Promoting mental wellbeing and enabling recovery from mental health problems in Hillingdon

Hillingdon's Joint commissioning plan for adults of all ages with mental health problems 2013-16

June 2013

CONTENTS

EXECUTIVE SUMMARY

In March 2012, Hillingdon Clinical Commissioning Group (Hillingdon CCG) and the London Borough of Hillingdon (LBH) initiated a refresh of the strategy for adults with mental health problems aged 18-64 years[1] and

[1] A strategy for adult services for mental health and wellbeing, 2008-13, NHS Hillingdon and London Borough of Hillingdon, 2008

the development of a plan to improve services for people with dementia in order to create a new all age adult mental health services strategy/plan.

In 2011,the government refreshed the strategic direction for mental health services publishing No health without mental health – a cross-government mental health outcomes strategy[2] . The strategy acknowledges the importance of mental health and wellbeing for individuals and the country's social and economic status and adopts a "lifecourse" approach bringing together priorities for children, adults and older adults into a single document. 6 key outcomes are specified for people with mental health problems of all ages:

- More people will have good mental health
- More people with mental health problems will recover
- More people with mental health problems will have good physical health
- More people will have a positive experience of care and support
- Fewer people will suffer avoidable harm
- Fewer people will experience stigma and discrimination

These are reflected in the key objectives in the new Hillingdon plan which have been carried forward from the 2008 strategy as they remain relevant:

- Adults of all ages living in Hillingdon with mental health problems should be able to:
    - Live a normal life as far as possible
    - Be included in local communities and activities
    - Not be stigmatised or discriminated against on any grounds
    - Have easy access to up to date and accurate information
    - Have options in the choices of care available locally
    - Have personalised care plans that are built around the wishes of each individual and their carers
    - Be supported with services that promote and enable recovery and well-being

National estimates suggest that 1 in 4 people will develop a mental health condition during their lifetime and this can range from depression to dementia. Mental health problems have traditionally been divided into 2 main groups:

- **Organic disorders:** Identifiable brain malfunction
- **Functional disorders:** Disorders not caused by structural abnormalities of the brain:
    - **Neurosis:** severe forms of normal experiences such as low mood, anxiety
    - **Psychosis:** severe distortion of a person's perception of reality

The level of deprivation impacts on the mental health status of a population and therefore its need for mental health services. Mental health need in Hillingdon is estimated to be 18 percent lower than the England average.
With the adult population growing at approximately 1 percent per annum, and a higher rate of increase for older adults - approximately 7 percent per annum, there will have been a slight, but not significant change to 2012.

It is estimated that there are 2,584 adults with dementia in Hillingdon. This is likely to increase by approximately 10% (240 people) between

[2] No health without mental health – a cross-government mental health outcomes strategy, DH, 2011

2012 and 2020[3]. 75% of the increase can be attributed to people aged 85 and over.

The plan builds on the strengths and addresses the weaknesses of services for adults with functional mental health problems in Hillingdon:

- Some aspects of primary care of mental health problems e.g. a higher percentage of patient on Coronary Heart Disease (CHD) and diabetes registers have been screened for depression (89.5% compared to 88.5%)
- Investment in home support services i.e. community based support is relatively high
- Investment in community based mental health services is proportionately (1%) higher than the average for benchmark comparator groups, i.e. the rest of London, thriving London periphery and the rest of England, whilst investment in inpatient services is 3% less
- The rate of readmission to inpatient services is low
- For its population need, Hillingdon has a larger mental health employment scheme caseload than the London average
- Expenditure on residential care is greater than Hillingdon's comparators (39% of care costs in 2011/12 compared to an average in London of 31% and a low figure of 8%)
- The rate of contact with secondary care in community mental health services is high compared to the London average
- There are inequalities in the rate of admission to inpatient services in Hillingdon; the rate for white ethnic groups in Hillingdon is 30% lower than the England average for all ethnic groups but the admission rate for black ethnic groups is 47% higher than the England average
- The rate for alcohol related harm is higher than the London average
- Hillingdon has only a small investment in services that respond to the needs of people with depression and anxiety (Improving Access to Psychological Therapies (IAPT) initiative)
- Hillingdon's use of secure and high dependency services is low as evidenced by low levels of expenditure.
- Hillingdon has no community team for eating disorder or for people with forensic needs

It addresses the key concerns relating to services for people with dementia and their carers:

- The waiting times for memory assessment and diagnosis is up to 6 months, which leads to delays in the provision of support and treatment. This is about to be addressed through reconfiguration of inpatient services leading to a reduction from 40 to 25 beds and re-investment in a Memory Assessment Service from November 2012
- There are gaps in the assessment, treatment and support available for people diagnosed with dementia and their carers, in particular, gaps in the provision of crisis support
- Most of the specialist dementia provision is provided in bed based hospital services. The average length of stay is 119 days and the majority of admissions to these services are from residents' own homes - 62%. However, 64% of residents are discharged to nursing homes

There is significant investment by both Hillingdon CCG and LBH in services for adults with mental health problems in Hillingdon. In 2011/12 Hillingdon CCG invested £27.2, with £4.8m being invested in services for older adults. During 2011/12 LBH invested £5.9m in supporting adults of

[3] These numbers include adults aged under 65 with dementia but the numbers are very small (approx. 55)

working age with mental health problems. LBH also spent £7m in supporting people with dementia.

The work undertaken to develop the strategy indicates that there is potential for significant improvement to the efficiency and effectiveness of the services in question through adoption of an integrated, whole systems approach, building on the current strength of GPs in managing adults with mental health problems in the community. It has been agreed that services should be personalized and community based with a focus on recovery and improved outcomes. Improvement will be achieved through effective partnership working that enables service reconfiguration and redesign, leading to a shift from a bed based to community based service with treatment provided at home as far as possible, and achieving a shift from secondary to primary care assessment, treatment and support. There will be a focus on monitoring and evidencing performance and improvements.

The key actions proposed to improve mental health services for adults with functional illness are:

- Ensuring early intervention and promoting mental health and wellbeing in all communities
- Strengthening the partnership between stakeholders, including service users and carers and establishing a joint approach to the improvement of mental health services assessment, treatment and support in primary care
- Developing and implementing integrated care pathways
- Improving support to carers, including during crises
- Creating personalised alternatives to residential care
- Ensuring effective assessment, treatment and suppor for people with specialist needs
- Maximising the contribution of voluntary and community services
- Involvement of service users and carers
- Informed priority setting
- Reducing incidents of suicide
- A focus on empowerment, recovery and outcomes

To support delivery of these changes and the overall improvement of assessment, treatment and support for adults with mental health problems in Hillingdon, Hillingdon CCG and LBH will provide strong leadership, adopting a partnership approach with all stakeholders including CNWL to integrate plans to implement personalisation, improve the range and quality of accommodation and ensure support for employment and training and community based activities and support initiating the following specific action:

- Improve the primary care based mental health services infrastructure – by implementing the “shifting settings of care” workstreams prioritised from the NW London Mental Health Integrated Care Pathway (ICP) /Strategy
- Improve the range of accommodation and support available in the community
- Improve the efficiency and reduce the cost of services

The key actions proposed to improve services for older adults with functional mental health problems and/or dementia are:

- Supporting people in their own homes for as long as possible
- Increasing the rate of diagnosis of dementia
- Improving the co-ordination of care through improved assessment and multi-disciplinary working in primary care
- Promoting awareness of dementia
- Reducing reliance on acute mental health beds
- Developing the infrastructure for community based assessment, treatment and support
- Maximising the contribution of the voluntary sector

- Commissioning a dementia resource centre
- Providing specialist advice to residential and nursing home services
- Confirming the resources available to continue the psychiatric liaison pilot at The Hillingdon Hospital
- Improving support to carers to enable them to continue in their caring role
- Developing care pathways for people with early onset dementia
- Developing care pathways for people with a learning disability with dementia

This will be achieved by implementing the revised care pathways and plans for specialist mental health services for older adults developed during 2012-13 by the multi-agency strategy group and building on the new intermediate care services being put in place for older adults.

As a result of the above, the population of Hillingdon should expect to see:

- Improved access for the general population and for disadvantaged groups
- Improved dementia diagnosis rates
- A shift from bed and secondary care based to community and primary care based assessment, treatment and support
- Inequalities for black and minority ethnic (BME) communities and disadvantaged/vulnerable people being addressed
- Mental health and wellbeing in the population as a whole being promoted
- Improved access to crisis support
- Provision of assessment, treatment and support as close to people's homes as possible, ensuring that specialist bed based and community services are accessed only when this is the best option to support recovery
- A focus on recovery and outcomes and personalised approaches to assessment, treatment and support
- Service users empowered through the promotion of choice and control and provision of easy access to information and advice
- Services that are informed by best practice and evidence of need and performance
- Carers being supported, having choice and control and being empowered through easy access to information and advice
- Best use of available resources being made to achieve value for money outcomes for residents

A plan to deliver the required improvements identifying both the joint and individual action required by Hillingdon CCG and LBH to improve services working with key partners has been agreed. See Figure 15 below. Through the process of consultation on the strategy and implementation plan and the LBH Policy and Overview Committee review of adult mental health services that was undertaken from September 2012 to January 2013, feedback was received that will be used to inform implementation of each element of the plan. The feedback received is summarised at Appendices 5 and 6. An implementation plan for year 1 of the strategy (2013-14) is included at Appendix 7. A full equalities impact assessment for the strategy was carried out following the consultation process. No negative indicators for equality were identified through this process. See Appendix 8.

PART 1: INTRODUCTION

1.1 Definitions of mental health disorder

There are many definitions of mental health but most would agree that it consists of a set of outwardly observable skills, attributes and behaviours (such as the ability to live productively, adjust to change and to maintain satisfying relationships with others) and a set of personal emotions and thoughts (such as enjoyment of life, a sense of self-worth and empathy).

The term 'mental health problem' is used in this document to describe the full spectrum of mental health issues, from common experiences such as 'feeling depressed' to more severe clinical symptoms such as clinical depression and enduring problems such as schizophrenia. Mental health problems have traditionally been divided into 2 main groups:

- **Organic disorders:** Identifiable brain malfunction
- **Functional disorders:** Disorders not caused by structural abnormalities of the brain: **Neurosis:** severe forms of normal experiences such a low mood, anxiety and **Psychosis:** severe distortion of a person's perception of reality

Terminology for mental health problems varies considerably across professions and cultures, according to prevailing attitudes towards mental health and current understanding. The following terms have been adopted for this plan:

- **Common mental health problems:** e.g. anxiety, depression, phobias, obsessive compulsive and panic disorders
- **Severe and enduring mental health problems:** e.g. psychotic disorders (including schizophrenia) and bipolar affective disorder (manic depression)
- **Personality disorder**: an enduring pattern of inner experience and behaviours that deviate markedly from the expectation of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time and leads to distress or impairment

More recently, a system of clustering mental health problems into care clusters has been adopted as shown in Figure 1 below.

Figure 1: Mental health care clusters

Cluster no.	Cluster label	Cluster review interval (maximum)
00	Variance	**Annual**
01	Common mental health problems (low severity)	**12 weeks**
02	Common mental health problems	**15 weeks**
03	Non-psychotic (moderate severity)	**6 months**
04	Non-psychotic (severe)	**6 months**
05	Non-psychotic (very severe)	**6 months**
06	Non-psychotic disorders of overvalued Ideas	**6 months**
07	Enduring non-psychotic disorders (high disability)	**Annual**
08	Non-psychotic chaotic and challenging disorders	**Annual**
09	DO NOT USE: Blank cluster (previously drug and alcohol)	**N/A**
10	First episode in psychosis	**Annual**
11	Ongoing recurrent psychosis (low symptoms)	**Annual**
12	Ongoing or recurrent psychosis (high disability)	**Annual**
13	Ongoing or recurrent psychosis (high symptom and disability)	**Annual**
14	Psychotic crisis	**4 weeks**
15	Severe psychotic depression	**4 weeks**
16	Dual diagnosis (substance abuse and mental illness)	**6 months**
17	Psychosis and affective disorder difficult to engage	**6 months**
18	Cognitive impairment (low need)	**6 months**
19	Cognitive impairment or dementia (moderate need)	**6 months**
20	Cognitive impairment or dementia (high need)	**6 months**
21	Cognitive impairment or dementia (high physical need or engagement)	**6 months**

Clusters 1-17 can be categorised as functional mental health problems. Clusters 18 – 21 can be categorised as organic mental health problems.

1.2 The approach to developing the adult mental health strategy

Written in 2008, the current strategy for adults with mental health problems aged 18-64 years addresses the needs of adults of “working age” with functional mental health problems. The needs of people with

either or both functional mental health problems and/or dementia aged 65 years and over are addressed separately within older people's mental health services. The intention of this separation is to facilitate access to services for older adults who require support for their mental health problems through the ageing process. However, it is now recognised that a single cut off in age – 65 years – does not adequately reflect individual difference/need as people and that this approach is in fact discriminatory.

In line with national policy, it has therefore been agreed that there will be a pathway for adults of all ages with functional mental health problems and separate pathway for older adults with functional mental health problems who are physically frail and/or have dementia. In addition, as the latter pathway may not allow the differential needs of younger adults with dementia (early onset dementia) to be addressed appropriately, there will be a further pathway for this client group. The needs of adults with early onset dementia are usually addressed appropriately by the community team for adults with mental health problems who are physically frail and/or have dementia.

The strategies to support improvement of services to deliver the pathways for adults and older adults stand alone but are brought together into a single document as a plan for services for adults with mental health problems of all ages in Hillingdon 2012-15[4].
The new strategy builds on the joint work undertaken during and since 2008 and describes the individual and joint action that both Hillingdon CCG and LBH intend to take. Current resources and the performance of both health and social care services are assessed and the need and potential for improvement of both health and social care services for adults with mental health problems in Hillingdon is identified.

1.3 London Borough of Hillingdon: profile

1.3.1 General characteristics of Hillingdon and health and social profile

Hillingdon is a diverse, prosperous borough in West London. It is the second largest of London's 32 boroughs covering 42 square miles. The borough is bordered by Hertfordshire, Buckinghamshire, Hounslow, Ealing, and Harrow. The north of the borough is semi-rural and Ruislip is the major centre of population. The south is more densely populated and urban and contains the administrative centre of Uxbridge and towns of Hayes and West Drayton. Hillingdon is home to Heathrow Airport and the largest RAF air station at RAF Northolt.

The estimated the population of Hillingdon is 266,100[5]. There is a significantly larger proportion of people in younger age groups (5-19 years) in comparison to England and London. The population of older age groups (50+) is larger than London but smaller than England. However, the population of 25-44 year olds is less than the London average but still larger than England, especially the female population.

The population aged 16-64 years in Hillingdon is growing by approximately 1% per annum. It is estimated that there are currently 36,200 people aged 65 year and over in the Borough. This number is projected to increase by to 38,600 - 7% - from 2012 to 2017. The number of people aged 85 and over is expected to increase to 5,400 within this period - 11 %. 89% of the older adult population are white with the remainder coming from black or minority ethnic (bme) backgrounds.

[4] *Throughout this document, the term adults with mental health problems is used to refer to adults of all ages with functional mental health problems who do not require access to services for older adults with mental health problems. The term older adults with mental health problems is used to refer to physically frail older adults with functional mental health problems and/or dementia whose needs are more appropriately met outside the pathway for adults with functional mental health problems

[5] ONS 2010 mid-year population estimates

It is estimated that there are 4,778 households with occupants who are frail elderly within the borough. Nearly a quarter of these are thought to be living in unsuitable housing. It is estimated that 13,495 older people are living alone in Hillingdon. It is predicted the population of older people living alone would have increased by 6% to 14,313 by 2016. 74% of Hillingdon's population aged over 60 are owner occupiers and of this 67% own their homes outright. Approximately 22% of older adults live in the social rented sector and only 4% in private rented accommodation. Approximately 14% of older adults live on their own. Stroke is a major cause of disability and in 2010/11 (the last year for which validated data is available) 3,305 people were reported by GPs as living with stroke. This is projected to increase to 4,351 by 2015. Currently there are 12,783 people over the age of 65 who have diabetes.

BME communities made up approximately 32% of the population of Hillingdon in 2011, an increase of 12% since 2001. The largest ethnic minority community is Asian-20%, of which 12% is Indian. The Black African population is 4% of the total population. A further 20% increase is projected to 2020. There are significant numbers of asylum seekers and refugees in Hillingdon putting significant pressure on providers in terms of the need to understand and respond to cultural differences and having to respond to individual behaviours.

Life expectancy for men in Hillingdon for 2008-10 was 78.7 years which was similar to London and England averages; and the female life expectancy for Hillingdon was 83.4 years significantly higher than the England average, but similar to London average. Life expectancy for men and women has increased on average by at least 2.5 years during the past 15 years. Geographic areas in the south of the borough have generally lower life expectancy that those in the north and whilst the Standardised Mortality Ratio (SMR) for Hillingdon is similar to London and England and improving, the SMR in the most deprived communities has been worsening.

Hillingdon is 157th out of 354 most deprived districts in England and 24th out of 33 most deprived London boroughs. However it is constituted of demographic zones ranging from very deprived to very affluent. The north of the borough is semi-rural with large sections of green belt land; the south of the borough is more urban and densely populated with some areas falling in the most deprived 20% nationally. Over a quarter - 26% - of all children in Hillingdon are living in poverty as compared with 22% in England and 30% in London. There is a high burden of households needing support for physical disabilities including frail elderly frail adults and there are significant health inequalities within the borough – life expectancy can vary by as much as 8.1 years for males between wards, and 7.4 years for females.

1.3.2 Profile of mental health need in Hillingdon

The level of deprivation and social status of people within a particular population has a significant impact on its mental health status and therefore its need for mental health services. Mental health need in Hillingdon is estimated to be 18 percent lower than England as a whole for the first two indices that are applicable to mental ill health–mental illness needs index (MINI) and mental illness needs index 2000(M2K).

