NHS
Central London
Clinical Commissioning Group

NHS
West London
Clinical Commissioning Group

Westminster City Council Adults, Health & Public Protection Committee
Strategic Approaches to Mental Health in Westminster

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1. BACKGROUND

Westminster has a relatively high prevalence of mental illness. The 2013/14 JSNA Highlight Report noted that:

- 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 highest 10% in London for incapacity benefit/employment support allowance claimant rates for mental health reasons.
- Common mental illness such as anxiety and depression affects around 1 in 6 people at any one point in time and is one of the leading causes of disability nationally. Westminster self-reported prevalence of anxiety and depression was above the national average in 2014, and estimates suggest this may rise steeply over the next 10 years.
- Westminster's suicide rate[1] is the 14th highest in London; there are around 23 completed suicides per year in the Borough. 3-year trend data since the mid1990s shows a downward trend for suicide rates over the past 20 years.
- 7% of London's population has an eating disorder
- 1 in 20 adults have a personality disorder[2]
- 1% are registered with their GP as having a psychotic disorder such as schizophrenia, bipolar disorder or other psychoses

This is in line with many inner London boroughs; however, Westminster's high homeless population and its proximity to transport hubs (meaning high inward migration from other UK cities and abroad, as well as a transient population) present particular challenges.

The NW London *Like Minded* strategy sets out a case for changing the way we commission and provide support to people with mental health needs which helps them to recover and live well. The aspiration is to ensure that people are supported to stay well and thrive, that appropriate and timely help is available for people in crisis, and that is joined up, sensitive to individual needs, and delivered in the most appropriate place (usually in a person's home and/or local community).

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[1] Defined as completed suicides per 100,000 population. See: http://data.london.gov.uk/dataset/suicide-mortality-rates-borough/resource/64ee7e57-52c7-41a9-b742-073391ffa02b

[2] Personality disorders (PD) are associated with ways of thinking and feeling about oneself and others that significantly and adversely affect how an individual functions in many aspects of life. They fall within 10 distinct types in the Diagnostic & Statistical Manual of Mental Disorders (DSM-5) , including paranoid PD, schizoid PD, antisocial PD, borderline PD, avoidant PD and obsessive compulsive PD.

Health services in Westminster are commissioned by Central London Clinical Commissioning Group (CCG) (for the majority of the borough) and West London CCG (for patients registered with GPs in the Queen's Park & Paddington area). Both CCGs have signed up to a number of ambitions in *Like Minded*, including:

- supporting resilience in the workplace,
- supporting people with longer-term mental health problems through simple, community-based pathways,
- rebalancing resources from acute to community,
- improving identification of common mental illness and improving coverage and quality of talking therapies
- integrating physical and mental healthcare, so that people's needs are met in a joined-up way.

2. STRATEGIC APPROACH

As above, the strategic framework for improving mental healthcare across the North West London collaborative is provided by *Like Minded*. The strategy comprises four key work streams:

- Serious and long-term mental health needs – developing a new model of care and support, with clear outcomes and financial impact across the system.
- Common mental health needs – implementing evidence-based interventions and models of care for under-diagnosed and under-treated common mental health needs.
- Children and young people – a NW London Transformation Plan in response to the national *Future in Mind* strategy, describing areas of work and outcomes for the next five years.
- Wellbeing and prevention – workplace wellbeing to promote wellbeing and prevent mental ill health, and parenting interventions to support parents of children at risk of conduct disorder.
- Further work streams, including delivery of Crisis Care Concordat, perinatal mental health, learning disabilities, out of hospital services and eating disorders are also in development.

Central London and West London CCGs work closely with Local Authority partners, service users, carers and other stakeholders to implement this work at a local level. Along with Harrow, Brent and Hillingdon CCGs, we commission Central & North West London NHS Foundation Trust (CNWL) as our main provider of secondary mental healthcare, as well as commissioning services from other

NHS Trusts and voluntary sector services. The Tri-Borough Local Authorities and CCGs are committed to working jointly to commission services. Currently just over £20m of services are jointly commissioned by RBKC, WCC, West London CCG and Central London CCG, the majority of which is on placements.

