Merton Council
Health and Wellbeing Board

Date: **30 September 2014**

Time: **1.00 pm**

Venue: **Committee rooms C, D & E - Merton Civic Centre, London Road, Morden SM4 5DX**

Merton Civic Centre, London Road, Morden, Surrey SM4 5DX

Future meeting dates
26 November, 28 January, 25 March, 24 June, 30 September, 25 November.

This is a public meeting – members of the public are very welcome to attend.

Requests to speak will be considered by the Chair. If you would like to speak, please contact democratic.services@merton.gov.uk by midday on the day before the meeting.

For more information about the work of this Board, please contact Clarissa Larsen, on 020 8545 4871 or e-mail democratic.services@merton.gov.uk

Press enquiries: press@merton.gov.uk or telephone 020 8545 3483 or 4093.

Note on declarations of interest

Members are advised to declare any Disclosable Pecuniary Interest in any matter to be considered at the meeting. If a pecuniary interest is declared they should withdraw from the meeting room during the whole of the consideration of that mater and must not participate in any vote on that matter. If members consider they should not participate because of a non-pecuniary interest which may give rise to a perception of bias, they should declare this, .withdraw and not participate in consideration of the item. For further advice please speak with the Assistant Director of Corporate Governance.

Health and Wellbeing Board Membership

Merton Councillors

- Caroline Cooper-Marbiah (Chair)
- Gilli Lewis-Lavender
- Maxi Martin

Council Officers (non-voting)

- Director of Community and Housing
- Director of Children, Schools and Families
- Director of Public Health

Statutory representatives

- Four representatives of Merton Clinical Commissioning Group (Eleanor Brown, Adam Doyle, Howard Freeman, Geoff Hollier)
- Barbara Price, Chair of Healthwatch

Non statutory representatives

- One representative of Merton Voluntary Services Council (Ian Beever)
- One representative of the Community Engagement Network (Melanie Monaghan)

Quorum

Any 3 of the whole number.

Voting

3 (1 vote per councillor)
4 Merton Clinical Commissioning Group (1 vote per CCG member)
1 vote Chair of Healthwatch
1 vote Merton Voluntary Services Council
1 vote Community Engagement Network

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HEALTH AND WELLBEING BOARD
24 JUNE 2014
(13.00 - 14.00)

PRESENT	Councillor Cooper-Marbiah (in the Chair), Councillor Maxi Martin, Kay Eilbert, Yvette Stanley, Simon Williams, Eleanor Brown, Howard Freeman, Geoffrey Hollier and Melanie Monaghan
	Also present: Clarissa Larsen, Health and Wellbeing Board Partnership Manager and Hilary Gullen, Democracy Services Officer

1.   APOLOGIES FOR ABSENCE (Agenda Item 1)

Ian Beever, Barbara Price

2.   DECLARATIONS OF PECUNIARY INTEREST (Agenda Item 2)

None

3.   MINUTES OF THE MEETING HELD ON 25 MARCH 2014 (Agenda Item 3)

Since the last meeting, Dr Howard Freeman had been awarded the MBE, and the Board warmly congratulated him on this achievement.

Following a question from Cllr Martin, Kay Eilbert agreed to follow up on what was being done to separate data as mentioned in paragraph 1 page 2.

Cllr Martin had not yet received the leaflets as mentioned in paragraph 2 page 2. Kay Eilbert had sent them by email, but would check whether printed leaflets could be provided.

Kay Eilbert also agreed to check the use of children's centres for vaccinations which was stated as being 'in 3-4 months time' in paragraph 4.

Eleanor Brown asked for the last line of item 11 page 3 to read '…… approximately 200 people to date'.

Regarding paragraph 2 page 5, Cllr Martin said that the volunteer day had been very well attended.

Cllr Martin asked for a paper on work in Merton on female genital mutilation to be brought to the Board.

4.   CHILDREN AND FAMILIES ACT -(PRESENTATION) (Agenda Item 4)

Yvette Stanley gave a presentation on the Children and Families Act and described some changes this would have in terms of timescales for adoptions etc and that this narrower window for care would present some challenges. Yvette described the need for early help, making sure it was successful for complex need families. They were seeking continuous improvement giving smarter services for better value. Yvette also described getting parents and children involved in the working group to help design services. An accessible plan was required, not multiple assessments. In the future they would revisit key points, talking to all the agencies involved and check that they were 'living those values'

5.   YOUNG CARERS MEMORANDUM OF UNDERSTANDING (Agenda Item 5)

Yvette Stanley introduced this item and explained it was a good practice benchmark. Yvette praised Melanie Monaghan's work and emphasised the importance of support for young carers.

Cllr Martin welcomed the Memorandum of Understanding and also praised Melanie's team.

Melanie Monaghan explained she was supported by a good team, and welcomed the Memorandum of Understanding as it raised the profile of young carers. The project funded by the Big Lottery was enabling working with the Mental Health Trust to embed thinking about a whole family approach. Melanie hoped to involve health agencies in the next steps.

The Board agreed:
the Memorandum of Understanding for signature by the Director of Children Schools and Families and the Director of Community and Housing.

6.   CALL TO ACTION (Agenda Item 6)

Eleanor Brown introduced the Call to Action and explained there would be a growth in need over the next ten years as the population increased and the incidence of diseases increased while there were static resources. Eleanor explained the series of discussions with residents that has taken place as part of the Call to Action. The discussion carried out in Merton had engaged with 425 people through surveys and group work. The key points raised were access to GP surgeries, increased integration of services and keeping well and healthy. The next steps should be through the One Merton Group, questioning what was already being done, and what else might be done.

Cllr Martin commented on the figures given, that 425 was a low proportion of the borough's population and that the demographic which showed that white, middle class, older people were over represented. Cllr Martin suggested that the good work done so far needed rolling out to a wider spectrum of the borough's population, ie the mosque.

Eleanor Brown responded that better advertising was needed, and that the demographic was a result of what they were able to achieve at the appointed time due to constraints in utilising other channels ie the LA publications etc. Eleanor said this could be an on-going debate (part of the five year strategy). Suggestions would be welcomed and that a member of the CCG could visit the mosque.

The Board agreed:
To note the Merton Clinical Commissioning Board Call to Action Report.

7.   MERTON INTEGRATION PROJECT (Agenda Item 7)

Simon Williams introduced the Merton Integration Project report, explaining the current position and how things would move forward with 6 workstreams. The Merton Model was the largest and most complex, and how progress was expected once staff were embedded. Workstream 3 was also discussed with the problem of how to find a solution with joining up data.

Board members commented on how this links very well with clinical design work around integration in the South West London sector. Adam Doyle said he would come back to the group with clarification of process regarding data.

Melanie Monaghan was pleased to see workstream 5 – engagement, and stated that having volunteers involved in the early states was very beneficial.

The Board agreed:
To note the progress of the Better Care Fund Plan
That consideration should be given to the proposal to apply for NHS England Tech Fund financing.

8.   SOUTH WEST LONDON COLLABORATIVE COMMISSIONING STRATEGY
        (Agenda Item 8)

Eleanor Brown apologised for the lateness of the report, which sets out the case for change locally, due to the sensitivity of election purdah. The report built on a workshop session with the members of the Health and Wellbeing Board. Members felt it was an interesting document, building a picture of the need for change.

The Board agreed:
To note the SW London Collaborative Commissioning 5 year Strategy Executive Summary and the full document available on the MCCG website

9.   EAST MERTON MODEL OF CARE (Agenda Item 9)

Adam Doyle introduced this report, explaining the three major parts:

A needs assessment of East Merton

The development of a model of care by GPs with patient engagement for the locality as a whole, with a care centre and GP practices responding to needs as set out in the needs assessment.

Submission of the business case to the Department of Health for permission to proceed.

In response to questions from board members, Adam explained that a stakeholder map was being drawn up to make sure everyone was involved, and how there was a need to demonstrate a good level of engagement. Some key partners needed to be more involved.

Cllr Martin asked that children be involved, and whether a presentation could be given to them.

Simon Williams remarked on the great progress and asked what the board could do to help.

Adam responded that help in communicating and the dissemination of information would be welcome and holding them to account over any unmet need.
The Board members felt it was a good piece of work.

The Board agreed to note the update.

10.   HEALTH AND WELLBEING BOARD DEVELOPMENT (Agenda Item 10)

Kay Eilbert introduced this report she explained that funding had been secured from the Local Government Association to fund a professional facilitator to deliver a half day development session to working with the Health and Wellbeing Board. The Board welcomed the plans and agreed to be involved in the development session.

The Board agreed:
To note the planned development of Merton Health and Wellbeing Board in its second year, the support secured from the London HWB Improvement Programme and agree to the proposed work programme.

Cllr Martin highlighted the need to keep Procurement of substance misuse, ending Gangs and Youth Violence and Female Genital Mutilation well on the agenda although the board noted the importance of not duplicating work carried out by other groups.

11.   HEALTHWATCH (Agenda Item 11)

This item was introduced by Kris Witherington on behalf of Dave Curtis.
Kris explained that the report was a catalogue of activities since the spring, and that it had been very busy with lots of events.

There is a formal annual report due shortly, which will be reported to the next meeting of the Health and Wellbeing Board.

 The Chair commented on a very successful presentation that was given to her local residents' association by a representative of Healthwatch.

Yvette Stanley asked for a focus on children and young people in the work programme, possibly in the East Merton development and how this could lead to consultation.

The Board agreed to note the progress made by HealthWatch Merton and asked that their thanks be passed on to Dave Curtis.

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Committee: Health and Wellbeing Board

Date: 30 September 2014

Wards: All

Subject: School Nursing Services in Merton

Lead officer: Dr Kay Eilbert, Director of Public Health

Lead member: Cllr Maxi Martin/Cllr Caroline Cooper-Marbiah

Forward Plan reference number:

Contact officer: Julia Groom, Consultant in Public Health

RECOMMENDATIONS:

- To note and consider findings from a review of School Nursing Services in Merton and progress following the review.
- To consider review recommendations, action plan and next steps for the development of School Nursing Services.
- To welcome the £30k increase in funds to provide additional capacity to address higher need schools in the east of the Borough.

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1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 The purpose of this report is to inform the Health and Wellbeing Board about School Nursing Services in Merton, and ask the Board to consider recommendations for the development of services in Merton. The report sets out findings from a local review carried out by Public Health of School Nursing Services, recent national guidance on commissioning services and recommendations for service development and next steps.

1.2 The review engaged with schools, pupils and parents and found that schools are positive about the Service and would like more school nurse time and pupils who had used the school nursing service said that it had made a positive difference to them.

1.3 The review confirmed that the School Nursing Service delivers core elements of the Healthy Child Programme, and is broadly meeting performance targets where these have been specified. However, the Service did not deliver a number of services recommended in the Healthy Child Programme.

1.4 A number of factors that were found to influence the school nurses' ability to deliver the full Healthy Child Programme, these included:
- workforce capacity and recruitment issues
- Population growth and increasing complexity of needs
- Resource and IT issues

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- Delivering all of health's statutory safeguarding responsibilities, which should sometimes be the responsibility of other health professionals.

1.5 An action plan has been developed in response to the findings of the review and recent national guidance on School Nursing.

1.6 Going forward, it has been agreed that from April 2016 School Nursing services will be commissioned for Merton only, and not jointly with Sutton. This will provide an opportunity to shape services to better meet local needs in the borough better.

2. DETAILS

2.1 Introduction

The purpose of this report is to inform the Health and Wellbeing Board about School Nursing Services in Merton, and ask the Board to consider recommendations for the development of services in Merton. The report sets out findings from a local review of School Nursing Services undertaken in 2013, recent national guidance on commissioning services and recommendations for service development and next steps.

2.2 Context

From April 2013 local authorities have been responsible for commissioning public health services for children aged 5-19 years, including school nursing services and a statutory responsibility for the National Child Measurement Programme. As commissioners, the Public Health team in the London Borough of Merton want to ensure that school nursing services are meeting the health needs of children and young people, in line with national guidance, including the Healthy Child Programme 5-19 years and other statutory guidance including National Child Measurement Programme and 'Working Together' safeguarding guidance.

School Nursing Services are provided by Sutton and Merton Community Services, Royal Marsden NHS Hospital Trust. There are two borough based teams. The Merton team is based at the Wilson Hospital in Mitcham and includes 12.38 wte staff with a skill mix including qualified school nurses, school nurses, and nursery nurses.

The teams provide a school nursing service to all children and young people who attend a state maintained school or academy in Merton irrespective of where they live. This encompasses both universal and enhanced services, including health screening at Reception, National Child Measurement Programme (NCMP) at Reception and Year 6; health promotion; High School weekly drop-in sessions; Individual health plans. School nurses play an important role in safeguarding and child protection. A School nurse-led enuresis service is also available for all children who live or have a GP in

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Merton. The School Nurse Immunisation team delivers a school based immunisation programme and works closely with the borough based team.

2.3 Review of School Nursing Services

The aim of the review of school nursing services in 2013 was to ensure commissioners had an in-depth understanding of the current service and make recommendations to shape service development and inform future commissioning of Public Health School Nursing Services by the Council.

The review focused on school nursing services provided to children and young people who attend a maintained school in the Boroughs of Sutton or Merton. It did not include service provision to young people who are not in school post-16; specialist nursing care in special schools; or immunisation services.

The review used both qualitative and quantitative methods, including:

- a review of evidence about policy and effective practice in school nursing; analysis of data to develop a population needs profile of children in schools; and review of service data and benchmarking with other boroughs to compare service models.

- The review made use of surveys and interviews in order to understand the views and experiences of stakeholders, including: online survey to schools (31 responses); online survey to parents of children in primary schools (261 responses); online survey to children in secondary schools (266 responses); online survey to school nurses (20 responses); and stakeholder interviews (21 interviews); feedback workshop with SMCS staff (40 participants).

2.4 Evidence base for School Nursing

There is strong evidence supporting delivery of all aspects of the Healthy Child Programme (DH 2009), which is based on '*Health for All Children'*, the recommendations of the National Screening Committee, guidance from the National Institute of Health and Clinical Excellence (NICE) and a review of health-led parenting programmes by the University of Warwick.

National guidance states that through the delivery of effective evidence based public health programmes and by implementing the Healthy Child Programme, school nurses services can enable a number of health outcomes including:

- Improving school readiness and a reduction in school absences
- Fewer children and young people requiring formal safeguarding arrangements – achieved through earlier identification and intervention;
- Improved mental health and emotional wellbeing among larger numbers of school-aged children;
- Greater numbers of children and young people living healthy lifestyles, including good diet and nutrition with reduced incidence of obesity and related health dangers that can affect later life;

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- Reduction in teenage pregnancies and reduction in the incidence of sexually transmitted diseases;
- Reduction in health inequalities via tailored work with communities of children, young people and families;
- Signposting and guidance to local specialised services that can address specific and identified needs.

The new model for school nursing is based on four levels:
- **Community**: school nurses have an important public health leadership role to the school and the wider community;
- **Universal Services**: School nurses will lead, co-ordinate and provide services to deliver the Healthy Child Programme for 5-19 year olds;
- **Universal Plus**: school nurses will offer early help through providing care and/or referral or signposting to other services;
- **Universal Partnership Plus**: school nurses will be part of teams providing on-going additional services for vulnerable children and young people.

There is a lack of research into the effectiveness and cost effectiveness of current School Nursing practice in England on improving outcomes for children. This needs further development and has been recognised nationally, DH have commissioned a review of available evidence.

