South London and Maudsley NHS
NHS Foundation Trust
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Proposed Changes to Lewisham Adult Mental Health Services

May 2013

Foreword

We would like to make changes to NHS adult mental health services in Lewisham. We hope to invest over the next year to reorganise the way our community teams work.

These changes are being driven by a number of factors, including the need for us to identify more cost effective ways of working and respond to reductions in the resources available to NHS and social care in Lewisham. At the same time, we are working with health, social care, primary care and voluntary sector partners in the local area we serve to look at how the whole system of care can be organised better so that patients receive high quality care and we make most effective use of the resources available to us.

We believe we could be better at supporting patients with serious mental health problems in their recovery. By reorganising our teams to deliver care based on the best evidence of what works, we can focus on supporting the most unwell patients, helping to prevent them from relapsing and having to be readmitted to hospital. If this proves successful, it should over time reduce dependence on hospital care. If we can reduce the cost of hospital care we can reinvest resources into other services.

We also want to improve how we respond to people when they become unwell, either for the first time or in a crisis by aligning our teams with Lewisham's primary care neighbourhoods so that we can be more responsive to GPs during extended surgery hours and provide faster assessments of people in mental health crisis.

For people who no longer need formal treatment we want to work more closely with GPs and voluntary groups to help support their independence. And for people with stable mental health needs, making the journey back to the care of their GP we will develop new teams to help and support them through their recovery.

Changing the way we do things now is the best way for us to ensure we can provide a service tailored to the needs of Lewisham residents in future. We have to adapt not only to the financial environment but to other factors, including an ageing population and changes to the way our services will be commissioned in future. The world is changing and we have to change with it. The changes we are proposing build on the work we have done over the last decade or more to help people at an early stage in their illness, rather than reacting when they reach 'crisis point' when the only option available is to admit them to hospital. It is about focusing upon recovery rather than just treating illness. We believe that our proposals could help us to make a lasting difference to people's experience of mental health care and support our goal of improving mental health for all.

Dr Martin Baggaley, Medical Director

1. Executive Summary.

Significant review and engagement work has taken place in Lewisham since 2010 to agree a new model for community adult mental health services. The process, led initially by Lewisham Primary Care Trust, in partnership with a range of stakeholders, GPs and South London and Maudsley NHS Foundation Trust, identified a number of key changes that need to take place to improve local services and in particular, to ensure that service users receive care within the most appropriate settings.

In addition to improving the quality and responsiveness of the service, attention was given to cost and productivity, and in line with the PCT 3 year QIPP development plan, financial efficiencies in the region of £800K were identified, most of which would have required reduction in staffing.

During this developmental phase, SLaM was involved in similar service reconfigurations in other boroughs and came to understand that there was a strong link between the removal of resource and concerns about quality. Reduction in community investment tended to lead to increased caseload sizes, resulting in teams becoming focussed almost exclusively on crisis work. This led to increased inpatient admissions and less proactive working with people using the recovery approach – thus leading to greater caseload sizes and relapse rates among service users who could have remained well.

Identifying these as possible risks to Lewisham services, led the Clinical Commissioning Group (CCG) and SLaM to reconsider the existing plan and to explore a proposal whereby resources were not removed from community services. Instead consideration could be given to the redesign of community team care pathways to make significant improvements to the rate of relapse and associated hospital admission rates. Such an approach would focus on diverting patients away from hospital settings and providing treatment in the community thereby identifying financial efficiency related to inpatient beds rather than from community teams.

In this paper we propose an enhanced adult mental health model with three key area of focus. **1. Relapse prevention**; requiring the remodelling of community teams to systematically deliver interventions that have good evidence in treating and supporting patients with serious mental health problems in their recovery and in reducing their relapse. This approach is very innovative and should reduce dependency in the medium - longer term for hospital based care. **2. Improving the capacity and competency of assessment and crisis resolution services**. Configured in line with the four primary care neighbourhoods and echoing similar reconfigurations of adult social care staff, the mental health assessment teams will have the

ability to respond to GPs during extended surgery hours and to respond in a timely manner to crisis situations. **3. Provide new pathways for people not requiring secondary services.** To be achieved through working closely with GPs and other voluntary sector providers to support the independence of people no longer requiring formal treatment. This will also be supported through the development of Low Intensity Teams (LIT) who will carefully facilitate the transition of care between secondary and primary for people with stable, non relapsing mental health needs.

