Like Minded Model of Care for Serious and Long Term Mental Health Needs

Update and discussion on progress and next steps with Hammersmith and Fulham OSC – 12 September 2016

1. Introduction

Like Minded is the North West London Strategy for Mental Health and Wellbeing. Taking a North West London approach means we can share good practice, avoid duplication and work collaboratively where developing services for a larger population means we can deliver better outcomes.

Like Minded's vision is for NW London to be a place where people say:

- "My wellbeing and happiness is valued and I am supported to stay well and thrive"
- "As soon as I am struggling, appropriate and timely help is available"
- "The care and support I receive is joined-up, sensitive to my own needs, my personal beliefs, and delivered at the place that's right for me and the people that matter to me".

Hammersmith and Fulham has a long standing commitment to mental health as a priority for the local population – and good examples of development of innovative services that support particular local needs.

Like Minded aims to set the overall strategic direction, the framework of outcomes and ambition – and then naturally as we implement in Hammersmith and Fulham there will be variation – due to specific population needs and existing services.

This paper provides an update on the work stream looking at the needs of adults with Serious and Long Term Mental Health Needs (SLTMHN). It reflects the joint work that is taking place between Like Minded, Hammersmith and Fulham CCG, Hammersmith and Fulham Local Authority, CNWL and others. We are keen to have the opportunity to discuss progress and next steps before all plans are finalised.

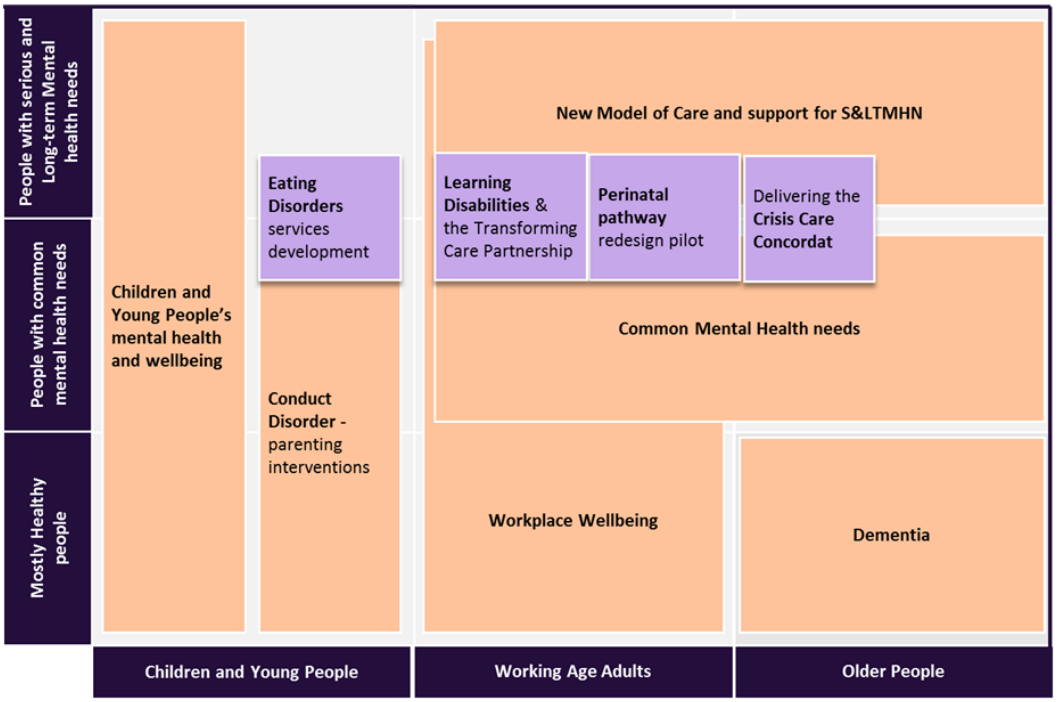
We are asking today for the chance for discussion and guidance ahead of formal decisions being required. We are keen to have clarity from you on the key questions you will need to have answered when we are next in front of you looking at formal decision making stages.

The Overview and Scrutiny Committee is being asked to note this paper, discuss and comment.

2. Background

Like Minded's goal is to promote wellbeing and to improve the mental health care and support we receive if we need it. Like Minded's Case for Change has identified eight major issues that we currently face in NW London and the ambitions that we must all sign up to if we are to improve things.

Like Minded addresses mental health needs for people of all ages and levels of need; whilst we know that people do not exist in a single box this is a useful framework to prioritise and focus within an area of vast need.



Like Minded takes account of work already happening locally in order to deliver on our vision. We have particularly valued taking a co-productive approach to developing plans – and delivering service change. This has included engaging widely with the population and supporting and enjoying the formal membership of the 'Making a Difference Alliance' of Service Users and Carers on our Boards and steering groups.

