North West London Integrated Care System
Working together for better health and care

North West London Joint Health Overview and Scrutiny Committee

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The four workstreams of the Mental Health, Learning Disabilities & Autism Programme aim to improve access, experience and outcomes for the local population of North West London

1) **Crisis Care** – There will be an increase in safe and satisfactory choices for people in crisis, avoiding A&E and admission, with more home treatment and greater community and voluntary sector support (phone, digital and face to face).

2) **Community** – Community teams will cover more days and longer times, for more local care and treatment, from a local system, including voluntary sector, that works together and builds confidence in people to take more care of their mental and physical health.

3) **Children and Young People** – Single points of access to services, more digital options, meeting new demands from services missing during Covid-19 (like schools); strengthened liaison between local NHS and non-NHS partners, with better transitions to adult services.

4) **Learning Disabilities and Autism** – Keeping people mentally and physically well, with right support in right place so hospital not always necessary; greater support for families and all services to guard against exclusion from service offer, including digital.

The Programme works at a North West London system level, driving transformation and strategic commissioning, continuing to work closely with local teams to ensure that mental health, learning disability and autism services meet the needs of people across North West London.

There have been notable key achievements across the four workstreams

Children & Young People

- Kooth, the **online mental health platform** for children and young people between 11 and 25 years, was commissioned to provide a single, consistent digital service offer across all NW London boroughs from 1 June 2021.
- NW London continues to **exceed trajectory and remains on track to increase the number of CYP accessing services** in line with the NHS Long Term Plan ambitions for 2021/22 and a 10% increase in activity compared to previous year.
- **19 Mental Health Support Teams in schools** deliver evidence-based interventions for mild-moderate MH issues, provide advice to school and college staff, and help CYP to get the right support and stay in education.

Mental Health Crisis Care

- **Expansion of liaison psychiatry services** meaning 6/7 acute hospitals now provide a Core 24 service. Winter funding at 7th site (EAL) used to expand team and improve response times.
- Expansion of **community crisis teams** with 24/7 provision.
- Expansion of **crisis alternatives** to every borough to offer an alternative to ED attendance/ admission.
- Establishment of **NW London Suicide Prevention Network** with co-production of projects offering direct support.
- **NW London-wide suicide post-vention** service continues to support people bereaved by suicide.

Learning Disabilities & Autism

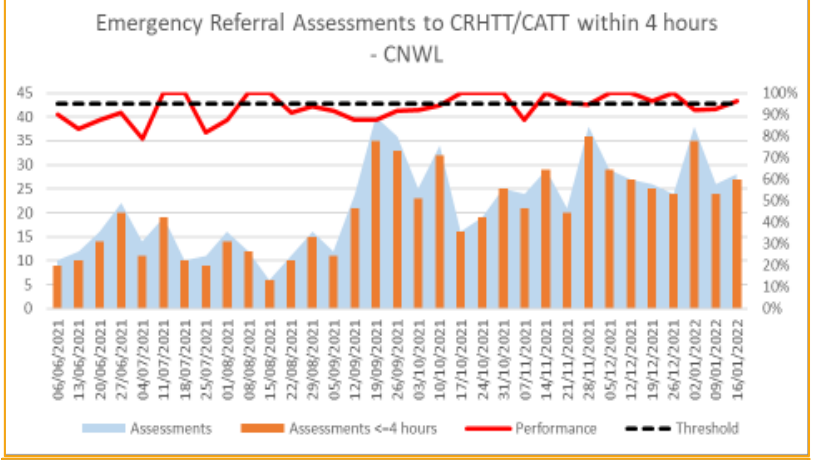
- NW London has achieved a **47% reduction in the number of inpatient admissions** for CYP with LDA since January 2020.
- Good performance on **annual health checks for people with LD at 47.9%** YTD compared to 44.8% previous year.
- **Care (Education) & Treatment Reviews continue to improve** and NW London is exceeding average London performance.
- **Dynamic Support Registers have been strengthened** with increased investment to support: the roll out of the CYP keyworker pilot; a positive behavioural support service; and specialist outreach autism posts. Together helping to **improve multi-agency community support for CYP in crisis.**

