Future Model of Care and Support for People with Serious and Long-Term Mental Health Needs (S&LTMHN)

Context:

Like Minded’s Case for Change identified three ambitions for the S&LTMHN population which guides what the future model must deliver to improve outcomes for this population:

- We will clarify and simplify the pathways for people with serious, long-term mental health needs
- We will develop new community-based care and support models that will improve the quality of care and outcomes for people with serious, long-term mental health needs
- We will rebalance resources from inpatient facilities to innovative community based support

What this document sets out to do:

- Provide an overall vision for providing care, support and treatment to individuals with S&LTMHN across NWL
- Describe a future model that will allow NWL to achieve this vision in a way that achieves consistent outcomes but allows for local delivery approaches
- Identify issues with the current model that need to be addressed to achieve the future model
- Detail specific interventions or changes across the system that will lead to delivery of the future model (again allowing for local delivery approaches)
- Describe, at a high level, the types of enablers required to achieve the future model

What this document does not set out to do (but will be addressed in further work):

- Describe all key details of the future model (including how implementation may vary across Boroughs)
- Describe the financial baseline, additional costs and/or savings that the future model could achieve
- Define the specific impact that the future model will have on resources within the system (though we cannot underestimate that a bold vision, must be supported by real system change)
- Define the requirements (or associated costs) associated with transition to the future model
- Describe in depth how enablers would function and be implemented in a way that supports working at scale across NWL
Contents

BACKGROUND AND OVERVIEW ........................................................................................................................................ 4
   Needs of Population..................................................................................................................................................... 4
   Evidence base............................................................................................................................................................ 6
   Design principles....................................................................................................................................................... 7
   Overview of the future model of care ...................................................................................................................... 8
   Vision for the future – what it could look like for an individual ............................................................................. 9

SECTION ONE: WHOLE SYSTEMS COMMUNITY BASED MODEL ..................................................................................... 11

PART ONE: LIVING A FULL AND HEALTHY LIFE IN THE COMMUNITY .......................................................................... 11
   1.1 What is the current model? .................................................................................................................................. 11
   1.2 What are the current issues? ................................................................................................................................ 12
   1.3 What should the future model deliver? ............................................................................................................... 13
   1.4 How should the future model work in order to deliver this? ............................................................................. 13

PART TWO: COORDINATED COMMUNITY, PRIMARY AND SOCIAL CARE ................................................................... 14
   2.1 What is the current model? .................................................................................................................................. 14
   2.2 What are the current issues? ................................................................................................................................ 15
   2.3 What should the future model deliver? ............................................................................................................... 15
   2.4 How should the future model work in order to deliver this? ............................................................................. 16

PART THREE: SPECIALIST COMMUNITY BASED SUPPORT ........................................................................................... 18
   3.1 What is the current model? .................................................................................................................................. 18
   3.2 What are the current issues? ................................................................................................................................ 19
   3.3 What should the future model deliver? ............................................................................................................... 20
   3.4 How should the future model work in order to deliver this? ............................................................................. 20

SECTION TWO: URGENT CARE PATHWAY TO LIVING WELL ............................................................................................ 22

PART FOUR: URGENT/CRISIS CARE IN THE COMMUNITY TO SUPPORT STABILISATION ............................................ 22
   4.1 What is the current model? .................................................................................................................................. 22
   4.2 What are the current issues? ................................................................................................................................ 23
   4.3 What should the future model deliver? ............................................................................................................... 23
   4.4 How should the future model work in order to deliver this? ............................................................................. 24

PART FIVE: INPATIENT ADMISSIONS ........................................................................................................................... 25
   5.1 What is the current model? .................................................................................................................................. 25
   5.2 What are the current issues? ................................................................................................................................ 26
   5.3 What should the future model deliver? ............................................................................................................... 26
   5.4 How should the future model work in order to deliver this? ............................................................................. 27
PART SIX: INTERFACES AND HAND-OFFS .................................................................................................................... 27
  6.1 What is the current model? .................................................................................................................................. 27
  6.2. What are the current issues? ............................................................................................................................ 28
  6.3 What should the future model deliver? ............................................................................................................ 28
  6.4 How should the future model work in order to deliver this? .......................................................................... 28
PART SEVEN: ENABLERS .............................................................................................................................................. 29
BACKGROUND AND OVERVIEW

Needs of Population

Approximately 31,000 to 37,500 people\(^1\) across North West London (NWL) have S&LTMHN\(^2\); this number may mask levels of unmet need. The needs of these individuals are wide-ranging and can be grouped into two non-exclusive sets (see exhibit 1):

- **Ongoing needs**: Routine and ongoing support including social support (e.g., employment, volunteering or meaningful activity, appropriate accommodation, personal relationships and wider social connections), support with mental health (initial assessment through to treatment and follow-up) and physical health (prevention of illness, management of conditions), as well as support for carers, family and personal support network.

- **Urgent/crisis needs**: Meaningful support in times of crisis and emergency including timely and skilled assessment and treatment characterised by kindness and compassion, effective specialist care and treatment, inpatient admission where necessary in a safe and therapeutic environment, tailored support for recovery and an agreed personalised plan for successful recovery once the crisis is over.

EXHIBIT 1

### Needs of individuals with S&LTMHN

<table>
<thead>
<tr>
<th>Urgent / crisis needs</th>
<th>Ongoing needs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Needs (not mutually exclusive)</strong></td>
<td><strong>Examples (not exhaustive)</strong></td>
</tr>
<tr>
<td>• Timely, skilled assessment</td>
<td>• People with acute psychotic or manic episode, or at imminent risk of harm</td>
</tr>
<tr>
<td>• Timely, appropriate treatment</td>
<td>• Person with a family history of serious mental illness, few close friends, and increasingly difficulties with the police</td>
</tr>
<tr>
<td>• Ensuring safety</td>
<td>• Person presenting to GP with symptoms and signs of depression with psychotic features, but not in acute crisis</td>
</tr>
<tr>
<td>• Support for recovery</td>
<td>• Person with new diagnosis of schizophrenia</td>
</tr>
<tr>
<td>• Early Detection: Timely, skilled assessment of people at high risk for developing serious mental health need</td>
<td>• Help finding safe, stable accommodation; skill-building to improve work prospects</td>
</tr>
<tr>
<td>• Timely, skilled assessment at presentation with a severe mental health need</td>
<td>• Person with new diagnosis of schizophrenia</td>
</tr>
<tr>
<td>• Timely, skilled assessment and care plan</td>
<td>• Support from community based assets for maintaining wellbeing</td>
</tr>
<tr>
<td>• Support for managing social care needs</td>
<td>• Community-based support by team including mental health professionals</td>
</tr>
<tr>
<td>• Support from community based assets for maintaining wellbeing</td>
<td>• Effective transition of care from CAMHS to adult services, or from adult to older adult services, for people with a current serious mental health need or a serious mental illness</td>
</tr>
<tr>
<td>• Support for carers</td>
<td>• Person presenting to GP with symptoms and signs of depression with psychotic features, supported in community by team including specialists</td>
</tr>
<tr>
<td>• Reducing risk of preventable physical illness</td>
<td>• People with new diagnosis of psychosis</td>
</tr>
<tr>
<td>• Support for managing chronic physical illness</td>
<td>• Person with depression with psychotic features, supported in community by team including specialists</td>
</tr>
<tr>
<td>• Identification and management of an early relapse phase to prevent deterioration</td>
<td>• Person with depression with psychotic features, supported in community by team including specialists</td>
</tr>
<tr>
<td>• Person presenting to GP with symptoms and signs of depression with psychotic features, but not in acute crisis</td>
<td>• Person with new diagnosis of schizophrenia</td>
</tr>
<tr>
<td>• Person with a family history of serious mental illness, few close friends, and increasingly difficulties with the police</td>
<td>• Person with bipolar disorder, with early signs of elevated mood and a history of stopping own medicines and progressing to manic phase</td>
</tr>
<tr>
<td>• Peer support sessions, carer education programmes</td>
<td>• Person presenting to GP with symptoms and signs of depression with psychotic features, supported in community by team including specialists</td>
</tr>
<tr>
<td>• Reducing CV risk (e.g., smoking) in person with schizophrenia</td>
<td>• Person with new diagnosis of psychosis</td>
</tr>
<tr>
<td>• Helping person with bipolar disorder and diabetes better manage their diabetes</td>
<td>• Person with new diagnosis of psychosis</td>
</tr>
<tr>
<td>• Person with new diagnosis of psychosis</td>
<td>• Person with depression with psychotic features, supported in community by team including specialists</td>
</tr>
</tbody>
</table>

**Broadly, this group includes:**

- Based on ‘need’ rather than ‘diagnosis’
- People with a serious mental illness (e.g., schizophrenia, bipolar disorder, or other psychosis)
- People with a more severe common mental illness (i.e., complex and/or longer-term CMI)

---

1 Numbers based on a triangulation of QOF registers and 9 month data from Trusts (Jan-Sep 2014)
2 Input from service users was that focus should be on needs rather than a formal diagnosis (i.e., SMI)
There are significant gaps between (a) needs that exist and (b) how need is being met across NWL; for example:

- Care-planning can be duplicative and disconnected: 87% of individuals with diagnosed Serious Mental Illness (SMI) have a GP care plan\(^3\), 28% of individuals in contact with a MH Trust have a secondary care package\(^4\), and a further proportion have a social care plan; these plans exist in isolation from each other.

