Like Minded workshop
25th September 2015 (1/6)

This workshop was arranged to further develop the thinking on the future model of care for people with serious and long term mental health needs (S&LTMHN). Approximately 20 people from across North West London attended the event representing service users and health and social care leaders.

The workshop started with a video account capturing the experiences of service users and their carers that was developed by the National Survivor User Network (NSUN) and the MAD alliance (Making a Difference).

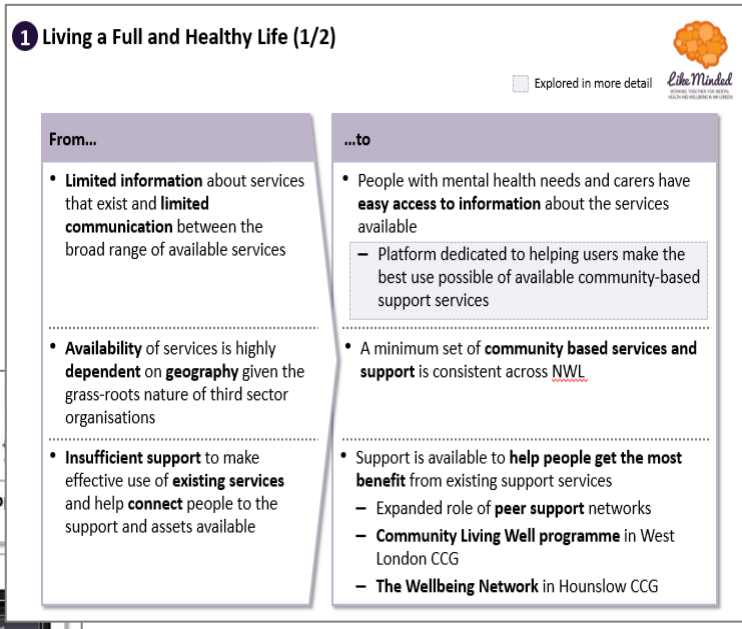
The video highlighted users' and carers' personal struggles with their symptoms and with the care they have (or have not) received. Several of the individuals who featured in the video were able to attend the workshop in person and contribute their thoughts on the model of care.

The key ideas that were developed at previous workshops on how needs must be better met were presented (below) as a starting point for discussion.

Ongoing care and support	Urgent/crisis care
• More support to **self-manage within the community and personal network** • **More joined up care** with one point of contact in the community (physical, mental, housing, social, primary care pharmacy, voluntary sector) and there is **more continuity of care** • **More flexibility** in the system to meet the varied needs of individuals • More **safe places to go** (and Mental Health and Physical Health community liaison workers) • **More consistency** of support services available across NWL	• **Extended remit and increased range of support** available from **Home Treatment Teams** • **Increased early access** to crisis prevention service package • **People have access to inpatient beds when they need it,** and stay only for the amount of time that is needed • **Improved discharge planning** should exist to support living well in the community • **Reduction in number of readmissions** and of multiple admissions must be an overall goal

Like Minded workshop (2/6)

The group then divided into two break-out sessions, where the two groups "pressure-tested" the model of care focusing specifically on how it could be improved. The elements of the early model were shown using the posters on this page and the next. Participants' suggestions were captured on post-its on the posters. These were then played back to the group at the end of the workshop.



1 Living a Full and Healthy Life (1/2)

Like Minded

Explored in more detail

From...	...to
• **Limited information** about services that exist and **limited communication** between the broad range of available services	• People with mental health needs and carers have **easy access to information** about the services available – Platform dedicated to helping users make the best use possible of available community-based support services
• **Availability** of services is highly **dependent** on **geography** given the grass-roots nature of third sector organisations	• A minimum set of **community based services and support** is consistent across NWL
• **Insufficient support** to make effective use of **existing services** and help **connect** people to the support and assets available	• Support is available to **help people get the most benefit** from existing support services – Expanded role of **peer support** networks – **Community Living Well programme** in West London CCG – **The Wellbeing Network** in Hounslow CCG

1 Living a Full and Healthy Life (2/2)

Goal: Supporting people to make the best possible use of available community-based sup and assets

