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

NHS
North West London

Strategy for meeting the mental health needs of adults in North West London

FINAL DRAFT September 2024

Overview and context

This document presents the work that has been undertaken to refresh the strategy for mental health care for adult residents of North West London. The document:

- Takes a **phased approach to refreshing the strategy**, initially focusing on adult community and inpatient mental health services. Children and Young People (CYP) will be covered in the next phase, supported by the annual refresh of the NW London CYP Mental Health Transformation Plan.
- Includes a **summary of current need** and anticipates how this need will change over the next five years.
- Reviews **current capacity** of NHS services and analyses how this could be optimised.

Engagement **with local residents** and service users was undertaken from late August to early October to hear personal experiences to understand what was working well and hear ideas on improvements.

The ICB, NHS providers, voluntary providers, local authorities and local residents have developed and discussed **key themes** of this strategy.

This document does…

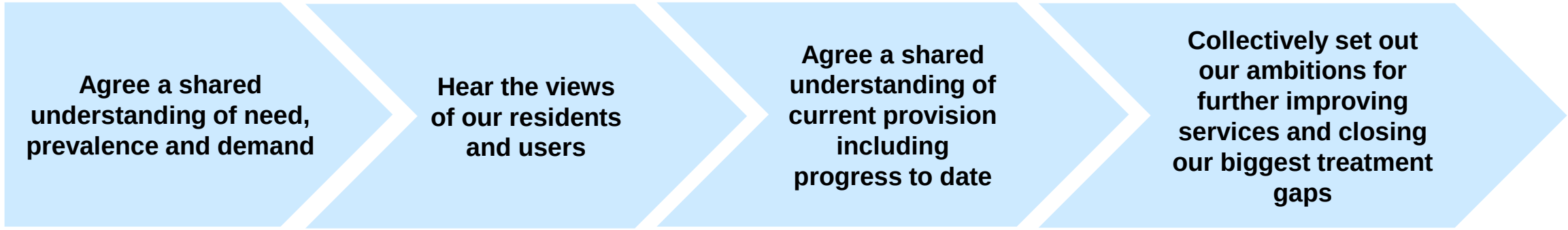
- Build upon the North West London's Integrated Care Strategy that was published in November 2023
- Build upon our boroughs' Joint Strategic Needs Assessments and complements their Joint Health and Wellbeing Strategies
- Recognise the stressors that may drive increase demand in mental health services. Each of our boroughs publishes its own health and wellbeing strategy, and this document is not intended to duplicate these – it acknowledges these existing local strategies/ plans in place for promoting resilience and wellbeing.

This document does not…

- Make recommendations as to how to improve overall wellbeing – that is the presence of our boroughs, in their health and welling services
- Recommend optimal inpatient capacity site by site. Instead, it models future demand for key services and highlights opportunities for transformation;
- Analyse workforce and finances in detail;
- Set out a detailed implementation plan: this will be developed following agreement of strategy.

Executive summary

We have developed this strategy in four stages



- Partners from Local Authorities, Borough-Based Partnerships, the VCSE, Service Users, ICS Programmes and ICB Core Teams have worked collaboratively to develop this strategy.
- Together, we have:
  - Reviewed and analysed data points from the Mental Health Joint Strategic Needs Assessment toolkit to demonstrate a shared understanding of need;
  - Reviewed the Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies developed for each of our boroughs;
  - Gathered insights from our regular outreach engagement programme, drop-in sessions in each borough and online focus groups. These have encouraged our residents to share their personal experiences and stories as well as their views on further improvements;
  - Collected views on areas of success, biggest challenges and current priorities, to inform the themes of this strategy. As we implement, we will continue to engage to ensure that services continue to support – and better support – all of our residents that use them.

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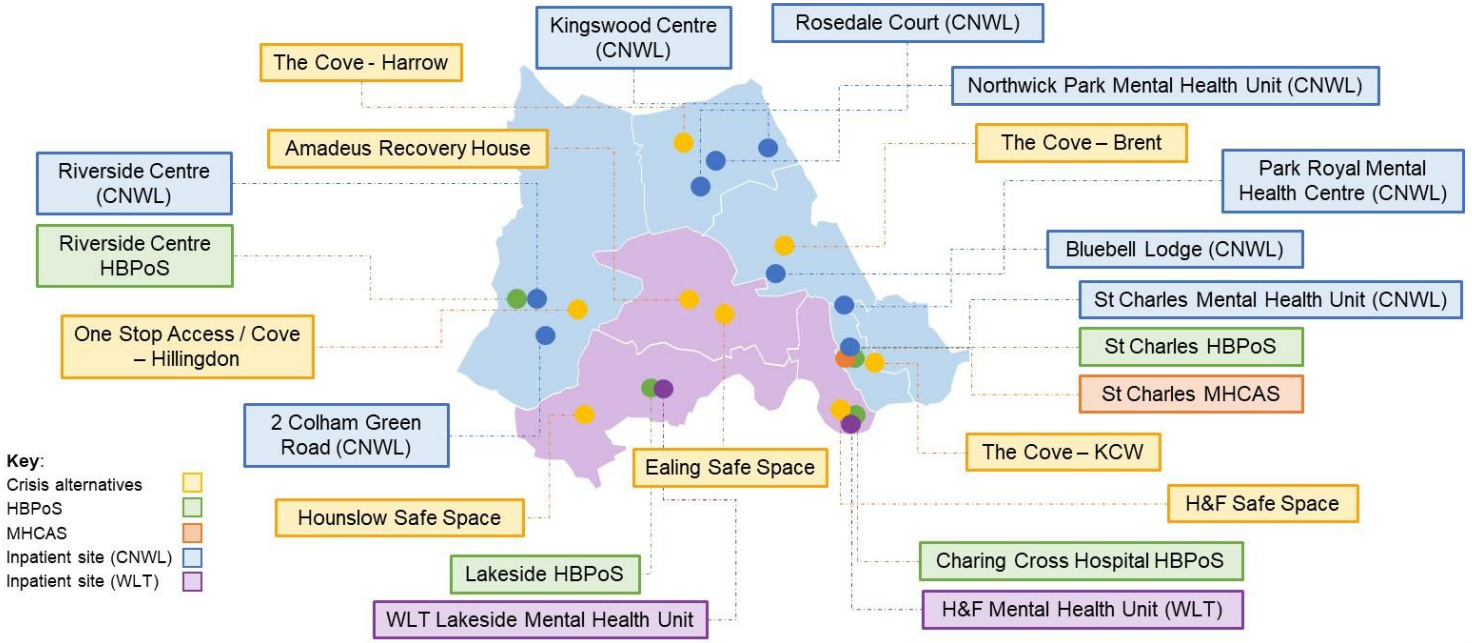
Mental health services in our ICS cover eight places for our 2.1m resident population



Our residents

- North West London is one of the largest, most diverse, and vibrant integrated care systems in England, with a population of over 2.1m people speaking over 100 languages.
- 19% of adults in North West London have common mental health problems such as anxiety or depression.
- 25,955 people are registered with a severe mental illness.
- The suicide rate in males is three times higher than that for females
- Over 23,000 adults are currently in contact with community mental health services and 50,300 in contact with Talking Therapies services

Mental health provider landscape

- The total spend by the ICB on mental health services (MHIS target) in 2022/23 was £472m, representing 12% of the ICB's total allocated budget.
  - This does not include time spent by general practice supporting residents with mental health issues
  - The ICB spent £380m on block contract adult mental health in 2022/23 with the main two mental health providers
- The main mental health service providers are:
  - Central and North West London NHS Foundation Trust (CNWL)
  - West London NHS Trust (WLT)

Adult mental health services in North West London

Talking Therapies	A range of talking therapies for people who feel anxious and worried, or down and depressed
Community mental health (Mental Health Integrated Network Teams and Community Mental Health Hubs)	Community based teams made up of different professionals with a wide range of skills. They focus on supporting people's mental health, alongside their physical health and social care needs. Teams work closely with GPs, social services, the voluntary sector and other organisations to offer treatment and care in a more integrated way.
Crisis services	(i) Home treatment teams providing intensive short-term care to vulnerable patients considered for admission or discharge as an alternative to inpatient care (ii) Community based crisis alternative services are a variety of complementary and alternative crisis services to A&E and admission, offering non-clinical support to individuals experiencing a crisis or mental distress
Liaison psychiatry	Specialist services providing mental health care in a physical health setting. They specialise in the link between people's physical and mental health, and typically provide support to people who may have co-occurring physical and mental health needs
Acute mental health inpatient	For adults and older adults in need of inpatient support for severe mental health difficulties or a mental health crisis

We face significant unmet need in addressing common mental health disorders, while our residents with severe mental illness continue to be much more likely to die prematurely

1 Adults in North West London

- Our residents generally report a **high level of happiness**, with **74%** of our residents reporting a high happiness score, compared to **72% nationally** and **71%** in the **rest of London**
- There are several risk factors for people developing mental health crises - including **poverty**, **unemployment, social isolation**, **homelessness and rough sleeping**, **smoking**, **alcohol and substance misuse** and **poor overall health.** In NWL, we have a particular issue in many of these areas (e.g., unemployment in **NWL** is **4.9%,** compared to **3.5% nationally**) – these will need to be addressed through our broader work on prevention, **working closely with ICS and wider partners.**

2 Adults with **common** mental health disorders

- In NWL, **178,000 adults** are currently registered with **depression** – **7.8%** of our adult GP-registered population. This is in stark contrast to the rest of **London (9.5%)** and the rest of the country **(13.2%).**
- **Depression** is the **4th leading cause** of disability-adjusted life years **(DALYs)** lost in NWL, behind lower back pain, heart disease, and diabetes.
- The prevalence of **depression** (recorded) has **increased at a significant rate** over the **past 10 years** – growing **6.6% year-on-year** – a slower growth rate than the rest of the country (8.5%), but a faster growth rate than many long-term physical conditions.
- This information, when considered alongside analyses of NWL demographics, national surveys, and service usage data, suggests that NWL has a substantial level of **unmet need** for common mental health disorders, with an estimated **under-diagnosis** of c. **30%.**

3 Adults with **severe mental illness (SMI)**

- **1.11%** of our population is registered as having **SMI** – approximately **33,000 people**, with prevalence relatively **constant** at this level over the last five years. Recorded prevalence is highest in **K&C (1.44%)** and **Westminster (1.39%)** – approximately 50% higher than the national level (**0.95%**).
- **Premature mortality** for patients with SMI is high in **H&F** and **Hillingdon,** with a **c. 45%** and **30%** higher rate than the national value.
- There is a strong link between **long term physical health** and **mental health** - particularly apparent in **patients with SMI**.
- Patients with **SMI** are **390%** more likely to **die prematurely** (i.e. under 75) than people without SMI. Whilst this is in line with the rest of London and the rest of the country, this demonstrates the need to develop a more **holistic and proactive** in supporting these patients.

4 Adults with **higher acuity** mental health needs

- The number of patients with mental health diagnoses **attending emergency departments** across North West London has increased by **5%** from pre-COVID pandemic levels – with a significant proportion (~25%) of patients attending still **'unknown'** to NWL mental health services. Waiting times in emergency departments remain high, with patients waiting 8-12 hours on average. In addition, a patient with mental illness will be **twice as likely** to breach the **12 hour mark** in ED than a physical health patient.
- The NWL **suicide rate** has **decreased** steadily over the last decade – now at **7.7 deaths** per 100,000 population. Whilst this is lower than the rest of the country (**10.3 deaths**), **5 out of our 8 boroughs** have a **higher suicide rate** than the rest of London (**6.9 deaths**).
- Whilst overall inpatient **admissions** have decreased **c. 15%** since pre-COVID levels, **CMHH/MINT referrals** have increased **55%** over the same period, reflecting our investment in this area. However, demand for **CMHH/MINT** remains high and further transformation is required.

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Variation in access and outcomes also exists for different population groups across our boroughs

North West London (NWL) is one of the largest and most diverse population of any ICS in England with 2.1m people speaking over 100 languages. Unfortunately, **19% of adults in NWL have common mental health problems such as anxiety or depression, whilst c25,000 people are registered with a severe mental illness.** Similarly to the rest of London and England, mental illness is not evenly distributed throughout the NWL population – differences in prevalence vary by geography, gender, ethnicity and deprivation level.

Hammersmith & Fulham and Kensington & Chelsea have the highest prevalence of depression and anxiety, conditions which predominately impact younger women. Brent, Ealing and Kensington & Chelsea have the highest prevalence of severe mental illness which predominately impacts younger men. Both common and severe mental illnesses are more prevalent in ethnic minority and deprived communities. **Ethnic minority and deprived populations have higher rates of admissions, referrals and caseloads compared to the rest of the population** – suggesting a level of proportionality between prevalence and service use. In absolute terms, protected populations in Brent, Ealing and Hounslow utilise more mental health services however, ethnic minorities from inner NWL utilise more mental health services on a per population basis.

Mixed and black ethnic groups have approximately 3 times per population admissions than other ethnic groups. Black British males in Kensington and Chelsea, Hammersmith and Fulham have the highest rates of admissions though the largest gross number of admissions is from Brent. **Males have higher rates of admission than females which may reflect the severity of their mental health conditions**. Mixed, black and 'other' ethnicities have the highest per population referrals into MH services. Females have 1.5 times more referrals into mental health services than males. Mixed females in Kensington & Chelsea and Westminster have the highest referral rate per population.

Mixed and black ethnicity populations have the highest rate of caseload per population. Hammersmith & Fulham, Westminster and Hounslow have the highest caseloads per population of any borough. The Kensington & Chelsea caseload is relatively low given the prevalence of depression and anxiety in the borough. The rate of mental health caseload in NWL is consistently higher for females than males (61% vs. 39%). **The number of caseloads per admission is lower for males than for females across all ethnicities,** particularly the black population. This may indicate a higher prevalence of serious mental illness that requires admission amongst males, and/or that males in NWL are not accessing community care in accordance with their need.

The black population has highest ED attendance rates for mental health conditions, which has increased nationally and in NWL since 2019. Harrow and Kensington & Chelsea have the highest rates of ED attendances for the black population, both of which have been increasing since 2020/21. **Hillingdon has the highest number of ED attendances in NWL**, over double that of Westminster, the borough with the lowest rate of ED attendances (28.3 vs 12.6). The number of ED attendances by 18-25 years old in NWL is below that of the Rest of England average.

Considering the demographic profile of the local population allows for strategic planning of services tailored to the needs of individual communities

The demographic analysis is useful to show where populations are clustered into geographical areas and are therefore more likely to be impacted by changes in the location of services. Populations will also be impacted by changes in the quality of services, but this impact is not necessarily dependent on the physical location of the service.

Demographic composition of the catchment population

Proportion of the potentially impacted population that are of particular population groups

Area	Households deprived in at least one domain*	Poor general health	Ethnic minorities	Disabled population	Economic inactivity	Unpaid carers	Poor English proficiency	Women of child bearing age**	18-25 year olds	Single person households	Gender
Brent	60%	4%	50%	14%	21%	7%	7%	45%	12%	26%	51% female
Ealing	54%	4%	37%	13%	20%	7%	6%	44%	10%	26%	51% female
Hammersmith & Fulham	49%	4%	33%	14%	18%	6%	2%	53%	14%	36%	53% female
Harrow	51%	4%	49%	13%	17%	8%	5%	41%	9%	21%	51% female
Hillingdon	54%	4%	45%	13%	18%	7%	4%	42%	10%	24%	50% female
Hounslow	56%	4%	40%	14%	20%	7%	5%	44%	9%	25%	50% female
Kensington & Chelsea	47%	4%	39%	15%	20%	6%	2%	46%	13%	43%	53% female
Westminster	50%	5%	44%	14%	21%	7%	3%	52%	15%	42%	52% female
NWL total	**53%**	**4%**	**42%**	**14%**	**19%**	**7%**	**5%**	**45%**	**11%**	**29%**	**51% female**

*See slide X with notes

Our current services have evolved considerably over the last few years

The NHS Long Term Plan brought an enormous opportunity to build on previous progress, and direct our attention to new areas of improvement and previously under-represented groups.

Implementation of the NHS Long Term Plan in North West London saw additional investment compared to 2018/19 of:

- £39.9m in integrated models of community care for people with severe mental illness;
- £16.9m in CYP mental health care, with a strong focus on community, crisis and eating disorder services;
- £15.1m to support people with common mental health disorders;
- £10.8m in adult crisis care;
- £8.3m in perinatal mental health care; and
- £1.7m to improve the therapeutic environment of inpatient care settings

- A range of service providers, particularly from the voluntary sector, are supporting local communities to **prevent mental health problems** and support wellbeing.
- For those with common mental health problems, such as anxiety and depression, capacity of **talking therapies** has increased**.**
- Community mental health for adults and older adults is increasingly joined up with primary care and community assets and will become part of the services on offer through our **integrated neighbourhood teams** but there continue to be a number of underserved communities.
- **We have expanded mental health crisis care significantly** with 24/7 community teams, a range of crisis alternatives to A&E and inpatient care available across the North West London as well as expanding liaison psychiatry teams to every A&E department.
- Psychosis services are delivered well across North West London, with a positive impact on **early intervention**.
- In line with recommendations from the Royal College of Psychiatrists, best practice and national policy, we have expanded care for people with severe mental health and acute needs in the **least restrictive setting** appropriate, using admission only when there is no better alternative.

But we still need to do more – continuing the focus on prevention, shifting to community based models of care and investing in alternatives to admission

1 **Adults** in North West London	• We must **expand our reach through other organisations, sectors and industries,** to further develop the broader health, social and economic improvements of North West London. • Our local system should continue to recognise and **harness the capacity and skills of the voluntary sector,** working together to enable our residents to take better care of their mental and physical health and build confidence in people to support their mental wellbeing.
2 Adults with **common** mental health disorders	• We must continue to raise awareness of our services so that **every resident knows how to access mental health support** more widely in the community • We must reach more people and address hesitancy to access mental health services by flexing our approach, in particular by **tailoring services to differing local communities**, addressing stigma and building trust by ensuring that our workforce reflects of our residents.
3 Adults with **severe mental illness (SMI)**	• We will ensure that we provide the **highest quality, compassionate, trauma-informed and most appropriate** mental health care for adults and older adults who need it across our boroughs. • We will promote and improve professional and public knowledge of **alternative crisis services** to better direct people to the most appropriate service, preventing the need for A&E attendances and admission. • We are committed to further increasing access and **advancing health equalities for those with SMI**. • We will continue to **tailor our offer for older adults**.
4 Adults with **higher acuity** mental health needs	• We continue to implement the principle that **acute inpatient care should only be used when there is no better alternative**. There will be improved support to reduce risk of re-admission. • When hospital based care is required, it will be delivered in **a timely way, by an expert team, within a therapeutic and compassionate** environment. • We will provide **inpatient facilities** that meet modern standards of acute mental health care, supporting patient dignity and privacy, with ease of access where required.

Looking at quality, our key mental health services are considered 'good' overall by the CQC, however some services have been rated as 'requires improvement' in the *safe* domain

Both CNWL and WLT have been **rated as 'good' overall** by the CQC in their most recent inspection reports (CNWL report – published **February 2024**; WLT report – published June **2020**). Both providers were deemed to provide similarly high quality services across most of the five CQC domains, with a rating of 'good' against the 'effective', 'responsive' and 'well-led' domains. Both providers were also rated **'outstanding' against the 'caring' domain** – a testament to the staff at those providers. However, both providers were also rated as 'requires improvement' against the 'safe' domain. See below for additional information against each CQC domain.

Mental health services provided in primary care are more difficult to assess, though the most recent GP Patient Survey (2023) suggests that **NWL primary care services are generally good** and perform in line with the national average. For example, **70% of survey respondents** in NWL rated their overall experience of their GP practice as **'very good'** or 'fairly good' – in line with the national average of 71%. In general, patients also find it easier to get through to their GP practice on the phone compared to the national average – 59% of NWL respondents rated this as 'easy', versus 50% nationally.

Safe

- CNWL and WLT rated as **'requires improvement'** in this domain, with most wards deemed to be safe, clean, and well equipped.
- The CQC found that CNWL had implemented quality improvement methodologies to improve areas such as **falls** and **pressure ulcer care**, and had already resulted in in reductions in violence, aggression and restrictive interventions.
- However waiting times for patients with higher MH needs may affect patient safety. For example, waiting times in A&E remain high (see responsive domain) and waiting times for **CMHT** range from c. 30 days to 40 days and waiting times for crisis resolution teams or home treatment teams can range from less than a day to multiple weeks depending on the month and borough. **Waiting times** for these services may need to be **reduced** to improve the safety of patients referred to these services.

Effective

- CNWL and WLT rated as **'good'** in this domain, with the CQC finding that staff assessed the physical and mental health of patients on admission and **individual care plans** were developed and reviewed regularly through MDTs.
- The latest GP Patient Survey (2023) concluded that GPs in NWL generally do recognise the mental health needs of the patients they see – **79% of patients** confirmed that their mental health needs were recognised in their last GP appointment. This is broadly in line with **the national average** – **81%.** However, variation is significant across PCNs in NWL – from **65%** to **91%.**
- Recovery rates for talking therapies are just below the **50% target**, with **44-48% of patients** deemed to be **'moving to recovery'** after completing treatment.
- Both CNWL and WLT have a **lower proportion** of **30 day readmissions** for adult acute services than other London providers (5-8%, compared to 9% for London).

Caring

- CNWL and WLT rated as **'outstanding'** in this domain.
- CQC inspectors highlighted that services were patient-centred and staff wanted patients to experience the best possible outcomes and that there were many examples of staff and leaders going the extra mile.
- However, the friends and family test (FFT) results for CNWL and WLT are slightly below the England average for mental health providers.
- In the latest 12 months of FFT submissions, CNWL had an average positive response rate of **86%**, and an average negative response rate of **5%**. WLT had an average positive response rate of **82%** and an average negative response rate of **11%.** This means that generally **82-86%** of respondents would recommend these services to friends and family.
- However, the FFT response rate for both providers is relatively low – approximately **1%** in February 2024.

Responsive

- CNWL and WLT rated as **'good'** in this domain.
- The CQC did highlight major pressures on the mental health urgent care pathway, with people waiting excessive periods of time in A&E and crisis assessment services. Across NWL, approx. **30%** of MH patients wait over 12 hours to be admitted, transferred or discharged from arrival – this is twice as high as patients attending for physical health reasons.
- Waiting times for most community mental health services are quite good or in line with national targets. For example, **99%** of patients had their first **talking therapies** appointment within **6 weeks** of referral, according to most recent data (December 2023). However, waiting times between appointments can be quite high and variable – anything from **29 days** on average to **67 days** on average.

Well-led

- CNWL and WLT rated as **'good'** in this domain.
- CNWL was committed to supporting staff to 'speak up' and also had a strong reporting culture for incidents, with 98% of all incidents were reported as resulting in no or low harm, and reports were completed to a high standard.
- However, the CQC did highlight that the **escalation and oversight** of operational risk at CNWL needed to be strengthened – though work is already underway.
- WLT received similarly good feedback from the CQC, stating that leaders had the **skills, knowledge and experience** to perform their roles and that **governance processes** operated effectively and per**formance and risk** were managed well.
- Staff at WLT also engaged actively in **quality improvement** activities.
- However, it should be noted that WLT's last CQC inspection took place almost four years ago.

Sources: CQC reports for CNWL/WLT; GP Patient Survey 2023 (sample size = c. 17,000); CNWL/WLT/NWL ICB Monthly Information Returns; NHS England FFT submission Mar 2023 – Feb 2024..

Enhancing our mental health services with new digital technologies will help improve outcomes and the patient experience, whilst also improving productivity

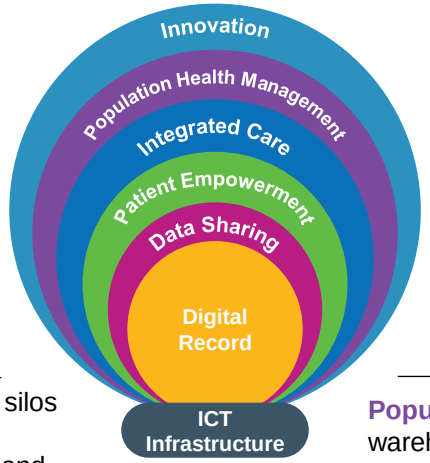
The NW London ICS Digital and Data Strategy sets out the digital and data technologies and actions that are required to enhance our mental health services. It will continue to be developed in the coming year to reflect this MH strategy and better support the recommendations that are being made.

ICT Infrastructure: Our providers have a mostly mature ICT infrastructure, with clinical systems hosted in the cloud and reasonable investment in resilience and cyber security.

Further planned work includes enhancing access in locations outside our main MH estates, better access management, and greater use of portable devices in the community.

Digital Record: Our key mental health providers have already deployed Electronic Patient Record (EPR) systems which have largely replaced paper-held records, but in many areas more work is required to optimise these systems and achieve the Digital Capabilities Framework defined by NHS England.

Data Sharing: We will continue to move beyond individual provider silos and ensure data is shared (as appropriate) between providers and between sectors – using systems such as the London Care Record and the Universal Care Plan. This will enable more effective care planning and improve handovers of care, but will require further investment.



Patient Empowerment: We will deliver a care model centred on the citizen/patient and prioritising the user experience – with patient facing systems that share care history and enable self-management of appointments. However, MH EPR systems require significant investment to deliver this functionality. We will also provide a greater range of smartphone and web-based apps to help people manage their own health and well-being.

Integrated Care: We know there is much more we can do to integrate MH services across care sectors. For example, we will continue to improve our integrated demand and capacity planning at system level – building on work completed as part of this MH strategy and including other sectors. We will also exploit shared records to better manage care that spans different settings – so that we understand people's issues as they move from primary care through to community, acute and specialist mental health services.

Population Health Management (PHM): Our MH providers are investing in internal data warehouses and BI tools to help track the outcomes and the quality and efficiency of the care they are delivering – supporting our ambitions to improve care quality, reduce inequalities and increase efficiency. Thinking about care in population health terms will help us target under-represented cohorts with specific interventions to improve outcomes for those groups. This will require a cross-sector, integrated approach to managing the mental health of our residents – as described above.

Innovation: We will develop capabilities for people who increasingly wish to interact with our mental health services using digital tools (bearing in mind the risk of digital exclusion) – both digital models of care and digital tools to navigate the mental health system. Whilst we have already implemented patient-facing tools in our CYP services such as Kooth (with some success), we will also look to implement other tools and continue to explore the wider digital mental health market and assess the suitability of new tools as appropriate, building them into our pathways.

As described in this strategy, we also know that there are productivity gains that could be made to increase the value for money of our mental health services – particularly in community services. Innovative digital tools such as e-rostering platforms and AI-assisted note taking and planning tools will help unlock these gains – reducing the administrative burden on 'caseload-carrying' staff and freeing up more time for patient care. This will require careful planning and close-working with patient-facing staff in a supportive manner.

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The ICS workforce priorities and programmes support the ambitions of the Mental Health Strategy

Our ICS Workforce Strategy

ICS Workforce priorities are grouped together into two strategic intentions:

A great place to work by bringing together our ICS wide collective **recruitment** and **retention** initiatives to ensure availability of the workforce capacity required, minimise attrition and maximise the capability of the registered and non-registered workforce.

Transform for the future in order to respond to the NHS Long Term Workforce Plan by conducting strategic workforce planning within 'collaboratives' and 'place', informed by modelling and forecasting to support **new ways of working,** improved workforce planning, efficiency and **tracking productivity across mental health services**, in particular community teams, as well maximising the opportunities afforded by **digital and technological innovations.**

Mental Health Strategy Workforce priorities

1

Recruitment and retention:
- Reducing vacancy rates to improve quality of care
- Increasing workforce capacity through improved retention

2

Equality and diversity:
- Diversifying senior leadership and improving experience of black and minority ethnic staff;
- Diversifying the allied health and psychological professions

3

Education and joint training:
- Investment in apprenticeships
- Investment in new roles
- Increasing clinical placement capacity to capitalise on investment outlined in the NHS Long term Workforce Plan

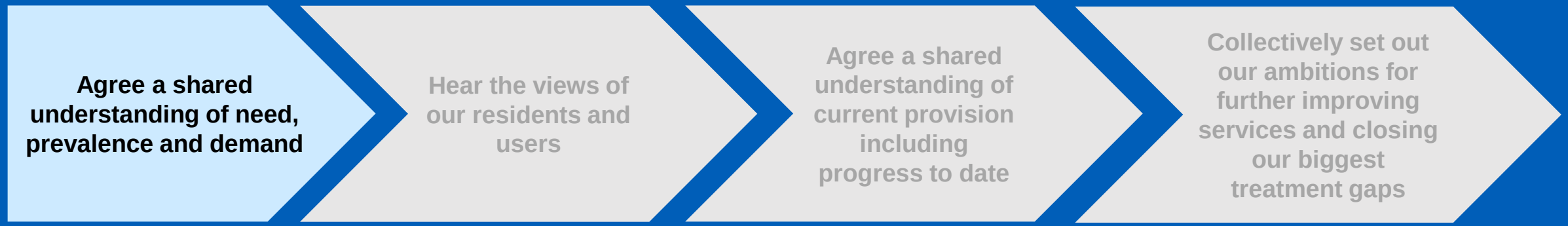
4

Workforce transformation and productivity:
- Development of new models of care and the integration of new roles (Mental Health Crisis Assessment Service and HBOS)
- Reducing reliance on the use of temporary (agency) staff

Our shared aims and ambitions for adult mental health services for the future

By 2028/29 we will have:

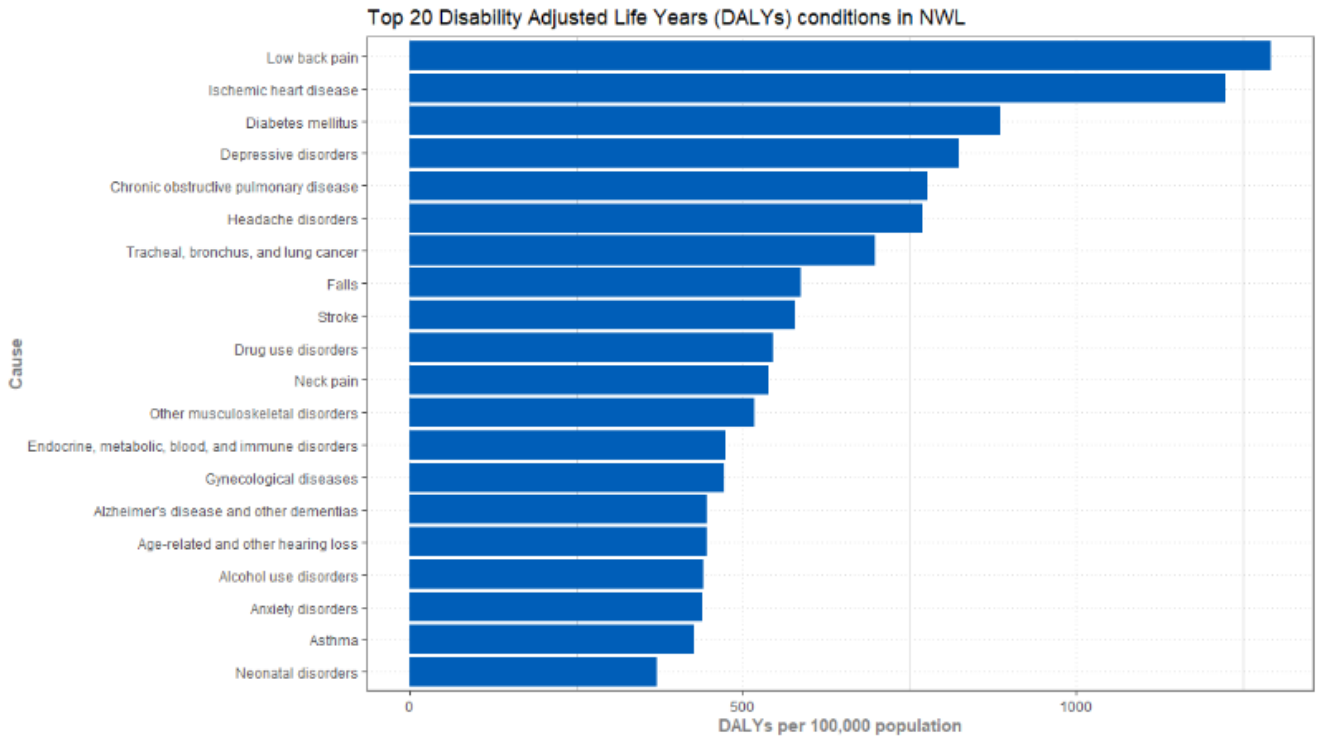
Ambitions	Outcomes
RAISED AWARENESS AND PROMOTING WELLBEING • Raised awareness across North West London so that every resident knows how to access mental health support both in crisis and more widely in the community. • Developed an assets-based approach to promoting mental health, wellbeing and independent living, partnering with and investing in local community organisations.	• Services responsive to population health needs and flexibly delivering changes with no unwarranted variation in outcomes. • Locally tailored and visible, community support services; built capacity in providers to plan and develop their services for patients. • Patients and staff reporting better experiences. • Optimal community and inpatient capacity to respond to growth in need whilst delivering our transformation goals and increasing care in a community setting. • All people known to mental health services with a crisis management plan that supports them to use crisis alternatives to A&E for de-escalating their needs, where there is no physical health need. • No person staying longer in a mental health bed than they need to. • Integrated solutions to housing pathways. • More people gaining and staying in meaningful employment. • Zero adult inappropriate acute inpatient stays outside of North West London.
INCREASED EQUITY AND EQUALITY OF ACCESS • Increased equity and equality of service access to reflect different needs of our local and diverse communities, with greater targeted support to those with severe mental illness. • A consistent core offer for community and crisis care for adults, with a focus on severe mental illness, that also enables flexibility for local and diverse needs. • Reduced variation and increased productivity in caseloads and staffing across community services. • Improved staff recruitment and retention. • Waiting times measuring in the top quartile in England.	
CARE IN THE RIGHT PLACE • Integrated care between primary care and mental health teams to enable more person-centred care and a greater focus on adults with severe mental illness. • High quality inpatient facilities that provide timely care, by an expert team in a therapeutic and compassionate environment. • Worked together with our Local Authority partners to develop solutions to the housing and employment pathway challenges.	Enabled by: • Increased funding into mental health, benchmarked with other areas nationally, in line with the medium-term financial plan, alongside increased productivity of services • Allocated resource based on need. • Consistent suite of outcome measures to demonstrate the value delivered


Agree a shared understanding of need, prevalence and demand
Hear the views of our residents and users
Agree a shared understanding of current provision including progress to date
Collectively set out our ambitions for further improving services and closing our biggest treatment gaps

Depression is the 4th largest contributor to the burden of disease experienced by residents of North West London, behind lower back pain, heart disease, and diabetes

- **Depression** is the 4th leading cause of disability adjusted life years (DALYs) lost in NWL, behind lower back pain, heart disease, and diabetes.
- In NWL, depression accounts for the loss of c. **800 DALYs** per **100,000** population.
- Anxiety is responsible for the loss of a further c. **450 DALYs** per **100,000** population.
- Under-diagnosis and under recording of anxiety and depression may mean that the burden of anxiety and depression may be even higher.
- Timely, high quality and sustainable mental health services are one of the most effective interventions we can undertake to reduce the burden of disease for our residents.