The scale of the financial efficiencies that can be delivered from a reduced dependency on hospital based care is significantly dependent on community mental health teams' ability to reduce relapse. This impact is contingent on the capacity of the community mental health team and their ability to introduce new levels of skilled intervention. As such, SLaM is in discussion with the CCG about possible investment into Lewisham adult services to help facilitate a greater pace of change, improvement and efficiency.

2. Current Adult Mental Health Services.

The current adult mental health services in Lewisham were developed in line with the National Service Framework (NSF) for mental health. The frameworks and standards prescribed within this process were designed to improve quality of care for people with serious mental health problems and to address variation in approaches to care provision that had developed over time.

Implementation in Lewisham (1999), was achieved by enhancing the services delivered from the three existing community mental health teams (CMHT) at Northover, Southbrook Road and Speedwell, who each developed the following additional service components; Community Forensic, Assertive Outreach, Early Intervention and Home Treatment Teams.

These services have served the borough well. However, recent guidance; New *Horizons* and *Next Stage Review* papers of 2009, and *No Health Without Mental Health* paper of 2011, require services to give a greater emphasis to delivering services that promote self-directed support, self-management, personalisation, and a shift of emphasis to maintain more people in primary care with input from third sector providers.

In addition to national changes, local developments at South London and Maudsley NHS Foundation Trust have provided an opportunity for delivery of innovative service approaches, based on the translation of clinical evidence, into services for local patients. This approach is a

key element of the approach taken by King's Health Partners, which is one of three Academic Health Science Centres (AHSC) in London, and in which SLaM is a partner.

On becoming a member of the AHSC in (2011), SLaM reconfigured its service delivery approach to one of Clinical Academic Groups (CAGs). Each CAG brings together clinical services, research and education to focus on the needs of particular groups of service users. The CAGs involved in this review are; Psychosis CAG, Mood, Anxiety and Personality (MAP CAG) and Psychological Medicine CAG.

Each CAG, through its close working with research activity and training, has developed clinical care pathways designed to improve the quality of patient care and outcomes through the delivery (where commissioned) of evidence based care and interventions.

The process of implementing CAG structures and associated care pathways has not yet been fully implemented in Lewisham.

The current configuration of community services for adults with mental health problems is fully integrated with London Borough of Lewisham Social Services and provides integrated mental health and social care in the following teams:

- Assessment and Brief Treatment: dealing with new referrals to the service, crisis intervention and short term work. Provided by the Mood, Anxiety and Personality CAG.

- Early Intervention: working with young people with a first or second episode of psychosis from 18 to 35 years old. Provided by the Psychosis CAG.

- Forensic Service: working with people who have a history of offending in the context of their mental illness. Provided by the Complex Care pathway of the Psychosis CAG.

- Home Treatment Team: 7 days a week, extended hours, borough wide community based acute treatment at home as an alternative to treatment in hospital. The service mainly provides crisis planning, support in maintaining and improving social networks and also looks to prevent a relapse. Provided by the Psychological Medicine CAG.

- Support and Recovery Services are for people who suffer severe and enduring mental illnesses. The service provides interventions and treatment to people with complex needs who have difficulty engaging with services and often require repeat hospital admission.

- Integrated Psychological Therapy Team (IPTT) provides assessment and delivery of a full range of therapies to people with complex psychological needs. The service was recently

reconfigured to bring together a range of services delivered in Lewisham and at the Maudsley Hospital. Provided by the MAP CAG.

- IAPT (Increasing Access to Psychological Therapy) provides therapy; primarily cognitive behaviour therapy and counselling to people at a primary care level. Implemented in 2009, the service provided treatment to 4559 patients, which equates to 12% of those in Lewisham experiencing depression or anxiety.

Further detail of the current services; staffing and caseload, are listed in Appendix A.

3. Approaches to developing proposed changes.

Identifying the key areas for future change was developed in a series of stakeholder events focused on developing mental health improvement plans to respond to NHS Quality, Innovation, Productivity and Prevention (QIPP) requirements.

The first seminar took place on 30th September 2010, led by Joint Commissioning with the two lead Mental Health GPs, lead SLaM clinicians and management and London Borough of Lewisham (LBL) staff, and was attended by 40 people. A second Mental Health QIPP meeting was held at the 11th Lewisham Mental Health Stakeholder Event in November 2010 open to all members of the general public attended by some 250 people. The event was coordinated by Lewisham Mental Health Partnership Board (MHPB) of Lewisham CCG, South London and Maudsley NHS Foundation Trust (SLaM) Lewisham Adult Services and London Borough of Lewisham. Again some 40 people attended the second event including GPs, service users, cares, voluntary sector and SLaM staff. Follow up workshops were held at subsequent years' Lewisham Mental Health Stakeholder Events.

