City of Westminster

Westminster Health & Wellbeing Board

Date:	21st January 2015
Classification:	**General Release**
Title:	Whole Systems Integrated Care Older Adults And Mental Health Programmes
Report of:	West London CCG
Wards Involved:	Queens Park and Paddington
Policy Context:	Health and Wellbeing Strategy: 1) Ensuring access to appropriate care at the right time 2) Supporting people to remain independent for longer
Financial Summary:	Not applicable
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1. Executive Summary

1.1 West London Clinical Commissioning Group (CCG) is implementing two Whole Systems Integrated Care programmes: one for older adults and another for people with long-term mental health needs. Programme updates are provided for the Health and Wellbeing Board's information.

2. Key Matters for the Board

2.1 **FOR INFORMATION:** It is recommended that the Health and Wellbeing Board notes the updates on the two programmes as described in this paper.

2.2 **FOR APPROVAL:** The Health and Wellbeing Board is asked to approve the attached Heads of Agreement document, which is a not a legally binding document, and is a key component in agreeing the programme objectives and high-level governance of the older adults programme.

3. Background

3.1 North West London is a pioneer site for the implementation of Whole Systems Integrated Care. West London CCG has two Early Adopter programmes: one for older adults (aged over 65) and another for people with long-term mental health needs. In this paper, these are referred to as 'older adults' and 'mental health' programmes respectively.

3.2 The two programmes are in different stages of development: the older adults programme is in the implementation phase and the mental health programme is in the business case development phase. The purpose of this paper is to provide an update on the two programmes, and request approval of the Heads of Agreement document, which is a key symbolic component to agree common programme objectives and high-level governance of the older adults programme.

3.3 Engagement and Needs

3.4 The CCG has undertaken extensive engagement to understand local need in relation to both programmes.

3.5 Healthwatch undertook a significant piece of engagement work with older adults on behalf of the CCG in 2014/15. The recommendations of this report have been used to inform the development of the model of care. In addition, the CCG has undertaken extensive engagement and co-production activities throughout the programme to date, and will continue to do so during the implementation phase to ensure the service best serves the needs of people in Queen's Park and Paddington (QPP).

3.6 The mental health programme has involved extensive, facilitated co-production during 2014/15 and early 2015/16 which has been used as the basis for the development of the detailed model of care. The programme has also used data on current patient numbers, profile and activity to determine the model of service delivery and the number and skill mix of staff required in the new service, to ensure this meets the needs of people with long term mental health needs in QPP.

3.7 Programme update: older adults

3.8 Following development of the model of care during 2014/15, the older adults programme has now moved into the implementation phase. Key components of

the model include: risk stratifying patients to identify their 'tier' of health/social care need; offering extended appointments and extended care planning appointments; developing integrated care hubs in north and south; recruiting teams of Case Managers and Health and Social Care Assistants to work with GPs to support older patients; and commissioning a self-care pilot with the third sector to support wellbeing.

3.9 Details about the key principles of the programme are provided in the attached Heads of Agreement document.

3.10 The St. Charles Integrated Care Centre (the North hub) is conveniently located for residents of QPP and opened on 21 September 2015. Currently, there are four GP practices operating from it and there is on-going work to consolidate the services that are available at the hub. At present, adult social care is providing a social worker to support the hub on a rotational basis for 5 days per week. Positive feedback has been received from GPs at the hub regarding the ability to access social care records, as well as support being available for patient assessments and carers' assessments.

3.11 A number of other services are also now available at the North hub, including: basic foot care; care of the elderly consultant sessions (on a pilot basis); a dementia nurse (available on different days each week to support practices); and community cardiology and respiratory services, which are able to take patients on a pre-booked or walk-in basis for services such as ECGs, spirometry and exercise tolerance tests.

3.12 The South hub will be at the Violet Melchett clinic. Building works are due to commence imminently, and it is expected that services should be able to start running from the hub early in 2016. Discussions are underway with adult social care, Central London Community Healthcare (CLCH) and a number of other services regarding consolidating services at the hub.

3.13 CLCH and Age UK are leading on a rolling recruitment programme, which aims to recruit significant numbers of Case Managers and Health and Social Care Assistants to support the model. At the time of writing, one Case Manager is in post and seven more have been appointed, and one Health and Social Care Assistant is in post and twelve more are in the process of being appointed.

3.14 The CCG is commissioning Kensington and Chelsea Social Council to deliver a self-care pilot, which will commence early in 2016. The pilot aims to bolster capacity in the third sector to provide a range of services to support wellbeing, and QPP is included within the scope of this pilot.

3.15 The CCG is now working with partners to schedule the wider roll-out across further practices in both north and south. The ambition is for all GP practices to be 'live' with the model of care by the summer of 2016.