Functional illness

Table 1 below shows the estimate of weekly prevalence of mental health problems in the age range 16-64 years used in the latest (2008) mental health joint strategic needs assessment (JSNA) for the Hillingdon GP

registered population [6]. With the adult population growing at approximately 1 percent per annum and a higher rate of increase for older adults of approximately 7 percent per annum, there will have been a slight, but not significant change in these figures to 2012.

Table 1: Estimate of the incidence of functional illness in Hillingdon

Incidence of Functional Illness in Hillingdon	
Psychotic illness	730
Mixed anxiety and depression	16,780
Generalised depression	8,570
Depressive Episode	5,110
All phobias	3,470
Obsessive compulsive disorder	2,290
Panic disorder	1,280
All Neurosis	31,550
Drug dependence	7,660
Alcohol dependence	14,770

Dementia

It is estimated that there are 2,584 adults with dementia in Hillingdon. Projections suggest that this number will increase by approximately 10 % (240 people) between 2012 and 2020[7]. 75% of the increase can be attributed to people aged 85 and over with anticipated growth of approximately 10% (from 1167 to 1280 people) within this period. See Table 2 below for estimated numbers of people with dementia in the Hillingdon population 2008 to 2025.

Table 2: Estimated prevalence of dementia (all ages) in Hillingdon 2008 – 2025[8]

Year	Early Onset	Mild	Moderate	Severe	Total	Increase on 2012 (%)
2008	56	1,328	776	308	**2,468**	**/**
2012	57	1,392	810	325	**2,584**	**/**
2015	59	1,414	831	334	**2,638**	**2.9**
2020	63	1,511	890	360	**2,824**	**10.2**
2025	66	1,612	951	387		**17.7**

853 people – 30% of the estimated number of adults were registered with GPs as having dementia in 2010/11 (the last year for which validated data is available).

People with learning disabilities who have dementia

People with learning disabilities are more susceptible to dementia as they age more quickly than the general population. Projections suggest that the number of people with learning disabilities living into old age is increasing and it is predicted that there will be an increase of 7% - from 13,495 to 14,313 - older people with learning disabilities between 2012 and 2016.

1.4 The national context for the delivery of mental health services for adults of all ages

1.4.1 The national context for the delivery of services for adults with mental health problems

[6] Hillingdon Joint Strategic Needs Assessment, Hillingdon PCT and London Borough of Hillingdon, 2008

[7] These numbers include adults aged under 65 with dementia but the numbers are very small (approx. 55)

[8] Sources: Dementia UK. GLA low estimate populations (2008 based) projections for 2008-2025

The importance of mental wellbeing for individuals and the country's social and economic status has been increasingly recognised over the last 15 years. As a result, improvement of mental health services has increasingly been prioritised by the government. 1999 saw the publication of the National Service Framework for Mental Health Services[9] (NSF). This specified the approach to delivery and the range of services that should be commissioned to ensure that both people with common mental health problems and people with serious mental illness were able to access the assessment, treatment and support they need. Almost 10 years later, New Horizons: A shared vision for mental health services[10] was published. This laid out a multi-stakeholder vision for mental health services and adopted a broad view of the action needed to promote the emotional wellbeing and mental health of the nation as a whole, clearly specifying the role of wider public health and community infrastructures in promoting emotional wellbeing and mental health. In 2011, the public health strategy, No health without mental health[11] reinforced this message and laid out plans to ensure improvement.

Over the past 10 years, increasing importance has been given to delivering personalised, person centred, effectively co-ordinated assessment, treatment and support for individuals and their carers. In addition, a "life course" approach to mental health services provision has been adopted. There has also been an increasing emphasis on ensuring the effectiveness and efficiency of services, with a focus on ensuring and measuring recovery from mental health problems. Identifying ways of measuring outcomes for individuals and the population as a whole has therefore become increasingly important.

[9] The National Services Framework for Mental Health Services in England, DH, 1999
[10] New Horizons: A shared vision for mental health services, DH, xxx
[11] No health without mental health, DH, 2011

Delivery of personalised, recovery and outcomes orientated services is the focus of the 2011, mental health strategy, No health without mental health: a cross government mental health outcomes strategy for people of all ages[12] and the 2012 implementation guide[13]. Over this period, the role of carers and the need to support them, the need to recognise and respond to individual preferences and life choices, including responding to the needs of people from different black minority and ethnic backgrounds and the need to ensure protection (safeguarding of the rights) of individuals who are vulnerable as a result of their mental health problems have come to the fore.

The concept of recovery has developed significantly over this period. In mental health, 'recovery' is summarised in Figure 2 below.

Figure 2: The concept of recovery in mental health[14]

RECOVERY is the process through which people find ways of living meaningful lives with or without ongoing symptoms of their condition. Users of mental health services have identified 3 key principles:

- **The continuing presence of hope that it is possible to pursue one's personal goals and ambitions**
- **The need to maintain a sense of control over one's life and one's symptoms**
- **The importance of having opportunities to build a life 'beyond illness'**

In 2011, The Centre for Mental Health and the NHS Confederation's Mental Health Network were commissioned to pilot an approach to organisational change based on promoting recovery. The Implementing Recovery Through Organisational Change (ImROC) project is a new

[12] No health without mental health: a cross government mental health outcomes strategy for people of all ages, DH, 2011
[13] No health without mental health: a cross government mental health outcomes strategy for people of all ages: Implementation Guide, DH, 2012
[14] Supporting Recovery in Mental Health, Mental Health Network, NHS Confederation, Briefing Issue 244, June 2012

approach to helping people with mental health problems that aims to change how the National Health Service (NHS) operates so it can focus more on helping those people with their recovery. Organisations that have adopted this approach have been shown to support significant improvement to the mental health status and quality of life of service users.
Recovery is one of 6 outcomes required for people with mental health problems that have been clearly specified in No health without mental health: a cross government mental health outcomes strategy for people of all ages[15]. See Figure 3 below.

Figure 3: Outcomes for people with mental health problems 2012[16]

- **More people will have good mental health**
- **More people with mental health problems will recover**
- **More people with mental health problems will have good physical health**
- **More people will have a positive experience of care and support**
- **Fewer people will suffer avoidable harm**
- **Fewer people will experience stigma and discrimination**

In essence, this means that "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"[17].
A key feature of the current context for mental health services delivery is the focus on early intervention and the promotion of health and wellbeing. There is an increased understanding of the impact of mental health on physical health and the overall wellbeing of the population. Responsibility for addressing this area of health and social care policy lies with public health departments.

Responsibility for public health will be transferred from the NHS to local authorities from April 2013. Health and Wellbeing Boards (HWBs), bringing together local councillors, GPs and directors of public health, adult and children's services have been established to ensure a co-ordinated approach to addressing the health and wellbeing of local communities. The HWBs aim to work with the local community to improve the health and wellbeing of the local population and reduce health inequalities. They also have a responsibility to promote integrated approaches to health and social care services and provide a setting to work with wider partners to address the other key influences on health such as housing and education. In order to identify local priorities, the HWBs are required to undertake a detailed assessment of local needs (JSNA) to assist with the identification of local priorities and how they can be addressed. The JSNA therefore underpins the health and wellbeing strategy.

1.4.2 The national context for the delivery of mental health services for older adults with mental health problems

Improving mental health services for older people has been prioritised recently. Standard Seven of the Older People's National Service Framework[18] and later publications such as Forget Me Not[19] Securing Better Mental Health for Older Adults[20], Everybody's Business[21] and Raising the Standard[22] specifically addressed the mental health needs of

[15] No health without mental health: a cross-Government mental health outcomes strategy for people of all ages, DH, 2011
[16] No health without mental health: a cross-government mental health outcomes strategy for people of all ages: Implementation plan, DH, 2012
[17] No health without mental health: a cross-government mental health outcomes strategy for people of all ages: Implementation plan, DH, 2012
[18] Older People's National Service Framework DH, 2001, London
[19] "Forget Me Not", Audit Commission, 2000, 2002, London
[20] "Securing Better Mental Health for Older Adults", DH, 2005, London
[21] "Everybody's Business", CSIP, 2005, London
[22] "Raising the Standard" Royal College of Psychiatrists, 2006, London

older adults. These documents were followed by the Clinical Guideline 42: Dementia, supporting people with dementia and their carers in health and social care[23]. This publication identified addressing discrimination, training, ensuring valid consent for treatment, improving carer assessment and support, co-ordination and integration of health and social care as priorities for improvement of dementia care. A single point of referral for dementia via memory clinics was identified as an essential service component.

Improving Mental Wellbeing and Older People[24] complemented the guidance in the NICE/SCIE Clinical Guideline, promoting the development and retention of skills of daily living by:

- Increasing access to reliable information about meeting health care needs, nutrition, personal care, staying active
- Accessing services and benefits, home and community safety and local transport schemes
- Developing tailored exercise and physical activity programmes for and with individuals
- The provision of training appropriate to their role to deliver the above for all professionals involved in the care of older people

In 2008, Transforming the Quality of Dementia Care: Consultation on a National Dementia Strategy[25], proposed improvements to the quality of dementia care. In 2009, The National Dementia Strategy[26] was published. This identified 17 objectives to ensure that people with dementia and their carers receive effective treatment and support. See Figure 4 below and Appendix 1.

[23] Clinical Guideline 42: Dementia: supporting people with dementia and their carers in health and social care, NICE/SCIE, 2006
[24] Public Health Guidance 16: Improving Mental Wellbeing and Older People, NICE, 2008, London
[25] Transforming the Quality of Dementia Care: Consultation on a National Dementia Strategy", DH/CSLG&CP/SCPI/SR 2008
[26] Living well with dementia: A National Dementia Strategy, DH, 2009

Figure 4: Summary of Objectives: living well with dementia[27]

Objective 1	Improving public and professional awareness and understanding of dementia
Objective 2	Good-quality early diagnosis and intervention for all
Objective 3	Good-quality information for those with diagnosed dementia and their carers
Objective 4	Enabling easy access to care, support and advice following diagnosis
Objective 5	Development of structured peer support and learning networks
Objective 6	Improved community personal support services
Objective 7	Implementing the Carers' Strategy
Objective 8	Improved quality of care for people with dementia in general hospitals
Objective 9	Improved intermediate care for people with dementia
Objective 10	Considering the potential for housing support, housing-related services and telecare to support people with dementia and their carers
Objective 11	Living well with dementia in care homes
Objective 12	Improved end of life care for people with dementia
Objective 13	An informed and effective workforce for people with dementia
Objective 14	A joint commissioning strategy for dementia
Objective 15	Improved assessment and regulation of health and care services and of how systems are working for people with dementia and their carers
Objective 16	A clear picture of research evidence and needs
Objective 17	Effective national and regional support for implementation of the Strategy

1.5 The local context for the delivery of mental health services for adults of all ages with mental health problems

Hillingdon CCG and LBH recognise the connection between broader community, environmental and social factors and health and the connection between physical and mental wellbeing . The two organisations are therefore increasingly adopting a joint approach and

[27] Living well with dementia: A National Dementia Strategy, DH, 2009

identifying cross cutting themes and a joint vision. See Figures 5 to 7 below.

Figure 5: Hillingdon CCG and LBH joint vision

To ensure that people who need health and social care treatment and support are empowered and supported to choose and commission services that will meet their specific needs, helping them to move towards recovery, regaining meaningful lives as individuals who are active members of the communities in which they live and work

A recent exercise has identified the priorities for health and wellbeing. See Figure 6 below.

Figure 6: Priority areas for action relevant to mental health from the JSNA

Children engaged in risky behaviour: Too many young people engage in potentially harmful behaviours that can risk their health, such as alcohol abuse, drug taking, smoking, taking risks with sexual behaviour or being overweight.
Dementia: As we live longer, more of us will suffer from dementia, and we are not currently doing enough to diagnose or support its treatment
Physical activity: If we can increase the amount of physical activity for people, then we can improve physical and mental health and reduce chronic disease
Obesity: Obesity is the most widespread threat to the health and wellbeing of the population
Adult and Child Mental Health: Mental illness is the largest single cause of disability in our society, and we can be more imaginative in the design of services to support adults and children
Older People including sight loss: With more of us living longer, the range of services for older people needs to be updated and improved

Figure 7: Priority themes for action from JSNA and joint working by Hillingdon CCG and LBH

I. Improve health and wellbeing and reduce inequalities **2. Invest in prevention and early intervention** **3. Develop high quality integrated social care and health services within the home and community** **4. Create a positive experience of care**

Specific priorities for the improvement of the mental health and wellbeing of adults in Hillingdon have been identified in the section on adult mental health and dementia. See Appendix 2.

Hillingdon CCG has identified shifting the balance of care from hospital to community settings as its main priority for 2013/14 and going forward. The objective is to use resources effectively to improve the health and well-being of the local population with the need to address the challenges from adverse health trends and focus on tackling and reducing health inequalities. This means:

- Faster and simpler access to local services
- More “one stop shop” style services that include diagnosis and treatment at first point of contact
- More “one stop shop” style services that include diagnosis and treatment at first point of contact
- Faster response to urgent care needs particularly for patients requiring care and support in their homes
- Seamless care, with Health and social care professionals working together
- Time in hospital focused on addressing healthcare needs that need hospital care and supporting rapid discharge to a safe environment at home as soon as appropriate

The core mission for LBH social care, health and housing is to “enable residents in need to live safe, healthy and independent lives”. A set of core principles underpinning this mission have been agreed. See Figure 8 opposite.

Figure 8: LBH: social care, health and housing core principles

1. Choice and control We will ensure that users of services are in the driving seat in deciding how their desired outcomes will be achieved within available resources **2. Safe, healthy and independent lives** We will shift from providing long-term institutional services to providing time-limited support which helps people regain independence in the community **3. Supportive local communities** We will achieve sustainable change by supporting individuals and communities to help themselves and each other **4. Different for less** We will use up to date, evidence based approaches to services which are more

PART 2: SERVICES FOR ADULTS WITH MENTAL HEALTH PROBLEMS IN HILLINGDON

2.1 Review of the strategy for adult services for mental health and wellbeing 2008-13

As part of the process of developing the 2008 strategy for services for adults with mental health problems, service users identified the following priorities for Hillingdon mental health services:

- Focus on mental wellbeing and support recovery from mental health problems
- Improve access to services
- Develop primary care and community-based services as a key component of the mental health care system
- Improve pathways and choice
- Increase inclusion and integration
- Ensure person and carer centred care
- Improve quality, effectiveness and value

The strategy identified the need for a new mental health partnership that would offer the range of support and care needed by individuals to sustain their recovery. This partnership would co-ordinate the delivery of all linked mental health strategies including child and adolescent mental health services (CAMHS), services for older adults and substance misuse services to ensure a holistic approach that would deliver the following outcomes and improvements:

- Maximise the health and social care resources available for mental health
- Reduce the impact of mental illness
- Ensure that services are provided in the least restrictive setting
- possible with a shift from acute to secondary and primary care community settings
- Ensure that the range of services available is informed by an understanding of the changing needs of the population
- Respond to the increasing diversity in the population, ensuring that resources are directed at the areas with greatest need and are sensitive to the needs of the different communities
- Support the development of skills of those working with people with mental health problems and their carers as either volunteers or as employed staff
- Meet the statutory duties and responsibilities
- Ensure that services meet nationally and locally set quality standards
- Develop the best possible network of services within Hillingdon

Since 2008, progress has been in a number of the key objectives identified within the strat

A vision for mental health services for adults aged 18 to 64 years was agreed. See Figure 9 below.

Figure 9: The 2008 vision for adult mental health services

People living in Hillingdon should benefit from opportunities for positive mental well-being which includes:

- **Involvement with community, friends and family**
- **Meaningful occupation learning and leisure**
- **Having the basics in place:**
  - **Good health care**
  - **Good housing**
  - **Financial security**
- **Access to the above for people with significant mental health problems as well as access to specialist services which provide for their individual needs and preferences, promoting recovery from the effect of mental health problems**

People with mental health problems in Hillingdon should be able to:

- **Live a normal life as far as possible**
- **Be included in local communities and activities**
- **Not be stigmatised or discriminated against on any grounds**
- **Have easy access to up to date and accurate information**
- **Have options in the choices of care available locally**
- **Have personalised care plans that are built around the wishes of each individual and their carers**
- **Be supported with services that promote and enable recovery and well-being**

Figure 10: Evaluation of key objectives: Hillingdon adult strategy for mental health and wellbeing 2008 -13

Patterns of service delivery	
Objective 2008	**Evaluation: 2012**
Patterns of service indicated that the role of CMHTs and CPA programmes needed to be more effectively targeted and access to services improved for people with mild to moderate needs to avoid referral to secondary care. Alternative care pathways needed to be developed and service and access models need to change to reflect the diversity of need in the population. Generally services were in line with benchmark peers and in line with predicted demand adjusted for deprivation The number of beds was deemed appropriate for the population size but further analysis was needed to understand: Utilisation rates Admission patterns Community services: CPA appeared to be poorly targeted with higher use of CPA than would be indicated based on need Access to psychological therapies and primary care counselling was not meeting current or predicted demand Investment in consultant psychiatrist resources was not best utilised	The proportion of people with mental health problems in contact with specialist mental health services is low compared with benchmark peers, with a larger than average proportion of people being supported in primary care There is still a need for more targeted use of specialist mental health services, with a shift of people with people with long term mental health problems who are stable being transferred from secondary to primary care. This includes reviewing investment and targeting of consultant psychiatrist resources and developing care pathways and service models that enable them to provide support to primary care Development of primary care based mental health services is needed to improve access and ensure early intervention to minimise the risk of escalation and need for secondary services There is insufficient diversity of provision to ensure an appropriate response to individual difference and the diverse needs of the population Use of acute mental health beds remains appropriate for the population size; patterns of utilisation and rates of admission are better understood. However, beds continue to be used disproportionately by people from black communities There has been investment in psychological therapies but further development is needed in order to ensure the full range of psychological interventions including CBT and other interventions specified under the Increasing Access to Psychological Therapies initiative are provided
Patterns of Investment	
Objective 2008	**Evaluation: 2012**
There was a lack of consistency in data about expenditure on services and an urgent need to assess whether the pattern of investment would deliver the vision for services The need to reconcile discrepancies was identified with an urgent need to: Relate investment to the needs of the population locally Assess whether investment was sufficient and/or appropriate Assess whether the pattern of investment would deliver the vision Potential to reduce capital charges for reinvestment was identified	Inconsistencies in data about expenditure continue, although there has been some improvement that has informed understanding of patterns of investment The redistribution of health care investment from secondary to primary care settings has not been achieved Action has been taken to reduce capital charges. However, overheads and indirect costs are indicated as being slightly higher and therefore there may be potential to release savings if reduced to the lower quartile of mental health trust performance

2.2 Use of resources in mental health services for adults with mental health problems in Hillingdon

2.2.1 Hillingdon CCG and London Borough of Hillingdon: use of resources

Hillingdon CCG and LBH invest £160.68 per weighted head of population in services for adults with mental health problems.

