Hammersmith and Fulham
Adults Mental Health
Service Overview

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Executive summary (1)

This is a service overview of local adult mental health services in Hammersmith and Fulham. It follows the recent reestablishment of a borough level Joint Delivery Board and sovereign Adult Social Care Department. The overview has two key aims. Firstly to support the strategic development of the local service offer in a joined up way. Secondly it provides a reference point and orientation for everyone with an interest and role to play in shaping the future direction of services. Locally we have made a commitment to put residents at the forefront of our continued efforts and coproduce our agenda for making the very best use of the collective resources we have for mental health services and deliver better outcomes.

The scope of this overview is services for adults aged 18-65. Overviews for Child and Adolescence Mental Health Services (CAMHS) and services for Older Residents aged 65 and over will follow shortly and the relationship between these three areas of service will need to be considered further.

Investment in local mental health services in 2017/18 totalled just under £44m. The CCG are the lead partner for the delivery of mental health services contributing over £35m. The contribution of universal services not within the scope of this specialist investment. Primary care and physical on the NHS side and housing and employment on the local authority side is also vital for the successful delivery of a local service system that is focused on both prevention and recovery. Further additional third sector contributions through volunteering, resident representation and independent fundraising are also significant.

The scale and diversity of mental health needs in the borough and the associated complexity of the local service system that is needed provides a challenge for providing an accessible service overview. There are high levels of need in the borough. We have the 13th highest population of residents with severe and enduring mental illness in the country.

This system reflects the co-produced vision and ambitions of the North-West London strategy that was agreed in 2015. This vision and ambitions remain clear and relevant. The local service offer and work taking place to improve it also reflects the recent national policy context for the development of local services - particularly the Independent Task Forces five year forward view for mental health services published in 2016.

There are some key strengths to the way in which services are working at each tier of the service system supported by a real focus on improvement in some key areas of service. The quality and improvement of discharge from acute settings over the last year has been a major achievement and there have been improvements to what is being offered in the community in urgent and crisis services, early intervention and improving access to psychological therapies

Executive summary (2)

Partners are now working closely together and building the foundations for delivering system wide change. Both well-established delivery arrangements (including the West London Mental Health Local Services Transformation Programme) and more recent developments (including a Joint Delivery Working Group and the Council's Specialist Housing Board) mean that some of the capability needed for further improvement is now in place. There is a collective commitment to co-production with residents and third sector partners and a range of initiatives are up and running to build on.

Challenges:

There are some long standing areas of weaker performance and a need for greater focus and pace for improvement. This includes aspects of social care delivery KPIs, out of hours services and limited public health investment. There is also a need to refocus the services performance management system as it does not offer a means to consider or manage the effectiveness of the whole system in delivering prevention and recovery outcomes. This is what drives demand, costs, and what matters most to residents affected by mental ill-health. Work to provide a view of performance on key areas of service including crisis and assessment and primary care is progressing but is not yet completed.

There is a need to further consider the both the overall levels of investment and balance of spend in the borough, supported by good benchmarking. The balance of spend is substantially skewed to high cost acute and placement services which is limiting what is available in the community to meet the diverse needs of the borough.

Work needs to start right away to support this ambition and the following issues are key;

- Apart from a view of Child and Adolescents Mental Health Services (CAMHS) and update of suicide prevention the current Joint Strategic Needs Assessment provides limted detail on mental health needs and an update is required.

- 60% of spend on services (£26.2m) is on tier 4 and 5 acute services and rehabilitation/placements/accommodation based services and the later element is an overspend pressure for both CCG and Local authority.

Executive summary (3)

- Tiers 2,3 and 4 also cater for those residents with the very highest levels of need or where risk to escalating needs is greatest. They provide urgent care, specialist community support and co-ordinated primary and social care. This accounts for a further 36% of spend (£15.9m). There is a need to more clearly understand how these services work together to both support recovery pathways from acute and placement settings *and* deliver the services that are needed to avoid them and effectively meet needs in the community. A number of related issues are key including flexibility of services to cater for fluctuating needs, creative solutions to support independent living and support for carers.

- The lowest tier (1) of services aim to enable a full and healthy life in the community and provide a service for most residents with low to moderate needs and those residents whose recovery means they no longer need specialist care or support but may need an enhanced primary care response. In Hammersmith and Fulham this tier of service accounts for just 4% of spend (£1.9m) and needs a clear management plan. A key issue is the very low level of public health and third sector investment.

- Resident representation on boards, delivery groups and programmes now needs to be secured with a mandate for co-production to lead on the development of a detailed programme of work to improve the local mental health service offer.

SECTION 1:
BACKGROUND

Local needs and context

Joint Strategic Needs Assessment Key Points

- Hammersmith and Fulham had the 5th highest population with **severe and enduring mental illness** known to GPs in the country in Mar 18 (3,077 people). There continue to be challenges supporting those with SMI in maintaining good mental and physical health (e.g. through health checks), being in employment, and being in secure housing. In some cases, patients are being treated in secondary care, when they could be treated in a community setting more efficiently.

- **Common mental illness** such as anxiety and depression affects around 1 in 6 people at any one point in time and is one of the leading causes of disability nationally.

- Levels of funding for the evidence-based IAPT programme have been increasing to meet a target of 16% of prevalence annually. Success of the programme relies on referrals into the service from a number of sources to ensure the service is meeting fair access for all.

- In White City, mental health 'champions' living locally are trained to identify people suffering from mental ill-health and offer them support in accessing mental health services as well as providing ongoing support after treatment.