Heads of Agreement (older adults)

3.16 The purpose of the Heads of Agreement document is to:

- Set out the **guiding principles** of collaboration
- State the **partners involved** in this programme
- Clarify the **objectives** of the programme
- Articulate the **conduct and behaviours** required to successfully deliver the objectives
- Include detail regarding the **governance** of the Hub and **wider engagement**.

3.17 As appendices, and for those seeking additional detail, it also includes for reference only:

- The **Information Sharing Agreement (ISA)**, which is fundamental to the success of the programme
- The high-level Hub Service Model (titled the **Hub Operating Plan**)
- A draft **Hub Services specification** which is being continually refined
- A high-level **Outcomes Framework** which will be used to evidence how objectives are being met

3.18 Key points to note:

- This is **not a legally binding agreement**
- This is not a contract; the purpose of this document is to get **agreement on a common approach**
- System partners have already been working under these arrangements for many months. We are **recognising a milestone** through partner signatures and continue further development of the programme

3.19 **Programme update: mental health**

3.20 Following extensive co-production with service users and carers, Local Authorities, Voluntary Sector Organisations (VSOs) and statutory providers across both QPP and Kensington & Chelsea in 2014/15, work commenced on developing the detailed model of care for the mental health programme.

3.21 The outline model of care has been agreed with the Project Steering Group and aims to create a vibrant, resilient and community-integrated model of care in primary care that better secures the mental, physical and social health of those with long-term mental health needs, and provides a seamless interface between GPs and secondary acute mental health.

3.22 The model is population-based with easy access points across the community and a single phone number to call. It is a tiered model, with people able to access services at different tiers simultaneously, based on need and risk.

3.23 Services will be located both in mainstream community venues and also operating from 'hub' venues across the CCG. This will provide service users, carers and professionals with a diverse range of 'contact points', provide safe and reliable 'walk in' and meeting place options, and provide the requisite space that workers require for networking, meetings and accessing resources for service users.

3.24 The plan is for two hubs, to be located at St. Charles and Violet Melchett Clinic. This will also provide a chance to identify opportunities to provide a wider, integrated service bringing together physical and mental health services.

3.25 The following table identifies the services at each tier:

Tier	Services Planned
0	**Self-Help & Community Support (including non-MH social activities)** *Online self-help platform, network access to a range of community-based services, leisure opportunities (e.g. swimming, gym, yoga, libraries, film and book clubs, walking groups, gardening groups), drop in to 'Living Well Hubs'.*
1	**Peer Support** *Co-Workers with lived experience to support those service users and carers, provide and maintain human contact, morale and motivation, engage in social activities, support a sense of purpose and structure. Along with other Co-Workers they will also develop and deliver a vibrant 'community recovery college' to complement the secondary-care based service at CNWL.*
2	**Navigation** *Co-workers with specific expertise in a range of specialist, non-mental health areas such as Housing, Employment/Occupation, Benefits and preventative social care, working with the service user, carer and GP to assess mutual needs and support them to deliver these aspects of their Recovery & Living Well Plan.*
3	**Primary Care Mental Health** *Co-workers with specific expertise and experience in mental health assessment and treatment, where this is the balance of presenting need, providing easy access consultancy to GPs on prescribing, to prevent avoidable referrals, short term brief treatment options, as well as access to a full range of psychological therapies for those with CMI and stable SMI, management of cases transferring from Tier 4 for safe transition.*
4	**Specialist Acute Mental Health Services** *Care Programme Approach Care Plan for those with acute or complex needs: Home Treatment, Early Intervention Services, In-patient Wards, Community Recovery Teams to prepare for transfer to Tier 3 PCMH Team.*

3.26 Engagement has continued during this stage of the programme. In addition to regular multi-agency 'Operational and Steering Group' meetings, a successful Workshop with VSOs was held, organised by Kensington & Chelsea Social Council, both to obtain voluntary sector input into the design of the model and to explore how they could contribute to the delivery of the new service. This included organisations based in QPP.

3.27 Service users and carers have also been involved in the design of the model, ethos and principles for the service and a workshop in January is planned to explore this with a wider group of people.

3.28 Current plans are to submit a business case to the March 2016 Governing Body meeting of West London CCG for approval. This will outline two phases for implementation in 2016/17 and 2017/18.

3.29 Further detail is provided in the attached slide pack (Appendix 2).

4. Options / Considerations

4.1 Not applicable

5. Legal Implications

5.1 The Heads of Agreement is not a legally binding document.

5.2 The mental health programme update is for information only.

6. Financial Implications

6.1 Not applicable

If you have any queries about this Report or wish to inspect any of the Background Papers please contact:

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APPENDICES:

Please find attached:

- Appendix 1: Heads of Agreement (Older Adults) – For approval

- Appendix 2: Mental Health Whole Systems update – For information