Analysis undertaken across NW London on the mental health ICP (Strategy) and the recent local DAS Challenge, demonstrated that there is potential to achieve significant efficiencies and improvement to effectiveness, patient experience and outcomes through a shift from a bed based to community based model. Recent work by LBH investment has also demonstrated that the same improvement could be made. Both organisations have started to implement these findings. This work will continue through 2013-15. The focus for both organisations working together and separately will therefore be to achieve a shift from a bed-based to community based services.

2.2.2 Hillingdon CCG: use of resources

2011/12 programme budgeting data shows that Hillingdon CCG invests £27.2M in services for adults with mental health problems. £21.7 m is invested with CNWL. An additional £1.9m was invested with the Trust following a rebasing exercise in 2010/11 and 2011/12 which addressed an imbalance in investment with the Trust across NW London. The remaining £5.5m is invested as follows in a range of specialist (tier 4) and voluntary sector services and specialist placements.

A recent analysis of investment made by Hillingdon CCG in mental health services for adults of all ages shows a better outcome in relation to investment when compared with other CCG s in England. See Figure 11 below (next page).

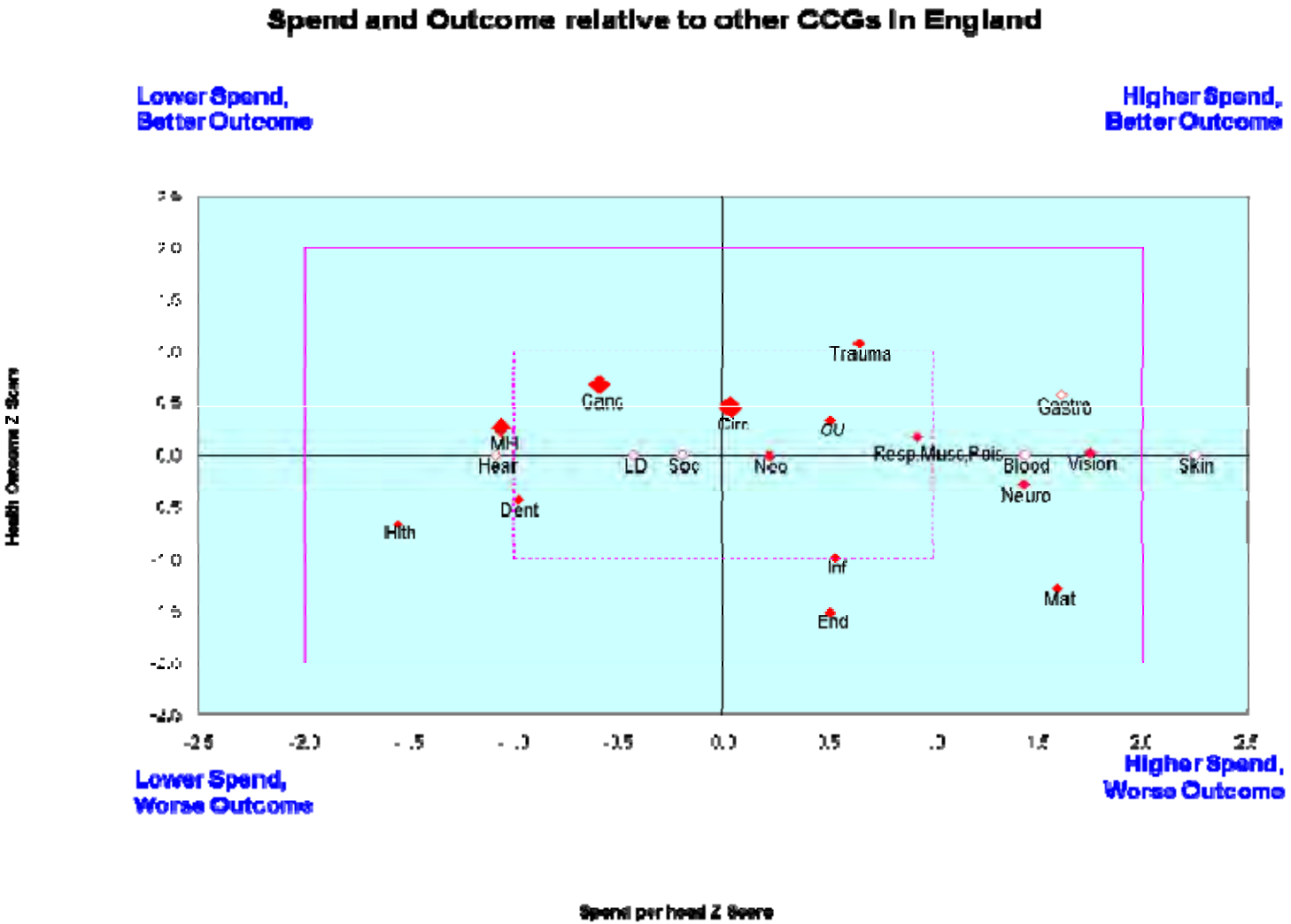
2.2.3 London Borough of Hillingdon: use of resources

In 2010-11, LBH invested 9 percent of its total expenditure in services for people with mental health problems. This compares with an average of 8 percent for its comparator group and 7 percent nationally. In 2011-12, LBH spent £6.2m on services. This expenditure was offset by £0.3m income with the net expenditure being £5.9m. See Table 3 below.

Table 3: LBH investment in adult mental health services 2011-12

Description	Budget (£000s)		
	Gross Expenditure	Income	Net
Staffing	2,638.2	(218.2)	2,420.0
Residential	3,139.8	(85.2)	3,054.6
Community Support	378.8	(5.5)	373.2
Other Costs	26.1	0.0	26.1
Management Contribution	50.0	0.0	50.0
Total	**6,232.8**	**(308.9)**	**5,923.9**

Figure 11: Spend and outcome in Hillingdon relative to other CCGs in England



2.3 The performance of services for adults with mental health problems in Hillingdon

2.3.1 The performance of NHS commissioned services for adults with mental health problems in Hillingdon

CNWL is the main provider of specialist mental health services in Hillingdon. There has been a significant improvement in the performance of NHS commissioned mental health services A summary of the key performance indicators for mental health services in Hillingdon during 2011-12 is given in Table 12 below.

Figure 12: Key performance indicators in NHS commissioned adult mental health services in Hillingdon 2011-12

Service	Performance
Assertive outreach	Following agreement with commissioners that treatment should be provided by other teams in Hillingdon, there is no assertive outreach service
Early Intervention service	Team caseload has been increasing and is now close to meeting its target of 38 new cases by year end
Home treatment service	Team caseload has been increasing and is now close to meeting its target of 38 new cases by year end
Inpatient services	The rate of readmission is well below target (11%) operating at 3% on an ongoing basis Delayed transfers of care from inpatient services have been decreasing: Mid 2011 at 10-12% Reduced to 4% in January 2012 Mid 2012 operating at 10-15% delays have been caused by delays within both health and social care
Community teams	DNAs for first appointment operated at 10% 2011/12 and have increased to 15% for Q1 DNAS for follow up appointments operated at 10% during Q3 and Q4, 2011/12 and at Q1 2012/13 have increased to 17%

The performance of mental health services in Hillingdon is strong in the following respects:

- Investment in counselling services is higher than average (NB see * below)
- Some aspects of primary care of mental health problems e.g. a higher percentage of patient on CHD and diabetes registers have been screened for depression (89.5% compared to 88.5%)
- Investment in home support services i.e. community based support is relatively high
- Investment in inpatient services is less per weighted head of population than the rest of London, the Thriving London Periphery and the rest of England
- he rate of readmission to inpatient services is low
- For its population need, Hillingdon has a larger mental health employment scheme caseload than the London average

There are, however, concerns about other aspects of the performance of Hillingdon's mental health services:

- The rate of contact with secondary care is community mental health services is high compared to the London average
- There are ethnic inequalities in admissions to adult psychiatric inpatient services in Hillingdon. The admission rate for white ethnic groups in Hillingdon is 30% lower than the England average

for all ethnic groups but the admission rate for black ethnic groups in Hillingdon is 47% higher than the England average

- There are ethnic inequalities in admissions to adult psychiatric inpatient services in Hillingdon. The admission rate for white ethnic groups in Hillingdon is 30% lower than the England average for all ethnic groups but the admission rate for black ethnic groups in Hillingdon is 47% higher than the England average
- The rate for alcohol related harm is higher than the London average
- Expenditure on residential care is greater than Hillingdon's comparators
- Hillingdon has only a small investment in services that respond to the needs of people with depression and anxiety (Increasing Access to Psychological Therapies initiative)
- Hillingdon's use of secure and high dependency services is low
- Hillingdon has no community team for eating disorder or for people with forensic needs

The performance of services in relation to key performance indicators has improved significantly. NHS commissioned services perform strongly in respect of the Key Performance Indicators (KPIs). See Figure 12 above.

2.3.2 The performance of LBH commissioned services for adults with mental health problems

LBH's performance is average for the key indicators of performance for councils:

- Self-reported experience of social care users
- Social care clients receiving self-directed support
- Carers receiving needs assessment or review and a specific carer's service, advice or information
- Adults in contact with secondary care mental health services in settled accommodation
- Adults in contact with secondary care mental health services in employment

2.3.3 Rates of suicide in Hillingdon

The rate of suicide and undetermined injury (DSR) per 100,000 in men in Hillingdon is within the London range and below the national average. In females the rates are higher than for London and nationally. Estimates made for 2011 to 2013 indicate that there is likely to be no significant change or variation from the current rates. See Tables 4 to 6 below.

Table 4: Directly age standardised rates by gender 2007-8[28]

Borough	Directly age-standardised rates (DSR) per 100,000 Males	*Directly age-standardised rates (DSR) per 100,000* Females
Ealing	10.08	2.66
Hillingdon	10.65	4.07
Hounslow	14.49	5.69
London	10.67	3.05
England	12.18	3.63

Source: London Health Programmes Health needs assessment toolkit.

Table 5: Suicide and injury: undetermined rates in outer Ealing Hillingdon and Hounslow: number of deaths and rates 2007-8[29]

Borough	Deaths from suicide & injury undetermined 2007 - 2009	*Directly age-standardised rates (DSR) per 100,000*	95% Confidence Interval
Ealing	69	*6.71*	5.08 – 8.33
Hillingdon	58	7.26	5.37 – 9.14

Table 6: Projected Rate of Suicide and undetermined injury 2011 to 2013

Borough	Projected Directly age-standardised rates (DSR) per 100,000 Males 2011 -2013	Directly age-standardised rates (DSR) per 100,000 Females 2011-2013
Ealing	9.6	3.9
Hillingdon	10.79	3.79
Hounslow	14.22	3.6
London	9.92	3.46
England	11.36	3.6

Last updated: Jun 2011, Next update expected: Dec 2011[30]

[28] London Health Programmes Health needs assessment toolkit, Last updated: Jun 2011, Next update expected: Dec 2011, http://hna.londonhp.nhs.uk/JSNA.aspxht

[29] London Health Programmes Health needs assessment toolkit, Last updated: Jun 2011, Next update expected: Dec 2011, http://hna.londonhp.nhs.uk/JSNA.aspxht

[30] http://hna.londonhp.nhs.uk/JSNA.aspxht

2.4 The strategy for services for adults with mental health problems in Hillingdon 2013-16

2.4.1 The vision for services for adults with mental health problems in Hillingdon 2013-16

The vision for adult mental health services agreed with service users and partners in 2008 is still relevant to current mental health service delivery. However, some revision has been made to:

- Acknowledge fully the contribution of carers of people with mental health problems and to ensure that they are supported effectively in their caring role
- Emphasise the need to ensure the empowerment of service users and carers by ensuring real involvement in service planning and delivery
- Emphasise the need to support service users to take control of their own lives and to offer choice through the provision of a range of high quality services See Figure 13 opposite.

The commitments made in 2008 by health and social care mental health partners also remain relevant and form the basis of the mental health services plan 2013-16. These include mental health and social care providers and commissioners committed to work together to:

- Maximise the health and social care resources available for mental health
- Reduce the impact of mental illness
- Ensure that services are provided in the least restrictive way possible with a shift from acute to secondary and primary care community settings
- Ensure that the range of services available is informed by an understanding of the changing needs of the population

Figure 13: The vision for services for adults with mental health problems in Hillingdon 2013-16

People with mental health problems and their carers living in Hillingdon should benefit from opportunities for positive mental well-being which includes:

- **Involvement with community, friends and family**
- **Meaningful occupation learning and leisure**
- **Having the basics in place:**
  - **Good health care**
  - **Good housing**
  - **Financial security**
- **Access to the above for people with significant mental health problems as well as access to specialist services which provide for their individual needs and preferences, promoting recovery from the effect of mental health problems**

Services should support people with mental health problems to recover and ensure that both they and their carers:

- **Are supported to live a normal life as far as possible**
- **Are empowered to take control of their own lives**
- **Are fully involved in the planning and delivery of services**
- **Are included in local communities and activities**
- **Are not stigmatised or discriminated against on any grounds**
- **Have easy access to up to date and accurate information**
- **Have options in the choices of high quality care and support available locally**
- **Have personalised care plans that are built around their needs and wishes**

- Respond to the increasing diversity in the population, ensuring that resources are directed at the areas with greatest need and are sensitive to the needs of the different communities
- Support the development of skills of those working with people with mental health problems and their carers as either volunteers or as employed staff
- Meet the statutory duties and responsibilities laid out in legislation
- Ensure that services meet nationally and locally set quality standards

- Develop the best possible network of services within Hillingdon

2.4.2 The joint strategy for services for adults with mental health problems in Hillingdon 2013-16

There is potential for significant improvement to the efficiency and effectiveness of the services for adults with mental health problems through the development of an integrated, whole systems approach, building on the current strength of GPs in managing adults with mental health problems in the community. Improvement will be achieved through effective partnership working that enables service reconfiguration and redesign, leading to a shift from a bed based to community based service with treatment provided at home as far as possible, and achieving a shift from secondary to primary care assessment, treatment and support. The objective will be to deliver integrated, recovery focused, personalised, outcomes based assessment treatment and support in the community. Individual and joint plans will be developed and costed to realise the potential gains. Key actions to achieve improvement are summarised below.

Hillingdon CCG and LBH will initiate the following specific actions with key partners, including CNWL:

- Develop the primary care based mental health services infrastructure – by implementing the "shifting settings of care" workstreams prioritised from the NW London Mental Health Integrated Care Pathway (ICP) /Strategy
- Improve the range of accommodation and support available in the community
- Improve the efficiency and reduce the cost of services

To support delivery of these changes and the overall improvement of assessment, treatment and support for adults with mental health problems in Hillingdon, Hillingdon CCG and LBH will provide strong leadership, adopting a partnership approach with all stakeholders to integrate plans to implement personalisation, improve the range and quality of accommodation and ensure support for employment and training and community based activities and support into the initiatives outlined above.

The main opportunity for Hillingdon within the shifting settings of care programme is to improve primary care based mental health services in order to:

- Enable a transfer of care for people with serious mental illness whose mental health state is stable from secondary to primary care
- Enable primary care to assess, treat and support people with common mental health problems and serious mental illness effectively
- Provide effective psychological interventions

There is some potential for a reduction in the number of mental health inpatient beds as community services are strengthened, a need for review of rehabilitation services and the opportunity to rationalise psychiatric intensive care service provision across NW London.

The new service model will require the development and implementation of integrated care pathways. This has been shown to facilitate new ways of working supporting significant improvement in the effectiveness and efficiency of health and social care services delivery. This approach will enable key concerns relating to the effectiveness and efficiency of services in Hillingdon to be addressed:

- Ensuring that services are personalised and recovery and outcomes focussed

- Ensuring that services empower people to take control of their own lives
- Ensuring that services offer choice of a range of high quality services
- Improving access and equity of services
- Ensuring access to evidence based interventions
- Ensuring that specialist needs are addressed effectively, in particular:
    - Eating disorder
    - Forensic needs

Action has already been taken by Hillingdon CCG, LBH and CNWL to ensure the effective and efficient use of specialist mental health placements with significant improvement being made in efficiency and outcomes for service users. This work will continue with implementation of a joint plan for improvement. See Appendix 3.

In order to help to achieve the required improvements, Hillingdon CCG and LBH are exploring new approaches to joint service delivery and commissioning.

As a result of the current reforms to the NHS and social care, LBH will assume responsibility for Public Health in 2013. Mental health promotion and prevention will therefore become part of the Council's overarching strategy and responsibilities. Applying the evidence base for effective mental health interventions, the Public Health department will develop and implement programmes that:

- Address health inequalities
- Promote positive mental wellbeing and mental health in all groups in the community by ensuring that area based groups across the borough consider and address mental health issues
- Support early intervention

Plans will be made to continue to implement interventions already proven to be effective in the borough including "get into reading/reading matters", walk Hillingdon, wellbeing initiative networks: promoting five ways to wellbeing. See Appendix 2.