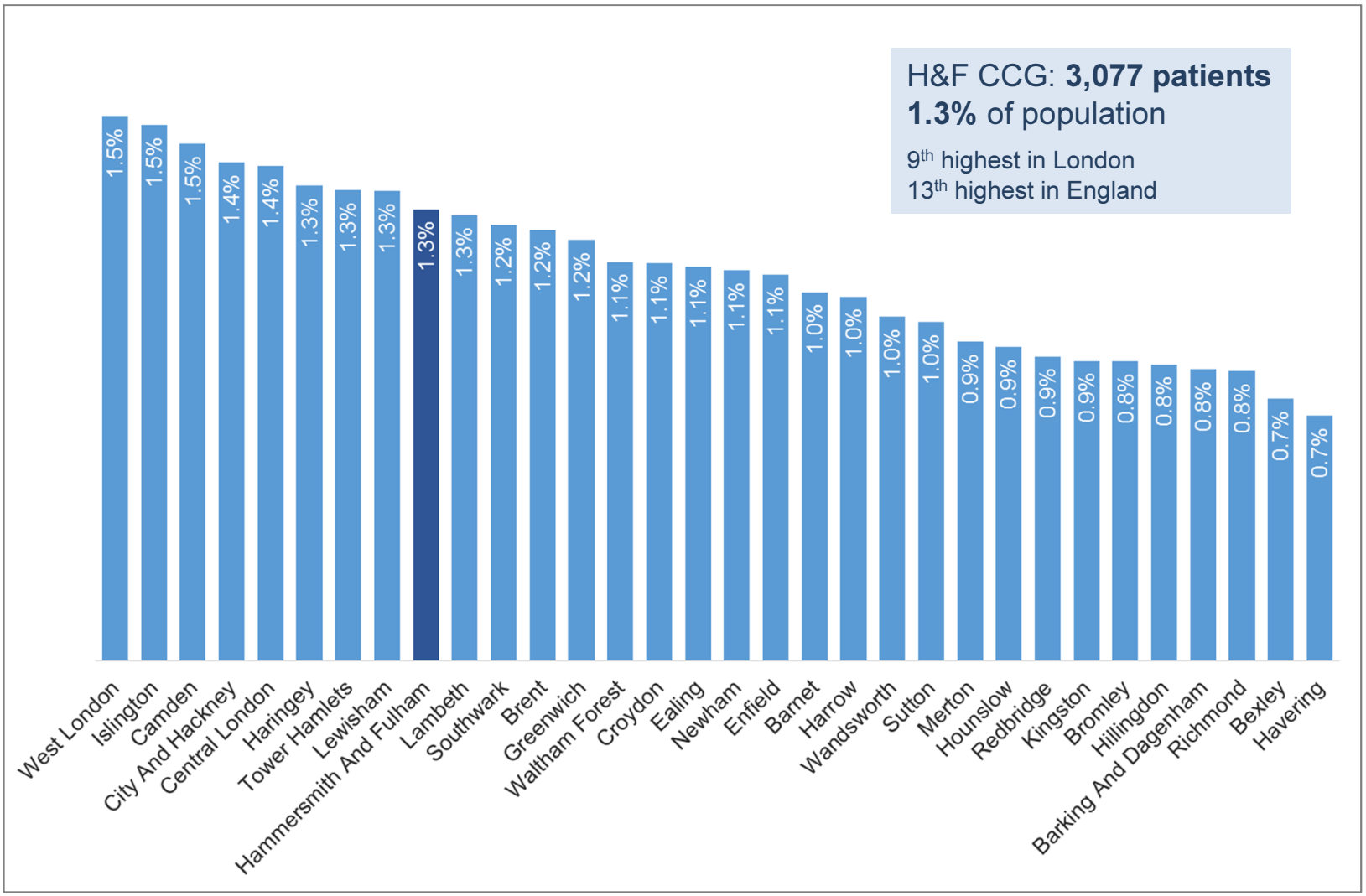
- A local needs assessment among the **prison population** in Wormwood Scrubs highlighted high levels of poor health exist in the prison (such as mental ill-health, dental health and levels of smoking),

- Regular **patient surveys** are carried out on all **healthcare providers**. The quality of community mental health services (2013) was considered 'about the same' as nationally

- 50% of residents claiming employment and support allowance do so due to mental health problems

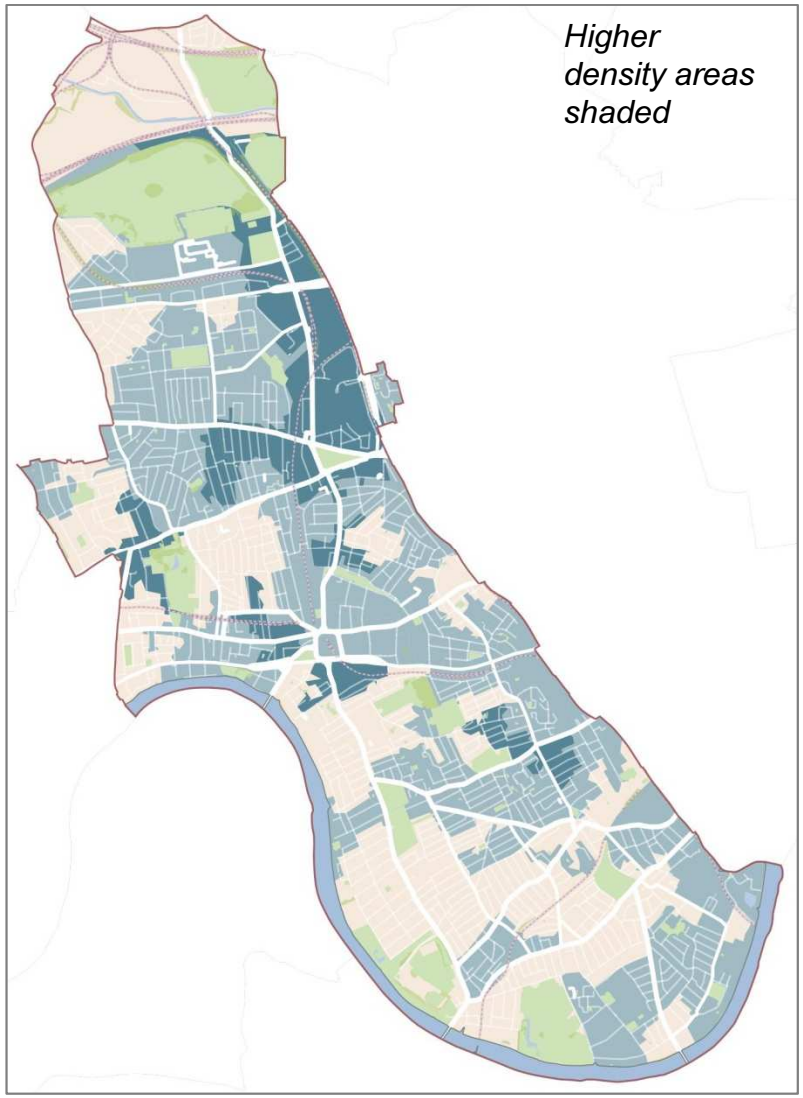
Patients with severe and enduring mental illness, H&F