Plans concerning mental health QIPP re configuration has also been discussed at the following meetings:

- Lewisham Mental Health Partnership Board
- Lewisham Mental Health Commissioning Executive
- NHS Lewisham Clinical Commissioning Executive Committee
- South London and Maudsley NHS Foundation Trust (SLaM) Core Contract meeting
- LBL Community Services Directorate Management Team Meeting
- NHS Lewisham Senior Management Team Meeting
- NHS Lewisham and LBL Adult Joint Strategic Commissioning Group
- NHS Lewisham and LBL Adult Joint Strategic Partnership Board
- Mayor and Cabinet when LBL savings are required
- NHS Lewisham Board for PCT savings
- All Mental Health voluntary sector providers commissioned
- Joint Consultative Forum – SLaM led patient and voluntary sector forum
- Healthier Communities Select Committee

In November 2012 focus groups were organised by service user consultants with the specific aim of gaining input into the emerging proposals: three groups for service users and one for carers were held on the 13th, 14th, 15th and 16th November 2012. In addition a meeting with Lewisham Users Forum was arranged for the 20th of November, and a meeting on the 21st with Family Health Isis. Commissioners and staff from SLaM also attended GP neighbourhood meetings where possible to discuss priorities from primary care, and jointly held two workshops as part of the Lewisham Mental Health and Wellbeing Day on the 7th of December. Overall some 150 people participated in these events.

4. Feedback from stakeholders

The following issues have been identified from stakeholder feedback as pertinent to improving Lewisham Adult Community Mental Health Services;

- Setting clear thresholds of eligibility for secondary care and discharge back to primary care
- Providing training to primary care to manage client group
- Ensuring consistent access to prompt advice and support from secondary care
- Ensuring primary and secondary care clinicians consistently have rapid access to clinical information as required
- Review of those that no longer require secondary care support in order to facilitate discharge
- Bolstering generic voluntary sector provision to deliver community support
- Reviewing culturally specific voluntary sector provision in line with borough demographics to deliver community support
- Recognising the support needs of those already within the Mental Health system
- Supporting secondary care clinicians to discharge people from caseloads where appropriate
- Instilling consistency across both primary and secondary care clinical teams/GPs so that people have access to the best possible treatment wherever they access care

5. Strategic Case for Change.

The following national and local priorities have also been taken into account in developing these draft proposals

5.1 No Health without Mental Health (2011)

This Department of Health guidance identified the following six objectives for mental health services

(i) More people will have good mental health

More people of all ages and backgrounds will have better wellbeing and good mental health. Fewer people will develop mental health problems – by starting well, developing well, working well, living well and ageing well.

(ii) More people with mental health problems will recover

More people who develop mental health problems will have a good quality of life – greater ability to manage their own lives, stronger social relationships, a greater sense of purpose, the skills they need for living and working, improved chances in education, better employment rates and a suitable and stable place to live.

(iii) More people with mental health problems will have good physical health

Fewer people with mental health problems will die prematurely, and more people with physical ill health will have better mental health.

(iv) More people will have a positive experience of care and support

Care and support, wherever it takes place, should offer access to timely, evidence-based interventions and approaches that give people the greatest choice and control over their own lives, in the least restrictive environment, and should ensure that people's human rights are protected.

(v) Fewer people will suffer avoidable harm

People receiving care and support should have confidence that the services they use are of the highest quality and at least as safe as any other public service.

(vi) Fewer people will experience stigma and discrimination

Public understanding of mental health will improve and, as a result, negative attitudes and behaviours to people with mental health problems will decrease.

5.2 Joint Strategic Needs Assessment.

Severe Mental Illness (SMI) describes a range of disorders characterised by psychosis, where individuals become apparently detached from reality. These conditions affect

approximately 0.7% of the UK population, and include schizophrenia and bipolar disorder (previously known as manic-depression).

Consistent with its demographic, Lewisham is thought to have substantially higher rates of SMI than England with a prevalence of 1.1% therefore affecting approximately 2900 people. About half of these are managed in primary care, with additional support for the remainder available via acute community and in-patient services.

Common Mental Illness (CMI) describes a range of mental health problems characterised by their self-limiting nature and of which a significant proportion remain undiagnosed. These conditions include anxiety/neuroses, sleep disorders and phobias. CMI is common; a third of the population suffer from CMI during their lifetime however, the majority (around 75%) go undiagnosed.