- Database of all community-based services and list of volunteer 'service navigators'
- Make information widely available (physical copies, online, smartphone digital solutions)
- Train 'service navigators' to support service users, carers and workforce
- Identify gaps in local services and work with local organisations, commissioners, public health to fill them
- Find new ideas, services, and tools that could help people better manage their own health and wellbeing

Living a full and health life; coordinated community, primary and social care; higher intensity community-based support

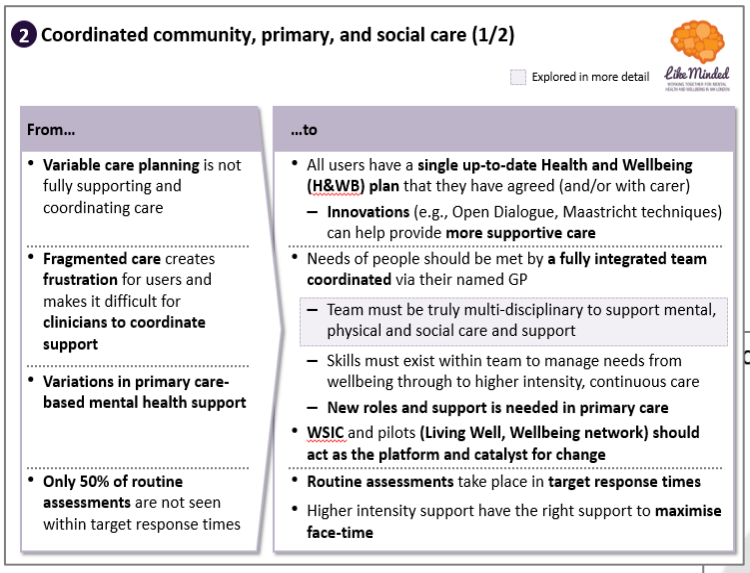
- Entire communities need to be more "geared" towards supporting mental health
  - E.g.; large-scale campaigns to challenge stigma (e.g.; one in Hillingdon recently), creating healthy environments, creating "safe spaces" that don't "feel like the NHS" – e.g.; wellbeing cafes
  - Some local authorities have developed good websites to signpost to services (e.g.; Westminster – "Go 4 mental health")
- The one, single care plan needs to be adaptive to fluctuations in the intensity of needs and services required
  - This care plan can be the vehicle for continuity of care
  - It should be updated at least annually
  - At times, users may "own" the plan (e.g.; Patient Knows Best). At other times, they may need a "backstop" to help "keep an eye" on the content of the plan
- Continuity of care is critical to building relationships with users
  - Despite challenges, we need to work harder to make this an attractive environment to work in (e.g.; growth opportunities, novel roles).

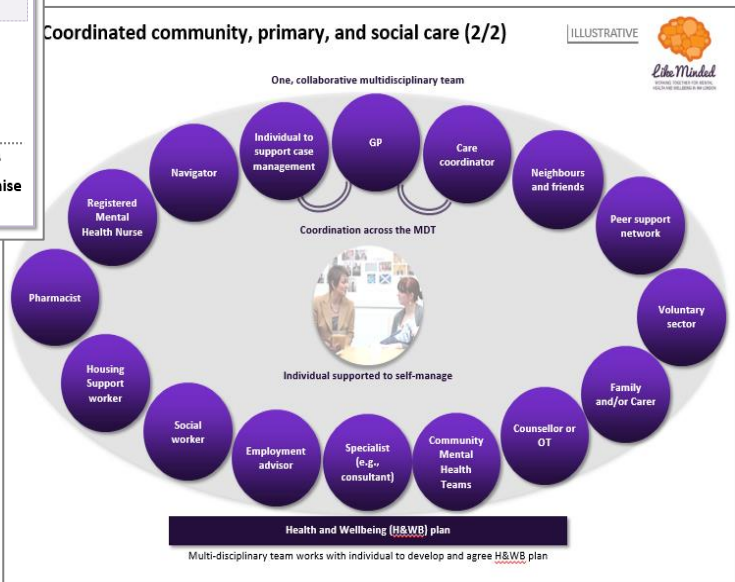
Like Minded workshop (3/6)