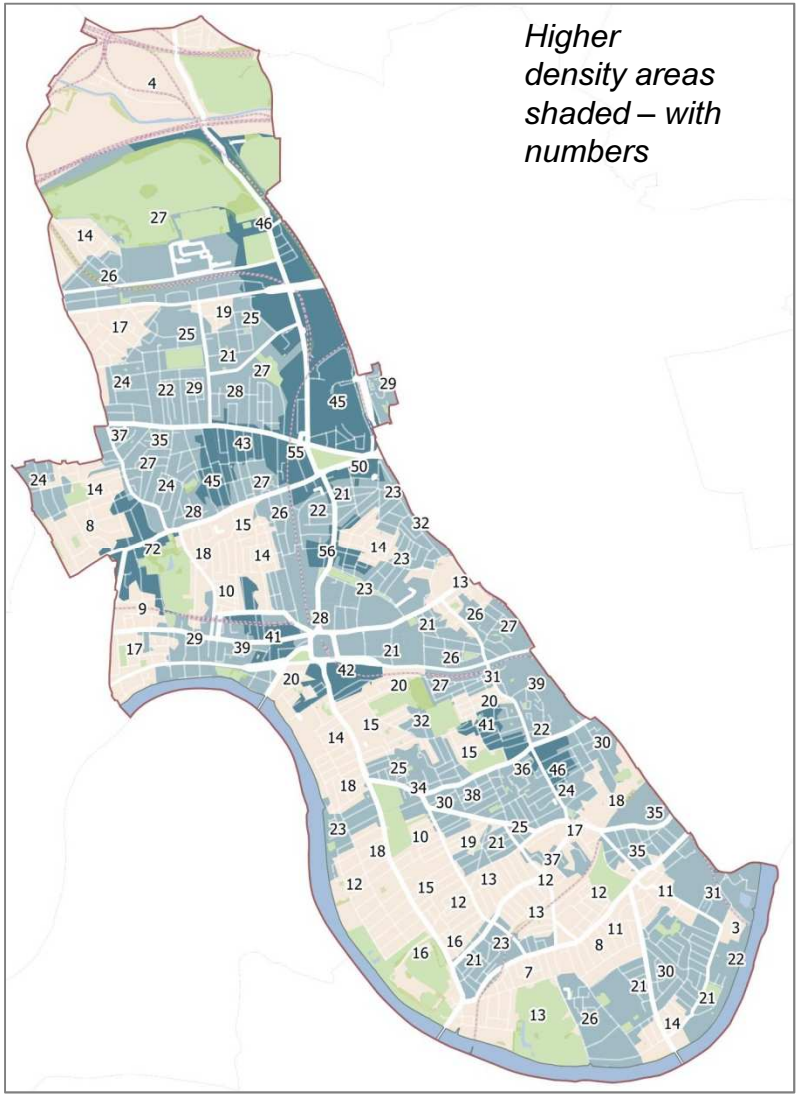
GP Practice prevalence of severe and enduring mental illness for London CCGs, Mar 18



Patients with severe and enduring mental illness, H&F

SMI register numbers by LSOA - H&F CCG Sep 18





National policy and local implementation

- The Mental Health Investment Standard (MHIS) was previously known as **Parity of Esteem (PoE)** and is the requirement for CCGs to increase investment in Mental Health (MH) services in line with their overall increase in allocation each year. Hammersmith and Fulham CCG has met this standard.

- The CCG has focused on **working towards the delivery of the five year forward view priorities** including expansion of psychological provision for people with common mental health problems focused on people living with long term physical health conditions (IAPT), perinatal services, Early Intervention in Psychosis services, 24hr community crisis care and development of 24/7 Psychiatric Liaison services, a doubling in access to Individual Placement and Support enabling people with severe mental illness to find and retain employment, Suicide prevention, Improvement of Child and Adolescent Mental Health Services (CAMHS) and Improvement of services for Armed service personal.

- The **West London Health Trust Local Services Transformation Programme** was developed to bring together clinical and management leaders from Clinical Commissioning Groups and West London NHS Trust, people with lived experience, including families, friends and carers, voluntary and community service representatives and local authority representatives to deliver improved local mental health services, through co-production. This has eliminated the use of out of area acute mental health beds.

- Healthy London Partnership has developed a London-wide proposal to support the **legislative changes relating to section 135 and section 136 of the Mental Health Act** in the Policing and Crime Act 2017. The proposal specifically relates to health based places of safety (HBPOS) and proposes how a new model of care, could improve the service and experience for those that may need to use a place of safety. It looks at how to improve the provision and quality HBPOS in line with increased demand, and with the view of having 24/7 dedicated centres. The CCG is working with the other NW London CCG's to see how this model could be implemented in NW London.

Partnership Working and Co-Production

There are evolving structures and relationships in place…..

- **H&F Disabilities Commission Implementation Group;** recruitment of lead and team from the local community is now well underway
- **CCG Governing Body Lay Members**
- **Health Watch;** H&F resident committee and wider member network
- **West London Mental Health Recovery College**; peer trainers with lived experience
- **Heads Up (Mind; Ealing and H&F);** 1000 registered members support the development and improvement of services
- **Making a Difference Alliance:** hosted by Rethink Mental Illness and covering NWL this is an established network for advisors trained in co-production and creative community leadership

- **West London Mental Health Local Services Transformation Programme (H&F, Ealing and Hounslow**); commission 'we co-produce to lead on co-production to embed it within all work streams
- **H&F Joint Mental Health Delivery Board & H&F Joint Mental Health Working Group;** recruitment of user reps and extending rep to the third sector is underway
- **Contractual and collaborative working relationships with key third sector partners;** including H&F Mind, Richmond Fellowship and Carers Network

….. work is underway to join up and co-ordinate them and realise our commitment for resident **leadership** and co-production – with staff providing a **supporting and enabling** role

Like Minded: Vision

'Like Minded' is a vision and strategy for local mental health services that was co-produced and established in 2015.