In Lewisham approximately 20% of 16-74 year olds are thought to suffer at any one time, totalling over 36,000 people annually. The consequences of CMI for the individual vary, but the effects sociologically and economically for the borough are immense. A range of talking therapies and medications are available to treat these problems, for the most part managed by GPs and psychologists.

5.3 Delivering Quality Innovation Productivity and Prevention (QIPP)

In March 2011 NHS South East London Cluster agreed to savings which would reduce the Lewisham Mental Health budget by £4.5m between 2011 and 2014. These savings form part of the contribution to the required £20 billion NHS Quality, Innovation, Productivity and Prevention (QIPP) efficiency savings.

5.4 Delivery of Care Pathways.

Care pathways are descriptions of the steps involved in treating and supporting a service user, and are designed to ensure that each service user can be clear about what care we deliver and can receive the best possible outcome. By using pathways to make sure that the right evidenced based care is provided at the right time in the right place, by the right person, services can be more efficient and provide better patient experience.

The Psychosis, Psychological Medicine and MAP CAGs have over the last 2 years, developed and piloted care pathways, taking input from staff and service users across all four boroughs to identify evidence-based best practice and trialling implementation in Lambeth and Croydon. Most of what is in the pathways is already familiar to staff as they include current practice. The difference will be the consistency of what is available to service users and a more structured approach.

The adult mental health pathways developed include:

- Psychosis: Early Intervention, Acute (inpatient services), Complex Care (inpatient placements and supported housing) , and Promoting Recovery (community teams)
- Psychological Medicine: Home Treatment Team, Liaison
- Mood, Anxiety and Personality: Engagement, assessment and stabilisation (EAI) and treatment pathways for anxiety, depression and personality disorder.

6. Key elements of proposed model.

6.1. Full implementation of care pathways and Clinical Academic Group structures.

Care pathways are designed to provide care and treatment that is focused on the needs of people with similar conditions or diagnosis. Although partially implemented, the Lewisham, community mental health teams are primarily configured in respect of the duration of care a person is likely to require, rather than in meeting the specific needs presented by people with particular conditions. As such, the full benefit of the pathways has not yet been realised.

The teams are currently divided into Support and Recovery teams who provide an ongoing service to people irrespective of diagnosis / area of need and Assessment and Brief Treatment Teams (ABT), who provide initial assessments and time limited interventions.

This generic configuration does not allow the teams to provide the dedicated care pathway focus that can benefit people with particular areas of need. It provides a sub optimal approach to people with longer term non psychotic disorders such as depression, anxiety disorders, traumatic stress disorder or personality disorder (to those cases requiring a level of input which cannot be provided by the recently formed Lewisham Integrated Psychological Therapies Service (IPTT).

Similarly the benefits of delivering a more specialised ‘Promoting Recovery’ service for psychotic illness cannot be fully realised by the current Support and Recovery teams while they continue to be responsible for managing all long term and disabling mental health conditions regardless of diagnosis.

The proposed model will allow delivery of the care pathways.

6.2. Improving Access and Interface between Primary and Secondary Care.

The initial referral for a mental health assessment (currently 1,700 per year) we believe is a crucial component of the overall mental health care system in Lewisham in respect of; the individual along with their family wanting a better experience, of the referrer

wanting a more responsive service with better communication, ourselves needing to gate keep the resources available and the commissioner wanting quality outcomes that are value for money.

We propose to enhance this 'front-end' assessment function to make it easier and quicker for GPs (and others) to refer patients into the system. This will strengthen our ability to manage demand for services and ensure that patients are directed to the most appropriate mental health service to meet their needs.

It is also important that once a person is assessed as needing a secondary mental health service, they receive an effective evidence based treatment. The assessment services have always been good at engaging people and stabilising their distress, however up until now evidence based treatments in community teams have been mainly for people with psychotic illnesses.

The Enhanced Assessment teams we propose should provide the following services:

- Assessment of all referrals from primary care and other referral sources (including police and other statutory services, emergency services and inpatient wards) of people who are not known to secondary care services. Referrals will be screened and in discussion with referrers some will be signposted to alternative sources.

- Face to face assessment of referrals from primary care and other referral sources, with signposting or onward referral to other sources of treatment and support including IPTT and IAPT.

- Working closely with Home Treatment Team to provide urgent assessments in primary care settings outside traditional office hours.

- Linked working with Reablement services in the Local Authority to facilitate, where appropriate, the management of people with social care needs in primary care.

- Linked working with Home Treatment Team to support people in a crisis to remain in primary care when possible. This is particularly so for people with a diagnosis of psychosis who have been successfully treated and discharged but at times may need extra support to remain in primary care.