We are currently working on plans for alignment and integration of strategic commissioning which would ensure better joined up, more local and personalised care, and a reduced reliance on out of area placements. Within this, employment, housing, personal health budgets, dementia and services for transition are shared high priorities.

Across Central London and West London CCGs, we have some particular drivers around enhancing primary care in order to support people to stay well longer (avoiding referral to secondary where possible) and also to provide a clear and empowering pathway into community and primary services for people whose care has been coordinated in secondary care. This involves services that attend to the determinants of good mental health, resilience and well-being, as well as physical and mental health support, all in one place.

In addition, we are prioritising:

- ensuring that our IAPT (Increased Access to Physiological Therapies) services are commissioned to provide good outcomes, including meeting access, recovery and waiting times targets;
- developing 24/7/365 access to crisis assessment in the community, through the introduction in January 2016 of rapid response home treatment teams, which will meet people's urgent care needs in their own home or other appropriate setting;
- ensuring that community mental health teams are fit for purpose, oriented towards independence and recovery and aligned to primary care; and
- taking a Whole Systems Integrated Care approach to meeting people's mental, social and physical needs are addressed in increasingly 'whole person' services.
- providing evidence-based interventions for people experiencing a first episode of psychosis
- developing joined-up perinatal services, which support women's mental health in the perinatal period in the community where possible, and in acute settings where appropriate.

We are also co-producing local strategic plans with clinicians, patients and stakeholders to ensure that we have a joined up response to the needs of patients in Westminster.

3. SPECIFIC DEVELOPMENTS

This section summarises the work we have undertaken in Westminster to improve outcomes for people with mental health conditions.

3a. Crisis Care Concordat

In March 2014, the NW London Mental Health Programme Board committed local organisations to meeting the requirements of the national Crisis Care Concordat. The Like Minded Strategy team continues to develop this programme of work with its 26 partners, including NW London CCG's, Local Authorities, police, the London Ambulance Service and user groups. This pledged the whole system to:

- make sure we meet the needs of vulnerable people in urgent situations, getting the right care at the right time from the right people to make sure of the best outcomes;
- make sure that all relevant public services, contractors and independent sector partners support people with a mental health problem to help them recover;
- putting in place, reviewing and regularly updating an Integrated Urgent Mental Health Care Delivery Plan.

To this end, Central London, West London, Harrow, Brent and Hillingdon CCGs have commissioned CNWL to re-design their urgent care pathways.

In November 2015, CNWL launched a Single Point of Access (SPA) for referrals into secondary care. The SPA takes referrals from GPs, patients, carers and other referrers, provides clinical triage and is committed to responding to all emergency referrals within 4 hours and all urgent referrals within 24 hours (as well as routine referrals within 28 days). In January 2016, home treatment / rapid response teams provided by CNWL extended their operational hours to become 24-hour teams. This means that a person in crisis should get a quick response and visit at home (or other appropriate community setting) from a mental health professional which supports their recovery, and prevents unnecessary or inappropriate hospital admissions.

CCGs are working closely with CNWL and primary care clinicians to assess activity and outcomes and understand the wider benefits on the whole system (e.g. the potential reduction in A&E attendances, as a result of people in crisis being seen quickly at home; also potential reduction in S136 admissions[3]). Supporting our police to navigate the system and care considerately for vulnerable people who are arrested subsequently found to be mentally ill is crucial. The launch of home treatment/rapid response teams gives our police 24/7 access to a Mental Health clinician, if the person is known to the service they will also have access to their care plan and the person to contact in a crisis.

Central London, West London & Hammersmith & Fulham CCGs have also secured non-recurrent funding from NHS England to develop liaison psychiatry, so that people with mental health problems who are inpatients in a general acute hospital, or who present at Accident and Emergency, have their physical and mental healthcare needs met, and that these services are funded and specified to national standards. We have used this money to fund additional capacity over the winter, and to fund a project to map pathways to ensure that we are commissioning an efficient service which complies with national "core24" requirements[4], and that acute and mental health providers work together effectively.