- Social needs (which research shows are related to more intensive mental health needs\(^5\)) are extensive; the existing level of support does not meet needs; for example, 93% of individuals are unemployed\(^6\), 17% are homeless\(^7\); support exists via Local Authorities and Mental Health (MH) Trusts, however there is unmet need which may result in increased use of other resources (e.g., Police and A&E departments).

- People with S&LTMHN have higher disease and risk factors prevalence than the general population are more prone to smoking and poor nutrition suggesting that, physical health is not effectively managed across the population.

- When more intensive support is required, access can be slower than it should be – the target response times by skilled individuals is only met 50% of the time meaning that 5,000 of the 10,000 emergency/crisis assessments are not done within a timely manner and by those with appropriate skill-set.

Given this range of needs, people with S&LTMHN are reliant upon a wide range of support from healthcare, social care, other statutory services and third sector resources, as well as their personal support network. More than half of the S&LTMHN population diagnosed with a serious mental health need (i.e., on the GP register) are not seen by the MH Trusts\(^8\). The emotional and financial costs to family members caring for sufferers of S&LTMHN may be considerable and are currently poorly quantified. In meeting the needs of the population, it is possible to summarise desired outcomes based on two overall domains:

- **People outcomes**: Better quality of life (people feel hopeful, empowered and resilient, define and meet their personal goals whilst maintaining good levels of physical, mental and social health and wellbeing). They receive a consistent and high quality of personalised care (people are able to receive the right care for them and get support within the least intensive setting possible, where as their care and support feels proactive and well-coordinated).

- **System outcomes**: The whole system is able to make the most effective use of all resources available, is minimising the level of unnecessary hospitalisation and preventing long term negative health outcomes and increased systemic cost; the clinical and non-clinical workforce feels empowered and supported to work in an effective, coordinated manner across organisational boundaries. The system is more in tune with the community it serves.

These outcomes are not being delivered to the extent they could be (as in the Case for Change). For example, although there is NICE guidance for all of the major mental health condition types, including psychosis and personality disorder, the full range of clinically and cost effective interventions described in this guidance remain unevenly available.

---

\(^3\) % patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive care plan documented in the record, in the preceding 12 months, agreed between individuals, their family, 2013/14, QOF (MH002), weighted average over the 8 CCGs

\(^4\) % People in contact with MH services who are on care programme approach (end of quarter snapshot), 2013/14 Q4, Public Health profiles England, weighted average over the 8 CCGs

\(^5\) http://www.sciencedirect.com/science/article/pii/S0277953606004722

\(^6\) % of people aged 18-69 on CPA not in employment (end of quarter snapshot), 2013/14 Q4, Public Health Profiles England, weighted average over the 8 CCGs

\(^7\) % of people aged 18-69 on CPA not in settled accommodation (end of quarter snapshot), 2013/14 Q4, Public Health Profiles England, weighted average over the 8 CCGs

\(^8\) Comparison of QOF registers and Trust 9 month data set (Jan-Sep 2014)
The current cost of meeting the needs of people with S&LTMHN is high; estimated at ~£720 million, or £19-23,000 per person (see exhibit 2). This does not capture support provided by the third sector, housing costs, and impact on personal support networks and families, as well as the opportunity costs in loss of earnings (including that of families and personal support network). Some individuals are isolated and cope alone; and others (e.g., homeless and refugees) receive no care, support or treatment at all.

Given the significant financial challenge across NWL, the question becomes how can more be done with the current resources in the system?

### EXHIBIT 2

The system across NWL spends approximately £720m to support people with S&LTMHN in NWL which is equivalent to £19-23k per head

<table>
<thead>
<tr>
<th>Estimated spend on S&amp;LTMHN across NWL</th>
<th>Cost per head</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2011, £m</strong></td>
<td><strong>£</strong></td>
</tr>
<tr>
<td>GP consultations &amp; medical care costs</td>
<td>32</td>
</tr>
<tr>
<td>Prescriptions</td>
<td>35</td>
</tr>
<tr>
<td>Primary care</td>
<td>67</td>
</tr>
<tr>
<td>Secondary and tertiary care</td>
<td>189</td>
</tr>
<tr>
<td>Forensics</td>
<td>67</td>
</tr>
<tr>
<td>Substance misuse</td>
<td>18</td>
</tr>
<tr>
<td>Other (including organic mental disorders)</td>
<td>0</td>
</tr>
<tr>
<td>Secondary and Tertiary Mental Health Care</td>
<td>274</td>
</tr>
<tr>
<td>Public spending on Mental health treatments</td>
<td>341</td>
</tr>
<tr>
<td>Increased treatment costs of long-term physical conditions</td>
<td>179</td>
</tr>
<tr>
<td>Medically unexplained symptoms</td>
<td>25</td>
</tr>
<tr>
<td>Physical health spend (for conditions caused/worsened by mental ill health)</td>
<td>204</td>
</tr>
<tr>
<td>Public spending on social care for sufferers of mental disorders</td>
<td>99</td>
</tr>
<tr>
<td>Spending on welfare benefits for sufferers of mental ill health</td>
<td>84</td>
</tr>
<tr>
<td>Criminal justice spending</td>
<td>20</td>
</tr>
<tr>
<td><strong>TOTAL TREATMENT COST</strong></td>
<td>718</td>
</tr>
</tbody>
</table>

1 Includes accommodation

Source: GLA - The invisible cost of mental illness; team analysis; CNWL and WL MHT Inpatient and community services dataset (Jan-Sep 2014), QOF 2013/14, team analysis, HSCIC, PSSRU 2014, Q Reaserch, Department of Work and Pensions FOI, CASSR, Department of Health National Survey of Investment in Adult Mental Health Services 2011/12

---

**Evidence base**

Effective mental health services should be integrated from prevention through to highly specialised services to recovery and delivered in collaboration with a range of partners and service users. Commissioning should improve outcomes and integration in a way that engages the voluntary and community sector and is based on an assets approach to enable living well in the community. Value Based Commissioning seeks to ensure more innovation and

---


10 nef and MIND: Co-production in mental health: Literature review, 2014
integration in services and across providers in order to improve patient outcomes and quality of services. The approach achieves higher levels of patient and carer engagement and service integration across providers.11

Recent years have seen an increase in the evidence for investment in prevention of mental illness and promotion of mental and emotional wellbeing that result in long-term cost savings and improves outcomes. Interventions include smoking cessation, befriending for older adults to reduce isolation and physical exercise.12

One of the main pillars in transforming mental health services is effective primary care mental health. Primary care mental health models should focus on teams made up of individuals from different health and social care backgrounds (multidisciplinary teams) in communities often arranged as ‘hubs’. Significant work is being done by national partners to build better data on outcomes and service availability, to set standards for key mental healthcare interventions (including access to Improving Access to Psychological Therapies (IAPT) and Early Intervention in Psychosis (EIP) services), and to build new payment models which incentivise adequate and responsive care models. Further work must be done, with reference to epidemiological data, available outcomes and quality indicators, and NICE guidance and other best practice resources to clarify expected pathways through the service levels for people experiencing different mental health conditions and to ensure that any new model of care offers access to the right evidence based interventions.

The ultimate aim of the system is to enable people to recover and help them better manage their health and care needs. This is best supported by timely evidence based interventions using an integrated care model that assist people to regain hope, control over their own life while providing them with opportunities to participate in a wider society by having adequate employment, decent housing and socially fulfilling life. ‘Recovery is For All’ publication describes integrated models of care and challenges current mental health services to radically change the way people with mental illness are perceived and treated. Evidence suggests that housing issues are more common in people with mental illness in terms of maintaining adequate tenancy and the overall satisfaction with housing conditions. National and international reviews that looked at the best model of housing support for people with mental illness are however inconclusive but do suggest that best outcomes are achieved where housing solution are secured first followed by adequate care wrapped around a person that is flexible and changes based on evolving needs over time.16

Design principles

Developing the future model has involved significant co-production between service users, carers and professionals within the Like Minded programme; it reflects the Urgent Care Business Cases and builds on the community redesign efforts by the Trusts and the Whole Systems Integrated Care (WSIC) S&LTMHN Early Adopters – all of these efforts have also involved substantial co-production. We have used a clear evidence base as it is vital that any NWL strategy is aligned to this, as well as to regional work across London, to ensure resources are targeted to delivery of evidence based mental health care, which will in turn be likely to deliver optimal people and system outcomes.