6.3. Reducing relapse in psychosis.

We recognise that psychosis is a Long Term Condition which may have a relapsing and remitting course. There is some evidence that using specific early warning sign focussed interventions lead to a significant reduction in the number of people who relapse compared with usual care, although the *time* to relapse does not differ between these two groups. Similarly the risk of rehospitalisation is significantly lower with early warning sign interventions compared with usual care although the *time* to

rehospitalisation does not differ between these two groups (Training to Recognise the Early Signs of Recurrence in Schizophrenia, Cochrane Review 2013).

At the moment Service Users with a diagnosis of psychosis in Lewisham fall into four groups:

1. No admissions in past 3 years (55%)
2. One admission in past 3 years (23%)
3. Two admissions in past 3 years (12%)
4. Three or more admissions in the past 3 years (11%)

For Service Users who relapse there are a range of interventions set out within NICE guidelines, research and best practice reports to treat and prevent relapse. The intention within the new model would be to develop the range and volume of interventions available and to provide them earlier, so reducing both the number and severity of relapses. The interventions include:

- Antipsychotic medication
- CBT for Psychosis
- Family Interventions
- Vocational interventions

There are also a range of activities that support people in their lives by ensuring that they are able to manage and maintain their activities of daily living and achieve their recovery goals, these include:

- Assessment of need and eligibility for services and development of recovery and support plans to meet identified needs
- Assessment, procurement and monitoring of funded support packages
- Assessment of risk and implementation of plans to minimise their impact
- Child and adult safeguarding assessments and formulation and delivery of care plans in relation to identified risks
- Education and support in relation to lifestyle, for example, the impact of drug use on psychosis, this includes motivation interviewing
- Interventions and education which promote medication concordance
- Administration of medication including depot injections and blood monitoring
- Physical health checks
- Monitoring for early warning signs of relapse and putting actions in place to reduce risk of major relapse at this point (this may include review and alteration to medication regimes, increased contact for people who are socially isolated, daily supervised medication or assessment and introduction of a specific personalised support package).

At times people will also require more intensive interventions involving up to twice daily visits for a period of time provided within the Home Treatment Team. A proportion of Service Users are admitted to inpatient care.

Current staffing resources (both in terms of numbers and qualification/experience) limit the range, number and frequency of the interventions that can be undertaken, this leads to a focus on crisis management rather than proactive early intervention and hence impact on the availability to reduce the number and severity of relapses. The proposal is to enhance the staff resources (both numbers and skills) and operate with smaller caseloads such that care co-ordinators are more proactive, able to deliver more interventions more frequently, and better able to direct the focus of activity promptly to those in greatest risk of relapse.

Work with the IAPT SMI teams has indicated that each therapist can carry out approximately 12 hours of face to face work with Service Users a week. Current care co-ordinator caseloads are high so people in crisis may receive increased visits at the expense of those who are at less risk of relapse at that time. The teams also have limited access to medication advice, review and changes to medication regimes. There is also limited availability of CBT for Psychosis and Family Interventions, so not all people who would benefit are able to receive them. Vocational input to teams is minimal which means either assessments of need or interventions, or both, are missing. The increase in Consultant Psychiatrists, Psychologists and vocational/Occupational Therapists in the teams will increase the interventions available.

The Promoting Recovery teams would have systems in place to allow the Care Co-ordinators to focus on non-crisis work for set times in the week and other times when they actively manage patients in crisis or showing early signs of relapse. The Care Coordinators need to have comprehensive assessments and formulations of their patients' needs with a resultant recovery care plan to address them. This is likely to involve a combination of interventions including medication, psychology interventions and vocational interventions as well as looking at social care needs and liaison with other services. Crisis work slots will involve more working across the team so the Service Users are held by the team as well as having input from the Care Co-ordinators. This will include a small group of Service Users in each team receiving daily supervised medication either through their attendance at the team base or via daily visits.

Overall the Promoting Recovery teams will aim to move the Service Users 'up a group' so that people in group 4 would move to group 3, group 3 to 2, 2 to 1 and group 1 will be in primary care.

6.4. Providing appropriate levels of care in the right place (LiTT and new relationship with primary care)

A new service (Low Intensity Treatment Team) will be developed to support people who are stable and at low risk of relapse having had no admissions in the last 3 years to prepare for discharge to primary care. The team will provide:

- A medication service
- An assessment and implementation of support of packages that help support the Service User to remain well
- A service to provide support and advice to primary care to enable them to take back responsibility for on-going care and treatment where appropriate

50% of current Service Users fall into the cohort of people who are stable and at low risk of relapse. Of this group 40% cannot be discharged because of the complexity of their medications, 40% have on going social care needs that require them to remain within services with the current model of provision and 20% (10% of total caseload) can be supported through the LiTT team back into primary care.