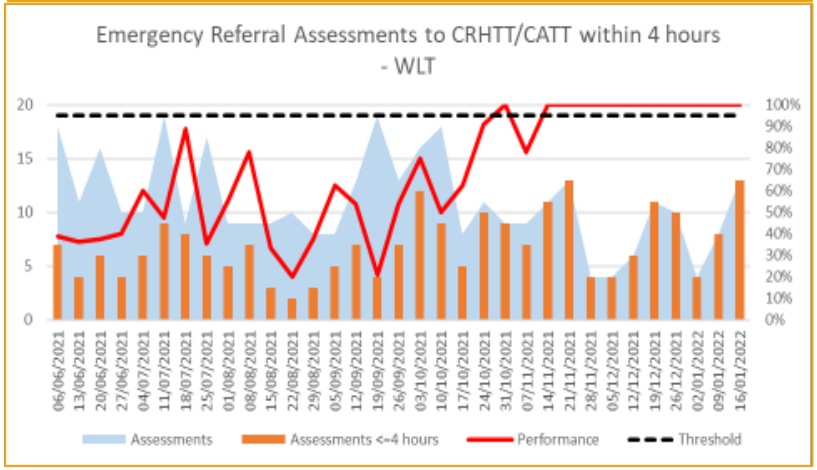
Community Mental Health

- Continued rollout of **community mental health transformation** with increased access.
- **ARRS mental health practitioner** roles are being recruited to in line with community mental health transformation plans.
- **Increased SMI healthchecks to 52% YTD** with 3/8 boroughs >55%. Targeted work with the support of the VCSE, to reduce variation and increase uptake continues.
- Developing a **single service specification for dementia** services in NW London to improve consistency of offer and outcomes.

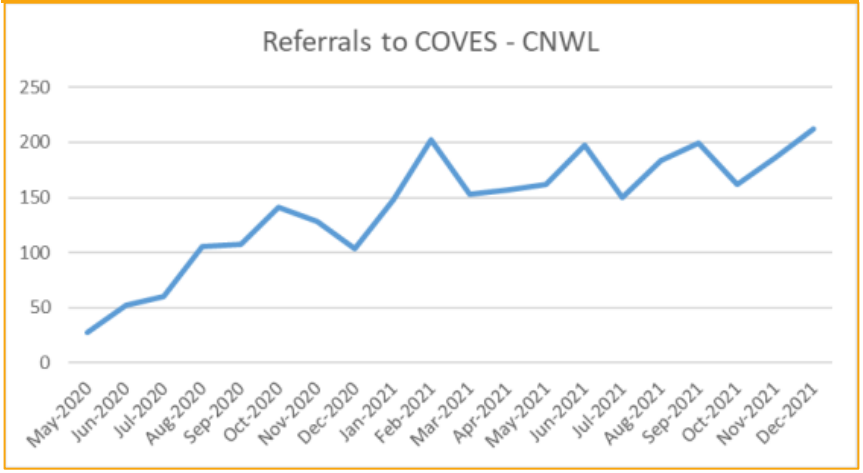
Expansion of community crisis teams and crisis alternatives to A&E has provided greater capacity to support people outside of A&E