- Our support services need to adapt to user needs, and wrap around both primary care and secondary care
  - The service navigators that help users access services need to be well-informed about the full range of 3rd sector/primary/secondary services and how to refer on
  - At times of great need (e.g.; immediately after being discharged), the degree of support might resemble a “personal shopper” – someone who accompanies a user to help them fulfil their most basic needs – e.g.; housing, debt support, meals
- Personal budgets are not being used enough
  - It’s hard for users to avail of them
  - Not enough relevant options to spend them on, but some compelling accounts of their impact (including an example on the video who benefitted greatly from pottery classes)
  - Harrow has a great IT system that makes it easier to avail oneself of personal budgets

A few challenges were highlighted

- We need to be aware that we’re putting more accountability on GPs who are increasingly overwhelmed
- Clarity on clinical governance
- Staff retention
- Future-proofing the model: “we need total integration to make it future proof”





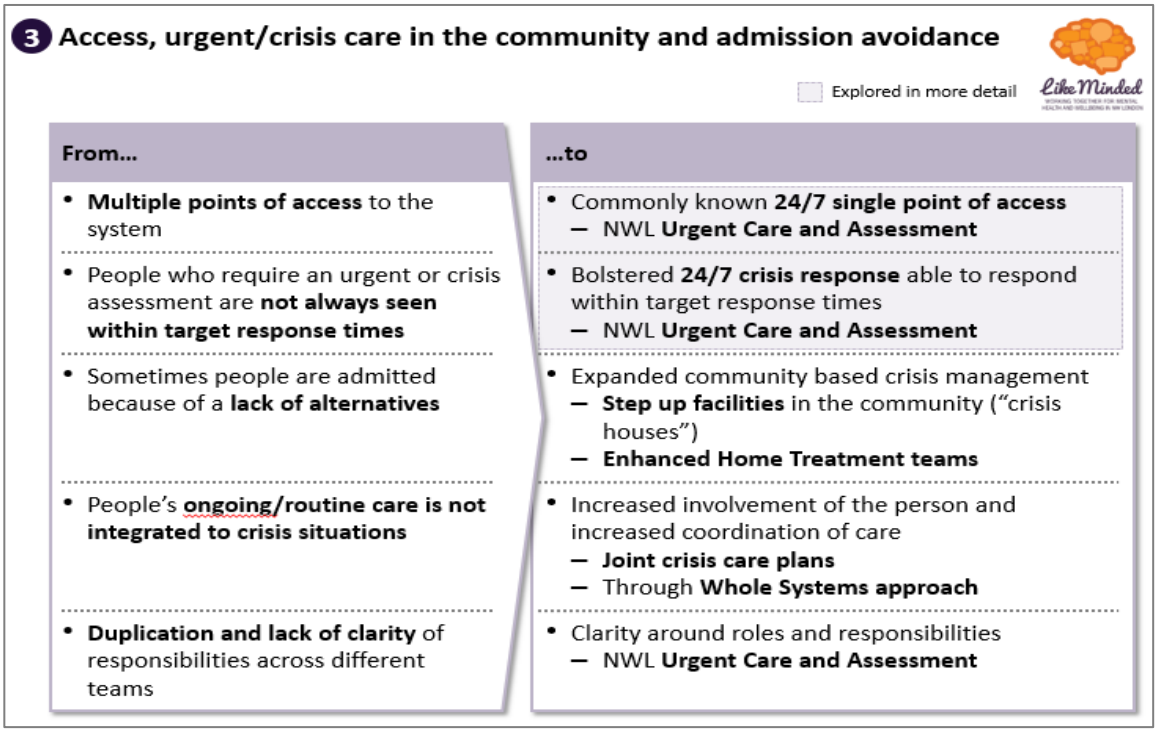
Like Minded workshop (4/6)