2.5 Key issues from new national guidelines

'Maximising the school nursing team contribution to the public health of school aged children: Guidance to support the commissioning of public health provision for school aged children 5-19' was published by DH/PHE in March 2014. This aims to set out the core school nurse offer and the innovative ways that school nursing services can be commissioned and developed to meet local need. Key issues include:
- **Skill mix of school nursing teams:** should reflect local need and be underpinned by a robust workforce plan which takes into account workload capacity and population health needs –however it does not include recommended staff-population ratios.
- **Service Model**: the guidance supports delivery of the 4 level model of school nursing: Community; universal; universal plus and universal partnership plus.
- **Service Delivery**: new recommendations include a move to a year-round service, including school holidays and delivery of the services in wider community settings, in addition to schools. This is not included in the current local service specification. It also includes recommendations for health and development reviews for Y6/7 and mid teens, which are not currently delivered locally due to capacity issues.
- **Children and Families Act**: school nursing will need to contribute to supporting schools as they take on new statutory requirements that governing bodies must make arrangements for supporting pupils at

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school with medical conditions, and will need to contribute to the health elements of the Education, Health and Care assessments and plans.

2.6 Key issues from the Review of School Nursing Services

What is working well: The review identified that:
- Schools are positive about the School Nursing Service and would like more school nurse time.
- Pupils who had used the school nursing service said that it had made a positive difference to them.
- There is a commitment and passion among school nurses to deliver the Healthy Child Programme.
- Staff were very positive about the supportive team leadership of the service from managers.

Capacity to deliver the current service specification: The School Nursing Service delivers core elements of the Healthy Child Programme, and is broadly meeting performance targets where these have been specified (2012/13). Safeguarding, NCMP, and high school Drop-ins and enuresis clinics are prioritised. All other referrals received are then triaged and prioritised. However, the Service did not deliver a number of services in the current service specification:-
- Profiling community health needs to inform local planning to meet public health priorities
- Health and Development reviews at Year 6/7
- Health and Development reviews in min-teens
- Contribute to school based Personal Health and Social Education (PHSE) programmes

The review identified that the Service currently has limited capacity to deliver:
- Provide expert advice to local agencies and schools to support development of effective local services
- Ensure the service is accessible to clients and the role of the school nurse is widely known
- Reviewing and responding to Reception level health screening questionnaires
- Provide follow up support to parents after initial feedback about overweight and obesity (NCMP outcomes)
- Provide targeted support for CYP and families on health and risk taking behaviour (mental and emotional health, obesity, sexual health, substance misuse)
- Work with Youth Offending Teams

Service Challenges: The Review identified a number of factors that were found to influence the school nurse's ability to deliver the full Healthy Child Programme, these included:
- workforce capacity and recruitment issues
- Population growth and increasing complexity of needs
- Resource and IT issues

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- Delivering all of health's statutory safeguarding responsibilities, which will sometimes be the responsibility of other health professionals

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Workforce allocation: Merton has a slightly lower proportion of staff allocated to the Merton Team that Sutton (12.38 wte Merton and 13.17 wte Sutton) and invests approx. £40k more in the service than Sutton. This indicates the need to be a re-balance workforce allocation between the school nursing teams in Sutton and Merton. This is under discussion with LB Sutton and the service manager.

Prioritising needs: The review identified that there was wide variation in levels of need in Merton schools, based on an analysis of deprivation, free school meals and ESOL population. This indicated the need to move to a needs-based model of service allocation within Merton. School Profiles are now being developed which will lead to a needs- based service level agreement with each school in Autumn 2014.

Safeguarding: the delivery of statutory safeguarding responsibilities has been identified as a significant pressure by staff and schools. School nurses prioritise their response to safeguarding concerns, which sometimes creates a tension between delivering child protection requirements and capacity to deliver the full Healthy Child Programme. The review identified that dependent on role, between 40-80% of school nursing time was spent on safeguarding related roles. Most recent information from the service provider estimates that 60% of School Nurse time is allocated to work towards safeguarding. Guidance from Department of Health states that School Nurses services should 'work collaboratively to ensure there is clarity regarding respective roles and responsibilities of appropriate health professionals as identified within local protocols and policies in line with Working Together to Safeguard Children and using the Safeguarding Pathway for health visitors and school nurses to provide clarity on roles and responsibilities'[1]

Service managers have looked at best practice in other areas (including Barts Health in central London and Warwickshire), with a view to proposing potential changes to working practices for school nurses, whist not undermining the robustness of the safeguarding system. This will need careful consideration and the aim is to progress this in academic year 2014/15. Any changes will provide assurance to Merton Safeguarding Children's Board and Directors from LBM and MCCG there would be no negative impact from any change, and in line with 'Working Together' guidance.

Resource and IT issues: the review identified a need to improve IT support, mobile working and opportunities for increased efficiency to minimise school nurse time spent on administration/record keeping.

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[1] Maximising the school nursing team contribution to the public health of school-aged children Guidance to support the commissioning of public health provision for school aged children 5-19 (DH 2014)

See Appendix 1 for Executive Summary of the Service Review.

2.7 Recommendations and Actions

The review identified a range of recommendations for service development and the new national guidelines for commissioning recommends a number of additional service developments, including a move the full year service and expanding access to services to community settings in addition to schools. At the same time new resources have not been identified, which is a significant challenge in the context of increasing population, particularly at primary school age.

An action plan has been developed in response to the review and recent developments. Key priorities include:

Recommendation for Action	Progress – August 2014
1. Ensure investment in School Nursing workforce reflects resource allocation in Merton –Priority action.	Negotiation underway between commissioners and LB Sutton. Report to Section 101 Board in September 2014.
2. Need to increase capacity of the teams in order to deliver more of the preventative aspects of the Healthy Child Programme –Priority action.	Recruitment to vacancies in Merton School Nurse team complete.
3.Manage safeguarding functions: need to review and address the impact of pressures of safeguarding roles –Priority action	Service managers have reviewed practice in other areas, with a view to proposing changes to the current process. Proposal to go to DPH and DCS, - September 2014, then One Merton Group and MSCB.
4.Need to move to a needs-based model of allocating school nurses to schools, to ensure that the service is more equitable –Priority action	Development of School Profiles for all schools in Merton by September 2014. Schools to be ranked by need (high, med, low) using 'Lancaster model'. Service level agreement offer to be made to all schools for academic year 2014/15 based on needs ranking. Investment of additional £30k from Public Health Grant to service to support higher needs schools from Autumn 2014.
5. Need to increase the visibility of the service	School Nurse to attend parent's evenings for children starting Reception in September 2014. To attend Year 7 and 9 assemblys Autumn term 2014.

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	School nurses to use every opportunity to promote the service and Public Health messages e.g. lunch time stall, school fairs etc. Plans subject capacity.
6. Need to increase on-going engagement with parents and pupils	Service to use 'Meridian' system to evaluate school nurse Drop-Ins and Year 7 questionnaires. Agreed to postpone stakeholder feedback questionnaires until new service interventions are in place.
7. Need to strengthen pathways and links with other services.	Areas to be developed include: • Reception transition and Year 6 transition. • Develop pathways for transition into and out of SNS and for high needs groups. • Develop clear referral routes and linkage across services. • Produce information for professionals including GPs; strengthen setting out School Nurse roles and remit.
8. Need to address the implications of the Children and Families Act 2014.	LB Merton and School Nurse Service reviewed and agreed guidance to schools on new statutory medical policy and role of school nurses in developing health plans for students with health needs in line with requirement for October 2014.
9. Need to review service recommendations from new National guidance and agree appropriate service response.	Need to review how to address recommendations subject to releasing capacity, including: Move to year round service and availability at evenings and weekends; availability of service in community settings other than schools; delivery of health and development reviews for Y6/7 and mid-teens.

3. Next steps

• The service provider aims to implement key recommendations in the academic year 2014/15 – progress will be reviewed by Public Health commissioners, DCS and MCCG.

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- There has been agreement on a revised set of KPIs for the service specification for 2014/15.

- As part of the NHS block contract with the Royal Marsden NHS Trust, the School Nursing service will continue to be delivered by SMCS until March 2016, in line with contractual arrangements.

- Going forward it has been agreed by Merton CCG and LB Merton, that from April 2016 community health services, including School Nursing Services, will be commissioned for Merton, and not jointly with Sutton.

- It has been agreed that the process of re-commissioning school nursing services will commence in September 2014, as part of the re-procurement of community services, in partnership with Merton CCG.

A local Review of Early Years, commissioned by Public Health and CSF, identified the need to develop integrated pathways across children's centres, midwifery, health visiting and the transition into school nursing services. This will be progressed in 2014/15. From October 2015 LB Merton will also become responsible for commissioning Health Visiting Services, which will be transferred from the current commissioner, NHS England. This will also provide the opportunity to look for synergies across services.

1   ALTERNATIVE OPTIONS

1.1.   n/a

2   CONSULTATION UNDERTAKEN OR PROPOSED

2.1.   The review involved consultation with a wide range of stakeholders including service users.

3   TIMETABLE

3.1.   The aim is to commence implementation of recommendations from academic year 2014-15.

4   FINANCIAL OR RESOURCE IMPLICATIONS

n/a

5   LEGAL AND STATUTORY IMPLICATIONS

5.1.   The Council has a statutory duty to commission the National Child Measurement Programme which is delivered by the School Nurse Service. The Council has statutory duties to safeguard and protect

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children and young people and the MSCB has a statutory duty to assure the safeguarding effectiveness of services locally.

6   HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

6.1.   n/a

7   CHILDREN & YOUNG PEOPLE'S PLAN IMPLICATIONS

7.1.   The Review and recommendations contribute to the delivery of Merton Health and Wellbeing Strategy: Priority 1:Giving Every Child a Healthy Start. The Children and Young People's Plan sets out ambitions to improve outcomes for all children and young people, but in particular to narrow the gap for the most vulnerable including children in need; with a child protection plan, Looked after children and children with complex needs.

7.2.

8   RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

8.1.   n/a

9   APPENDICES – THE FOLLOWING DOCUMENTS ARE TO BE PUBLISHED WITH THIS REPORT AND FORM PART OF THE REPORT

APPENDIX1: Executive Summary of Review of Sutton and Merton School Nursing Service –December 2013

Appendix 1

Executive Summary of the Review of Sutton and Merton School Nursing Services –December 2013

Introduction
From April 2013 local authorities have been responsible for commissioning public health services for children aged 5-19 years, including school nursing services and a statutory responsibility for the National Child Measurement Programme. As commissioners, the London Borough of Merton and London Borough of Sutton want to ensure that school nursing services are meeting the health needs of children and young people, in line with national guidance set out in the Healthy Child Programme 5-19 years and the 'Getting it right for Children and Young People' vision and model for school nursing.

In order to understand local services fully and make recommendations to inform and shape service development and future commissioning, a review of the Sutton and Merton school nursing service was undertaken between July and October 2013. The review was led by Merton public health team, with input from Sutton public health and officers from LB Merton and LB Sutton, with full support from the Sutton and Merton School Nursing Service.

Scope and methods
The review focused on school nursing services provided to children and young people who attend a maintained school in the Boroughs of Sutton or Merton. It did not include service provision to young people who are not in school post-16; specialist nursing care in special schools; or immunisation services.

The review used both qualitative and quantitative methods, including: a review of evidence about policy and effective practice in school nursing; analysis of data to develop a population needs profile of children in schools; and benchmarking with other boroughs to compare service models. The review made use of surveys and interviews in order to understand the views and experiences of stakeholders, including: online survey to schools (31 responses); online survey to parents of children in primary schools (261 responses); online survey to children in secondary schools (266 responses); online survey to school nurses (20 responses); and stakeholder interviews (21 interviews).

Context
Nationally a new 'vision and call to action' (2012) set out opportunities to maximise the contribution of the school nursing team to improving the health of children and young people. This outlined the need for services that are visible, accessible, confidential, which deliver universal public health and ensure that there is early help and advice for young people when they need it.

The new model for school nursing is based on four levels:
- Community: school nurses have an important public health leadership role to the school and the wider community;

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- Universal Services: School nurses will lead, co-ordinate and provide services to deliver the Healthy Child Programme for 5-19 year olds;
- Universal Plus: school nurses will offer early help through providing care and/or referral or signposting to other services;
- Universal Partnership Plus: school nurses will be part of teams providing on-going additional services for vulnerable children and young people.

Locally the school nurse service is delivered through two borough based teams, by Sutton and Merton Community Services, part of the Royal Marsden Hospital NHS Trust. The Sutton team is made up of just over 13 whole time equivalent staff and the Merton Team is made up of just under 10 whole time equivalent staff. In addition the Sutton team has 0.7 WTE staff as part of a buy-back service. Both teams have a skill mix including team leader, practice teacher, specialist school nurses, school nurses, community nursery nurses and administrative support. A number of staff work part-time and term-time only.

Key findings
Schools are positive about the school nursing service, they value the school nurse role and want an increased presence and visibility of the school nurse. They recognise the importance of safeguarding and supporting pupils with long term health needs, but also want an increase in preventive work in schools. There is a low level of visibility and awareness about the service among parents and pupils who participated in the review, and there is limited awareness and understanding of what can be expected from school nurses among some professionals, such as GPs.

There is commitment and passion among school nurses to deliver the full Healthy Child Programme, but the workforce feel under significant pressure and under-resourced. Staff highlighted the importance of the positive support they get from team leaders and administrative staff in addition to good training and development opportunities.

Overall Sutton has a bigger school population than Merton, with significantly higher numbers at secondary school level. Overall Merton has a higher level of estimated needs than schools in Sutton (based on analysis of free school meals, ethnicity, English as a second language and special educational needs). There is a high level of variation in need between schools within both Sutton and in Merton.

All schools in Sutton and Merton are offered core universal services for all pupils. These include health screening on entry to Reception; delivery of the National Child Measurement Programme in Reception and Year 6; weekly drop-in service for secondary schools. Time pressures to deliver safeguarding responsibilities and administrative burdens have been identified as barriers to delivering some preventive aspects of the Healthy Child Programme and some functions set out in the service specification 2013/14 are not being delivered, including health and development reviews at Year 6 and mid-teens.

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In addition to the universal caseload, school nurses have an enhanced caseload for children with additional needs, including safeguarding. Merton has a lower proportion of pupils on the enhanced caseload compared to Sutton. The review found that there is some correlation between the enhanced caseload and proportion of children eligible for free school meals in schools, and this relationship is strongest in Sutton schools and weakest in Merton secondary schools. There is no correlation between enhanced caseload and children who have English as a second language.

Both Sutton and Merton school nursing service teams do not meet best practice recommended workforce levels based on '1 specialist school nurse to every secondary school and its feeder schools'. In Sutton the gap is stark with 6.01 WTE specialist school nurses (Band 6 and 7) and 14 secondary schools (out of a total workforce of 13.07 WTE). In Merton there are 5.55 WTE specialist school nurses and 8 secondary schools (out of a total workforce of 9.74 WTE). However, Merton has 10,000 more pupils at Primary School than Secondary School, so a recommendation based on total school population would be more meaningful for Merton. Overall, Sutton has a higher workforce allocation than Merton, with a gap of 3.33 WTEs in Sutton's favour, not including the buy-back service. There is a high vacancy rate among specialist school nurses and challenges in recruiting both school nurse teams. Current vacancies are partially filled by agency/bank staff.

Maintaining robust child protection systems is paramount to ensure the safety of vulnerable children and school nurses have an important role to play in safeguarding. However, the review highlighted challenges in the quantity of school nurse time taken up with safeguarding (estimated at between 40-80%), the appropriateness of school nurses routinely being the health lead, regardless of their knowledge of the child or lack of knowledge, and the impact on capacity to deliver their role in preventing children and families entering the child protection system.

School Nurses work closely with a range of partners including teachers, social care, safeguarding teams and health visitors and signpost to local services, and have positive working links with other professionals. However, the review did not identify clear local pathways for children and young people of school age, for example, children with specific needs such as complex needs, youth justice, looked-after children or mental health needs. Linkages across public health services were identified as mixed and linkages with some groups of professionals are limited, such as GPs and youth justice.

The review indicated that core school nursing workforce allocation is lower in Merton. A 'buy-back' service is only offered to Sutton Schools, four schools currently buy this service resulting in an additional 0.7 WTE of school nurse capacity. The school nursing service performance indicators are not outcomes focused, in common with other school nurse services identified by the review. New KPIs for 2013/14 were agreed to report on from Quarter 3, however, these are not currently being reported.