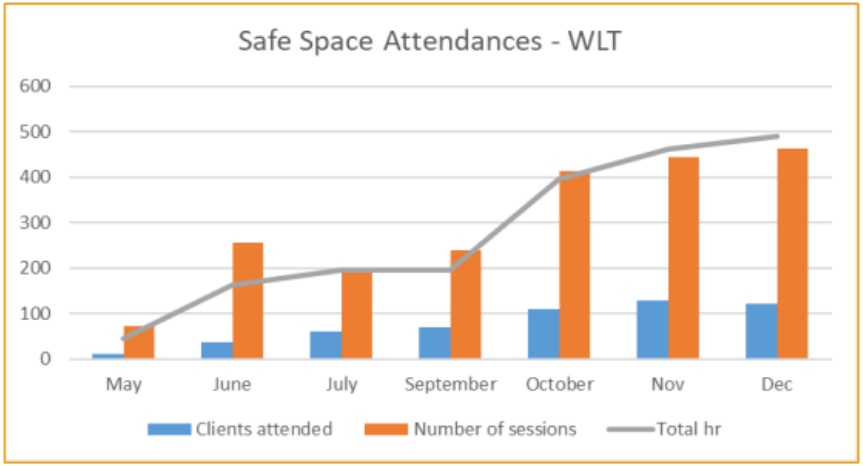
Community Crisis Teams





Crisis alternatives to A&E





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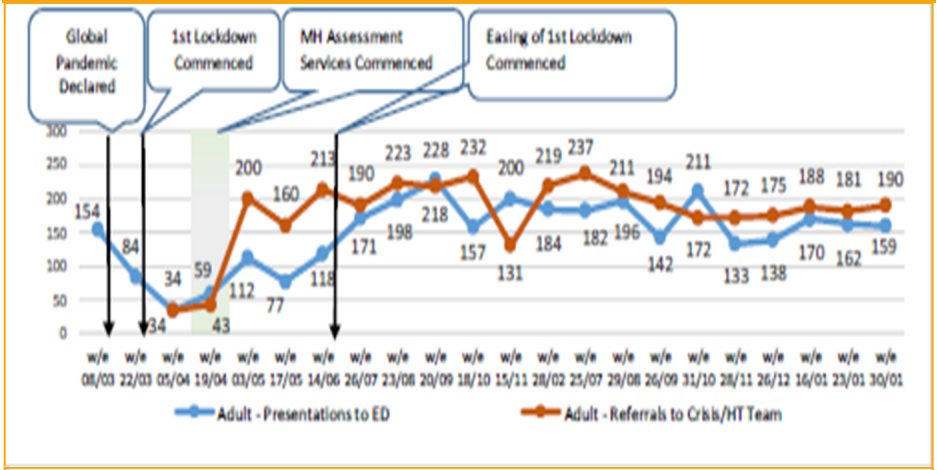
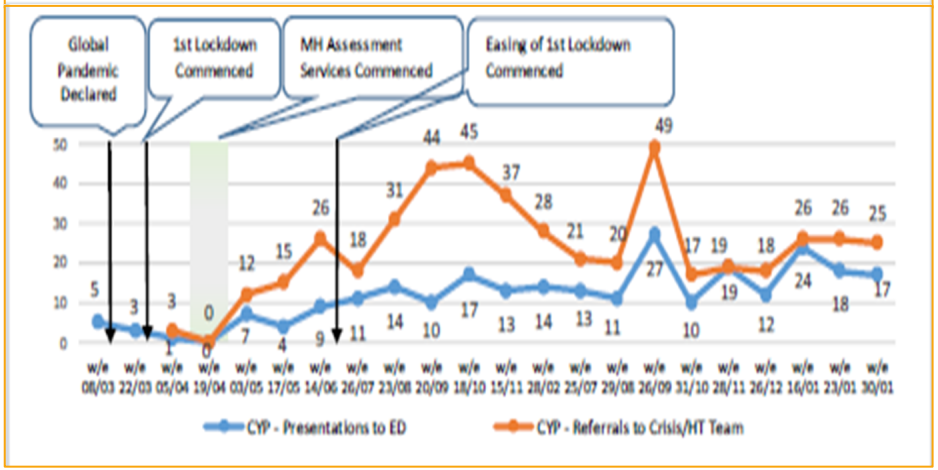
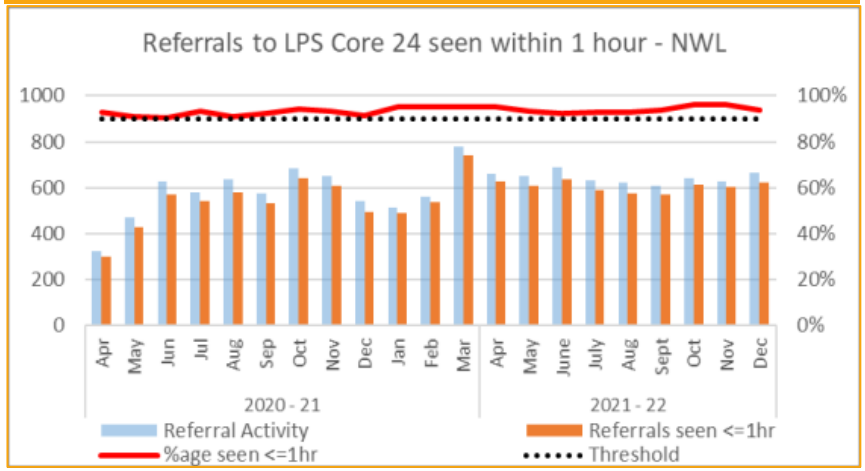
Referrals to community crisis teams are increasing and higher than attendances to A&E; psychiatric liaison teams' response <1 hour has improved