6.5. Providing improved pathways for people with mood, anxiety and personality disorders.

We propose to develop 'Community MAP Treatment Services' who will provide specific care and treatment for people with non psychotic disorders. This service will work closely with the primary care level IAPT Service and Integrated Psychological Therapy Service (IPTT) which provides complex psychological therapy

The treatment teams will provide the following services:

- Treatments for depression and anxiety which are recommended by NICE guidelines as being provided in secondary care, including specialist review of medication, care co-ordination under the Care Programme Approach, and specific psychological treatments where indicated which cannot be provided by IPTT due to the complexity of the client's presentation.

- Treatments for bipolar affective disorder which are recommended by NICE guidelines as being provided in secondary care, including specialist review of medication and care co-ordination under the Care Programme Approach, or long term outpatient follow-up in secondary care where preferred by client and GP, and specific psychological treatments where indicated.

- Treatments for personality disorder which are recommended by NICE guidelines as being provided in secondary care, including care co-ordination under the Care Programme Approach, and specific psychological treatments where indicated which cannot be provided by IPTT due to the complexity of the client's presentation.

- In addition, people with a diagnosis of a psychotic illness who have not been in contact with secondary care services in the previous year will be assessed by the A&T teams and may benefit from the proposed reablement element of the service, or will be referred to the Promoting Recovery teams if appropriate.

7. Proposed Service Configuration and Accommodation.

It is proposed that the current configuration for mental health services of three catchment areas and associated teams is changed to align with the four primary care neighbourhoods as outlined in the map in Appendix B. This allows a greater coherence between primary care and the secondary care teams and helps support the working relationships between secondary care and the CCG.

This would require the reconfiguration of the three current Assessment and Brief Treatment teams into four locality teams and the reconfiguration of the three current Support and Recovery Teams into four Recovery teams each with 1WTE Consultant Psychiatrist post per team. The Early Intervention Teams would then operate as a single team based in the same building as would the Community Forensic Team. The remaining teams would continue to operate as they do currently serving the whole borough. Proposed accommodation for the teams is outlined in Appendix C. The in patient services would remain as they are with 1WTE Consultant Psychiatrist post per ward.

8. Investment and Productivity.

Discussions are underway between SLaM and the CCG with respect to potential investment from SLaM in developing this enhanced service. Investment will be made against realizing savings in reduced dependency on hospital based care through preventing relapse and by reducing the length of stay for those who are admitted.

9. Equalities and Quality Impact Screening.

Equalities leads and service leads have jointly completed the equalities relevance checklist. This process identified that the proposed service development will have no differential negative impact on any of the protected characteristics, but there was a potential positive impact on race. People from BME communities are more likely to be admitted onto the wards and this model seeks to reduce admissions. As plans develop, the equalities impact will be reviewed. Any impact on service users and carers in respect of changes to team location will be carefully planned with them and full consideration given to personal issues and circumstances.

10. Stakeholder Engagement

Before any changes are implemented, we intend to engage fully with stakeholders in Lewisham mental health services and will be preparing a detailed plan outlining this process.

Appendix A

Current Adult Mental Health Services provided by South London and Maudsley NHS Foundation Trust

Function	Teams	Caseload / Beds*	Clinical Staffing in whole time equivalents (wte)**
Acute Inpatient Wards	Powell Clare Wharton	18 beds 17 beds 18 beds	Average of 17 nurses per ward, 1 consultant, 1 manager and sessional Psychology and Occupational Therapy input
Psychiatric Intensive Care Unit	Johnson	10 beds	23 nurses, 1 consultant, 1 manager and sessional Psychology and Occupational Therapy input
Triage Ward	Triage Ward	Total: 16 beds	31 nurses, 1.2 consultants, 1 manager and sessional Psychology and Occupational Therapy input
Assessment and Brief Treatment	Speedwell CMHT Southbrook CMHT Northover CMHT TOTAL	262 384 357 1003	1 care co-ordinator/1 social worker/1 team leader/1 Consultant 2 care co-ordinators/1 team leader/1 Consultant 2 care co-ordinators/1 social worker/1 team leader/1 Consultant
Support and Recovery	Speedwell CMHT Southbrook CMHT Northover CMHT TOTAL	337 360 386 1083	8 Nurses/3 Psychologists/10 social workers/1 team leader/1 Consultant/1 Occupational Therapist/1 Care Support Worker 10.7 Nurses/5.6 social workers/1 team leader/1 Consultant 7 social workers/9 Nurses/1 team leader/1 Consultant