The vision is **"for North West London to be a place where people say…"**:

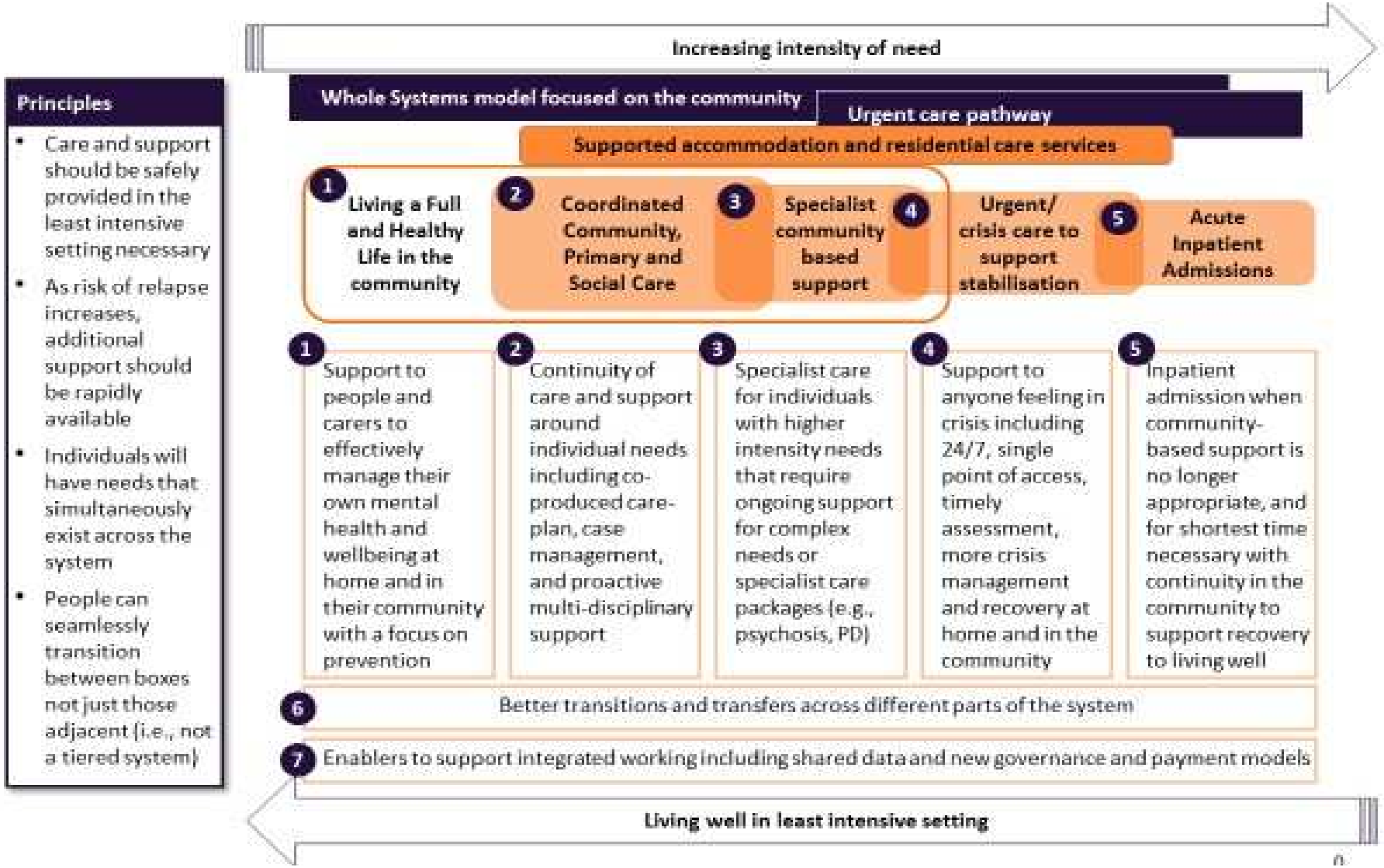
"My wellbeing and happiness is valued and I am supported to stay well and thrive."

"As soon as I am struggling, appropriate and timely help is available."

"The care and support I receive is joined-up, sensitive to my own needs, my personal beliefs, and delivered at the place that's right for me and the people that matter to me."

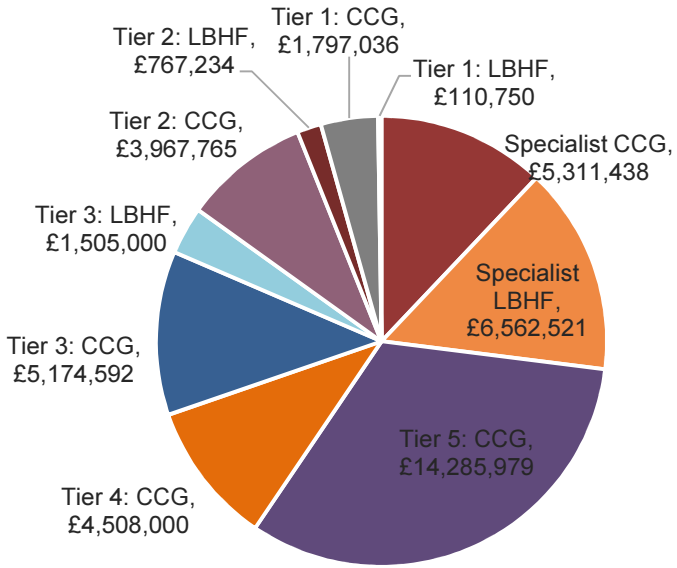
Associated key ambitions were defined and are being delivered through the West London MH Local Services Transformation Programme

Like Minded: Model of care



Like Minded: Service and financial overview

Tier	CCG Spend	LBHF Spend
Specialist rehabilitation beds, residential placements, nursing home and supported accommodation	£5,311,438	£6,562,521
Tier 5: Acute inpatient admissions	£14,285,979	-
Tier 4: Urgent and crisis care to support stabilisation	£4,508,000	-
Tier 3: Specialist community based support	£5,174,592	£1,505,000
Tier 2: Co-ordinated community primary and social care	£3,967,765	£767,234
Tier 1: Living a full and health life in the community	£1,797,036	£110,750
Total	**£35,044,810**	**£8,945,505**
Total £43,990,315		



West London MH Local Services Transformation Programme

The programme is making good progress in delivering Like Minded priorities, particularly those associated with the Serious and Long Term Mental Health Needs Clinical Model of Care across Hammersmith and Fulham, Ealing and Hounslow. Local borough level arrangements will support continued delivery of these priorities and the wider agenda for local mental health and well being services that is needed.