Improvements have already been made in the use of specialist mental health housing and residential placements through effective joint action between LBH, Hillingdon CCG and CNWL (see above). LBH has prioritised ensuring further improvement in the offer of accommodation for people with mental health problems to 2016. Improvement will be made by:

- Increasing the range of supported housing options
- Moving from a model of residential care to independent living with packages of support tailored to individual need
- Implementing personalised approaches to support. See Appendix 3

Moving towards personalised, recovery and outcome focussed mental health services in Hillingdon will be a priority for Hillingdon CCG and LBH working with key partners. It will be a particular focus of their work with CNWL:

- A national dashboard will be utilised and reported by CCG to evidence the performance of local mental health services. See Appendix 4; this will be used to inform commissioning decisions and priorities.
- The Health of the Nation Outcome Score (HoNOS) has been used to measure the impact of interventions made by specialist mental health services for some time. Under Payment by Results, the use of Patient Reported Outcome Measures (PROMS) and Clinician Reported Outcome Measures (CLOMS) is planned during 2013 -14
- Since 2008, CNWL has established a Recovery College. The Recovery College offers a range of courses, seminars and

workshops which are co-designed and co-delivered by Peer Recovery Trainers (people with lived experience of mental health issues) and mental health practitioners. The College aims to:

- Offer support for people who use services, and enable them to become experts in their own self care
- Enable family, friends, carers and CNWL staff to better understand mental health conditions and support people in their personal recovery journeys.

Working with CNWL, it is proposed that a programme of courses on recovery available to both service users and carers in Hillingdon will be established. In addition, work will be done to explore the potential benefit of implementing the recovery star as a tool for working with service users to measure their progress towards recovery. See Figure 14 opposite.

A plan to deliver the required improvements identifying both the joint and individual action required by Hillingdon CCG and LBH to improve services working with key partners has been agreed. See Figure 15 below. Through the process of consultation on the strategy and implementation plan and the LBH Policy and Overview Committee review of adult mental health services that was undertaken from September 2012 to January 2013, feedback was received that will be used to inform implementation of each element of the plan. The feedback received is summarised at Appendices 5 and 6. An implementation plan for year 1 of the strategy (2013-14) is included at Appendix 7. A full equalities impact assessment for the strategy was carried out following the consultation process. No negative indicators for equality were identified through this process. See Appendix 8.

Figure 14: The mental health recovery outcomes star

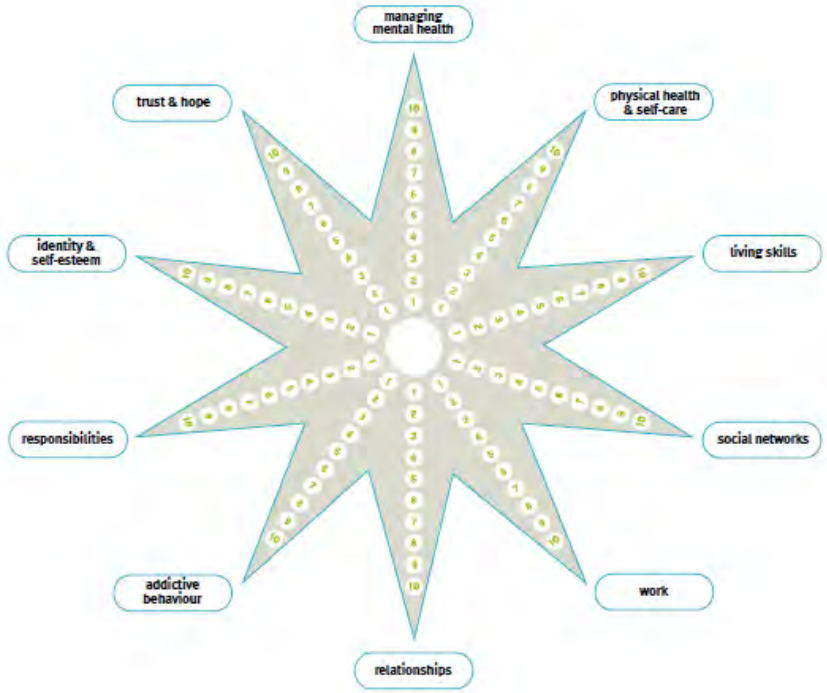


Figure 15: Hillingdon CCG and LBH joint plan for the improvement of services for adults with mental health problems 2013-16

Objective	Actions	Organisation	Year
Promote mental health and wellbeing and early intervention through the prioritisation and implementation of the evidence base for effective mental wellbeing and mental health promotion interventions	Applying the evidence base for effective mental health interventions, the Public Health department will develop and implement programmes that: • Address health inequalities • Promote positive mental wellbeing and mental health in all groups in the community by ensuring that area based groups across the borough consider and address mental health issues • Support early intervention • Address stigma Strategies will be developed to implement interventions already proven to be effective in the borough The mental health joint strategic needs assessment will be updated	**LBH** **LBH** **LBH**	**2013-16** **2013-16** **2013-16**
Agree and implement a suicide prevention strategy	Work with NHS Brent, NHS Ealing and NHS Harrow to agree a suicide prevention strategy building on the current draft.	**Hillingdon CCG and LBH**	**2013-16**
Ensure that the interface between services for children and adolescents and adult mental health services are addressed effectively	Review and improve the pathway that supports transition from child and adolescent to adult mental health services Ensure that the needs of children and adolescents whose parents are diagnosed with mental health problems are addressed effectively Review and develop support for young carers	**Hillingdon CCG and LBH** **LBH**	**2013-16** **2013-16**
Support primary care to further develop their role in providing mental health services assessment, treatment and support by developing the mental health services infrastructure within primary care and enhancing arrangements for specialist mental health services support for primary care and ensuring that people whose mental health is stable are managed in primary care	Commission an enhanced community and primary care based mental health service that enables discharge from secondary care and ensures that assessment, treatment and support is provided in the least restrictive setting possible, thereby reducing specialist services activity and cost and re-investing in primary care based mental health services and other community services: • Manage people with serious mental illness whose mental health condition is stable effectively • Provide effective assessment and treatment for people with serious mental illness in the community where possible/appropriate • Provide access to psychological therapies for people with common mental health problems in primary care/the community.	**Hillingdon CCG**	**2013-16**
Improve client experience of services, recovery	Develop and implement effective integrated care pathways to ensure	**Hillingdon CCG and**	**2013-16**

and outcomes and ensure that mental health need is addressed effectively and efficiently through redesign of local services and the implementation of the evidence base for effective assessment, treatment and support	timely access to effective, efficient health and social care assessment, treatment and support, ensuring access to specialist (evidence based) interventions and support	**LBH**	
Ensure that the specialist needs of service users are addressed effectively through service reconfiguration and redesign	Work with NW London commissioners and the National Commissioning Board to develop effective: i) Pathways from Heathrow and detention centres ii) Pathways for people with a learning disability who also have a mental health problem	**Hillingdon CCG and LBH**	**2013-16**
Provide assessment and treatment for acute physical and mental health problems in the least restrictive setting possible	Work with NW London commissioners to rationalise PICU provision Ensure effective and appropriate use of inpatient services to inform acute bed capacity and ensure onward transfer of care enables timely discharge and effective treatment and support in the community Improve the effectiveness and efficiency of rehabilitation services; this will include reviewing bed usage and determining the number required to meet need Evaluate the psychiatric liaison service in Hillingdon Hospital to reduce admissions ensuring admission only where necessary to treat a physical health care need and to ensure effective treatment of mental health problems of those admitted to hospital Ensure that arrangements are in place to provide effective support to service users in crisis	**Hillingdon CCG** **Hillingdon CCG** **Hillingdon CCG** **Hillingdon CCG and LBH**	**2013-16** **2013-16** **2012-13** **2013-14**
Ensure that the physical health care needs of people with mental health problems are addressed effectively	Ensure consistent and appropriate assessment and treatment for the physical health needs of people with mental health problems in primary care Ensure that secondary care services monitor clients' physical health care needs	**Hillingdon CCG** **Hillingdon CCG**	**2013-16** **2013-16**
Ensure effective use of resources	Continue to ensure the effective use of specialist mental health placements Maximise the benefit of current investment in order to make best use of resources (direct costs/indirect cost/capital charges) Explore the potential to improve effectiveness and efficiency through improvements to the model of: • Joint delivery • Joint commissioning	**Hillingdon CCG and LBH** **Hillingdon CCG** **Hillingdon CCG and LBH**	**2013-16** **2013-16** **2013-16**

Promote independence and empower people with mental health problems by increasing the supply of supported housing and the range of services available and providing personalised packages of support	Review and improve the range of services available to enable people to live independently as fully participating members of their communities (community connections)	**LBH**	**2013-16**
	Deliver an additional 55 units of supported housing accommodation for people with functional mental health problems	**LBH**	**2013-16**
	Ensure the personalisation of existing supported housing services for people with mental health needs	**LBH**	**2013-16**
	Ensure the personalisation of existing supported housing services for people with mental health problems	**LBH**	**2013-16**
Ensure that service users and carers have access to support that is as de-stigmatising and empowering as possible and addresses inequalities in mental health status	Work with key stakeholders to review all contracts with non-specialists mental health services commissioned by Hillingdon CCG and LBH in order to establish an integrated "community connections" service (may not be a single contract but contracts will be set within a framework specifying required outcomes)	**Hillingdon CCG and LBH**	**2013-16**
	Work with bme and faith groups and leaders to identify and begin to address mental health inequalities	**Hillingdon CCG and LBH**	**2013-16**
Ensure that service delivery is focussed on recovery, personalisation and outcomes for service users and carers	Implement nationally agreed performance measures (PROMS/CLOMS/ HoNOS)	**Hillingdon CCG/LBH/ CNWL**	**2013-14**
	Explore the potential benefit of implementing a service user outcome measure e.g. Recovery Star	**Hillingdon CCG/LBH/ CNWL**	**2013-14**
Improve support to carers of adults with mental health needs	Explore the need to establish a Borough wide forum for carers of people with mental health problems	**Hillingdon CCG/LBH/ CNWL**	**2013-14**
	Establish a programme of courses run by the Recovery College so that a programme for carers in Hillingdon is provided routinely	**Hillingdon CCG/LBH/ CNWL**	**2013-14**
	Address the psychological needs of carers by promoting awareness of the right of carers to referral to psychological therapies in their own right amongst GPs and other professionals	**Hillingdon CCG/LBH/ CNWL**	**2013-14**
	Work with carers – individually and collectively - to find effective ways of providing support when the person they support is in crisis	**Hillingdon CCG/LBH/ CNWL**	**2013-14**
Ensure the effective involvement of service users in service delivery and planning	Work with service users and key agencies to develop the Borough wide service user forum to ensure effective involvement of service users in service delivery and planning	**Hillingdon CCG/LBH/ CNWL**	**2013-16**
	Establish a programme of courses run by the Recovery College so that a programme for service users in Hillingdon is provided routinely	**Hillingdon CCG/CNWL**	**2013-16**

PART 3: SERVICES FOR OLDER ADULTS WITH MENTAL HEALTH PROBLEMS IN HILLINGDON

3.1 The development of services for older adults with mental health problems in Hillingdon 2011-13

Hillingdon CCG and LBH have been working together to agree a strategy for the improvement of services for older adults with mental health problems and their carers for implementation 2013-2016. The objective is to ensure that people with dementia and their carers living in Hillingdon have timely access to evidence based assessment, treatment and support i.e. as defined in the National Dementia Strategy[31] and SCIE guidelines for dementia[32]. Early in 2012, both organisations prioritised and made a commitment to the improvement of services for adults with mental health problems:

- Ensuring that health and social care services work together with partners to deliver effective assessment, treatment and support
- Ensuring that resources are used effectively and efficiently
- Optimising the experience of services and outcomes for people diagnosed with dementia and their carers
- Ensuring timely diagnosis and early intervention, including the provision of information and advice
- Providing assessment, treatment and support in community settings

and to the development of a joint strategy. In order to develop a robust strategy, a multi-agency capacity planning and service modelling exercise was undertaken during 2012/13.

As a result of the commitment to improve services for older adults with mental health problems, the following specific developments are being implemented with completion 2012/13:

- Establishment of a memory assessment service to replace the existing memory clinic; the new service will commence operation in November 2012 and will be fully operational by February 2013. (This development has been achieved by re-investing resources committed to unoccupied inpatient beds)
- Training for the Hillingdon workforce using Section 256 monies allocated to LBH
- The Alzheimer's Society have recently opened an additional 2 cafes within the borough specifically for carers of people with dementia
- A specialist dementia information, advice and guidance service has recently been established. This service is available to all carers regardless of age i.e. not restricted for carers of older adults
- Hillingdon Carers operates as the local "One Stop Shop". It has 3 cafes located across the borough providing good geographical access and providing flexibility as they offer drop in sessions which do not require pre-booked appointments
- Revision of the deployment of Admiral Nurses Scheme to offer a specialist 1:1, individually tailored service for carers of older adults with mental health problems

[31] Living well with dementia: A National Dementia Strategy, DH, 2009

[32] Clinical Guideline 42: Dementia: supporting people with dementia and their carers in health and social care, NICE/SCIE, 2006

In 2011, the LBH External Services Committee completed a review of dementia services in Hillingdon. The Committee found that a significant number of people were not using services as they had not been diagnosed with dementia and their presentation did not require support from specialist mental health services. It concluded that it was best to focus on people know to services as there are not sufficient resources to meet the needs of everyone who may have dementia. In general, the group known to services would be those most in need of services and therefore the group on which services should be targeted. As a result of the work of the External Services Committee, the recommendations in Figure 15 below were made.

Figure 15: LBH External Services Committee review of dementia services 2011-12: summary of recommendations

LBH External Services Committee Review of Dementia Services 2011: Summary of Recommendations	
Recommendation 1	To ensure timely assessment, diagnosis and treatment of dementia, Cabinet requests that Hillingdon CCG and the Local Clinical Commissioning Group be asked to explore the expansion of memory clinic services in Hillingdon and that this be done on a multi-disciplinary, multi-agency basis, reporting back to the Health and Wellbeing Board
Recommendation 2	That Cabinet gives its full support for the development of a single point of access through the Council's on-line information portal (which will be provided in partnership with the West London Alliance) to ensure that people with dementia and their carers/families can access timely information, advice and sign-posting to the memory clinic and other appropriate services to aid early diagnosis
Recommendation 3	That Cabinet endorses the Working Group's enthusiastic support for the wider distribution as well as online publication of the dementia information booklet to GPs, other professionals and voluntary organisations and, in particular, to people with dementia and their carers. As such, Cabinet agrees that officers work with NHS partners to encourage them to identify funding streams to enable this wider distribution
Recommendation 4	That Cabinet takes into consideration the increasing pressure on those voluntary sector organisations that deliver services to people with dementia when developing its budget proposals for 2013/2014 onwards
Recommendation 5	That Cabinet agrees that the information gathered from the Dementia Stakeholder Event held on 12 January 2012 and throughout this review be used to form the foundation of Hillingdon's Dementia Strategy
Recommendation 6	That Cabinet endorses the provision of a programme of effective basic training and continuous professional and vocational development in relation to dementia for community health and social care staff, GPs and staff within care homes to be developed jointly by the Council and Hillingdon CCG

And the following priorities for dementia were agreed by LBH and Hillingdon CCG:

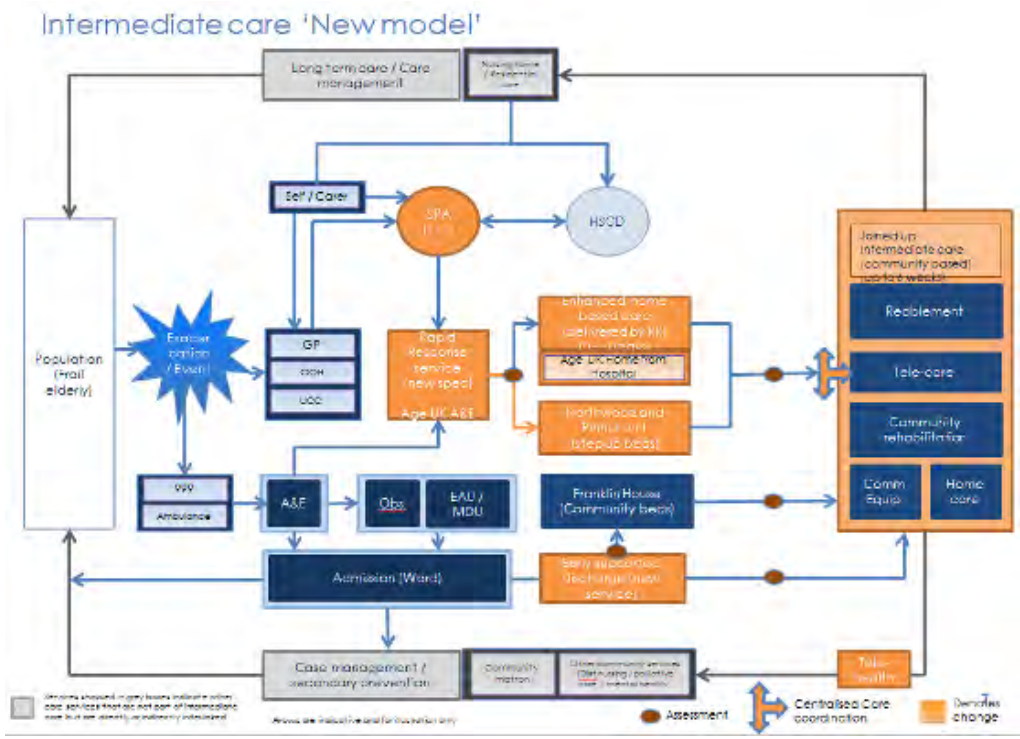
- To increase awareness and understanding of dementia
- To develop early diagnosis and intervention
- To ensure a high quality of care/living well with dementia
- To reduce dementia-related hospital admissions and avoidable care costs
- To support residents in the community
- To facilitate future planning i.e. finances/decisions

In addition to the specific work on services for older adults with mental health problems, there has been a focus on the improvement of services for older adults with physical health care needs. Initiatives include the agreement of a plan for improvement of services for older people 2012-16[33] and an "out of hospital" strategy. These initiatives include

[33] Older People's Commissioning Plan 2012-16, Hillingdon CCG and LBH, 2012

establishing a range of intermediate care services including a rapid response team to assess and support older adults in the community when in crisis, offering alternatives to hospital admission and the establishment of a rapid assessment team in the accident and emergency department at The Hillingdon Hospital. The aim of this team is to ensure admission to an inpatient bed only when this is the appropriate response to the presenting need. Older adults with mental health problems are included in the criteria for these services, although additional mental health expertise is needed to realise the full potential to support them effectively. See Figure 16 opposite.