The Case for Change was endorsed by the NHS NW London Collaboration Board, the Governing Bodies of all eight CCGs and all eight Health and Wellbeing Boards in Autumn 2015. The Like Minded programme is addressing the identified issues through transformation programmes on Children and Young People, Common Mental Health Needs, Wellbeing and Prevention, Perinatal, Learning Disabilities and Serious and Long Term Mental Health Needs. This paper focusses on the SLTMHN work stream aims and objectives, the model of care and support, progress and next steps.

3. Serious and Long Term Mental Health Needs (SLTMHN)

3.1 Aims and objectives of SLTMHN work stream

We need to improve the quality of care for those with serious and long term mental health needs, where illness can have a devastating impact on lives from relationships, jobs and friends. Compared to the rest of London[1],Hammersmith and Fulham have a higher than average burden of Severe and Enduring Mental Illness (SMI) and is likely to have a similar burden of common mental illness. People with severe and common mental illness in Hammersmith and Fulham suffer from significant co-morbidities, and their healthcare costs

[1]A Mental Health Strategy for Hammersmith (Draft 4) May 2016.

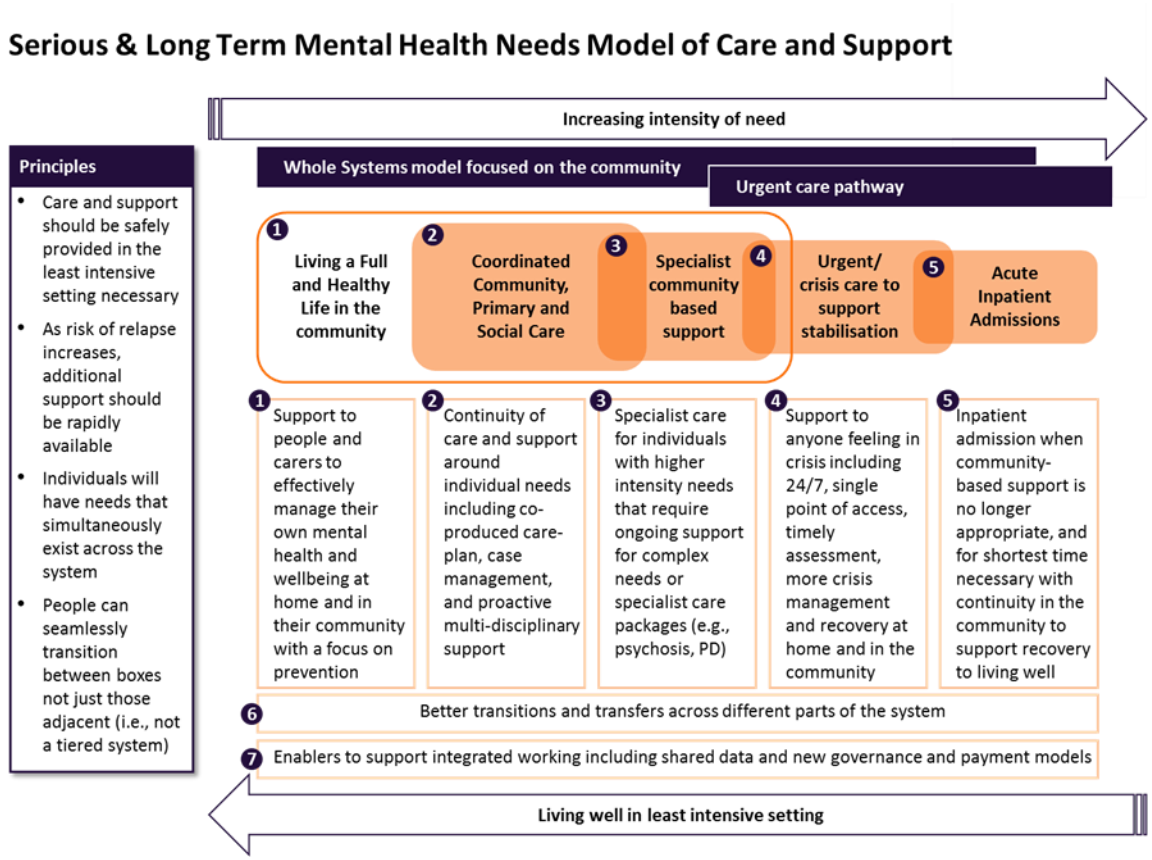
are higher than average[2]. Locally, mental health is the most common reason for long term sickness absence and several of the wards in the deprived parts of the borough fall into the 20% highest in London for incapacity benefit/ ESA claimant rates for mental health reasons[3]

Our ambition is that for people with serious and long-term mental health needs we will:

- Make their care journey simpler and easy to understand
- Develop new, high-quality, services in the community
- Focus care on community based multi-disciplinary support rather than just in-patient care so people can stay closer to home

3.2 Model of Care and Support for people with SLTMHN

Our Model of Care and Support for people with Serious and Long Term Mental Health Needs was endorsed at the Mental Health and Wellbeing Transformation Board in October 2015 which is attended by CCG teams, representatives from Local Government, service users and carers and other key stakeholders.