Nationally, a school nursing service specification in being developed and it will be important to consider this in the context of findings from this review.

Key recommendations

Increase school nurse capacity to deliver universal services:
- Use innovative approaches. Including the skill-mix of the school nurse teams.
- Improve IT support and opportunities for increased efficiency to minimise school nurse time spent on administration/record keeping.
- Increase administrative support for data inputting.
- Agree information sharing protocols with schools and Local Authorities.
- Clarify requirements from schools in securing office space and timely access to pupils.
- Ensure gaps in workforce are filled on temporary or permanent basis; increased focus on prevention may attract workforce and help reduce recruitment challenges.
- Consider further investment in areas of highest need.

Manage safeguarding functions:
- Review and define safeguarding roles to ensure that these are both robust and efficient in use of time, using 'LEAN' approaches.
- Review findings from the provider audit of efficacy of the school nurse role in child protection (Jan 2013).
- Negotiate a formal memorandum of understanding between providers and Local Safeguarding Children's Board on school nurse safeguarding roles.

Respond better to school population needs:
- Undertake school health needs profiling/assessment to better understand needs.
- Move to a needs-based model of allocating school nurses workforce to schools
- Subject to evaluation of effectiveness, expand the school nurse buy-back service offer to Merton schools, with priority to higher need schools, and look to extend to wider range of Sutton schools.

Increase visibility of the service:
- Establish a standard approach to the introduction of the school nurse in primary and secondary schools; hold a termly drop-in session for primary parents.
- Develop a website for the school nurse service/ e-newsletter
- Use technology, such as an 'App' with and for children and young people, which provides a single point for information and signposting on a range of health topics.
- Further engagement with parents of primary school in order to manage expectations and prioritise resources.
- Further engagement with secondary school pupils in order to explore communication methods to increase effective use of nurse time.

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- Engage Youth Advisors and the British Youth Council School Nurse Champions programme

Strengthen pathways and links across services
- Develop local pathways for transition into and out of the school nurse service and for high need groups of children and young people, including clear referral routes across services for children and young people.
- Produce information for other professionals setting out school nurse roles and remit and increase routine communication.

Commission effectively:
- Ensure that workforce allocation to borough-based teams is fair and fully reflects investment by Local Authorities.
- Review performance indicators to reflect quality and outcomes better.
- Review local specification for 2014/15 in light of new National service specification framework (expected early 2014).
- Specify the 'core offer' that all schools should receive and a menu of options that schools can buy-in over and above the core offer.
- Increase provider evaluation of initiatives to provide evidence of impact of services.
- Introduce quarterly monitoring meetings with Public Health Commissioners.

Agree model for future services:
- Hold a stakeholder event to co-create a local vision for future services for school nursing in line with national model for a 'whole systems approach through the delivery of integrated pathways'.
- Review options for closer alignment with other preventive services for children and young people (including sexual health, weight management, substance-misuse and stop smoking services).
- Ensure future commissioning arrangements better reflect different needs of schools within both Sutton and Merton. Consider co-commissioning approaches with schools.

Conclusion and next steps
This review is timely and is part of the process of developing school nursing services and has provided a range of information about school nursing in Sutton and Merton. The findings and recommendations will be used to inform service development and future commissioning arrangements, in a joint effort with NHS England, which is working with local government and Directors of Public Health. Engaging with stakeholders, and in particular young people, in the development of school nursing services will be important to ensure that services are responsive to children and young people's needs.

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Committee: Health and Wellbeing Board

Date: 30 September 2014

Subject: Progress Report on Merton Health and Wellbeing Strategy - Priority 1: Giving Every Child a Healthy Start

Lead officer: Dr Kay Eilbert, Director of Public Health, Yvette Stanley, Director Children, Schools and Families

Lead member: Cllr Maxi Martin

Forward Plan reference number:

Contact officer: Julia Groom, Consultant in Public Health, Leanne Wallder, Commissioning Manager, CSF

RECOMMENDATIONS:

- To note and consider progress on the development and delivery of the Health and Wellbeing Strategy Priority 1: Giving Every Child a Healthy Start.
- To consider opportunities for further integration and partnership work to progress the development and delivery of Priority 1 outcomes.

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 The purpose of this report is to update the Health and Wellbeing Board on progress on the delivery of the Health and Wellbeing Strategy Priority 1: Giving Every Child a Healthy Start, and ask the Board to consider opportunities for further integration and partnership work.

1.2 The report sets out the context and priorities within the Strategy and outlines current progress on priorities and next steps for delivery.

1.3 The report highlights key areas of good progress including, maintenance of a low number of babies born with low birth weight, a downward trend in overweight or obesity in 4-5 year olds which is better than London and England averages, Teenage conception rate of 25.5 per 1000 which exceeds the 2015 target of 27 per 1000.

1.4 The report also highlights areas for improvement including increasing our breastfeeding rates and immunisation rates and halting the upward trend in overweight and obesity rates in 10-11yr olds.

1.5 Finally the report provides an overview of a number of next steps that are anticipated will enable us to address those areas that require further work to meet the targets set.

1.6 Priority 1 outcomes will be reviewed in 2014/15 as part of the refresh of the Health and Wellbeing Strategy for 2015/16 and beyond, this provides an

opportunity to engage with stakeholders and further develop our focus on tackling health inequalities.

2. DETAILS

2.1 Introduction

2.1.1 Merton Health and Wellbeing Strategy 2013/14 includes Priority 1: 'Giving every child a healthy start'. This reflects evidence set out in the Marmot Review 'Fair Society, Healthy Lives (2010)' which set out the case for focusing investment on early years and advocated a life-course approach to tackling health inequalities, demonstrating that giving every child the best start in life is crucial to reducing health inequalities across the life-course.

2.1.2 The Strategy includes a commitment to further strengthening our partnership approach to preventative strategies for health and wellbeing, across all universal services and settings, and ensuring the earliest identification of health and wellbeing issues to better target services to those families that are in greatest need of support, particularly for residents living in the east of the borough.

2.1.3 The Strategy complements Merton's Children and Young People's Plan 2013/16, which focuses on improving outcomes for a number of key groups of children vulnerable to poorer outcomes including safeguarding children, looked after children, youth offending/youth inclusion, and children with special educational needs and disabilities, alongside our focus on Early Intervention and Prevention.

2.1.4 Outcomes for Priority 1: 'Giving Every Child a Healthy Start':

- All babies have the best start in life
- Promoting the emotional wellbeing of our children and young people
- Promoting a healthy weight
- Helping young people to make healthy life choices

The Children's Trust Board lead on the delivery of these outcomes. Priorities within the Strategy are reported to the Board throughout the year and high level outcomes are part of the Trust's performance indicators, which a reviewed quarterly.

High level performance measures are set out under each outcome area below. In addition progress against the Public Health Outcomes Framework indicators for Children and Young People 2013/14 are set out in **Appendix 1**. The Joint Strategic Needs Assessment for 2013/14 is now available online and provides detailed information on all areas of the Strategy: http://www.merton.gov.uk/health-social-care/publichealth/jsna.htm

2.1.5 A delivery plan was developed alongside the Strategy in January 2013. However, since the plan was published there have been a number of changes in national and local commissioning arrangements and plans, therefore the Delivery Plan has been amended, a summary of progress reflecting these changes is set out under each outcome below.

The Health and Wellbeing Strategy will be fully refreshed by March 2015, with a focus on reducing health inequalities. A task and finish group to oversee the refresh is starting in September 2014.

2.2 Progress to Date and Plans for 2014/15

<u>**OUTCOME 1.1: Ensure Every Baby has the Best Start in Life**</u>

This outcome aims to provide every baby with the best start in life setting a foundation that helps reduce health inequalities across the life course.

High level indicators:

- **Breastfeeding prevalence at 6-8 weeks**: 2013/14 Merton- 69.3% compared to Sutton & Merton baseline: 2012/13 -59.6%, and London - 68.5%, England– 47.2%. (2012/13 data was only available Sutton and Merton combined)

- **Childhood Immunisation**: MMR1 at age 2 years: 2013/14 Merton-82.8%, compared to Merton baseline: 2012/13 – 80.7%, and London 87.1% and England 92.3%.

    MMR2 at age 5 years: 2013/14 Merton 72.3% compared Merton baseline: 2012/13 – 68.9% and London 80.8% and England 87.7%.

- **Low birth weight of all babies**: 2012 Merton 6.7%, compared to Merton baseline 2011 - 7.1%, and London 7.9%, England 7.3% in 2012.

These indicate that breastfeeding rates are higher in Merton than England and that breastfeeding rates are higher in Merton than Sutton. Data is now available on a borough level, but trends from earlier joint data with Sutton indicates that there has been no increase is breastfeeding rates over time. Local data shows that there are ethnic variations, with lower levels of breastfeeding among with white British mothers than mothers from BAME communities. Data also indicates that support should be targeted at mothers living in more deprived wards where there are lower rates of breastfeeding.

There have been some increases in childhood immunisation coverage, but this is still below London and England levels. The percentage of low birth weight babies is below both London and England levels.

Current Progress

Progress has focussed on the delivery of the Healthy Child Programme and Children's Centres; the Family Nurse Partnership and Childhood Immunisations.

Healthy Child Programme and Children's Centres: the Healthy Child Programme (HCP) is a universal service that sets out an integrated approach to improving health and wellbeing and supporting families. In 2013 a review was undertaken of

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Children's Centres and Early Years, to review the effectiveness of current delivery models and services and the extent to which the integrated working practices between the key agencies deliver the core purpose of Children's Centres. This identified a range of good practice where health and children's centres are working together. This includes:

- Borough wide delivery of the Healthy Child Programme via Children's Centres – includes child health clinics, development reviews and health promotion
- Co-delivery of evidence based parenting programmes (Baby Incredible Years)
- New birth visit by Health Visitor includes registration with local Children's Centre
- Health Visitor attendance on Children's Centre Locality Advisory Board and participation in multi-agency targeted family work
- Specialist Health Visitor working with Early Years Integrated Service for Children with SEN and Disabilities

Supporting indicators:

- Percentage of all children aged 0-5 years registered with a Children's Centre: 2013/14 -91%

- Percentage of children aged 0-5 year old living in deprivation (30% IDACI) registered with a children's Centre: 2013/14 – 100%

- Percentage and (number) of children aged 0-5 year old living in deprivation (30% IDACI) accessing children's centre services 2013/14: 78% (4109 children seen) against a target – 75%.

- Completion rate of parents attending accredited evidence-based parenting programmes in Children's Centres 2013-14: 77.8% against a target - 80%.

These indicators show that Children's Centres are performing well in ensuring that a high proportion of children are registered and access services, particularly among children living in deprivation.

Findings from the review are reflected in the recent outstanding Ofsted report for South Mitcham Locality/Acacia Children's Centre, which highlighted the high level of registrations at children's centres, citing well established partnerships with health visiting partners as a key factor. The report noted that health outcomes are all improving; especially the case for babies being breastfed at six to eight weeks of age, where the centre's figures were substantially higher than those for the locality as a whole.

The review set out a range of recommendations to further strengthen current commissioning and practice. A public health programme is under development, including the development of early years pathways to further enhance integration, communication, referrals and knowledge; and a programme of training and support for staff to support parents with low level mental health issues.

Family Nurse Partnership (FNP): the Family Nurse partnership is now established with a team in place delivering an evidence-based preventative early intervention

programme for vulnerable first time mothers under 20. There are currently 17active cases in Merton. The programme is based on a strong evidence base from a US programme and has strict eligibility criteria.

Health Visiting Services: In October 2015 responsibility for commissioning Health Visiting Services and the Family Nurse Partnership will transfer from NHS England to the Local Authority. In order to inform the safe and effective transition of services to LB Merton, Public Health, in partnership with Children, Schools and Families, have commissioned a review of Health Visiting Services which will make recommendations to improve outcomes for children aged 0-5 years and inform service development and future commissioning arrangements. Findings will be available in October 2014.

Childhood Immunisation: NHS England is the new commissioner for childhood immunisations across the country since April 2013. Public Health has an assurance role. As part of the PH assurance role, an action plan was developed with the Merton Clinical Commissioning Group to address the low performance on childhood immunisations. Data recording was identified as a potential issue affecting the accuracy of published data, and plans have been implemented in Sutton and Merton to improve the data recording system. Merton CCG is working with GP practices to improve coverage. Public Health works with the 3 GP localities to review childhood immunisation rates and share best practice to improve performance.

Breastfeeding: Progress on developing a multi-agency approach to breastfeeding has been slower than anticipated due to lack of capacity during transition. In September 2014 a Sutton and Merton Breastfeeding Strategic Group will be established to develop and agree an Action plan by early 2015. However, providers, including Sutton and Merton Community Services, are working towards UNICEF Baby Friendly accreditation level 3, which aims to improve breastfeeding rates. A breastfeeding 'App' has also been developed to provide easy to access information and advice.

OUTCOME 1.2: Promote the emotional wellbeing of children and young people

This outcome aims to develop a proactive approach to child mental health and wellbeing, with the provision of prompt support and early interventions to promote good mental health.

High level indicators:

- **Children achieving a good level of development at age 4-5**: academic year 2013-14 –Merton 60%, compared to Merton baseline 2012-13 - 46%, compared to London 52.8% and England 51.7%. National and regional data is not yet available for 2013-14.

- In 2013 a new Early Years Foundation Stage measure was introduced – called Good Level of Development (GLD) and therefore comparable data from 2012 is not appropriate. The data from academic year 2012 – 2013 showed a

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mixed picture across the country with wide variations across LAs and statistical neighbours. Local data from the second year of the new measure shows an improved performance.
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- **Gap between free school meals cohort achieving a good level of development at age 4-5 and non-free school meals cohort at age 4-5**: academic year 2012-13 Merton - 15%

Parenting Strategy: Merton Parenting Strategy is currently being refreshed, setting out our approach to parenting support including the need to signpost our parents to a range of universally available services to which all parents are entitled, provide targeted services for parents who need specific support at particular times and provide mandatory interventions for those parents who are unable to seek out or engage with existing support services. The targeted parenting offer includes a range of evidence based accredited parenting programmes. The need for a targeted parenting programme is identified using a Common and Shared Assessment (CASA) or Single Assessment as part of the multi-agency support provided at the enhanced and specialist levels of our Merton Child Well Being Model (MCWBM). 78% of parents that commenced a programme during 2013-2014 completed the course.

Targeted mental health support in schools (TAMHS): This aims to transform the way that mental health support is delivered to children, to improve their mental wellbeing and tackle problems in a timely way. 23 Primary Schools and 1 Secondary school directly commissioned TAMHS in 2013/14. Tier 2 level mental health support commissioned by schools also includes learning mentors, home-school link workers, nurture groups and emotional literacy support advisors.

Specialist mental health support to children and young people: Following the NHS changes in April 2013; Tier 4 CAMHS is now commissioned by NHS England. Tier 3 CAMHS is part of the overall mental health contract provided by South West London and St George's Mental Health NHS Trust. This is commissioned through a collaborative commissioning arrangement led by Kingston CCG on behalf of Merton CCG (and other sector CCGs).

A range of Tier 2 services is available in Merton for young people and a number of CAMHS workers are embedded within the London Borough of Merton's Looked after Children's Team, Youth Offending Team and our Special Schools, working with some of most vulnerable children and young people. Current plans include to undertake a review of CAMHS, which will assist Merton CCG in developing its commissioning intentions from 2015. The provider is currently in the process of implementing young people's IAPT (improving access to psychological therapies).

OUTCOME 1.3: Promote and increase the proportion of healthy weight children

This outcome aims to tackle childhood obesity and help children achieve a healthy weight as a key way to prevent future illness.

High level indicators:

Excess weight (overweight and obesity) in 4-5 year olds: 2012-13 Merton - 21.1% (502 children) compared to Merton baseline 2011-12 – 21.6%. London 23% and England 22.2% - 2012-13.