This has led to the following guiding principles which support the future model of care:

- The model must meet holistic needs of individuals and carers

---

11 Joint Commissioning Panel for Mental Health 2014, Guidance for implementing values-based commissioning in mental health
12 Department of Health 2011: The Mental Health Promotion, Mental Health Prevention: Economic Case
16 Crisis UK and University of York: Staircases, elevators and cycles of change, 2010
- There is a strong aspiration to be bold and ambitious, and to propose innovative approaches which will be followed consistently to best meet local need (building off of what already works well locally)

- The future model must be consistent with the NWL WSIC programme, which already includes two S&LTMHN pilot projects

- There are major financial constraints on the health and social care systems; therefore the future model of care will have to show significant productivity improvements in order to deliver much better value

- Movement towards the future model of care will require transition and transformation funding for providers as elements of the new model will be implemented before savings can be realised from changing parts of the current model; in addition, a focus on the substantial evidence base in mental health will be critical in achieving this, as will investment in service improvement capability and capacity across the system.

- There will need to be a significant programme of organisational culture change and workforce development to support this transformation across the whole system

**Overview of the future model of care**

The Like Minded Programme’s Case for Change identified three main ambitions for the S&LTMHN population. These guide what the future model must deliver to improve outcomes for this population and their personal support network, ensure equity of access to services, and achieve parity of esteem between mental and physical health:

- We will clarify and simplify the pathways for people with serious, long-term mental health needs

- We will develop new community-based care and support models that will improve the quality of care and outcomes for people with serious, long-term mental health needs

- We will rebalance resources from inpatient facilities to innovative community based support

The future model of care is described in Exhibit 3 and consists of a Whole Systems community based model and urgent care pathway:
The rest of this document explore these areas in more detail, describing:

- The current model
- Issues with this model
- What the future model must deliver
- How the future model should work to deliver set outcomes

It then describes the set of enablers that need to put into place to make the future model work in practice.

**Vision for the future – what it could look like for an individual**

**Johnny is 30.** He is in a relationship and has one child. He has a recent diagnosis of paranoid schizophrenia.

He’s had some previous contact with services and was supported by an early intervention team at age 18, although he did not receive a diagnosis. He was discharged after two years. He has recently been discharged from an acute ward where he was given a first diagnosis of paranoid schizophrenia. He was admitted due to sudden auditory hallucinations and paranoia.
Johnny’s partner fears he is becoming unwell (his voices are becoming troublesome) and he has agreed to see the GP. What he wants is someone to talk to about the underlying causes and to find ways of keeping him self-well. However, he is fearful that visiting the GP will mean an increase in medication or a return to hospital – potentially leading him to being put on a Community Treatment Order. Currently side effects of his medication are causing sexual dysfunction and lethargy and he is worried about the impact of this on his ability to return to work and the future of his relationship. Johnny lives geographically close to the same GP he shares with his extended family.

In the future... Johnny calls up the i-connect project, saying he needs to see his GP. The receptionist says she can offer him some choices, a named GP appointment within 3 days or he can pop in today to see Harry who is running today’s “Connect Session.” Johnnie makes the appointment for 3 days’ time and agrees to pop in later.

Johnny turns up, is given a cup of tea and sits down in the comfortable and private i-connect space. He talks to Harry who asks him how he is feeling. Harry explores ‘what’s important to you who is important and what keeps you well. He also explores around housing, benefits and work and asks about his physical health. Johnny says he isolated and doesn’t want to worry his partner and really misses his brother.

Harry offers to take notes, so he can give them to Johnny to take to the GP if it’s helpful of he offers to forward them in advance if that’s what he prefers. Then Harry suggests that Johnnie books onto a “network mapping” session, Johnny agrees. However, Harry has increasing concerns during the conversation that Johnny might need immediate attention. He suggests he sees the duty GP today. This is available and Johnny accepts.

The duty GP has access to all of Johnny’s notes. She uses Johnny’s advance directive that was produced when he was well. She assesses him and considers a full range of possibilities including the local recovery house and the community home treatment team, which he agrees to. She contacts his brother as directed.

With support from the community home treatment team Johnny has returned for his network-mapping meeting. This always happens prior to any MDP (multi-disciplinary partnership) being formed. This enables Johnny to identify all the people and key places important to his wellbeing and recovery. Johnny is now prepared for the development of his care plan with the MDP and the decision-making resides with him. The members of his MDP are always defined by Johnny’s hopes, strengths and goals - but will always include the GP and advocate of choice if required.

A person led care plan is then produced reflecting any specialist interventions required. This is reviewed at agreed intervals. It is supported with an advance directive and updated network maps as they develop. The care plan is rooted in his cultural frame of reference and meanings, utilizes his personal choices and treatment preferences and offers access to support networks locally, nationally and online. Johnny is able to review his care plan and map, as he requires. As part of his care plan Johnny is receiving a personal budget that has enabled him to buy a bicycle and visit his brother Mick once a month extending his positive social networks and keeping him well.

*****
SECTION ONE: WHOLE SYSTEMS COMMUNITY BASED MODEL

Individuals should be able to achieve their own personal goals, supported by people they trust in places that help reinforce well-being. Meeting this objective requires taking a broad definition of what a community and personal network means, such that individuals are able to set and meet their own goals. They should have a holistic care-plan that is comprehensive in terms of helping them meet their own goals; the plan should be created by and with them. This should be done with their named GP and primary-care based team and, where relevant, drawing down on specialist input to ensure that evidence based options for care are accessible to the user. Where appropriate to meet needs, the individual should have access to case management support that can act as a coordinator across a multi-disciplinary team made up of all the individuals that are required to meet the individual’s holistic needs. This multi-disciplinary team should form the basis for mobilising the right type and intensity of support, care and treatment that meets the individual’s need in their community including specialist care and treatment where appropriate.

PART ONE: LIVING A FULL AND HEALTHY LIFE IN THE COMMUNITY

1.1 What is the current model?

To live full and healthy lives, people with S&LTMHN may need support with health, housing, employment, education, engaging with and being part of their local community. Their personal support network also need support. The level of support can be high: the rate of those not working in this group is 93%6 vs. 6.3% across London17 (including unemployment as well as individuals unable or deemed unfit to work); the homelessness rate is 17%7 vs. 0.5% across NWL18; and smoking rates are 41%19 vs. 17% in the general population20.

Some people with S&LTMHN have their own networks and ways of maintaining their health and wellbeing that help build resilience and support connectivity, and for various reasons (including cultural ones) may choose not to access support services. For those who access support, it is mainly provided by third-sector organisations, local authorities (largely social care, with significant provision of housing and employment advice) as well as various parts of the overall health and case system such as primary and community care. This support is provided and funded by a wide variety of organisations that poses significant challenges in term of co-ordination and holistic support package wrapped around individual needs:

■ **Voluntary and community sector:** The ‘Like Minded’ programme has identified over 280 third sector organisations services providing support to people with mental health needs21 ranging from support groups, information, advice, guidance and advocacy to initiatives preventing social isolation and loneliness. Examples include the Support Group for Parents and Carers (Hounslow), the Advocacy Group Mental Health (Hillingdon) and the MIND resettlement team (Brent). These services are usually borough-specific, and the range of services available varies from borough to borough, in some cases reflecting specific local need. Some larger support groups are also provided by national charitable organizations and their offer is usually similar across the whole NWL.

■ **Local Authorities:** The Local Authority (LA) role in relation to serious mental health needs is wide-ranging and involves both, commissioning and provision of services. It spans from focus on promoting wellbeing (as per duties specified in the Care Act22), delivering and commissioning mental health promotion and mental illness prevention interventions, smoking cessation services, dual diagnosis services (substance misuse) to a provision

---

17 Greater London Authority Data store, quarter ending July 2015
18 Statutory homelessness, 2013/14, Public Health England
19 Hounslow GP Mental Health Audit 2014
20 JSNA
21 Like Minded Experience Mirror
of care packages, domiciliary care, supported living, access to social housing and employment services. Local Authorities also provide joint funding for multidisciplinary teams which include Occupational Therapy, personal budget/personal health budget support, social workers, employment advice or housing support. LAs provide other community resources that are important for maintaining physical and mental wellbeing, such as libraries, leisure centres and open spaces. In responding to the Care Act’s requirement on providing information and advice to promote wellbeing, LAs have invested into resources that help connect people to support in their communities such as PeopleFirst (across the tri-borough) and CarePlace (London-wide).

- **Primary Care:** Primary care plays a pivotal role in providing ongoing support to those who have severe mental health needs and in particular, monitor their specific physical and mental health needs; in addition – primary care often acts as a focal point for co-ordination and signposting, as well as social prescribing. This is pivotal for the 50% of individuals diagnosed with a serious mental health need that are not under the care of MH Trusts, and access their care and support from primary care.

- **Mental Health Trusts:** The MH Trusts run a ‘Recovery College’ which offers a range of educational courses, workshops and resources to help people who have experienced a S&LTMHN to help develop skills to enable transition towards living well in the community. Such courses are however only available to people under the care of the Mental Health Trust.

People with S&LTMHN often seek information on services from resources they are in contact with, such as professionals within their General Practices, job centres, Citizens Advice Bureau and libraries. They access these services directly, or are directed to them by peers, carers, or care providers. The roles of peer support, community assets and personal networks are often informal and therefore unquantified though critical to the health, wellbeing and resilience of those suffering with S&LTMHN. Finally, people will seek advice online, from friends, their family, or others in their community.

