FEP) for some time but only just started
- York – Not all on CPA if simple cases (if they exist)
- NAViGO ARMS and Wakefield ARMS – All on CPA
- York and NAViGO have fully mixed caseloads
- Large team sizes – Discussion of how to manage larger team sizes
- Contact with GP is more important for ARMS]
- ARMS impacting on psychology waiting - ? Taking priority to meet NICE
- Barnsley – dedicated CC in ARMS / SEP EIP
- Key pathway theme – Embed behind front door of EIP (suspected FEP)
- CC – Linking community services – Self-efficacy - > time limited
- Does it need to be a Band6 CC? Or band 5/4 keyworker?
- Dedicated role