Figure 16: Hillingdon revised intermediate care model 2012



Following strategic work undertaken across NW London, the implementation of integrated care pathways (ICPs) for:

- Elderly frail adults (elderly frail ICP for adults aged 75 years and over)
- Older adults with mental health problem (mental health ICP)

has been prioritised as a key strategy for improved effectiveness and efficiency, patient experience and outcomes. The development of effective care pathways for people with dementia has been prioritised within this. The effective management of people with complex needs through improved multi-disciplinary working in primary care is a key component of the proposed improvements.

The mental health ICP prioritises the implementation of psychiatric liaison in acute hospitals in order to ensure appropriate response to crises and the provision of alternatives to hospital assessment and treatment where appropriate, ensuring effective management and appropriate use of resources.

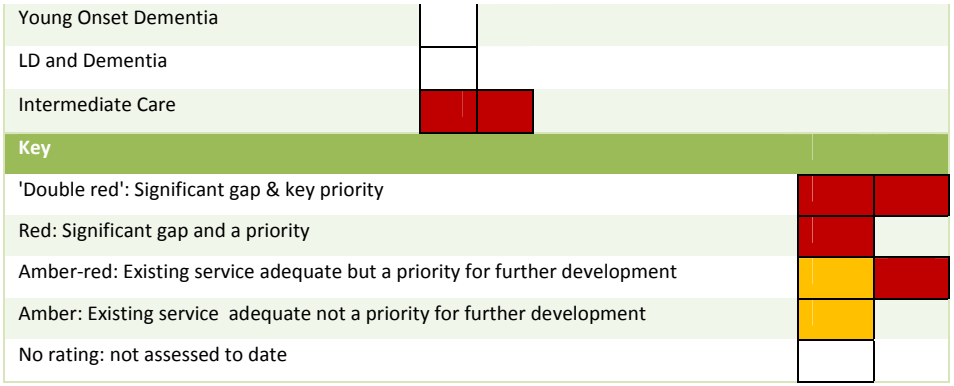
Hillingdon CCG commissions a specialist assessment, treatment and service for older adults with mental health problems. The service comprises a community mental health team and inpatient services. The CCG has also recently commissioned a memory assessment service.

Specialist services for people with dementia need significant improvement as there are concerns about capacity and current pathways to and within these. Concerns include ensuring that a diagnosis of dementia is made early, providing effective support to carers to enable them to continue in their caring role – identified as the top priority for improvement in Hillingdon, effective crisis response and intensive home treatment services and improving the quality of care in some residential and nursing home settings . A gap analysis undertaken by stakeholders involved in capacity planning and modelling work prioritised the improvements required. See Figure 17 below. In addition, detailed integrated care pathways for older adults with dementia are under development. This is work in progress. Copies of the current draft pathways are available on request[34].

Figure 17: Gap analysis: dementia capacity planning and modelling project 2012

Service	Rating	Notes
Crisis Support (Rapid Response)		
Home Treatment		
Extra Care Homes - Dementia		Additional 69 places. Agreement to fund.
Memory Assessment Service		Additional investment in 3 Dementia Advisors
Support For Carers		
Respite Care		Enable carers to have quality of life to maintain caring role: - 2 hours to 24/7 - flexible - sitting service - bed and home based
Information and Advice		
Daytime and Social Activity		
Dementia Public Awareness		
Training for Support		
Staff and Professionals		- CNWL - Residential Care / Nursing Homes - GPs
Liaison with Residential Care / Nursing Homes		
Psychiatric Liaison (Acute)		

[34] Contact: Fiona Davies, Snr Commissioning Manager: fiona.davies4@nhs.net



LBH commissions a care management service which works alongside the specialist mental health service as well as commissioning support and accommodation in the community through voluntary sector and private service providers.

In addition to the above, Hillingdon CCG has a number of carer forums which provide opportunity for user feedback which are used for service improvement/redesign.

3.2 Use of resources in services for older adults with mental health problems in Hillingdon

3.2.1 Hillingdon CCG and LBH: Use of resources for older adults with mental health problems

LBH and Hillingdon CCG invest £198.68 per head in older people's mental health services. This investment is currently invested in services that are significantly bed based. In addition, there is significant inappropriate use of acute general hospital beds by older people with dementia. Recent work within both organisations and across NW London has demonstrated that there is potential to achieve significant efficiencies and improvement to effectiveness, patient experience and outcomes through a shift from bed based to community based services.

3.2.2 Hillingdon CCG: use of resources for older adults with mental health problems

Hillingdon CCG invests £4.8m in services for older people with mental health problems. £4.5m of the total Is invested with CNWL. £3.7m of this total is invested in acute inpatient services.

3.2.3 London Borough of Hillingdon: use of resources for older adults with mental health problems

LBH does not differentiate between investment in services for people with dementia and expenditure on services for older people although information is available on expenditure on residential and nursing home care.

In 2012-11, LBH spent 51 percent of its total expenditure on services for older people – 2 percent less than the expenditure of its comparator group and 5 percent less than the average for England. Total expenditure was £36m. £22m was spent on residential/nursing care and £6.2m on domiciliary and day services. Of the 2,531 people receiving domiciliary care, 156 had been diagnosed with dementia. Of the 290 older people attending day services, 97 had been diagnosed with dementia and of the 575 permanent placements, 163 were in dementia residential homes and 86 were in dementia nursing homes.

In early 2011, the projected expenditure on older people 2011/12 was £30m, £6m less than the previous year. An increase of £0.8m to £7m on support for people with dementia was projected within this.

3.3 The performance of services for older adults with mental health problems in Hillingdon

3.3.1 The performance of NHS commissioned services for older adults with mental health problems

CNWL is the main provider of specialist mental health services in Hillingdon. The Trust has recently assessed the performance of their services for older adults with functional mental health problems and/or dementia. They identified the following areas of concern:

- Service provision for the assessment and early diagnosis of people who may have or go on to develop dementia is minimal, delivered by a memory clinic. There is no memory assessment service. Therefore demand for community memory service diagnosis and treatment is far greater than capacity with waiting times for memory assessment/diagnosis up to 6 months
- Most of the specialist dementia provision is provided in bedded services. Average length of stay is 119 days. The majority of admissions are from patients' own homes (62%). However, 64 percent of patients are discharged to nursing homes (64%)

Therefore, prevention of admissions, reduction in the length of inpatient stay, to avoid institutionalisation of patients and more comprehensive community provision (Community Mental Health Team and Memory Service) is needed.

3.3.2 The Performance of LBH commissioned services for older adults with mental health problems

In 2012/11, LBH performed well in comparison with other London boroughs – 3rd out of its comparator and group and significantly better than England as a whole for achieving independence for older people through rehabilitation and intermediate care.

In 2012/11, LBH performed well in comparison with other London boroughs – 3rd out of its comparator and group and significantly better than England as a whole for achieving independence for older people through rehabilitation and intermediate care.

3.4 The strategy for services for older adults with mental health problems in Hillingdon 2013-16

The work undertaken has identified that significant improvements to the efficiency and effectiveness of the services for older adults with mental health problems can be made through the development of an integrated, whole systems approach, building on the current strength of GPs in managing adults with mental health problems in the community. Improvement will be achieved through effective partnership working that enables service reconfiguration and redesign, leading to a shift from a bed based to community based service with treatment provided at home as far as possible, and achieving a shift from secondary to primary care assessment, treatment and support. The objective will be to deliver recovery focused, personalised, outcomes based assessment treatment and support in the community. Individual and joint plans will need to be developed and costed to realise the potential gains. Key actions to achieve improvement are summarised below.

- Supporting people in their own homes for as long as possible by providing specialist expertise within services for older adults where appropriate, in particular as part of the out of hospital strategy
- Increasing the rate of diagnosis of dementia; including training GPs and establishing a memory assessment service

- Improving the co-ordination of care through improved assessment and multi-disciplinary working in primary care (Elderly ICP) and integration of the work of all relevant agencies into an effective model of care
- Promoting awareness of dementia amongst the general public and staff working with older adults
- Reducing reliance on acute mental health beds
- Developing the infrastructure for community based assessment, treatment and support through the implementation of agreed integrated care pathways
- Maximising the contribution of the voluntary sector
- Considering the commissioning a dementia resource centre to provide an accessible community resource for the delivery of health and social care services
- Agreeing a cost-effective way of providing specialist advice to residential and nursing home services in order to prevent escalation of need and avoid admission to inpatient or more intensively nursed care
- Evaluating and considering continued operation of the psychiatric liaison service at The Hillingdon Hospital (MH ICP) as an effective way to ensure appropriate response to physical and mental health care crises
- Improving support to carers to enable them to continue in their caring role; includes improving carers' assessment and improving respite care
- Reviewing services and developing and implementing improved care pathways to identify need and initiate improvement to people with early onset dementia
- Reviewing services and developing and implementing improved care pathways to identify need and initiate improvement to people with a learning disability with dementia

This will be achieved by:

- Implementing the revised care pathways for specialist mental health services developed by the multi-agency strategy group
- Implementing the detailed plans arising from the capacity and modelling work undertaken during the work to revise the care pathways
- Building on the new intermediate care services established for older adults by ensuring that pathways and services identify and meet the needs of people with dementia and their carers

A plan to deliver the required improvements identifying both the joint and individual action required by Hillingdon CCG and LBH to improve services working with key partners has been agreed. See Figure 18 below.

Figure 18: Hillingdon CCG and LBH joint plan for the improvement of services for older adults with mental health problems 2013-16

Objective	Actions	Organisation	Year
Improve the rate of dementia diagnosis in order to promote early intervention	Maximise the availability of, and access to, memory assessment services	**Hillingdon CCG**	**2013-16**
Promote awareness of dementia	Ensure that organisations take action to promote knowledge of dementia of the general public and the health and social care workforce Provide dementia awareness training for the public and professionals.	**Hillingdon CCG and LBH** **Hillingdon CCG and LBH**	**2013-16** **2013-16**
Provide assessment and treatment for acute physical and mental health problems in the least restrictive setting possible	Evaluate the psychiatric liaison service in Hillingdon Hospital to ensure admission only where necessary to treat a physical health care needs and to ensure effective treatment of people with mental health problems admitted to hospital Seek to improve prevention and responses to crises, enhancing intermediate care and rapid response services to respond effectively to the needs of people with dementia and considering the establishment of an intensive home treatment service Further review bed use and determine whether further bed reductions (from 25) is indicated in order to facilitate the establishment of a community based service	**Hillingdon CCG** **Hillingdon CCG and LBH** **Hillingdon CCG**	**2013-14** **2013-14** **2013-14**
Ensure that the need for specialist mental health assessment, treatment and support of service users and carers is addressed effectively and efficiently through service reconfiguration and service redesign of local services	Implement the agreed care pathways for older adults with mental health problems, ensuring that they build on and interface with the recently agreed care pathways for older adults in Hillingdon Establish a single point of access to LBH services Improve community based assessment, treatment and support services, including exploring the cost/benefit of establishing intensive treatment and support to prevent and manage crises in the community Find cost effective ways of improving support to carers to enable them to continue in their caring role: • Improve carers' assessment • Develop a single point of access to services, ensuring access to appropriate advice, information and support • Improve access to respite care • Explore the need for a night sitting service Consider commissioning a dementia resource centre to provide a setting for both health and social care commissioned services Remodel the community services supporting people with dementia to	**Hillingdon CCG and LBH** **LBH** **Hillingdon CCG** **Hillingdon CCG** **Hillingdon CCG and LBH** **Hillingdon CCG and**	**2013-14** **2013-14** **2013-14** **2013-16** **2013-16** **2013-16** **2013-16**

	ensure that they are contributing to the delivery of the dementia pathway	**LBH**	**2013-16**
	Maximise the contribution of the voluntary sector to the provision of cost effective support; this includes maximising their contribution to: • Promoting awareness of dementia • Providing training to staff working with people with dementia • Providing information and advice to people with dementia and their carers • Supporting carers • Providing day and leisure activities to people with dementia	**Hillingdon CCG and LBH**	
	Agree a cost effective way of providing specialist advice effectively to residential and nursing home services in order to prevent escalation of need to avoid admission to inpatient or nursing home services	**Hillingdon CCG**	**2013-16**
	Review services and develop and implement care pathways to identify need and initiate improvements to services for people with early onset dementia	**Hillingdon CCG and LBH**	**2013-16**
	Review services and develop and implement care pathways to provide effective assessment, treatment and support for people with a learning disability who also have dementia	**Hillingdon CCG and LBH**	**2013-16**
Promote independence and empower adults with mental health problems by increasing the supply of supported housing and providing personalised packages of support	Deliver 55 units of supported housing accommodation for people with functional mental health needs, including older adults.	**LBH**	**2013-16**
	Deliver 69 units of extra care accommodation for people with dementia In partnership with registered providers and private sector developers	**LBH**	**2013-16**
	Personalise existing supported housing services for people with mental health need	**LBH**	**2013-16**
	Remodel the community support services for people with functional mental health needs provided by the third sector to reflect personalisation and the prevention agenda	**LBH**	**2013-16**

GLOSSARY

BME: black and minority ethnic communities
CAMHS: Child and Adolescent Mental Health Services
CPA: Care Programme Approach
CNWL: Central and North West London Mental Health Trust
DH: Department of Health
HCCG: Hillingdon Clinical Commissioning Group
HHWB: Hillingdon Health and Wellbeing Board
ICP: Integrated Care Pathway
ImROC: Implementing Recovery Through Organisational Change (an approach to implementing recovery piloted during 2011 by the Mental Health Network NHS Confederation)
JSNA: Joint Strategic Needs Assessment
KPIs: Key Performance Indicators
LBH: London Borough of Hillingdon
MHDG: Mental Health Delivery Group
MINI: Mental Illness Needs Index
M2K: mental Illness Needs Index 2000
NHS: National Health Service
NWL: North West London
ONS: Office of National Statistics
SMR: Standardised Mortality Ratio

APPENDIX 1: Living well with dementia: The National Dementia Strategy, 2009: Objectives

Objective 1: Improving public and professional awareness and understanding of dementia.
Public and professional awareness and understanding of dementia to be improved and the stigma associated with it addressed. This should inform individuals of the benefits of timely diagnosis and care, promote the prevention of dementia, and reduce social exclusion and discrimination. It should encourage behaviour change in terms of appropriate help-seeking and help provision.

Objective 2: Good-quality early diagnosis and intervention for all.
All people with dementia to have access to a pathway of care that delivers: a rapid and competent specialist assessment; an accurate diagnosis, sensitively communicated to the person with dementia and their carers; and treatment, care and support provided as needed following diagnosis. The system needs to have the capacity to see all new cases of dementia in the area.

Objective 3: Good-quality information for those with diagnosed dementia and their carers.
Providing people with dementia and their carers with good-quality information on the illness and on the services available, both at diagnosis and throughout the course of their care.

Objective 4: Enabling easy access to care, support and advice following diagnosis.
A dementia adviser to facilitate easy access to appropriate care, support and advice for those diagnosed with dementia and their carers.

Objective 5: Development of structured peer support and learning networks.
The establishment and maintenance of such networks will provide direct local peer support for people with dementia and their carers. It will also enable people with dementia and their carers to take an active role in the development and prioritisation of local services.

Objective 6: Improved community personal support services.
Provision of an appropriate range of services to support people with dementia living at home and their carers. Access to flexible and reliable services, ranging from early intervention to specialist home care services, which are responsive to the personal needs and preferences of each individual and take account of their broader family circumstances. Accessible to people living alone or with carers, and people who pay for their care privately, through personal budgets or through local authority arranged services.

Objective 7: Implementing the Carers' Strategy.
Family carers are the most important resource available for people with dementia. Active work is needed to ensure that the provisions of the Carers' Strategy are available for carers of people with dementia. Carers have a right to an assessment of their needs and can be supported through an agreed plan to support the important role they play in the care of the person with dementia. This will include good-quality, personalised breaks. Action should also be taken to strengthen support for children who are in caring roles, ensuring that their particular needs as children are protected.

Objective 8: Improved quality of care for people with dementia in general hospitals.
Identifying leadership for dementia in general hospitals, defining the care pathway for dementia there and the commissioning of specialist liaison older people's mental health teams to work in general hospitals.

Objective 9: Improved intermediate care for people with dementia.
Intermediate care which is accessible to people with dementia and which meets their needs.

Objective 10: Considering the potential for housing support, housing-related services and telecare to support people with dementia and their carers.
The needs of people with dementia and their carers should be included in the development of housing options, assistive technology and telecare. As evidence emerges, commissioners should consider the provision of options to prolong independent living and delay reliance on more intensive services.

Objective 11: Living well with dementia in care homes.
Improved quality of care for people with dementia in care homes by the development of Explicit leadership for dementia within care homes, defining the care pathway there, the commissioning of specialist in-reach services from community mental health teams, and through inspection regimes.