Top 20 health conditions, ranked by disability adjusted life years (DALYs) lost
North West London, 2019



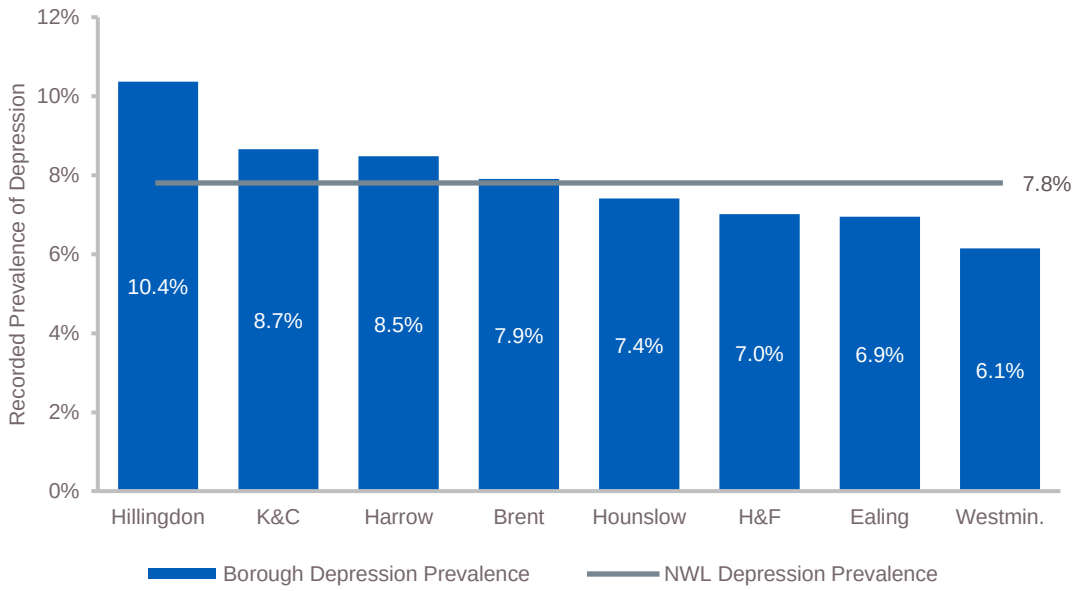
Sources: Institute for Health Metrics and Evaluation (IHME), Global Burden of Disease, 2019

NHS North West London

Recorded prevalence of depression has increased significantly across North West London, though still well below national levels, suggesting potential under-diagnosis

Depression: Recorded Prevalence

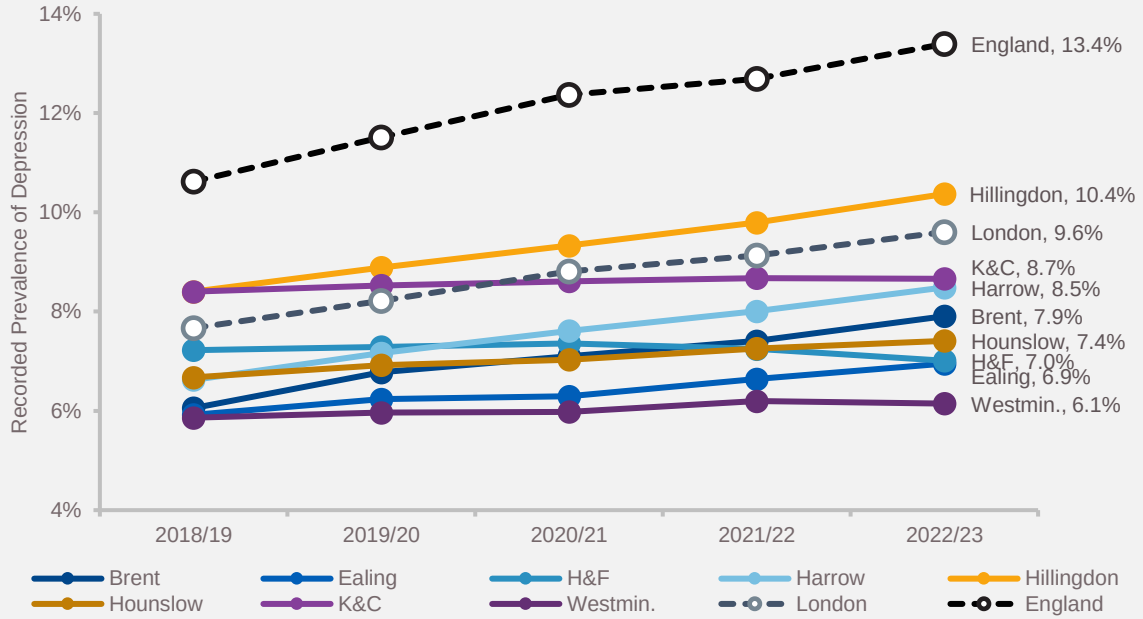
As a proportion of registered population, 18+ [FY23]



- **Though Hammersmith & Fulham and Westminster both have lower prevalence than the rest of North West London, they also have the two highest suicide rates** – adding weight to the hypothesis that there may be unmet need in the system that needs to be addressed (see analysis on suicide rates at the end of this section).
- Of our 8 boroughs, Hillingdon has the highest recorded prevalence for depression.

Depression: Recorded Prevalence

As a proportion of registered population, 18+: Trend over time



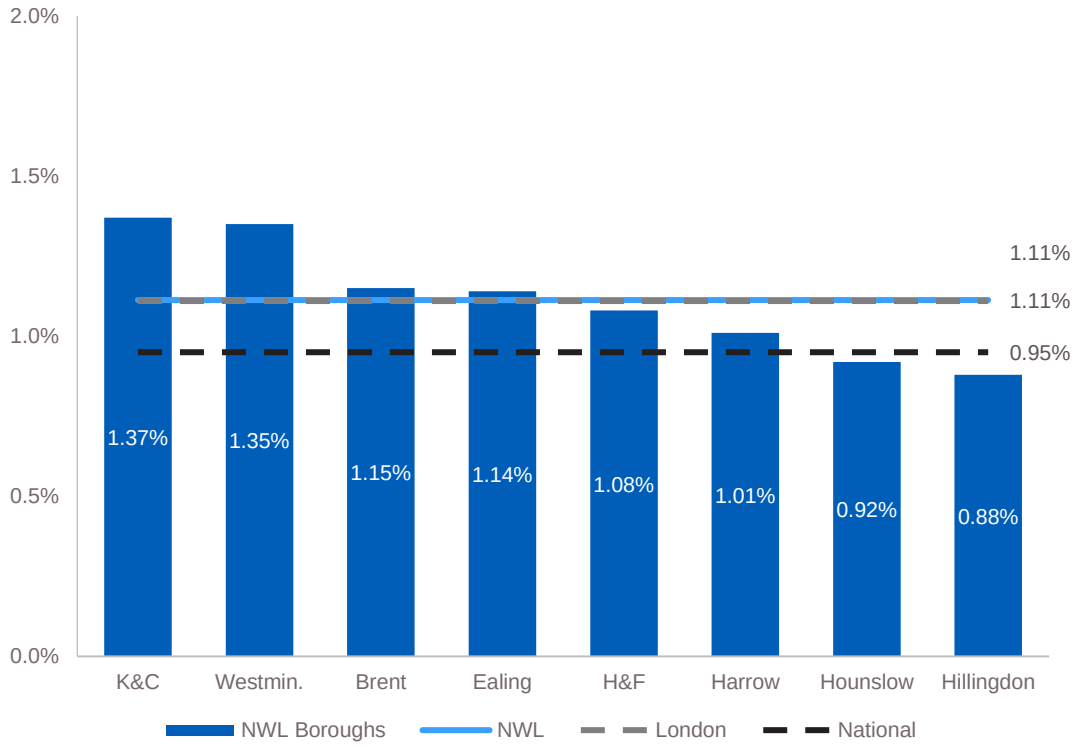
- Recorded depression prevalence in Hammersmith and Fulham has reduced over the period
- K&C and Westminster's recorded depression prevalence has remained flat over the period.
- Most other boroughs have experienced an increase in recorded prevalence in line with the rest of London and the country.
- NWL's (and London)'s recorded prevalence is far below the England average, suggesting either lower actual prevalence or significant under diagnosis. This in turn may reflect hesitancy amongst our residents to seek help, and/ or less effective support for our communities.

Sources: NHS Digital, Quality and Outcomes Framework (QOF) – 2022/23 – recorded depression prevalence.

Kensington and Chelsea and Westminster see higher recorded prevalence of severe mental illness; everywhere residents with severe mental illness are much more likely to die prematurely

Recorded prevalence of severe mental illness
Percentage of registered population aged 18 and over [2021/22]

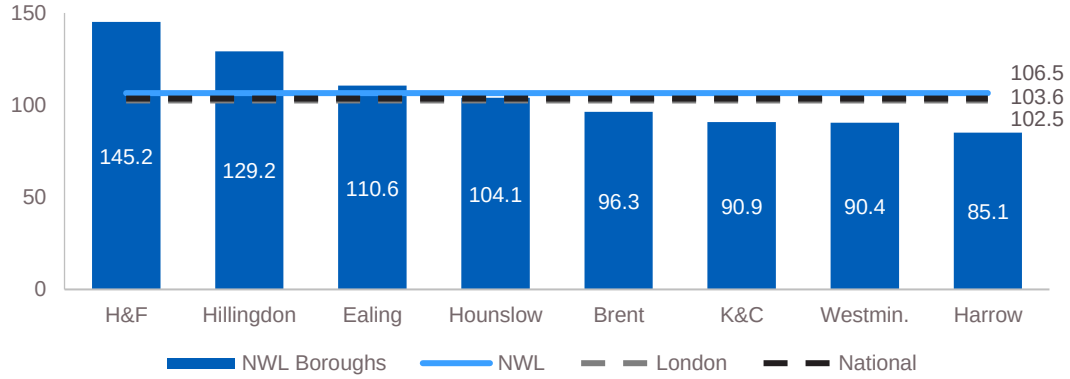
Source: Quality and Outcomes Framework, NHS England, 2021/22



***Note:** SMI for these particular indicators have been defined by Public Health England as having a referral to secondary mental health services in the five years preceding death. It is not directly comparable to the definition of SMI under the NHS QOF.

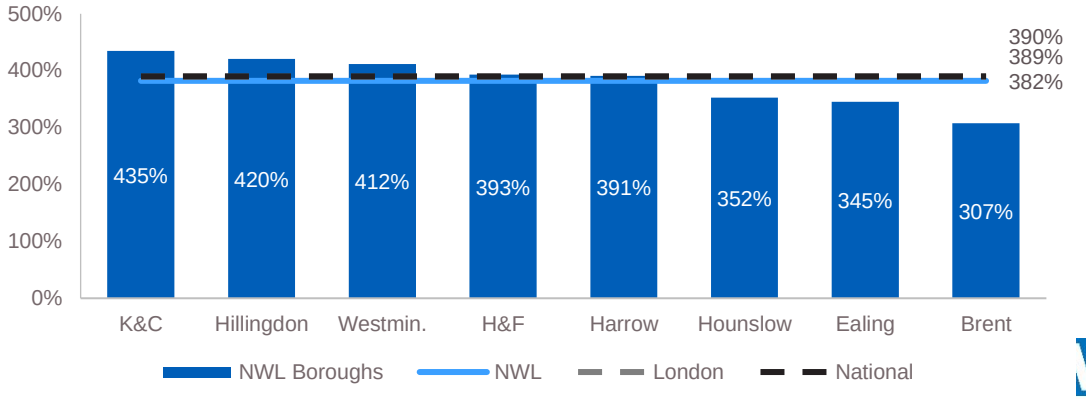
Premature mortality (before age of 75) in adults with SMI*
Directly standardised rate, per 100,000 population [2018-20]

Source: PHE, NHS MHSDS, ONS, 2018-2020



Excess mortality in under 75s with SMI*
Excess risk – i.e. x% higher/lower risk of premature death (before age 75) than adults without SMI* (%) [2018-20]

Source: PHE, NHS MHSDS, ONS, 2018-2020

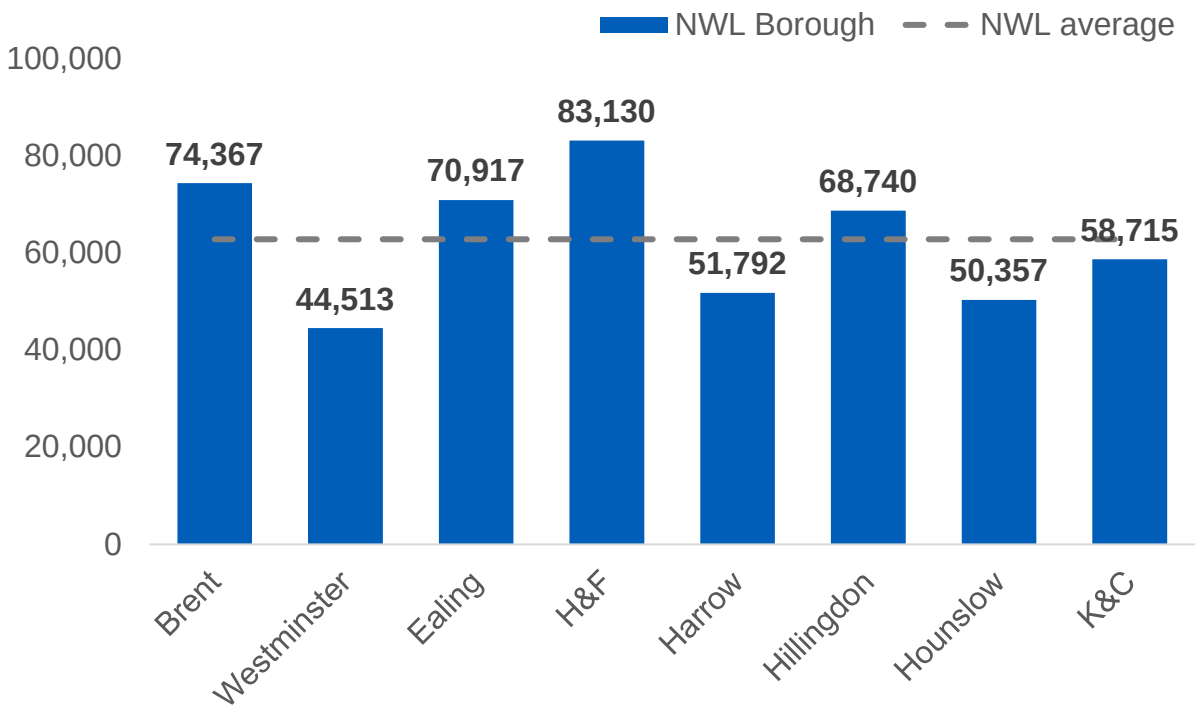


North West London

Hammersmith and Fulham has the highest prevalence of anxiety and depression in 18-65 year olds throughout NWL

Prevalence of anxiety and depression by borough in NWL

Total number of 18+ years old with anxiety and/or depression by borough



Gender	# of people with anxiety	# of people depression
Female	166,138	146,070
Male	97,067	93,256

Age	# of people with anxiety	# of people depression
18-64	223,498	206,146
65+	36,491	33,180

Ethnicity	# of people with anxiety	# of people depression
Asian / Asian British	52,477	48,110
Black / Black British	21,379	21,903
Mixed	10,185	9,925
Other ethnic groups	30,119	29,876
Unknown	2,873	2,496
White	146,172	127,016

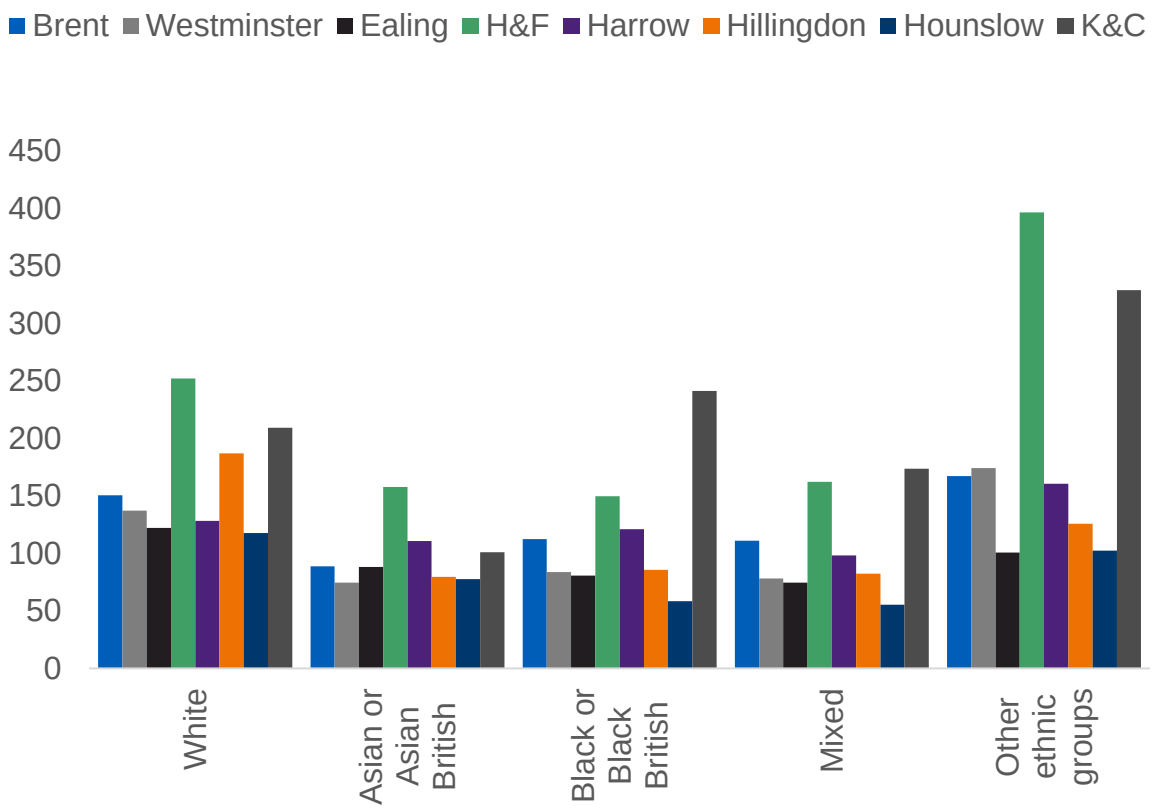
Deprivation Quintile	# of people with anxiety	# of people depression
1 (Most deprived)	39,045	39,866
2	85,347	81,694
3	71,267	63,243
4	46,053	38,043
5 (Least Deprived)	21,004	16,031

Source: Quality Outcomes Framework 2022/23, CF analysis

The highest prevalence of anxiety and depression is seen in the other ethnic groups living in Hammersmith & Fulham, and Kensington & Chelsea

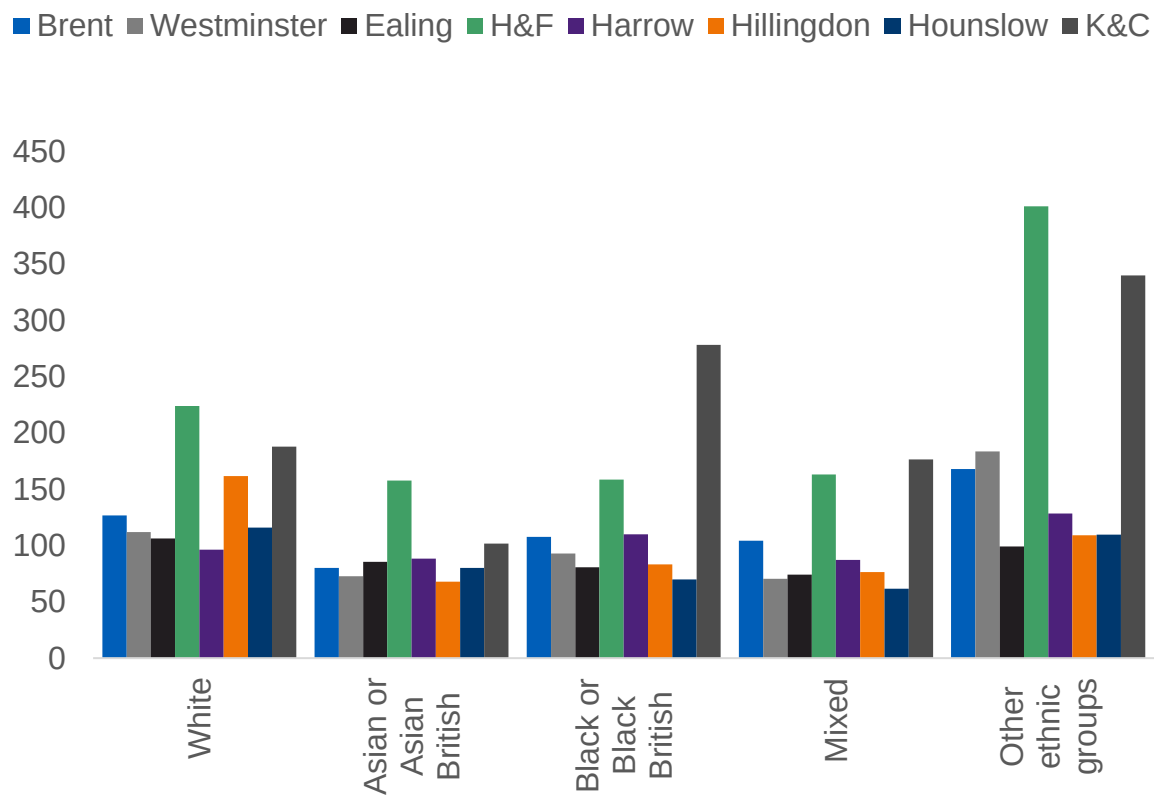
Prevalence of anxiety by ethnicity in NWL

Prevalence of anxiety in the catchment population by ethnicity per 1,000



Prevalence of depression by ethnicity in NWL

Prevalence of depression in the catchment population by ethnicity per 1,000

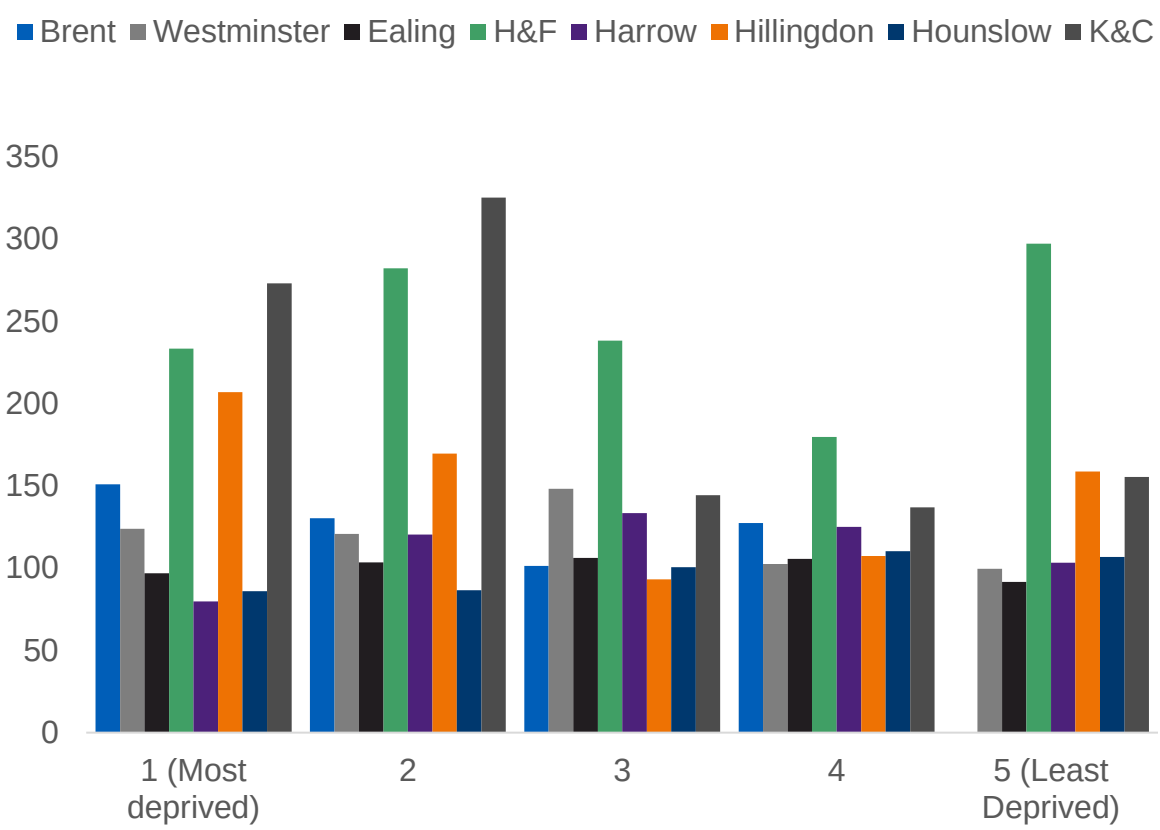


Source: Quality Outcomes Framework 2022/23, CF analysis

People living in the first and second most deprived quintile in Kensington & Chelsea have the highest rate of anxiety and depression

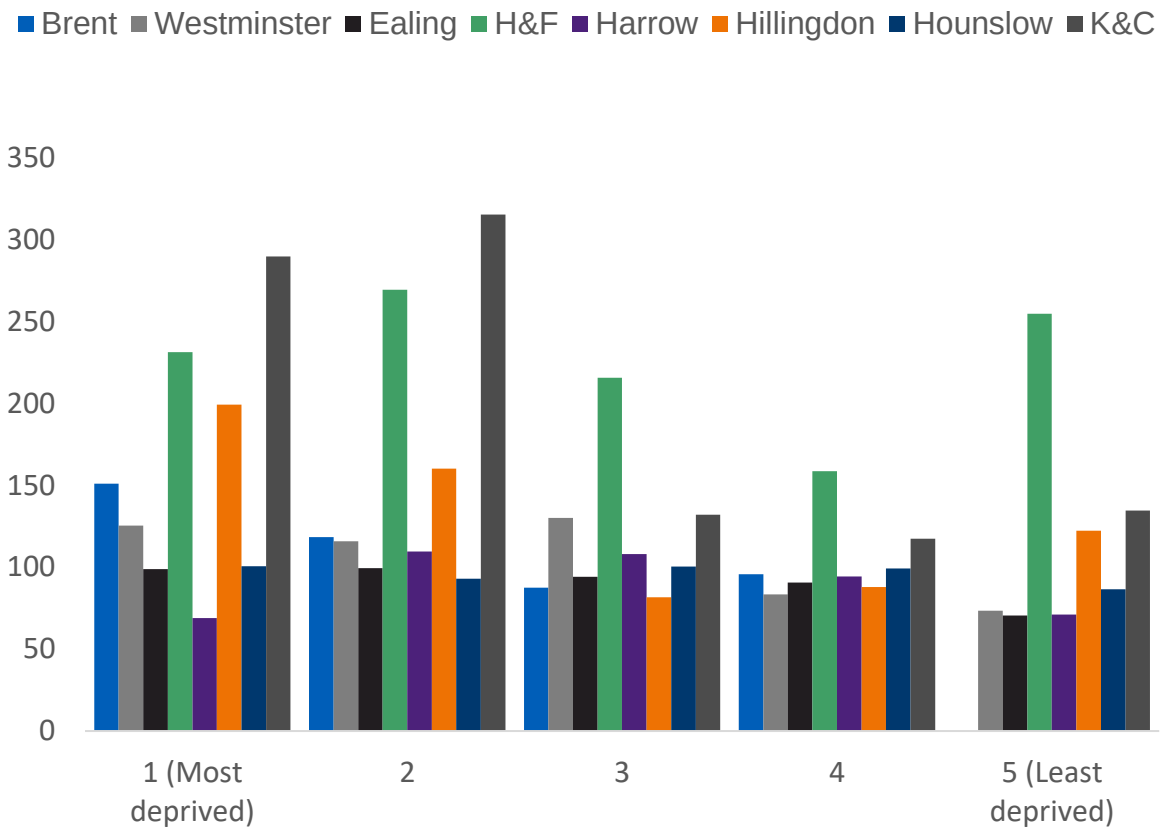
Prevalence of anxiety by deprivation in NWL

Prevalence of anxiety in the catchment population by IMD quintile per 1,000



Prevalence of depression by deprivation in NWL

Prevalence of depression in the catchment population by IMD quintile per 1,000

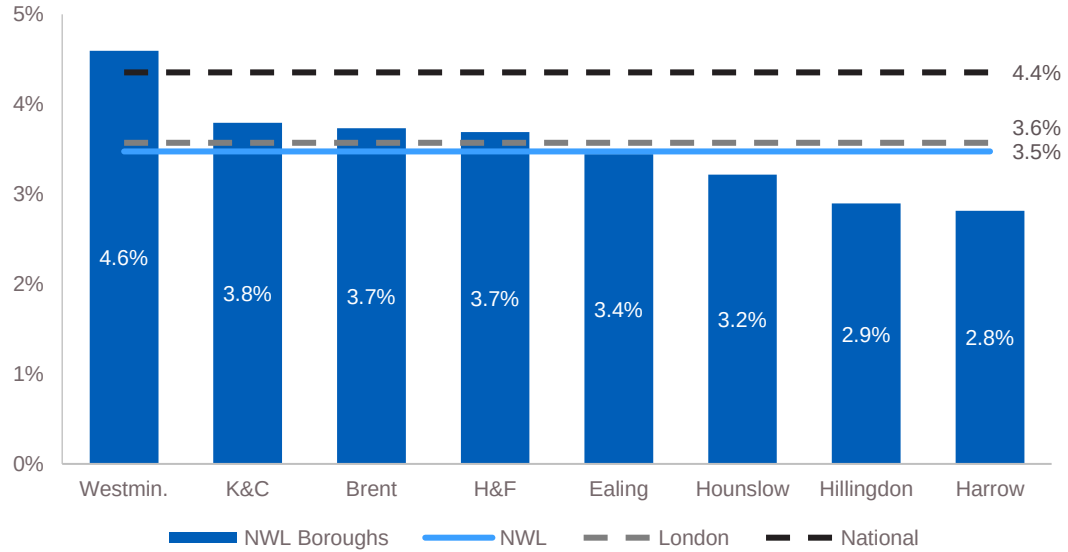


Source: Quality Outcomes Framework 2022/23, CF analysis

Approximately 60,000 NWL residents are economically inactive due to long-term illness – with c.17,000-33,000 inactive due to mental illness

Economically inactive due to being long-term sick or disabled (NWL)
No. of inactive residents (16+) as a proportion of total resident population (16+)

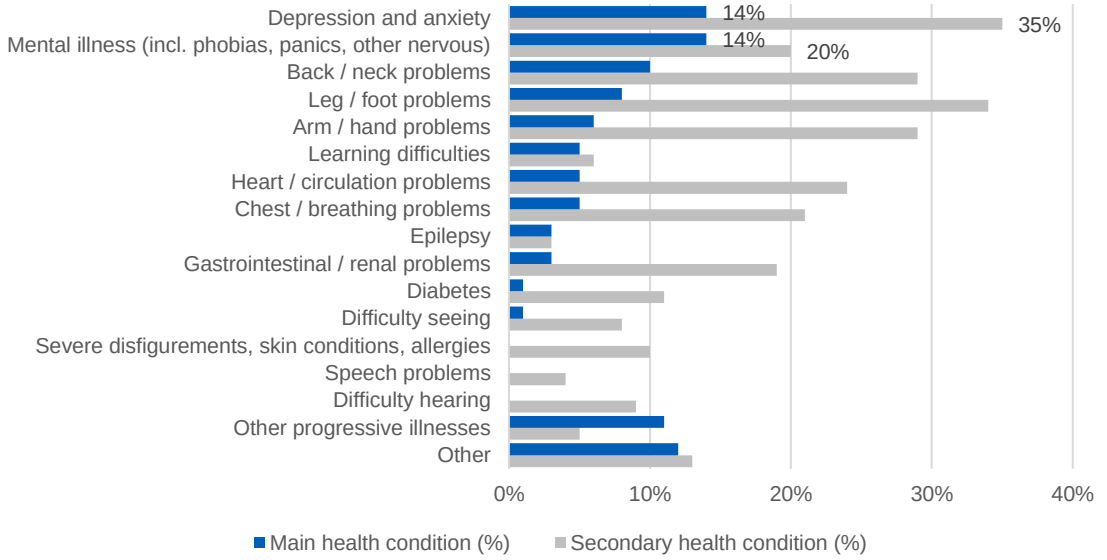
Source: ONS Census Data, 2021



- There are **60,000** people in NWL who are economically inactive due to being long-term sick or disabled – this equates to **3.5%** of our resident population.
- This accounts for approximately **10%** of our **total** economically inactive population – **610,000.**
- Most people are economically inactive for **other reasons**, e.g., retirement, students, or needing to look after the home or family (in that order).
- Our rate of economic activity due to health reasons is **lower than the London** rate of inactivity (**3.6%)** and the **national** rate (**4.4%**).
- However, **variation between boroughs** suggests room for improvement in Westminster, Kensington & Chelsea, Brent, and Hammersmith and Fulham.

Reason for sickness or disability-related economic inactivity (UK)
Percentage of respondents identifying their main or secondary health condition(s)

Source: ONS Labour force survey dataset, 2019



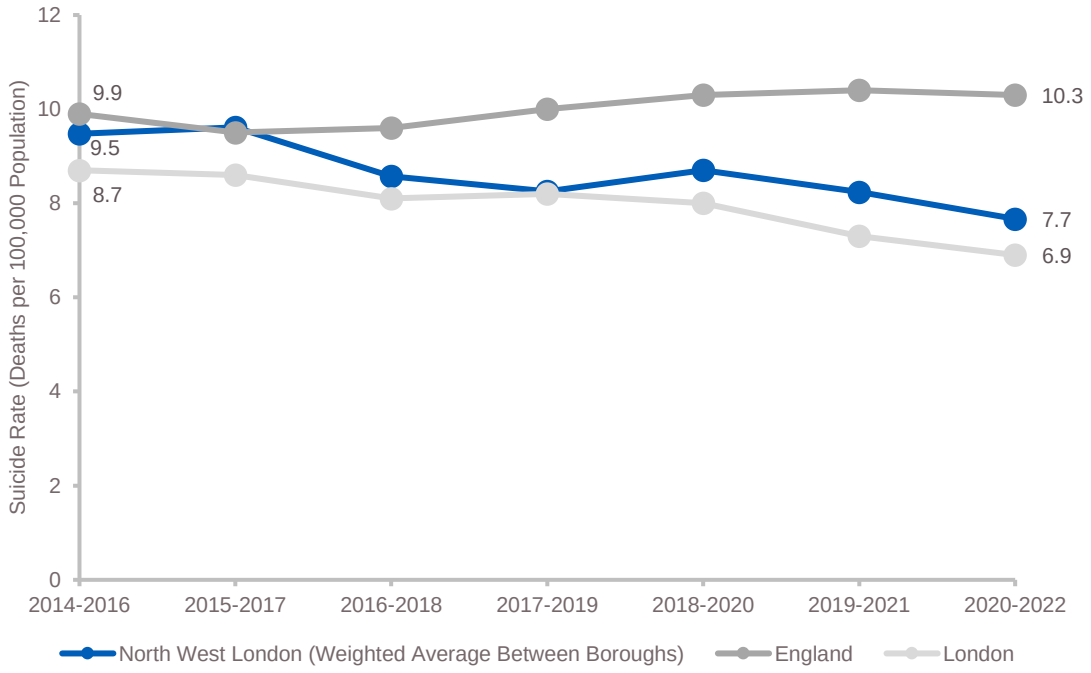
- Of the long-term sickness or disability related economically inactive people surveyed by the ONS nationally, **14% were inactive** due to depression and anxiety as their main reason, and another **14% were inactive** due to other mental illnesses, such as SMI, phobias, and other nervous disorders.
- Respondents were also asked to list any secondary health conditions that were driving their inactivity, and a total of **55% of respondents** listed depression, anxiety or other mental illnesses as the cause.
- If we apply these **proportions to NWL**, we can infer that **17,000** to **33,000** residents are inactive due to mental illness as the primary or secondary reason respectively.

