Community Living Well – Kensington & Chelsea

Background

In 2013/14 it was a Whole System Integrated Care pilot site. Building on what was already in place in primary care mental health. Got some funding as it was a pilot site.

Funding for the service is now part of CCG budgets and is recurrent (service did a business case to enable this).

What is it?

An integrated service bringing together a variety of community partners to respond to the mental health and broader wellbeing needs of service users, including:

- **Mental health:** IAPT, primary care liaison nurses, step 4 psychology service in primary care (to provide longer-term support)
- **Wellbeing** (some new, some already existing services)**:** Employment service, Housing support, Peer support and facilitated meet-ups, training programme for people who wanted to be peer support workers for co-facilitated groups, and 1:1 support *[include link to wellbeing JDs]*
- **Navigator service** (signposting to other services and supporting those with complex needs). This service is very popular – waiting lists have increased recently.

The focus is on keeping people well in the community and prevent secondary care attendance/admission.

How does it work?

Co-located in two hubs (one in north of the borough, one in the south), which helps people get to know and trust each other.

Working in partnership with GP practices and other partners - team leads come together on a fortnightly basis..

Single point of access. Patients are able to self-refer (via the Community Living Well website) for all elements apart from step 4 psychology and primary care liaison nurses. Doesn't have the stigma of referring to mental health service.

Model was co-produced with service users and carers, who said that as important to them as the clinical support were social networks, support re: housing / debt advice etc. Perception that they weren't alone.

Team look at referrals to develop/adapt services to meet the needs of individuals.

What's been the impact?

Positive reaction to service by people who use it – although they are not always aware of the wider offer within Community Living Well.

It's a very helpful model in terms of patient care, because staff can easily refer patients to other services e.g. peer support or employment advice.

Shared IT platform / patient record system makes it easy for partners to see what services patients have already accessed, and then refer them to additional services as needed.

It facilitates conversations between partner organisations.

A qualitative and quantitative evaluation was undertaken by the Centre for Mental Health, although this is not yet available.

Any challenges?

Getting all providers onto the same IT system was a major and lengthy process, and involved close working between the CCG and the local MH Trust. All non-NHS provider staff are on honorary contracts so they are able to now access SystemOne (hosted by the MH Trust). NB IAPT services still use iaptus for all IAPT patient records.

Putting in place consistent policies across providers, e.g. information governance and safeguarding procedures.

Community MH Transformation pilot likely to change the way the service is delivered. The hub model will be extended across secondary care as well, so that service users with both primary and secondary care levels of need can benefit from the integrated hub model.

MH hubs are moving closer to secondary care level of need, and away from primary care / IAPT level of need. It is unclear how IAPT will fit within the new model.