Objective 12: Improved end of life care for people with dementia.
People with dementia and their carers to be involved in planning end of life care which recognises the principles outlined in the Department of Health End of Life Care Strategy. Local work on the End of Life Care Strategy to consider dementia.

Objective 13: An informed and effective workforce for people with dementia.
Health and social care staff involved in the care of people who may have dementia to have the necessary skills to provide the best quality of care in the roles and settings where they work. To be achieved by effective basic training and continuous professional and vocational development in dementia.

Objective 14: A joint commissioning strategy for dementia.
Local commissioning and planning mechanisms to be established to determine the services needed for people with dementia and their carers, and how best to meet these needs. These commissioning plans should be informed by the World Class Commissioning guidance for dementia developed to support this Strategy.

Objective 15: Improved assessment and regulation of health and care services and of how systems are working for people with dementia and their carers.
Inspection regimes for care homes and other services that better assure the quality of dementia care provided.

Objective 16: A clear picture of research evidence and needs.
Evidence to be available on the existing research base on dementia in the UK and gaps that need to be filled.

Objective 17: Effective national and regional support for implementation of the Strategy.
Appropriate national and regional support to be available to advise and assist local implementation of the Strategy. Good-quality information to be available on the development of dementia services, including information from evaluations and demonstrator sites.

APPENDIX 2: Mental Health Promotion and Wellbeing: Achievements 2011-12 and Intentions 2012-15

Mental Health Promotion and Wellbeing

Promoting and Protecting Better Mental Health

- Evidence shows the positive impact of improving public mental health and well-being on health, social and economic outcomes (see Appendices). Building a sense of long-term wellbeing in individuals and communities is crucial. Wellbeing drives up productivity and can reduce the burden of poor mental health which currently costs the UK over £100 billion.
-
- National recommendations set out the escalating need to shift programmes towards mental health prevention, promotion, and early intervention in order to make significant contribution to health, quality of life, economic and social recovery within communities. Services and stakeholders should focus effort and resources to promote and protect better mental health, not just among the unwell but across whole populations

- Positive mental health is a resource for everyday life and is therefore everybody's business. Many factors influence mental health and wellbeing: genes, childhood experiences, life events, individual ability to cope, health literacy and levels of support, as well as factors such as housing, employment, financial security and access to appropriate health care.

- Mental health promotion focuses on improving the social, physical and economic environments that determine the mental health of communities, families and individuals. Robust evidence exists to show that positive mental health programmes can result in impressive long-lasting effects on multiple areas of functioning and can also have the dual effect of reducing risks of mental disorders. Examples of positive mental health indicators include:
    - Better physical health
    - Minimising or preventing mental illness
    - Improved mental health literacy
    - Improved coping and problem solving skills
    - Ability to develop emotionally, creatively, intellectually
    - Improved parenting skills and family functioning
    - Improved confidence
    - Increased community participation and connectedness
    - Ability to develop personal relationships
    - Reduced mortality

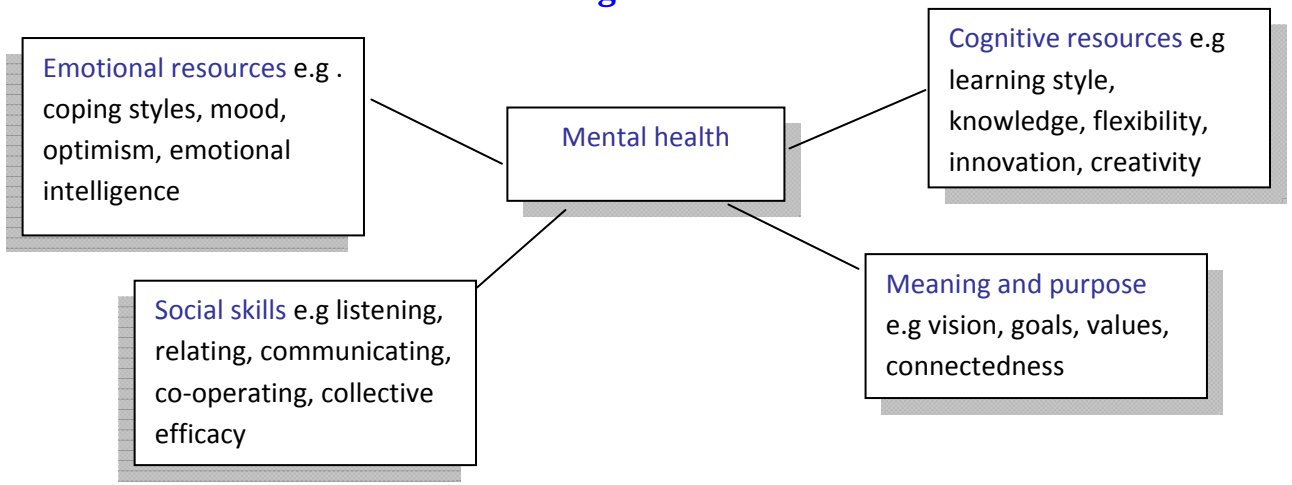
Mental Health Promotion and Wellbeing

Hillingdon programmes: developed by the Specialist Health Promotion Team

The Specialist Health Promotion Team (within Public Health) have set up a number of programmes to promote the mental health and wellbeing of local residents across the Life Course. Based on evidence of good practice the programmes are low-cost or free, set within a non-medical community setting. The programmes have been developed with a range of agencies to ensure that mental health and wellbeing messages and opportunities are promoted through a wide range of stakeholders across the borough. The outcomes of the programmes have focussed on the indicators that build and maintain indicators for positive mental health.

The programmes have been designed to enhance people's inherent resources as well as the physical and social assets within a community setting. This approach changes the focus from relying on services only and to enabling people to be active participants in shaping what improves their mental health and wellbeing.

Table to show Dimensions of mental well-being



Good Practice Examples

Activity	**'Get Into Reading' - 'Read Out Loud' Group** *"No comparison. This is ground breaking… very high standards – never had a course as good."* *"I can't wait till next week to attend the next session" "The session makes me happy" "I forget all my problems when I come to the session" "They are addictive"* *"My brain and concentration has been switched on again leading me to want to pursue other avenues of English Literature and using the English language to express myself, my feelings and desires."* *"We normally go back to our rooms and think about nothing in particular but now I can read the poem and imagine being at the seaside"*
Key Messages	Early, minimal intervention – led by trained facilitators (non clinical therapists), focus is on participant-initiated groups. Mental health and wellbeing is shown to improve through shared reading and reading of books out loud. Up to 12 participants attend each group across a range of local settings and age groups
Indicators for positive mental health	▪ Increased confidence and coping skills ▪ Improved vocabulary ▪ Increased friendships, community participation and sense of 'community' ▪ Enhanced meaningful conversation and opportunity to talk openly and honestly about feelings ▪ Decrease in feelings of isolation and loneliness ▪ Decrease in feelings of distress and anxiety
Hillingdon Outcomes	▪ 17 Groups set up across Hillingdon: including Libraries, Sheltered Housing, Mental Health Ward, Day Centres, Young People's groups ▪ Further 5 CNWL staff trained and using model within their work ▪ Self reported wellbeing and positive experience from group facilitators and participants.

Good Practice Examples

Activity	**Walk Hillingdon – nationally accredited by 'Walking for Health'** *"The walks have helped our tenants in many ways – they are integrated more in the local community, they get regular exercise, they have met new friends, it has helped to boost their self-esteem and confidence by being warmly welcomed and included regardless of any disability. Thanks everyone!"* *"The walks have many benefits for me which have included discovering parts of the borough that were all new to me, being out in the fresh air and meeting new friends who have helped me during a very difficult time in my life"*
Key Messages	Walking is recommended as an intervention in NICE guidance relating to a range of physical and mental health conditions ((CHD, Cancers, Diabetes, Osteoporosis, Anxiety, Stress). Research indicates that people who are over 50 who are physically active have between 1.1 and 3.7 added "quality life years" (QALY). It is estimated that every £1 spent on a health walk will save a Primary Care Trust £7 on expenditure such as hospital admissions and medication. Led by trained Walk Leader Volunteers, everyone is encouraged to walk at their own pace so that strength and confidence can be built up slowly. All the walks are free, risk assessed and the health status of all new walkers is obtained when they come on a walk for the first time.
Indicators for positive mental health and wellbeing	▪ Increased social connectedness, confidence and enjoyment in exploring local areas ▪ Increased use of green and open spaces ▪ Improved health and mental health benefits – reduction in blood pressure, weight loss; improved heart rate, muscle tone; reduction in stress and anxiety
Hillingdon	▪ 17 led walks across the borough; 23 walk leaders trained including members of the public, NHS services, voluntary sector, Hillingdon MIND, community leaders.

Outcomes	▪ Walk Hillingdon programmes are available from all Hillingdon libraries, GP surgeries, pharmacies, and The Hillingdon Hospital Trust services ▪ Walkers log their walks and experiences of walks on Walk4Life through London Borough of Hillingdon website ▪ Diabeticare and Cardiac Care patients attend regular Walks as part of their care pathway. ▪ 98% - 100% positive feedback from residents about enjoying the walks, socialising, exploring new local areas
Activity	**Tea Dance and Health Fair for over 55's – Older People's Wellbeing Festival June 2012** *"I haven't laughed so much in years"* *"I met someone I used to work with 40 years ago"* *"It's lovely to feel alive"* *"The organisation was excellent and we were made to feel welcome"* *"Very good atmosphere"*
Key Messages	In Hillingdon there are 34,700 people aged 65 years.. Research has shown that taking part in activities and social events increases health and mental well-being through offering opportunities to be active and develop new social interactions; help plan for life transition from working to retirement through gaining awareness of activities and services available locally; be informed about prevention and support for key issues including falls, dementia, strokes and incontinence; better understand what is available in the through the personalisation agenda
Indicators for	▪ Increased access and utilisation of green space ▪ Improved perception of community safety by older people

positive mental health and wellbeing	▪ Improved Social connectedness ▪ Participation in physical activity: walking, cycling ▪ Improved self reported wellbeing ▪ Improved health related quality of life for older people
Hillingdon Outcomes	▪ 559 residents attended 7 tea dances held across the borough in June'12 ▪ 118 people out of 407 said they would like more physical activity; 69% reported back they wanted to do more dancing ▪ The three most common reasons stated that made the event enjoyable were[35]: music 87%; dancing 85%; socialising 84% ▪ 99.8% people said that they enjoyed the event and 98% said they would attend again

Good Practice Examples

Activity	**Wellbeing Initiative Network (WIN) – Promoting Five Ways to Wellbeing**  *" I feel better. I like to learn English. More friends made. I enjoy the group. I have more confidence"* *"Today I am happy. I am feeling interested in this one hour"*
Key Messages	A recent UK study to measure well-being estimated that only 14 per cent of the population has a high level of well-being, referred to as 'flourishing'. A further 14 per cent has very low well-being, notwithstanding individuals with a diagnosed mental disorder. A whole range

	of factors determine an individual's level of personal well-being but evidence indicates that the things we do and the way we think can have the greatest impact. Well-being comprises two main elements: feeling good and functioning well. Experiencing positive relationships, having some control over one's life and having a sense of purpose are all important attributes of wellbeing. The Warwick-Edinburgh Mental Well-being Scale (WEMWBS) has 14 questions on an individual's wellbeing.. It has been used successfully used in Scotland and the UK and is becoming the accepted benchmark for wellbeing.
Indicators for positive mental wellbeing	▪ Increase in emotional well-being: frequency of positive emotions and absence of negative feelings ▪ Increase in positive evaluation of a person's life overall ▪ Improved vitality: increase in energy, feeling well-rested and healthy, and being physically active ▪ Improved resilience: self-esteem, optimism, resilience ▪ Enhanced positive functioning: autonomy, competence, engagement, meaning and purpose
Hillingdon Outcomes	▪ 3 WIN Champions set up pilot programmes to promote Five Ways to Wellbeing in 3 wards in Hillingdon ▪ Following resident demand 'Create your own Wellbeing' toolkit group activities set up in Harefield ▪ 200 Wellbeing questionnaires administered - individuals attending any group for at least 4 times a month (an average of once a week), report higher on their well-being score ▪ 115 new contacts (individuals and groups) linked into Wellbeing programme: swimming classes, exercise classes for over 65's, cooking classes, volunteering, attending conversation classes (for BME groups), walking groups

Benefits

- Access for residents and services to community based programmes is straightforward and free
- Wide range of local programmes are available that are non-medical and focus on promoting positive health, wellbeing and physical health
- Improved prevention and enhanced recovery

Overview for 2012/13

Currently there is no mental health commissioning into the Specialist Health Promotion Team to address mental health promotion and wellbeing. The programmes have been funded through core NHS funds and have been set up to address the wider health improvements objectives within the Public Health Outcomes. Total funds for the current programmes are approximately £35k.

Current Outputs and areas for development

Get Into Reading	▪ 104 participants attending Get Into Reading Groups across the borough ▪ Excellent feedback on self-reported wellbeing, improvement in literacy, enjoyment of reading in a group Areas for development Further 3 groups set up within voluntary and statutory settings; libraries are commissioned to deliver mental health activities, number of facilitators is expanded across the borough, explore Accreditation model
Walk Hillingdon	▪ 3400 units of walking occurred across the borough ▪ Walkers report they enjoy walks and that it helps them with their mobility, health and sense of wellbeing Areas for development 5% increase in units of walking; Library services and NHS services have walks as part of their core community support objectives; referral process developed as part of CCG; link into MacMillan volunteers; GPs actively promote Walk Hillingdon programme as part of care pathways
Older People's Wellbeing	▪ 600 Older people participated in variety of activities across the borough ▪ Positive self-reporting including feeling valued, enjoyment from going out, interested in more and similar activities Areas for development "Breathe" project for people with dementia and their carers (to include music and Get Into Reading programme); "Opening Doors" pilot

	(at Grassy Meadows Day Centre) to encourage Older People to work together to actively organise a series of activities and events for them to take part in; Re-ablement Provision by developing a package of physical activity opportunities that Older People can take part in (Age Well on Wheels – cycling; Football; Dance); Wellbeing activities – 3 more Tea Dances, Film events in local community settings, outings within the borough.
Wellbeing Initiative Network (WIN)	▪ 3 wards working with local community groups, voluntary sector and services. 100 residents – older people, parents, BME groups, participating in WIN activities that address 'Five Ways to Wellbeing' ▪ Participants have self-reported that they have learnt about their area, feel better connected, more confident to be involved in local groups and engage in local facilities Areas for development Develop 'Five Ways to Wellbeing' Framework that incorporates other wellbeing providers and resources; publicise and promote 'Five Ways to Wellbeing' messages and activities in local areas across the borough using Communications department, media (paper and digital); engage with NHS services and CCGs to promote positive mental health through their care pathways

Intentions for 2013/14, 2014/15

To address the national recommendations to promote positive mental health and well being, local ownership of programmes needs to be more robust and lead by the Mental Health Delivery Group (and its partners). Although funding is not critical for the current programmes to develop in 2013/14 – as partnership working and pooling existing resources is a key principle of the health promotion approach – a costed, time-tabled framework is important. This will ensure that the indicators for positive mental health are experienced by a wider population group within a changing landscape that will impact on mental health service services (adults and older people) and residents who are not yet known to health services but need local, evidenced based support within community settings. Next steps would be for the Mental Health Delivery Group to review current programmes, costings and opportunities to expand the Specialist Health Promotion Team programmes that impact on positive mental health and wellbeing

APPENDIX 3: LBH Priorities for Improvement 2012-15

Mental Health Placements Efficiency Project

Extensive work has been done by the key agencies in Hillingdon to improvement the placement management system over the past year. Key savings are required in addition to improvements in quality e.g. personalisation and range of options. This all needs to be supported by new IT, performance management, training and Service User/Carer involvement. This paper comes from a survey of key staff and agencies about progress on the 6 point plan agreed by all Directors earlier in the year. Progress is being made on financial targets – see PEP plan. Yet much more is needed to ensure meaningful improvements in the medium term. Leadership is changing in the agencies and replacements need to be identified who can realistically undertake the key responsibilities and thus be accountable for progress – especially in a process that demands effective joint working.