1.2 What are the current issues?

- **No comprehensive information about broader support networks readily available and accessible to support choice or how to access support:** Like Minded mapping exercise highlighted a plethora of locally available services across each borough. People with S&LTMHN and their personal support networks describe challenges in connecting to services that are available to them in their communities and how to access them. In addition, teams based in General Practice who, are often the first point of contact into the system, and may not have a formal mechanism for accessing information about services which limits social prescribing. While LAs, in response to the Care Act, have made significant investment and progress in providing information on locally available services, more work clearly needs to be done (in collaboration with the CCGs and wider system) to ensure that people with S&LTMHN are able to navigate this information effectively and connect to appropriate support; and that it is kept up to date.

- **Availability and quality of services varies greatly across geographies:** Across the 8 boroughs in NWL, services available to promote wellbeing and prevent people deteriorating vary significantly and do not always reflect variation in local need. Some of this is due to the diversity of grass-roots, local nature of the third sector, some of it is due to variable demand and/or variable levels of investment.

- **More support is needed to make effective use of existing assets:** People with S&LTMHN and their personal support networks sometimes need more help performing the activities that will help them to maintain or improve their mental health and wellbeing, for example, access to physical activities, access to stop smoking clinics, making appointments, getting to an appointment on time, communicating their needs and preferences effectively, filling in forms, or following through on planned activities (e.g., learning courses). As a result, the benefit they receive from accessed services may be limited. Support to maximise such benefit could come in many forms, for example coaching, structured teaching, or accompaniment to key meetings, introducing mental health navigators etc.
1.3 What should the future model deliver?

The future model should provide everyone with a S&LTMHN, as well as their personal support network, a holistic offer of easily accessible community support tailored to their individual needs and aimed at promoting independence and self-support. Some of the key concepts of a new model should include:

- **Easy access to up-to-date information on local services and community assets:**
  People with S&LTMHN, and those caring for and supporting them, are able to easily access up-to-date, relevant information about the services available to them and community assets that exist; where appropriate personal health budgets could put people in control of accessing the services and support they need and want.

- **Appropriate consistency and delivery of services across NWL:**
  People can access a consistent set of services, regardless of their residence, with further services also available depending on local needs. Many areas have started good work on strengthening accommodation pathway and supported living that would be helpful to share across and ensure that accommodation support is efficient and based on evidence of what works.

- **Multiple ways to access and benefit from community networks:**
  Availability of a wide range of tools and resources to help people benefit from available services. These could include technology-based tools, coaching, teaching and innovative approaches to help better manage one’s own care.

- **People enabled to make their own decisions:**
  People should feel empowered to make the decisions about support that is right for them; building off of the base of easy access to up-to-date effective local amenities and support – individuals should have access to personal budgets.

1.4 How should the future model work in order to deliver this?

People should be supported to access care, support and make use of community assets that is relevant to their needs and preferences, and local circumstances (e.g., responding to cultural choice and norms)

The future model should focus on providing a holistic support package for people with S&LTMHN tailored to their individual needs and should include clear pathways to securing permanent housing solution with appropriate care package; enabling people to find either suitable employment or/and meaningful activity, promoting adult learning and the importance of social and personal relationships and easy access to a range of activities that tackle risk behaviours such as smoking, substance misuse etc. One of the main proposed enablers for this model would be a comprehensive database of community assets that could be linked to Information, Advice and Guidance work that Local Authorities are undertaking in response to the Care Act.

This may require putting in place a dedicated team (TBC where they would be employed and hosted) to ensure the value from efforts to date are maximised for the S&LTMHN population. This set of individuals would support accelerating these efforts by performing the following tasks:

- **Work with existing efforts** to continue to build, maintain and update the relevant databases of community-based services and assets; and ensure that parity of esteem is being achieved in terms of access to support for individuals with S&LTMHN. Such an effort must be routed in co-production such that the solution will be fully utilised by those that need it and would use it.

- **Make this information available to people,** their personal support networks, and care providers through e.g., physical copies in GP practices, community centres, libraries, etc. as well as materials available online and through digital solutions.
Identify and train navigators across all the Boroughs to work with other services already in place to connect people to the right support, for example navigators (or case management support, as defined in next section of document) may rotate through GP practices for weekly drop-in sessions to support social prescribing by GPs

Identify any gaps and opportunities in local services working with relevant organisations in health and social care and in the voluntary sector and prepare business cases for commissioners to consider when necessary

PART TWO: COORDINATED COMMUNITY, PRIMARY AND SOCIAL CARE

2.1 What is the current model?

Primary health and social care for people with S&LTMHN includes planning and coordination to promote health & wellbeing, routine assessments by mental health professionals when needed, management of mental and physical health conditions; and provision of a wide range of community-based care and support. This care and support needs to be able to address a range of intensity of need including specialist treatment and care packages. This primary care based support is delivered via the following individuals and resource:

- There are 1,450 GPs across NWL\(^23\); the way that these GPs work is changing – many are working closely together in more of a network based approach in order to provide an expanded set of services out-of-hospital

- Primary Care Mental Health (PCMH) services in NWL are staffed by ~40 specialist MH nurses, 3 OTs, 2 social workers, 4 volunteer support workers, and 6 navigators from MIND. They offer social care, wellbeing support, case management support, GP training, and help in finding appropriate community services and peer support. Support levels vary significantly by borough: West London has 13 community psychiatric nurses (CPNs) while Harrow has 2; only Brent and West London have dedicated consultant psychiatrist input; only Ealing, and Central London have dedicated OT support\(^24\). More support or resource is not, however, consistent with better outcomes\(^25\)

- IAPT services will often be seeing people with S&LTMHN needs – particularly in the case of individuals with personality disorders to use self-help material, and helping people remain or re-engage in employment/education

- A&E Liaison Service, for those who present to A&E and need to be assessed there (~14,500 assessments\(^26\)), and LA Emergency Duty Teams, which operate in H&F, K&C, Westminster, and Ealing/Hounslow (this resource exists for routine and urgent/crisis mental health needs)

- Primary Care Plus (PCP) exists in different CCGs and provides a range of additional support; in some Boroughs it includes professional triage and signposting to direct service users to the wide range of mental health services available. In other Boroughs, it extends to a PCMH service staffed by MH nurses

- Personal support networks, carers and families, local authorities, and the third sector, (as described in Part 1)

The main tool for identifying and coordinating care and support for these needs is the care plan or health & wellbeing plan. 85% of people with S&LTMHN have a care plan within their GP medical record\(^3\), some have separate

\(^{23}\) HSCIC 2014
\(^{24}\) North West London Mental Health and Wellbeing-Models of Care Primary Care Evaluation 17 July 2015
\(^{25}\) Carnall Farrar
\(^{26}\) 7336 from CNWL (taken from App 13 of the Urgent Care Business Case) and 7159 from WLMHT – an annualised value for LPS activity taken from April-Aug 15, provided by the Trust
care plans from secondary care (described below), and others have care plans via interaction with LAs. People may thus have multiple unconnected care plans. Some people who might benefit from an active care plan have none.

As more specialised support is required to meet need – individuals usually need to receive a referral from their GP; based on the triage and assessment of the secondary care teams – this specialised support is then provided as part of a care package. The individual then receives their care and treatment for the mental health need from the secondary care team. Once the individual is deemed well enough (which, in cases, will involve receiving support in inpatient settings, including recovery), they are transitioned back to primary care.

2.2. What are the current issues?

There are a range of issues with how generalist mental health care and support is provided:

- **Care planning does not always lead to more effective or coordinated care and support.** As described above, care plans are sometimes absent, partial, or overlapping and duplicated. Both service users and clinicians report that people are not adequately engaged in their own planning process and the details of care plans are not owned by the individual.

- **Mental health expertise across GPs varies significantly.** The personal expertise on mental health needs varies considerably across GPs which impacts their ability and willingness to handle more complex, longer-term cases; as well as identify and refer for assessment cases of mental health need in individuals. In addition, as best practice approaches have evolved – not all GPs will have been able to keep up.

- **Primary care based mental health support varies greatly by borough,** much more than can be explained by varying patient needs. For example, some general practices employ their own specialist mental health workers, others do not. The number of PCMH nurses per 100,000 population varies 7-fold between boroughs and two of the eight boroughs have no occupational therapy support, and access to dedicated community psychiatrist support varies widely27. Currently, this prevents the delivery of a consistent service to support people in the community across NWL and seriously restricts capacity to deliver evidence based interventions.

- **Care delivery can feel fragmented, poorly communicated, and un-coordinated between different providers.** Described in part six of this document.

- **Handovers between primary and secondary care do not always work well.** Described in part six of this document.

2.3 What should the future model deliver?

The future model for people with S&LTMHN has a bold vision of care and support organised around people’s need when care and support is needed, with one care plan, case management where appropriate and providers working together in the community delivering that care plan with no uncoordinated hand-offs between organisations. Each individual should be able to access the right support based on the intensity of their needs.