Attendances to A&E (Adult & CYP)





Psychiatry liaison



- To reduce adult mental health A&E attendances and long waits, preventative mitigations are in place, these include:
  - Improving the use of crisis alternatives and SPAs
  - Utilising CRHTT / CATT to provide urgent assessment at home within 4 hours
  - Improved response times from psychiatric liaison teams
- For CYP MH attendances, community provision has been expanded, including:
  - Urgent Care /Crises and home treatment teams
  - Additional capacity and capabilities in the community Eating Disorder Teams

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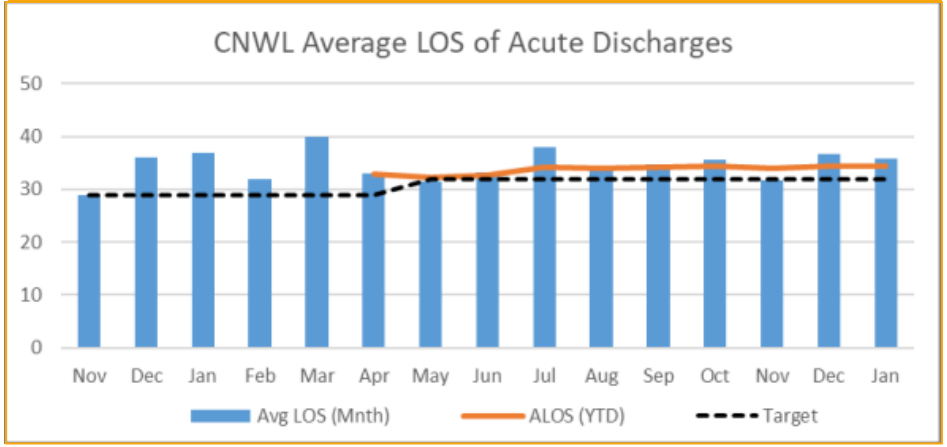
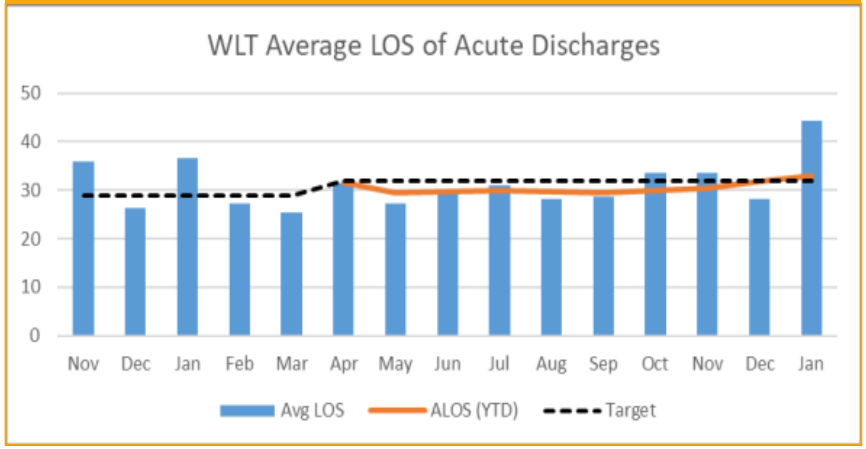
Both mental health providers are working to reduce average length of stay to 30 days