Note: This analysis has limitations related to variation in prevalence across the UK and further work is required to derive a more robust estimate, given NWL has a lower prevalence of common mental illness.

NHS North West London

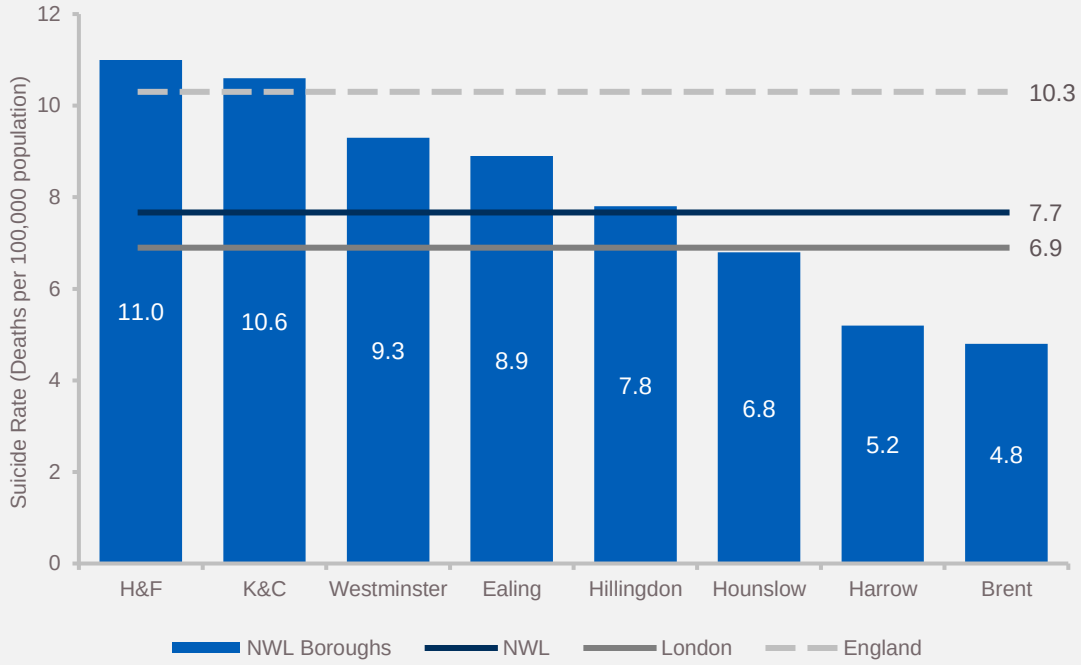
While North West London's (and London's) suicide rates appear to be falling and are lower than England's, there is still significant variation within North West London

NWL Suicide Rates vs **London** and **England** [2014-2022]



- Suicide rates in NWL and the rest of London have gone down over the last 10 years, in contrast to the slight increase in suicide rates across England.
- However, throughout this period, suicide rates in NWL have remained higher than the rest of London, implying a level of unmet need in MH services that should be investigated further.

NWL Suicide Rates by Borough [2020-2022]



Sources: ONS, 2020-22.

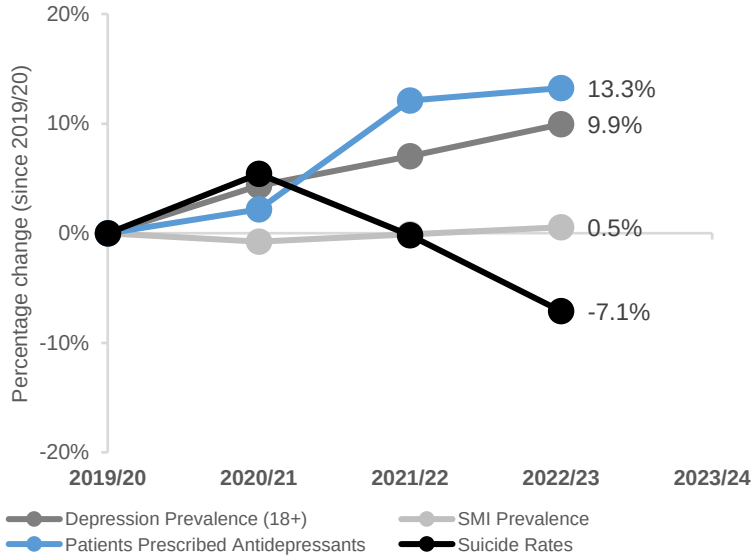
Note: Registering a death as a suicide can take a long time, often taking multiple years. This means that there is a significant delay between the actual suicide rate and what is reported by the ONS (and shown here). And reported figures may not yet reflect the full effect of the COVID-19 pandemic on suicides.

The ONS publishes suicide statistics on a rolling 3-year basis for this reason.

North West London has experienced a significant increase in recorded prevalence and demand for community services, and a decrease in inpatient admissions

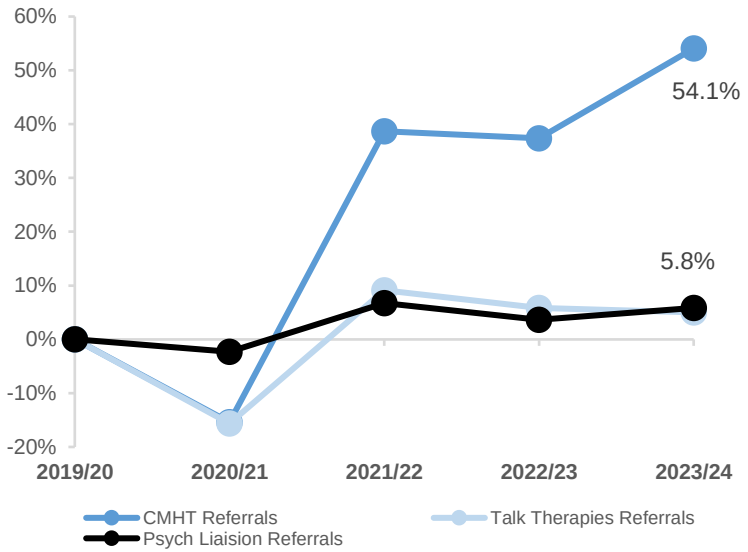
Need: key trends

- The recorded **prevalence of depression** has increased **9.9%** over the past 4 years – roughly in line with our rate of antidepressant prescribing. This may reflect improved case finding, rising actual prevalence, or both
- The recorded prevalence of **severe mental illness** has remained approximately flat over the period.
- Whilst our **suicide rate** has decreased by **7%**, our suicide rate remains higher than the rest of London (see Appendix 1).



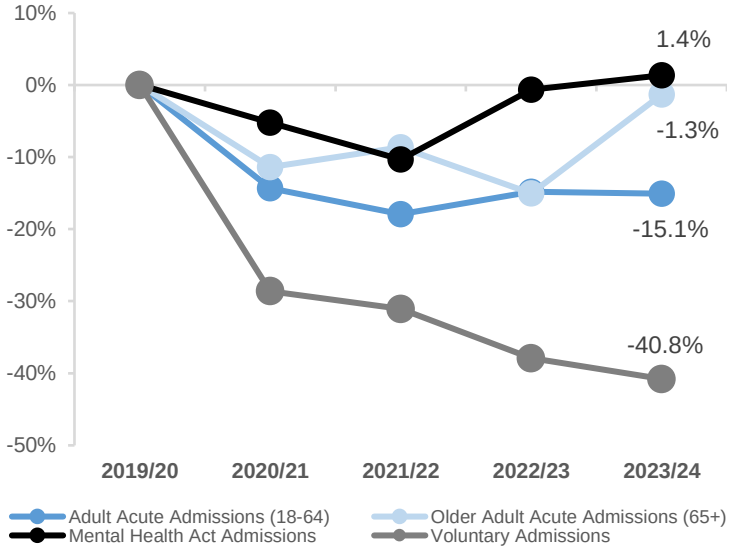
Community service demand: key trends

- **CMHH / MINT** referrals have **significantly increased - 54%** over the period, supported by increased investment in MH community services.
- **Talking Therapy** referrals have increased by **6%** over the same period, though **true caseloads** have increased at a greater rate.
- **Psychiatry Liaison** referrals in our hospitals have also increased. This may reflect increased provision of liaison psychiatry, or unmet need to be addressed (i.e. through providing appropriate care to patients before they need to attend ED / hospital for a MH crisis).



Inpatient service demand: key trends

- Reflecting our focus on improving access to community mental health services and providing care in the least restrictive setting appropriate, **voluntary admissions** have decreased significantly by **40%.**
- Admissions made under the **MH Act** have increased slightly over the past 2 years
- Overall acute admissions for **working age adults** have **reduced by 15%** over the past 4 years.
- Admissions for **older adults** have also decreased, though at a lower rate.



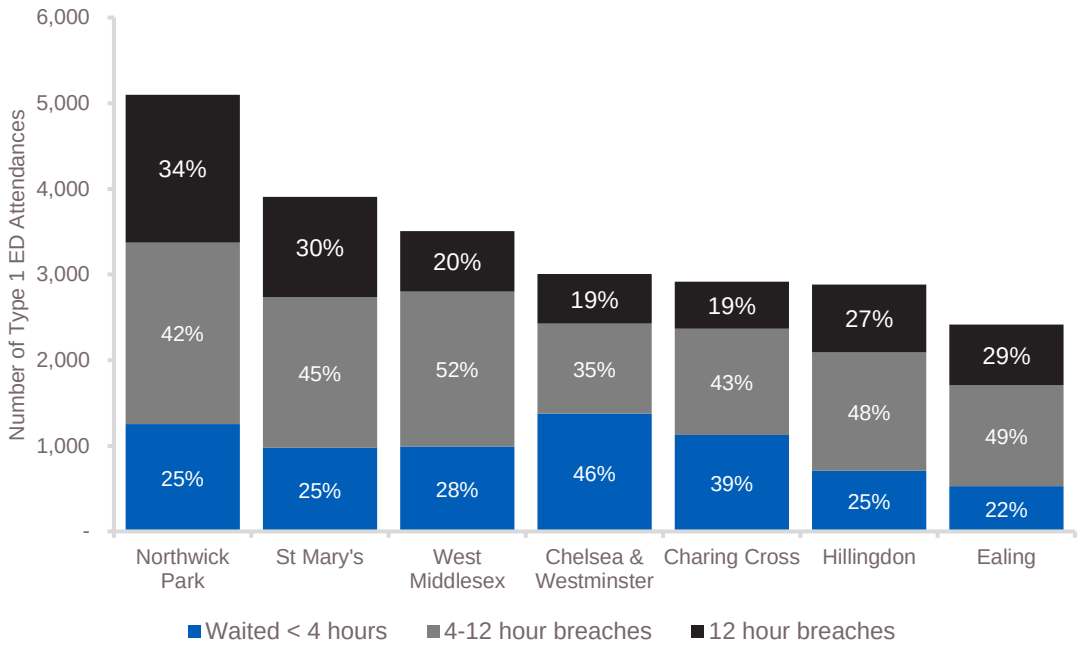
Sources: NHS Digital, QOF Data; ONS; NHS BSA, Medicines Used in Mental Health; CNWL and WLT EPRs.

NHS
North West London

Residents attending A&E departments with a mental health diagnosis are twice as likely to wait more than 12 hours compared to those without such a diagnosis

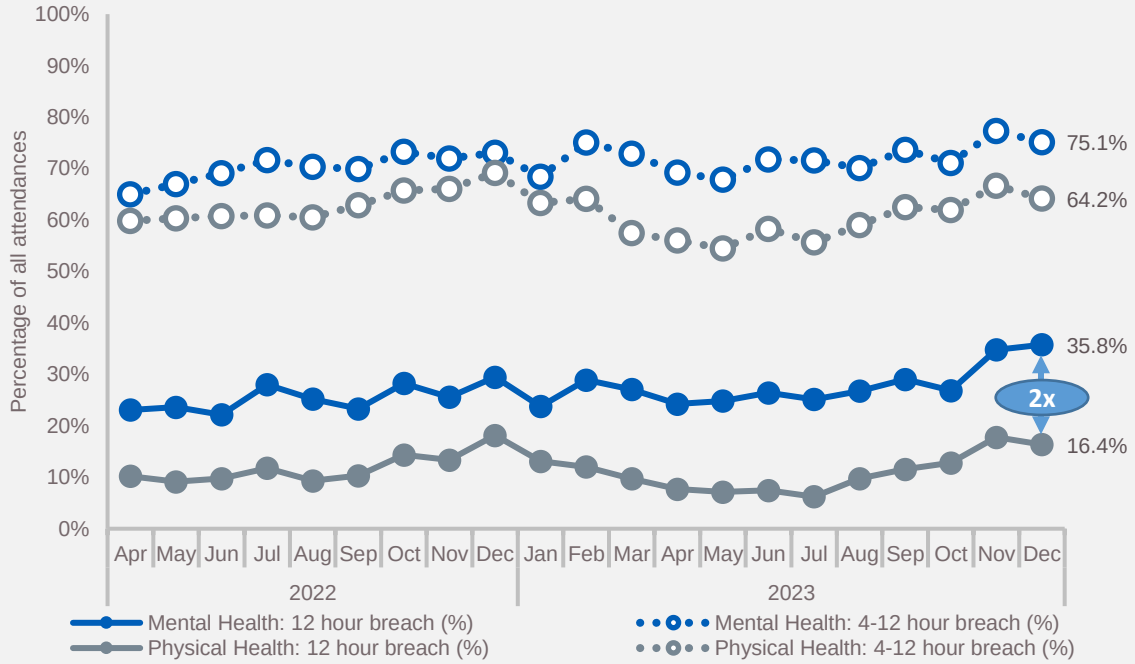
Patients attending ED with a MH diagnosis

Split by waiting time bracket [Jan – Dec 2023]



Mental Health breaches compared to Physical Health breaches

Split by 4-12 hour breaches and 12 hour breaches [Jan – Dec 2023]

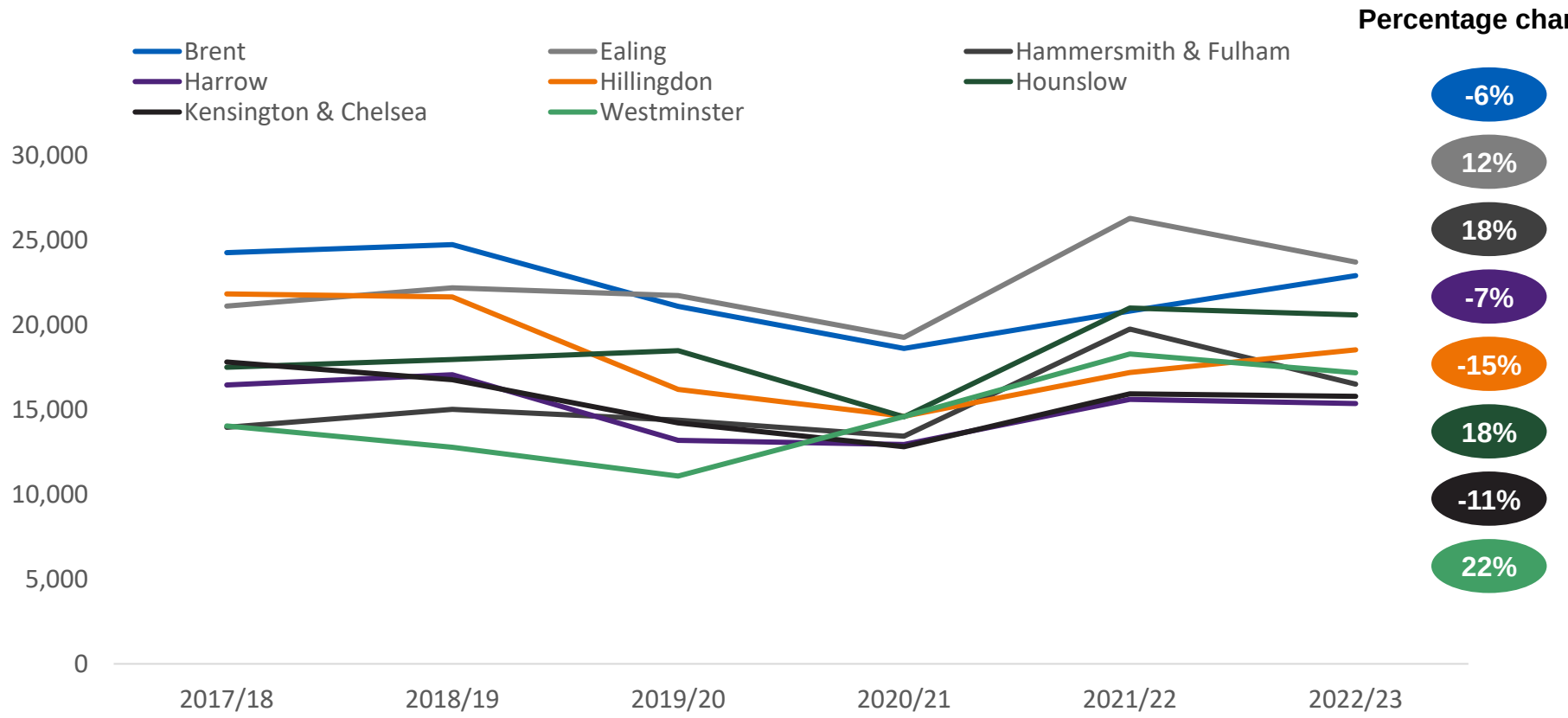


Source: NWL ECDS Data [Jan 2023 – Dec 31st 2023] used to quantify daily MH ED attendances using custom NWL logic (through use of primary and secondary diagnoses and other logic.
Note: ECDS data is currently part of a thorough data quality improvement programme.

Total mental health referrals have increased by 2% across NWL between 2017/18 and 2022/23

Mental Health referrals in NWL

MH referrals, 2017/18-2022/23



- Whilst mental health admissions have decreased compared to pre-pandemic levels, the total referrals across NWL have increased by 2%.
- Referrals have increased by 22% in Westminster and 18% in Hammersmith & Fulham but have decreased by 15% in Hillingdon and 11 % in Kensington & Chelsea
- This increase in referrals is likely to be an impact of the pandemic
- However, the differing trend to total admissions suggests more service users are being cared for in the community

Source: CNWL activity data (provided by Real World Health), CF analysis

Mixed, black and other ethnic populations have the highest rate of referrals in the catchment area per 1000 population, with females typically having higher rates

Mental health referrals by ethnic groups by gender by borough per 1,000 population

MH referrals, 2022/23

	Brent		Ealing		Hammersmith and Fulham		Harrow		Hillingdon		Hounslow		Kensington and Chelsea		Westminster	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Asian or Asian British	24	27	31	37	38	41	19	26	16	24	35	49	27	42	37	50
Black or Black British	45	62	41	46	62	71	47	74	41	58	45	57	85	123	72	83
Mixed	58	69	62	78	75	105	59	109	32	77	65	87	141	187	119	164
Other Ethnic Groups	73	121	43	73	48	85	56	101	49	89	43	82	61	114	50	89
White	51	58	54	60	84	103	44	60	33	52	68	81	90	97	68	66
Total	34	42	37	46	43	52	27	37	26	44	43	58	45	62	48	58

- The mixed ethnicity population in Kensington and Chelsea and Westminster have the highest rate of mental health referrals in NWL, with females having higher rates than males
- The Asian population has the lowest mental health referral rates across all ethnicities in NWL

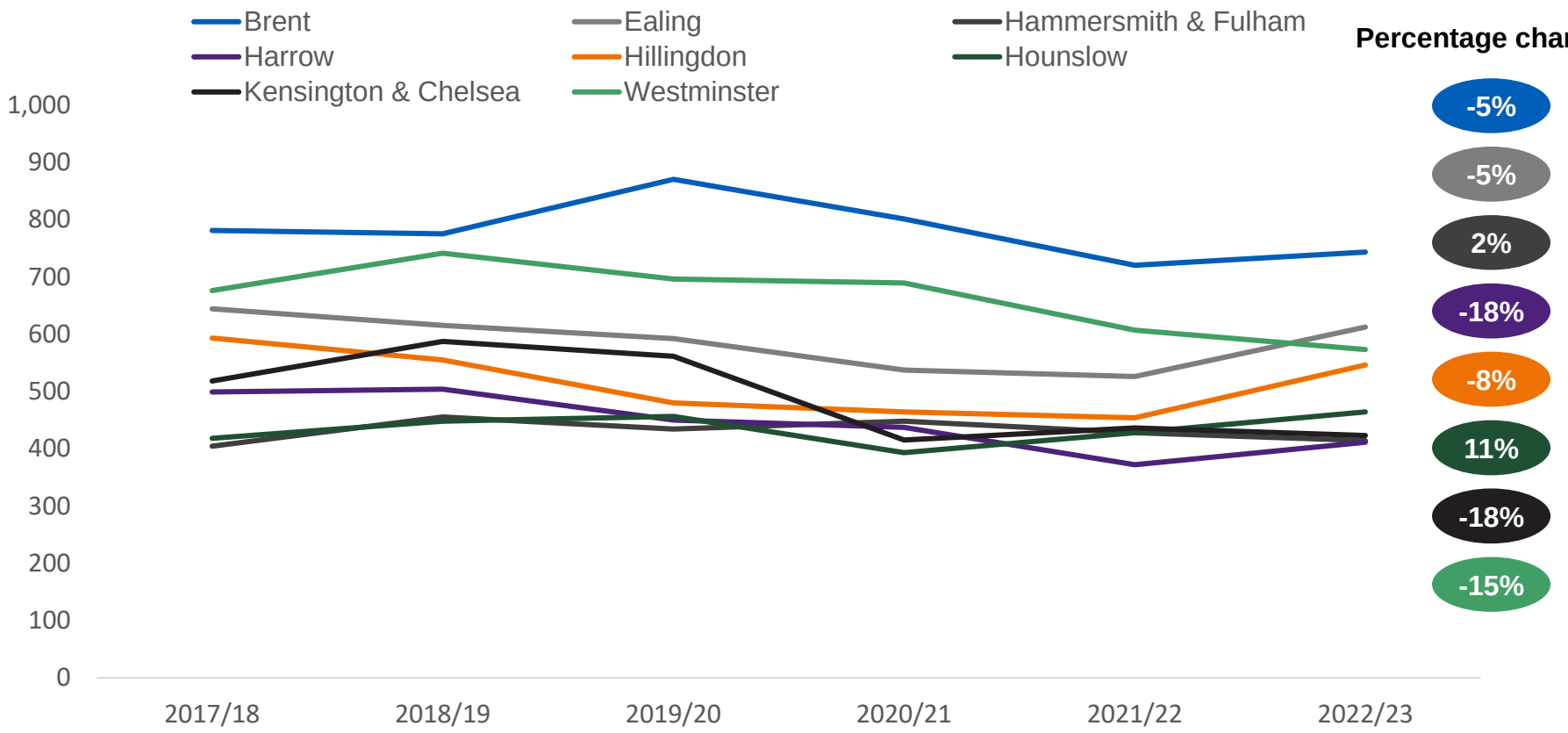
Note this analysis excludes patients where ethnicity is not stated

Source: CNWL activity data (provided by Real World Health), ONS demographic data, CF analysis

Total mental health admissions have declined by 7% compared to 2017/18 levels across the catchment population

Mental Health admissions in NWL

MH admissions, all ages and ward types, 2017/18-2022/23



Percentage change

-5%
-5%
2%
-18%
-8%
11%
-18%
-15%

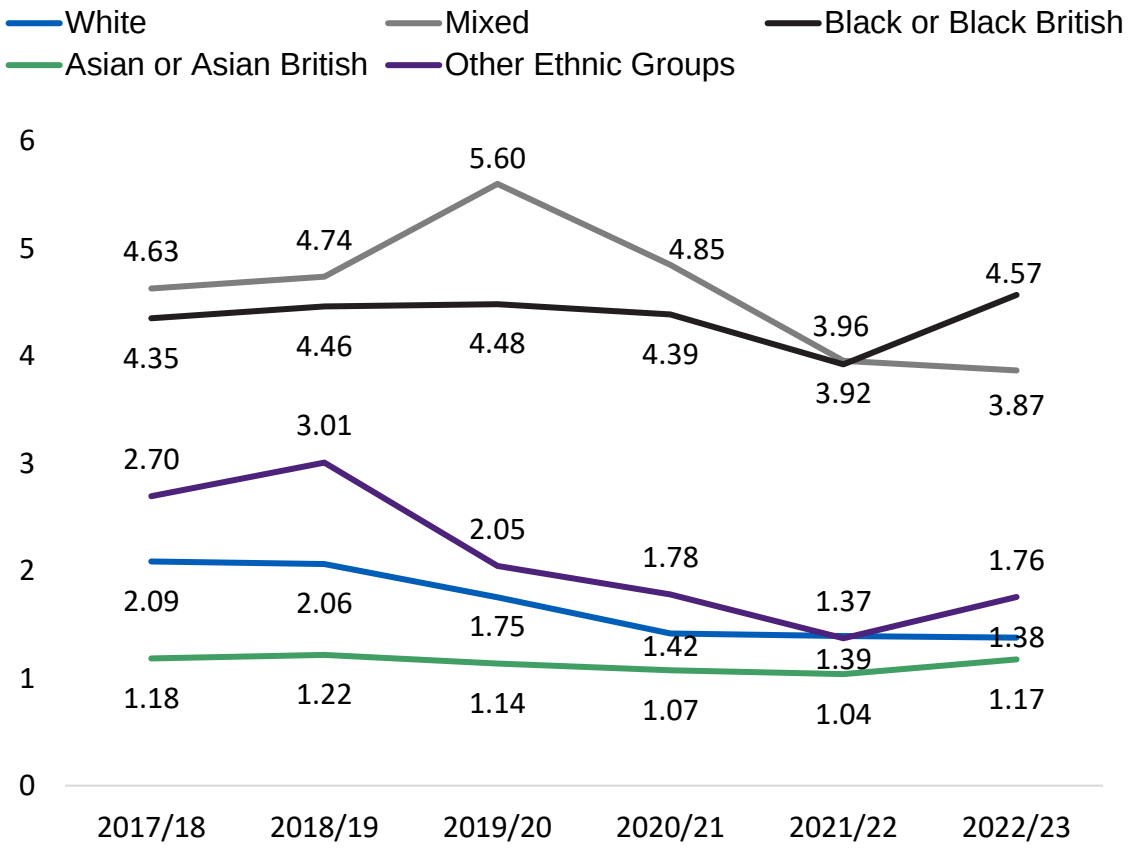
- The mental health admissions for the general NWL population has declined by 7% since pre-pandemic levels
- The decline is most pronounced in Harrow and Kensington & Chelsea (-18%) in 2022/23 compared to 2017/2018
- Hounslow has seen the greatest increase in mental health admissions (11%)

Source: CNWL activity data (provided by Real World Health), CF analysis

The mixed and black ethnic groups have the highest proportion of admissions per 1,000 population; the white population had the proportion of highest total admissions

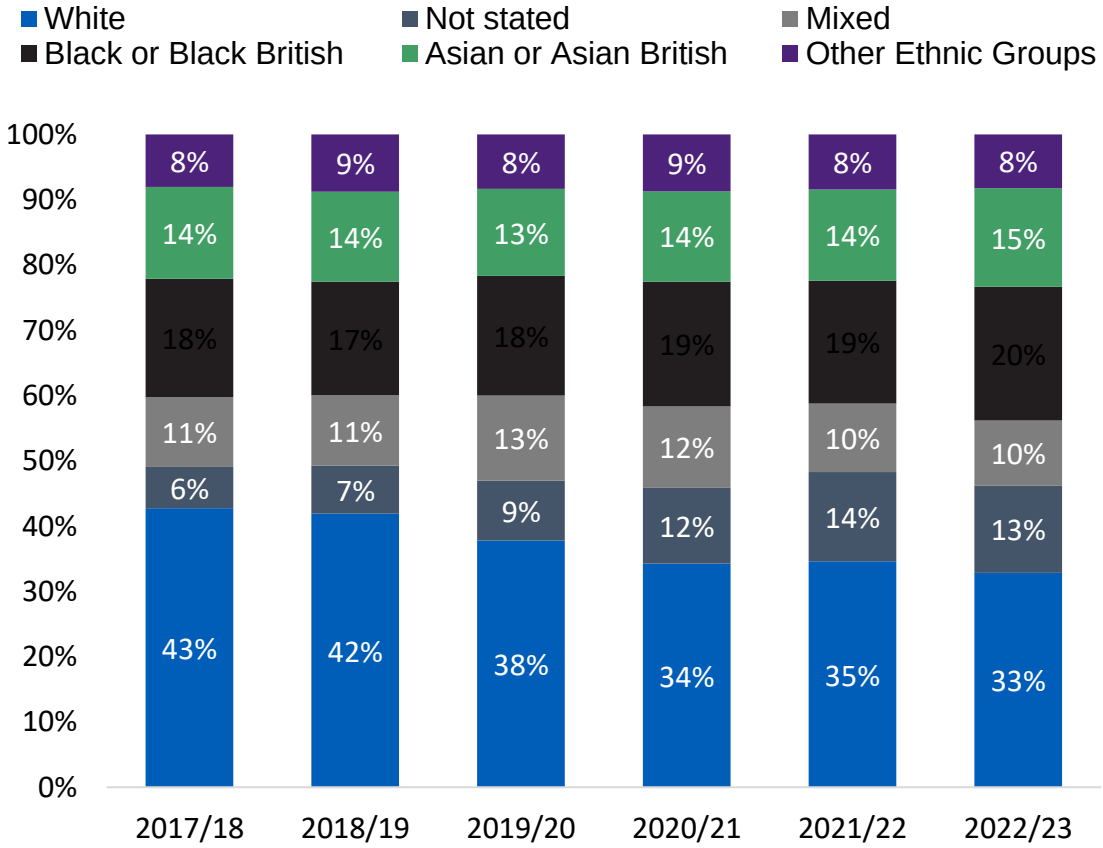
Mental health admissions by ethnic groups per 1,000 population

MH admissions in NWL by ethnic group, 2017/18-2022/23



Proportion of mental health admissions by ethnic groups

Proportion of MH admissions by ethnic group, 2017/18-2022/23



Source: CNWL activity data (provided by Real World Health), ONS demographic data, CF analysis

Mixed and black ethnicity populations have the highest rate of admission in NWL per 1000 population, with males typically having higher rates than females

Mental health admissions by ethnic groups by gender by borough per 1,000 population

MH admissions, 2022/23

	Brent		Ealing		Hammersmith and Fulham		Harrow		Hillingdon		Hounslow		Kensington and Chelsea		Westminster	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Asian or Asian British	1.4	0.5	1.5	1.2	1.7	1.6	0.8	0.8	1.3	0.7	1.7	1.2	1.5	0.9	1.9	1.9
Black or Black British	5.3	3.6	2.8	3.0	8.2	4.0	6.5	4.1	5.4	3.8	4.5	2.8	10.5	2.5	7.0	5.9
Mixed	4.6	1.7	3.6	1.9	4.0	4.3	3.1	4.4	1.7	3.3	1.5	1.5	6.6	8.2	6.8	7.2
Other Ethnic Groups	1.4	1.3	1.2	1.3	1.5	1.1	1.3	1.0	1.6	1.5	1.4	1.3	1.4	1.5	1.0	0.7
White	2.6	2.4	1.3	1.1	2.5	1.3	1.7	2.0	1.9	1.8	2.6	1.9	4.4	2.6	3.0	2.0
Total	2.3	1.6	1.6	1.5	2.5	1.7	1.5	1.3	1.8	1.4	1.8	1.4	2.8	2.0	2.8	2.3

- The black male population living in Kensington and Chelsea have the highest rate of mental health admission in NWL, with 10.5 admissions per 1,000 population
- This rate is significantly higher than that of the black female population living in the same area (2.5 admissions per 1,000 population)

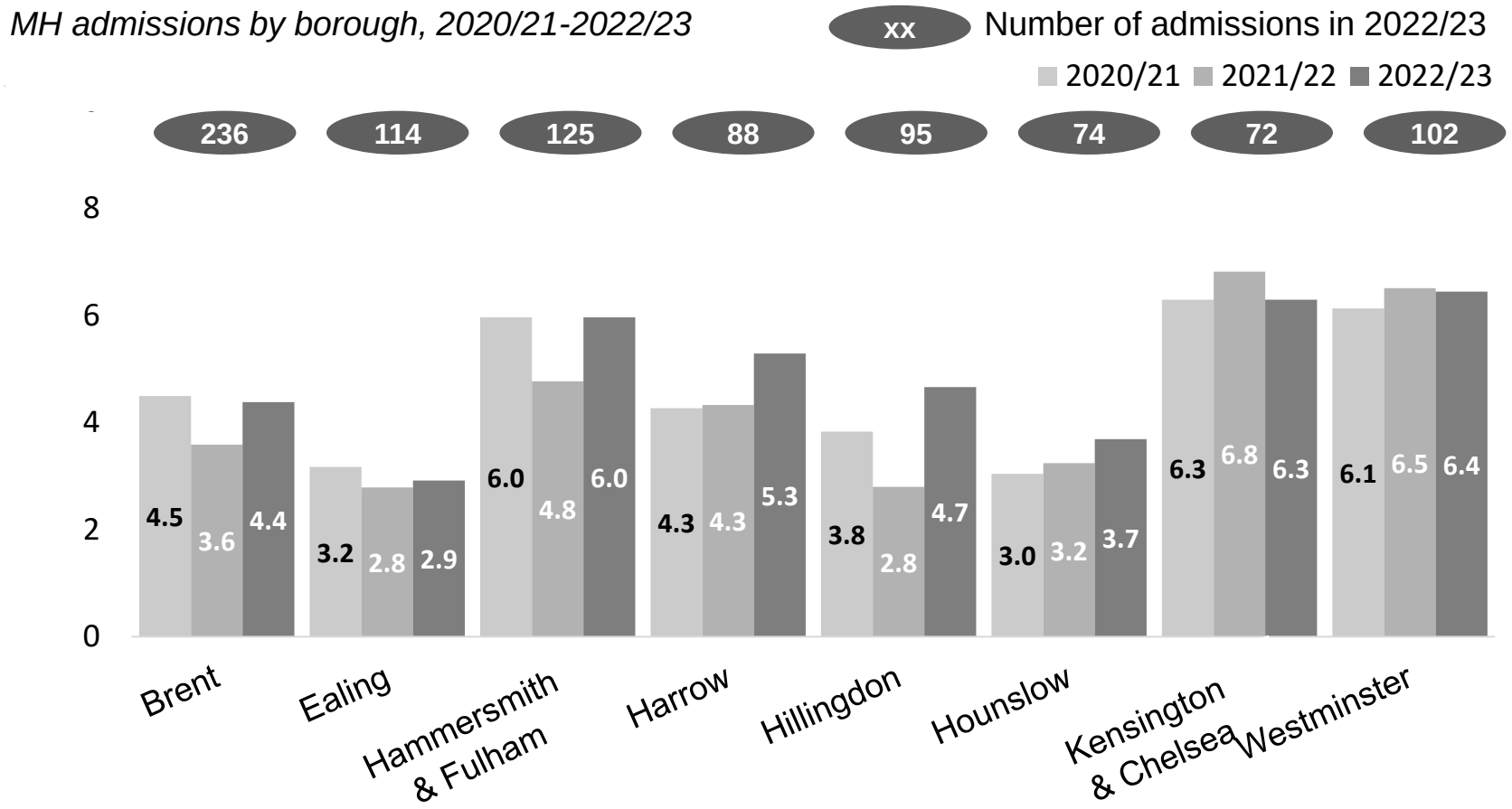
Note this analysis excludes patients where ethnicity is not stated

Source: CNWL activity data (provided by Real World Health), ONS demographic data, CF analysis

The mental health admission rate within the Black population in Westminster was 2.2 times higher than that of Ealing in 2022/23

Mental health admissions per 1,000 population with Black ethnicity

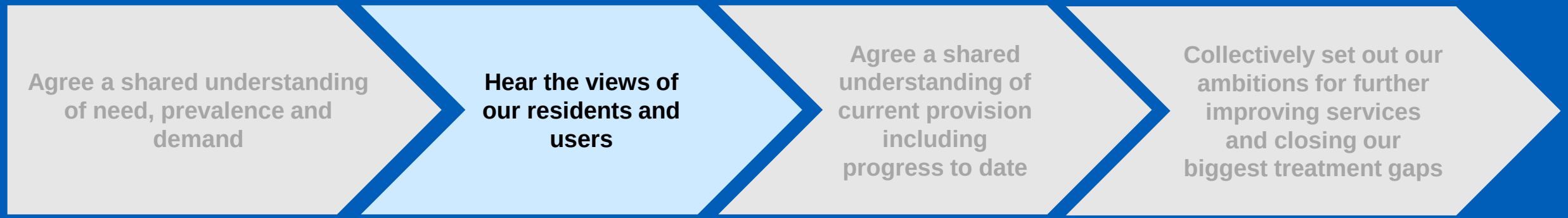
MH admissions by borough, 2020/21-2022/23



Note: Admissions where the ethnicity was unknown have been excluded

- There is variation in the trend of mental health admission rates in NWL boroughs within the Black population, with half of NWL boroughs seeing an increase in rates since 2020/21
- The admission rate within the Black population in Westminster was 2.2 times higher than that of Ealing in 2022/23
- Kensington & Chelsea and Westminster had the highest admission rates within the Black population in 2022/23
- Brent had the highest absolute number of mental health admissions within the Black population in 2022/23

Source: CNWL activity data (provided by Real World Health), ONS demographic data, CF analysis


Agree a shared understanding of need, prevalence and demand
Hear the views of our residents and users
Agree a shared understanding of current provision including progress to date
Collectively set out our ambitions for further improving services and closing our biggest treatment gaps

Insights from our local residents: Key themes

The heart of our engagement process involved eight pivotal sessions that took place in various locations across each of the eight boroughs. These sessions held from late August to early October, brought together a diverse range of residents and service users to share their experiences. Two online sessions (lunchtime and evening) open to all residents also took place.