Our aim is integrated transformation across health and social care and there are twelve separate initiatives which help define how the Model is to be delivered.

[2] A Mental Health Strategy for Hammersmith (Draft 4) May 2016.
[3] Hammersmith and Fulham Joint Strategic Needs Assessment Highlights. Report 2013-14

Whole systems community based model	**Living a full and healthy life in the community**	**Community mapping and navigation service** – develop and maintain an active database of community services and assets; make this information available to people, carers and care providers; work with community to reduce stigma and build better community based support	
	Coordinated community, primary and social care	**Whole Systems model, likely (but not necessarily) in primary care with model defined locally on how to provide; example described and costed**	Longer **GP appointments** (or alternative) to assist with more intensive care planning and case management
			Increased **PCMH Resources (e.g., social workers, OTs, nurses)** to ensure that **all Boroughs can provide primary care based MH care and support**
			Case Management (by case manager or appropriate alternative) to work with service users to support with case management, care planning and coordination
			Working in **Multidisciplinary Teams** to support better care planning and coordination
	Specialist community based support	**Community Based Packages** – implementing evidence based (i.e., NICE guidelines) specialist care and treatment packages in the community	
		Technological Advancement – e.g. software to centrally schedule community team visits and minimise the time spent on non-face-to-face activities; install hard/software infrastructure to allow for video conferencing	
Urgent care pathway to living well	**Urgent/crisis care in the community**	**Crisis Response & Home Treatment teams** – Expanded resourcing and role of CRHT teams, so that they can provide as much intensive home-based care and treatment as possible to minimise the need for admission	
		Crisis/recovery houses – Alternative safe places in the community and step up/step down facilities in the community, to provide preferred alternative options for users	
	Inpatient admissions	**Supported accommodation** – More accommodation (or more appropriate provision) to receive people who no longer need an acute inpatient bed but also cannot be safely discharged to their home	
		Discharge planning - Greater collaboration on discharge planning between inpatient teams and ongoing-care teams	
		Closer **post discharge follow-up**	

4.3 Work to date in Hammersmith and Fulham

The mental health team, Hammersmith and Fulham CCG, West London Mental Health Trust and the Local Authority are working closely together to define what will be required to implement the model of care. For example, work is taking place to:

- Define how Hammersmith and Fulham will meet the ambitions in the model for a primary care mental health team, building on services already in place
- Define the resources required to meet an increase in community-based care and ensure pragmatic areas of support such as housing, employment, financial and peer support are included
- Understand the impacts of the model of care on social care services and resolve or identify issues to be addressed as part of service design
- Begin to define the 'alternatives' that will help avoid unnecessary acute admission and get people out of hospital when they don't need to be there
- Define how existing developments are taken forward, such as the 24/7 Single Point of Access already live for the Hammersmith and Fulham population.

We are drafting a North West London business case of shared ambition, with CCG chapters related to specific local need, services and pace of change. The local business case for Hammersmith and Fulham is developed in parallel with Hammersmith and Fulham Council to ensure we quantify and address the impacts of the business case for the Council.

Locally, the model defines a shift in activity away from in-patient beds towards alternative forms of community-based support which are to be developed in Hammersmith and Fulham.

4.4 Integrating the Model of Care and Support in Hammersmith and Fulham

The Business case will bring together the impact of work already underway, describe any additional work required – and critically address how working as a whole system with the right multi-disciplinary support at all stages of the patient experience (including a greater focus on early intervention and prevention) is required. The overall outcome will be a description of outcomes and benefits that we as a system can then hold ourselves to jointly deliver.

Our ambition is to achieve endorsement of the model as *'the right thing to do'* with Hammersmith and Fulham Council and CCG in parallel.

Questions posed by local teams in Hammersmith and Fulham Clinical Commissioning Group and the London Borough of Hammersmith and Fulham so far are helping us to shape the local Model of Care and Support. These questions include:

- Which service users will benefit from any additional supported accommodation?
- What sort of additional supported accommodation (or equivalent) will be needed (e.g. crisis avoidance, step-down)?
- Do the increased resources/roles for community-based support in the model 'fit'? Are there any gaps?
- What ways of working together will be important from the Local Authority and Clinical Commissioning Group perspective a) during design and implementation b) delivering the service?
- What other changes will be needed to achieve the shifts in activity in the model (e.g. improved processes for admission avoidance, discharge, delayed transfers of care, trusted assessment, joint multi-disciplinary team working?)

4.5 Next steps and timeline

The timeline for the next stage of work is to develop and approve the local business case by Autumn 2016.

5. Recommendations

The OSC is asked to comment on the following questions:

1. What other questions should we be asking to help shape the SLTMHN Model of Care and Support on a local or North West London level?
2. What other elements will be important to explain or demonstrate to members in order for the SLTMHN Model of Care and Support to receive endorsement from Hammersmith and Fulham Council and the CCG?
3. What forums would be helpful to attend to further inform relevant stakeholders?