Performance update:

Work stream and actions	Progress
1, In borough resources for effective placements [Lead LBH] Objectives: 1. Stimulate the provider market 2. Increase step-down and move-on options 3. Develop clear pathways and exists through the recovery s. line and primary care s. line. **Actions:** **1. Map all provision including local provision not currently used by commissioners** **2. Conduct a gap analysis/need analysis – including future growth** **3. Develop provider engagement plan to work with new and potential providers** 4. **Develop a system of disseminating this information to maximise the options available in the borough.**	1. Options and lack of awareness of the options is a key issues e.g. fostering, Telecare, Care space, supporting housing options, Mind, day centre, access to groups. Achla of the Rehabilitation Service is trying to work with new providers (who contract Achla, send info about openings) and passes information on to brokerage to look at the documents. Achla has little time to go out and assess new providers. New providers include First Choice, Church Far, Airial Care, Brampton view, mental health psychiatric rehab for adults etc. They have developed an options folder and could possibly create a directory. 2. Quality monitoring of existing and future options – placement options/placement reviews etc. Differences in experiences of commissioners, users and advocates. CQC system in Hillingdon for quality/procurement needs to be incorporated. It will also help to overcome differences in perspectives between Panels, Providers Services and Key workers - where understandings and experiences differ. A quality/audit officer could provide key information about actual standards of provision to help commissioners, panels and care co-ordinators work in a transparent way with service users – giving them genuine choice. 3. Local Hillingdon Borough Mental Health Policy Overview and scrutiny Committee review will help to clarify the services that are available, gaps, and proposals for development. The POC review working with the borough Mental Health Strategy being developed by the PCT will help to build a better range of options available to s. users at the various stage of the ICP (2012)

	4. Clearer pathways between services at different levels including between service lines will need to be clarified to ensure clarity of option selection and ease of placement. **5.** Actions 2, 3 and 4 to be picked up in commissioning plan.
Work stream 2: Personalisation for effective placements [Lead LBH] Objectives: 1. Move from block contracts to individual budgets 2. Support mental health workers to implement the personalisation policy with services users so that they benefit 3. Reduce perceived barriers to personalisation **Actions:** **1. Develop, deliver and evaluate a range of tailored training programmes for all workers on Personalisation, its implementation and the overcoming of barriers to successful use.** **2. Undertake a personalisation systems and process review.** **3. Research and introduce best practice in personalisation from other boroughs.**	1. There is a need to clarify that the lead responsibility is with the Local Borough. Adrian Frith of LBH is leading the work, in consultation with Anne Sheridan of CNWL. 2. A saving plan is needed and needs to be developed between LBH and PCT. 3. A good estimate of the total number of mental health service users to be incorporated into the personalisation budget system needs to be made clear. **4.** There is a need to see a shift from 1% of Mental Health Service Users with Personal Budgets to 100**%.** **<u>A clear plan is needed for this with detailed milestones for the next 3 and 6 months.</u>** 5. A progress report from Anne Sheridan: • 'We have done a lot of work on personalisation in this borough which has been very much led by the Borough... with active input from CNWL to ensure that the plan reflects a MH and integrated perspective that is the reality of delivering modern MH services. One person key to this work has been Adrian Frith from the Borough. A t recently updated work plan has not as yet been sent out. We plan to meet again on the 12th September at 2pm at the Civic Centre. The process to date has been - • agree one set of documents for assessment and review - essentially the integrated process developed in Westminster • Develop a RAS - resource allocation system - the process for turning an assessment into money • Use existing cases to calibrate the RAS - to see if it works • Train key staff in support planning - like our care planning but with a more assertive creative element in giving people greater freedom in accessing support - seen as key to personalisation success • Look at who inputs on IT LA system and transport assessment and care plan onto IT LA system • How to train staff - this is where we are at present • Set training dates for late Sept. • I have also been keen to think of ABT and the reablement agenda, from a systematic process - its reablement first to get people to their maximum level of well being and then if needed redirect into personalisation. • This stage has not really been developed and I suggested to Adrian that he, Paul, Sandra or Martin and I need to meet to map out a process like above for Personalisation'

	6. Jennifer the manager of the Recovery Team with Achla has done 60 case descriptions for the development of the personalisation software package. Training has been provided to staff – however more theoretical than practical as this stage. When the personalisation software is up and running further training will be needed. This will need to be rolled out to all agencies and include Service users and Carers. 7. Personalisation is not specifically for those on S117; however some of those case descriptions have been sent off. 8. There is a need to discuss with teams about S117 reviews – to be held prior to the CPA reviews. There is also a need to work up the process for carers and get carer budget? 9. Training will need to include admin and clinicians. **10.** The new software should provide a costing for packages. The next stage will be the training of staff to put in the data. Need to be careful as S117 will not get personalisation budgets. Encouraging discussion about s117 when discussing CPA reviews. CPA/S117 reviews - accommodation, budget management, understanding step-down within S117 needed. Combined training in S117/CPA/Personalisation is need. **11.** Ensure that all review processes are integrated and not duplicated i.e.: • CPA review • RAP • S.117 Review • Personalisation Budget Review
Work stream 3: Funding streams for effective placements [Lead CNWL] Objectives: 1. Increase awareness of S117, continuing care and implications for placements. 2. Ensure prompt review of S117 in relation to accommodation support. 3. Increase awareness of S117 discharge and implications of delayed or avoiding discharge on service users, services and commissioners. **Actions:** **1. A formal review of CNWL's S117 discharge process to lead to a more regular and**	1. Lead organisation CNWL. 2. John Duguid with Alan Coe of LBH and Fiona Davies of the PCT are developing a new S117 policy and procedure. Need to bring on board Team leaders and consultants about legal issues and recovery gains from step-down within and from S117. 3. Need a register of clients on CPA and s117 for auditing. Leadership for significant culture changes will be needed. 4. Team is dependent on the policy for guidance on S117 - which needs to be signed off. 5. Following the sign-off the training will have to be put in place. 6. The policy needs to make the link between CPA and S117 plans/review. S117 needs to be clearly highlighted on the CPA care plan. A plan to involve the medical colleagues is needed.

proactive management approach. **2. Develop training on S117 review and funding streams for CNWL and allied teams across service lines.** **3. Develop and make easily available support material for S117 review e.g. via intranet and library sources which are easy to access.** **4. A formal review of current CPA review and monitoring processes and their impact on S117 review and its process.**	7. Dissemination of the new S117 information is needed.
Work stream 4: Placement management process – effectiveness [Lead LBH/PCT] **Objectives:** **1. Ensure effective panels by improving understanding of them and their use.** **2. Increase the knowledge and skills of those reviewing placements** **3. Improve panel decision making tools and resources and ensure they are fully maximised.** **Actions:** **1. Review panels and their procedures, processes and systems, and ensure they are resources adequately e.g. administrative staff.** **2. Update panel procedures, processes and documentation used for placement reviews**	1. Lead organisations are LBH with PCT. 2. Panels up and running with policy and procedure. Overall review needed of effectiveness and liaison between all the panels e.g. substance misuse. 3. Need metrics for monitoring and review. 4. Need to involve team leaders. 5. Placement Efficiency Project report providing key monitoring and evaluation data each month. 6. Care Funding Calculator (CFC) helps to identify personalisation costs. More training of staff to use this is needed. Lots of providers are now using the tool. 7. A system of staff rotation to help staff develop their placemen skills is needed. A supernumerary post is needed for this. Funding to be explored. 8. Placement Procedure, Placement Review Forms, Application to Panels, Panel Decision Sheets have been agreed amongst clinical leads via PEP for utilisation across CNWL pending commissioner agreement 9. New procedure has been circulated to all CNWL Hillingdon services. Achla regularly advises/updates other Team Managers. 10. Ensure compliance via effective performance management. 11. A review of the four panels that S. Users may access and their connectivity is needed: • Supported housing panel; • Complex care panel; • Panel for supported housing – extra care; • Substance misuse panel (dually diagnosed s.users).

3. Review brokerage and its role within the placement pathway. Review how it could be developed to meet future needs. **4. Develop effective placement training packages to be delivered to CNWL teams across all service lines.** **5. Raise awareness of panels and their processes via agreed placement procedures** 6. **Develop local LBH joint protocols for the application of CFC procedures.**	
Work stream 5: Service line placement development for effective placements [Lead CNWL] Objectives: 1. Develop both capacity and capability within the rehabilitation service line to manage all 24 hours placements in LBH Mental Health Services. 2. Develop effective placement specialism and cross fertilise their capabilities across all service lines. 3. Provide training to increase the knowledge of staff about effective placement procedures in all service lines. 4. Ensure clear communication pathways between service lines and monitor these internally and their effectiveness externally. **Actions:** **1. Map community rehabilitation service line staff needs for both current and future growth to meet placement growth.**	1. Lead for this work is CNWL. 2. Discussion with service line directors and senior manager is needed to clarify implementation. 3. PCT to explore with Programme Board for London to look at rehab services. 4. Panels and experts needed to train others in making funding decisions and health and social care provision. 5. A lot of work needed to develop all Recovery Key workers as expert placement presenters. Alternatively a few highly skilled staff need to be developed for this work e.g. team leaders. Clarity on this is needed so as not to waste clients' time and busy key workers. Panel leaders need to be clear. **6.** Rehabilitation staff have become very knowledgeable. Sharon Townsend has given two social workers for 2 for placements. There is also a locum and an advert out for another one. Achla is now managing rehab service line working with Hillingdon and harrow.

2. Map and analyse the skill set needs via training needs analysis for all staff to use the effective placement procedures in Hillingdon. **3. Develop and implement effective placement training which is targeted at the specific needs of the different service lines.** **4. Develop a programme of support – including shadowing and mentoring with experienced staff.** 5. **Build communication and interface structures and processes between key stakeholders in the effectives placement process.**	
Work stream 6: Joint commissioning of effective placements [Lead LBH/PCT] Objectives: 1. Review joints commissioning arrangements and develop new arrangements where gaps are identified. 2. Ensure shared objectives for joint commissioning that are signed up to by all parties. 3. Joint funding packages to be developed for those subject to treatment orders and MOJ restrictions. Good practice guidelines are needed. **Actions:** **1. Identify potential gaps in arrangement for joint commissioning – particularly the joint process for panels.** **2. Review S117 funding arrangements**	**1.** An 'Enabler' is needed for this work from the PCT. 2. Jennifer Lewis identifies that joint commissioning with substance misuse service i.e. 50/50 on occasion. PCT is not doing much joint commissioning. Sec 37/41 joint for is needed as it is the most expensive placement work. 3. Sometimes Service Users remain on the wards as 'delayed discharges' because of a lack of joint decisions. This also applies to joint working with service lines and taking a multi-agency approach. There is a lack of pool budget and whole system thinking procedures. 4. The PEP team identify that It is recommended we adopt Option c) as this represents the client group most closely aligned with FACS criteria i.e. receiving ongoing joint social care and health interventions. Both options a) and b) also include a substantial proportion of clients receiving only healthcare interventions at the time the calculation for reviews is undertaken.

3. Develop agreement for those affected by treatment orders and MOJ restrictions.	

KEY PERFORMANCE INDICATORS

An array of possible performance indicators were placed into the 6 point plan. A partnership approach between CNWL, LBH and PCT is producing a one sheet scorecard. Clear financial outcome are being focused upon as well as a number of process indictors that should lead to financial outcomes in the medium term. The monthly PEP report provides a comprehensive set of metrics to describe the PEP placement work and its process metric and financial outcomes.

LBH Social Care, Health and Housing Priorities 2011-15

Priority One: Managing Demand	Priority Two: Managing the Support System	Priority Three: Managing Supply
Universal Services Work jointly with leisure, libraries, adult education and other council services, to ensure that community resources are used effectively to support local residents. **Information, Advice and Guidance** Deliver social care, housing and benefits information and advice services that are either provided directly or updated and managed by the voluntary sector and local communities to enable residents to identify for themselves how their needs can be addressed **Carer Support** Deliver specialist services for carers to support them in their caring role and in their everyday lives, including specialist information and advice services and developing Personal Budgets for Carers **Preventative Services** Commission preventative services that can demonstrate significant benefits in helping people to lead independent active lives as well as reduce pressures on statutory services Use the benefits system to reduce poverty and support independence.	**Personal Budgets** Ensure all adult social care customers have access to a Personal Budget by April 2013. Through collaborative commissioning, support and develop the external provider market for personalised services Work with Health partners to support the development of personal healthcare budgets to enable service users to achieve positive outcomes in health and wellbeing Work with other Council Directorates, the voluntary sector and local communities to support social care service users to access generic public services Offer Personal Budget holders a 'Pre-paid debit card' to provide greater purchasing flexibility, significant reduction in onerous paperwork, safeguarding against financial abuse Deliver creative support planning and increased choice and control for residents **Housing-related Support** Deliver advice and support to residents to help people live independently Ensure that housing support and adult social care services are provided in a way that maximises the choice and control for tenants, leaseholders and owner occupiers over the services they receive and how they are provided and the ability to purchase independent support using their personal budgets **Reablement** Deliver a specialist reablement service to help people to maximise their ability to live independently and within their own home Make best use of all community intermediate facilities across health and social care as a stepping stone between leaving hospital and going home and to prevent unnecessary admission to hospital	**Market Management** Work with the private sector to make best use of housing supply Apply strategic market management through framework care contracts and leveraging economies of scale with local health services and other West London councils Support the development of a personalised services business model within the voluntary sector organisations **Reduced and Renegotiated High cost Care Packages and Placements** Review and renegotiate costly support packages while retaining quality and good outcomes for service users **Supported Housing and Independent Living** Reduce the use of unnecessary residential care by extending the range of supported housing options Safe, warm, affordable environments to live in Support the development of affordable housing Reduce overcrowding and the use of temporary accommodation Reduce fuel poverty Homes that are suitable and hazard-free for the people living in them:

	TeleCareLine Further expand the assistive technology and telecare offer for Hillingdon residents to maximise independence **Safeguarding Adults** Support adults at risk to live free from harm and exploitation **Modernise Day Opportunities Services** Develop more choice and a wider range of community services or support to access those services that can be purchased by personal budget holders and self-funders. Ensure that council provided buildings-based day services have the flexibility to support people with the most complex needs and be transparently costed to enable personal budget holders to purchase these services Develop dementia care services and complex care to support people in their own homes or the community where possible Ensure that council provided or funded transport services are available to residents in the greatest need whilst providing opportunities for those residents to have the choice to develop, individual, more flexible travel solutions	• Deliver housing adaptations • Promote energy efficiency

APPENDIX 4: Draft Mental Health Dashboard: No health without mental health – a cross-government mental health outcomes strategy for people

Measures being considered for the first mental health dashboard

1. More people have better mental health	2. More people will recover	3. Better physical health
• Self-reported wellbeing (PHOF) • Rate of access to NHS mental health services per 100,000 population (MHMDS) • Number of detained patients (MHMDS) • Ethnicity of detained patients (MHMDS) • First-time entrants into youth justice system (PHOF) • School readiness (PHOF) • Emotional wellbeing of looked after children (PHOF, Placeholder) • Child development at 2–2.5 years (PHOF, Placeholder) • IAPT: access rate (IAPT Programme)	• Employment of people with mental illness (NHSOF) • People with mental illness or disability in settled accommodation (PHOF) • The proportion of people who use services who have control over their daily life (ASCOF) • IAPT recovery rate (IAPT Programme)	• Excess under-75 mortality rate in adults with severe mental illness (NHSOF & PHOF, Placeholder)
4. Positive experience of care and support	**5. Fewer people suffer avoidable harm**	**6. Fewer people experience stigma and discrimination**
• Patient experience of community mental health services (NHSOF) • Overall satisfaction of people who use services with their care and support (ASCOF) • The proportion of people who use services who say that those services have made them feel safe and secure (ASCOF) • Proportion of people feeling supported to manage their condition (NHSOF) • Indicator to be derived from a children's patient experience questionnaire (NHSOF, Placeholder)	• Safety incidents reported (NHSOF) • Safety incidents involving severe harm or death (NHSOF) • Hospital admissions as a result of self harm (PHOF) • Suicide (PHOF) • Absence without leave of detained patients (MHMDS)	• National Attitudes to Mental Health Survey (Time to Change) • Press cuttings and broadcast media analysis of stigma (Time to Change) • National Viewpoint Survey – discrimination experienced by people with mental health problems (Time to Change)

Key

ASCOF – Adult Social Care Outcomes Framework
IAPT – Improving Access to Psychological Therapies
MHMDS – Mental Health Minimum Dataset
NHSOF – NHS Outcomes Framework
PHOF – Public Health Outcomes Framework

APPENDIX 5: The Joint Strategy and Commissioning Plan for Adults with Mental Health Problems in Hillingdon: 2013-14: Implementation Plan

STRATEGIC OBJECTIVE	ACTIONS	RESPONSIBLE	TIME-SCALE	OUTCOMES
To ensure the best use of resources	• Agree contract efficiencies with the main provider of mental health services 2013-14 • Retender community support services commissioned from the voluntary sector • Improve the range of supported accommodation and the floating support available • Reduce the use of out of area specialist, nursing home and residential care placements • Implement objectives in the joint commissioning plan aimed at reducing crises (as listed below) • Agree plans with key providers of mental health services to improve the use of resources 2014-15 and 2015-16	• HCCG • LBH • LBH • LBH and HCCG • LBH and HCCG • LBH and HCCG	01.04.13 31.03.14 31.03.14 31.03.14 31.03.14 31.03.14	• Improved value for money and effective targeting of resources • Improved choice • Evidence based services offered • A shift from bed to community based assessment, treatment and support • Reduction in the number and cost of specialist, residential and nursing home care • Reduction in the proportion of presentations in crisis to health and social care services
To improve the mental health and wellbeing of the population of Hillingdon	• Consider the development of a Mental Health Wellbeing Collaborative and/or Recovery College in Hillingdon • Develop a range of mental health promotion and prevention initiatives with individuals and communities • Identify and address the needs of communities and individuals from BME backgrounds for mental wellbeing and community based and specialist assessment and treatment	• LBH • LBH and HCCG • LBH and HCCG	31.03.14 31.03.14 31.03.14	• Improved mental wellbeing and self-directed care via Hillingdon Mental Health and Wellbeing Collaborative and/or Recovery College considered and work to initiate commenced if appropriate • Increased access to a range of mental health promotion/prevention activities for individuals and communities • Improved mental health and wellbeing • Intervention earlier in the course of illness with a reduction in the impact of mental illness • Improved recovery from mental health problems

To improve support to carers enabling them to continue in their caring role and to enjoy quality of life for themselves	• Agree and begin to implement an action plan for carers of people with mental health problems • Ensure that the needs of carers of adults with dementia are addressed within the action plan for carers of older people	• LBH • LBH	31.03.14 31.03.14	• Improved access to information, advice and support for carers of adults of all ages • Reduction in the proportion of adults presenting in crisis to health and social care services • Reduction in crises arising from carer breakdown
To provide care closer to home by increasing access to community based assessment and treatment	• Agree and commence implementation of a model of enhanced primary care based mental health services, including psychological therapies. • Ensure access to psychological therapies for adults with anxiety and depression as specified under the national initiative to increase access to psychological therapies; meet 5% of the prevalence of the disorder in the adult population in Hillingdon • Agree the target cohort of service users currently supported by outpatient mental health services who could be more effectively supported in primary care based settings with access to enhanced support • Identify and agree the support and the service model and plan needed to enable a cohort of service users who could be more effectively supported in primary care based settings to be transferred • Develop and implement a schedule of training in the management of mental health problems for GPs and other primary care practitioners • Reduce the use of out of area specialist, nursing home and residential care placements • Improve access and choice of community based social, leisure, work and training opportunities (community connections) • Explore options for continuation of the psychiatric liaison pilot at The Hillingdon Hospital	• HCCG • HCCG • HCCG • HCCG • HCCG • HCCG • LBH • HCCG	31.03.14 31.03.14 31.03.14 31.03.14 31.03.14 31.03.14 31.03.14 31.07.13	• Earlier intervention with reduced impact of mental illness for individuals and communities • Shift from a secondary care based to primary care based mental health service • Enhanced model of primary care based mental health services • Increased expertise in the management of mental health problems by and in primary care • A shift from bed to community based assessment, treatment and support • Reduction in the number and cost of specialist, residential and nursing home care • Evaluation of the potential for reduction in the number of inpatient assessment and treatment beds for older adults • Improved mental health and wellbeing • Improved recovery from mental health problems ; increase in number of people recovering, shorter duration of mental ill health • Confirmation of the extension and evaluation of the pilot o psychiatric liaison pilot at The Hillingdon Hospital