Function	Teams	Caseload / Beds*	Clinical Staffing in whole time equivalents (wte)**
Home Treatment Team	Lewisham Home Treatment Team	Episodes: 916	22 Nurses, 1 Consultant, 1 team manager, 1 social worker
Early Intervention	Lewisham Early Intervention Service (LEIS)	176	4 Nurses/5 social workers/2 Supp Worker/1 Voc-Welfare Officer/1 Consultant /1 Occupational Therapist
Social Inclusion and Recovery Service	Occupational Therapy Self Directed Support TOTAL	89 81 170	3 Support Workers 6 Occupational Therapists 4 Vocational Specialists
Complex Care Wards	Heather Close	29 beds	23 Nurses/1 Occupational Therapist/1 Activity Coordinator/9 Support Workers
Placement Team and High Support Housing	Enhanced Recovery Team Edward Street	87 13 beds and 4 independent flats	3 Social Workers / 2 Nurses 18 Healthcare Assistants / 5 Nurses
Community Forensic Team	Speedwell Forensics Northover Forensics Southbrook Forensics TOTAL	70 62 67 199	6 Social Workers 6 Nurses 1 OT

*** caseloads as at 13th May 2013**
**** Staff numbers exclude administrative staff and trainees but include team management**

Current Accommodation
Currently service users are seen at three community sites: Speedwell, Southbrook Road and Northover. Whilst these buildings have their limitations in terms of accessibility, it is proposed that these will continue to be the team bases until better alternatives have been identified.

Staff are also based in a number of other buildings in the borough including Ladywell House and Kirkdale. The Trust is currently considering vacating these buildings and relocating staff into the Ladywell Unit as well as other community bases.

SLaM also owns the Lee Centre which is currently occupied by Family Health ISIS and Network Arts.

Speedwell: 62 Speedwell Street, Deptford, London, SE8 4AT

Southbrook: 1 Southbrook Road, Lee, London, SE12 8LH

Northover: 98-102 Northover, Downham, Bromley, BR1 5JX

Current Structure

The community teams in Lewisham are split across three sectors each with a small Assessment and Brief Treatment (ABT) team, and a Support and Recovery Team.

The ABT team do time limited work and any client who needs an allocated worker will be referred into the promoting recovery service. This model of working differs significantly from that now provided by equivalent services in the other boroughs served by SLaM, as the relatively small level of staffing in the ABT teams does not allow them to provide longer term or specialised treatment for non-psychotic conditions such as depression, anxiety disorders, traumatic stress disorder or personality disorder (those cases requiring a level of input which cannot be provided by the recently formed Lewisham Integrated Psychological Therapies Service (IPTT), which also provides treatments for these conditions). The benefits of the condition specific care pathways being delivered in other boroughs to patients with these conditions cannot be offered in Lewisham, and the positive aspects of SLaM's reconfiguration into CAGs has not been fully realised. Similarly the benefits of delivering a more specialised Promoting Recovery service for psychotic illness cannot be fully realised by the Recovery and Support teams while they continue to be responsible for managing all long term and disabling mental health conditions regardless of diagnosis.