CNWL Average LoS of Acute Discharges



WLT Average LoS of Acute Discharges



Multi-Disciplinary Discharge Events

- Multi-Agency Discharge Events (MADEs) are held regularly for all older adults and complex patients with wider partners focussing on facilitating discharge for all patients with LoS above national average (75 days).
- The first rehab MADE was held in July for CNWL and reviewed 45 patients with the longest LoS - 18 discharges to date

To support acute inpatients to return to their homes and communities both Mental Health Trusts have a robust discharge pathway in place

CNWL Community Access Service

One team for each site made up of 1x B7 Patient Flow Social Worker and 1x B4/5 Peer Support Worker, with support from the Urgent Care Patient Flow Senior Lead. The service is designed for patients with complex mental health needs and/or social care needs which relates to their mental health needs which translate to prolonged acute inpatient care. The team will:

- Support with referrals to supported housing/rehab/complex placements – helping to complete applications and follow up/chase where necessary to avoid delays
- The Patient Flow Social Worker will prioritise working with patients who are not currently known to a Community Team and support the early completion of a Care Act assessment.
- The CAS will work closely with Care Coordinators to help facilitate discharge and avoid delays
- The Patient Flow Social Workers will also work with the local teams to complete the relevant assessments to help determine the patient's needs.

This is not exhaustive – the CAS screen patients on admission, and again as part of MDT/whiteboard/ward rounds to identify potential barriers to discharge and reablement needs as early as possible.

WLT discharge pathway

To support acute inpatients to return to their homes and communities' mental health bed, a robust discharge pathway in place. The following services/ functions are in place to facilitate timely and safe discharges:

- Ealing mental health rapid discharge (comprising of social workers funded by the Trust) facilitates safe discharge for Ealing mental health service users. This team links with Charing Cross and Lakeside Mental Health Units. The team undertakes care act and 117 assessments; facilitates signposting and advice, makes referrals to partners in the community and other health and social care agencies, and commissions packages of care.
- Similar arrangements are in place across all boroughs, in Hounslow for instance two placement officers, a team leader and a transitional social worker work on supporting safe discharges.
- The mental health community rehabilitation service aims to support patients to transition between different services e.g. from inpatient care to community accommodation, from higher to medium to low supported housing provision and from supported housing to independent living. It is set up to work closely with CCG, local authority and placement reviewers to ensure a flow through the system and reduce the risk of placement breakdowns.

There are a range of other measures in place across North West London to support discharge from hospital for mental health patients

Leadership and bed management functions

- Leadership calls to monitor daily demand and capacity, through daily bed huddle calls scrutinizing flow, weekly escalated bed management meetings focussing on long stayers

Step Down beds

Step Down beds across all boroughs to support patient flow. Teams work jointly with local community teams including crisis teams, community mental health teams and third sector to support successful discharge planning:

- To support the discharge of patients safely in the community
- To support the reduction of the length of stay in acute mental health wards
- To provide in-reach support in relation to benefits/housing process
- Create recovery focused environment that supports engagement with activities of daily living.
- To support patient with discharge goals

Individual Placement & Support

- Increasing access to Individual Placement and Support (IPS) services to support people with severe mental illnesses where this is a personal goal to find and retain employment
- By the end of 2021/22, NW London will have supported over 1,000 people with SMI to find and retain employment