1. Provide a streamlined adult inpatient service that best meets the needs of the local population and enhances patient experience

- **Embedding** new **standards** that have been **co-produced with service users, carers and staff**
- **Continued flow improvement work to** address blockers and interface issues
- Significantly **improving length of stay, bed occupancy** and **Delayed Transfer of Care** rates

2. Optimise access to urgent care through single point of access (SPA); Provide timely, 24/7 and responsive assessment and care to patients in mental health crisis

- Continue **ito mplement recommendations** from evaluation of Urgent Care Pathway
- Implemented **24/7 Liaison Psychiatry Service and Crisis Assessment and Treatment teams** and further enhance out of hours crisis access
- Progress local work in terms of **Health Based Places of Safety pathway** changes associated with London Compact as well as London wide site configuration proposals

3. Increase number of patients who have timely discharge from acute (in-patient)care into community/ primary based care

- Continue to **improve interface** between inpatient and community teams and **delayed transfers of care** rates
- Improve **effectiveness of community teams**

West London MH Local Services Transformation Programme

4. **Enable transfer of care for patients with stable long term mental health needs into primary care when safe and appropriate**

➢ Continue to **implement Shifting Settings of Care action plan** and achieve trajectories for each borough

5. **Undertake an active role in the redesign of the primary, secondary and social care pathways to improve productivity and efficiency**

➢ **Embed the care pathways** in each borough; hence optimizing recovery team caseloads and throughput as well as improving quality/ effectiveness of care

6. **Redesign rehabilitation service with increasing community focus**

➢ **Develop and deliver a future model of specialist rehab provision**

SECTION 2:
DETAIL ON SERVICE TIERS

Tier 5: Acute inpatient admissions:
Services & funding 17/18

Service	Description	CCG Spend	LBHF spend
Acute inpatient care	West London NHS Trust provide inpatient beds for patients in the most need who cannot be cared for in the community. It has approximately 89 beds in the Hammersmith and Fulham Mental Health Unit which is on the site of Charing Cross Hospital. These beds are also available for Hounslow and Ealing residents The CCG also commissions other Mental Health Trusts to deliver care for patients who are registered with Hammersmith and Fulham GP's but do not live in the borough	£13,200,000	-
Psychiatric Intensive Care Ward	This is a specialist ward which treats the most complex and acute patients who cannot be cared for on a normal acute ward	£1,039,000	-
Hospital discharge co-ordinator	CCG funded specialist social work post to help facilitate discharges from the Hammersmith and Fulham Mental Health Unit	£46,979	-
Total		**£14,285,979**	-

Tier 5: Acute inpatient admissions: Residents & performance picture

Profile of residents	Performance
Key numbers: 88 beds at H&F Mental Health Unit on the Charing Cross hospital site; three are specifically for men and one for women. They admit patients from Hounslow and Ealing as well.	**On Target:** • **Length of Stay less than 50 days** (Target 50%/ current performance 43.8%) • **Delayed transfers of Care in September 18 (**9.3% within target range) • **Occupancy** (Target 86%/current performance 85%)
Profile of residents in services: Acute admissions are limited to residents that require a hospital setting due to very high risk, the need for medical stabilisation and/or sectioning under the Mental Health Act 1983. There is normally an clear underlying diagnosed condition such as Schizophrenia or Bi-polar and the resident will be in a state of psychosis and/or extreme distress. The aims is to get them to a more stable and 'medically optimised' position so that their care and support can continue in an appropriate residential or community setting, ideally returning to their own home, as quickly as possible.	**Needing Improvement:** • **Readmissions within 50 days** (Target 8.8%/current performance 9.8%) • **% followed up either by face to face contact or by a phone discussion within 7 days of discharge** (Target 95%/current performance 92.9%). • **Direction of travel for Delayed Transfers of Care positive but more work required to maintain and consolidate performance.**

Tier 5: Acute inpatient admissions: Service improvement agenda

Service developments delivered in last two years	• West London Health Trust is implementing a continuous improvement plan has implemented a full transformation programme which has delivered significant reductions in length of stay, and a reduction in delayed transfers of care. Occupancy levels reduced from 97% in March 2017 to 82% in March 2018 • Inpatient standards co-produced to clarify the expectations of the level of service each inpatient should receive.
On going challenges	• West London Health Trust has a higher number of adult acute beds compared to other Trusts . It has 9.1 adult acute beds per 100,000 registered population significantly over the national mean of 21.1 beds population • Staff recruitment and retention is challenging and this creates challenges to deliver quality of care required. The use of agency staff to cover vacancies adds a significant financial pressure in the system • Time needed to embedding significant change and managing the interface across service areas. • Ward sizes at the Hammersmith and Fulham Mental Health Unit are larger than recommended by the Royal institute of psychiatry • The West London Mental Health Trust has made significant changes however embedding these changes takes time and sustaining the improvements will require significant amount of effort
Further service and value for money improvement plans	• On-going work to improve inpatient standards, length of stay, occupancy levels and delayed transfers of care and patient flow. • Environmental improvements to Hammersmith and Fulham mental health inpatient unit. • Following on from the achievement in reducing occupancy levels and delayed transfers of care further work needs to be undertaken to assess and define capacity needed for bedded and non-bedded service provision • Embed new standards that have been co-produced with residents using services, carers and staff.