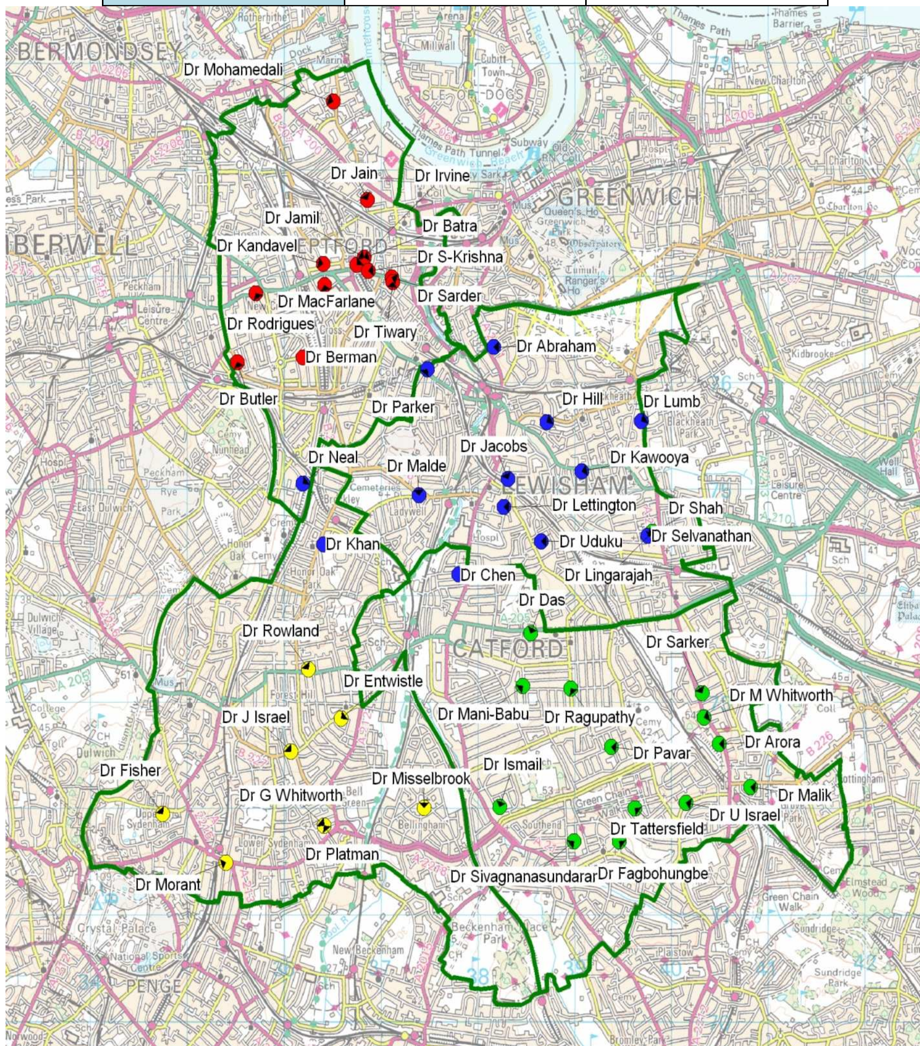
Each of the three current sectors relates to a defined group of GP practices but the three sectors do not map onto the four GP neighbourhoods. Thus each of the six teams in the three sectors must develop its own working relationships with the practices in its area, without being able to take advantage of the networks and opportunities for face to face contact available at neighbourhood level.

Appendix B

GP Neighbourhoods

There are four GP neighbourhoods in the borough of Lewisham co-operating within their areas to deliver services in primary care. Currently there are just over 300,000 patients registered in Lewisham:

Neighbourhood	Registered patients	Percentage
1	64,924	21%
2	108,948	36%
3	63,590	21%
4	68,916	22%
Total	306,378	100%



Appendix C

It is proposed that the following teams will be based in the identified buildings but that all community bases will be used flexibly with the ability to book consultation rooms through an electronic booking system.

The longer term Estates strategy for the Trust is to reduce accommodation costs by implementing flexible working and providing staff with mobile technology. The aim will be to create one or two hubs in each borough and work with other public services to provide local accommodation to see patients. This may involve relocating Lewisham sites to more central locations.

Current Accommodation	Current teams	Proposed teams
Speedwell Centre	Speedwell Assessment and Treatment Early Intervention in Psychosis Team Community Forensic Service Speedwell Support and Recovery team	Neighbourhood 1 Promoting Recovery Team Neighbourhood 2 Promoting Recovery Team Neighbourhood 1 Assessment and Liaison Team Neighbourhood 2 Assessment and Liaison Team
Southbrook Road	Southbrook Assessment and Treatment Early Intervention in Psychosis Team Community Forensic Service Southbrook Support and Recovery team	Early Intervention in Psychosis Team Community Forensic Service
Northover Centre	Northover Assessment and Treatment Early Intervention in Psychosis Team Community Forensic Service Northover Support and Recovery	Neighbourhood 3 Promoting Recovery Team Neighbourhood 4 Promoting Recovery Team Neighbourhood 3 Assessment and Liaison Team

Current Accommodation	Current teams	Proposed teams
	Team	Neighbourhood 4 Assessment and Liaison Team
Ladywell House / Ladywell Unit	Enhanced Recovery Team (Complex Care placements team) Home Treatment Team	to move to Ladywell Unit or alternative accommodation.

The Trust owns an additional property in Lewisham, the Lee Centre, that is used for the provision of mental health services. For the past year the Lee Centre has been used by the voluntary sector to provide services for people with mental health problems. The Trust proposes to continue with this arrangement with formal lease terms in place with the voluntary providers currently using the Lee Centre.