These sessions were pivotal in opening a dialogue with our communities as individuals and families to help us understand the positive aspects of services as well as challenges they face in accessing and experiencing mental health services.

A number of **key themes** were highlighted through the engagement sessions.

- **Access**
- **Community mental health offers**
- **Waiting times**
- **System integration**
- **Approach of services**
- **Awareness of services**

Insights from our local residents: What we heard

Access

"They offer good touchpoints throughout the week and help build people's networks."

"A need for more accessible mental health support for inpatients in hospitals and post-hospitalisation community support."

"More contacts throughout the week would be good. Hestia and other charity organisations are stepping in where people have nowhere else to turn to."

Community mental health offers

Waiting times

"The IAPT programme is generally effective but requires additional resources."

"The wait to see a psychologist or for someone to see a therapist or for talking therapies is way too long. By the point they end up seeing someone, they are now much worse off than when they first ever saw a GP"

"Concerns about long waiting lists for assessments, especially when patients are at their breaking points.

System integration

"There is no accountability. It's passed from one person to another, and I am the one who has to deal with it all."

"Need for a social systems approach"

"Empowerment, mutual respect, kindness, solidarity, care, and love as essential for improving health and well-being"

Approach of services

Awareness of services

"Wish services were better advertised because there are people that need it that don't know about it."

"Suggestions to utilise platforms like TikTok for mental health education, specifically highlighting the need for awareness regarding women's hormones and mental health."

"Include community organisations in trauma-informed care"

Insights from our local residents: Recommendations

There were several core recommendations arising from the themes gathered through our engagement to support the development of the mental health strategy.

1) Improve access and reduce waiting times

- Develop strategies to improve access and significantly reduce waiting times for mental health services.
- Support ‘waiting well’, with clear communication on the stages of the mental health pathway and provision.

2) Improve community outreach, connection and communication

- Increase in awareness campaigns about the community mental health support services that are available.
- Promote services through accessible channels such as local libraries, social media, community partners and influencers, to reach diverse audiences.
- Simplify the process for seeking help and connecting to services, particularly at points of transition.

3) Foster community resilience

- Provide training for grass roots community organisations and families in how individuals and families can support themselves.
- Support these groups with resources and facilities for effective advocacy and support.

4) Prioritise cultural competence

- Ensure cultural competence and awareness in mental health services to serve diverse populations.
- Provide training for healthcare professionals on cultural backgrounds, religion, and inequalities, to enhance patient care.

5) Focus on the impact of the wider determinants of health

- Recognise the strong link between housing and employment challenges and mental health problems.
- Invest in housing support programs to alleviate overcrowding and other housing related crises.
- Consider the wider determinants of health’s impact upon residents’ mental health.

6) Strengthen a trauma-informed workforce

- Expand the adoption of trauma-informed care and ensure that the voluntary community sector workforce is trained in these approaches.
- Foster collaboration between mental health services and community organisations to provide comprehensive support.

NHS
North West London

We have focused our work on the following service areas

1 **Adults** in North West London	• Prevention of mental health problems and promoting wellbeing – understanding local plans in place to promote wellbeing and support early intervention to prevent the need for greater intervention
2 Adults with **common** mental health disorders	• Access to Talking Therapies for Anxiety and Depression – understanding current need as well as unmet need against referrals to identify how capacity can address waiting lists and enable reliable recovery and improvement. • Community Care – highlighting the opportunities through Integrated Network Teams.
3 Adults with **severe mental illness (SMI)**	• Community Care – Outlining the need for greater consistency and productivity improvements to ensure services can meet the needs and demand of adults and older adults with serious mental illness. • Early Intervention in Psychosis – services have expanded and there is sufficient capacity to provide early intervention within two weeks however more could be done to optimise service delivery.
4 Adults with **higher acuity** mental health needs	• Care for people in crisis – expansion of community services has enabled a local alternative offer to A&E and admission however more needs to be done to tackle long waits in A&E. • Inpatient care for adults and older adults – modelling demonstrates that demand growth for inpatient services can be addressed through several transformation opportunities

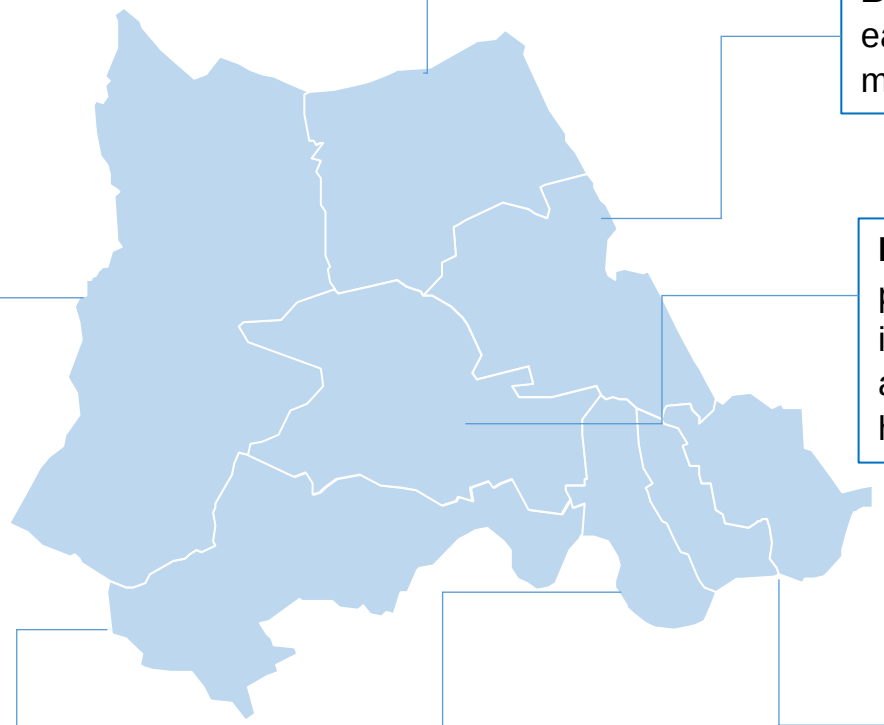
Prevention of mental health problems

A review of local Joint Strategic Needs Assessments and local priorities highlights commitment to preventing mental ill health and promoting wellbeing

Harrow: Reducing health inequalities through **embedding CORE20Plus5** focus and increasing community capacity for action and strengthening our preventative approach

Hillingdon: Proactive care and mental health with a particular focus on the health needs in the south of the borough

Hounslow: Reduce health inequalities in the population so that fewer residents miss life opportunities due to avoidable long-term health conditions. Achieved through prevention and early detection of illness to reduce people developing long term conditions.



Brent: Increasing access to mental health support earlier for communities and reducing variation in mental health care for the local Brent communities

Ealing: Prevention and Wellbeing for the whole population: including reducing stigma and social isolation; identifying mental health needs earlier; addressing the links between physical and mental health; suicide prevention.

Bi-borough: Prevention and early intervention, evidence suggests an increase in demand for mental health services. Focusing on prevention as well as early intervention, also addressing the increasing demand by service planning for the future.

Hammersmith & Fulham: Effective prevention planning with focus on socio-economic determinants and environmental surroundings as part of the broad range of factors which affect resident's mental health.

North West London Integrated Care System

NHS North West London

Several actions are already in place to support the prevention of mental illness, however we recognise that there is still more work to be done

1 Adults in North West London

+

2 Adults with common mental health disorders

- In the context of this strategy, prevention is defined holistically as **primary, secondary and tertiary prevention*** - recognising that different prevention measures are required for different types of residents and mental health patients.
- Though this MH strategy is focused on adults, we know that evidence suggests that **prevention of mental illness needs to at an early age** – 50% of all mental illnesses present before children turn 14, and 75% present before the age of 24 (WHO[1]). This will need to be addressed in detail in the next phase of this work (refreshing our children and young people's mental health strategy).
- We know the recorded prevalence of **common mental health disorders** is increasing, so as a system we need to better understand the **wider determinants of mental health** (i.e. housing, education, finance, relationships etc.) and develop **joint interventions** (working with our local authority partners and VCSE organisations) to address these issues before a person's mental health deteriorates and requires a formal diagnosis.
- This could include interventions such as **relationship counselling**, **housing interventions**, **financial advice, employment support** and **workplace wellbeing support.** NWL-reported data shows **significant room for improvement for assessments completed**: employment (33% of patients with employment assessments completed); finance status (32% completed); accommodation (9% completed); carer status (32% completed)[2].
- The difficulty of implementing this should not be underestimated and will require **proactive approaches to intervention** and **population health approaches** to managing the overall mental health of our residents. **Primary care has a significant role** in delivering some of these interventions and helping residents navigate the system – however we should recognise the impact of this on a sector that continues to be under significant pressure.
- This will also require ensuring our relevant patient-facing staff across the system have **appropriate training** to support people's mental health.

3 Adults with severe mental illness (SMI)

- The **prevalence of SMI is relatively stable** in NWL, and so prevention for this cohort will focus on **preventing the deterioration** of these patients' **overall health.** For example, we know that people with SMI are **3-4 times more likely** to die **before the age of 75** than people without SMI.
- The NHS Long Term Plan outlined the importance of annual physical healthchecks for patients with SMI, and in the most recent published data (for the 12 months preceding March 2024), NWL had a **80% completion rate** for **full physical health checks**, which is higher than the England average and London average. However, there is still room for improvement in this area.
- In addition, we also need to **tackle smoking, alcohol and substance misuse** in this cohort – with only 39%, 3% and 2% of patients with smoking, alcohol and substance misuse (respectively) receiving relevant interventions. Improving in this area will close multi-disciplinary working and coordinated treatment plans.

4 Adults with higher acuity mental health needs

- We have invested significantly to help **prevent the deterioration** of patients with higher acuity mental health needs, for example, investing heavily 24/7 community crisis and home treatment teams and **crisis alternative services** (such as our mental health crisis assessment service – MHCAS, our Coves and our Safe Spaces).
- These services were put in place (in part) to prevent unnecessary A&E attendances (that can often result in MH patients waiting over 24 hours for a transfer to another service) and provide a more suitable safe space for patients in crisis.
- Ultimately, these crisis alternatives should prevent further deterioration of these patients and prevent suicide attempts. However, further work is required to understand the **effectiveness** of these crisis alternatives, with a **full evaluation** underway.

***Primary prevention:** preventing illness from developing in the first place; **secondary prevention:** detecting and treating illness at an early stage; **tertiary prevention:** managing illness to slow or stop its progression and limit the extent to which the illness is disabling. **Sources:** 1 - Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication, Kessler et al.; 2 – NWL whole systems integrated care dashboard (WSIC)

Access to Talking Therapies for Anxiety and Depression

North West London
Integrated Care System

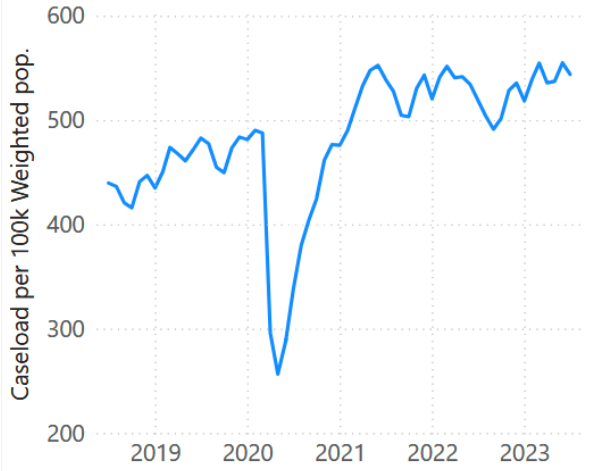
NHS
North West London

While North West London meets access targets for Talking Therapies, waits for first contacts indicate significant unmet need

- The proportion of the adult (18+) population in-treatment at any one time has increased and now stands at c.544 per 100k weighted population (+24% on 5yrs ago). We define 'In-treatment' as those service users with at least one contact in the past 60 days*
- About one fifth of the caseload are waiting for first contact, an indicator of unmet demand. For Brent, about two fifths of the caseload are waiting for first contact
- Overall, access (using discharged service users as a proxy) is about 20% higher than the 23/24 access target, with only Ealing falling short (by 4%)

IAPT In-Treatment Caseload per 100k Weighted Population, Per Month

01/07/2018 - 30/06/2023



Talking Therapies Treatment Met & Unmet Need

Latest 12-Months (01/07/2022 - 30/06/2023)

Service	Av. Caseload	Av. In-Treatment Caseload	Av. Waiting List (Caseload Waiting for First Contact)	Discharged in the 12-Month Period	2023/24 Access Goal	Difference	18+ Pop.	Discharged as a % of 18+ Pop.
IAPT - Brent	3,008	1,656	1,034	11,610	9,422	2,188	236,907	5%
IAPT - Ealing	2,637	1,990	307	9,597	9,987	-390	243,031	4%
IAPT - H&F	2,113	1,480	471	8,416	6,861	1,555	139,004	6%
IAPT - Harr	1,223	995	117	7,654	5,980	1,674	181,646	4%
IAPT - Hill	1,900	1,592	153	9,125	7,072	2,053	221,491	4%
IAPT - Hounslow	2,068	1,417	518	9,199	6,812	2,387	194,848	5%
IAPT - K&C	1,843	1,320	310	9,717	8,740	977	120,664	8%
IAPT - Westm	2,439	1,471	483	8,525	7,158	1,367	210,025	4%
Total	**17,221**	**11,919**	**3,391**	**73,843**	**62,032**	**11,811**	**1,547,616**	**5%**

* This reduces caseload across North West London by 31% on average (low 16% (Hillingdon) to high 45% (Brent)

Sources: Activity Data – EPR System Feeds; Absolute population – ONS mid-2020 population estimates, Weighted population – See Appendix 1; 23/24 Access Goal – NWL provided MH trajectories

North West London Integrated Care System

NHS North West London

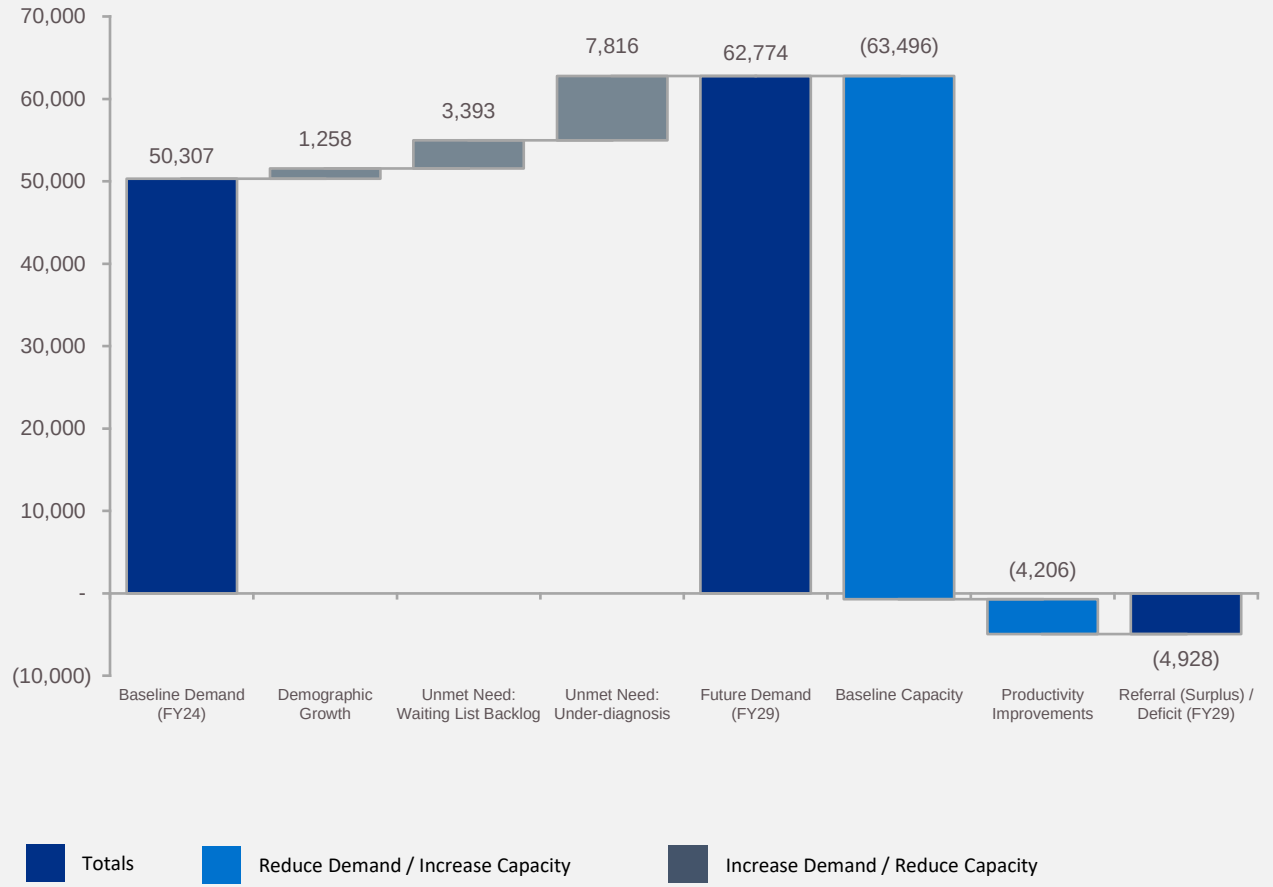
Modelling demonstrates that we can service our Talking Therapies waiting lists and address some unmet need by FY29

Talking Therapies Referrals:

- The modelling demonstrates that in **FY29, NWL's** referral surplus / deficit could range from a **deficit of 7k referrals** to a **surplus of 8k referrals**, depending primarily on the level of unmet need in the system that we can service, and the productivity improvements that we can unlock.
- The **'central case' scenario** (which is the most realistic of the three scenarios) concludes that we have plenty of capacity to service a significant level of unmet need.
- Ongoing work will continue to refine inputs and assumptions.

Scenarios	Worst	Central	Best
Current Demand [FY24 outturn]	**50k**	**50k**	**50k**
Demographic Growth	1k	1k	1k
Unmet Need: Waiting List Backlog	3k	3k	3k
Unmet Need: Under-diagnosis	15k	8k	9k
Future Demand [FY29 'Do Nothing']	**71k**	**63k**	**60k**
Current Capacity [FY24]	(63k)	(63k)	(63k)
Productivity Improvements	-	(4k)	4k
Referral (Surplus) / Deficit [FY29 'Do Something']	**7k**	**(5k)**	**(8k)**

Talking Therapies Referrals: 'Central' Case Modelling Scenario



Sources: CNWL / WLT demand data and available beds data [Jan 2023 – Dec 2023].

North West London Integrated Care System

North West London

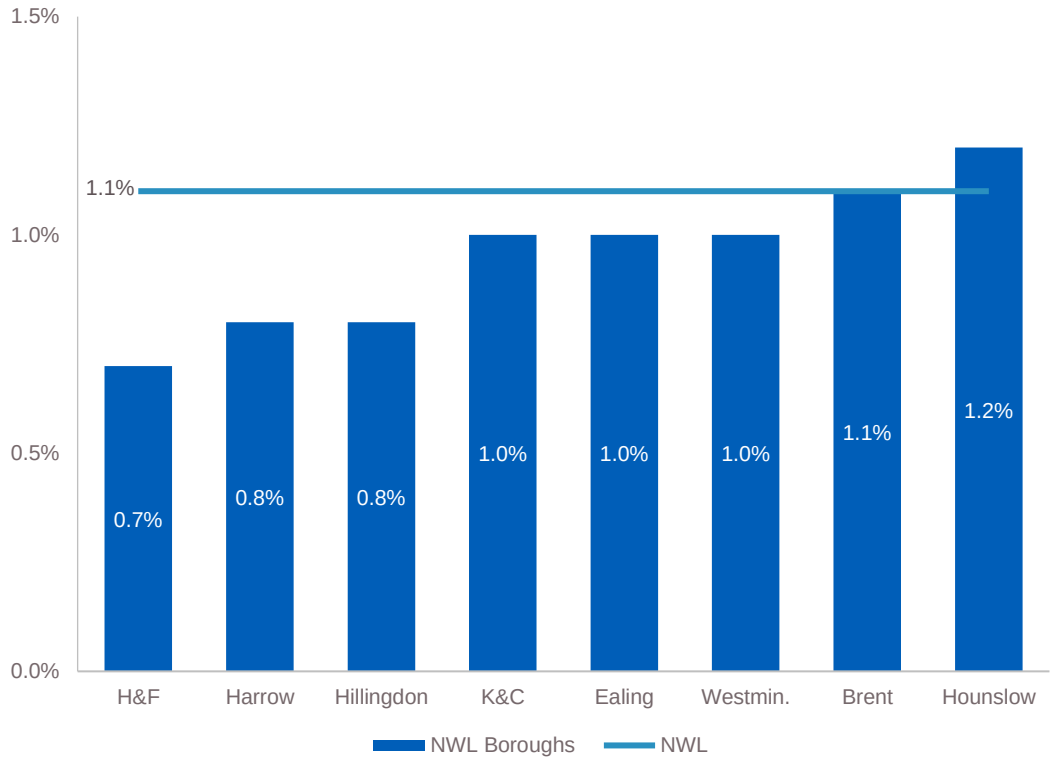
Work is underway to increase access to talking therapies – only 1.11% of people estimated to have anxiety or depression receive talking therapies, with variation across North West London

.
North West London has continued to improve access to talking therapies for those with common mental health problems, such as anxiety and depression. Whilst capacity has expanded rapidly in recent years, people's access to care remains relatively low compared with prevalence and nationally, the attrition rate of 45% between one and two contacts.

- We will reach more people by flexing the approach e.g. accessibility, group work, particularly tailoring the service to differing local communities and ensuring that the workforce is reflective of the local population.
- We must also expand our reach through other organisations, sectors and industries, to further develop the broader health, social and economic improvements of NW London.
- We will ensure closer alignment with community mental health and primary care to reduce the attrition so that more people to get to the right service first time, enabling reliable recovery and improvement.

Access to Talking Therapies: People entering Talking Therapies as a percentage of those estimated to have anxiety / depression

Source: NWL local data, August 2023



Community care

Community Mental Health Care in North West London is now more focused on treatment and recovery

- Community mental health is increasingly joined up with primary care and community assets and will become part of the services on offer through our Integrated Neighbourhood Teams, which are central to development community based models of care.

- This enables people to receive more holistic, person centered care based on individual need – joining up physical health, social and mental health interventions closer to their homes that address underlying issues and problem.

10 principles for Community Mental Health Transformation

1. A local delivery model. All resource will be **'place based'** positioned in the Hubs and MINT Locality Teams.
2. There will be a 24/7 **referral route.**
3. Community Hubs and MINT Locality Teams **aligned to Primary Care Networks** (PCNs) with shared care protocols and records where necessary.
4. Regular Community Hub/MINT Locality Team and PCN **catch ups.**
5. Less focus on caseloads and more on responsive and **timely easy to access** support offers, including a therapeutic menu and **voluntary sector led provision**.
6. Daily **senior triage meetings**.
7. **DIALOG+** to be used to inform every assessment with a stepped care model reducing repeat assessments and multiple referrals.
8. Every person to have a named worker with **individualised care**.
9. Delivery of intervention based care meeting clinical and social needs which make use of existing **community assets and individual strengths**, not generic care coordination.
10. Every member of staff dedicated to **empowering their service user** to maintain good physical health and working to enhance mental health equalities.

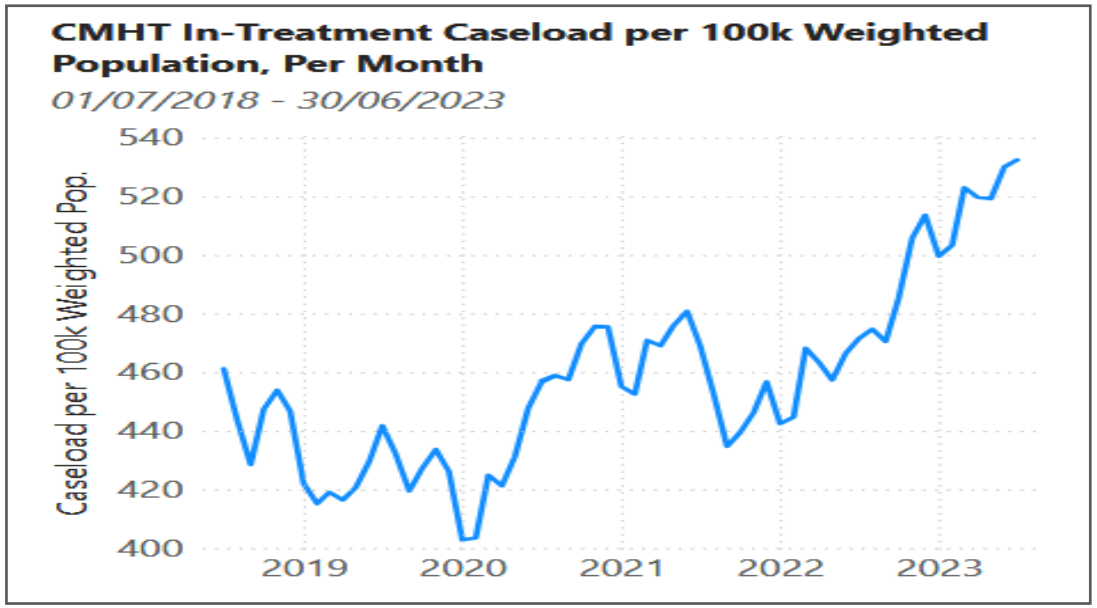
Opportunities for community mental health in INTs:

- Information sharing between mental health services, primary care teams, community services and VCSE providers.
- Strong promotion of good mental health and wellbeing with a focus on the most at-risk populations.
- Consider the role of INTs in the commissioning of VCSE led mental health services in the community.
- Making the right connections with housing services, to prevent homelessness and address need arising from housing issues.
- Address a holisitic approach to care through addressing physical and mental health needs through integrated complex care.

NHS North West London

Capacity in community mental health teams has expanded to enable greater access

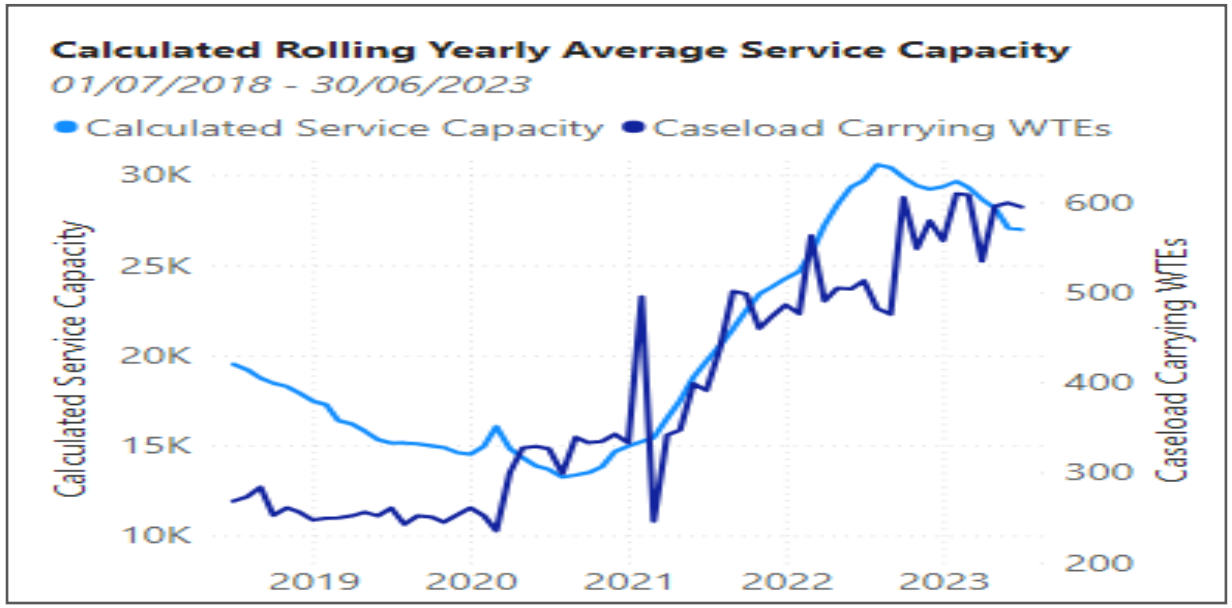
The proportion of adults 18+ [1] in community mental health treatment at any one time has increased by ~16% on 5 years ago



In-treatment caseload is determined by excluding service users on caseload without at least one contact in the past 60 days; this reduces the caseload by -50%. This varies greatly between CMHH (-36%) & MINT (-65%[2]).

CMHH/MINT teams will have services users on their caseloads that do not require high contact intensity, e.g. a 6 monthly medication review. Of 11,219 excluded service users 4,569 were waiting for first contact, a measure of unmet need

Caseload carrying WTEs has increased by ~150% – we have calculated what this should mean for our capacity



We have calculated service capacity as the number of cases a team appear to be able to complete in a year. This is a function of the clinical workforce size, each team's average caseload per clinician and average case length (at discharge) – see details on next page

Capacity has generally moved in line with the caseload carrying WTE increase in recent years

(1) AWA and OA services are merged for comparison as the cut off age differs between CNWL and WLT
(2) WLT's MINT teams operate across two EPR systems, which does affect contact capture completeness

Sources: Activity Data – EPR System Feeds; Absolute population – ONS mid-2020 population estimates; Weighted population – See Appendix 1; 23/24 Access Goal – NWL provided MH trajectories

There is variation in access to community teams between boroughs, while just under one third of service users are awaiting first contact

- Service users with 2+ contacts is lower than planned access with Westminster as the exception in surpassing its access goal.
- Further work has taken place to understand workforce differences between teams to inform service improvements and productivity.

CMHT Treatment Met & Unmet Need

Latest 12-Months (01/07/2022 - 30/06/2023)

Service	Av. Caseload	Av. In-Treatment Caseload	Av. Waiting List (Caseload Waiting for First Contact)	SUs With At Least 2 Contacts in the 12-Month Period	2023/24 Access Goal	Difference	18+ Pop.	Discharged as a % of 18+ Pop.
CMHT - Brent	2,503	1,770	476	3,506	4,235	-729	236,907	1.48%
CMHT - Harr	2,182	1,342	460	2,635	2,842	-207	181,646	1.45%
CMHT - Hill	2,562	1,349	519	2,469	3,581	-1112	221,491	1.11%
CMHT - K&C	1,700	1,217	252	2,388	2,767	-379	120,664	1.98%
CMHT - Westm	2,621	1,736	403	3,390	2,370	1020	210,025	1.61%
MINT - Ealing	4,313	1,710	933	3,419	4,751	-1332	243,031	1.41%
MINT - H&F	3,178	1,053	739	2,034	2,525	-491	139,004	1.46%
MINT - Hounslow	3,668	1,185	787	2,766	3,361	-595	194,848	1.42%
Total	**22,565**	**11,346**	**4,569**	**22,607**	**26,433**	**-3826**	**1,547,616**	**1.46%**

Sources: Activity Data – EPR System Feeds; Absolute population – ONS mid-2020 population estimates; Weighted population – See Appendix 1; 23/24 Access Goal – NWL provided MH trajectories

(1) AWA and OA services are merged for comparison as the cut off age differs between CNWL and WLT
(2) WLT's MINT teams operate across two EPR systems, which does affect contact capture completeness

Unless significantly higher productivity improvements can be made in community mental health teams, there could be a significant capacity gap in FY29

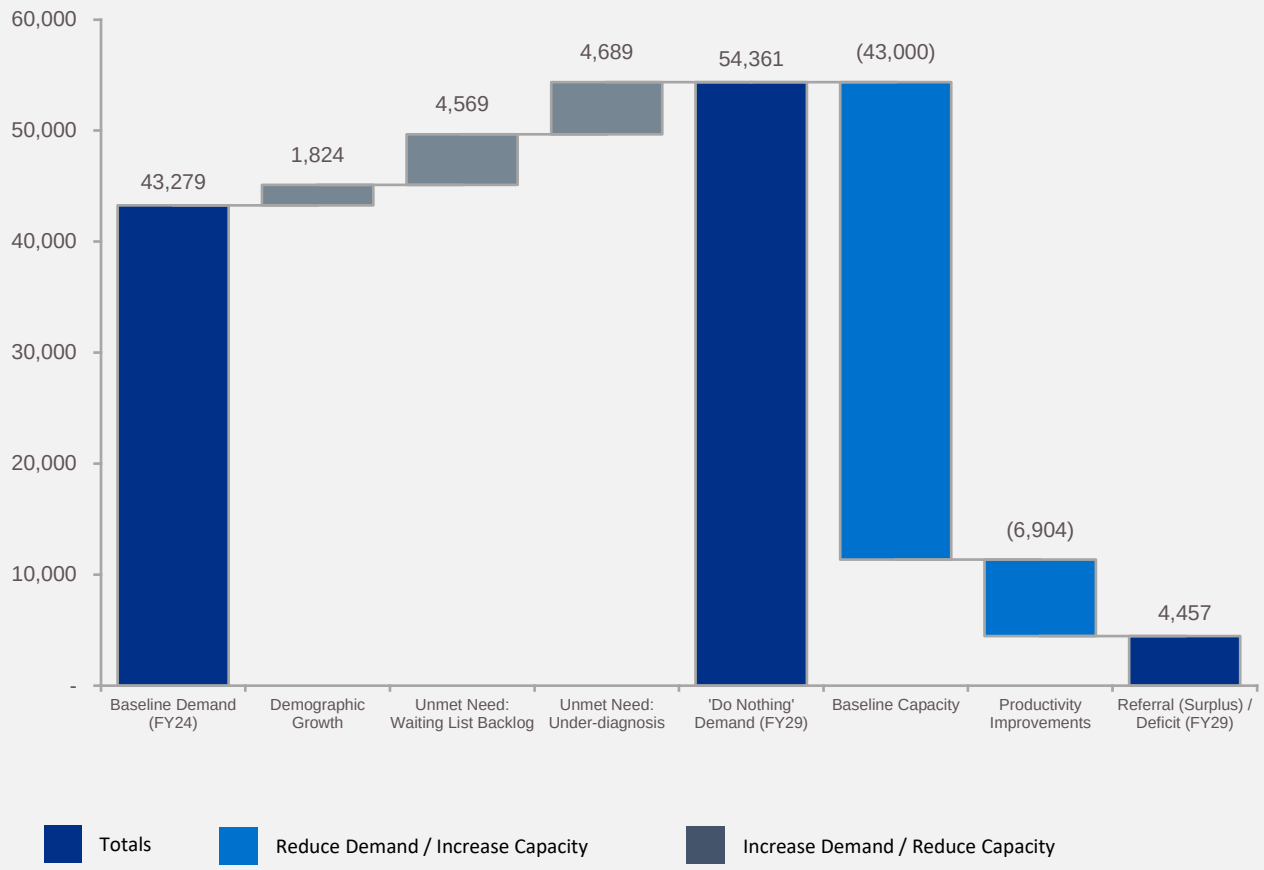
CMHH / MINT Referrals:

- The modelling demonstrates that in **FY29, NWL's** referral surplus / deficit could range from a **deficit of 12k referrals** to a **deficit of 3k referrals** depending primarily on the level of unmet need in the system that we can service, and the productivity improvements that we can unlock.
- The **'central case' scenario** (which is the most realistic of the three scenarios) concludes that we need to make higher productivity improvements to meet the currently estimated level of unmet need in the system.
- Work continues to refine inputs and assumptions, particularly around the existing CMHH / MINT capacity.