Excess weight (overweight and obesity) in 10-11 year olds: 2012-13 Merton - 35% (610 children) compared to Merton baseline 2011-12 – 35.6%. London 37.4% and England 33.3% - 2012-13.

Supporting indicators:

Gap in excess weight between 4-5 year old cohort and 10-11 year old cohort: 2012-13 - 13.9% higher at age 10-11 years.

Gap in excess weight at age 10-11 years between wards in east and west of Merton: 10.3% (2010/11-2012/13 - East Merton -37.9%; West Merton -27.6%)

Trends in excess weight: levels of excess weight have reduced by 2.8% for 4-5 year olds and increased by 0.9% for 10-11 year olds since 2006-07.

These indicators show that there is an increase in excess weight of nearly 14% between 4-5 year olds and 10-11 year olds and that on average levels of excess weight are over 10% higher in the east of the Borough.

Current progress

Progress has focussed on delivering the National Child Measurement Programme and targeted services for child weight management; the Healthy Child Programme and School Nursing; and healthy schools:

Healthy Weight: The National Child Measurement Programme is a mandatory service that measures children in Reception and Year 6 in order to monitor trends in weight and offer support to children and families. Merton has a targeted service for child weight management, with a 12 week programme for children between ages 4-19 years. In 2013-14 In addition to the core service a number of workforce training sessions were delivered, and a 6 week obesity prevention programme focused on schools in central and east Mitcham.

Supporting Indicators:

- **Rate and (number) of children participating in the National Child Measurement Programme 2012/13:**
- Reception: Merton- 93.5% (2,378) compared to London - 94% and England - 94%
- Year 6: Merton- 96.4% (1,743) compared to London- 93.8% and England- 92.7%

- **Number of families completing weight management programme**: 113

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families in 2013-14.

- **Number of children in east Merton completing obesity prevention programme**: 911 children from 17 schools in 2013-14 – new programme.

In 2014-15 a Merton Healthy Weight Strategy for adults, children and families is being developed which will take a multi-agency approach to prevention and early support. Weight management services for children and their families will be re-commissioned with an increased focus on prevention.

The Healthy Child Programme (HCP) and School Nursing: a review of School Nursing Services took place in 2013, in order to inform service development and future commissioning. This included reviewing data and engaging with staff, schools, parents and young people. The review identified a number of recommendations including the need to ensure a fair balance of workforce between Sutton and Merton; the need to move to a needs-based model of service allocation, reflecting the different levels of needs in schools across the Borough; and the need to increase capacity through service modernisation and addressing service pressures including the increasing demand to undertake work on safeguarding. It also identified the need to develop integrated pathways across services including transition from health visiting services. The service continues to deliver the National Child Measurement Programme, and providers are keen to increase preventative work with schools, subject to capacity issues.

Healthy Schools: A Merton Healthy schools framework has been developed, which will focus on supporting the 20 schools in east of the borough and is currently being put in place. The local Merton Healthy Schools Programme will include core areas such as promoting healthy eating through running healthy cooking groups for pupils and parents and school food growing as well as promoting Physical Activity and emotional health and well-being (starting September 2014).

OUTCOME 1.4: Young people making healthy life choices

This outcome aims to help young people feel confident and informed to make healthy lifestyle choices as they move into adulthood and to ensure that their parents and carers are fully informed to encourage and support them.

High level indicators:

- **Under 18 conception rate**: 2012 Merton - 25.5 per 1,000 compared to Merton baseline 1998 – 51 per thousand and 2011 – 27.6 per thousand. London 25.9 per 1,000 and England 27.7 per 1,000 – 2012. Target of 27 per 1,000 has been exceeded.

- **Four week successful smoking quitters in young people**: 2013-14 Merton- 18 quitters, 27% quit rate (local target –no London or England data available). This reflects 3 quarters of data as Q1 focused on mobilisation of a

new service.

- **Hospital admissions for alcohol specific causes in under 18s**: 2010/11-2012/13 Merton 38.17 per 100,000 compared to Merton baseline 2009/10-2011/12 47.27 per 100,000. London 29.76 per 100,000 and England 44.88 per 100,000 (2010/11-2012/13)

Current progress

Current progress has focused on smoking, teenage pregnancy and substance misuse:

Smoking: 70% of smokers begin before their 18th birthday and vulnerable young people are more likely to smoke. Stop smoking services for young people are integrated with the LiveWell service.

In 2013/14 66 young people set a quit date and 18 were successful, which is a 27% quit rate, below London and England levels. Work is underway to increase referrals to the service by increasing links with other health professionals, schools and partners.

Teenage Pregnancy: the current rate of teenage pregnancy has now exceeded the target for 2015, of 27 per 1000. Abortion data has also shown a decrease in the number of girls under 19 years old, attending for terminations and a decrease in the percentage of those attending for a repeat abortion.

Although teenage pregnancy rates have reduced, it remains an important issue and a new teenage pregnancy strategy has been developed for 2014-17. Interventions are focused on:

- Prevention: through education and building resilience and good provision of positive activities for young people
- Early help: such as condom distribution, young people friendly sexual health services, targeted work with vulnerable groups (such as LAC) and parenting support
- Teenage parent support: through our Family Nurse Partnership, Health Visiting Services and Children Centre Services.
- Training for practitioners: through awareness raising of the signs of risk-taking behaviours and potential exploitation and equipping practitioners with the tools to help them talk with adolescents about healthy relationships and healthy life choices.

Sexual health services for young people 'Check it Out', have been incorporated with the main Contraceptive and Sexual Health Service (CASH), and targeted clinics for young people in schools and community settings continue to be delivered.

Substance Misuse: Needs assessment has identified increases in access to drug treatment services and indicated increases in higher risk drinking among young people. A new 'Risk and Resilience' service for young people is currently being

commissioned which recognises the links between the use of drugs, alcohol and sexual activity and will integrate substance misuse treatment and prevention, detached youth outreach service and some sexual health promotion services. The new service will commence in April 2015.

2.5 Next Steps and priorities for 2014/15

2.5.1 This report has provided an overview and update on current activity to deliver priority 1: Giving every child a healthy start. All partners, including LB Merton, Merton CCG, NHS England and the Community and Voluntary sector must work together to continue to deliver joint priorities. The following activity highlighted in this report is being undertaken in 2014/15:

- Review of Health Visiting Services and planning for transfer of commissioning responsibility to Local Authority in October 2015.
- Development of Early Years integrated pathways to ensure there is effective communication and transition across services.
- Development of Multi-agency Breastfeeding Action Plan.
- Work with NHS England and GPs to increase Childhood Immunisation coverage.
- Development of training and support for staff in children's centres in addressing parental mental health in Children's Centres
- CAMHS review to inform future commissioning intentions in line with local need and to develop more robust impact measures for local services.
- Delivery of Healthy Schools Programme to 20 schools in the east of the Borough.
- Launch of Healthy weight strategy and re-commissioning of Children's Healthy Weight Services
- Commissioning of integrated 'Risk and Resilience' service of young people.

2.5.2 There are a number of challenges to the delivery of Priority 1, including financial pressures; workforce recruitment for some services, capacity issues and the timescales and deadlines for re-commissioning some services.

2.5.3 The London Borough of Merton and Merton Clinical Commissioning Group are currently undertaking a review of commissioning arrangements for children's health and health-related services to examine the potential benefits and possible options for achieving closer working in order to provide more 'joined up' and comprehensive services for children and families.

2.5.3 Changes to commissioning responsibility, potential changes to commissioning arrangements and the development of a new health infrastructure provide important opportunities to build on and strengthen Merton's approach to improving health and tackling health inequalities, working in partnership with the Children's Trust Board and health partners in the NHS, Community and Voluntary sector. The refresh of the Health and Wellbeing Strategy in 2015 provides an opportunity to take a refreshed look at a more integrated approach and focus on prevention and early intervention for children and young people.

3. ALTERNATIVE OPTIONS

None

4. CONSULTATION UNDERTAKEN OR PROPOSED

None

5. TIMETABLE

Children's Trust Board to report to Health and Wellbeing Board on Priority 1 in Health and Wellbeing Strategy on an annual basis.

6. FINANCIAL OR RESOURCE IMPLICATIONS

7. LEGAL AND STATUTORY IMPLICATIONS

None

8. HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

None

9. CHILDREN & YOUNG PEOPLE'S PLAN IMPLICATIONS

The activities identified in this report will contribute to delivery of priorities for prevention and early intervention.

10. RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

None

11. APPENDICES – THE FOLLOWING DOCUMENTS ARE TO BE PUBLISHED WITH THIS REPORT AND FORM PART OF THE REPORT

APPENDIX 1. PUBLIC HEALTH OUTCOMES INDICATORS FOR CHILDREN AND YOUNG PEOPLE –AUGUST 2014

PHOF indicators relevant to children for Merton compared to statistical neighbours, London & England – Tartan rug

	Period	England	Merton	Barnet	Ealing	Harrow	Hounslow	Redbridge	Sutton	London
Wider determinants of health										
1.01i - Children in poverty (all dependent children under 20)	2011	20.10	17.70	20.10	25.10	19.90	24.40	23.40	16.00	26.70
1.01ii - Children in poverty (under 16s)	2011	20.60	17.50	19.90	24.60	19.70	24.30	23.00	16.60	26.50
1.02i - School Readiness: The percentage of children achieving a good level of development at the end of reception	2012/13	51.68	46.00	59.56	56.32	44.73	40.30	59.74	40.76	52.81
1.02i - School Readiness: The percentage of children with free school meal status achieving a good level of development at the end of reception	2012/13	36.22	32.87	46.47	48.88	30.73	29.15	48.25	26.61	43.06
1.02ii - School Readiness: The percentage of Year 1 pupils achieving the expected level in the phonics screening check	2012/13	69.09	67.62	72.17	71.62	77.65	72.61	66.99	77.76	72.05
1.02ii - School Readiness: The percentage of Year 1 pupils with free school meal status achieving the expected level in the phonics screening check	2012/13	55.76	52.10	60.81	64.50	66.15	62.00	54.86	66.75	62.97
1.03 - Pupil absence	2012/13	5.26	4.92	5.06	4.66	4.89	4.84	4.84	4.74	4.82
1.04 - First time entrants to the youth justice system	2013	440.93	382.49	315.05	382.42	334.59	424.26	405.87	290.59	458.24
1.05 - 16-18 year olds not in education employment or training	2013	5.30	4.60	2.30	3.30	1.80	4.10	3.40	4.00	3.80
Health improvement										
2.01 - Low birth weight of term babies	2011	2.85	2.89	3.34	3.57	4.40	3.58	4.26	2.23	3.22
2.02i - Breastfeeding - Breastfeeding initiation	2012/13	73.86	85.53	89.23	88.29	84.81	85.74	86.46	85.53	86.77
2.02ii - Breastfeeding - Breastfeeding prevalence at 6-8 weeks after birth	2012/13	47.22	59.57	X	70.99	74.15	X	67.76	59.57	68.52
2.03 - Smoking status at time of delivery	2012/13	12.69	6.46	4.76	3.80	4.39	3.78	5.49	6.46	5.72
2.04 - Under 18 conceptions	2012	27.75	25.51	14.66	22.43	14.22	30.35	16.16	25.82	25.87
2.04 - Under 18 conceptions: conceptions in those aged under 16	2012	5.55	3.28	2.58	5.22	2.14	6.29	1.97	3.44	4.45
2.06i - Excess weight in 4-5 and 10-11 year olds - 4-5 year olds	2012/13	22.23	21.11	23.56	22.43	21.16	23.05	20.71	20.04	23.02
2.06ii - Excess weight in 4-5 and 10-11 year olds - 10-11 year olds	2012/13	33.32	35.00	33.63	37.95	34.20	39.45	36.26	32.98	37.42
2.07i - Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14 years)	2012/13	103.83	83.63	69.31	91.31	89.27	76.87	67.98	103.65	84.55
2.07i - Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-4 years)	2012/13	134.70	102.40	80.69	115.44	126.55	91.72	89.45	133.28	104.88
2.07ii - Hospital admissions caused by unintentional and deliberate injuries in young people (aged 15-24)	2012/13	130.65	110.47	86.94	125.19	86.93	125.31	101.82	127.54	100.67
2.08 - Emotional well-being of looked after children	2012/13	14.00	14.50	13.00	13.30	15.80	13.50	11.90	17.60	13.50
Health Protection										
3.02i - Chlamydia diagnoses (15-24 year olds) - Old NCSP data	2011	2092.25	1966.38	1344.72	1430.57	1080.39	1904.47	1442.57	1960.87	2188.21
3.02ii - Chlamydia diagnoses (15-24 year olds) - CTAD - Persons	2013	2015.63	2063.36	1098.13	1391.80	1087.42	1696.48	1175.74	1997.10	2179.29
3.02ii - Chlamydia diagnoses (15-24 year olds) - CTAD - Males	2013	1387.46	1516.10	648.91	836.45	658.55	1943.95	750.49	1193.08	1555.06
3.02ii - Chlamydia diagnoses (15-24 year olds) - CTAD - Females	2013	2633.52	2630.36	1548.97	1984.34	1559.61	1425.93	1625.06	2795.87	2737.64
3.03i - Population vaccination coverage - Hepatitis B (1 year old)	2012/13	X	66.67	68.42	82.86	X	69.23	77.78	66.67	X
3.03i - Population vaccination coverage - Hepatitis B (2 years old)	2012/13	X	90.00	50.00	80.77	X	45.00	72.73	90.00	X
3.03iii - Population vaccination coverage - Dtap / IPV / Hib (1 year old)	2012/13	94.74	82.58	91.76	95.28	95.48	92.24	93.57	82.58	91.10
3.03iii - Population vaccination coverage - Dtap / IPV / Hib (2 years old)	2012/13	96.30	89.16	94.27	96.84	96.57	93.72	94.79	89.16	93.58
3.03iv - Population vaccination coverage - MenC	2012/13	93.89	83.63	91.36	93.47	95.01	86.71	91.46	83.63	89.94
3.03v - Population vaccination coverage - PCV	2012/13	94.43	83.20	92.29	94.07	95.91	91.56	92.50	83.20	90.83
3.03vi - Population vaccination coverage - Hib / MenC booster (2 years old)	2012/13	92.66	80.31	87.82	90.12	92.49	88.55	89.05	80.31	87.35
3.03vi - Population vaccination coverage - Hib / Men C booster (5 years)	2012/13	91.49	75.73	86.94	90.02	91.11	89.71	87.06	75.73	86.92
3.03vii - Population vaccination coverage - PCV booster	2012/13	92.47	80.21	88.32	88.81	90.53	87.62	88.80	80.21	86.58
3.03viii - Population vaccination coverage - MMR for one dose (2 years old)	2012/13	92.32	80.71	87.82	89.29	92.46	87.71	89.75	80.71	87.14
3.03ix - Population vaccination coverage - MMR for one dose (5 years old)	2012/13	93.87	82.07	92.27	94.05	94.64	93.42	90.90	82.07	90.58
3.03x - Population vaccination coverage - MMR for two doses (5 years old)	2012/13	87.72	68.86	78.13	82.52	89.08	77.44	80.09	68.86	80.77
3.03xii - Population vaccination coverage - HPV	2012/13	86.08	82.71	62.11	79.08	85.37	87.33	75.70	82.71	78.88
3.03xiii - Population vaccination coverage - PPV	2012/13	69.09	58.33	67.35	67.67	65.44	66.22	66.59	58.33	64.24
Healthcare and premature mortality										
4.01 - Infant mortality	2010 - 12	4.11	4.46	3.01	3.54	5.87	4.41	3.75	2.33	4.14
4.02 - Tooth decay in children aged 5	2011/12	.94	.92	.86	1.67	1.36	1.08	.96	.80	1.23

Better	Significantly better than the England average	Lower	Lower than the England value
Worse	Significantly worse than the England average	Similar	Similar to the England value
Similar	Not significantly different from the England average	Higher	Higher than the England value
		Not compared	

Source: Public Health Outcomes Framework (PHOF), 5th August 2014

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Committee: Health and Wellbeing

Date: 30 September 2014

Agenda item:

Wards: All

Subject: **Domestic Violence Needs Assessment and Proposed Way Forward**

Lead officer: Yvette Stanley

Lead member: Cllr Maxi Martin; Cllr Edith Macaulay

Contact officer: Yvette Stanley & Zoe Gallen

Recommendations:

A. To agree the recommendations in the needs assessment

B. To agree the way forward with further work to be done in the light of potential changes to Safer Merton

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1   PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1.   To present the findings of the domestic violence strategic needs assessment and agree Merton's response to the specific recommendations arising from the needs assessment.