Central London CCG also leads on implementing the Tri-Borough Suicide Prevention Strategy, which aims to promote inter-agency working in reducing the numbers of suicides in the Inner North West London boroughs of Westminster, Hammersmith and Fulham and Kensington and Chelsea by 30% by 2018. There are a number of different actions, which are intended to be practical and given to regular monitoring and continual evaluation. These actions are based on four overarching goals:

- Timely communication and information sharing between agencies on identification of at risk individuals and care pathways.
- Public education and awareness on suicide and/or mental health promotion through community outreach, anti-stigma campaigns, etc.
- Promotion of existing suicide prevention resources, interventions and support services like the May tree respite or telephone help lines like those operated by Samaritans or Campaign Against Living Miserably (CALM).
- Priority training for frontline workers (GPs, A&E, and concerned others) through

[3] Section 136 Mental Health Act provides a power for police officers to detain a person, adult or juvenile, found in a place to which the public has access, who appears to be suffering from a mental disorder and be in immediate need of care or control.
[4] Core24 liaison psychiatry is available 24 hours a day, 7 days a week, and is the minimum level of resourcing which is expected to generate a return on investment in terms of reducing acute spend.

3b. Redesign of secondary community services

As part of our strategy to move away from an over-reliance on acute beds, we are investing both strategic resource and funding into redesigning community services to better meet the needs of people with mental health needs. Following extensive co-production with commissioners, clinicians, patients and other stakeholders, CNWL have redesigned the community pathway which was launched early in 2016. This includes the remodelling of community mental health teams to align with GP localities, the development of a more recovery-focused model of care, the introduction of a central Approved Mental Health Professional (AMHP) team, and the establishment of a single team with responsibility for all clients in rehab or specialist supported housing placements. There is also a therapies hub, including a range of therapeutic interventions for individuals and families, which will embed these approaches into everyday CMHT practice.

This redesign project has been aligned with work being undertaken by the Local Authorities to develop a new, recovery-focused day services pathway. This new model also acknowledges and celebrates the vital role that the voluntary sector has to play in supporting people to live well, realise their potential, create and sustain social networks, and play a role in the community.

3c. Redesign of primary community services

A key part of *Like Minded* is the development of a new model of care for people with serious and long-term mental health problems; at the heart of this model is enhanced primary and community care which supports people's mental and physical healthcare needs, and their social support needs. Most patients in this category are cared for by their GP and hence the commitment is to ensure they have adequate bio-psycho-social support around them, available in a timely way, to ensure that GPs can agree robust 'Recovery and Staying Well Plans' with their patients.

West London CCG

West London CCG, together with Tri-Borough Local Authorities, service providers and users and carers, submitted a successful proposal to become a Department of Health Whole Systems Integrated Pioneer for people with Serious & Long Term Mental Health Needs. Over the last 18 months, partners have worked locally to co-produce a model of care that will:

- Be population-based, for all those over 16, with Complex and Common or Stable Serious Mental Illness – there are over 13,000 people with a Common Mental Illness already known to GPs (estimated to be a further 26,000 not in contact), and 3500 people with a serious mental illness.
- Offer, within 5 days, a face to face 'mutual needs assessment' for anyone identified as needing mental health or social care support that is non-crisis.
- Provide packages of support, including up to six sessions with a primary care liaison nurse (PCLN) or Navigator to help resolve issues early and quickly.
- Be pro-active in nature – offering tiered access matched to needs, from Self Care, through Peer Support, Health and Social Care Navigation and specialist primary mental health case management (including psychiatry, psychotherapy, social work and nursing support).
- Be Bio-Psycho-Social in nature – having the right skills mix and training to work with whole person needs, and with a prevention and sustained recovery focus.
- Offer a range of services, including talking therapies and specialist employment support, for people with Common & Serious Mental Health needs.
- Bring together a range of third sector and statutory services into a single 'living well' partnership for the benefit of our residents: better coordinated, more diverse care that delivers better outcomes and increased efficiency.