Scenarios	Worst	Central	Best
Current Demand [FY24 outturn]	**43k**	**43k**	**43k**
Demographic Growth	2k	2k	1k
Unmet Need: Waiting List Backlog	5k	5k	5k
Unmet Need: Under-diagnosis	5k	5k	4k
Future Demand [FY29 'Do Nothing']	**55k**	**54k**	**53k**
Current Capacity Estimate* [FY24]	(43k)	(43k)	(43k)
Productivity Improvements	-	(7k)	(7k)
Referral (Surplus) / Deficit [FY29 'Do Something']	**12k**	**5k**	**3k**

CMHH – Community Mental Health Hubs (CNWL)
MINT – Mental Health Integrated Network Teams (WLT)
***NOTE:** Further work is required to refine this capacity estimate.
Sources: CNWL / WLT demand data and available beds data [Jan 2023 – Dec 2023].

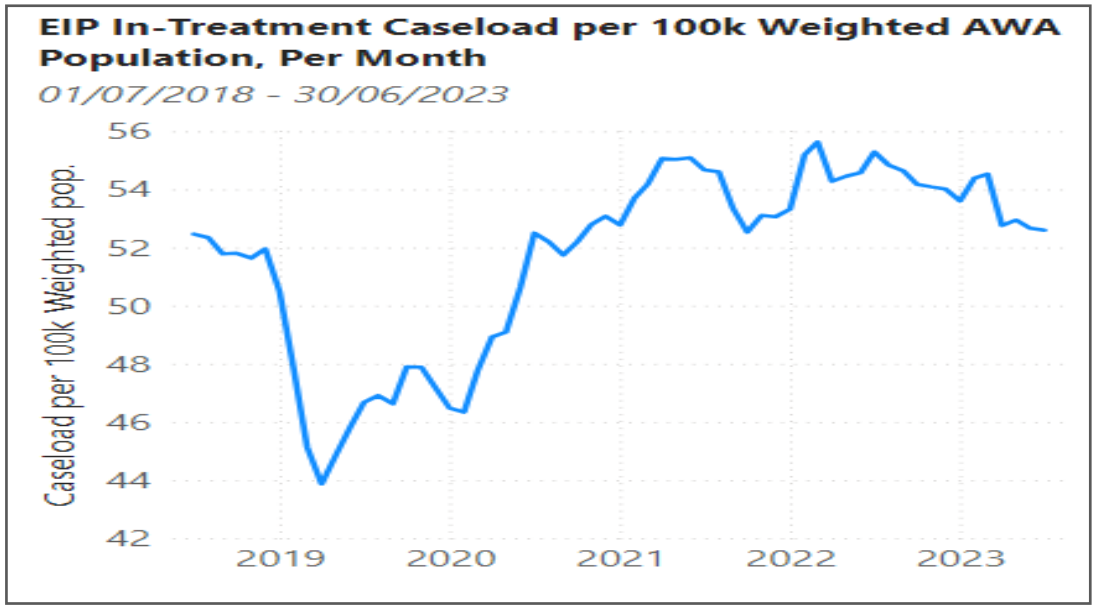
CMHH / MINT Referrals: 'Central' Case Modelling Scenario



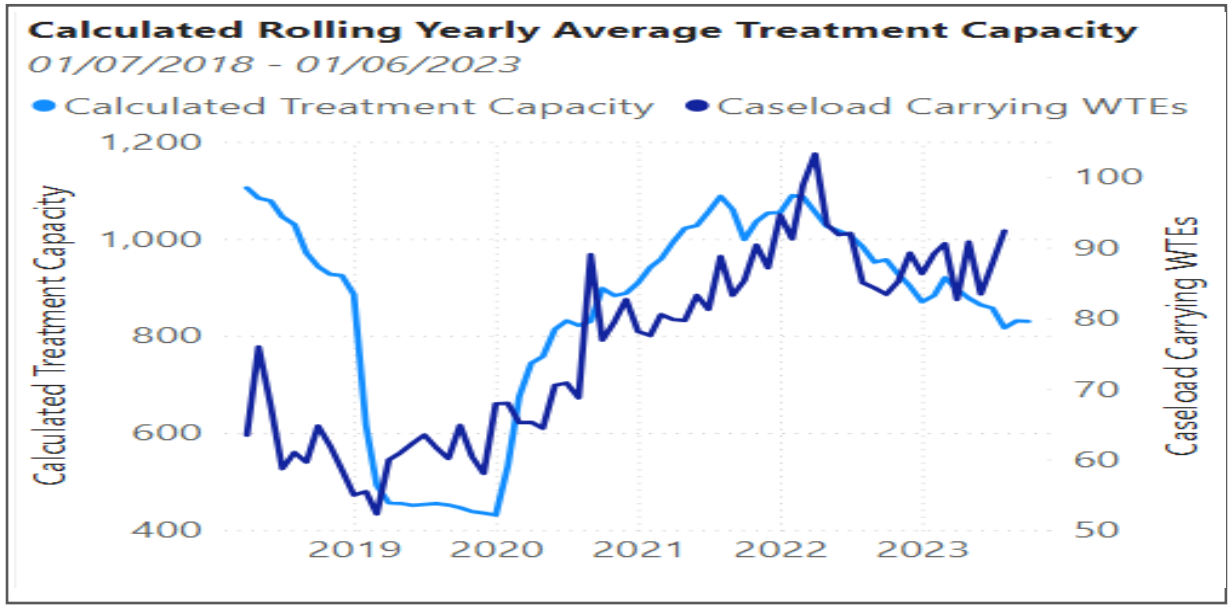
Early Intervention in Psychosis

Capacity in early intervention services has expanded to enable greater access

The proportion of the adult working age (AWA) population in-treatment for EIP is largely back to pre-Covid levels



Caseload carrying WTEs for EIP has increased by ~30%



In-treatment has been determined by excluding Service Users (SUs) on caseload without at least one contact in the past 60 days, EIP will have a cohort at any one time not engaged with the service

Very few SUs are waiting for first contact, our first indicator of unmet demand.

Note: EIP accepts referrals from SUs aged 14 years +; Determining 14-65 pop. is not straightforward, AWA pop. used as a proxy.

Sources: Activity Data – EPR System Feeds; Absolute population – ONS mid-2020 population estimates; Weighted population – See Appendix 1; 23/24 Access Goal – NWL provided MH trajectories

North West London appears to have sufficient capacity to support early intervention in psychosis

- We have calculated treatment capacity as the no. of cases a team appear to be able to complete in a year. This is a function of the clinical workforce size, each team's average caseload per clinician & average case length (at discharge).
- Capacity has generally moved in line with the caseload carrying WTE increase in recent years. The pandemic did reduce capacity by elongating case length. Case length increase is also the prime driver of capacity decline since Feb-22. This is not, however, necessarily a concern if EIP is adhering to its evidence-based model of intense support for up to 3 years. However, only WLT EIP services seem to be adopting 3 year model when we review team discharge profiles.
- Brent and Hammersmith & Fulham place lower caseload demands on staff, which reduces treatment capacity.

Calculated Service Treatment Capacity and Estimated Service Deficit

Latest 12-Months (01/07/2022 - 30/06/2023)

Service	Caseload Carrying WTEs (A)	In-Treatment Caseload per Caseload Carrying WTE (B)	Av. Case Length (C)	Annual Treatment Capacity (A*B*365)/C	Treatment Capacity per 100k Weighted AWA Pop.	Treatment Capacity Deficit per 100k Weighted AWA Pop.	Treatment Capacity per 100k AWA Pop.	Treatment Capacity Deficit per 100k AWA Pop.
Early Intervention - Brent	16	9	459	117	39		59	
Early Intervention - Hill /Harr	15	13	390	178	60		54	
Early Intervention - KCW	17	12	495	156	33		56	
EIP - Ealing	15	14	404	195	51		96	
EIP - H&F	10	10	400	93	39		77	
EIP - Hounslow	13	14	414	157	65		95	
Total	**87**	**12**	**429**	**886**	**46**		**68**	

Note: EIP accepts referrals from SUs aged 14 years +; Determining 14-65 pop. is not straightforward, AWA pop. used as a proxy.

Sources: Activity Data – EPR System Feeds; WTEs – NWL Trial Balance Data; Absolute population – ONS mid-2020 population estimates, Weighted population – See Appendix 1

Optimising the delivery model would increase capacity by 24%

- If we look at the efficacy of services as measured by step down success (a recovery pathway) and avoidance of A&E crisis presentations. Then replicating Ealing's results would appear to raise standards, it currently has a high step-down success rate of 81% and a crisis presentation rate lower than most at 2%.
- If we, for illustration purposes, align all services to Ealing's operating model metrics then the treatment capacity would increase by 213 (24%) across North West London per the table below.

Optimising Treatment Capacity

Latest 12-Months (01/07/2023 - 30/06/2023)

Service	Caseload Carrying WTEs	In-Treatment Caseload per Caseload Carrying WTE	Av. Case Length	Annual Treatment Capacity	Annual Optimised Treatment Capacity	Optimised Capacity Per 100k Weighted AWA Pop.	Optimised Treatment Capacity Deficit Per 100k Weighted AWA Pop.	Optimised Capacity Per 100k AWA Pop.	Optimised Treatment Capacity Deficit Per 100k AWA Pop.
Early Intervention - Brent	16	9	459	117	200	66		100	
Early Intervention - Hill	15	13	390	178	191	65		58	
Early Intervention - KCW	17	12	495	156	219	47		79	
EIP - Ealing	15	14	404	195	195	51		96	
EIP - H&F	10	10	400	93	128	54		106	
EIP - Hounslow	13	14	414	157	165	68		100	
Total	**87**	**12**	**429**	**886**	**1099**	**57**		**85**	

Note: EIP accepts referrals from SUs aged 14 years +; Determining 14-65 pop. is not straightforward, AWA pop. used as a proxy.

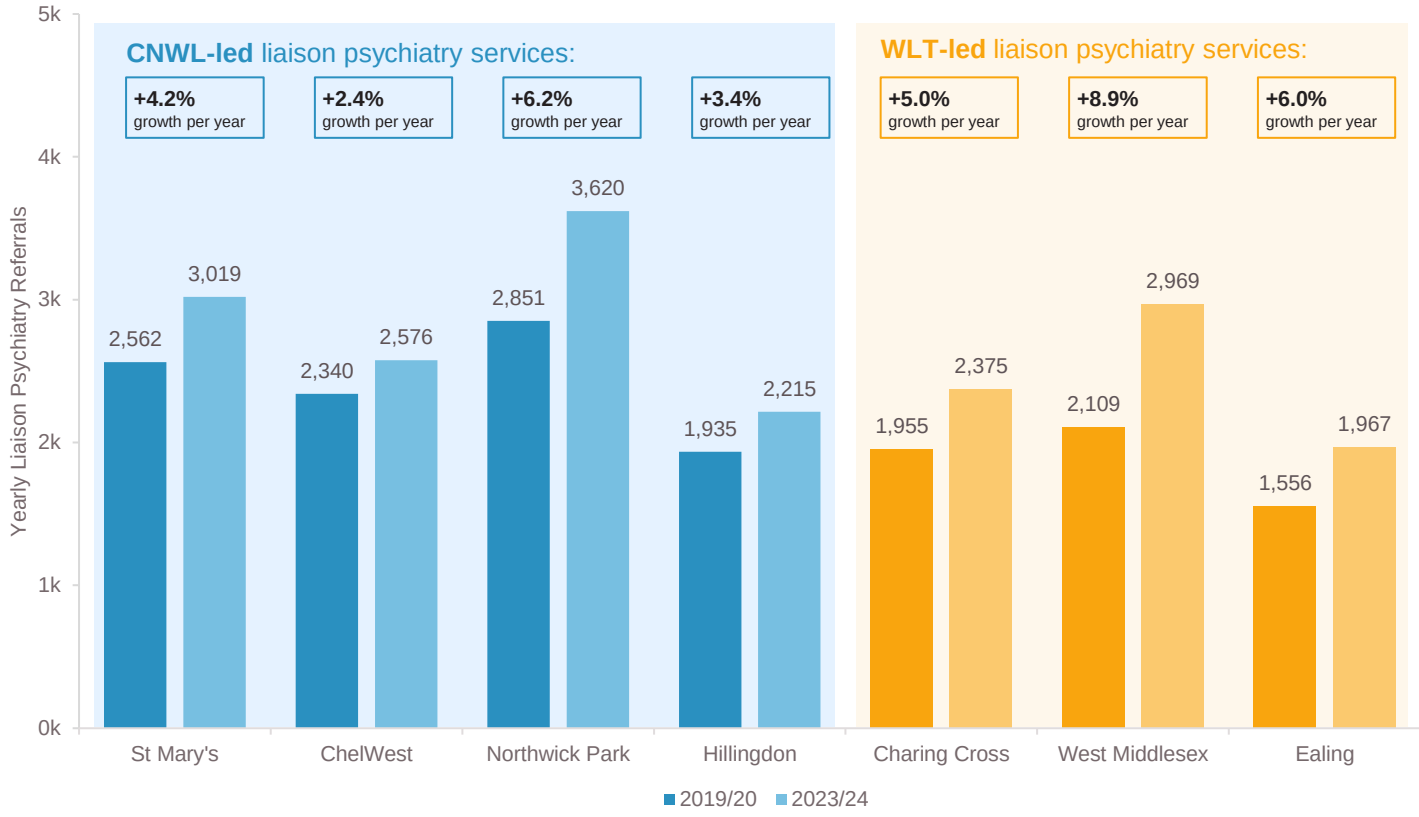
Sources: Activity Data – EPR System Feeds; Absolute population – ONS mid-2020 population estimates, Weighted population – See Appendix 1

Care for people in crisis

Demand for mental health crises in A&E departments has also grown significantly over the last 5 years – at 5.2% per year

- There are now **51 patients** attending NWL A&E departments **every day** for a mental health crisis – this is up 25% from 2019/20 (41 patients per day), equivalent to 5.2% growth per year.
- This figure is derived purely from A&E referrals to liaison psychiatry teams. There are likely to be even more patients who are attending A&E departments for a physical health condition, but also have an underlying mental health condition.
- As shown previously, the **recorded prevalence** of depression and SMI has grown by **6.6% per year**, and therefore liaison psychiatry demand tracks broadly in line with overall mental health prevalence – as expected.
- **25% of overall liaison psychiatry demand** is associated with patients **registered outside of NWL**, foreign nationals, or patients with unknown GP registration status. This varies significantly by site – **40%** of patients attending **Chelsea & Westminster Hospital** for a mental health crisis are considered to be non-NWL patients.
- Growth in mental health demand in Type 1 A&E departments is significantly higher than physical health demand (**1.6% per year**).

Growth in liaison psychiatry referrals by A&E department: 2019/20 – 2023/24 [4 years]



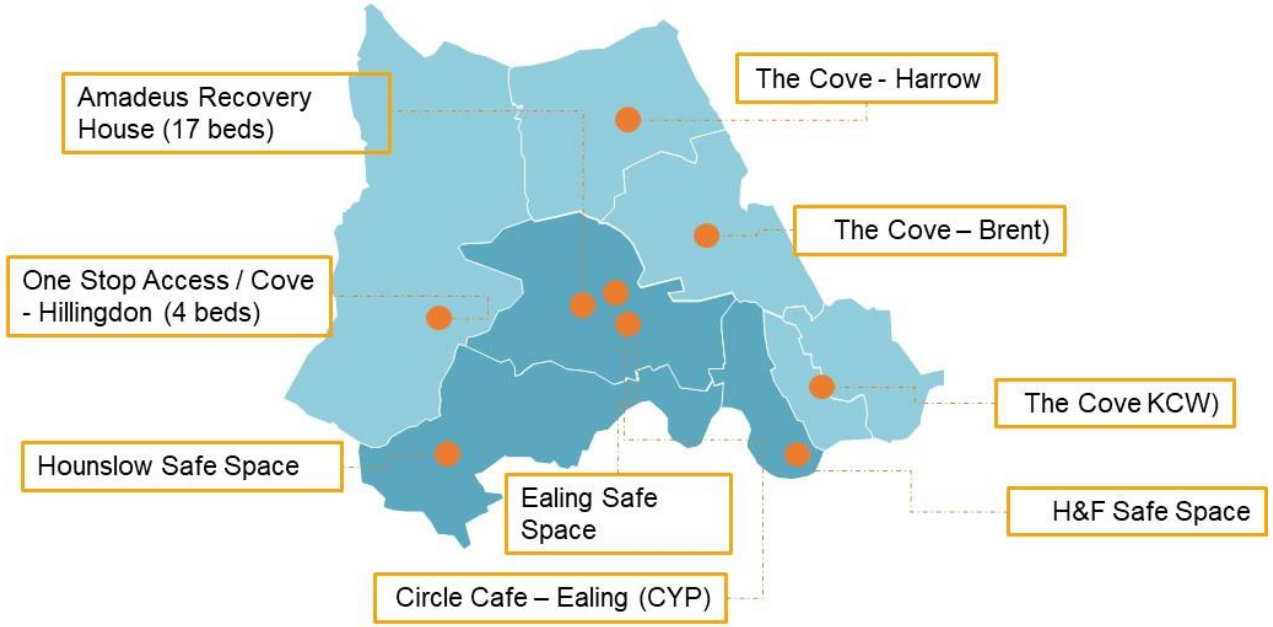
Source: CNWL and WLT internal liaison psychiatry referral data, Type 1 A&E departments only (2019/20 – 2023/24)

North West London Integrated Care System

NHS North West London

Mental Health Crisis Care has continued the shift to community based models of care and investing in alternatives to admission

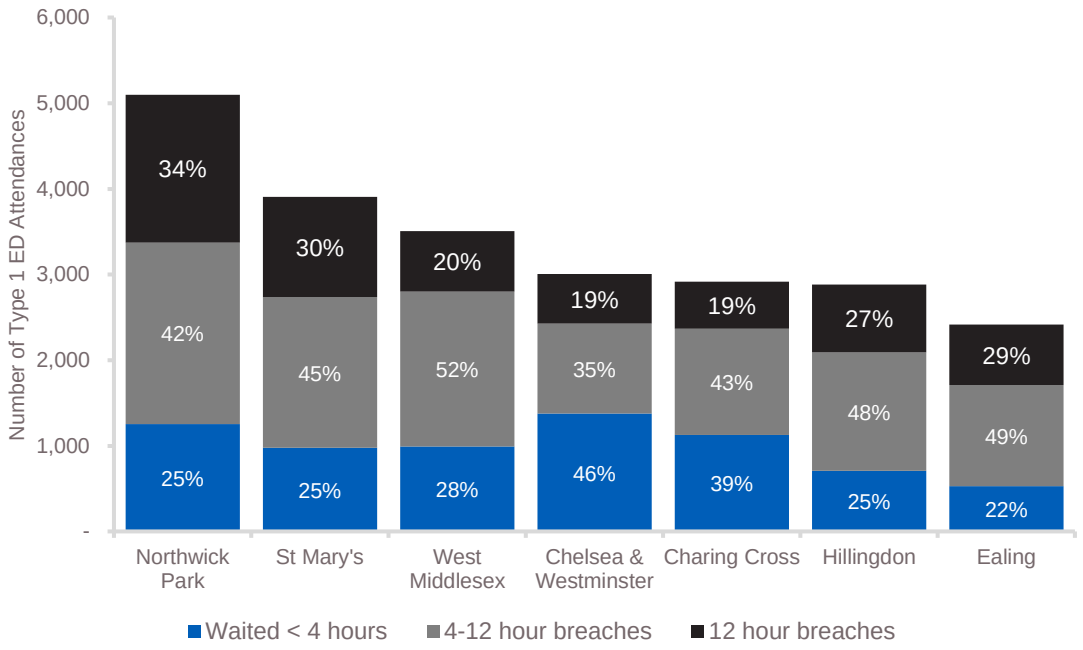
- For those experience mental health crisis, our aim is, and always will be, to ensure that we provide the highest quality, compassionate, trauma-informed and most appropriate mental health care for people who need it across our boroughs.
- Mental health crisis care has significantly expanded with 24/7 community teams, a range of crisis alternatives to A&E and inpatient care available across the ICS. The expansion of liaison psychiatry teams means that every A&E department in NW London has a team in place that meets Core 24 standards.
- There is a growing need to further promote and improve professional and public knowledge of alternative crisis services to better direct people to the most appropriate service and prevent the need for A&E attendances and admission. Added to this, we continue to improve the existing 24/7 open access urgent mental health helplines.



Residents attending A&E departments with a mental health diagnosis are twice as likely to wait more than 12 hours compared to those without such a diagnosis

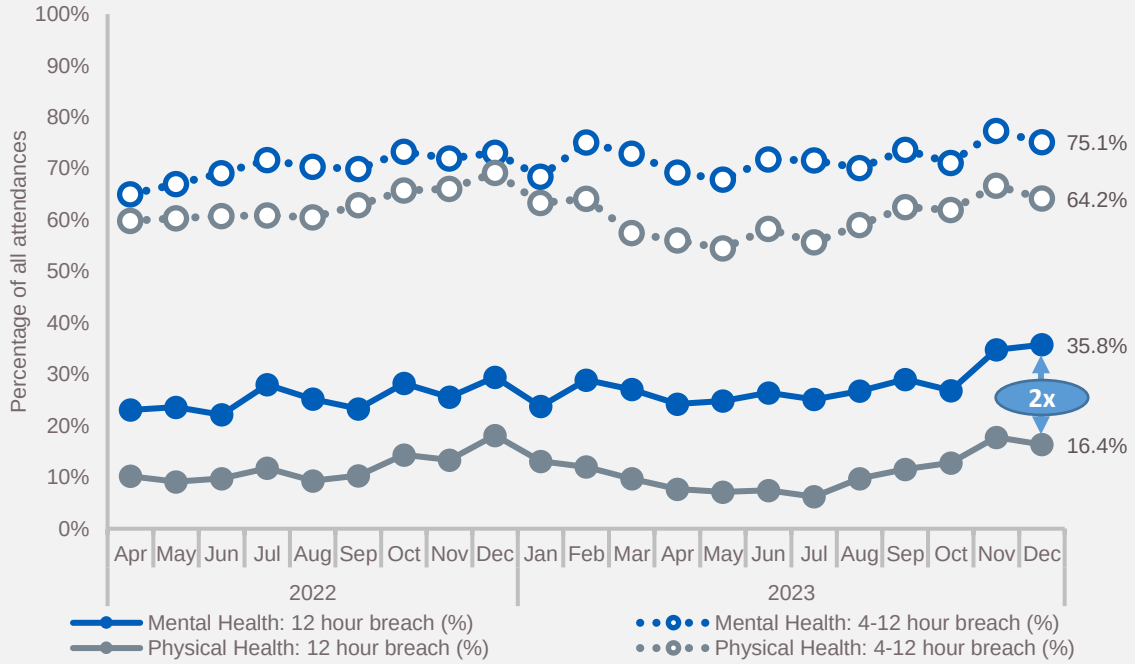
Patients attending ED with a MH diagnosis

Split by waiting time bracket [Jan – Dec 2023]



Mental Health breaches compared to Physical Health breaches

Split by 4-12 hour breaches and 12 hour breaches [Jan – Dec 2023]

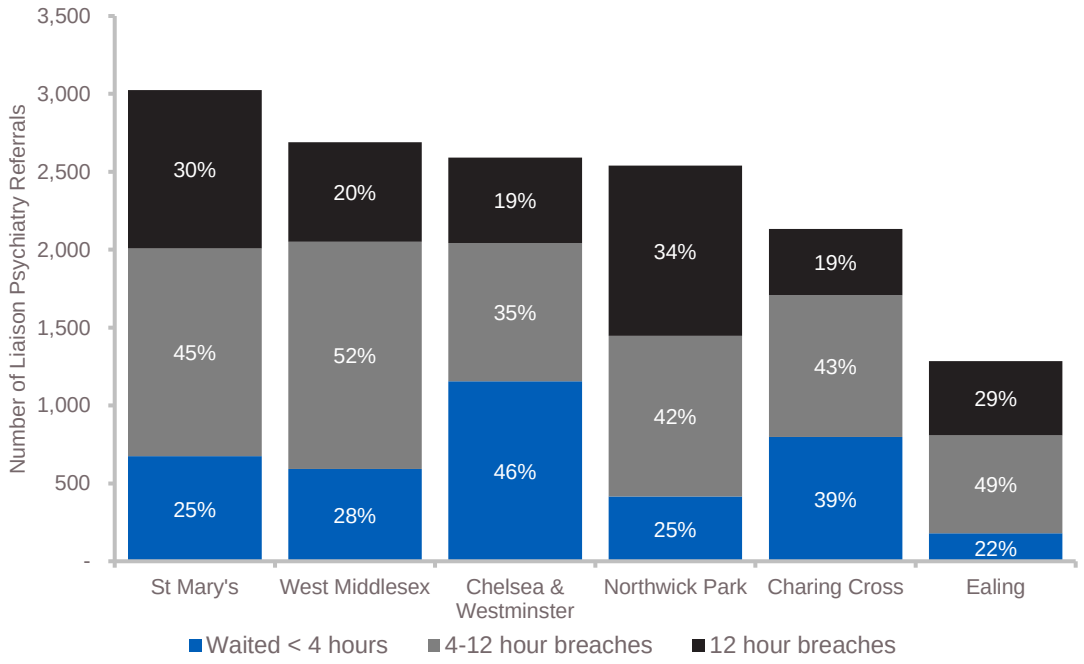


Source: NWL ECDS Data [Jan 2023 – Dec 31st 2023] used to quantify daily MH ED attendances using custom NWL logic (through use of primary and secondary diagnoses and other logic.
Note: ECDS data is currently part of a thorough data quality improvement programme.

Patients being referred to Liaison Psychiatry wait on average 8-12 hours in ED, with those breaching 12 hours spending c. 24 hrs in ED

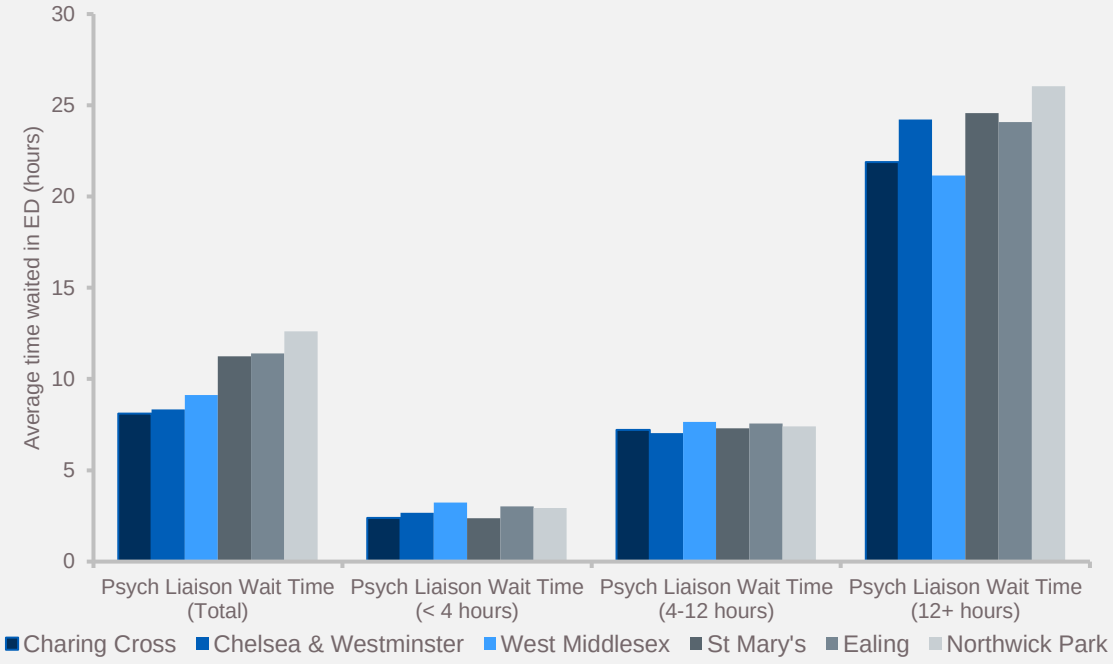
Patients referred to Liaison Psychiatry

Split by waiting time bracket [Jan – Dec 2023]



Waiting times for patients referred to Liaison Psychiatry

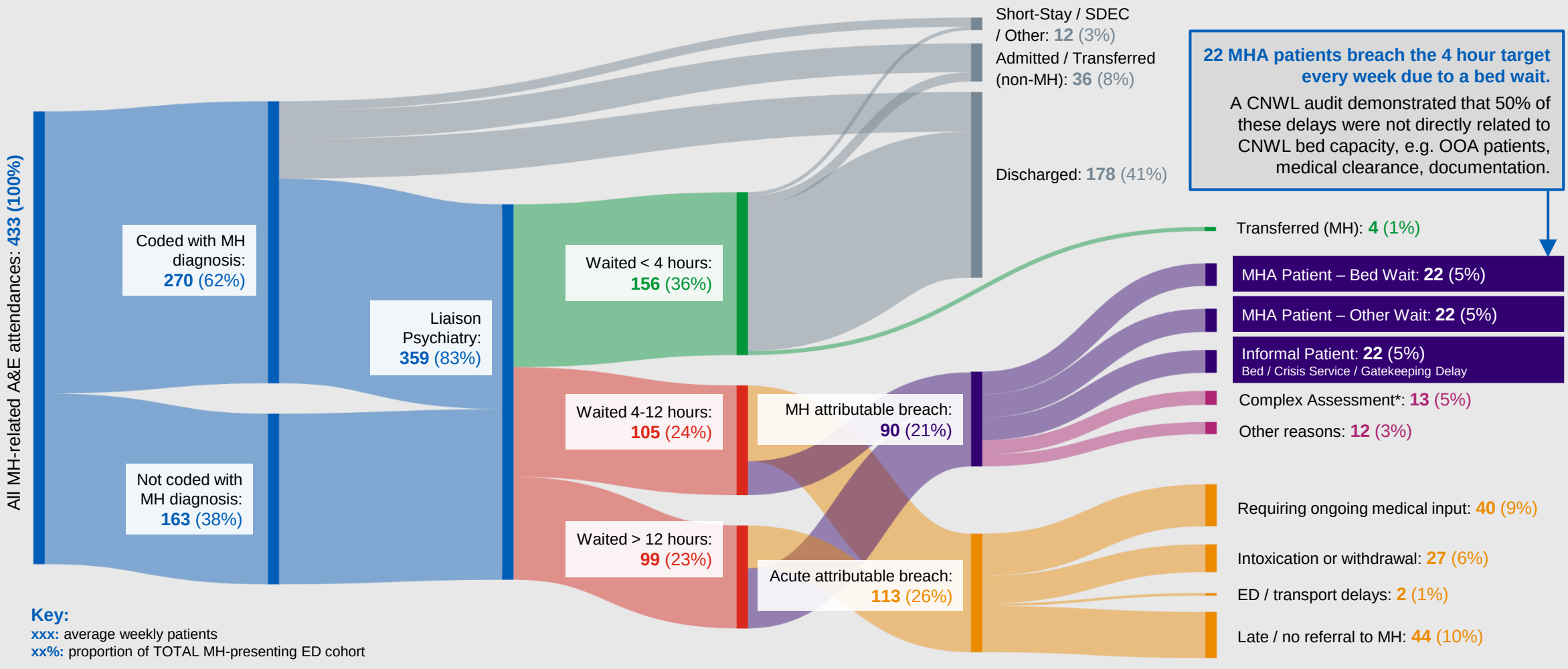
Split by waiting time bracket [Jan – Dec 2023]



Source: NWL ECDS Data [Jan 2023 – Dec 31st 2023] filtered by patients referred to Liaison Psychiatry.
Note: ECDS data is currently part of a thorough data quality improvement programme.

On average, over 98 mental health patients are required to wait over 12 hours in our A&E departments every week with 22 waiting over 4 hours due to a lack of mental health beds

- **433** patients attend our A&E departments every week with an urgent mental health need.
- **359** of these patients are referred to our Liaison Psychiatry teams, with **156** of these patients waiting less than 4 hrs, **105** patients waiting between 4 and 12 hrs, and **99** patients waiting over 12 hrs.