2   DETAILS

2.1.   The Council has a number of statutory duties relating to tackling and effectively responding to domestic abuse and violence against women and girls, duties which are delivered across a number of departments and in partnership with a range of partners.

2.2.   At a partnership level the overarching strategy has been led by the Safer Merton Partnership who have the lead on prevention, prosecution, overseeing and performance managing the MARAC and commissioning any Domestic Homicide Reviews agreed by the partnership including reporting to the Home Office on such matters. The MSCB has statutory oversight of a range of related issues including child sexual exploitation, girls and gangs and the safeguarding aspects of FGM. The Health and Well Being Board also have an interest due to their leadership of our overall Health and Wellbeing Strategy.

2.3.   In terms of service responses, CSF department provides a broad range of services from safeguarding and child protection to work with schools around young people's wellbeing which prevent or respond to domestic violence and violence against women and girls. Community and Housing commission our local refuges and have a role in relation to vulnerable adults who experience abuse including domestic violence. Safer Merton have historically led the strategic needs analysis process, commissioned the IDVA Service, administered the MARAC, overseen any DHR process and supported the

overall strategic response including governance of the strategy overall and supporting work groups such as the practitioners' forum.

2.4. The Director of E&R is currently developing proposals to locate specific areas of Safer Merton's work into other services/departments as part of the TOM process and the impact of these changes will need to be built into our future arrangements.

2.5. Given the need to have an up to date strategy and response to DV encompassing the various partnerships and roles of specific service departments the Director of E&R and Director of CSF agreed that an up to date needs assessments should be commissioned and officers from both service departments and the Public Health Team specified and commissioned a new needs assessment. The assessment was undertaken by Cordis Bright during the spring and summer 2014 and they have now presented their findings to a workshop involving key partners. The next section of the report summarises their key findings and recommendations.

3 KEY FINDINGS AND RECOMMENDATIONS

3.1 Domestic violence has been highlighted by the Coalition Government and by the Mayor of London as an area that increasingly demands focus and attention from a multi- agency partnership approach. It is also a priority issue for the council and our Health and Wellbeing Board, Safeguarding Children's Board and the Safer Merton Partnership (the Crime and Disorder Partnership).

3.2 Domestic abuse is in particular a key feature of the work of the CSF departments as DVI is one of the "toxic trio" featuring in the majority (60%+) of child protection cases and we have a strong track record of working with partners tackling domestic violence within families. However, in relationships where children are not present there are limited identified resources to support the victims of abuse and the review has established that the partnership's response to this small but important group is limited and less coherent than the current response to families.

3.3 The review also noted that Merton's population has been changing rapidly over time. 35% of our adult population are BME but 55% of our child population are BME. The fastest growing populations are the overall Asian population, which grew by 6% between 2000 and 2011, specifically those with Pakistani ethnicity which increased by 1.3% and Other Asian ethnicity which increased by 4.4%. The overall Black population grew by 3% over the same time period, with the Black African population growing by 1.8%. Any future service commissioning needs to respond to these changing profiles.

3.4 The review also looked at services available to victims of domestic abuse that are not commissioned directly by the council and are either funded by external agencies (HO and LGA) or are direct provision from the voluntary sector.

3.5 The full needs assessment covers some 170 pages but is available on request. The Executive Summary is attached as appendix 1 and this report focuses on the 6 specific recommendations arising from the review.

3.6 **Recommendation 1**
Agree a common definition for domestic violence and abuse, which should be applied across all future strategic and operational activity in the borough.

Response:
That Merton in future has a Violence Against Women and Girl's Strategy incorporating domestic violence but encompassing:

- Domestic Violence (including men, same sex relationships, and people with and without children)
- Rape and Sexual Violence
- Female Genital Mutilation
- Forced Marriage
- Crimes in the name of "honour"
- Sexual Harassment
- Stalking
- Trafficking
- Prostitution and Sexual Exploitation of adults
- Children and Young People at risk of Sexual exploitation

We will need to identify lead agencies and officers for each strand.

3.7 **Recommendation 2**
Put in place strong leadership and governance arrangements surrounding the Domestic Violence, Abuse and Violence Against Women and Girls agenda.

With this in mind the Director CSF has agreed to be the CMT lead and to chair a new governance board. As part of the consultation on future arrangements for Safer Merton functions CMT will need to consider how the strategic and partnership support for this area is supported and to have clarity re each department's contributions.

Draft structures and terms of reference for the board are attached as appendices 2 and 3.

3.8 **Recommendations 3 and 5**
The governance arrangements will oversee the development of an outcome-focussed strategy to be developed and delivered by a partnership group.

The governance arrangements will clarify and implement strong performance management arrangements.

Response:
It is recommended that the new board oversees the development of a performance framework as part of its new role.

3.9 **Recommendation 4**
To develop an outcome focussed evidence-led commissioning plan to ensure the strategy is delivered.

Response
The board will be supported by a working group of commissioners from PH, CSF, C&H and partners whose task will be to ensure we have a joined up commissioning response to this agenda.

3.10 **Recommendation 6**
To clarify, articulate and publicise arrangements for identifying victims/survivors, assessing risk and referring.

Response
The board will be supported by a practitioners' forum which will respond to this recommendation and make recommendations to strengthen our risk assessment and response

4 **CONSULTATION UNDERTAKEN OR PROPOSED**

4.1 The work started in the borough in March 2014 and was finished early in September. The work started with stakeholder interviews, reviewing strategies in the borough and nationally. In June a stakeholders' workshop to review the recommendations proposed by Cordis Bright was held.

This paper to CMT is also part of the consultation for the changes. The findings and officers recommended responses will need to go through our partnership infrastructure.

5 **FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS**

5.1. The Council and partners will find the most cost effective ways of delivering these functions with the aim to deliver the responses to the recommendations within existing resources. A separate paper on the future arrangements for Safer Merton will address the resource implications under recommendation 2.

6 **LEGAL AND STATUTORY IMPLICATIONS**

6.1. The Council and partners have a range of statutory functions relating to the services detailed in this report. The new arrangements are intended to strengthen our oversight of the delivery of these duties.

7   HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

8   APPENDICES – THE FOLLOWING DOCUMENTS ARE TO BE PUBLISHED WITH THIS REPORT AND FORM PART OF THE REPORT

Appendix 1: Cordis Bright Executive Summary and recommendations

Appendix 2: Draft proposed structure chart under the new governance

Appendix 3: Draft terms of reference for the new VAWG strategic board

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9   BACKGROUND PAPERS

Cordis Bright needs analysis - September 2014

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Executive Summary

London Borough of Merton

Domestic Violence and Abuse Strategic Needs Assessment

September 2014

CordisBright
Consulting

Executive Summary

Introduction

This document summarises the findings and recommendations arising from the London Borough of Merton's Domestic Violence and Abuse strategic needs assessment, delivered by Cordis Bright between April and July 2014. Please see the full report for more information and evidence that informs the following.

Review of European, National, Regional and Local strategies

We reviewed strategies aimed at tackling domestic violence and abuse and also violence against women and girls. There is a high level of consistency among these strategies, which should offer clarity to the London Borough of Merton in developing their future strategic plans. The central recurring themes are:

- Culture change and prevention (including programmes for perpetrators).

- Multi-agency working and information sharing, including the need to recognise the wider vulnerabilities of victims/survivors and perpetrators.

- Providing effective support for victims/survivors.

- Including under-represented groups.

- Supporting those aged 16-17.

- Providing services for women who are subject to sexual violence and exploitation.

- Securing health, social and economic wellbeing for victims/survivors.

- Securing justice (through specialist courts where possible) and effective management of perpetrators.

- Effective leadership.

- Focusing on outcomes.

What works in tackling domestic violence and abuse?

The literature suggests that an effective response to tackling domestic violence and abuse and other forms of VAWG displays the following attributes:

- Strategic, joint commissioning which demonstrates:

  o A focus on outcomes.

- o Effective partnership working across a range of providers to ensure co-ordinated intervention, including health, police, probation, education, children and young people's services, social care, housing, voluntary and community services.
  - o Clear links between commissioning and strategic plans.
  - o Specification of governance processes, incorporating victims/survivors views.
  - o Standardisation and clarity of principles and standards across services.
  - o Sustainability of VAWG services.
  - o Clear care pathways.
  - o Comprehensive needs assessment.
  - o Community engagement.
  - o Effective monitoring and evaluation.

- Effective partnership working, ideally based on the Identification and Referral to Improve Safety programme (IRIS), and an understanding of care pathways.

- Effective information sharing within and between agencies.

- Targeted, coordinated multi-agency support for high-risk victim/survivors. This should include four Independent Domestic Violence Advisors (IDVAs) and one Multi-Agency Risk Assessment Conference (MARAC) Co-ordinator per 100,000 of adult female population.

- Taking opportunities to embed IDVAs into other agencies where domestic violence and abuse may come to light (especially maternity services or A&E).

- A focus on prevention via cultural change within communities, including awareness-raising in schools.

- Specialist services to support children who are involved in domestic violence situations, including joint services with their mothers/carers, and children's workers who can deliver services in refuges and through play therapy.

- Ongoing training and development for practitioners, especially regarding first responses, across a range of partner agencies (e.g. education, children and young people's services, police, health, social care).

- Providing separate services for men who are victims/survivors.

- The use of Specialist Domestic Violence Courts which have strong partnerships and systems, dedicated staff receiving good training, strong MARACs and IDVAs, safe court facilities and criminal justice perpetrator programmes.

Our review was unable to uncover clear evidence of the benefits of perpetrator programmes. It was also difficult to uncover evidence of "what works" in relation to FGM, forced marriage, honour-based violence and services for minority groups. This is similar to the findings of the review contained in the latest NICE

guidance (NICE, 2014). However, it is generally agreed that voluntary and community groups have an important role to play in tackling these issues.

Prevalence and demand for services

Introduction

There are a number of difficulties in gathering reliable data regarding prevalence of domestic violence and abuse. Forms of domestic violence and abuse are often "under-reported" and "hidden". Equally, a low level of reporting may not necessarily mean an absence: it may instead reflect difficulties in reporting and recording.

Number and nature of domestic violence and abuse incidents

- Applying findings from the ONS statistical bulletin *Focus on: Violence Crime and Sexual Offences, 2011-2012* (ONS, 2013) indicates that 4,760 women and 3,225 men may have experienced **some form of domestic abuse** in Merton (including partner or family non-physical abuse, threats, force, sexual assault or stalking).[1]

- Merton's JSNA indicates that in 2012 and 2013, 79% of the victims of *reported* offences in Merton were female.

- Merton's JSNA indicates that in 2012-2013 most reported offences occurred in Mitcham and the East of the borough.

- The majority of victims of *reported* domestic abuse and violence are white and aged between 20 and 29.

- In 2012, 8% of victims in Merton were repeat victims of domestic violence and abuse.

- National research suggests that 66% of victims are likely to have children living in or visiting the home where domestic violence or abuse is taking place (CAADA, 2012a).

- The Crime Survey for England and Wales indicates that, nationally, victims are likely to be experiencing other challenges or vulnerabilities in their lives. Examples include: being single (or divorced), unemployed, frequenters of bars and nightclubs, on low incomes, living in relatively deprived circumstances, etc.

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[1] These figures have been gathered by applying crime rates from the ONS statistical bulletin which related to those aged 16-59 against Merton resident population data for those aged 16-59.

- Merton's JSNA indicates that perpetrators are most likely to be male, White European, aged between 30 and 39, and the ex-boyfriend, boyfriend, husband or son of the victim.

- The Crime Survey for England and Wales shows that in 40% of domestic violence cases, the perpetrator had been under the influence of alcohol, and in 13% of cases, the perpetrator had been under the influence of drugs.

- Data from Public Health England suggests that alcohol may be a factor in around 10-15% of sexual offences in Merton.

Comparison with similar boroughs

There is some evidence to suggest that rates of domestic violence and abuse in Merton may be lower than in other comparable boroughs:

- Metropolitan Police Service (MPS) data and findings from Merton's joint strategic needs assessment (JSNA) suggest that the reported number of domestic violence offences in the borough has been reasonably stable at somewhere between 750 and 900 for the last three years.

- Merton has fewer reported domestic violence incidents and offences than almost any other London Borough. (Only Kingston, Kensington & Chelsea and Richmond have fewer).

- Merton residents appear to make around 19 calls per month to the pan-London sexual and domestic violence helpline; residents from the majority of other London boroughs make more use of this helpline.

However, MPS data suggests that there may have been an increase in rape cases in 2012-2013 in Merton, taking the total number of cases to around 80. This is slightly higher than similarly-sized Sutton and Richmond.

This data also suggests that the number of reported sexual offences in Merton was relatively stable at just under 150 per year for the last 5 years. This is consistent with the findings for similarly-sized Sutton, although somewhat higher than for Richmond.

Prevalence of VAWG-related issues

Local data is not available for the prevalence of some VAWG related issues. However, national and regional data suggests the following:

- Estimates of Female Genital Mutilation vary enormously, from 11 offences between 2006 and 2011 (Freedom of Information request to the MPS in June 2011) to 4.5% of all maternities in Greater London.

- The Forced Marriage Unit (FMU) gave advice in 1,485 cases in 2012, of which 114 involved victims with disabilities and 21% were based in Greater London.

- Iranian Kurdish Women's Rights Organisation research in 2011 finds that the MPS were alerted to 495 honour based crimes in a 12-month period.

- Reports of trafficking and sexual exploitation to the police have increased significantly over the last five years; 447 offences were reported to the MPS in 2012-2013.

- Research by Project Acumen finds that 2,600 women are victims of trafficking for sexual exploitation in England and Wales and 9,600 are vulnerable to it.

- 2012 MPS data indicates that there were 58 prostitution-related sexual offences across London in 2011 of which 37 related to trafficking for sexual exploitation.

- Stalking is one of the most common types of intimate violence, with the 2010-11 British Crime Survey showing that 4.1% of women aged 16-59 and 3.2% of men aged 16-59 having experienced stalking in the last year.

Service mapping and analysis of gaps

The service mapping and gap analysis exercise suggests that there may be demand for:

- More casework provision (both high-risk IDVA-style provision and medium risk case-worker provision).

- A greater focus on multi-agency interventions to address the complex set of vulnerabilities which many victims/survivors and perpetrators display or experience. This focus should also include consideration of children as victims and of the impact of domestic abuse on children's outcomes.

- A slightly greater focus on services for LGBT, male and ethnic minority victims/survivors.

- Work with perpetrators.

- Services specifically focussing on early intervention and prevention.

We have been provided with evidence of around £545,000 being spent on Domestic Violence and Abuse and VAWG services across different departments in the London Borough of Merton, of which:

- 46% comes from Children's Schools and Families.

- 27% comes from Adult Social Care (Supporting People).

- 28% comes from Safer Merton.

Around 40% is spent "in-house" with the remainder being independently-provided. At least eight of these independent providers draw in additional

financial support from voluntary sector or other sources. It should be noted that these expenditure estimates are not complete. As such, they will not be entirely accurate. However, they offer some insight into current spending priorities.

