The Community Living Well Service
Sustainable recovery, hope and ambition
&
Social Prescription for Mental Health
Mental Health in Primary and Community Care
12\textsuperscript{th} June 2019
Introduction and Overview

What is Community Living Well?

• A primary care mental health service built on partnership and co-production
• Covers c 240,000 population of Royal Borough of Kensington & Chelsea and Queens Park & Paddington in Westminster. Highest SMI QOF prevalence in England (1.55%)
• Offers a menu of services to wrap around the individual and improve mental, physical and social wellbeing of those with long term mental health needs
• Has primary care and GPs at its heart
• Offers hope, resilience, wellbeing and secures lasting recovery
• Pro-active, preventative and watchful care, based on membership rather than referral / acceptance models.
Community Living Well Partners

Central and North West London NHS Foundation Trust

Kensington and Chelsea

Mind - for better mental health

Brent, Wandsworth and Westminster

SMART - St Mary Abbots Rehabilitation & Training
Key Features of the Model of Care

- Single partnership structure – all services into one operating arrangement, improving efficiency and join up.
- Attends to well-being with equal weight to mental/physical health.
- Accessible - first contact within 10 days.
- Integrated delivery - wraps round the patient/carer and their accountable GP.
- Proactive and population (not service) based: clinical profiling of practice registers.
- Single:
  - Point of Contact/Entry through self, GP or other professional referral
  - IT platform – based on Systm1, meaning records can be viewed by CLW and GPs.
  - ‘Recovery & Staying Well’ Plan.
- Hub and Spoke model - integrated into Health & Well-Being Centres – not a silo – with spokes across the area in community settings.
- Mental Health Out of Hospital Service (local GP-provided specification) for all on GP registers with long-term mental health needs, to give GPs more time to do proactive care, engage with CLW and sets quality standards.
GP Specifications for care of those with long term mental health needs involving Recovery & Staying Well Plan
Integrated Clinical Services

- Primary care liaison nurses, primary care psychiatrists, Step 2, 3 and 4 psychological therapists, Mother Tongue Arabic and Farsi counselling
- A central case management and coordinating role.
- Is GP-facing and responsive.
- Ensures that the existing investment in talking therapies yields an integrated offer - high visibility across Hubs, community spokes, and GP Practices.
- Plays to clinical strengths, linking with Navigators for non-clinical needs. ‘Working to to top of licence’
- Continued improvement in efficiency and productivity to secure excellent return on investment.
Integrated Wellbeing Services

**Navigation**
- practical support with a range of issues
  - e.g. benefits, debt, housing options, access to health and social care services, rights and entitlements
- access to specialist advice and information
- support to take steps to improve physical and mental wellbeing

**Employment Support**
- help to find work
- improve employability skills
- support to retain employment if you are struggling at work or on sick leave
Integrated Wellbeing Services

Peer Support
peer led and peer facilitated activities

To help people share and develop skills and strategies, to self-manage and maintain emotional and physical wellbeing.

• 1-2-1
• group
• workshops
• social events and meet ups
• online
• peer support training
Why relevant to mental health?

- Social prescription Involves: a Prescriber .. a Link worker .. a menu of activities
- Proven benefits of many of the interventions e.g. exercise; better diet; reducing social isolation
- Patient an active participant in their intervention
- Creates a new local social environment
- Local survey of GP patients on SMI registers showed 46% of consultations (200/438 consults) involved a social support need
Self- Care in Community Living Well

- Programme of changing self-care activities to help people take more control over their health and wellbeing, build social contact, and help them access community, leisure and volunteering opportunities
- Accessed through CLW or by self-referral

- Unwind sessions (massage, reflexology, reiki)
- LGBT+ Mental health Advocacy
- Multi-lingual emotional & practical 1-1 support
- “Like The Old Days” Club for Older African men
- Re-connect Mindfulness Group
- Better life befriending
- Volunteering on Prescription
- Queen’s Park Community Theatre

- CLW website provides a range of self-care materials
What we’ve learnt

• Bringing together range of clinical and wellbeing services under a **single partnership structure** requires time, as does a **single IT solution**, integrating governance and **on-going organisational development**.

• **Communications and Branding:** Keep it simple.

• **Accountability:** Service users and carers are part of continued governance of the new service

• **Wellbeing services** should be at the heart of the service offer

• **Demonstrating benefits and monitoring change:** Important to be able to demonstrate outcomes and benefits of investment- Outcome and Performance Framework, with focus on GP feedback, performance management, and external evaluation.

• **Interfaces:** No silos and seamless pathways- both in and out of expert mental health care and with models of care for the wider population.

• **The long game:** It’s definitely a marathon, not a sprint. Key to keep listening, learning, growing as a partnership, but keep faithful to the common goals set out in co-production.
Thank you

For further information on CLW:

www.communitylivingwell.co.uk

fionasutcliffe@nhs.net