Tier 4: Urgent & crisis care to support stabilisation: Services & funding 17/18

Service		“	LBH&F Spend
Single point of Access Crisis Assessment and Treatment Team. (CATT)	In 2016, a single point of access (SPA) helpline was launched. Patients, carers and health professionals call this helpline for help or advice in a crisis from trained mental health advisors and clinicians, 24 hours a day, 7 days a week, 365 days a year. GPs and colleagues from the police can also call this number to make referrals and seek advice The Crisis Assessment and Treatment Team provides fast and responsive assessment and care in the community for people in a mental health crisis. Since August 2018 it is available 24 hours a day. It can response to emergency referrals within 4 hours and urgent referrals within 24 hours .	£2,908,000	
Psychiatric Liaison services at Charing Cross and Hammersmith Hospitals	This service provides specialist psychiatric assessment and consultation for patients admitted to the hospitals and also people presenting to the A&E department.	£1,600,000	
Approved Mental Health Professional Service	This service is provided by Approved professionals usually social workers. They assess whether people meet the criteria for detention under the Mental Health Act and if needed arrange for a person to be admitted under section to hospital. In H&F there are 11 have ASW status although they also undertake a range of tier 3 work.		£280,000
Total		**£4,508,000**	£280,000

Tier 4: Urgent & crisis care to support stabilisation: Residents & performance picture

Profile of residents	Performance
Key numbers: **Crisis and Assessment Team; It has 3 tiers** **Tier 1: Alternative to admission. Caseload 30- 44** **Tier 2; Urgent psychological interventions** Caseload 10-15 **Tier 3; Assessment and brief interventions delivered within 7 days**: Caseload 60-90 **Liaison psychiatry;** typical A& E workload per 24 hours; mean 6 referrals with a range of 4-8 per day. Wider caseload in the hospitals; Charing Cross & the Hammersmith. Receives approximately 1285 referrals a year. **136 Suite;** one room; when occupied any other presentations may be taken to the A&E or another WLT suite	**On Target:** **Crisis and Assessment Team standards** are to meet Emergency referral – 4 hours Urgent referrals – 24 hours Routine plus referral – 7 days Other referrals – 28 days No threshold agreed as yet will be monitored going forward **Liaison psychiatry;** to respond to A&E referrals within one hour of referral. Current performance 89.9%. (target 95% **s136 Suite;** Target for all presentations is to meet the completion of the Mental Health act within 24 hours. Mostly meeting this but development of accurate data is needed.
Profile of residents in services: **Crisis and Assessment Team** Tier 1. residents with severe mental illness who would have been admitted if service not available Tier 2. residents often having psychosocial crisis with high levels of distress Tier 3 . residents who need urgent assessments within 7 days **Liaison Psychiatry;** seeing people with acute mental illness who present in the ED or on general wards who have mental health symptom/crises as a result of their physical illness	**Needing Improvement:** **Crisis and Assessment Team**– Reporting against agreed service standards **Liaison psychiatry –** to meet the one hour response time out of hours **s136 –** work on the Health based place of safety work to put in place dedicated staff team to deliver required quality of service

Tier 4: Urgent & crisis care to support stabilisation: Service improvement agenda

Service developments delivered in the last 2 years	• Mental health Single point of Access and Crisis Assessment and Treatment Team implemented • Psychiatric liaison service at Charing cross hospital has received investment to enable it to go 24/7 and allow limited 24 hour crisis support in the community from the CATT team significantly enhancing out of hours crisis service offer. • The Recovery house (a short term alternative to hospital) in Ealing started admitting Hammersmith and Fulham residents in Summer 2017 • Towards the end of 2016 and early 2017 and evaluation of SPA and CATT services was undertaken. This evaluation is positive and we are working on some of the recommendations to improve these services even further
On going challenges	• Poor quality Health Based Place of Safety service at Charing Cross Hospital. Health - based places of safety are places where ambulance crews or the police can take people who are in mental health crisis; it has no dedicated staffing and continued work with the London Compact is needed. • No community based alternatives to inpatient admission for example crisis house, café or street triage
Further service and value for money improvement plans	• Review of SPA undertaken and plans in place to implement recommendations including additional training of staff , imbedding learning from feedback, integrating pathways and Joint working with third sector, police, GP's and carers • Common data set and outcomes to be developed across NW London to be able to benchmark performance • Healthy London Partnership have developed proposals to support the legislative changes relating to section 135 and section 136 of the Mental Health Act in the Policing and Crime Act 2017. The proposal specifically relates to health based places of safety (HBPOS) and proposes how a new model of care. A business case is being developed to implement model across NW London.
Biggest opportunity to improve outcomes for residents	• Expansion of crisis services to incorporate a community crisis café and /or street triage to reduce demand on spend on acute and placement services

Tier 3: Specialist community support: Services & funding 17/18 (1)

Service		CCG Spend	LBHF spend
Community Mental Health Team- locally named Recovery Team	This is a specialist team made up of psychiatrists, nurses , psychologists, Occupational therapists and social workers who provide specialist support to people with serious and long term mental health problems in the community Its current caseload is 2,113 service users	£3,444,000	£1,505,000
Early Intervention Team	This team offers specialist support to people with first episode psychosis (the most severe mental illness) between 18-35 years old. It is one of the key priorities of the mental health Five Year Forward View (FVFY)	£774,000	
Employment support Service	This service provides intensive interventions to support people with serious mental health problems back into work. It is delivered by Richmond Fellowship charity and is now part of of new Employment and Wellbeing service commissioned from October 2018. it provides the model of employment support recommended in the FYFV.	£158,446	
Recovery college and vocational workers	The recovery college offers tailed courses like Mindfulness and managing anxiety and depression to people in the Recovery Team and those discharged in the last 2 years. The Vocational staff mainly Occupational therapists offer vocational support for service users in the Recovery Team	£209,000	
Psychotherapy service	Offers very specialist long term psychodynamic therapy and consultation service	£ 409,920	

Tier 3: Specialist community support: Services & funding 17/18 (2)

Service		CCG spend	LBH&F spend
Peer support service	People with lived experience of mental health problems supporting service users in the community mental health team.		£81,501 (reduced to £40k in 2019-20.
Perinatal Mental Health Service	A team of psychiatrists, nurses, psychologists and social workers who treat women with mental health problems who are pregnant up until the baby is 12 months old. This provision was a key government priority outlined in the FYFV.	£107,000	
Dual Diagnosis Post	A specialist worker who workers with people with mental illness and substance misuse difficulties	£25,250	£25,250
Hospital Liaison Post	A social worker who provides liaison support between the hospital and community	£46,976	
Total		**£5,174,592**	