Although there is some good practice in gathering evidence on outputs and outcomes achieved, there is generally an inconsistent approach to this across all stakeholders in Merton. This makes it difficult to assess the success or otherwise of these investments and also to compare the relative benefits of different services or interventions.

Consultation with stakeholders

This methodology uncovered a relatively complicated set of messages, because there is a wide diversity of opinion regarding priorities and key areas for improvement. This may be linked to a lack of clarity regarding the strategy for domestic violence, abuse and VAWG in Merton.

- There is agreement on the importance of establishing a clear, robust, multi-agency strategy and leadership, as well as on the need for this strategy to drive joint commissioning and service delivery.

- Stakeholders agreed that demand for services is high and is likely to increase.

- Stakeholders identified future priorities in the areas of strategy and commissioning; prevention and early intervention; provision of specific services/interventions; the service user journey; professional training and awareness-raising; partnership working and collective response; supporting minority groups; services for perpetrators; recognising children as victims; substance misuse and exploring contextual factors.

- Stakeholders reported the importance of effectively addressing the needs of adult victims/survivors of domestic violence and abuse whilst also recognising the importance of supporting children and young people who have experienced domestic violence and abuse.

- Identified gaps in service provision included: support for male victims/survivors; support for minority groups; support for children and young people; services for perpetrators; prevention and early intervention; shortage of specific services/interventions; support for other types of abuse; use of mainstream services and professional training/awareness-raising.

Understanding the victim/survivor experience

- There is evidence that repeat-victimisation may be relatively low in Merton, although this finding must be treated with caution.

- In keeping with good practice, there are a broad range of agencies actively involved in identifying, referring and supporting victims/survivors.

- However, the extent to which this activity is effectively co-ordinated, articulated and understood by all parties is not clear.

- Equally it is not clear that victims/survivors' wider vulnerabilities are necessarily being addressed.

- Efforts are underway to ensure that as many agencies as possible are able to effectively assess and prioritise risk, although ideally this work should be broadened.

Recommendations

Figure 1 below outlines the recommendations which emerge from the needs assessment. In all cases, the financial costs of these recommendations are relatively low, although it is important to note that they will require officer time (including Director-level input) to implement effectively.

Figure 1 Recommendations

Recommendation	More Detail	Evidence base
1. **Agree a common definition for domestic violence and abuse, which should be applied across all future strategic and operational activity in the borough**	This definition should extend beyond the current Home Office definition (which recognises victims aged 16 and over) and explicitly identify children and young people as potential victims of domestic violence and abuse. It would also be helpful for this definition to specifically articulate Merton's position regarding domestic violence and abuse and VAWG. The current terminology appears (erroneously) to exclude the VAWG agenda, which can be confusing for stakeholders.	- Review of European, National, Regional and Local Strategies - Consultation with stakeholders
2. **Put in place strong leadership and governance arrangements surrounding the Domestic Violence, Abuse and Violence Against Women and Girls agenda**	A credible leader for this agenda needs to be identified and appointed within the local authority to ensure that Merton is able to comply with the good practice advice reiterated across European, National, Regional and Local strategies. Ideally this individual will have easy access to senior counterparts in the Police and Clinical Commissioning Group to ensure that all key agencies are aligning their strategies and activities. The re-instatement of a cross-departmental governance or leadership group is also essential to the effective functioning of Domestic Violence, Abuse and VAWG services in the London Borough of Merton. Key partners are likely to include: Police, Public Health, Communities and Housing, Children's Schools and Families, Primary Care and Voluntary and Community Sector representation. Merton's Domestic Violence forum will play an important role in the development and delivery of domestic violence, abuse and VAWG services.	- Review of European, National, Regional and Local Strategies - Review of "what works" in tackling domestic violence and abuse - Consultation with stakeholders

Recommendation	More Detail	Evidence base
	Its membership should be reviewed to ensure that it includes the following: • Representation from the cross-departmental governance or leadership group. • All operational leads for domestic violence, abuse and VAWG. • Practitioners from specialist domestic violence, abuse and VAWG services. • Practitioners from more universal services which are likely to encounter victim/survivors of domestic violence and abuse. • Service user representation. Its terms of reference should be reviewed to ensure it offers the following: • A forum for practitioners to share experiences, knowledge and good practice. • A channel of communication allowing the front-line experiences of service users and practitioners to be reflected "upwards" and for strategic messages and operational plans to be discussed, reviewed and implemented.	
3. **The new governance arrangements will oversee the development of an**	This strategy should have measurable outcomes and goals which are endorsed by the diverse departments and agencies involved in this agenda. This is likely to include the "pooling" of relevant indicators from Safer Merton Strategies, Children School & Family Strategies,	- Review of European, National, Regional and Local Strategies

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Recommendation	More Detail	Evidence base
outcome-focused strategy, to be developed and delivered by a partnership or operational group.	Community & Housing Strategies and Public Health Strategies. It also needs to account for the reporting requirements of any local boards with an interest in domestic violence, abuse and VAWG (including, for example, the Local Safeguarding Children Board and Health and Wellbeing Board). In addition, it may be helpful to link this strategy to the outcomes articulated in the Home Office's 2014 action plan and the Mayoral Violence Against Women and Girls strategy. This group should also be responsible for monitoring any legislative changes which are likely to affect or change the proposed strategy.	- Review of "what works" in tackling domestic violence and abuse - Consultation with stakeholders - Service mapping and analysis of gaps
4. **Develop an outcome-focused evidence-led commissioning plan to ensure the strategy is delivered**	In developing this plan, it is important to ensure the findings of recent, related needs assessments (i.e. Mental Health Needs Assessment, Dual Diagnosis Needs Assessment) are incorporated. Many of the planned interventions arising from these needs assessments will be targeted at a similar cohort of vulnerable individuals in Merton, so it is crucial to ensure that the commissioning and service delivery approach is sufficiently "joined-up". The plan should also include the following elements: • Where practical, pool funds in order to reduce duplication of effort. (This report finds that at least £470,000 could be available for a domestic violence, abuse and VAWG pooled fund). • Consider wider streams of funding in addition to core business budgets.	- Review of European, National, Regional and Local Strategies - Review of "what works" in tackling domestic violence and abuse - Consultation with stakeholders - Service mapping and analysis of gaps

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Recommendation	More Detail	Evidence base
	• Take into account the apparent service gaps identified in this needs assessment, i.e.: - Demand for more casework provision (both high-risk IDVA-style provision and medium risk case-worker provision). - A greater focus on multi-agency interventions to address the complex set of vulnerabilities which many victim/survivors and perpetrators display or experience, including considerations around children as victims. - A slightly greater focus on services for LGBT, male and ethnic minority victims/survivors. - Work with perpetrators and low threshold early intervention/prevention services (although it is important to be aware that the evidence base for "what works" in these fields is limited). • Ensure that sub-contractors are involved in regular (for example, 6-monthly) dialogue about the overarching strategy for tackling domestic violence, abuse and VAWG in Merton. This may include: - Clarity about the overall goals for the borough, and their roles and responsibilities for delivering against these goals. - Opportunities for them to add value or undertake non-contracted activities in pursuit of these goals.	
5. **Clarify and implement strong performance management arrangements**	This should include the following aspects: • Ensure that monitoring data across all departments is gathered collated, analysed and distilled in a joined-up way which enables effective comparison between services. • Require subcontractors to deliver against outcomes and gather evidence of outputs and outcomes.	- Review of "what works" in tackling domestic violence and abuse - Consultation with stakeholders

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Recommendation	More Detail	Evidence base
	• Outline clear mechanisms for capturing service users' perspectives of services and ensure that these are systematically incorporated into performance management arrangements. • Ensure that performance monitoring data supports informed decision-making regarding "what works", and what is "less successful" so that funds can be confidently channelled into activities which are making a difference. • Consider linking London Borough of Merton's performance management arrangements to the London VAWG panel dashboard.	- Service mapping and analysis of gaps
6. Clarify, articulate and publicise arrangements for identifying victim/survivors, assessing risk and referring.	This should include the following elements: • Provide and publicise ongoing training for the workforce in relevant services to enable them to: identify victim/survivors of domestic violence, abuse and VAWG; encourage victim/survivors to seek support; and make appropriate onward referrals. • Ensure that an up-to-date directory of services (including referral criteria) is produced, regularly reviewed and well publicised so that practitioners and victim/survivors are informed about available services and how to access them. • Continue and broaden efforts to ensure a commonly-agreed approach to the identification and prioritisation of risk, including the complexities of risk management in situations which are	- Review of what works in tackling domestic violence and abuse. - Service mapping and analysis of gaps. - Consultation with stakeholders. - Understanding the victim/survivor experience.

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Recommendation	More Detail	Evidence base
	likely to be fluid and changing. These activities are likely to include: - Continued efforts to train front-line professionals across a range of agencies to identify and prioritise risk, using the CAADA DASH (or similar jointly-agreed tool). - Ensure that arrangements for prioritising low-risk, medium-risk and high-risk cases is clear and consistent. This is likely to include IDVA involvement in reviewing medium- and high-risk cases which have been referred from elsewhere. - Ensure that practitioners other than IDVAs are competent and confident to effectively guide low-risk victim/survivors to those organisations that can best support them.	

CordisBright Limited

Epworth House
25/35 City Road
London EC1Y 1AA

T 020 7330 9170
F 020 7330 9171
E info@cordisbright.co.uk

www.cordisbright.co.uk

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DRAFT VAWG Governance Structure Chart

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│ Health & Wellbeing│  │ Safer & Stronger │  │ Children's Trust │  │ Merton Safeguarding│ │ Adult Safeguarding│
│                  │  │                  │  │                  │  │  Children's Board │  │                  │
└──────────────────┘  └──────────────────┘  └──────────────────┘  └──────────────────┘  └──────────────────┘
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          │     Practitioners Forum      │─┴─│ Commissioning Group│
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Health & Wellbeing

Safer & Stronger

Children's Trust

Merton Safeguarding Children's Board

Adult Safeguarding

VAWG Board

Practitioners Forum

Commissioning Group

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DRAFT
Violence against Women and Girls Board

Section1: Terms of Reference

The VAWG Board will oversee the delivery of the council's and partnership's response to:
- Domestic Violence
- Rape and Sexual Violence
- Female Genital Mutilation
- Forced Marriage
- Crimes in the name of "honour"
- Sexual Harassment
- Stalking
- Trafficking
- Prostitution and Sexual Exploitation
- Children at risk of sexual Exploitation

This will be carried out inline with the Mayor of London's "The way forward a call for action to end violence against women" and in the context of the London Safeguarding Children's Board agreed pan London Protocols.

Purpose

To set the strategic direction for Merton's partnership work on VAWG

To commission an over-arching strategy encompassing the VAWG key strands and establishing clear local priorities.

To hold partnership leads for specific strands of activity to account through and effective performance framework.

To improve joint working in relation to commissioning VAWG services

To improve practitioner joint working, risk assessment and practice

To ensure the operational delivery of the recommendations from the VAWG Needs Assessment and to implement the VAWG agenda within the borough.

Section 2: Operation of the Board

Good Practice

The VAWG Board agrees to work to the best practice.

Membership

- CMT Lead (co-chair)
- Strategic Lead within Merton Police (co-chair)
- Chair of the MARAC
- Representatives from Children's Safeguarding, Education and Care
- Housing Needs Manager
- Assistant Chief Probation Officer
- Merton Victim Support Manager
- Strategic Lead within Public Health
- Lead within Adult Safeguarding
- Lead within MVSC
- Victim Support, Merton Manager

Support

This will need to be resolved through the discussions re Safer Merton but will need to cover policy and strategy development, performance/needs assessment and administration.

Designated leads will be needed from service areas

Substitution

All members will attempt to send a named substitute with delegated authority to the meetings that they are unable to attend.

Chairing

The Director for Children Schools and Families and senior Police officer will co-chair the meeting.

Frequency

There will be two meetings held in 2014. From 2015 the board will meet 3 times a year with the practitioners group and Commissioning group meeting between this board.

The duration of these meeting will be no longer than 2hrs.

The first year's meetings will be booked in advance at the first meeting, and then annual bookings will be made.

Core Agenda Items

The agenda will contain certain core items that will appear each meeting, as well as meeting-specific items. The agenda will always include:

- Welcome/apologies
- Minutes of the last meeting
- Outstanding actions

A full standard agenda will be agreed by the board.

Reporting

The work of the VAWG Board will report to: Children's Trust, Merton Safeguarding Children's Board, Safer & Stronger Strategy Group and the Health and Wellbeing Board.

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Committee: Health & Wellbeing Board

Date: 30 September 2014

Wards:

Subject: Merton CCG Commissioning Intentions

Lead officer: **Adam Doyle, Director of Commissioning and Planning**

Contact officer: **Adam Doyle, Director of Commissioning and Planning**

Recommendations:

A. The Health and Wellbeing Board is asked to note the Merton Clinical Commissioning Group (CCG) Commissioning Intentions

1   PURPOSE OF REPORT AND EXECUTIVE SUMMARY

This is the second set of commissioning intentions Merton Clinical Commissioning Group has developed. These commissioning intentions continue to build on the two year operating plan we developed for 2014/16 and form part of our 5 Year Strategic Plan which is being developed with other commissioners including local Clinical Commissioning Group's, NHS England and the local authority. For 2015/16 we have overarching commissioning intentions across all SWL CCGs and this helps us to start to shape the future direction of our 5 year plan. In addition to the collective SWL commissioning intentions issued in this document, each CCG will issue independent intentions that reflect local initiatives that complement the collective commissioning intentions.

2   DETAILS

Last year, Merton CCG worked through the commissioning cycle with our patient's clinicians and members, to identify the emerging priorities for 2014/16, based on the Joint Strategic Needs Assessment and other intelligence and we are continuing with the identified priorities as follows:

- Older and Vulnerable Adults
- Mental Health
- Children and Maternity Services
- Keeping Healthy and Well
- Early Detection and Management
- Urgent Care

Our commissioning intentions describe the high level the priorities and actions we will deliver during 2015/2016 and outlines the platform for delivery of continuous commissioning improvement in subsequent years. This is an iterative document subject to active review as national and local policy emerges and areas of delegated accountability are assigned. We look forward to working with our population and colleagues across the health and social care economy to continue to deliver high quality care. We have developed a Plan on a Page for Merton CCG that can be used in to ensure key stakeholders are aware of our plans.

3   ALTERNATIVE OPTIONS

4   CONSULTATION UNDERTAKEN OR PROPOSED

Summary of channels used:

GP members; promotion to CCG members, Patient Participation Groups

Face to face meetings; linking into existing engagement activities, events and regular meetings

Social media; promotion via Merton CCG's twitter account

5   TIMETABLE

N/A

6   FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

N/A

7   LEGAL AND STATUTORY IMPLICATIONS

8   HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION 8.1IMPLICATIONS

N/A

9   CRIME AND DISORDER IMPLICATIONS

None for the purposes of this report.

10   RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

None for the purposes of this report

11   APPENDICES – THE FOLLOWING DOCUMENTS ARE TO BE PUBLISHED WITH THIS REPORT AND FORM PART OF THE REPORT

None for the purposes of this report

12   BACKGROUND PAPERS

None for the purposes of this report.

"Right care, right place, right time, right outcome"

Merton CCG 2015/2016 Commissioning Intentions

Adam Doyle, Director of Commissioning

17 September 2014

Version 1.4

Foreword

This is the second set of commissioning intentions Merton Clinical Commissioning Group has developed. These commissioning intentions continue to build on the two year operating plan we developed for 2014/16 and form part of our 5 Year Strategic Plan which is being developed with other commissioners including local Clinical Commissioning Group's, NHS England and the local authority. For 2015/16 we have overarching commissioning intentions across all SWL CCGs and this helps us to start to shape the future direction of our 5 year plan. In addition to the collective SWL commissioning intentions issued in this document, each CCG will issue independent intentions that reflect local initiatives that complement the collective commissioning intentions.