Urgent/crisis care in the community

Be there earlier, with all assets available, to avoid admissions

- This includes working with the criminal justice system (street triage); expanding the remit of CRHT teams to provide support before a crisis; making sure we provide the best assessment as soon as possible and in the right setting
- Particularly in A&E, we need prompt assessment (there is still a lot of variation in pathway - liaison is a 9-5 service at Charing Cross)

- Cultural changes we want to see
  - "Patient knows best" approach; easy availability of 24/7 support to help and reassure people; assessment methods to see whole person, not the diagnosis (like the "this is me" example in dementia care); acknowledgement of cultural perspectives; "blurring the lines" between housing support, voluntary support; patient safety first
- How we deliver the services:
  - Multi-skilled staff, a focus on transitions between care; team alerts; future single point of access (SPA) should be smaller and wrap around primary care much better
- Need to think of providing better support to groups we do not serve well now:
  - Consider what support will be needed to the children of parents with MH needs; student halls (lots of universities in patch, people arrive, disconnected from their families, many encounter problems)



Like Minded workshop (5/6)

4 Acute inpatient admissions (1/2)

Explored in more detail

From...	...to
• People spend longer than necessary in inpatient beds, while **waiting for a bed or place** in less acute beds or facilities (~36 people at any given time)	• People remain in inpatient care only for the time necessary – a more appropriate and broader **set of recovery, step down and housing support** – improved **capacity for assessment** and strengthen **discharge planning process**
• People spend longer than necessary as inpatients, while **waiting for an assessment or for other services** to be in place (20 people at any given time) • Once discharged, some people are rapidly **readmitted** (~7% of those discharged)	• Improved follow up post discharge – **Clear plan** agreed upon between the person, the GP, case manager and carer – Case manager **follow up**
• A **small number of admissions take up a large number of beds** (12% admissions to 45% bed days)	• People should be cared for in the lowest intensity setting that is safely possible

Best practice being developed across NWL in the emergency pathway and productivity is applied in Mental Health Trusts

4 Acute inpatient admissions (2/2)

About Amadeus House crisis house and next steps

- About to open in October 2015, close to Ealing Broadway station
- Up to **17 beds**
- **Residential supported facilities** to service people in acute mental health need who require a stable, supported environment on a very short-term basis in a community setting, and a few longer stay beds
  - **Step up** alternative to hospitalisation
  - **Step down** to facilitate discharge
- **3rd sector partner** (Rethink Mental Illness) provide the recovery workers managing the day to day running of the property with daily input from the Crisis Response and Home Treatment teams
- **One more house planned** for Hounslow and potentially for H&F (being discussed)

- **More appropriate care setting, reducing time in acute hospital**
- **Better outcomes by speeding up recovery, by supporting guests to recognise and develop their own strategies for crisis prevention and management**
- **Decrease stigma and discrimination, so leading to an improved quality of life**
- **Reduced cost vs. acute ward**

Acute inpatient admissions:

- Improving how we deliver service
  - early contact with CRHT team once admitted; develop community “green rooms” as therapeutic spaces; utilise innovations such as the Maastricht interview technique; be proactive with follow up; process to identify barriers and clearer accountabilities for rapid discharge
- Cultural shift needed
  - don’t separate “crisis” and “ongoing” phases of care; lose the word “discharge” –should be “change in intensity”
- Payment models
  - personal care budgets for alternatives; integrated personal commissioning?
- Recovery/crisis houses
  - We need these alternative options; these should have basic comforts to feel homely (this applies to hospitals too!); use these facilities for the right people
- Challenges:
  - Funding
  - Specialist housing/placement is a very slow process

What people said (6/6)

Local Authorities now have good websites to support carers/care access - Westminster has a great example, run by users "Go 4 Mental health"

"We need third sector service navigators"

"We are not using personal/social care budgets enough - it is hard for users to avail them"

"Review the care plan regularly… we need 1 care plan"

Can users become the "care coordinator"?

Some services "Don't want us" –user

"The care plan is the vehicle for continuity"

"Communities need to be more geared to supporting mental health (e.g., libraries, community events)"

"Total integration of health/social care is needed to make the model future proof"

"Are we putting too much reliance on GPs when they are getting overwhelmed?"

People need "Safe spaces" that don't feel like the "NHS"