To improve access to evidence based assessment, treatment and support for people with dementia and their carers	• Ensure an increase in the rate of diagnosis of dementia through the Memory Assessment service established during 2012-13 • Finalise and begin to implement a joint plan for dementia services to include a service model that delivers effective assessment, treatment and community based support and intervenes earlier in the course of the disease • Agree a joint implementation plan for years 2 and 3 of the Adult Mental Health Strategy	• HCCG • LBH and HCCG • LBH and HCCG	31.03.14 31.03.14 31.03.14	• Improved rate of diagnosis of dementia • Earlier intervention for people with dementia and their carers • Improved access to specialist and community based assessment, treatment and support • Reduction in crises • Reduction in proportion of adults presenting in crisis to health and social care services

APPENDIX 6: The Joint Strategy and Commissioning Plan for Adults with Mental Health Problems in Hillingdon 2013-16: Equality Impact Assessment

Section 1: General information
Background: In March 2012, Hillingdon Clinical Commissioning Group (HCCG) and London Borough of Hillingdon (LBH) jointly initiated a refresh of the 2008 strategy for adults with mental health problems aged 18-64 years[36] and the development of an implementation plan to improve services for people with dementia in order to create a new Plan that would provide a framework for improvement over the next 2 years. The Council and Hillingdon CCG worked together to undertake a full public consultation on the strategic direction, priorities and action plan presented in the document over a period of 12 weeks starting on 24 January 2013.
Date completed: 25th April 2013

Relevant documents:

Name of document	Year	Owner(s)
A strategy for adult services for mental health and wellbeing	2008 - 2013	Hillingdon Primary Care Trust and London Borough of Hillingdon
Promoting mental wellbeing and enabling recovery from mental health problems for adults of all ages in Hillingdon: A joint strategy for mental health and wellbeing	2013 - 2015	Hillingdon Primary Care Trust and London Borough of Hillingdon
Joint commissioning plan for adults of all ages with Mental Health problems	2013 - 2015	Hillingdon Primary Care Trust and London Borough of Hillingdon
Summary from the Adult Mental Health Strategy consultation	2013	Hillingdon Primary Care Trust and London Borough of Hillingdon

Accountable officers

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Section 2: Data gathering

Purpose of Strategy

The refreshed strategy aims to promote recovery, mental health and wellbeing for adults.

The Hillingdon vision for mental health and well-being is that people living in Hillingdon will benefit from opportunities for positive mental wellbeing, which includes involvement with community, friends and family; meaningful occupation, learning and leisure, and having the basics in place, such as good health care, housing and financial security.

People with significant mental health problems should have access to the same opportunity to lead meaningful lives as active members of the communities in which they live as others in the Hillingdon population. In order to do this, they should also be able to benefit from opportunities for positive mental wellbeing as well as have access to the specialist services which provide for their individual needs and preferences, promoting their recovery from mental health problems.

How does the service currently meet the needs of the whole community?

The strategy agreed in 2008 delivered some significant improvements to mental health services including:

- Better access to psychological therapies for people with depression and anxiety by significantly increasing the size of this service
- Improvement to promoting mental wellbeing
- Re-organising services to improve access
- Improving diagnosis and support for people with dementia and their carers through establishment of a memory assessment service
- Providing support for more people than the average for a population such as Hillingdon in community and primary care settings; people experience hospital admissions less frequently and are less likely to be admitted when their illness does not require hospital treatment
- Treatment to support recovery from episodes of serious mental illness are no longer provided in day hospital settings; people have access to a range of community based activities to assist them with recovery
- Adopting a more personalized approach to care

How will the refreshed strategy improve community involvement?

The refreshed strategy aims to continue to help mental health services to move towards the goals laid out in the 2008 strategy. Within the refreshed strategy, action plans have been developed to assist with attaining goals not yet achieved and to continue to improve services that have already progressed.

In addition to the above, the refreshed strategy now incorporates an implementation plan, developed by HCCG and LBH that aims to improve services for people with dementia over the next 2 years including:

- Mental health promotion and wellbeing
- Promoting community based care: shifting the setting of care to community settings wherever possible/safe, with a transfer of responsibility for care from secondary to primary care, enabled by investment in primary care based mental health services

- Developing community connections: improving the infrastructure for support and information in the community
- Improved dementia assessment, treatment and support
- Addressing inequalities and tackling exclusion
- Improving the quality and effectiveness of services
- Improving the efficiency of services: value for money
- Improving the way in which care is delivered so that care is:
    - Personalised
    - Targeted: treatment will address the issues of greatest concern to the individual in terms of their mental health and/or recovery from mental health problems
    - Focussed on recovery and outcomes
    - Effectively co-ordinated and seamless

Who will benefit from the changes proposed in the refreshed strategy?

People aged 18 years and over including those who have a dual diagnosis of a drug and/or alcohol problem.

It includes people who are registered with a GP in Hillingdon or living in the borough of Hillingdon, regardless of their gender, ethnicity, disability, sexual orientation, or economic status.

Mental health care and support in Hillingdon will be targeted to support:

- People who are at risk of developing mental health problems
- People suffering mental health problems (however long the duration of their illness)
- People who are recovering from mental health problems and need help to re-establish their lives
- The families and other carers of people with mental health problems

What is their equality profile?

39.4% of the population in Hillingdon is from a community that is either mixed, Asian or Asian British, Black or Black British, Arab or other.

See table below.

3 Ethnic group	**No**	**%**
White	166,031	60.6
Mixed	10,479	3.8
Asian or Asian British	69,253	25.3
Black or Black British	20,082	7.3
Arab or other	8,091	3.0
Source: 2011 Census		

The profile of religions in the borough is summarised below.

7 Religion	***No***	***%***
Christian	134,813	49.2
Buddhist	2,386	0.9
Hindu	22,033	8.0
Jewish	1,753	0.6
Muslim	29,065	10.

		6
Sikh	18,230	6.7
Other	1,669	0.6
No religion	46,492	17.0
Not stated	17,495	6.4

Source: 2011 Census

What outcomes are wanted from the refreshed strategy?

- Improved mental health and wellbeing in the population as a whole
- A reduction in health and mental health inequalities
- Improved access, diagnosis and earlier intervention for both the general population and for disadvantaged groups with mental health problems
- A co-ordinated approach to assessment, treatment and support for both physical and mental health needs
- Services provided on the basis of need not age
- A shift from bed and secondary care based to community and primary care based assessment, treatment and support, with this being delivered as close to people's homes as possible
- Improved support in crisis
- Improved access to specialist assessment, treatment and support for those who need it
- Greater choice and flexibility in the range of housing and options for personalised support
- A focus on supporting recovery and real outcomes
- A personalised approach to assessment, treatment and support
- Priority given to improving support to retain or secure employment

- Increased control and choice for service users, empowered through the provision of more accessible information and advice, a partnership approach and increased involvement in service development and delivery
- Increased control and choice for carers empowered through more accessible information and advice, a partnership approach and increased involvement in service development and delivery
- Improvements in patient experience
- Services that are informed by best practice and evidence of need and performance
- Improved use of the resources available

Are there any factors that might prevent these outcomes being achieved?

None arising

Did you carry out any consultation or engagement as part of this assessment?

Yes

Who was consulted or engaged?

As part of the strategy's refresh the Hillingdon Clinical Commissioning Group (HCCG) and London Borough of Hillingdon (LBH) conducted a 12 week consultation to seek the views of, and discuss the strategy with, service users, carers and service providers living and/or working in Hillingdon.

The full consultation consisted of an online invitation to members of the public to submit comments on the strategy and 2 LBH and HCCG led public consultation events. A summary of the responses received from the consultation events can be found in the summary from the Adult Mental Health Strategy consultation document.

In addition to the above, HCCG and LBH attended and presented at the following public events:

- Mental Health Service User and Carer Forum

- Mental Health Carers group
- Oaktree Group (Local service user forum)
- Re-Think carers group

In total HCCG and LBH engaged with over 75 members of the public, which included amongst service users and carers, representatives from various organisations including, but not limited to; Hillingdon Mind, Hillingdon Association of Voluntary Sector (HAVs), CNWL, Refugees in Effective and Active Partnership (REAP), Age UK and Hillingdon Housing Support.

HCCG and LBH received no forms / comments were received via the online form.

In addition to the public consultation, Hillingdon GPs and Practice Managers have been kept informed and provided the opportunity to engage with the strategy at the HCCG's GP Quarterly forum and at sub-group level. Updates were also submitted via the HCCG GP monthly newsletter.

HCCG Communications are in the process of developing a communications and engagement plan to further involve HCCG GP staff.

To assist with the consultation, the CCG and LBH developed supporting public documents to support interested parties in understanding the strategy:

i) Summary of the 2013 – 15 strategy

The summary was placed on both LBH and HCCGs public facing websites accompanying the full strategy and a form for submitting comments to the strategy. The aim of this document was to provide the reader with an overview of the strategy and key changes from the 2008 strategy. Copies of this summary were also made available at all public events. HCCG and LBH received no written comments via the online form

ii) Presentation slide deck for public events

The presentation slide deck was used at both the consultation events and locally led user forums.

Who has been sighted on the strategy, when and what feedback did you receive?

The Policy Overview Committee (POC) reviewed the strategy as part of their own review of adult mental health services in Hillingdon undertaken September 2012 to January 2013.

Following the review, the POC recommended that in order to ensure that there is access to, and accessibility of excellent outreach services in the community for all service users and their carers, the Council and CNWL should work in partnership to make improvements in the following areas:

a) Identifying needs and early identification
b) Information and support for users and carers
c) Enabling people to make choices, balancing risks and community involvement
d) Partnership working
e) Staff training and development
f) Learning from best practice
g) Use of resources

In December 2012, Cabinet approved the strategy subject to a full public consultation. The Governing Body of the Hillingdon Clinical Commissioning Group also approved the strategy subject to full public consultation.

The public consultation approach was reviewed by the HCCG's Patient Public Involvement Committee in January 2013 and approved.

What changes have been made as a result of the feedback you have received?

The Plan has been revised following the feedback received from the consultation and the POC review. Where an issue was also identified

following both the consultation and the POC review, even greater emphasis was given to it in revision.

Following the consultation, the following commitments already made in the Plan have been given greater emphasis/priority and therefore strengthened:

a) Ensuring that service users and carers continue to be fully informed, involved and engaged in service delivery and development.
b) Adopting a full and real partnership approach to service improvement and delivery.
c) Prioritising mental health promotion and prevention, in particular challenging and tackling stigma.
d) Supporting staff to develop new ways of working and achieve the significant cultural shift needed to achieve the required improvement in outcomes for service users and carers.
e) Prioritising the provision of support to enable people to gain or retain employment.
f) Improving access to services and providing robust and accessible information and support for service users and carers (including review of the Council's website and directory of services)
g) Ensuring more timely access to housing by ensuring closer working between mental health services and the Council's housing teams
h) Ensuring the delivery of a life course approach, ensuring a seamless transition from child and adolescent to adult mental health services and ensuring that there is effective joint working between health and social care services to the provision of assessment, treatment and support.
i) Ensuring that people are properly supported as they leave services and know how to re-access support if necessary.
j) Prioritising staff training and development for staff including ensuring that those who are in the front line working with the wider population have mental health first aid training.
k) Consideration of the potential for greater independence offered by the use of assistive technologies.
l) Focussing on service quality.

The timescale for implementation of the Plan has been extended from 2 to 3 years in order to give sufficient time to work with key partners to achieve the significant changes in service models and culture. This extension also aligns the actions to the timescales in the Hillingdon CCG recovery plan.

The detailed consultation results and POC review will be referenced to inform implementation.

Section 3: Impact

Consider the information gathered in section 2 of this assessment form and assess:

1. Where you think that the strategy could have a **NEGATIVE** impact on any of the equality groups, i.e. it could disadvantage them

2. Where you think that the strategy could have a **POSITIVE** impact on any of the equality groups like promoting equality and equal opportunities or improving relations within equality groups

3. Where you think that this strategy has a **NEUTRAL** effect on any of the equality groups listed below i.e. it has no effect currently on equality groups.

Do you think that the strategy impacts on people on the grounds of their **race/ethnicity**?

Race	**Positive**	**Negative**	**Neutral**	**Reasons for your decision**
Promoting equality of opportunity	X			In 2008, significant differences and inequalities in service experience and outcome for some minority groups was identified. This is still the case in 2012. The refreshed strategy plans to address these inequalities as a matter of priority during the timeframe of the strategy.
Promoting good				

race relations			X	
Eliminating unlawful discrimination			X	

Do you think that the strategy impacts on people because of their **religion or faith?**

Religion or Faith	**Positive**	**Negative**	**Neutral**	**Reasons for your decision**
	X			The refreshed strategy targets BME Communities and will work with faith leaders to achieve the outcomes set out in the refreshed strategy.

Do you think that the strategy impacts on people with a **disability?**

Disability	**Positive**	**Negative**	**Neutral**	**Reasons for your decision**
Visually impaired	X			People with long term conditions and disabilities will benefit from the development of primary care based mental health services that have been prioritised in the refreshed strategy.
Hearing impaired	X			People with long term conditions and disabilities will benefit from the development of primary care based mental health services that have been prioritised in the refreshed strategy.

Physically disabled	X			People with long term conditions and disabilities will benefit from the development of primary care based mental health services that have been prioritised in the refreshed strategy.
Learning disability	X			The strategy targets the mental health needs of people with complex needs. People with learning disability who also have mental health problems are a priority group.
Mental health	X			People living in Hillingdon will benefit from opportunities for positive mental wellbeing which includes involvement with the community and increased access to care.
Other (HIV positive, multiple sclerosis, cancer, diabetes, epilepsy)	X			People with long term conditions and disabilities will benefit from the development of primary care based mental health services that have been prioritised in the refreshed strategy.

Do you think that the strategy affects **men and women** in different ways?

Gender	Positive	Negative	Neutral	Reasons for your decision
Male			X	
Female			X	

Do you think that the strategy impacts on people because of their **sexual orientation?**

Sexual Orientation	Positive	Negative	Neutral	Reasons for your decision
Lesbian			X	
Gay			X	
Heterosexual			X	
Bisexual			X	
Transsexual			X	

Do you think that the strategy impacts on people because of their **age?**

Age	**Positive**	**Negative**	**Neutral**	**Reasons for your decision**
Young (Children and young people, working age)	X			Life course strategy. The strategy proposes to improve mental health services for adults by ensuring early intervention and promotion of mental health and wellbeing is established in all communities.
Older (Working age, 60+, and retirement age)	X			Life course strategy. The strategy will ensure that specialist needs for people with dementia and older adults who are physically frail who are experiencing mental health problems are addressed

Section 4: Assessment

From your responses gathered in section 3 has a 'No differential impact' been identified and does this/is this likely to amount to an adverse impact?

No

If yes please state below:

If a differential impact has been identified which can amount to an adverse impact you will need to complete and attach to this EIA an Equalities Implications Action Plan.

Contact Diana Garanito diana.garanito@nhs.net for the form.

Is the strategy directly or indirectly discriminatory under the equalities legislation?

No

If the strategy is indirectly discriminatory can it be justified under the relevant legislation?

N/A

Section 5: Publish Assessment Results

In order demonstrate openness about the way Hillingdon Clinical Commissioning Groups policies, services and partnerships are developed and our commitment to promoting equality and diversity, results of the impact assessment will be published on to the public facing website. www.hillingdonccg.nhs.uk

Is there any reason why this Equality Impact Assessment should not be published, please use this space to state your reasons:

N/A

Section 6: Sign off

Section 7: Glossary

Listed below are definitions of key words that will provide additional guidance in relation to meeting requirements of an Equality

Direct Discrimination

That is treating people less favourably than others as it would apply to age, disability, gender, race, religion and belief, sexual orientation. There is no justification for direct discrimination

Indirect discrimination

Applying a provision, criterion or practice that disadvantages people as applies to age, disability, gender, race, religion and belief, sexual orientation and can't be justified as a proportionate means of achieving a legitimate aim. The concept of 'provision, criterion or practice' covers the way in which an intention or policy is actually carried out, and includes attitudes and behaviour that could amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and stereotyping. To find discrimination it will be sufficient to show that a practice is likely to affect the group in question

adversely.

Definition of Disability

The Disability Discrimination Act 1995 defines Disability as being:

“an impairment which has a substantial, long term adverse effect on person’s ability to carry out normal day-to-day activities”.

Differential Impact
Suggests that a particular group has been affected differently by a policy, in either a positive, neutral or negative way.

Adverse Impact
This is a significant difference in patterns of representation or outcomes between equalities groups, with the difference amounting to a detriment for one or more equalities groups.

Ethnic monitoring
A process for collecting, storing and analysing data about individuals' ethnic (or racial) background and linking this data and analysis with planning and implementing policies.

Functions

The full range of activities carried out by a public authority to meet its duties.