There has been close joint working with the Local Authority during development and it has been presented, discussed and approved at the WCC Health & Well-Being Board in January 2016.

Subject to final business case approval by West London CCG, who will be funding this new service, it will operate from two key hubs. St Charles Hospital – Health and Wellbeing Centre will be the Hub covering Queen's Park and Paddington (though members of the service will be able to access wherever is most convenient). Third Sector engagement identified 18 agencies, some of whom work specialise in mental health, with others more general in nature, who have committed to be part of the living well network and use hubs. Critically, this ensures the service has a diverse and comprehensive range of community spokes.

The service will, if the business case is approved, become operational during summer 2016. It builds on an existing significant primary care mental health service in West London CCG that delivers primary care liaison nurse and IAPT support across the whole CCG.

Please see Appendix One for a visual 'model on a page'.

Central London CCG

In Central London, Primary Care Plus (PCP) was set up in 2012. It is a multi-disciplinary service provided by a partnership of CNWL, Central London Healthcare (CLH) and Westminster & Wandsworth Mind which provides a triage function for non-urgent mental health referrals, as well as integrated support within primary care for patients who require it. The team includes clinical (OT and nursing) and non-clinical (community navigator) input, and is based in GP practices, as well as having a hub at the CLH offices. The specified outcomes of the service are: improved patient experience through simplifying pathways; better transfer of care of CMI and stable SMI into primary care; more active interface between primary and secondary care and the voluntary sector; better awareness, diagnosis and mgmt within primary care; provision of support in the least restrictive setting; better gatekeeping; better management of people who are homeless, have a dual diagnosis and other co-morbidities; improved GP awareness.

A review carried out in October 2015 noted a number of positives which PCP had achieved, including:

- Low rates of people being readmitted to secondary care within 90 days of discharge;
- Increased efficiency through targeted appointments and more streamlined triage;
- Timely sharing of care plans with patients;
- Good performance on waiting times for assessments, carer assessments.

The review also identified a number of challenges, including:

- DNA rates (although recent performance data show that DNAs have reduced in the latter half of 2015/16);
- Closer liaison needed with secondary care, especially around patients deemed ready to step down;
- The need to more proactively work with older and housebound patients, who have been under-represented in the service.

There are also two out of hospital services for people with mental health problems:

- Serious mental illness – includes shared care prescribing for people in secondary care, and a safe transition and increased consultations and Recovery / Stay Well planning for patients in primary care who are on the serious mental illness (SMI) register (i.e. those patients who have either stepped down from secondary care, or who may be at risk of stepping up).
- Common mental illness – includes identification, proactive case management, and monitoring via increased consultations, use of depression and anxiety questionnaires, annual health review and Recovery / Stay Well plan.

These services operate across CWHHE CCGs and, like PCP, aim to provide consistent care for patients in primary care, support safe and sustainable transfer of care from secondary to primary care, and improve the physical health of patients with long-term mental health conditions.

While this provision is a good platform, it is acknowledged that further work is required to provide genuinely integrated care for people with mental health problems. We have initiated a series of workshops, with strong clinical and patient input, to further develop primary community care which consistently meets people's mental health needs (with specialist input where required), so that only people with the most complex needs are managed in secondary care. This work, which will be aligned with the wider whole systems integrated care agenda, will also ensure that people's mental and physical healthcare needs are treated together rather than in silos. It will include a review of PCP and pathways into and out of specialist care, including pathways for older people.

Improving access to psychological therapies

It is estimated that there are currently more than 36,000 people living in Westminster with a common mental illness. CCGs must ensure that 15% of their prevalent population access psychological therapies every year. Central London & West London CCGs commission IAPT and counselling services from a number of providers, including Central London Community Healthcare, Central North West London Mental Health Trust, Wandsworth and Westminster MIND, Depression Alliance and practice based counselling.