Overall, the model should fully take into account each person’s needs and preferences, offer a range of evidence based treatment and support options, and do so in the least intensive setting possible. It should support timely and effective transition to and from specialist care as needed. Handovers will be critical to make this work (see part four).

Within the community, the following should be delivered across the population:

- **A single up-to-date care plan, created and held by the user and shared with providers that allows the individual to set and meet their own goals:** People are enabled to prepare and hold their own care and support plan which is aimed at achieving their personal goals. This plan is held by the person it is written by or with, updated regularly with the group supporting the individual (which should be defined in a way that the

---

27 North West London Mental Health and Wellbeing-Models of Care Primary Care Evaluation 17 July 2015
person’s goals can be effectively met), and made accessible to all relevant and appropriate care providers. Normally, this would be done within primary care in order to support continuity and a holistic approach; however, specialist input is key to ensure that people can make decisions in their care plan based on receiving information from skilled staff who understand the clinical evidence base and options available. Importantly, care plans should be focused and designed in a way that they can be engaged with; where necessary (e.g., secondary care packages or Joint Crisis Plans) – they should be a sub-section (or double-click) into the overall care plan. The care plan must be an evolving document reflecting the service user’s life

- **Consistent case management support across NWL within primary care to support coordination of care:** Where appropriate, based on the level of need, users should have access to an individual that can provide case management and care coordination support; this individual would take the lead in working with the service user (and their named GP) to co-produce the care-plan (described above) as well as pulling down the right type and intensity of support to deliver the care plan from the multi-disciplinary team (described below). Much of this support may already exist via PCP, so understanding the current baseline will be critical to determine the additional support required.

- **A multidisciplinary team that provides holistic care, support and treatment based on the needs of the individual:** The multi-disciplinary team provides the holistic care and support based on individuals need including a consistent case management approach and an accountable named clinician (the accountable GP can delegate case management responsibilities to the case manager). In cases (based on the goals laid out in the care plan) – it may be more appropriate that a specialist coordinates the care for an individual (e.g., in the case of specialised care packages) or a shared role between a case manager and specialist (i.e., for continuity of care). This should be defined and agreed in the care planning process. The team (and especially the case manager) supporting the service users should be as constant as possible over time, with limited turnover, so that people are able to build relationships and receive continuity of care. This team must include sufficient mental health expertise in primary care (both in terms of dedicated resource, but also in terms of virtual or physical access to more experienced specialists). In order to achieve this, there should be a consistent core of mental health support or resource dedicated to primary care in each borough. Finally, GPs should have a minimum knowledge of mental health needs (being delivered via London-wide training initiative)

2.4 How should the future model work in order to deliver this?

To deliver on the above, the future model should be the based on the principles embodied in the WSIC model being rolled out across NWL. This programme is aimed at enabling the entire system across NWL to better support needs; at the highest level, this involves ensuring each person has a single care plan which they personally develop, ensuring individuals have an individual that can provide case management support, fostering integrated care teams that work together to effectively meet the needs of the person and the promotion of personal recovery. Specifically, within this programme, there are two Early Adopter pilot models for the S&LTMHN population – as these initiatives move from design to implementation, lessons should be captured and best practice translated across NWL where relevant and appropriate:

- **The Community Living Well Service** developed through Co-Production in West London CCG is a population model that will provide stepped care and support, with a single personalized plan to match individuals’ needs. This could be from self-management to primary care based treatment for all those with a S&LTMHN who do not need more intensive secondary support (e.g. for a crisis or complex needs). The aim is to enable more people to live well, receive all their bio-psycho-social needs in one place, and prevent crisis escalations. At its heart will be peer support, as well as health and social care navigation support for housing and employment and an integrated care record system with General Practice.

- **Wellbeing Network** ‘Mapping Conversations’ in Hounslow CCG are at the heart of this structured person-centric approach to support people with long term mental health needs to lead lives hopefully and achieve self-determined goals to improve their health and wellbeing. Developed through Co-Production it focuses on creating opportunities and building community networks to address isolation.
The future “Model” should use the same WSIC principles consistently across Boroughs to provide care and support to individuals with S&LTMHN (see exhibit).

EXHIBIT 4

Multi-disciplinary team approach

In line with the WSIC approach and with achieving the future vision described enough; the following should be commissioned across NWL:

- Each person with a S&LTMHN should have a care plan that they have been part of developing and meets the goals that they have in life; the plan will be owned by them and shared with all relevant and appropriate individuals that are part of supporting them in the care plan.

- Each service user has a named individual (this could be their named GP, a case manager or, where needs are more intensive, a specialist) of their choice (based on preference and need) responsible for co-creating this care plan and supporting the coordination of care across the multi-disciplinary team and pulling down the right input and expertise where required.

- Integrated multi-disciplinary teams (including primary care, secondary care, local authorities, third-sector and personal support network) work across organisation boundaries to meet the specific needs of the individual, with shared objectives and performance evaluation.
New roles in the community (e.g., case management or peer support) to support people where needed as well as existing roles working differently; in addition – it will require understanding population size and expected prevalence of different mental health condition groups to ensure that the right type of care and support is commissioned to meet the need of the population;

Implementing this will require a mapping of what currently exists and where new resource is needed as much is being delivered by PCP as well as the NWL Primary Care Transformation.

Finally, delivering this type of model means an expanded approach to the meaning of community; as well as a greater requirement to work across organisational boundaries; there are multiple ways to deliver this including physical hubs (akin to the model in West London CCG), co-working areas or virtual wards and networks; the right model with depend on the circumstances in the Borough.

*****

PART THREE: SPECIALIST COMMUNITY BASED SUPPORT

3.1 What is the current model?

Increasing case complexity and comorbidities result in increasing level of risk and a need for more intensive care and support. Higher intensity community-based support is appropriate for people with S&LTMHN in accordance with evidence based pathways (e.g., NICE guidelines) and/or when their needs are more urgent, severe or complex – for example when social stressors or clinical factors put them at higher risk of relapse, or when they are recovering from an acute event or inpatient stay and are not yet back to their usual state of health and wellbeing.

This support is critical to the viability of the whole system as it is the level most likely to be working with individuals who would otherwise be requiring admission or other intensive crisis support. Indeed, many individuals will, in spite of good care at this level, continue to need specialist interventions to manage relapse. It may take a range of (not mutually exclusive) forms that allow for more intensive care and treatment over and above meeting holistic needs:

- Intensive support to avoid an unnecessary admission (i.e., home treatment) when factors are placing individuals at a higher risk of relapse, or provide more intensive support post-discharge to support recovery and transition back to living well in the community
- Ongoing care coordination for people whose needs cannot be met at less intensive levels of the system because of ongoing clinical risks, or serious difficulties in engaging in services requiring a more assertive approach to engagement, or complexity and comorbidity which requires a more formally coordinated approach to care
- Specialised care packages that meet the pathway of needs for certain population groups with diagnosed conditions such as psychosis, personality disorder, or complex post-traumatic stress disorder; although these care packages stretch from living well to inpatient, they tend to be coordinated by specialist community based teams

The resource for supporting these needs includes:

- Assessment teams (Assessment and Brief Treatment (ABT) team – CNWL, and Assessment Team (AT) – WLMHT) carry out ~3,800 and ~4,000 routine assessments respectively every year

---

28 Trust provided data
13 Recovery Teams (311 WTE) across both Trusts provide Care Programme Approach (CPA) and Lead Professional Care (LPC) care packages. They have caseloads of ~7,000 (CNWL) and ~5,600 (WLMHT). CNWL’s Assessment and Brief Treatment team also carries a caseload of ~2,660 people.

6 multidisciplinary Early Intervention in Psychosis (EIP) teams (88 WTE) for people aged 14-35 who are experiencing their first episode of psychosis. They handle ~500 referrals a year (65% of estimated total need) and manage a caseload of 1,300.

Specialist Personality Disorder and complex trauma services where they exist; as well as Community Treatment Orders

Individuals usually access this more specialised care and treatment via their GP; based on the triage and assessment of the secondary care teams – this specialised support is then provided as part of a care package. The individual then receives their care and treatment for the mental health need from the secondary care team. Once the individual is deemed well enough (which, in cases, will involve receiving support in inpatient settings, including recovery), they are transitioned back to primary care.

3.2. What are the current issues?

There are a range of issues with how specialist mental health care and support is provided:

Trust-provided support is currently not enough to meet demand from other parts of the system: Only 50% of routine assessments are completed within 28 days, vs. a 95% target. Readmission rates can be as high as 8%, and 7-day follow up rates as low as 52%, suggesting that more community-based support is needed after discharge from an inpatient stay. In addition, the frequency and intensity of follow-up contact is reported to be very low for some care clusters. EIP teams currently see only 65% of eligible users, despite good evidence that EIP improves outcomes and costs.