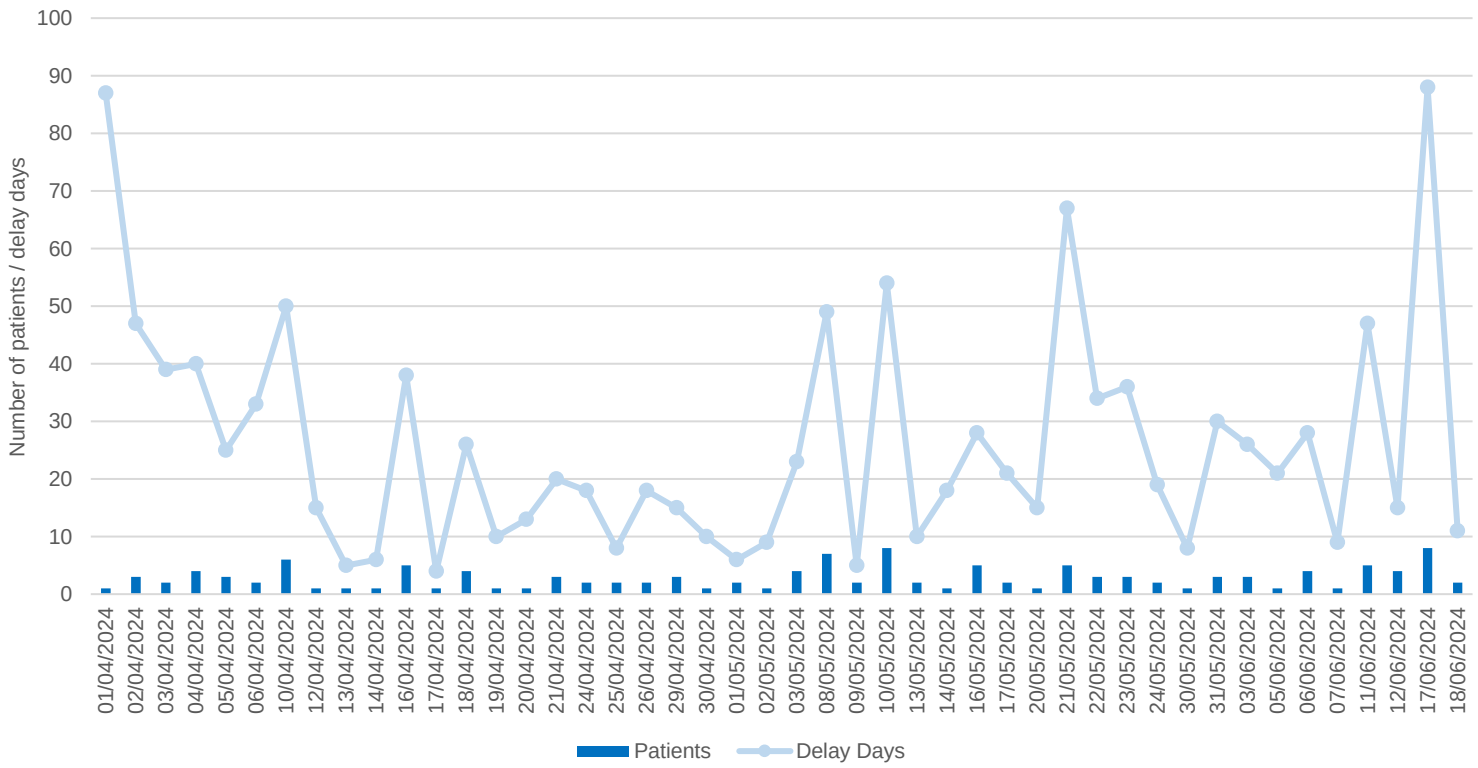


Sources: ***NWL ECDS Data (June 1st 2023 – May 31st 2024)*** used to quantify daily MH ED attendances and Liaison Psychiatry referrals using national logic. Breach reasons analysis derived from ***manual reporting collated by CNWL (June 5th 2023 – June 4th 2024)***. Note: ECDS data is currently part of a thorough data quality improvement programme. Where available, manual reporting takes precedence in quantifying total liaison psychiatry referrals, 4-12hr breaches and 12hr breaches.
*Complex assessments include items such as multiple reviews, interpreters required, appropriate adult required, medical queries, etc.

Across all NWL acute hospital wards, 129 patients were identified with discharge delays attributed to transfer to a mental health bed

Number of mental health patients admitted to an acute ward (physical health and the number of delay days

Snapshot [01 Apr- 18 Jun 2024]

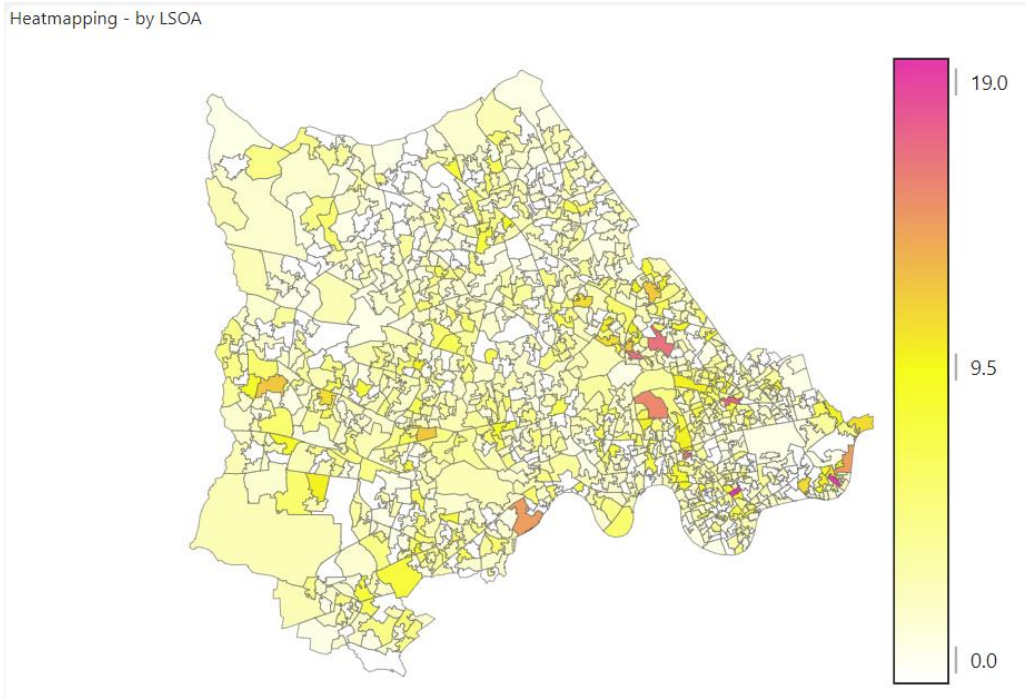


- A snapshot (01 April 2024 to 18 June 2024) of mental health patients in acute physical health beds awaiting admission to a mental health bed highlights that 129 discharge delays were attributed to waits for mental health beds.
- Approximately 26 patients (20%) were from a borough outside NW London but these were not generally the patients waiting the longest.
- Overall, the 129 patients were delayed for **1,204** days overall, which equates to approximately **15 beds** of **acute hospital capacity per day** over that period (0.5% of NWL's acute bed base).
- Each patient was delayed for an average of **9.3 days.**
- **Further work** is being completed to understand how many of these patients still required some level of acute care (e.g. intravenous fluids) that cannot be provided in acute mental health wards.

Source: NWL PM scorecard, 01 April 2024 to 18 June 2024

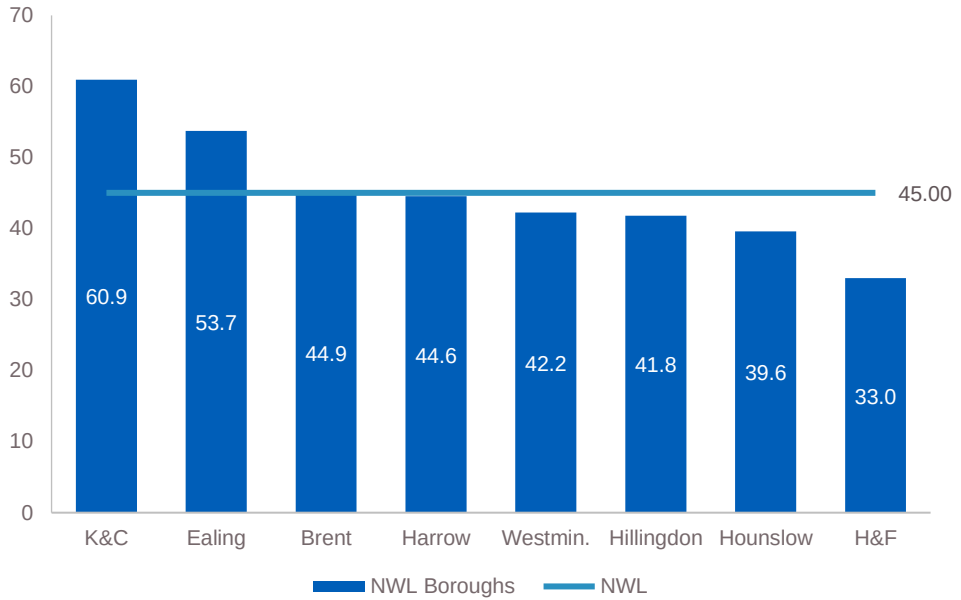
Acute/ inpatient care

There is variation in admissions and inpatient lengths of stay across our boroughs



Occupied bed days in acute mental health services
Per 100,000 population

Source: NWL local data, August 2023



- Our aim across North West London ICS is, and always will be, to ensure that we provide the highest quality, compassionate, trauma-informed and most appropriate mental health care for people who need it across our boroughs.

- This includes increased access to integrated services in the community, inpatient facilities that meet modern standards of acute mental health care, supporting patient dignity and privacy, with ease of access where required. We follow the principles laid out in the Mental Health Capacity Act 2005 that mental health care should be in the least restrictive setting and acute inpatient care should only be used where there is no better alternative.

Modelling demonstrates that demand growth for inpatient services can be addressed through several transformation opportunities

MH Inpatient Services: Central Case Modelling Summary

Service	Current Demand [FY24 Outturn]	Demographic Growth [5 yrs]	Unmet Need Estimate [p.a.]	Future Demand [FY29 – 'Do Nothing']	Capacity [Current + Plan]	Transformation opportunities [p.a.]	(Surplus) / Deficit [FY29 – 'Do Something']
Adult Acute	**330** beds	**11 beds**	**8** beds for OOA patients **4** beds to better service ED long waits	**353** beds	**(343)** current **(8)** future	**(20)** [-6% admissions] **(20)** [-6% Av LoS] **+35** [adjustment to hit target occupancy of 90%]	**(2)** bed surplus
Older Adult Acute	**86** beds	**6 beds**	-	**93** beds	**(102)** current	**(12)** [-13% admissions] **(23)** [-28% Av LoS] **+6** [adjustment to hit target occupancy of 90%]	**(37)** bed surplus
Rehab	**144** beds	**6 beds**	-	**151** beds	**(144)** current	**(10)** [-6% Av LoS] **+16** [adjustment to hit target occupancy of 90%]	**13** bed deficit
PICU	**48** beds	**1 bed**	-	**49** beds	**(54)** current	**(0.3)** [-1% Av LoS] **+5** [adjustment to hit target occupancy of 90%]	**1** bed deficit
LTC / CC	**17** beds	**3 beds**	-	**20** beds	**(37)** current	**(9)** [-1% Av LoS] **+5** [adjustment to hit target occupancy of 90%]	**(25)** bed surplus

PICU: Psychiatric Intensive Care Unit; **LTC / CC:** Long-Term Complex / Continuing Care; **AvLoS:** Average Length of Stay.
Note: Demographic growth for each service differs due to the varying age profile and borough breakdown of demand for those service.

Adult Acute: Our ‘Central’ scenario demonstrates we can manage future demand through realising several transformation opportunities

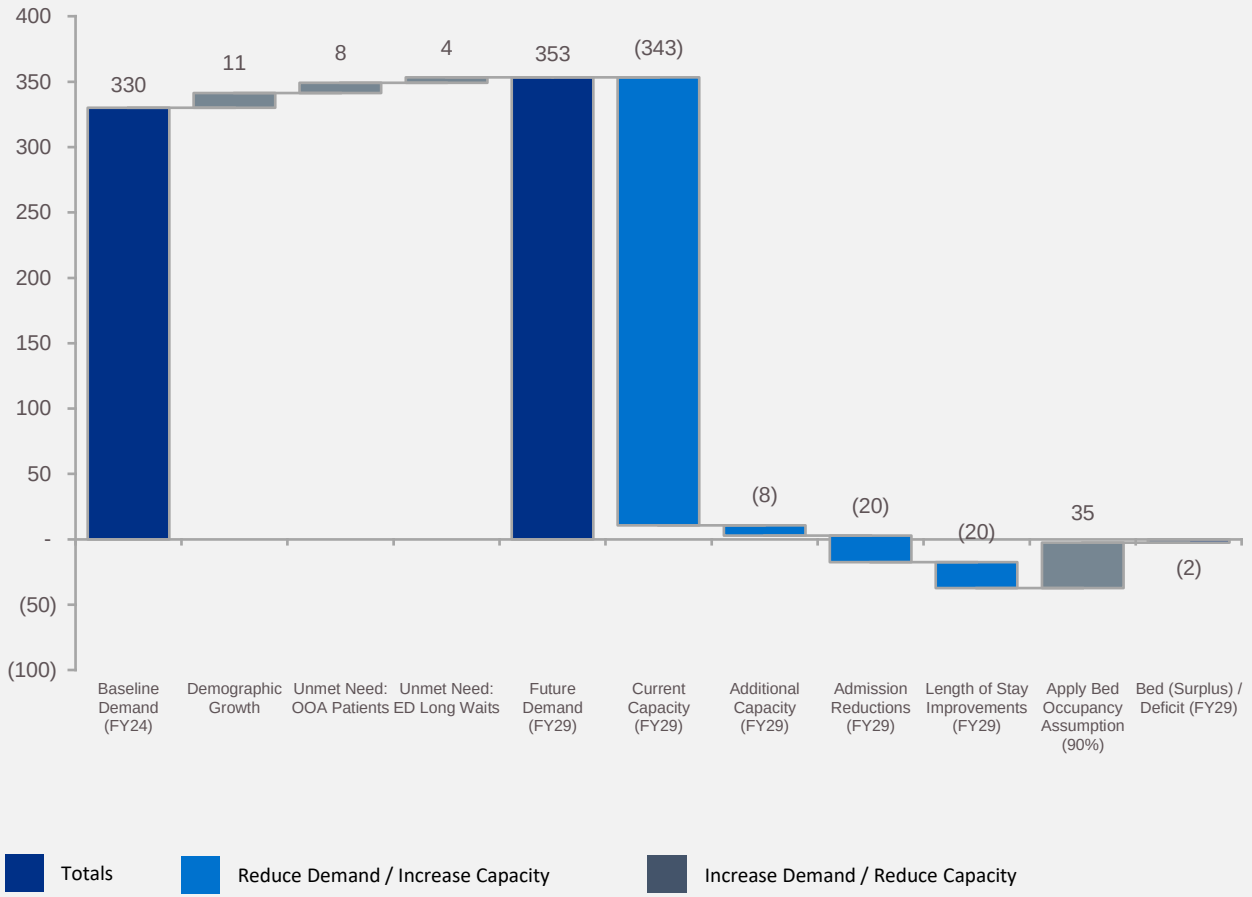
Adult (18-64) Acute Beds:

- The modelling demonstrates that in **FY29, NWL’s** bed surplus / deficit could range from a **deficit of 50 beds** to a **surplus of 38 beds**, depending primarily on our ability to transform our services through reducing length of stay, reducing bed occupancy, and reducing admissions through providing alternative, more suitable settings for patients in crisis.
- The **‘central case’ scenario** (which is the most realistic of the three scenarios) concludes that we currently have sufficient adult acute MH beds, assuming that we can appropriately transform our services.

Scenarios	Worst	Central	Best
Current Demand [FY24 outturn]	**330**	**330**	**330**
Demographic Growth [FY24-FY29]	11	11	2
Unmet Need: OOA Patients [FY29]	8	8	8
Unmet Need: ED Long Waits [FY29]	4	4	4
Future Demand [FY29 ‘Do Nothing’]	**353**	**353**	**343**
Current Capacity [FY24]	(343)	(343)	(343)
Additional Capacity [FY24-FY29]**	(8)	(8)	(8)
Admission reductions [FY29]	-	(20)	(36)
Length of stay improvement [FY29]	-	(20)	(18)
Apply bed occupancy assumption	39	35	15
Bed (Surplus) / Deficit [FY29 ‘Do Something’]	**50**	**(2)**	**(38)**

Sources: CNWL / WLT demand data and available beds data [Jan 2023 – Dec 2023].
*Further **Relates to a 16 bed ward being built at Park Royal, though 8 beds are currently temporarily being provided at Kingswood.

Adult (18-64) Acute Beds: ‘Central’ Case Modelling Scenario



Older Adult Acute: Our ‘Central’ scenario demonstrates we could have a bed surplus through achieving transformation opportunities

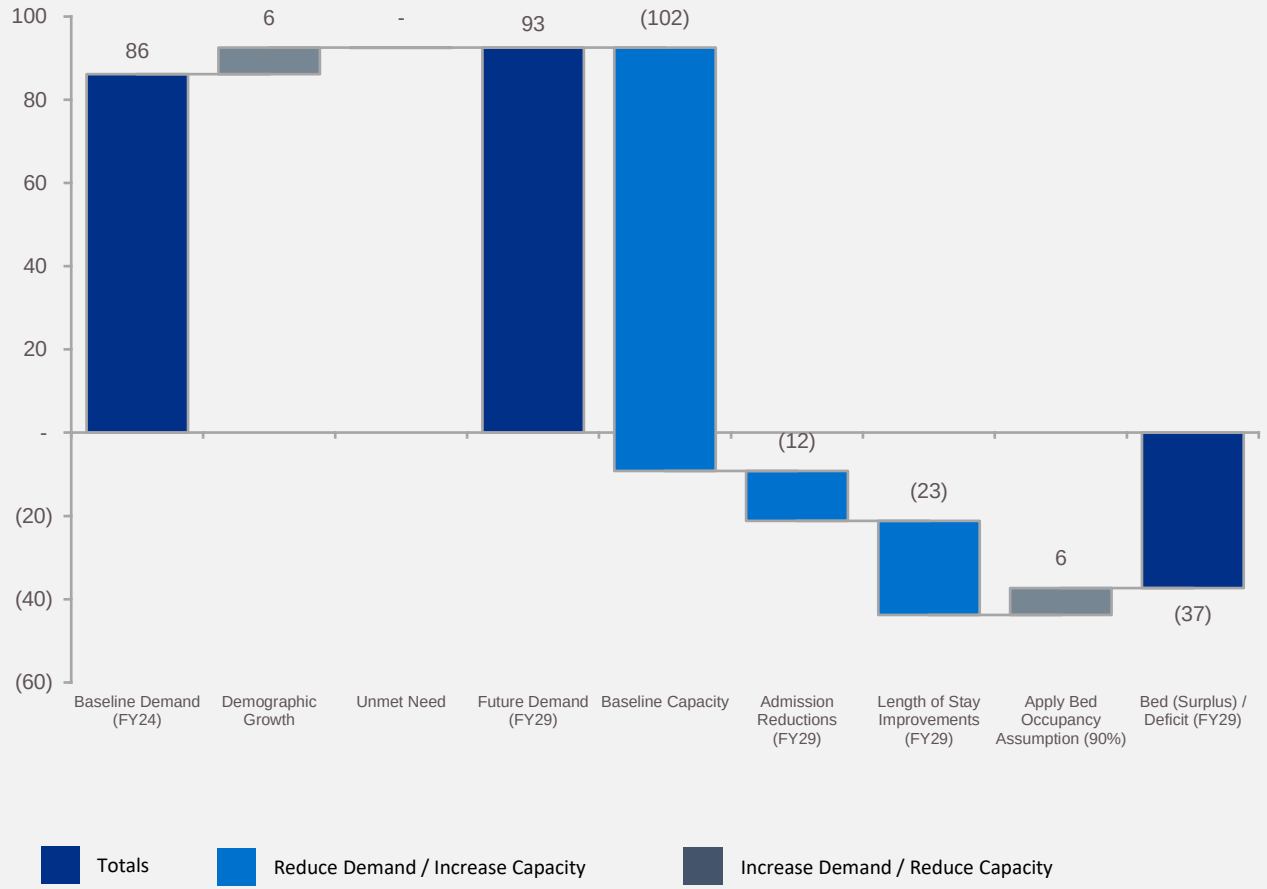
Older Adult (65+) Acute Beds:

- The modelling demonstrates that in **FY29, NWL’s** bed surplus / deficit could range from a **deficit of 1 bed** to a **surplus of 46 beds**, depending primarily on our ability to transform our services through reducing length of stay, reducing bed occupancy, and reducing admissions through providing alternative, more suitable settings for older adults.
- The **‘central case’ scenario** (which is the most realistic of the three scenarios) concludes that we will have plenty of beds for older adult acute patients, assuming we can transform our services appropriately.

Scenarios	Worst	Central	Best
Current Demand [FY24 outturn]	**86**	**86**	**86**
Demographic Growth [FY24-FY29]	6	6	10
Unmet Need	-	-	-
Future Demand [FY29 ‘Do Nothing’]	**93**	**93**	**97**
Current Capacity [FY24]	(102)	(102)	(102)
Admission reductions [FY29]	-	(12)	(22)
Length of stay reductions [FY29]	-	(23)	(21)
Apply bed occupancy assumption	10	6	3
Bed (Surplus) / Deficit [FY29 ‘Do Something’]	**1**	**(37)**	**(46)**

Sources: CNWL / WLT demand data and available beds data [Jan 2023 – Dec 2023].

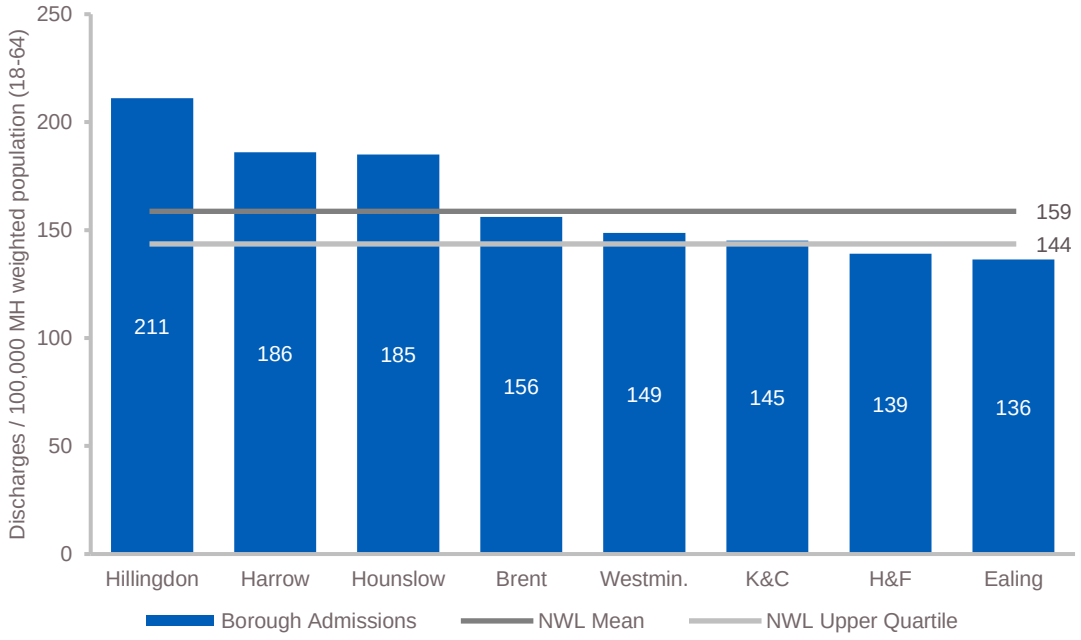
Older Adult (18-64) Acute Beds: ‘Central’ Case Modelling Scenario



Acute Admissions: Benchmarking within North West London shows some room for improvement in preventing admissions (e.g. by aligning care models)

Adult Acute Admissions

per 100,000 MH weighted population (18-64): Jan – Dec 2023 benchmark

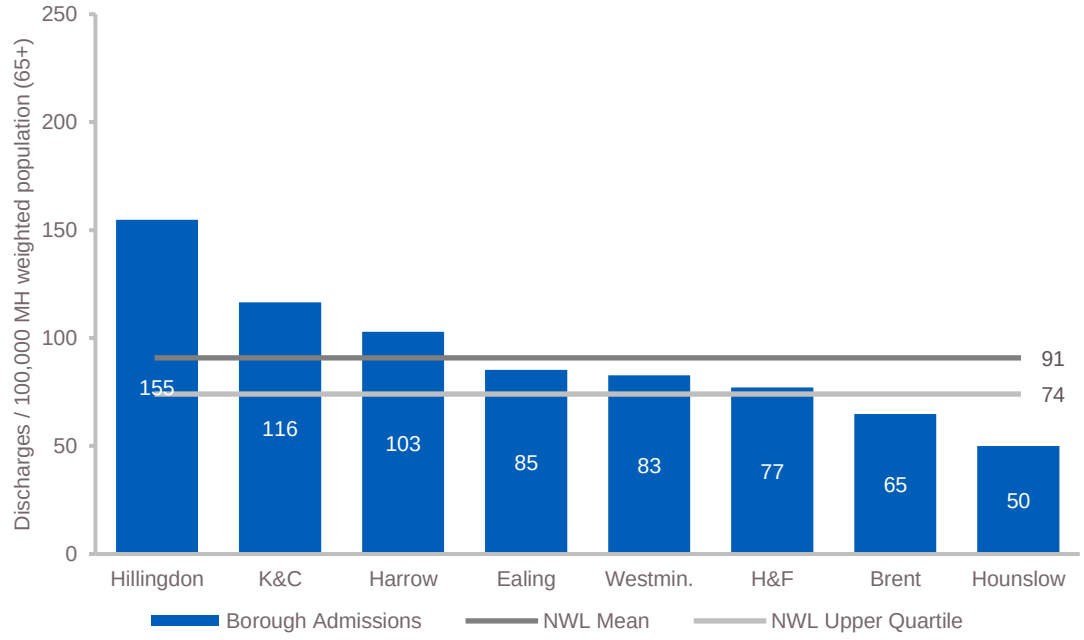


Reducing unwarranted variation:

- Internal benchmarking estimates an improvement opportunity of **6% fewer admissions** across NWL, if all boroughs are able to achieve the NWL mean level of admissions – i.e. Hillingdon, Harrow and Hounslow are able to prevent unnecessary admissions.
- Boroughs achieving the NWL upper quartile would result in **11%** fewer admissions.
- This could be achieved by aligning care models, focusing on prevention, and/or providing alternative services such as the Mental Health Crisis Assessment Service (MHCAS).

Older Adult Acute Admissions

per 100,000 MH weighted population (18-64): Jan – Dec 2023 benchmark



Reducing unwarranted variation:

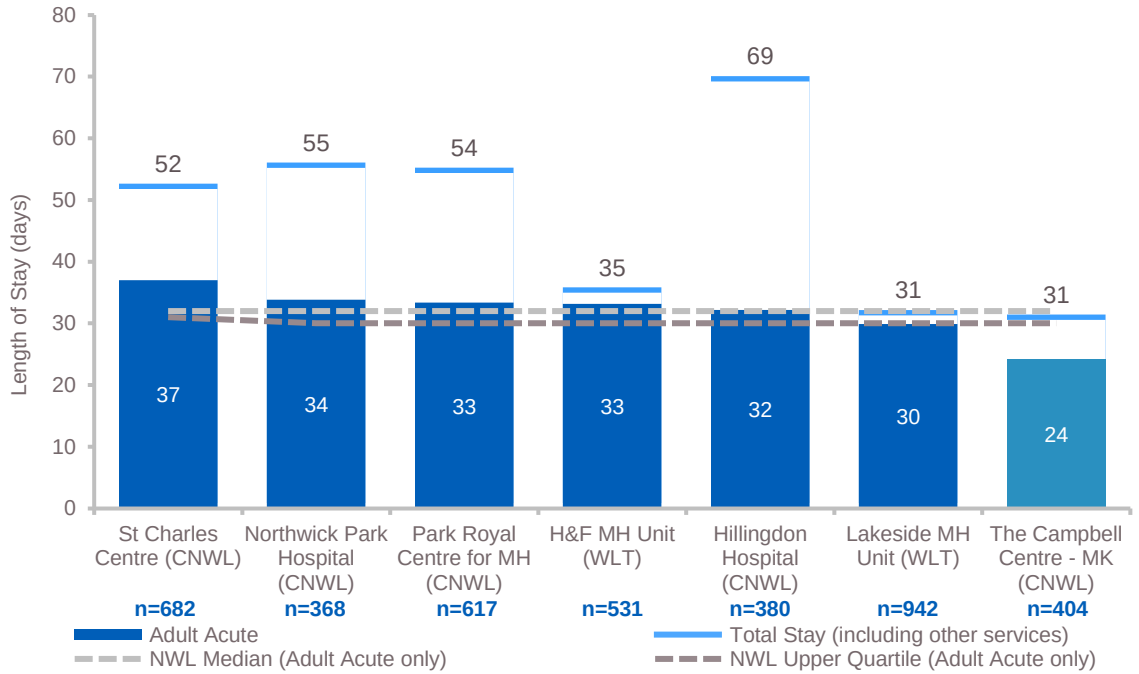
- Internal benchmarking estimates an improvement opportunity of **13% fewer admissions** across NWL, if all boroughs are able to achieve the NWL mean level of admissions – i.e. Hillingdon, Harrow and Hounslow are able to prevent unnecessary admissions.
- Boroughs achieving the NWL upper quartile would result in **23%** fewer admissions.
- This could be achieved by aligning care models, focusing on prevention, etc.

Sources: CNWL / WLT patient-level activity data [Jan 2023 – Dec 2023]. Av. LoS excludes leave.

Average Length of Stay for Acute Services: Benchmarking within North West London indicates some room for improvement in reducing average length of stay

Adult Acute:

Average length of stay by NWL (+ Milton Keynes) site [Jan – Dec 2023]

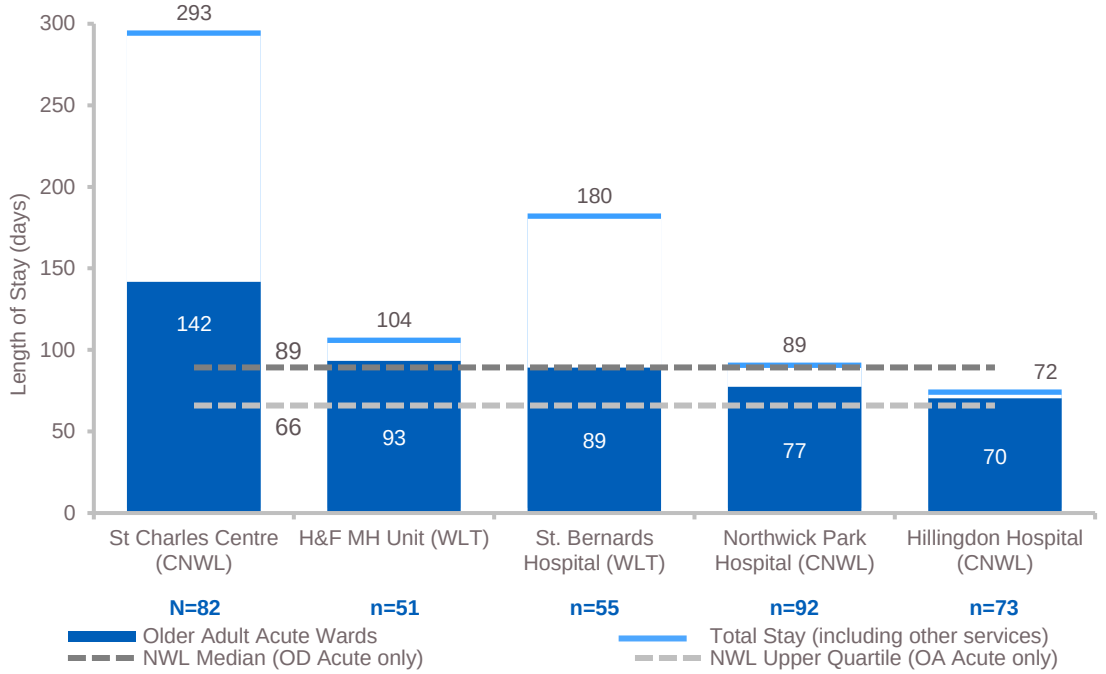


Reducing unwarranted variation:

- Benchmarking estimates an improvement opportunity of **3% fewer bed days across NWL** if each site achieved the NWL median Av. LoS of **32 bed days** (from an Av. LoS of 33.1).
- Benchmarking estimates an improvement opportunity of **7% fewer bed days across NWL** if each site achieved the NWL upper quartile Av. LoS of **31 bed days.**
- Av. LoS could be reduced by 16% if each site were able to achieve the NWL upper decile performance (27.6 bed days).

Older Adult Acute:

Average length of stay by NWL site [Jan – Dec 2023]



Reducing unwarranted variation:

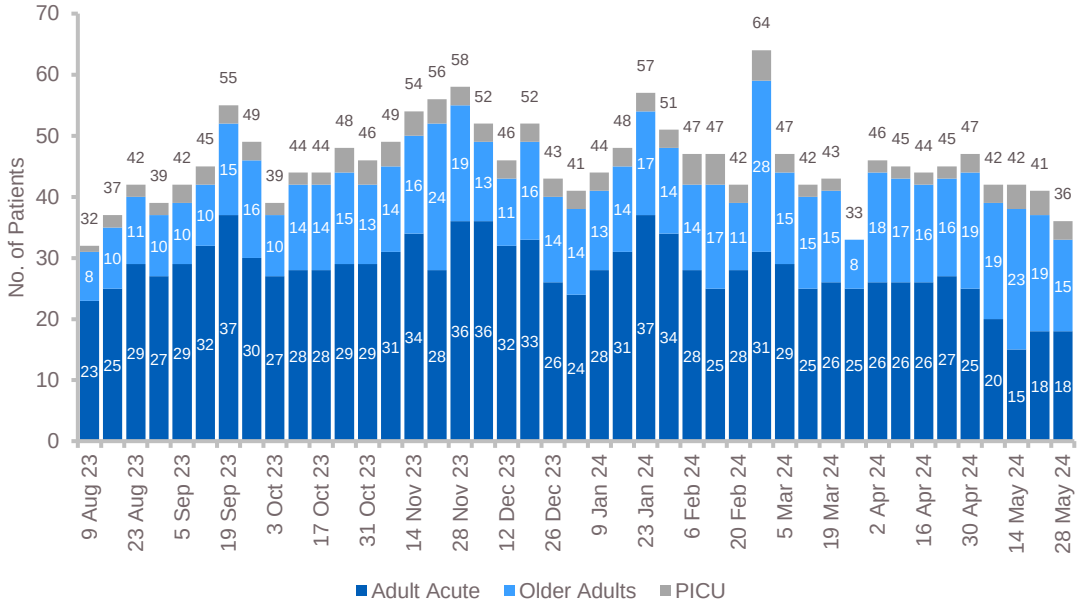
- Benchmarking estimates an improvement opportunity of 1**3% fewer bed days across NWL** if each site achieved the NWL median Av. LoS of **89 bed days** (from an Av. LoS of 91.6).
- Benchmarking estimates an improvement opportunity of **20% fewer bed days across NWL** if each site achieved the NWL upper quartile Av. LoS of **77 bed days.**

Sources: CNWL / WLT patient-level activity data [Jan 2023 – Dec 2023]. Av. LoS excludes leave.