Commissioning intentions signal the direction of travel for service improvement. These commissioning intentions from Merton CCG, notify all relevant stakeholders and service providers of the priorities for 2014/16.

The Operating Plan continues to be delivered by the CCG in partnership with the Local Authority & Public Health (London Borough of Merton), support from the South London Commissioning Support Unit and the Voluntary Sector and we are achieving a significant improvement in the delivery of services that we commission.

Last year, Merton CCG worked through the commissioning cycle with our patient's clinicians and members, to identify the emerging priorities for 2014/16, based on the Joint Strategic Needs Assessment and other intelligence and we are continuing with the identified priorities as follows:

- Older and Vulnerable Adults
- Mental Health
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Our commissioning intentions describe the high level the priorities and actions we will deliver during 2015/2016 and outlines the platform for delivery of continuous commissioning improvement in subsequent years. This is an iterative document subject to active review as national and local policy emerges and areas of delegated accountability are assigned. We look forward to working with our population and colleagues across the health and social care economy to continue to deliver high quality care. We have developed a Plan on a Page for Merton CCG that can be used in to ensure key stakeholders are aware of our plans.

Dr Howard Freeman   Eleanor Brown
Clinical Chair   Chief Officer

Merton Clinical Commissioning Group (CCG) Plan on a Page 2015/16
Merton CCG – Right Care, Right Time, Right Place, Right Outcome

Merton – registered population 215, 018 | 3 Acute Trusts | 1 Local Authority | 1 Mental Health Trust | 1 Community Services | 3 Localities

Key Strategic Projects

South West London Commissioning Collaborative, Integration of Key Services, Merton Better Healthcare Closer to Home (MBHCH), System Resilience

Context and scale of the challenge

One clinically-led CCG with 25 member practices covering the same area as Merton Local Authority.	A financially challenged health and social care system due to historical low levels of funding and increasing demands on services.	Large inequality gap between more affluent (West) and less affluent (East) wards.	A need to operate to scale but still provide a local solution to commissioning
• A clinically and patient led organisation with 1 Clinical Chair, 1 Secondary Care Doctor, 1 Nurse, 2 GPs and lay member for PPI on the governing body • An Executive Management Team led by the Chief Officer. • 3 Locality Clinical Leads • 13 Clinical Directors • 25 Practice Leads • Over 100 GPs • 60 Practice Nurses	• Historically low levels of funding, however, 4.92% allocation growth in 14/15 and 4.49% allocation growth in 15/16 to bring Merton CCG closer to target. • The 2015/16 indicative resource limit is £229m. • A 1% surplus of £2,287k will need to be delivered. • The net Quality Innovation Productivity and Prevention target for 15/16 is £5.8m which is 2.5% of the resource limit. • A joint Better Care Fund (BCF) plan of £12.2m and a CCG investment plan will need to be delivered.	• East Merton is younger, more ethnically diverse and more deprived than West Merton. • Residents of East Merton have lower educational achievement and levels of income (the biggest influences on health) • If East Merton had the same rate of deaths as West Merton, it is estimated that there would be around 113 fewer deaths each year in East Merton • Cardiovascular disease contributes the most to the differences in mortality between East and West Merton, but admission rates for cardiovascular disorders are lower in East Merton • West Merton has an increasing older population with associated health and social care needs • Challenges we face with regard to healthy life expectancy are an increase in obesity, ageing population, ethnic diverse population with different health needs, high levels of smoking , co-morbidities, and mental health issues	• To work with CCGs and NHSE in South West London through the South West London Commissioning Collaborative (SWLCC) to redesign services as part of our 5 year strategic plan. • To continue to link our local six priority themes to the seven themes of the SWLCC. • To embed quality improvements across all key areas. • To procure Community Health Services now that Transforming Community Services (TCS) has come to an end. • To ensure a quality assurance programme is embedded within the organisation • To ensure that prevention and wellbeing are considered at every stage of clinical pathway redesign. • To ensure that where relevant, pathways optimise the use of medicines and that we use the skill of our medicines management team to assist all areas of delivery

CCG Organisational Development Priorities	Patient Involvement Priorities	SWLCC Priorities	Better Care Fund Priorities	System Resilience Priorities
• Strong clinical leadership is the core of how the CCG makes decisions, redesigns pathways and provides better outcomes for patients. • To have demonstrated and delivered robust managerial and clinical succession planning and to work with neighbouring CCG's and the Local Authority to ensure, where practical, joint pieces of work are undertaken. • To aspire to be a good employer, supporting staff to develop the skills and competencies to undertake their roles efficiently and effectively	• To ensure the key principles and values of the NHS Constitution are integral to everything we do by providing safe care and ensuring people experience better care • To ensure the patient voice is heard throughout all levels within the organisations • To ensure that the views of patients, service users and carers are represented in the planning, delivery and evaluation of commissioning decisions within the organisation. • To ensure that the values underpinning equality, diversity and human rights are central to our policy making, service planning, employment practices and community engagement and involvement	• Children's services • Maternity Services • Planned Care • Urgent and Emergency Care • Integrated Care • Mental Health • Primary Care **Merton BHCH Priorities** • Full utilisation of the Nelson Health Care Centre • Business Case approval of the business case for the Mitcham development with an associated clinical-led model of care	• Reducing emergency admissions • Improve effectiveness of reablement • Reducing length of hospital stay • Reducing permanent admissions to care homes • Improving service user and carer experience **Performance Priorities** • A&E and emergency admissions • Referral to Treatment (RTT) • Cancer • Diagnostics • Health Visiting • Improving Access to Psychological Therapies (IAPT) • Dementia • Winterbourne experience	• To enable better and more accurate capacity modelling and scenario planning across the system • Work with NHS 111 providers to identify the service that is best able to meet patients urgent care needs • Additional capacity and service redesign for primary care • Enable better integration through the Better Care Fund • Seven day working arrangements • Expand and improve ambulatory pathways for high intensity users within the emergency department i.e. Frail elderly, minors pathways, mental health pathways. Consultant-led rapid assessment and treatment systems within the emergency department and acute medical units during hours of peak demand • All parts of the system should work towards ensuring patients medicines are optimised prior to discharge • Cross system patient risk assessment systems in place and being used effectively

Our Six Delivery Areas

Older and Vulnerable Adults = SWLCC Integrated Care.
- We will aim to increase resources to our community services to extend the hours in which it operates including improved access to dementia services in crisis
- We will continue to use of risk stratification and we will target those with particular needs to ensure that people are given a robust care plan and that we proactively support them to be independent as possible
- We will monitor patients through Winterbourne
- We will ensure that work is targeted to reduce unnecessary non-elective admissions in people with long term conditions, co-morbidities or frailty through our redesign of the Older People's Assessment service and our Interface Older Persons services
- We will commission our services for people with learning disability services with greater rigor through our contract with the local authority
- We will aim to increase the number of people offered choice at end of life and supported and enabled to die at home where this is their preference

Mental Health = SWLCC Mental Health.
- We will be focussing the results of our Health Needs assessment to make sure that services respond to the collective challenge we face
- We will work to ensure all aspects of the Crisis Care Concordat are appropriately implemented
- We will have delivered increased transfer of services to the community and considered models where mental health and physical health teams are co-located.
- We will continue to redesign step down services to ensure all long term placements are tailored to the individual patient's needs.
- We will have redesigned IAPT services and procured a new model of care
- We will continue to review our out of borough placements to ensure where possible, that people are able to access long term care within Merton.

Children's and Maternity = SWLCC Children's Care and Maternity Care.
- We will review of implementation of the Children's and Families act and review our arrangements for Education, Health and Care plans and Personal Health Budgets
- We will invest in Community Services to ensure that we can start to treat children more closely to their home. Our East Merton development is a key platform for this initiative.
- We will provide better access and innovative models for CAMHS services to ensure that children access psychological support in a way that meets their needs.
- We will support a woman-centred pathway to ensure high quality of obstetric care is in place.
- We will ensure that all post natal care has a defined standard.
- We will ensure that our safeguarding and looked after children services are robust and meet the population needs

Urgent Care = SWLCC Urgent and Emergency Care.
- We will work across SWL to find a 111 solution that is resilient yet flexible.
- We will review our Out of Hours services in line with Primary Care and Community transformation to ensure patients can access primary care services at a time that suits them.
- We will ensure there is greater system surveillance across Merton and that it links in to the wider urgent care picture for South West London.
- We will work with our providers to develop more ambulatory care pathways linked to our Urgent Care Centres

Early Detection and Management = SWLCC Planned Care
- We will draw up a strategy, based on local need, which will inform future commissioning priorities through identifying and prioritising the long term conditions and the planned care pathways for which we can deliver improvements
- We will work with partners to develop and deliver models of care, ensuring that mental health and wellbeing is included as part of the patient care process
- We will work with partners to improve to develop and deliver models of care to deliver improvements in proactive detection, diagnosis and management of disease, starting with cancer and respiratory diseases
- We will use the opportunity presented by the Nelson Local Care Centre to begin the delivery of improved models of care, starting with cardiology, respiratory and gynaecology services
- We will monitor access to diagnostic services and treatment to ensure that waiting time from referral to treatment (RTT) is in line with, or better than, national targets
- We aim to improve diagnostic services for housebound patients.

Keeping Healthy and Well = SWLCC Commissioning themes.
- We will design a coordinated weight management pathway and commission Tiers 2 -3 services
- We will embed prevention and provide training for frontline health staff in behaviour change techniques and in providing brief advice and signposting
- We will work with CCG colleagues to design plans to encourage the population to take a more active role in their health (diet, exercise, smoking cessation and risky drinking)
- We will be rolling out a Proactive GP programmes within East Merton and support Public Health closely in this initiative

Primary Care Support and Improvement

This theme is aligned to the NHSE theme of Transforming Primary Care
- We will work with our membership to ensure transforming is built on a platform of solid robust and resourced Primary Care.
- We will work with our membership to ensure that they are supported to find new solutions by working closely together to provide improved access, specialism, and improved patient outcome.
- We will ensure that when we are transferring services to primary care and community services we will educate practitioners about new pathways and update/up skill practitioners to manages the new responsibilities

We will deliver	Enhanced Commissioning through	Key Risks and mitigations

• The NHS Constitution for people in Merton • The NHS Outcomes Framework • The Social Care Outcomes Framework • Public Health Outcomes Framework • Innovation by turning good ideas into services to benefit patients • Moving towards London Quality Standard for Acute and Primary Care	• Working closely with patients and clinicians to design services and following our own commissioning methodology • Working with CSU, CCG and NHSE colleagues to ensure decisions evidence based • Integration of services through our commissioning	• Call to Action – system wide financial pressure and an ageing population, • Rising emergency admissions • Provider ability to make the efficiency savings required

1 Context

1.1 Introduction/Overview

Merton Clinical Commissioning Group's (CCG's) Commissioning Intentions for 2015/16 outlines the next 12 months of commissioning across Merton, describing our aims and ambitions and how we are working across the health system to improve quality and drive efficiency. We are working together as a health and social care economy to be clear about how the system will achieve sustainable services and financial performance whilst delivering quality and productivity improvements.

1.2 Aims and Ambition

The commissioning intentions continue to articulate Merton CCG's vision for what the Merton system will look like over the coming years. This vision has been further developed with member practices through our three localities, Clinical Reference Group, user and carer feedback. Our aims and ambition are built on the Joint Strategic Needs Assessment[i] (JSNA), jointly agreed priorities with the Merton Health and Wellbeing Board (HWBB), patients, health and social care professionals, the voluntary sector and other stakeholders.

1.3 NHS Planning Guidance

In October 2013 the NHS Chief Executive wrote to commissioners outlining the planning approach for the NHS over the next 5 years, including:

> "Strategic and operational plans – given the scale of the challenges we are facing, we are asking commissioners (CCGs and NHS England commissioners) to develop ambitious plans that look forward to the next five years, with the first two years mapped out in the form of detailed operating plans. Taking a five year perspective is crucial, as commissioners need to develop bold and ambitious plans rather than edging forward on an incremental basis one year at a time."

Merton CCG received national Business Planning Guidance in mid-December 2013 to define the structure and content of the two year operating plan. The likely requirement for longer term strategic plans was signalled in NHS England's "A Call To Action[ii]" document published in July 2013. This describes anticipated "…future pressures that threaten to overwhelm the NHS and identifies some key challenges which can only be tackled by doing things differently within the following set of requirements:

- How can we improve the quality of NHS care?
- How can we meet everyone's healthcare needs?
- How can we maintain financial sustainability?
- What must we do to build an excellent NHS now and for future generations?

Merton CCG is part of the South West London Commissioning Collaborative which includes Merton, Wandsworth, Kingston, Richmond,

Sutton and Croydon CCGs, and NHSE for Specialist Commissioning and Primary Care services.

It is expected that we may receive further planning guidance throughout 2014/15 to inform future commissioning in 2015/16

1.4 Delivery over 5 years

Merton CCG is committed to our decision to concentrating on wider transformational service redesign to deliver a financially sustainable health system over 2 years, rather than having unrealistic annual activity reduction targets.

The funding Merton CCG received in 2014/15 increased by 4.92%. In 2015-16 Merton will receive 4.49% increased allocation, which is based on estimated population growth of 2.16% and 2.33% linked to bringing the in funding in Merton closer to what we feel is the appropriate amount for our population.

2 Commissioning intentions

2.1 What are Commissioning Intentions?

The purpose of this section is to inform all Merton CCG stakeholders of the commissioning priorities for the next two years. The commissioning intentions are in effect the CCG's annual plans for the next year outlining which areas we have prioritised for improvement, the changes we wish to make and how we will look to transact those changes.

Merton CCG is the co-ordinating commissioner for the Community Services contracts with The Royal Marsden NHS Foundation Trust, who host Sutton and Merton Community Services (SMCS). We are also a significant associate commissioner in the contracts with:

- St George's Healthcare NHS Trust
- Epsom and St Helier University Hospital NHS Trust
- Kingston Hospital NHS Foundation Trust
- South West London and St George's Mental Health Trust

Figure 2: South West London locality map and the seven providers engaged with Merton commissioner
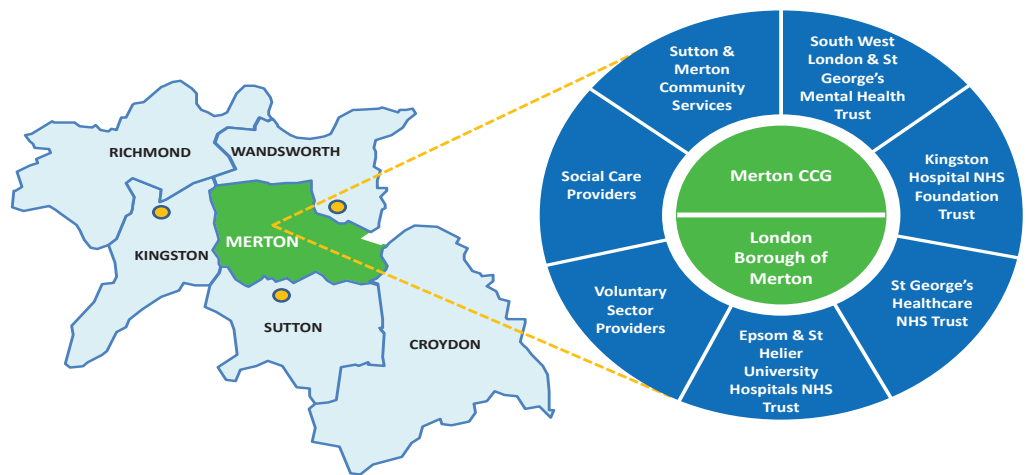
Our CCG also holds contracts with a range of other hospitals, hospice, voluntary and independent sector providers.