Community based support is not being provided to all those that need it: A significant group of people will, in spite of service improvements, continue to need long term community care packages and for whom “living well” will mean remaining under the care of specialist mental health services for significant time. Even in the best funded CCGs, there are gaps in the availability of NICE guided interventions. In less well funded CCGs, there are significant gaps in evidence based services for psychosis. Other areas, such as personality disorder, have not yet been the focus of detailed review where there are similar gaps and disparities, meaning people cannot access evidence based care and treatment, leading to unnecessary inpatient activity and poor outcomes.

Productivity of community-based intensive support teams: Clinicians and managers report that the teams that provide more intensive, specialised support are not able to maximise their potential time with people due to spending time travelling to appointments (often crossing Boroughs multiple times per day) and/or waiting for appointments; in addition staff are reliant on face-to-face interactions as a sole delivery model.

---

29 Trust provided data
30 CNWL Service Framework CMHT v 3.1
31 Trust provided data
32 Trust reporting to CCGs (2014/15)
33 Trust provided data
34 ICHP Outcomes Framework Workshop, 2014/15
35 Number of new referrals to EIP (ICHP) over the number of estimated new cases of psychosis (Public Health England)
36 ICHP Outcomes Framework Workshop, 2014/15 and WLMHT provided data
37 Trust Urgent Care Business cases
38 % of admissions which were emergency readmissions, 2014/15 Q2, Public Health England
39 Mental Health and Learning disabilities statistics monthly report (April 2015)
3.3 What should the future model deliver?

In the future, specialist community based care should exist when it is required; it should be very focused on just providing the care and treatment that only specialist can and should deliver, and that as individuals do not need that type of care and treatment – they are transitioned back to a less intensive setting. The notion of siloes between primary and secondary care should not exist; instead – each individual should be able to access the right support based on the intensity of their needs. In terms of specialist support, care and treatment:

- **Specialist resource able to meet higher-intensity care, support and treatment in the community:**
  Community-based specialist teams are resourced sufficiently and provided with the right tools to help them deliver all the high-intensity community-based care that people need where they need it, including evidence based interventions as specified in relevant NICE guidance that people need, with minimum time spent away from providing care and support. They are resourced sufficiently such that they can participate actively in multi-disciplinary teams, as well as provide direct care and treatment. This must mean that teams can provide timely assessments (over 95% of routine assessments should be done within 28 days; those which need a more rapid response but are not urgent (need to be done within 7 days) are identified by multidisciplinary teams and managed in a timely way)

- **Improved flexibility of specialist support in the community:**
  Community mental health teams will be resourced to deliver flexible support in order to contain and manage potential crises for people whose mental health conditions relapse regularly over time. This will be necessary in order to avoid unduly frequent handovers and transitions between these teams and more intensive crisis support teams, and to allow for the maintenance of established relationships through crisis wherever possible

- **Individuals should have access to evidence based care package:**
  Everyone that is eligible for a specialist care package and needs one should have access to one; this will involve expanding the Early Intervention in Psychosis programme to all individuals that need it (and not restricting it to certain age bands) as well as ensuring that care packages for Specialist Personality Disorder and Complex Trauma services and Community Treatment Orders are available to those that need it across NWL; and that these packages are provided in a way that the right specialist support is received by the individual to meet their specific needs, whilst the rest of the MDT is still working collaboratively with the specialists to ensure that holistic needs are met

3.4 How should the future model work in order to deliver this?

As intensity of need increases and the ability of users to manage their needs independently decreases – there needs to be a smooth yet deliberate shift towards specialist care and treatment that cannot be delivered safely and efficiently in a generalist setting. In order to make sure this works and is safe, it is critical that the full range of specialist care and treatment required (based on evidence base) can be accessed.

Any case management the individual is receiving via primary care will continue to ensure continuity of care; however the coordination of the specialist care package should be done by specialist care coordinators. Transition to and from this level of support should be planned by the multi-disciplinary team. Specialists should be able to bring experience and evidence based approaches to the individuals that need it; using innovative approaches such as telemedicine and other digital innovations, supported by best practice, evidence based care and treatment packages.
To deliver this effectively, **the resourcing, productivity and skill-mix of community-based specialist teams will need to be significantly changed**: the future model will need significantly higher activity levels from specialists, whether to ensure that routine assessments are done on time, provide more intensive community based care to avert an admission, visit someone in an inpatient unit to start planning discharge, or provide more support after discharge to minimise risk of readmission. It will be critical to provide community-based teams with the tools and technologies that can enable them to increase their productivity. These tools could include central scheduling and appointment management, route-planning tools, and basic videoconferencing when in-person visits are not needed.

*****
SECTION TWO: URGENT CARE PATHWAY TO LIVING WELL

Urgent and crisis care should be a function that supports the entire system; it should exist to be able to rapidly and, where possible, proactively provide support to individuals that need it. If a person (or their personal support network) feels that they are in or transitioning towards an urgent or crisis situation – they should be able to rapidly access and receive, in a compassionate manner, care, support and treatment with the goal of both providing stabilisation in the least intensive setting necessary, whilst also helping the individual embark on a journey of recovery, and avoidance of future crisis by understanding what triggered the crisis. Safe, appropriate treatment (based on NICE guidelines) in the community should always be preferential to an inpatient admission; where an admission or any form of step-up is necessary – it should be for the shortest amount of time necessary supported by effective planning to ensure safe transition back to living well in the community such that the individual can continue to meet their own goals.

PART FOUR: URGENT/CRISIS CARE IN THE COMMUNITY TO SUPPORT STABILISATION

4.1 What is the current model?

NOTE: A major programme of work is already under way to improve urgent and crisis care across NWL. Many of the issues described below already have solutions that have been agreed and will be implemented (CNWL in November 2015, WLMHT in April 2016); in addition NWL boroughs and CCGs have signed up to the crisis concordat, to give parity between physical and mental health crisis response.

Urgent and crisis care is normally managed within acute care, which has four aims: undertaking a thorough assessment, ensuring safety, identifying goals for recovery, and implementing a care plan which starts a person on a trajectory of recovery that enables them to move forward with less intensive services\(^\text{40}\). Urgent and crisis care and treatment in the community for people with S&LTMHN includes urgent and emergency assessment and community-based treatment. Admission to an inpatient unit is sometimes also an outcome.

Urgent and crisis care and support is accessed via a referral for an assessment. In 2014/15, there were ~800 emergency assessments (~600 CNWL, ~200 WLMHT), and ~8,800 Urgent assessments (~6,600 CNWL and ~2,200 WLMHT) in the community.\(^\text{41}\) Currently assessments conducted by different teams, mainly based on time and location:

- **CNWL Assessment and Brief Treatment Team (ABT) and WLMHT Assessment Team (AT):** 105 WTE (90 CNWL and 15 WLMHT)\(^\text{42}\) organised by borough and operating Mon-Fri, 0900-1700.

- **Crisis Response and Home Treatment Teams (CRHT – HTT in CNWL):** 179 WTE (104 CNWL and 75 WLMHT)\(^\text{42}\) organised by borough and operating every day: 0800-2200 (CNWL) 0700-2030 with night cover (WLMHT). These teams are activated when an acute admission is likely. They will try to stabilise the person at home where possible, and if not, arrange for admission.

- **Urgent Advice Lines (UAL at CNWL, SUTS at WLMHT):** provide advice and information, and direct people to services. UAL is active only out of hours and SUTS is available 24/7.

- **A&E Liaison Service:** for those who present to A&E and need to be assessed there (~14,500 assessments\(^\text{43}\)), and LA Emergency Duty Teams, which operate in H&F, K&C, Westminster, and Ealing/Hounslow (this resource exists for routine and urgent/crisis mental health needs).

\(^{40}\) Joint Commissioning Panel for Mental Health

\(^{41}\) Trust provided data, 2014/15

\(^{42}\) Trust provided data

\(^{43}\) 7336 from CNWL (taken from App 13 of the Urgent Care Business Case) and 7159 from WLMHT – an annualised value for LPS activity taken from April-Aug 15, provided by the Trust
- Hillingdon, Brent and Harrow A&E LPS team in Northwick Park Hospital has an assessment lounge, which provides a safe and confidential place away from A&E to complete assessments in the time required without interruption

Based on the intensity of need, and the associated risk – there are a range of different places that an individual’s safety can be assured:

- Inpatient ward – for intensive, specialised care and treatment
- Recovery house – for less ill individuals, that don’t need in-house specialists, but lots of care and support; this can help avoid an admission of step-down from one
- Crisis facilities – place where time-limited crisis management can be done

After assessment, community-based treatment or acute admission may be needed:

- CRHT teams offer short (under 6 months) care packages, providing ~46,500 home visits in a year. CNWL’s ABT team also carries a caseload of ~2,660 people receiving short-term intensive support (~13,400 visits)\(^4\)

4.2 What are the current issues?

- **Multiple points of access to the system**, to different teams based on need, geography and time of the day, mean that people, their personal support networks, and health professionals do not always know whom to contact for support with a crisis. For example, referral pathways change from day to night, and multiple teams (see above) handle referrals

- **Crisis can escalate due to lack of earlier or pro-active response**, making in-patient admission and formal detention more likely, in particular if the Police have to become involved (section 135 or section 136).