Tier 3: Specialist community support: Residents & performance picture

Profile of residents	Performance
Key numbers: • **Recovery Team;** Caseload of 2113 people • **Perinatal Team;** 208 referrals have been received within the first 8 months of the service • **Early Intervention in Psychosis team;** caseload of 117 • **Primary Care Mental Health Team;** Caseload of 136 • **Ellerslie Centre**: 60 Registered users but average attendance at groups 18 and in drop in 13	**On Target:** • **Discharges from Recovery team to Primary Care Team.** Teams are meeting the targets to enable transfer of care for patients with stable long term mental health needs into primary care when safe and appropriate. Target 218 people which was met • **Early intervention in Psychosis;** current performance to meet completed assessment in two weeks of referral is 72.7% • **Percentage of adults in contact with secondary mental health services in paid employment** 6.3 & against target of 5%
Profile of residents in services: • **Recovery Team:** The service works with people with complex serious mental illness who need care co-ordination and follow up over a longer period of time • **Perinatal team;** The service works with mother who are due to and have just given birth who have serious mental illness • **Primary Care Mental Health Team;** The service orks with GPs with people who have emerging mental illness and those with stable serious mental illness	**Needing Improvement:** • **Percentage of adults in contact with secondary mental health services living independently** is 71% against a target of 73% • **Percentage of people and carers who have an assessment/review of their needs in the last 12 months** performance is 61.6% and 46.2”% respectively against 90% targets • **Perinatal team;** need to secure recurrent funding to ensure service continues to treat women up to 12 months post birth • **Early Intervention in Psychosis;** need to start monitoring outcomes against NICE standards for care packages and expand to all age currently only 18-35

Tier 3: Specialist community support: Service improvement agenda

Service developments delivered in the last 2 years	• Peer support- A new re-ablement focussed service model was introduced in October 2018 • Employment services retendered and integrated into Employment and wellbeing service • The Perinatal service is newly set up and offered support to over 112 mothers in the first 8 months of the service. Expanded to cover women up to 12 months post birth in October 2018 • Specific mental health condition pathways implemented in the recovery team to improve quality of care. These outline the treatments and interventions a service user can be offered. • As part of the West London Trust transformation programme targets were set to transfer patients who no longer needed secondary care to primary care. The target was met transferring 218 patients last year
On-going challenges	• High caseloads in Recovery team with long length of stay • New cases of psychosis are 42.7 per 100,000 population - higher than London average and double that of England. • The Early intervention in Psychosis team is currently only for people aged 18-35 but the FYFV requires areas to have an all age service • Ensuring that the physical health needs of people with serious mental health problems are met • Ensuring that Carers receive a carers assessment • Embedding recovery focused culture and reducing lengths of stay in Ellerslie Centre
Further service and value for money improvement plans	• Embedding mental health specific pathway in Recovery team and improve efficiency , effectiveness and flow. • Work towards reducing caseloads to national average (taking into account needs) • Older adults with functional illness are treated in the Recovery Team. This model is not recommended due to their different needs functional + complex physical health care. Plan to create older peoples team being developed
Biggest opportunity to improve outcomes for residents	• Improved pathway management: faster and more effective recovery to enable people to be treated in primary care.

Tier 2: Coordinated community primary & social care: Services & funding 17/18 (1)

Service		CCG Spend	LBH&F Spend
Primary Care Mental Health Service	The service consists on 4 Community Psychiatric nurses and team Leader who offer enhanced support for people with serious mental health problems in primary care	£265,369	
Improving access to psychological therapies (IAPT)	Offers psychological interventions to people with mild to moderate mental health problems.	£2,913,490	
Home Care packages	Provides home care for social needs in peoples Own home		£310,830
Service User Engagement service called 'Heads up'	The group is commissioned to organise service user forums and support individuals to participate safely and effectively in commissioning processes to review/re-design services and/or feedback their experiences of services. It gathers a broad views of people using mental health services using a variety of methods.	£90,000	

Tier 2: Coordinated community primary & social care:
Services & funding 17/18 (2)

Service		CCG Spend	LBH&F Spend
Employment, day care and advice services delivered by MIND, Barons court and Mental Health Matters .	CCG funded services are now part of Employment and Wellbeing service delivered by Richmond Fellowship from Oct 18. This service offers signposting and advice, employment support a programme of recovery groups and individual recovery support activities. LBHF funding mainly relates to the directly provided Ellerslie Day Centre that provides a rolling recovery programme and drop in service.	£503,616	£210,000
Ellerslie centre	A centre for people with serious and long term mental health problems. Runs recovery groups 3.5 days a week and drop-ins 1.5 days a week.		£220,087
Personal Budgets and Direct payments	Payments made directly to person or carer to purchase own care package		£246,394
Total		**£3,967,765**	**£767,234**

Tier 2: Coordinated community primary & social care: Residents & performance picture

Profile of residents	Current Performance
Key numbers: • **IAPT :** Referrals received IAPT in 17/18 – 4,474 • **Primary Care Mental Health Team**: Caseload is 167 and it receives approximately 40 referrals a month • **Home Care:** in 17/18 between 58-35 packages of care. Most are under 7 hours a week, with 2 currently over 28 hours. • **Direct Payments and Personal Budgets:** • Between 20-23 people per month in receipt of a Direct Payments. Average cost of Personal Budget £179 to £211	**On Target:** • There is a need to develop the performance management system for this tier of service • **Direct Payments:** Number of people who receive a direct payment. Performance 18.6% against a target of 31%
Profile of residents in services: Residents receiving this tier of service are largely made up of two groups. Those with long term, enduring needs where a level of recovery and stabilisation has been achieved and Those with mild to moderate needs that require focused psychological intervention	**Needing Improvement:** • **IAPT:** Need to increase access to IAPT to meet government target 25% by 20/21 • **Direct Payments** Increased uptake

Tier 2: Coordinated community primary & social care: Service improvement agenda

Service developments delivered in last two years	• IAPT has been expanded treat patients with anxiety and depression and physical health problems. It is successfully treating patients with a range of conditions. There are 7 psychological wellbeing practitioners in 3 GP surgeries and therapists in respiratory and Bariatric outpatient clinics. • Launch of the Employment and Wellbeing service from October 2018 . This will offer a single point of access to employment and wellbeing services to streamline the system . Demand and performance will be actively monitored.
On going challenges	• Hammersmith and Fulham have a less developed Primary Care Mental Health service compared to other boroughs with no social work input or consultant psychiatric resource • New Employment and wellbeing service excellent addition to the borough but it will have challenges meeting the demand • There are challenges transferring patients from secondary care to primary care due to limited resources in primary care • FYFV target is to expansion IAPT from 16% to 25% of people with common mental health problems. Access by 20/21
Further service and value for money improvement plans	• Low numbers of people in receipt of Direct Payments. Need to develop home care packages to support people to move from more intensive settings to living in the community.
Biggest opportunity to improve outcomes for residents	• Improved pathway management: faster and more effective recovery. • Improved choice and creativity in service solutions.