At any time over the past 10 months there were c. 43 patients that were clinically ready for discharge from a mental health bed

Patients Clinically Ready for Discharge (CRFD)

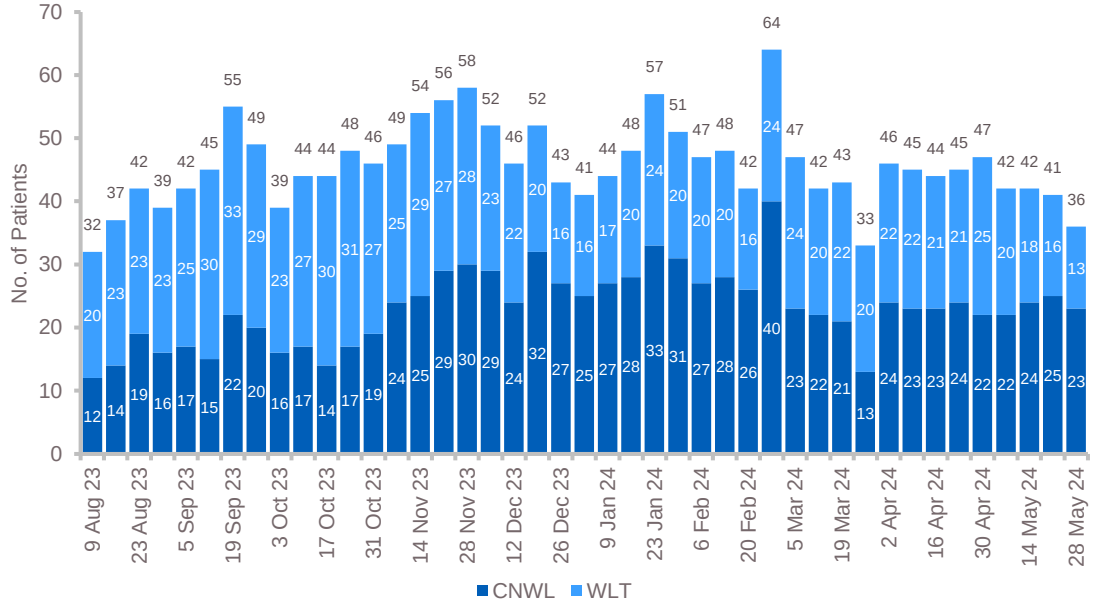
Split by service / bed type: Manual weekly audits [Aug 2023 – May 2024]



- On any given day, there has been 32 – 64 patients that are clinically ready for discharge (CRFD) over the period August 2023 to May 2024.
- This is driven primarily by patients in Adult Acute beds and Older Adult Acute beds (approximately in line with our overall bed base).

Patients Clinically Ready for Discharge (CRFD)

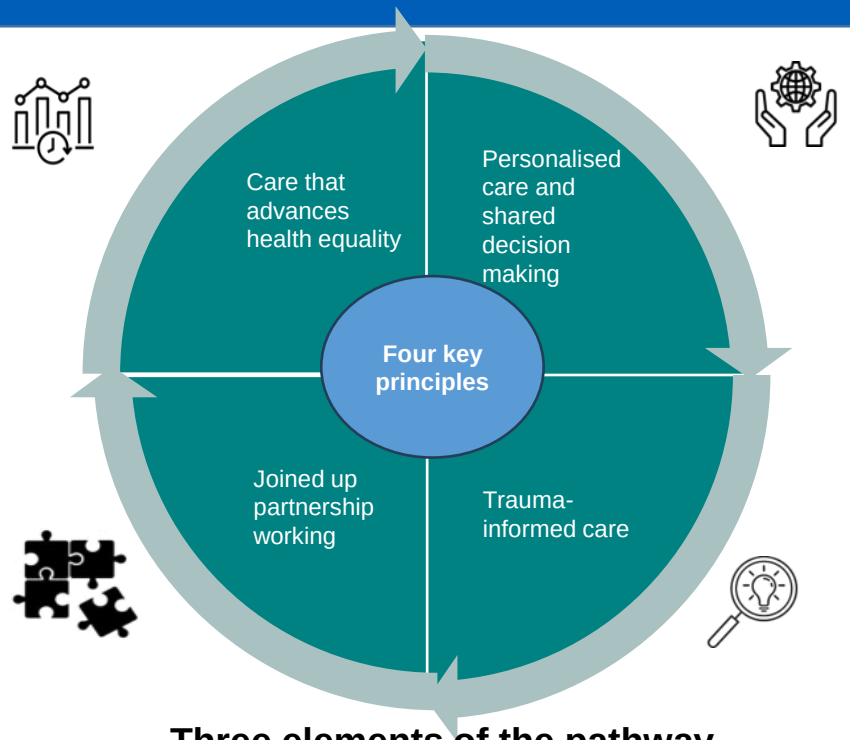
Split by service / bed type: Manual weekly audits [Aug 2023 – May 2024]



- The chart above shows a steady increase in CRFD over the winter period, with approximately 45-55 CRFD patients, though this has started to decrease in recent weeks.
- This implies that average length of stay (and therefore our overall requirement for MH beds) could be reduced substantially by carefully diagnosing and resolving delays in discharge – for example through working with our ICS housing partners.

Sources: NWL CRFD Dataset (manually submitted weekly since Aug 2023)

As part of the Quality Transformation Programme, NWL is developing a plan to localise and realign mental health, learning disability and autism inpatient services



Three elements of the pathway

Purposeful admissions

Therapeutic inpatient care

Proactive discharge planning an effective post discharge support

Two key enablers

A fully multidisciplinary, skilled and supported workforce

Continuous improvement of the inpatient pathway. Using data, co-production and quality improvement methodology

Purposeful admissions

People are only admitted to inpatient care when they require assessments, interventions or treatment that can only be provided in hospital, and if admitted, it is to the most suitable available bed for the persons needs and there is a clearly stated purpose for the admission.

Therapeutic inpatient care

Care is planned and regularly reviewed with the person and their chose carer/s, so that they receive the therapeutic activities, interventions and treatments they need each day to support their recovery and meet their purpose of admission.

Proactive discharge planning an effective post discharge support

Discharge is planned with the person and chosen carer/s from the start of their inpatient stay, so they can leave hospital as soon as they no longer require assessments, interventions or treatments that can only be provided in an in-patient setting, with all planned post-discharge support provided promptly on leaving hospital.


Agree a shared understanding of need, prevalence and demand
Hear the views of our residents and users
Agree a shared understanding of current provision including progress to date
Collectively set out our ambitions for further improving services and closing our biggest treatment gaps

We have four key themes

We will work together in trusted partnership to build a supportive community environment that harnesses a broad range of roles, providers and sectors to enable care and support, recognising and advocating for the skills, expertise and benefit of the whole community. We will improve access to education, training, employment and broader health settings and interventions to promote good mental wellbeing for all.

Organisations and services that support residents' mental health, in both statutory and VCSE sector, will be equipped to meet the diverse health and social needs of the local population in a culturally effective manner. There will be a clear emphasis on prevention, early intervention, maximising independence and embedding strengths based approaches to both community and individual interventions.

For people (including carers) in crisis or requiring an urgent response, they will be able to access a multi-agency response that supports a holistic psycho, social and welfare approach to preventing, supporting and managing the crisis.

Care will be delivered in the least restrictive setting, but when hospital based care is required, it will be delivered in a timely way, by an expert team, within a therapeutic and compassionate environment.

Detailed recommendations (1)

1) **Prioritise equity and equality of access** to services, using local data to drive co-produced service developments that meet the needs of specific communities; ensuring locally tailored and culturally appropriate solutions to improve access for these groups.

2) **Raise awareness** across North West London so that **every resident knows how to access mental health support** both in crisis and more widely in the community, also aiming to reduce stigma in all communities and prevent suicides.

3) Ensure **local community mental health offers are provided more widely** in each borough where people can access help with social issues and gain meaningful employment, with a view to seeking help earlier to prevent mental health problems and crisis.

4) Provide **signposting to mental health support in each local authority housing department** in North West London and ensure close liaison between mental health and housing services by having named link staff with expertise in this area.

5) Support further **integration between primary care and mental health services** to facilitate better joined up working so that care can be delivered in the right setting, at the right time, to respond to the needs of patients.

6) **Reduce waiting times** for therapeutic interventions within our community services to be better than the London average, and where waiting is necessary, **support patients and carers to 'wait well'** with up to date information on waiting times, self help information and community resources that can provide additional engagement and support.

Detailed recommendations (2)

7) Ensure equitable access and **consistent provision in North West London of crisis alternative services to A&E and admission**, and raise awareness so that all residents know where and how to access these in times of crisis.

8) Ensure **appropriately adjusted mental health services that use trauma informed approaches** are available for different groups, such as young adults and neuro-diverse adults, informed by local and national analysis.

9) Review the quality of our inpatient services to ensure we are providing timely care, by an expert team in a therapeutic and compassionate environment.

10) Continue to push productivity, in particular:

- **a) Optimising inpatient lengths of stay** so that no patient stays in hospital longer than they need to, by improving early discharge planning with system partners and post discharge support in order to reduce re-admission to hospital.
- **b) Reducing unwarranted variation** in caseloads and staffing so that patients receive person-centred and timely care from community mental health teams.

11) Improve staff retention and continue our good track record with growing our own. Review the impact of service change on staff, with a view to supporting culture change and managing workloads so that staff vacancies and turnover does not reduce the effectiveness of service developments.

12) Invest in and support the Voluntary, Community and Social Enterprise Sector (VCSE) to enable locally tailored and visible, community support services; building capacity in providers to plan and develop their services for patients.

Our shared aims and ambitions for adult mental health services for the future

By 2028/29 we will have:

Ambitions	Outcomes
RAISED AWARENESS AND PROMOTING WELLBEING • Raised awareness across North West London so that every resident knows how to access mental health support both in crisis and more widely in the community. • Developed an assets-based approach to promoting mental health, wellbeing and independent living, partnering with and investing in local community organisations.	• Services responsive to population health needs and flexibly delivering changes with no unwarranted variation in outcomes. • Locally tailored and visible, community support services; built capacity in providers to plan and develop their services for patients. • Patients and staff reporting better experiences. • Optimal community and inpatient capacity to respond to growth in need whilst delivering our transformation goals and increasing care in a community setting. • All people known to mental health services with a crisis management plan that supports them to use crisis alternatives to A&E for de-escalating their needs, where there is no physical health need. • No person staying longer in a mental health bed than they need to. • Integrated solutions to housing pathways. • More people gaining and staying in meaningful employment. • Zero adult inappropriate acute inpatient stays outside of North West London.
INCREASED EQUITY AND EQUALITY OF ACCESS • Increased equity and equality of service access to reflect different needs of our local and diverse communities, with greater targeted support to those with severe mental illness. • A consistent core offer for community and crisis care for adults, with a focus on severe mental illness, that also enables flexibility for local and diverse needs. • Reduced variation and increased productivity in caseloads and staffing across community services. • Improved staff recruitment and retention. • Waiting times measuring in the top quartile in England.	
CARE IN THE RIGHT PLACE • Integrated care between primary care and mental health teams to enable more person-centred care and a greater focus on adults with severe mental illness. • High quality inpatient facilities that provide timely care, by an expert team in a therapeutic and compassionate environment. • Worked together with our Local Authority partners to develop solutions to the housing and employment pathway challenges.	Enabled by: • Increased funding into mental health, benchmarked with other areas nationally, in line with the medium-term financial plan, alongside increased productivity of services • Allocated resource based on need. • Consistent suite of outcome measures to demonstrate the value delivered

Proposed phasing

	Ambition	Year 1	Year 2	Year 3	Year 4	Year 5
RAISED AWARENESS AND PROMOTING WELLBEING	Every resident knows how to access mental health support both in crisis and more widely in the community	• Agree local demographic data and local insights to understand barriers to access • Identify target groups with lower access	• Develop outreach models	• Implement outreach models for target groups with barriers to access/ lower levels of access		
	An assets-based approach to promoting mental health, wellbeing and independent living	• Review community mental health support offer • Develop common support offer	• Review delivery partner capacity	• Build capacity in VCSE to enable greater testing/ delivery of models		
INCREASED EQUITY AND EQUALITY	Increased equity and equality of service access to reflect different needs of our local and diverse communities, with targeted support for SMI	• Identify target groups with largest variation • Identify actions to reduce variation	• Take forward actions to reduce variation in outcomes and experience			
	A consistent core offer for community and crisis care for adults, with focus on SMI, that also enables flexibility for local and diverse needs	• Review current offer(s) • Develop common community and crisis offer	• Move towards common offers using productivity improvements and/ or resource			
	Reduced variation and increased productivity in caseloads and staffing across community services	• Single approach to monitoring, baselining and evaluation to identify areas for action	• Embed QI approach, with initial focus on older adults	• Agree further set of initiatives, with continued shared learning		
	Improved staff recruitment and retention	• Recruitment to the top five hard to fill vacancies (MH nurses)				
	Waiting times measuring in the top quartile in England	• Develop standard approach to waiting well information across all services	• Identify services that have the longest waits or greatest need, along with indicative opportunities	• Take forward opportunities, better informed by population health management		
CARE IN THE RIGHT PLACE	Integrated care between primary care and mental health teams, with focus on SMI		• Consider further opportunities of Mental Health ARRS in primary care	• Mapped to the further development of Integrated Neighbourhood Teams		
	High quality inpatient facilities	• Review inpatient facilities in line with developing plan	• Implement as per Inpatient Quality Transformation Plan			
	Develop solutions to the housing and employment pathway challenges	• Expansion in employment advisors in Talking Therapies	• Identify opportunities with LA on housing pathway	• Take forward opportunities, better informed by population health management		

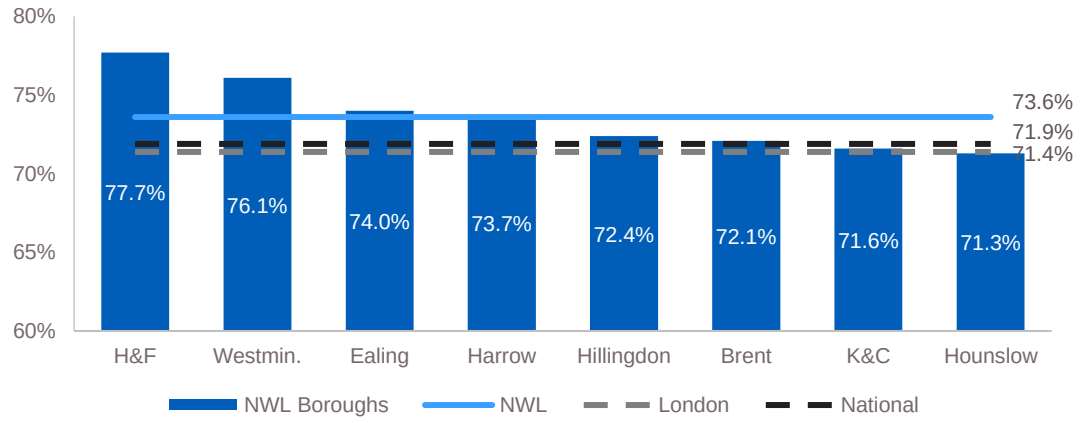
Appendix 1 – supporting information for needs assessment

NHS
North West London

~75% of people in North West London self report high happiness/ satisfaction this drops to below 30% for those with a high anxiety score

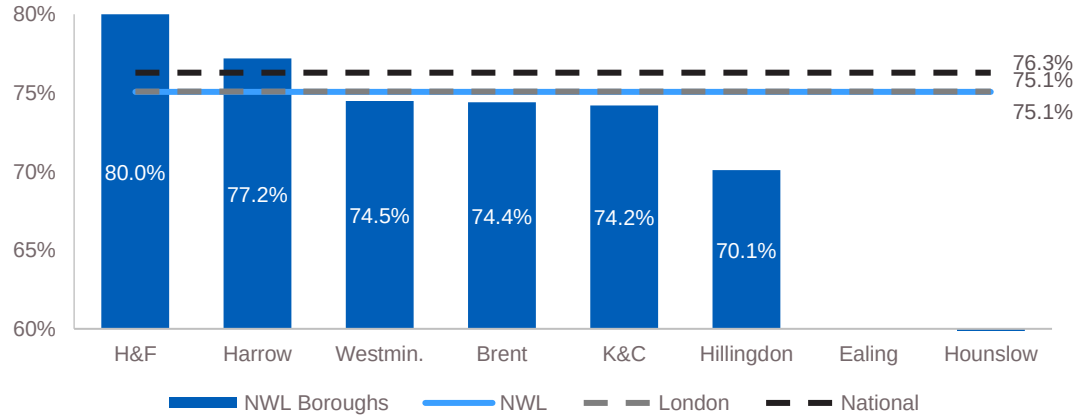
Self-reported happiness
Percentage of respondents with a high score [2020/21]

Source: Public health profiles, OHID, 2020/21



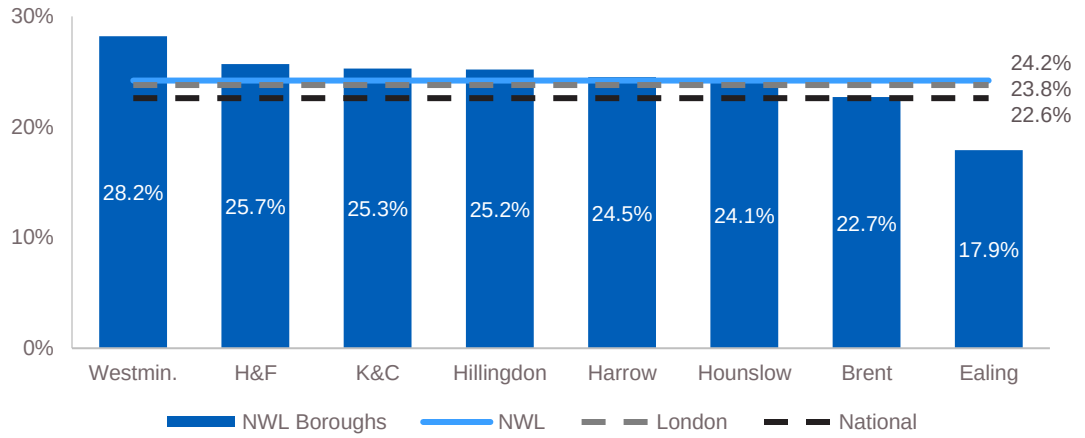
Self-reported satisfaction
Percentage of respondents with a high score [2020/21]

Source: Public health profiles, OHID, 2020/21



Self-reported anxiety
Percentage of respondents with a high score [2020/21]

Source: Public health profiles, OHID, 2020/21

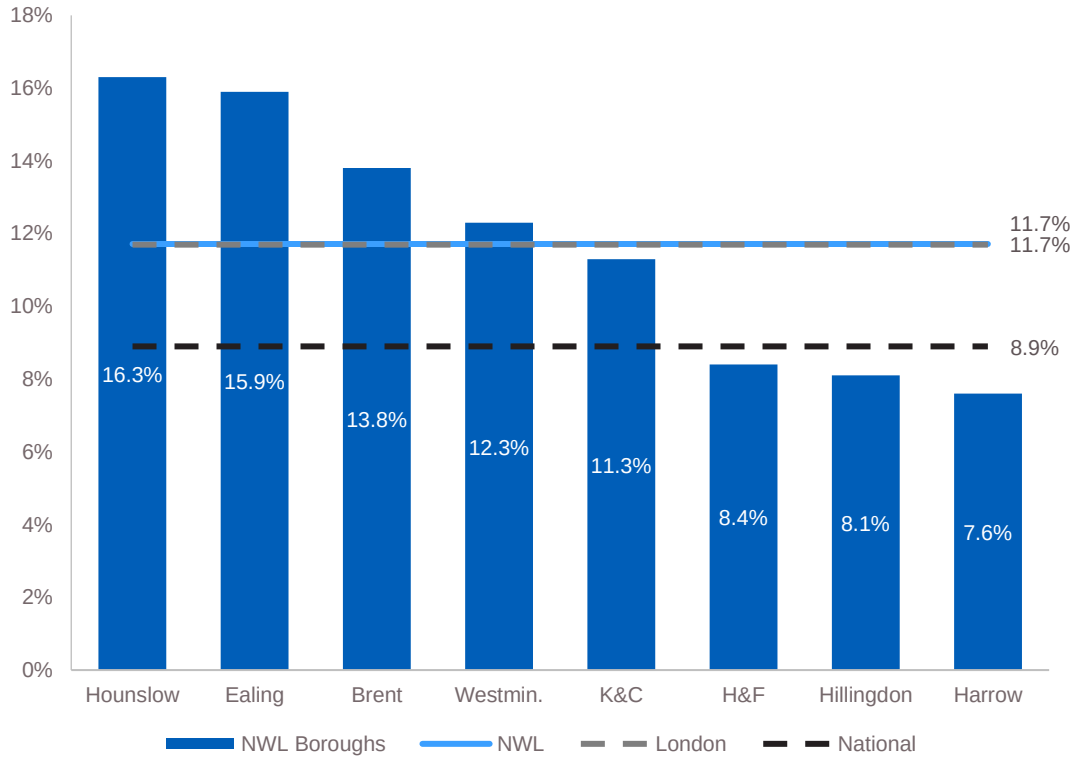


NHS North West London

Smoking rates are higher amongst adults with a long term mental health condition – and vary across Boroughs

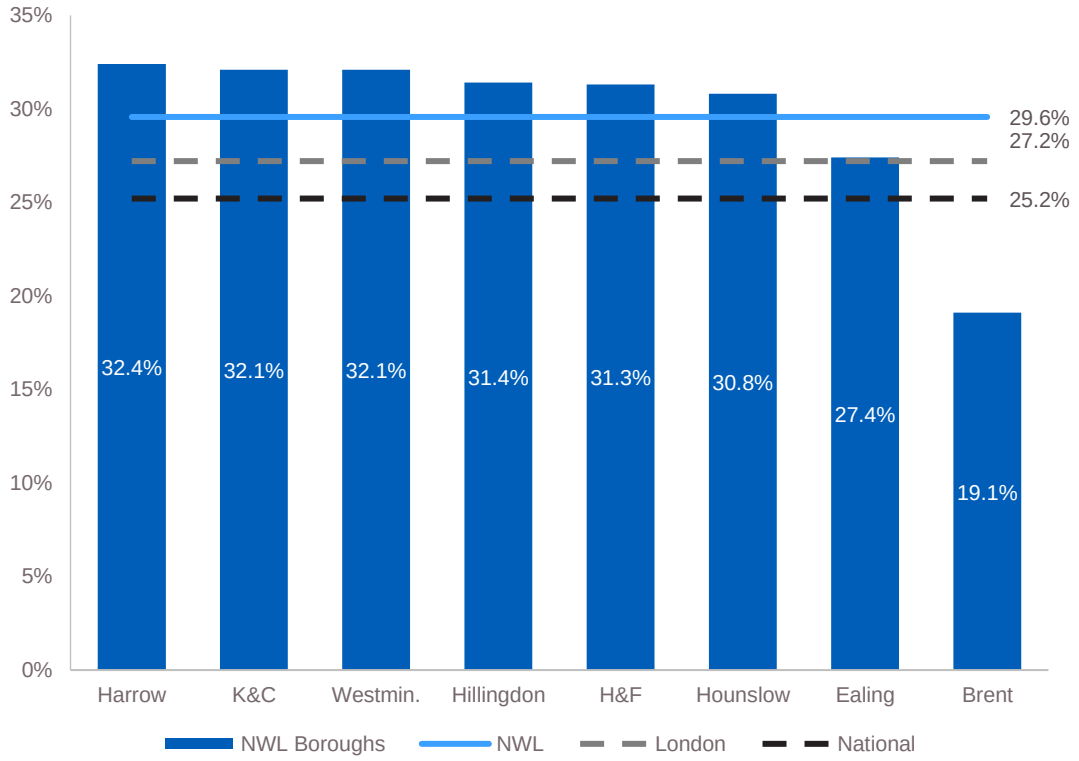
Smoking prevalence in adults (18+)
Current smokers as a percentage of adult population [2022]

Source: Public Health England, 2022



Smoking prevalence in adults with a long-term MH condition:
Current smokers as a percentage of population with MH conditions [2021/22]

Source: Public Health England, 2021/22

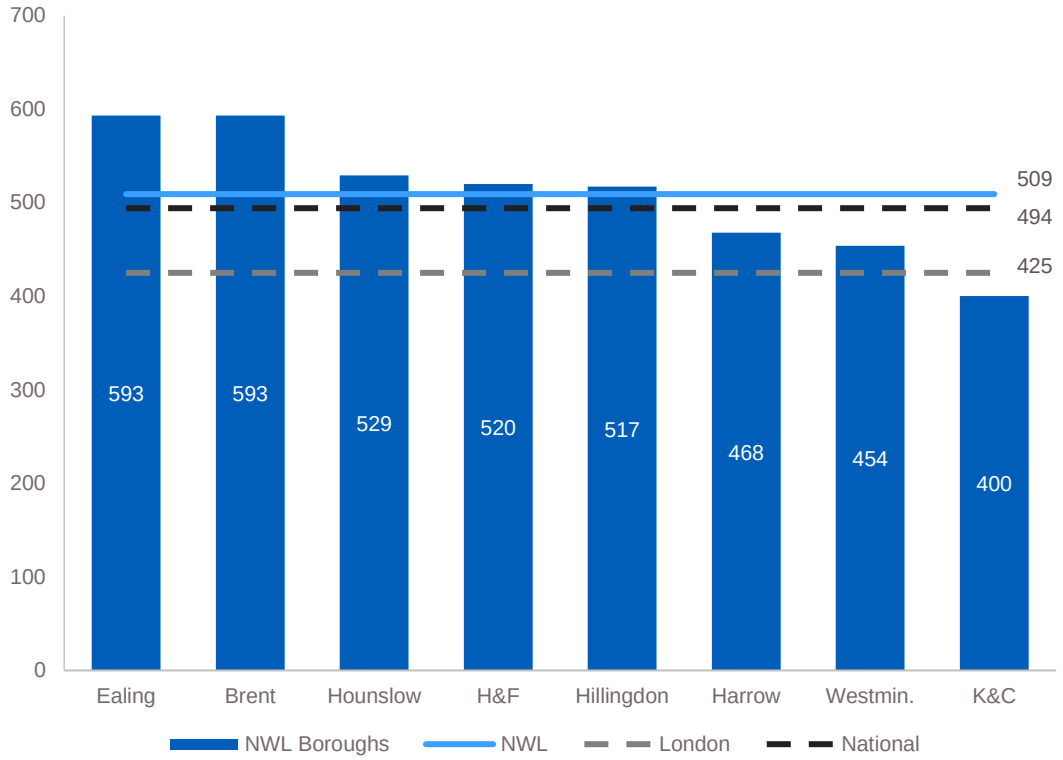


North West London

Alcohol misuse is a risk factor for poor mental health, with variable levels of prevalence and variable success rates

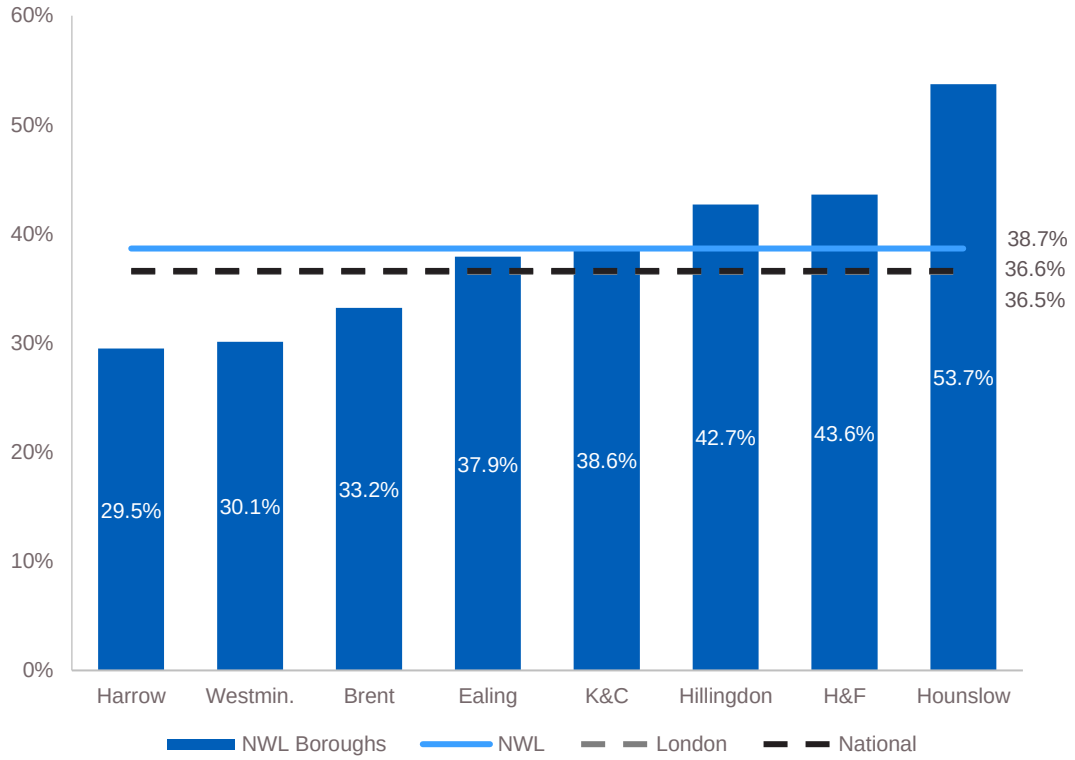
Admission episodes for alcohol-related conditions: Number of episodes (primary diagnosis) per 100,000 standardised population [2021/22]

Source: Public Health England, 2021/22



Successful completion of structured alcohol treatment: Percentage of alcohol users that left treatment successfully [2021]

Source: Public Health England, 2021/22

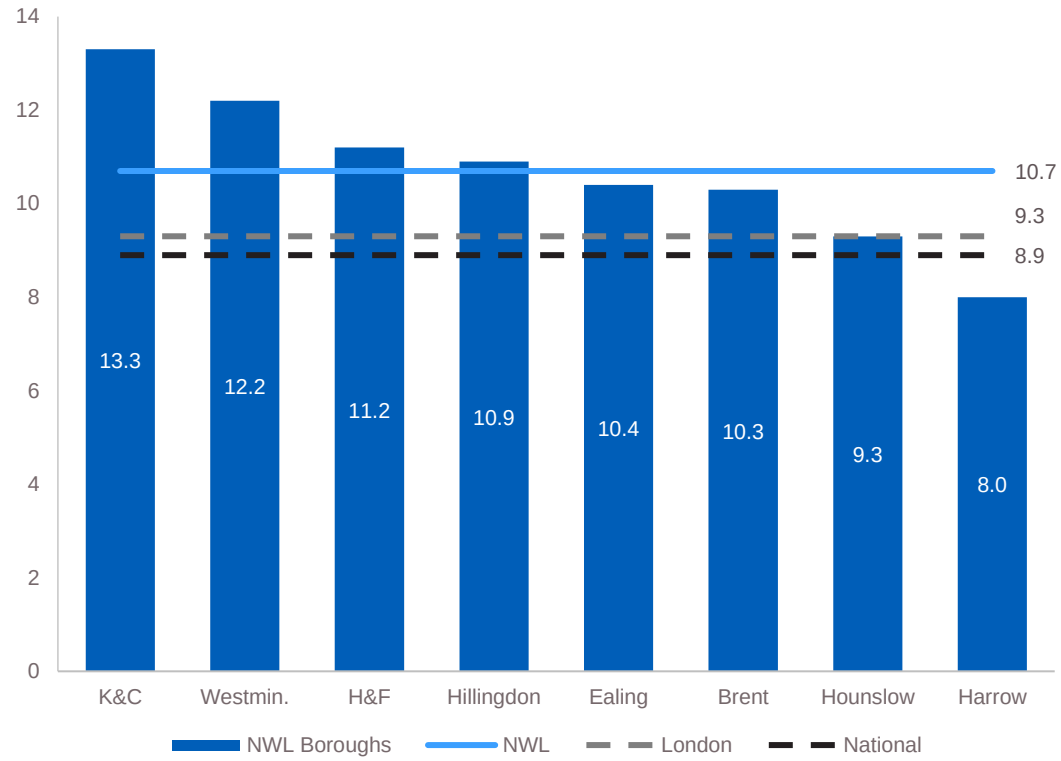


NHS North West London

Drug misuse is also a risk factor for poor mental health, with variable levels of prevalence and variable success rates

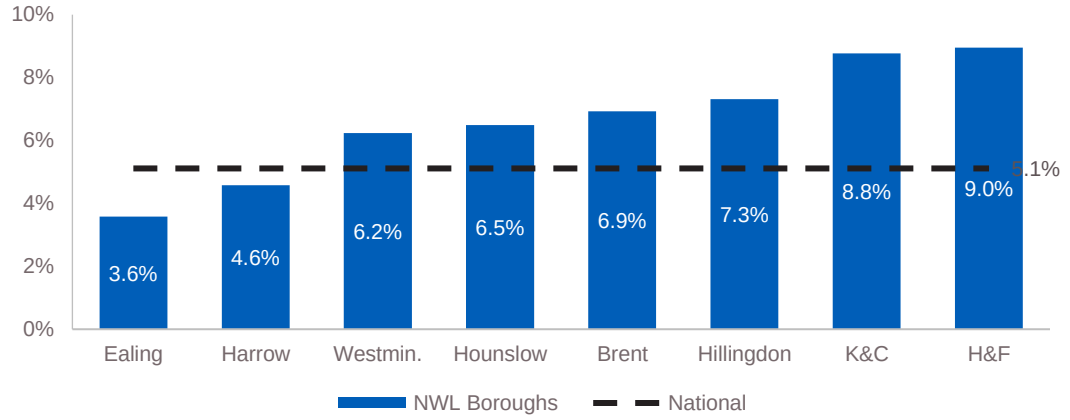
Estimated prevalence of opiate and/or crack cocaine use
Crude rate per 1,000 population aged 15-64 [2016/17]

Source: Public Health England, 2016/17



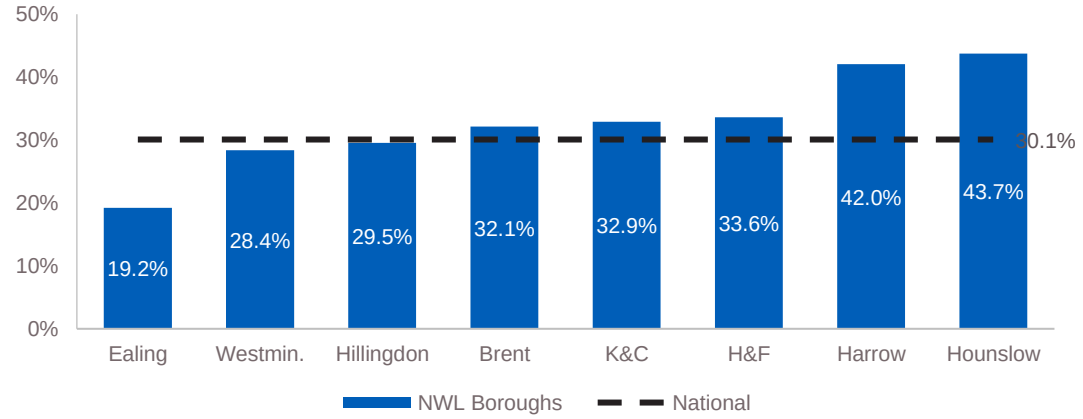
Successful completion of opiate treatment:
Percentage of treatment plans completed [August 2022 – July 2023]

Source: National Drug Treatment Monitoring System (NDTMS), 2023



Successful completion of non-opiate treatment
Percentage of treatment plans completed [August 2022 – July 2023]