- **Only ~50% of people who require an urgent or crisis assessment are assessed within target times**

- **No 24/7 support outside of A&E**, Out of hours (5pm – 9am) people in crisis are currently required to visit A&E for assessment by Liaison Psychiatry Service, which is not the appropriate pathway if they have no co-morbid acute physical needs.

- **People are sometimes admitted because of a lack of step-up alternatives in the community**, in particular because of insufficient resource to provide high-intensity care at home, or because there is no other safe setting for care and support

- **Information transfer between ongoing care and crisis care teams is poor**. There is no standard protocol for informing GPs and others providing ongoing care that someone is being assessed for an urgent or crisis need or being admitted. Similarly, there is no easy way to access someone’s ongoing care information during a crisis

4.3 What should the future model deliver?

The future model for urgent and crisis care in the community for people with S&LTMHN should ensure that they, their personal support networks and care providers, have a simple and direct way to access urgent services and have access to timely and skilled assessment when either in a crisis, or as triggers to a crisis are evident. Should they need care or treatment, the future model should offer community-based care and support that is in line with their own expressed needs and wishes, joined up with their ongoing care, and as much as possible delivered at home or in other safe community-based settings to minimise the need for inpatient admission. Finally, interventions should be used to help the individual understand what led to the crisis so that triggers can be better detected and managed in the future to support individuals in living well. This will require:

\(^{44}\) Trust reporting to CCGs (2014/15)
- **Single point of access, available 24/7**, with sufficient specialist expertise and functionality to rapidly and safely triage individuals who use the service, as well as directing people to the most appropriate service.

- **Timely, skilled assessment**, with 95% of urgent and emergency assessments completed within target times (i.e., emergency within 4 hours, urgent within 24 hours) and most appropriate setting (e.g., home-based, GP practices, avoidance of A&E).

- **More community-based crisis management**: sufficient resource to provide intensive home and community based care, and enough capacity in safe, community-based settings, crisis houses and recovery houses to avoid an inpatient admission.

- **Crisis care that follows peoples’ expressed needs and preferences**, e.g., as expressed in a crisis care plan.

- **Crisis care which facilitates access to evidence based treatment packages as recommended by NICE**.

- **Crisis care that is joined up with ongoing care and focused on mitigation**, e.g., through rapid communication with GPs and other primary care givers, and through access to an up to date care plan as described in Section 2; as well as a focus on understand what led to the crisis and how this can be mitigated in the future by understanding triggers.

4.4 How should the future model work in order to deliver this?

The Trusts’ Urgent Care Business Cases, developed via significant co-production, will move the system towards the future state described above, through the implementation of a Single Point of Access with 24/7 service for each Trust, and the restructuring of the different teams described above into crisis response and home treatment (CRHT) teams (HTRT in CNWL and RT in WLMHT) that also provide 24/7 coverage for assessment, brief intervention, early discharge facilitation, and where possible intensive home treatment.

The care plan and WSIC proposals in sections 2 and 3 should also help join up ongoing and urgent care.

Three additional initiatives should also be considered:

- **Urgent response function for the system**: Expanded resourcing and role of CRHT teams, so that they can provide as much intensive home-based care as possible to minimise the chances of the person’s health deteriorating. At the moment, CRHT resourcing (and therefore scope of their remit) is to perform assessments in a timely way and offer brief home-based care. Additional resourcing will also help CRHT teams providing ongoing care, so that the ongoing needs of a person in crisis are known and met (e.g., housing and support for family members) and that community-based teams can “in-reach” quickly at the beginning of a crisis to start support for the transition back to lower-intensity care.

- **Step up/step down facilities in the community**: There is good evidence to support the expanded use of community-based facilities that are alternatives to inpatient units for care and support of people experiencing a crisis and in doing so offering kind, gentle, caring and person-centred alternative. The evidence shows that people prefer these alternatives, clinical outcomes are the same as in inpatient settings, lengths of stay are shorter, and after one year, costs are lower as well. These facilities can be run by Trusts, LAs, or the voluntary sector. They can offer different levels of service, support, and accommodation (e.g., day-only or overnight stays). WLMHT is about to open its first recovery house, Amadeus House, in Ealing, and is discussing plans for a recovery house in Hounslow with partner organisations and exploring possible options for Hammersmith & Fulham. The goal is to replace acute beds with a similar number of beds in these recovery houses to offer a safe, more pleasant alternative for people.

- **Joint crisis care plan (JCP)**: A joint crisis care plan is a care plan for crisis situations, developed by the person with a S&LTMHN when they are not in crisis. Depending on the level of need – this should either be a concise and straight-forward statement of what to do in a crisis; or where need is greater – should be more in-depth and include preferred treatments, advance choice of refusals for treatment, preferences for admission or treatment in the community, whom to alert and engage in a crisis, etc. The JCP should be shared with all...
relevant individuals, as well as being accessible to authorities such as the Police and other emergency services.

PART FIVE: INPATIENT ADMISSIONS

5.1 What is the current model?

Inpatient admissions are a component of a care pathway and for more acute cases, they have four aims: undertaking a thorough assessment, ensuring safety, identifying goals for recovery, and implementing a care plan which starts a person on a trajectory of recovery based on transitioning to less intensive services. Based on the intensity of need, and the associated risk – there are a range of different places that an individual’s safety can be assured:

- Inpatient ward or units – these aim to provide a high standard of humane treatment and care in a safe and therapeutic setting for patients in the most acute and vulnerable stage of their illness. Admissions are considered where this would play a necessary and purposeful part in a person’s progress to recovery from the acute stage of their illness.
- Step-down and supported housing – housing support can help reduce hospital admissions by signposting to other services and providing housing and support for people leaving hospital. This may include support to manage a tenancy and live independently, to connect with other services and to rebuild life after a crisis.
- Crisis facilities – these community-based crisis services provide support in a residential setting to people in crisis who (a) cannot be treated at home but who (b) do not need to be admitted to hospital.

There are four different types of wards or units which have different purposes:

- Acute inpatient wards – these usually provide inpatient facilities for a broad range of psychiatric diagnoses for people within a local area. In some areas they are separated into acute assessment/triage wards and longer stay/recovery wards.
- Psychiatric intensive care units (PICUs) – these provide high intensity nursing and medical care for patients whose illness means they cannot be safely or easily managed on general acute wards. PICUs usually serve a wider catchment area population than a CRHT or admission ward. They can be sited as a stand-alone unit adjacent to other mental health inpatient facilities or as a ward within a larger unit.
- Rehabilitation units – these units provide care for patients, usually with severe mental illness, who require inpatient admission for longer periods than is usually available on acute wards.
- Specialist beds – these include, for example, mother and baby beds and eating disorder beds, and are the subject of separate commissioning guidance and are commissioned nationally.

Across NWL, there are 4,000 admissions for S&LTMHN p.a. (~2,400 in CNWL and ~1,600 in WLMHT in 2014/15). These take place in eight inpatient facilities (one per borough), which together have 516 acute inpatient beds, 50 PICU beds, 253 rehabilitation beds (used by people with mental health needs and other challenges such as learning disabilities), and 69 continuity-of-care beds in CNWL (used by older people with dementia, nursing care needs, and end of life care). These facilities are staffed by over 1,700 WTEs (including clinical and administrative staff at all levels). Additionally, there are ~400 beds available in the community offering supported accommodation to people with S&LTMH needs. The provision of these beds varies significantly across NWL, with most available in Brent, K&C, and

45 Joint Commissioning Panel for Mental Health
46 Joint Commissioning Panel for Mental Health
47 Number of Acute and PICU admissions, trust provided data
and Westminster\textsuperscript{48}. Finally (and most importantly for people) are the beds in their own stable accommodation where this exists.

Admission to an acute bed is generally based on triage followed by assessment by one of the assessment teams (see section 4) which deem that the individual requires hospitalisation to undertake thorough assessment, ensure safely and support recovery. Once admitted, average length of stay (ALOS) in adult acute beds is 49.5 days in CNWL, 45.3 in WLMHT\textsuperscript{49}. Occupancy rates are currently very high –106% at CNWL and 93% at WLMHT\textsuperscript{50}.

Discharge from an inpatient stay is based on clinical recovery (i.e. the person being mentally well enough to return safely to the community), as well as practical issues such as the availability of suitable and safe accommodation. CRHTs and CHMTs are often involved to support transition back into the community, although there are also a substantial minority of cases where brief crisis admissions do not translate into a need for support at this level of the system, and there are at present few options for locating suitable follow-up support.

5.2 What are the current issues?

- **Different wards, units and facilities are being inappropriately used to meet need.** It is reported by clinicians and managers (and demonstrated via the reasons around delayed discharge caused by lack of lower acuity facilities) that acute inpatient beds are being used inappropriately by individuals who no longer have needs that should be met by an acute inpatient bed.