Tier 1: Living a full and health life in the community Services & funding 17/18

Service		CCG Spend	LBHF spend
Out of hospital mental health GP contracts.	This is the additional payments given to GP's to provide enhanced levels of service for people with severe mental illness or people with complex common mental health problems	£303,634	-
Primary Care prescribing	This is the amount the CCG spends on prescribing the most common drugs used to treat mental health problems	£1,359,440	-
Public Health and wellbeing programmes	Opportunity for All - £14,520k CALM (campaign against living miserably)- £8,73. Focused on reducing male suicide		£23,250
Mental health Advocacy	This is provided by MIND for people who are inpatients and in the community. The Local Authority have a statutory duty to provide advocacy	£133,962	£75,000
Total		**£1,797,036**	**£110,750**

Tier 1: Living a full and health life in the community
Residents & performance picture

Profile of residents	Current Performance
Key numbers: The number of annual reviews for people with severe and enduring mental illness 1,535 equating to 64% of this population 14,199 residents (7.5% of population) were prescribed anti-depressants between March 2018 - August 2018 . This provides a crude estimate of the number of residents with lower level mental health needs that require support from universal services.	There is a need to develop the performance management system for this tier of service
Profile of residents in services: This wide group of residents includes people who manage their mental health problems without accessing to specific mental health professionals	There is a need to develop a strategy for reducing the level and cost of prescribed drugs. This would need to look at the underlying issues that lead to a variety of issues including depression and anxiety and opportunities for time limiting drug use.

Tier 1: Living a full and health life in the community
Service improvement agenda

Improvements delivered in last 2 years	• A new service specification outlying the enhanced service that GP's can provide has been developed. This will enable patients to have longer more regular appointments in primary care • In 2016/17 the CCG commissioned a 3 year rolling programme of suicide prevention training face to face, e-learning and train the trainer which was delivered to GPs and Voluntary Sector. It is part of the NW London suicide prevention network and working with public health developing the H&F multi-agency suicide prevention plan.
On going challenges	• Very limited public health investment in mental health • Empowering people to make healthy lifestyle choices enhancing their physical and mental wellbeing • Helping people make connections and reducing social isolation
Further service and value for money improvement plans	• Mental Health advocacy services and user involvement services to be reviewed to ensure that the model commissioned meets the needs of local residents
Biggest opportunity to improve outcomes for residents	• Maximising the value of universal services to support independent living. • Co-producing strategies to reduce loneliness and develop resilience in population

Specialist rehab beds, res. nursing home & supported accommodation
Services & funding 17/18

	Unique no. people	H&F CCG spend	LBHF spend	Total Spend
Specialist rehabilitation beds.	39	£3,222,743.42	£ -	£3,22,743.42
Residential and Nursing- fully CCG funded	31	£1,292,784.67	£ -	£1,292,784.67
Residential - Fully LBHF funded	113		£3,950,098.00	£ 3,950,098.00
Residential and Nursing Care Joint Funded	77	£1,457,941.97	£1,390,770.48	£2,848,712.44
Supported accommodation out of borough- Fully CCG funded	2	£112,286.05	£ -	£112,286.05
Supported accommodation Out of borough- Fully LBHF funded	16		£462,867.00	£462,867.00
Supported accommodation Out of Borough- Joint Funded	9	£97,697.84	£83,895.44	£181,593.29
Supported accommodation In borough Joint Funded	131	£80,260.00	£1,707,700.00	£1,787,960.00
Total	**418**	**£6,261,713.95**	**£7,595,330.92**	**£13,857,044.87**

Specialist rehab beds, residential. nursing home & supported accommodation Residents & performance picture

Profile of residents	Current Performance
Key numbers: • 418 residents are currently residing within accommodation based services that range from very high cost and secure services to low level floating support in the community.	• Services are subject to national Care Quality Commission and other local standards frameworks. The performance management focus is on exception management where there are concerns – including those identified through annual reviews. • Throughput and move on are major issues and housing needs are driving a significant level of referrals into and extended use of services.
Profile of residents in services: • Services are provided for residents with needs across tiers 2, 3 and 4.	

Specialist inpatient rehab beds, residential, nursing home & supported accommodation Service improvement agenda

Improvements delivered in last two years	Reduction in length of stay of block commissioned rehabilitation beds and reduction of the number of open rehabilitation beds used. Supported accommodation throughput improved in 2017-18 compared to previous year. Better partnership working with key stakeholders including the safer neighbourhood teams and substance misuse
On-going challenges	A significant proportion of the LA and CCG spend is on placements and rehabilitation beds. The CCG is an outlier in number of rehab beds it commissions per 100,000 population. It is the 174th highest commissioner out of 221 CCG's. Mix and level of support offered in the current supported accommodation does not meet local need The CCG and LA budgets for rehabilitation and residential accommodation are overspent and are rising rapidly year on year. Reducing dependency and spend on these services which requires increased contributions from universal services and investment in specialist community based support – at a time when there are overspend pressures on both health and social care budgets. Whilst CCG investment on supported accommodation is lower than in Kensington and Chelsea and Westminster the total share of health investment across the whole service portfolio is 45% which is comporable to K&C (46%) and much higher than in Westminster (26%). The total spend and whole portfolio of services needs to be developed through as a joint commissioning priority.
Further improvement plans and areas for development	Move-on action plan in place. to increase throughput for supported accommodation and rehabilitation beds – this is being overseen by the Speicalist Housing Board established in August 2018. Re commissioning of in borough supported accommodation presents an opportunity to develop new models including Housing First, Homeshare.
Invest to save opportunities	The whole service portfolio needs to be reviewed to identify opportunities for reducing the levels of and time needed for these services. This will require improving the housing, specialist community support and universal services offer (particularly housing, primary care and employment services) and putting recovery at the very forefront of assessment, review and case management. Opportunity to develop an in borough innovative supported accommodation scheme with enhanced levels of housing support and dedicated mental health professional input. This would enable patients to be brought back from expensive out of borough placements reducing costs, improving quality of care and enabling people to be cared for in their local communities close to family and friends