CCGs are also set a national target that 50% of patients who complete therapy should recover[5]. This target has proven challenging for many CCGs nationally, and especially in London. Although Central London and West London CCGs are forecasting year-end performance below 50%, performance in both CCGs has improved throughout the year, and in January 2016, West London reported in-month recovery rate of 43% and Central London of 50%. This is as a result of work led by commissioners and including stakeholders to address the causes of recovery, and both CCGs are now on track to delivery 50% from April 2016.

Employment support

There is growing awareness that (long-term) worklessness is detrimental to mental health and wellbeing. Increasing employment and supporting people into work are key elements of the UK Government's public health and welfare reform agendas. Central London & West London CCGs have signed up to an integrated pathway to support this programme of work with our Local Authority and 3rd Sector colleagues. Central London CCG commissions Jobs in Mind to provide employment support for IAPT patients, and West London CCG commissions Jobs in Mind and SMART to provide an integrated pathway that spans the whole CCG, covering Common and Serious Mental Illness, and job retention as well as attainment. The service in WLCCG will operate a single assessment process, meaning there is 'no wrong door', and a portable support plan so that if your needs can be better met by a given service you will have access to that service without being re-assessed. The services will resource share, creating greater resilience between providers.

The models in both CCGs support:

- employees experiencing problems with their mental health to remain at work or return after sickness absence
- employers with supporting staff who have a mental health condition
- unemployed people affected by a mental health condition to return to work
- those recovering from mental ill health;

4. PATIENT DEATHS

[5] Recovery is defined as reaching specific scores on patient-reported depression and anxiety questionnaires.

All our providers have a duty of care to all their patients and to give commissioners assurances that they are protecting patients in their care from harm. There is a statutory responsibility on these providers to report a serious incident (SI) through a national reporting mechanism. There is a strict protocol that determines the classification of a serious incident and the protocol for managing and reporting on them. Suicide is classified as a Serious Incident. There have been no Serious Incidents reported within the last three months.

As commissioners we would receive notification of such incidents and monitor and support the management and reporting of them in line with national guidance.

5. SUCCESSES AND CHALLENGES

The developments summarised above are based on detailed business plans, including benefits realisation around quality and value for money. CCGs hold providers to account through specific project management frameworks, celebrating successes and working together to resolve common challenges. We also commission user-focused monitoring to ensure that the voice of the patient is the heart of all evaluations. Alongside this, CCGs assess performance primarily through formalised contract management channels, and use contractual levers to incentivise good outcomes for people.

Some of our key successes include:

- Central & West London CCG's are exceeding access rates (15%) for IAPT patients,
- All patients in Westminster have access to enhanced primary care services (including access to psychiatry, psychology, nursing, OT) without having to be referred or re-referred into secondary care; there is a particular focus on ensuring we address the needs of our diverse population which can be a challenge. CWHHE GP practices can also sign up to out of hospital contracts, whereby people with mental health problems get additional support and coordination to enable them to live independently.
- Central London CCG are managing patients who have been discharged from secondary care with support only from primary care, showing a sustained level of recovery and support for this cohort of patients.
- Development of community-based perinatal services
- Both CCGs meeting well exceeding the assessment for Dementia target of 65%

- Mobilisation of suicide awareness training – highly innovative approach which has attracted attention from the National Clinical Director.

Challenges:

- Achieving and maintaining recovery rates in IAPT of 50%, and meeting a higher level of demand if and when this becomes mandated by the Government;
- Ambition to re-pattern care towards home settings with sustainable and effective community provision;
- Developing an approach to Section 117 of the Mental Health Act, which ensures that people's aftercare needs are met appropriately, and that services provided to patient under Section 117, as well as S117 eligibility itself, is reviewed regularly and that people are discharged where appropriate;
- Developing post-diagnosis services for people with dementia which enable them and their carers to live well and have their care needs met in an integrated way;

One

Appendix

"Community Living Well': core features of model