- **There are many delayed discharges, accounting for 8.1\% of total bed days at CNWL and 7.1\% at WLMHT (vs. 4.1\% nationally).** These are mainly due to two reasons: (1) no place available in lower acuity facilities including specialist support accommodation – 62\% of delayed discharges at CNWL, 44\% at WLMHT; (2) waiting for an assessment or for a care package to be prepared – 21\% of delayed discharges at CNWL, 36\% at WLMHT\textsuperscript{51}.

- **A small number of admissions take up a large number of beds.** ~12\% of the admissions take up 45\% of bed days in the Trusts, due to some people staying in the hospital for very long periods of time which puts a large pressure on bed availability, and resources in the Trusts\textsuperscript{52}.

- **Delayed discharges, long LOS, and high admission rates collectively mean that for many people who need an acute bed, the right bed is not available at the right time.**

- **Handovers between primary and secondary care do not always work well.** Described in part six of this document.

5.3 What should the future model deliver?

The future model should ensure that people are cared for in the lowest intensity setting that is safe –as described in the previous sections. Should an inpatient admission be necessary, the future model should ensure that the inpatient stay is only for the time that is necessary. This requires that:

- Enough safe alternatives to an inpatient stay are available in the community to receive people from the inpatient facility as soon as they are ready for discharge.

- Enough high-intensity care and treatment is available in the community to support the transition from inpatient towards low-intensity, ongoing care and support.

\textsuperscript{48} Trust provided data
\textsuperscript{49} Calculation based on Trust provided data
\textsuperscript{50} Trust reported numbers
\textsuperscript{51} NHS benchmarking data
\textsuperscript{52} Based on NHS benchmarking data
Within the inpatient provision which remains in place, attention is paid to quality and capacity – so that the very high levels of acuity and need presented by people using inpatient services can be responded to, and to ensure positive clinical outcomes and service user experience. This may require increasing levels of resourcing per bed whilst reducing the number of beds overall.

Discharge planning is started on the day of admission and coordinated with the multidisciplinary team providing ongoing care and support and capacity in the CMHTs and other community teams to provide in-reach support to the wards and begin transition work prior to discharge.

5.4 How should the future model work in order to deliver this?

Trusts are already working on initiatives to improve bed management and discharge planning. There is also an emergency pathway performance improvement effort being rolled out across NWL that includes improving discharge processes, which could also be drawn on. Four additional initiatives should also be considered:

- **More community-based beds and other accommodation** to receive people who no longer need an acute inpatient bed but also cannot be safely discharged to their home or usual accommodations including recovery houses that offer a safe, yet more pleasant environment for people to be compared to an inpatient bed.

- **Greater collaboration on discharge planning between inpatient teams and ongoing-care teams**: The accountable GP or case manager (with the personal support network) should be enabled to support in proactive discharge planning via “in-reach” as soon as possible after admission and work with the inpatient team and the CRHT team to plan the care and support likely to be needed after discharge.

- **Inpatient care meets national best practice**: Clearer attention to best quality standards in inpatient mental health care, including ensuring staffing levels conform to national best practice standards, and using other accreditation schemes as appropriate to provide assurance that support at this level is of optimal quality and cost-effectiveness.

- **Closer post-discharge follow-up**: Effective post-discharge follow-up can reduce readmission rates by 40%. Those coordinating care should designate one person (i.e., a Well-being partner to provide case management support to people) to provide regular follow-up after discharge to ensure that post-discharge care is being delivered and recovery and health and wellbeing are improving as planned.

**PART SIX: INTERFACES AND HAND-OFFS**

6.1 What is the current model?

Currently, the interfaces between generalist parts of the system, and specialist parts is done via referrals and discharges. Referrals would normally come from a registered GP to the relevant secondary care team who, if the individual meets the necessary criteria, assesses the individual and makes a decision about whether specialist care and treatment is required. If it does – then in the care and treatment for the individual for the mental health need is transitioned to the secondary care team; discharge from secondary care is then done once the secondary care team believes specialist care and treatment is no longer required to meet need. This happens via a letter that goes back to the referring GP to transition the individual back to primary care. Much variation exists across NWL.
6.2. What are the current issues?

Currently, the system does not work as one to deliver continuity for service users as needs change and must be met by different members of the workforce in a coordinated way across the system. Specifically:

- **Care delivery can feel fragmented, poorly communicated, and un-coordinated between different providers.** Many examples and stories exist of fragmented care delivery (e.g., meeting a different professional at every appointment), unclear communication about future care, and poor coordination between providers. These problems sometimes lead to a crisis situation, or an inpatient admission, which could have been avoided.

- **Handovers between primary and secondary care are not happening quickly and effectively.** Targets for the timeliness of routine assessments are not met across NWL; only 50% of routine assessments are completed within 28 days, vs. a 95% target. In addition, people feel they end up remaining within secondary care without a clear transition plan back to living well in the community.

- **Lack of consistent confidence across the system during transition.** Many clinicians report a lack of confidence or trust in other parts of the system having the capacity or capabilities to handle referrals or discharges; this can result in users feeling that they are being passed between providers without a set of individuals taking joint-responsibility for planning and agreeing the right type of care and support for them. Finally, service users do not always feel ready or prepared when transitions and hand-offs occur.

6.3 What should the future model deliver?

In order to achieve the future model, creating the right level of agility and cohesiveness between providers will be critical which must be supported by:

- **Effective handovers, supported by updated care plans and integrated working:** As soon as the need for more or less intensive care is identified, that care should be available via the multi-disciplinary team. Where appropriate, the specialist then coordinates the necessary care and treatment in a way that supports continuity of care. The care plan is updated to reflect the evolving situation. Similarly, as soon as it is considered appropriate to begin transitioning from high to low intensity care, a similar set of actions is undertaken so that the case manager, GP and multidisciplinary team supporting ongoing care are fully up to date on the higher intensity care delivered and transition plans.

6.4 How should the future model work in order to deliver this?

Much of the future model hinges on making these handovers work effectively – more work will clearly be needed to ensure that NWL becomes really great at doing this; in addition there are some complex questions to address around clinical governance and necessary transfer of care protocols.

However, there are a range of ways in which interfaces can be improved; some will be consistent across NWL but the majority will be based on good, trust-based relationships existing, as well as the capacity and capability of different parts of the system to effectively manage hand-offs and interfaces in a supportive and collaborative manner. Some examples of where this can be done better include:

- Greater access to information on community services and assets to support primary care in social prescribing
- Role of specialists on MDTs supporting primary care based teams to provide input and act as navigators back to secondary care to access right support

---

53 Trust Urgent Care Business cases
Structured approaches to communication (as well as building relationships) between primary care and specialists whilst care and treatment is under secondary care to build up confidence and trust across the system

*****

PART SEVEN: ENABLERS

In order to achieve this transformation, the system will need to be enabled to work very differently together; there are a range of enablers (many of which can be implemented via the WSIC programme) that will support the transitions that the system is trying to achieve:

- **Engagement of people**: It is important to continue to engage people during the transition to ensure that the changes are made in a way that meets their need; in addition supporting people (and their personal support networks and families) is critical such that people are able to easily navigate the system and access the services that they require – not “losing” people during the transition will be key

- **Outcomes**: A prerequisite of enabling the new model, and a key metric for enabling commissioners, providers, and service users to understand and evaluate the quality of mental health service provision is the measurement of meaningful clinical outcomes. These should include both clinician and service user rated measures, as well as the intelligent use of system data (as in the work by Carnall Farrar, for instance)

- **Information and data sharing**: People with S&LTMHN will need to be identified and flagged within different organisations’ information systems, so that information on activity, costs, and outcomes can be tracked. The ability to share data safely and securely across organisational boundaries and to ensure the right access is achieved is key: it will help care providers share all the relevant information about someone, and it will also help system-level management of activities, outcomes and costs, and identification of opportunities to improve performance

- **Organisational Development**: The new model will involve fundamentally new ways of working, as well as a range of new skills (or roles) in delivering it; the workforce will need to be supported and trained to make the transition towards this new working model. The changes will involve professionals working across existing organisational boundaries; and will involve the need for upskilling of individuals (e.g., care coordination and care navigation) to enable the new model. NWL’s Change Academy provides a great platform to develop this enabling function from

- **Governance**: Commissioners and providers need to be making decisions across organisational boundaries; commissioning needs to shift to joint-commissioning across health and local authorities; providers need to be able to make decisions across their organisational boundaries, e.g., via new models such as Accountable Care Partnerships where they collectively take the full accountability for the outcomes for the population

- **Commissioning**: Commissioning needs to shift towards an outcomes based approach; this will give providers the incentive to improve the way that their activity and resource improves outcomes and better meets need. Moving in the direction of joint-commissioning between health and local authorities, pooling of budgets (and/or personalised budgets), and tracking of cost data at a patient level will all help the system move to an outcomes/needs based commissioning

- **Estates**: The changes that are required are aiming to have substantial changes in terms of resources and the settings where care will be delivered; it will be essential to plan and understand how Estates need to change and be reconfigured to both ensure that services and activity can be effectively delivered where its required in the community; and that existing acute sites can be reconfigured in a way that allows for savings to be realised and reinvested in better community care, whilst maintaining equal access to services for people