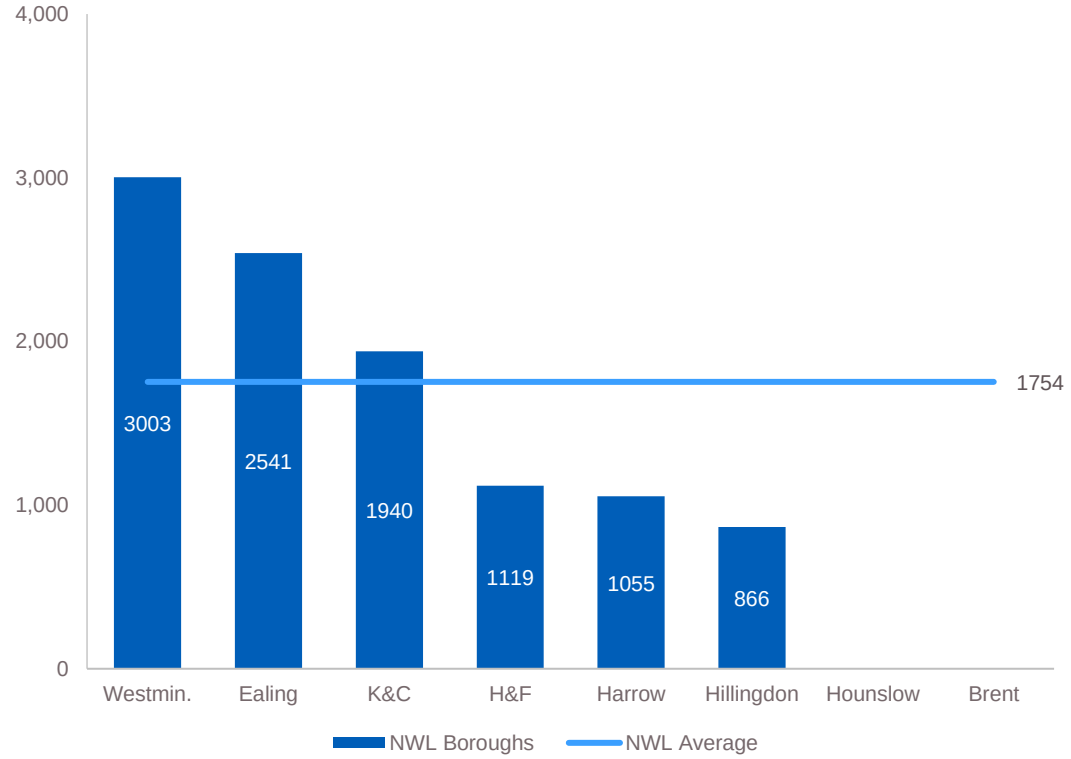
Source: National Drug Treatment Monitoring System (NDTMS), 2023



Housing is a challenge for c. 1/3 of people with more severe mental health conditions

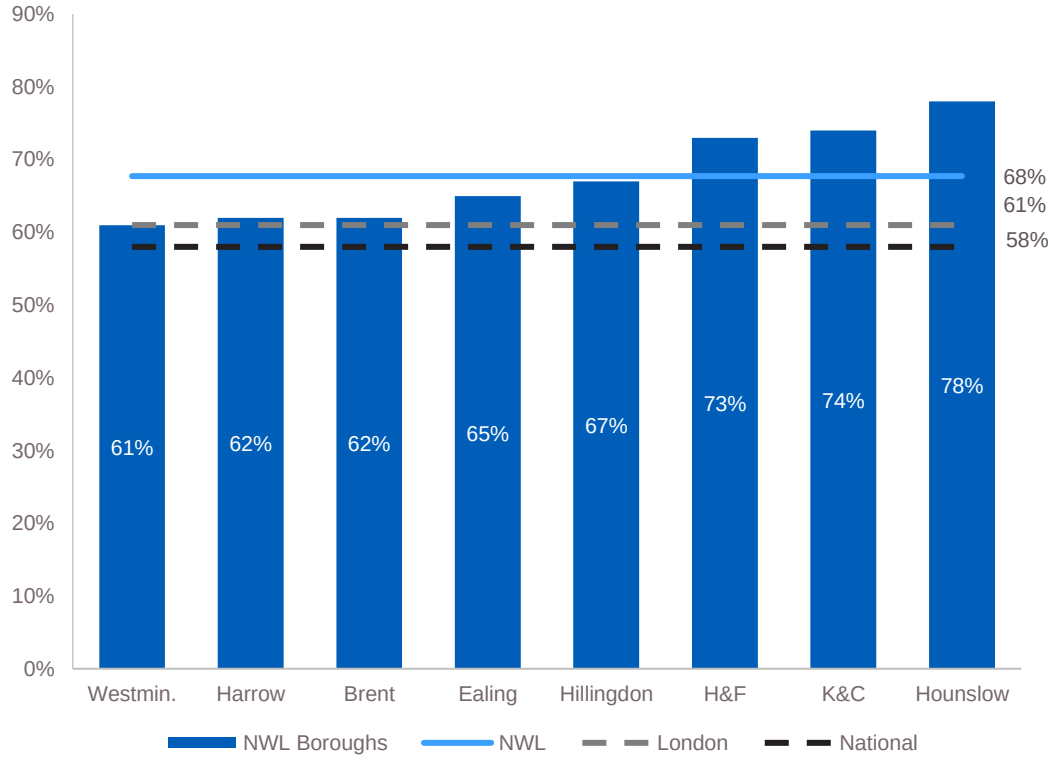
Homelessness: households in temporary accommodation
Total number of households [2023 Q1]

Source: Gov.uk, 2023 Q1



Adults receiving secondary MH services who live in stable and appropriate accommodation: Proportion of adults [2020/21]

Source: Public Health England, 2020/21

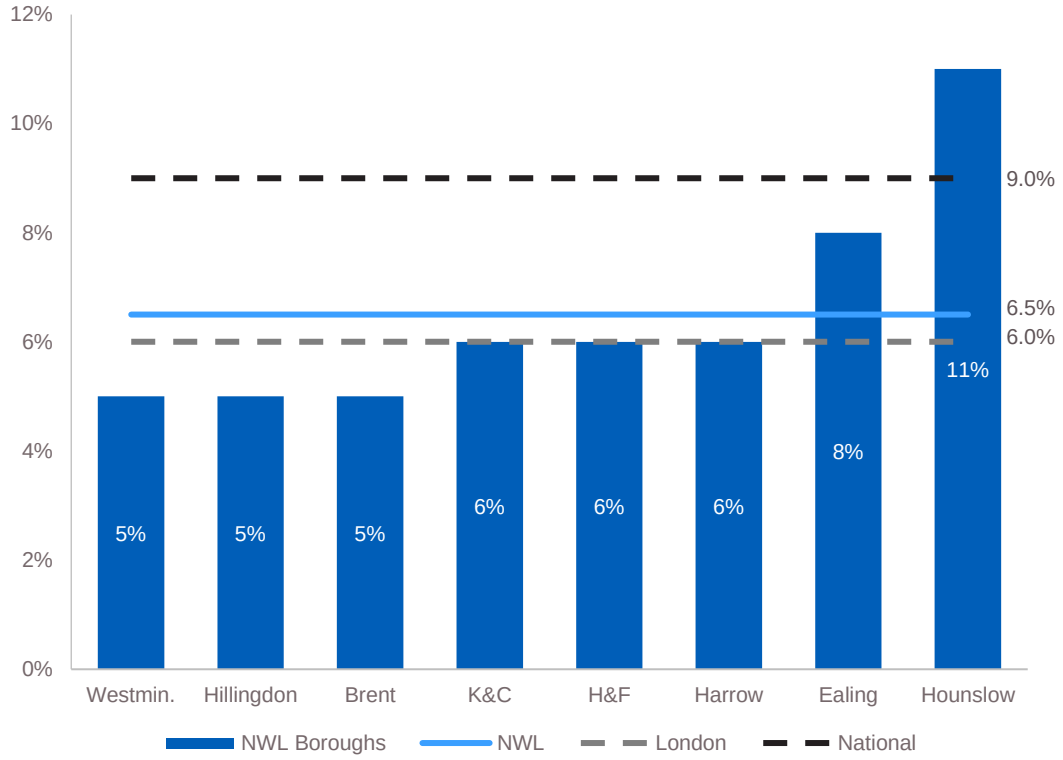


North West London

Less than 3% of people in contact with secondary mental health services are in paid employment – versus over 60% with a physical/mental long term condition

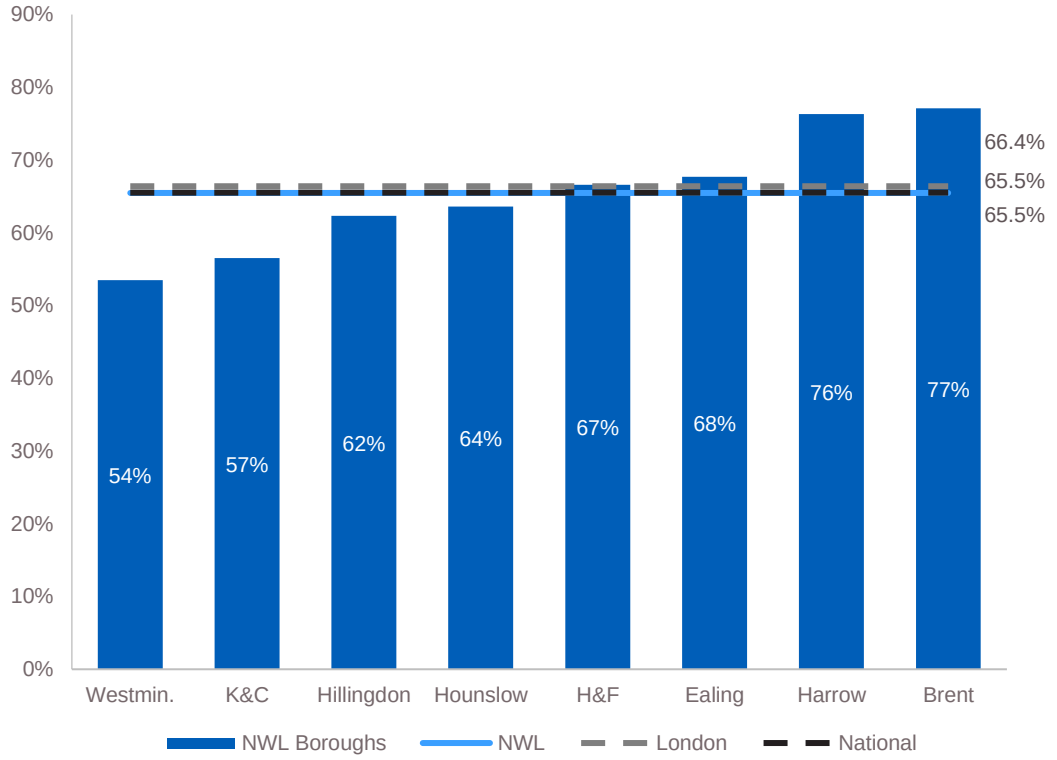
People receiving secondary MH services who are in paid employment: Proportion of people [2021/22]

Source: Public Health England, 2021/22



People with physical / mental LTC who are in paid employment: Proportion of people [2021/22]

Source: Public Health England, 2021/22

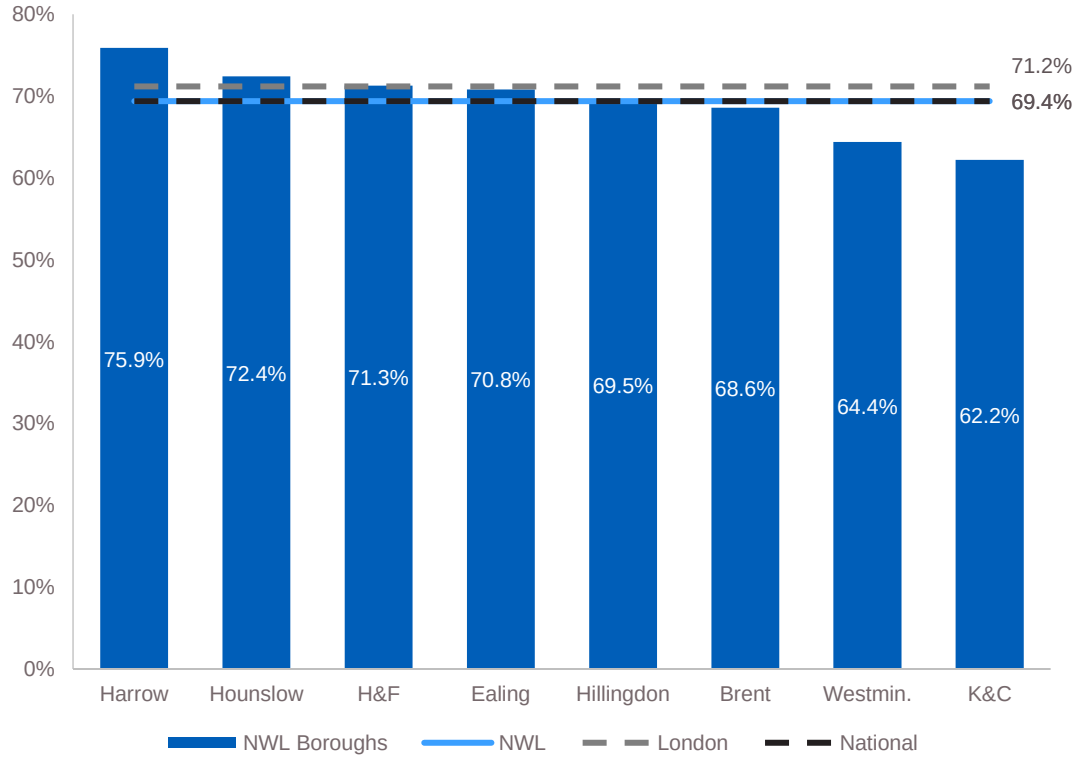


NHS North West London

People helped into employment are less likely to need support from community mental health services and have further inpatient admissions

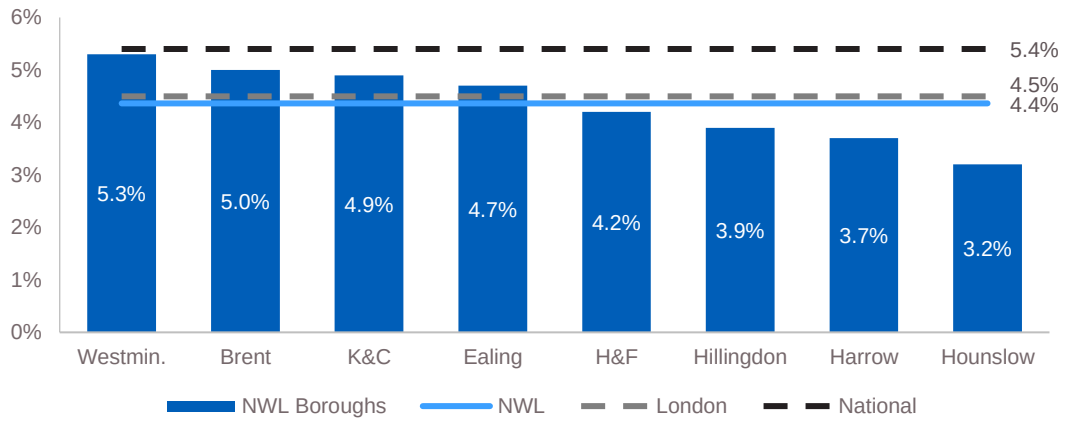
Gap in employment rate for those who receive secondary MH services: Percentage point difference with overall rate [2021/22]

Source: Public Health England, 2021/22



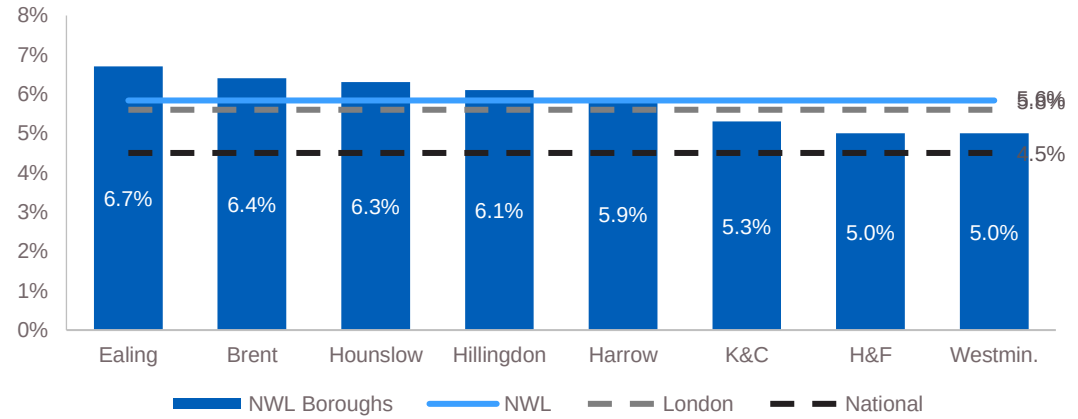
Employment and support allowance claimants: Proportion of population [2018]

Source: Public Health England, 2018



Unemployment rate: Percentage of over 16 population who are unemployed

Source: NOMIS – Labour Force Survey, 2021-22



Other risk factors related to mental health problems

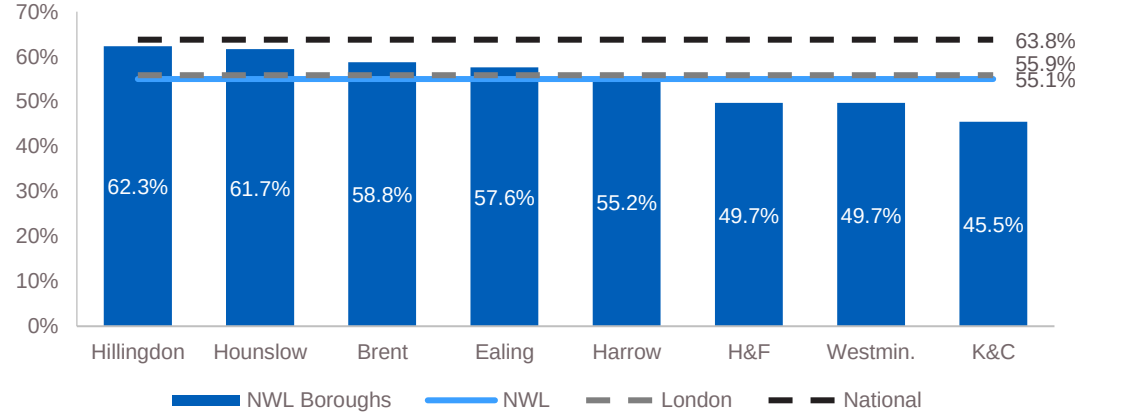
Fuel poverty (households with low income, poor energy efficiency, energy prices): Proportion of households in fuel poverty [2020]

Source: Gov.uk, 2020

Percentage of population classified as overweight or obese

Percentage of over 18 population [2021/22]

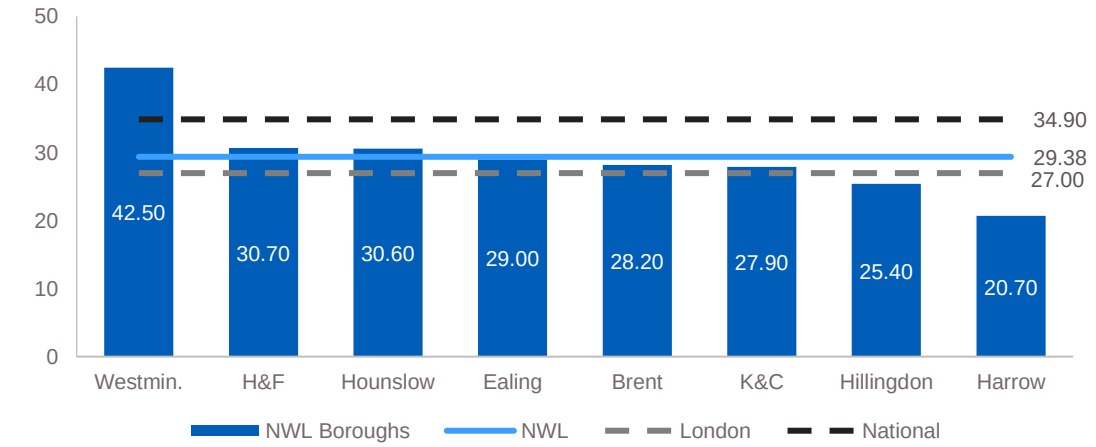
Source: Public Health Outcomes Framework, 2021/22



Violent crime rate:

Violent offences per 1,000 population [2021/22]

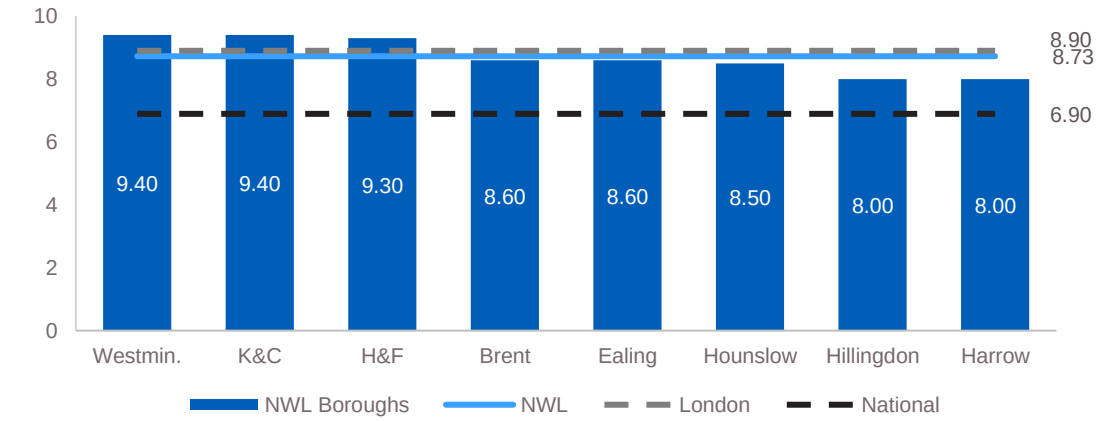
Source: Public Health Outcomes Framework, 2021/22



Air pollution:

Mean fine particulate matter in micrograms per m3

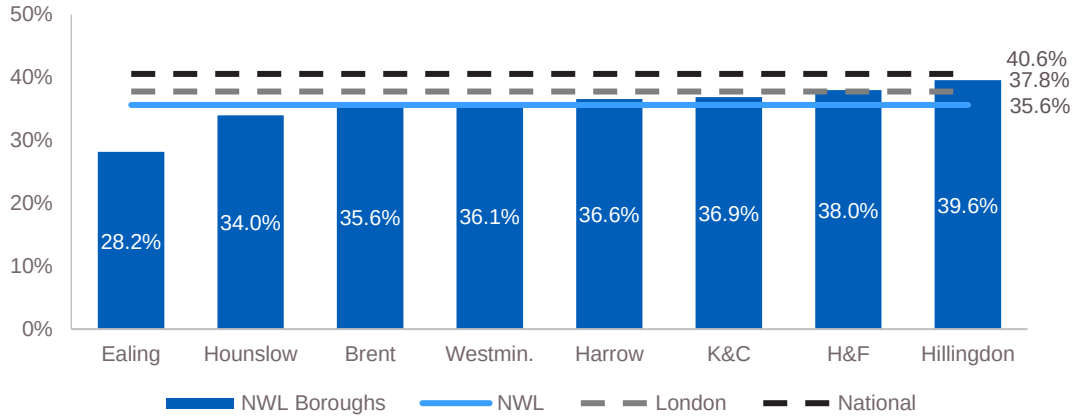
Source: Public health profiles, 2020



Social interaction and physical activity are vital to good mental health

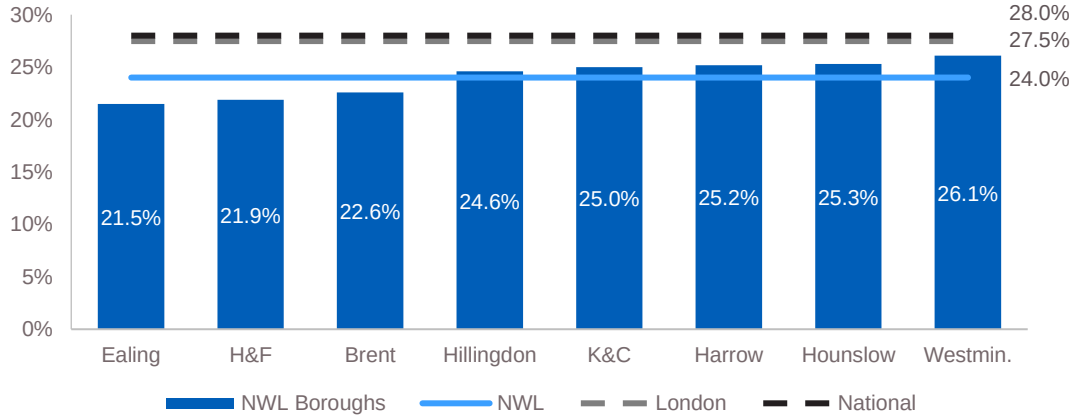
Social isolation (adult social care): Proportion of adult social care users who have as much social contact as they would like [2021/22]

Source: Public Health Outcomes Framework, 2021/22



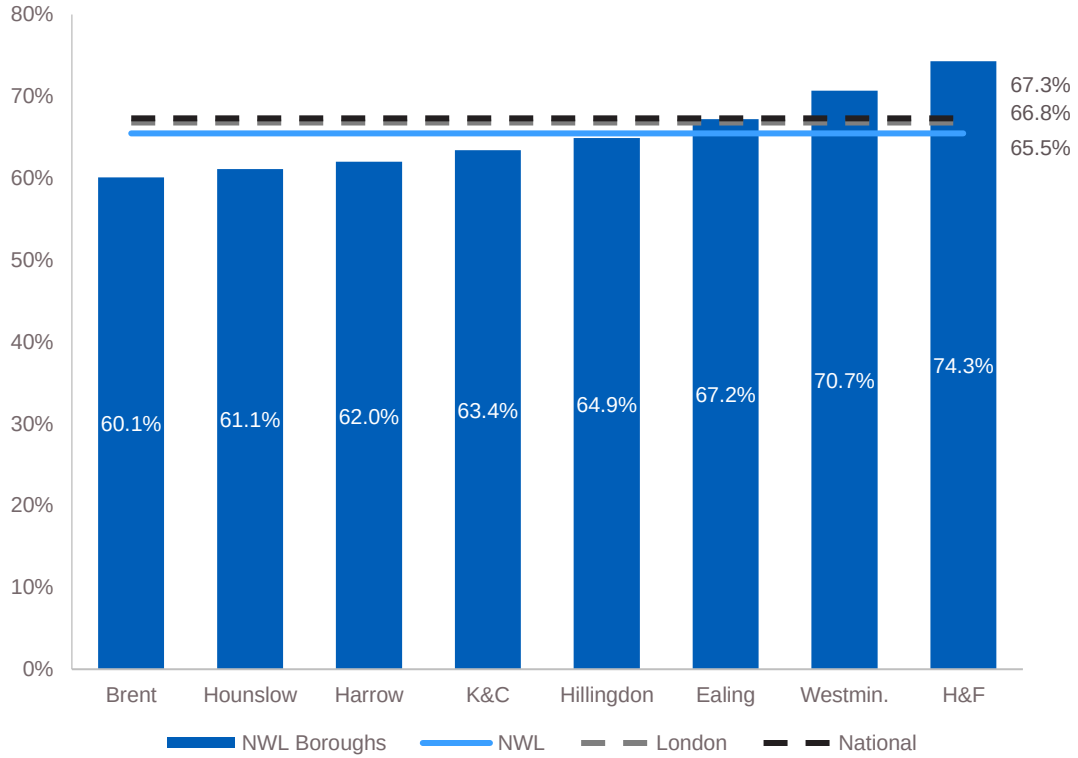
Social isolation (adult carers): Proportion of adult carers who have as much social contact as they would like [2021/22]

Source: Public Health Outcomes Framework, 2021/22



Physical activity: Percentage of adults who are physically active [2021/22]

Source: Public Health Outcomes Framework, 2021/22

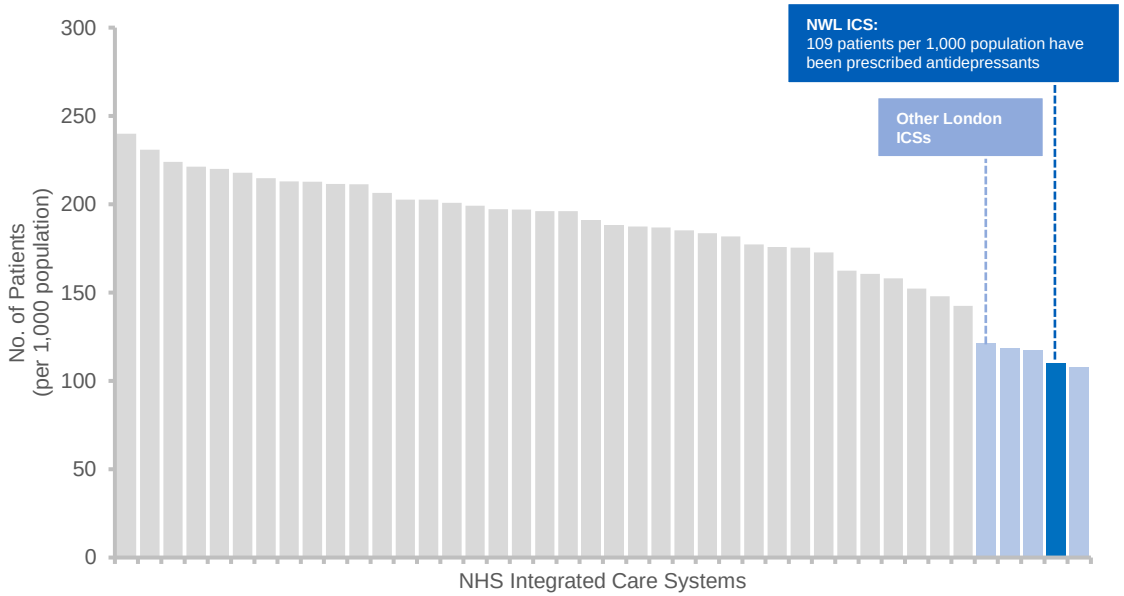


North West London

North West London has one of the lowest levels of antidepressant prescribing in the country, though this has grown 14% since the pandemic

No. of patients prescribed antidepressants

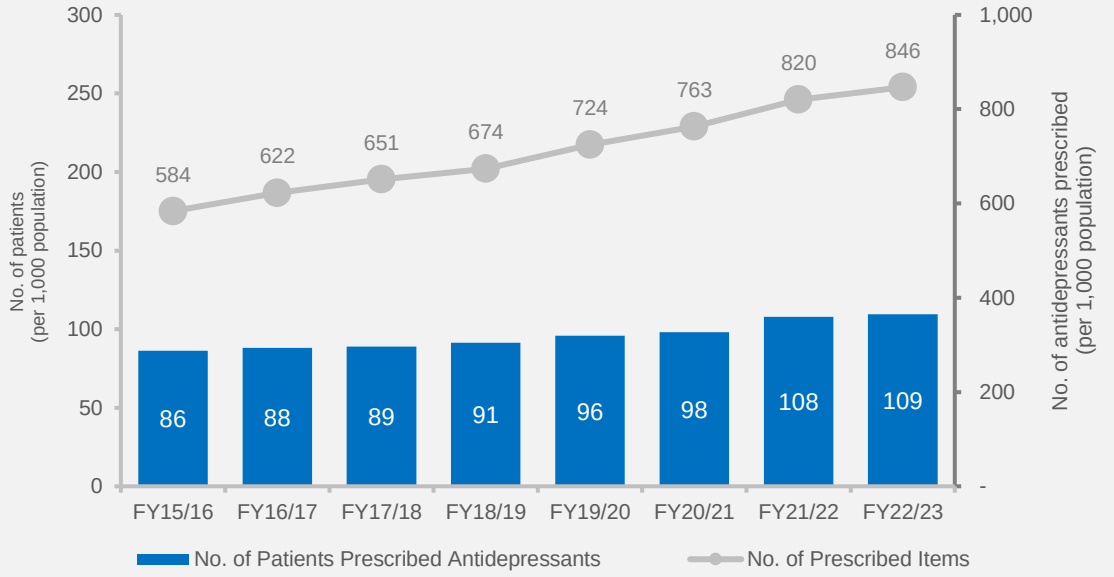
per 1,000 population: FY22/23



- **North West London ICB** has the **2nd lowest** level of antidepressant prescribing.
- **This is in line with other London ICBs**, which together have significantly lower levels of antidepressant prescribing than other England ICBs.
- **The national median is 190 patients per 1,000 population** being prescribed antidepressants – **72% higher than NWL.**
- North East and North Cumbria (NENC) ICB has the highest rate of antidepressant prescribing, with 240 patients per 1,000 population being prescribed antidepressants.

No. of patients and no. of antidepressants prescribed

per 1,000 population: FY16 – FY23



- North West London ICB's level of antidepressant prescribing has **grown 3% year-on-year** over the **past 8 years,** with **total growth of 27%.**
- The level of antidepressant prescribing has **grown 14% since the COVID-19 pandemic.**
- The no. of antidepressants prescribed has grown at a higher rate – **4.8% year-on-year**, with **total growth of 45%,** suggesting patients with depression are taking more antidepressants than previous levels.

Source: NHS BSA Medicines Used in Mental Health Dataset (2015/16 – 2022/23)

Appendix 2 – workforce priorities

NHS
North West London

Mental Health Strategy: Workforce priorities 2024-2026

WF priority	Initiative	Outcomes
Recruitment and retention	• Recruitment to the top five hard to fill, high impact roles that are a core driver for temporary staffing usage: 1. Mental Heath nurses 2. Psychiatrists 3. Occupational therapists 4. Psychologists; and 5. Social workers	Meet the collective target: • Vacancy rate of 10% or below
	• Increase retention of current staff by making our organisations better places to work through the implementation of the exemplar initiatives within the People Promise themes	• Voluntary Turnover Rate at 12% or below
	• Recruit refugees, care leavers, volunteers (including service users) into employment each year through Care leavers, refugee and volunteers schemes	• Agreed number each year each year
Equality and diversity	• Diversify senior leadership and improving experience of black and minority ethnic staff	• Achieve ICS model employer goal of 50% by 2025
	• Agree collective and organisational action to implement the medium term interventions that will embed equality, equity, social and racial justice within our organisations	• Sustained improvement against all 9 indicators of the Workforce Race Equality Standard and the Annual Staff Survey
	• Diversify routes into employment to provide a more inclusive pipeline of staff into roles into our allied health, psychological professions and support the new NWL graduate scheme	• Demographic workforce data

Mental Health Strategy: Workforce priorities 2024-2026

WF priority	Initiative	Outcomes
Education and training	• Ensure that the development of a multi professional Education strategy at ICS level reflects the needs of the mental health workforce	• Education Strategy with Mental health delivery Plan
	• Allocate places to NW London Graduate Leadership scheme with rotations across all organisations	• Annual cohort of graduates agreed
	• Expand number of apprenticeships and use this route to widen access and diversify entry into professional registered roles	• Increase by apprenticeship from xx to yy
	• Review clinical placement capacity to support expansion of apprenticeships and student training numbers	• Additional capacity identified in each provider
	• Deliver the Oliver McGowan Mandatory Training via the training academies across all organisations as well as continuing a focus on cultural competency and trauma informed practices	• 30% of staff completing the training each year
Workforce transformation and productivity	• Promote, monitor and track new role development focusing on RNDAs, Psychology CAP roles, advance practice and scope feasibility of physician associate roles	• Track increase in number from 2023 baseline
	• Workforce transformation to redesign new ways of working required to support community based models of care through Integrated Neighbourhood Teams	• tba
	• Support teams and services to make productivity improvements, ensuring skill sets such as QI are developed to support this	• tba
	• Ensure that all the rules for providers on agency expenditure, collectively known as the ‘agency rules’ are enforced and put in measures to reduce reliance on the use of agency staff	• Comply with a ceiling for total system agency expenditure