2.2 The health of people in Merton

- **Joint Strategic Needs Assessment (JSNA)**

Our Commissioning Intentions are informed by the 2014/15 JSNA and we are active partners in the process for developing the JSNA for 2015/16. The JSNA sets out a big picture for commissioning partners, to agree key priorities for improving the health and wellbeing of all our communities at the same time as reducing health inequalities. The JSNA provides the rationale and evidence base for the Joint Health and Wellbeing Strategy, and underpins Merton CCG's commissioning intentions. The health and wellbeing of Merton's population is closely defined by the characteristics which make Merton a unique borough.

Merton continues to be "healthy" in comparison with much of London, but within the borough there are unacceptably wide differences in life expectancy and death rates for some of the major causes of death—cancer, heart disease and respiratory disease. These inequalities are reflected in key predictors of health and wellbeing such as obesity prevalence, smoking prevalence and teenage conceptions. Strong partnerships and innovative ways of working are central to improving health and reducing inequalities. The east of the borough experiences higher levels of social and economic deprivation, which contrasts the resulting poorer health outcomes in the East. The JSNA is an assessment of the health and wellbeing of the people of Merton. Locally, the JSNA programme is led by the Merton Public Health team, and involves partner organisations, such as the local NHS, local authority, and voluntary and third sector organisations.

- **Place**

Merton is suburban in character, and has significant amounts of green space, with over 60 parks and open spaces. 18% of the borough area is

open space, compared to a 10% London average. The health and wellbeing of Merton's population is closely defined by the characteristics which make Merton a unique borough. While Merton generally performs well on health indicators overall, the east of the borough experiences higher levels of social and economic deprivation, which result in significant differences in life expectancy and mortality between and within electoral wards in Merton.

- **People**

Merton is part of one of the world's largest cities. The 2011 Census identified a resident population of 199,693. The age profile in Merton is atypical to outer London Boroughs currently. There is a very high proportion of young working age adults, and a smaller proportion of older people. There are around 3,500 new births each year, a 40% increase since 2002. By 2021 it is expected that there will be a 20% increase in children born each year. The population is predicted to increase in size through increasing birth rates and migration, and will remain relatively young compared to the national profile and more in line with what is expected in London. However, there is an expected increase of the very elderly population that is more in line with the national profile.

Approximately 35% of the population are from Black, Asian and Minority Ethnic (BAME) communities. An additional 16% of the population are from non-British White communities (mainly South African, Polish and Irish). Combined, 51% of Merton's population are from diverse communities.

In 2012, Merton continued to be healthy in comparison with much of London, but within the borough there are unacceptably wide differences in life expectancy and death rates for some of the major causes of death. A man born in Ravensbury ward can expect to live 71.6 years, while a man born in Wimbledon 84.8 years – a difference of 9 years and no change from 2005/09. A woman born in Figges March can expect to live 79.5 years and one born in Hillside 92 years, a difference of 13 years and 2 years more than in 2005/09.

We will refresh our commissioning intentions and plans once the 2015/16 JSNA is complete

2.3 Moving care closer to home

Merton CCG aims to keep people out of hospital when care can be provided in other settings such as the community. As part of Merton Better Health Care Closer to Home (MBHCH) programme, we are developing care outside a hospital setting. Our Primary Care and multidisciplinary assessment unit at the Nelson Health Care Centre opens in April 2015 and the MBHCH Programme are actively seeking to ensure that the new model delivers fully integrated care. In order to ensure that the people of Merton have full access to excellent facilities, we are assessing a new model of care in East Merton and working with the HWBB to ensure that healthcare needs of our most deprived area within the Borough are taken into account. We are working hard on ensuring that we will have a robust business case signed off by NHS England in July 2015. This will enable us to start building the new centre.

2.4 Addressing Health Inequalities in Merton

The Joint Strategic Needs Assessment shows that overall health outcomes in Merton are good compared to London and England. There are however significant inequalities in health outcomes. The maps below show the differences in life expectancy between the east and the west of the borough. The darker shaded areas represent those areas with the shorter life expectancy.

Figure 4 – Life Expectancy in Merton

Male Life Expectancy at birth by small area, small area, 2006-10

Female Life Expectancy at birth 2006-10
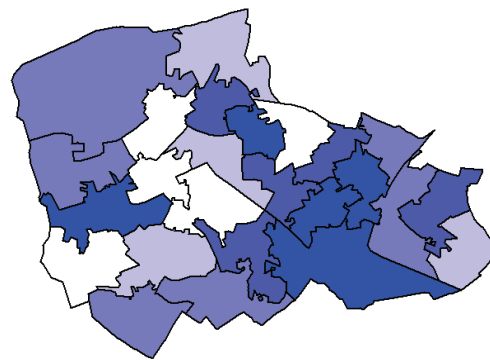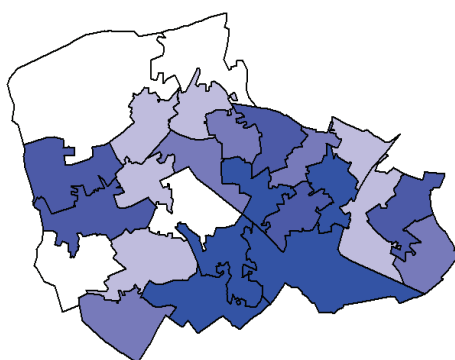
Public Health and Merton CCG then agreed to work together to address the health care inequalities in the East. A health needs assessment of health for East Merton residents completed in January 2014 found that for the biggest killers in Merton (coronary heart disease, cancer and respiratory diseases)

- They are more frequent in poorer people
- They can be prevented. All are related to lifestyle factors such as smoking, obesity, lack of physical activity, an unhealthy diet and excessive alcohol consumption
- Primary care has a key role in preventing and treating them

The needs assessment therefore recommended:

- Improvements should be made in early detection and management of long-term conditions in primary care, especially in East Merton
- A new local healthcare centre in East Merton should contribute to health improvement in that locality. Its purpose might include accommodating services moving from elsewhere, housing novel services to complement what exists now, providing the public with an accessible point of contact for a range of local services and acting as a focus for quality improvement initiatives in primary care
- The CCG should consider new models of service provision that involve more care being provided in community settings and less at hospital sites, including intermediate care for people with diabetes for example

The Mitcham Project Board, led by representatives from GP practices in the East Merton locality, includes the MCCG, the Council and Public Health colleagues. The group are developing a model of care that ensures

disease is detected early when it can be cured or managed closest to home. Work will be two fold – over the next 6 months the task and finish group will finalise a new Model of Care. At the same time, a full business strategic case for the development of a local health care centre in Mitcham is under development for consideration by the Department of Health. This process should be completed by July 2015, when, if approved work can begin on the centre.

3 Delivery

4.1 CCG Programme Work streams

As indicated in our operating plan we have developed key areas to deliver our vision, each is clinically–led with robust project management methodology applied to each work stream including:

- Older and Vulnerable Adults
- Mental Health
- Children and Maternity Services
- Keeping Healthy and Well
- Early Detection and Management
- Urgent Care

4.2 Procurements within 2015/16

Throughout 2015/16 we plan to procure the following clinical services either as a single CCG or with local CCGs

- 111
- Community Health Services
- IAPT services
- Musculoskeletal Services

4.3 Summary of Commissioning Intentions

The clinical leaders and executive team within Merton CCG are addressing the challenges and know that there is still a significant amount of work to do.

4.4 Timetable

Final submission of the commissioning intentions is due for 30th September 2015.

References

i http://www.merton.gov.uk/health-social-care/publichealth/jsna.htm

ii http://www.england.nhs.uk/wp-content/uploads/2013/07/nhs_belongs.pdf

Committee: Health and Wellbeing Board

Date: 30 September 2014

Agenda item:

Wards: All

Subject: Better Care Fund

Lead officer: Simon Williams, Director of Community and Housing

Lead member: Cllr Caroline Cooper-Marbiah

Forward Plan reference number:

Contact officer: Simon Williams, Director of Community and Housing

Recommendations:

A. That the resubmission of the Better Care Fund Plan together with the associated documentation is noted.

1	PURPOSE OF REPORT AND EXECUTIVE SUMMARY

This report sets out the reasons for the resubmission of the Better Care Fund (PCF) Plan by 19 September and provides detail of the changes to the overall BCF environment, to which the resubmission had to respond. The report confirms that the Plan was agreed by the Chair of the Health and Wellbeing Board under delegated powers on 16 September, as well as by the Chairman of Merton CCG, Dr Howard Freeman, the LBM Director of Community and Housing and by the chief executives of each of the NHS provider Trusts

2.	BACKGROUND

1.1. The Better Care Fund was a rebranding of the DH's 'Integration Fund' and plans were submitted to NHS England and the Local Government Association by all Health and Wellbeing Boards by 4 April 2014 setting out how the local area would use the Fund primarily to support integrated working.

1.2. There was no new money attached to the BCF; it was about pooling existing resources to fund new ways of working that would keep people out of hospital. It had a secondary but no less important objective of supporting and protecting social care by ensuring that the wider health and social care economy used existing funds to make up for funding gaps in social care.

1.3. Following submission, delivery of Merton's plans continued with a revised and more formal project management environment with effect from April 2014. The schemes outlined in the original BCF Plan were being developed and implemented in accordance with the stated timescales and the need to start delivering the anticipated benefits of the BCF by the beginning of 2015/16.

1.4. The schemes were originally set up to respond to both (a) the local integration environment in Merton, which had been operating fully since

February 2013 and (b) the need to meet the requirements of the 'National Conditions' set out by the Department of Health around seven-day working, data sharing initiatives, carers' breaks, etc.

1.5. Rumours circulated for a few months following the original submission regarding additional work that might be required to align plans but it was not until the end of July that there was any formal notification of the detail of further work that would be required.

1.6. When they were received, the instructions from NHS England set out the need for a complete resubmission of plans and with a specific focus on ensuring that HWBs had plans that would reduce the levels of non-elective admissions (NELs) to their local Acute hospitals by at least 3.5%, which, when considering that the CCG's QIPP plans also projected an overall growth in NELs of 2.2%, meant that Merton's target would be an overall reduction of 5.7% for 2015/16.

1.7. There was also a specific requirement for local Acute providers to sign off that they agreed with the data relating to the impact of the BCF in terms of a reduction in NEL admissions.

2 DETAILS

2.1. The resubmission, like the original plan before it, comprises two related documents: a narrative and a spreadsheet setting out the figures.

2.2. The timescale for delivering the resubmission was very challengingly set for 19 September. This effectively required a completely rewritten submission focusing on the reduction of NELs and was compounded by a landscape of changing advice and templates issued by NHS England, the need for full provider engagement and the fact that this occurred over the Summer holiday period meaning that essential people were often on leave.

2.3. Nevertheless, the revised plan has been completed on time and has met the principal requirements of identifying a 3.5% reduction in NEL growth and of achieving agreement from the local Acute providers of the plans.

2.4. The next steps following the signing of the Plan are that there will be a period of assessment, during which NHS England local area teams will make appointments to discuss the plans with HWB areas. We don't have precise details on how these appointments will be conducted (whether by phone or in person) or the subject matter that they wish to discuss. It has been stated, however, that they will expect to be able to discuss plans with members of the Health and Wellbeing Board.

2.5. Following the assessment and assurance process, plans will be presented to the heads of NHS England and the Local Government Association for final review before being submitted to Ministers in the middle of October.

2.6. Plans will then be put into one of the following categories:

- Approved.
- Approved with support.
- Approved with conditions.
- Not approved.

2.7. The National BCF Programme Manager, Andrew Ridley, has stated that he anticipates the vast majority of plans will fall into one of the two middle categories, following submission of the first six 'pathfinder' plans, all of which were approved 'with support'. We should therefore assume that our plans will not be passed as 'approved' first time.

2.8. The headline matters to note in the submission are as follows:

- The formal project to deliver the original BCF schemes began in April 2014 so there was already four months' worth of intensive work completed by the time the notice to resubmit plans was received. Consequently, there was little opportunity to change the structural delivery of the schemes as originally set out in the April submission.

- Changes to schemes were made to reflect the nature of 'proactive' and 'reactive' schemes and so various components were reorganised to match these titles, although principally the same work is taking place to deliver them.

- The 'proactive' schemes focus principally on the 'risk stratification' and multi-disciplinary teams (MDT) model of identifying patients and service users at risk of deteriorating health and managing their care more proactively to prevent avoidable admissions to care homes or Acute hospitals.

- The 'reactive' schemes focus on having seven-day services available to respond to 'crisis' situations and to put in place care on a short-term basis that maintains independence and prevents further deterioration.

- There is a significant focus within the BCF on supporting social care as a component of the delivery mechanism. This is due to the need to provide funding to meet gaps in other budget streams. The plan delivers this.

- The 3.5% is achievable in Merton and the figures indicate that the 2.2% growth is also able to be accommodated. However, Epsom & St Helier has indicated in its approval of the plans that NEL growth is already being recorded at 5% in year.

- The only area of concern that has been submitted to NHSE during the 'temperature check' process (evaluating progress on resubmission) is around data sharing, which is being explored on a SW London basis and is unlikely to deliver a fully integrated environment by 2016/17. All HWB areas are submitting the same response.

3 ALTERNATIVE OPTIONS

3.1. The Plan was submitted on 17 September, having been signed off under delegated powers by the Chair of the Health and Wellbeing Board on 16 September. There are, therefore, no alternative options.

4   **CONSULTATION UNDERTAKEN OR PROPOSED**

4.1.   Consultation with service providers was an essential component of this resubmission, as it was an imperative that providers agreed and signed off the plans. Consequently, there has been broad consultation through workshops and other meetings with Merton's service providers and the plan has been agreed and signed off by the chief executives of the provider trusts. There is already wide scale consultation throughout the project with service users, patients and the voluntary sector, both through the mechanisms of the project governance structure and through engagement via Healthwatch.

5   **TIMETABLE**

5.1.   The deadline for submission of the plans was 19 September. Next steps are outlined in the section, 'Details', above.

6   **FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS**

6.1.   The commitment of the partner commissioning authorities in financial terms is set out the report and can be summarised as follows:

	Expenditure	
	2014/15 £m	2015/16 £m
Acute	-	-
Mental Health	-	-
Community Health	3,231	3,813
Continuing Care	-	-
Primary Care	-	-
Social Care	3,183	6,452
Other	1,434	1,933
Total	**7,848**	**12,198**

7   **LEGAL AND STATUTORY IMPLICATIONS**

7.1.   No specific implications.

8   **HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS**

8.1.   None specific to this report.

9   **CRIME AND DISORDER IMPLICATIONS**

9.1.   None.

9.2.

10   **RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS**

10.1.   None specific to this report.

11   APPENDICES – THE FOLLOWING DOCUMENTS ARE TO BE PUBLISHED WITH THIS REPORT AND FORM PART OF THE REPORT

- BCF Plan Submission: 17 September 2014.
- BCF Plan Technical Template: 17 September 2014.

12   BACKGROUND PAPERS

12.1.   Better Care Fund Guidance issued by DCLG and DH July2014, followed by significant documentation, toolkits, supplementary advice, etc.

12.2.   Merton Better Care Fund Plan Submission: 4 April 2014.

12.3.   Project documentation.

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Updated July 2014

Better Care Fund planning template – Part 1

Please note, there are two parts to the Better Care Fund planning template. Both parts must be completed as part of your Better Care Fund Submission. Part 2 is in Excel and contains metrics and finance.

Both parts of the plans are to be submitted by 12 noon on 19th September 2014. Please send as attachments to bettercarefund@dh.gsi.gov.uk as well as to the relevant NHS England Area Team and Local government representative.
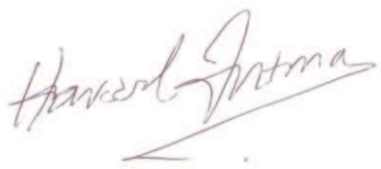
To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1 PLAN DETAILS

(a) Summary of Plan

Local Authority	**London Borough of Merton**
Clinical Commissioning Groups	**Merton Clinical Commissioning Group**
Boundary Differences	**None significant**
Date agreed at Health and Well-Being Boardton:	**16 September 2014**
Date submitted:	**17 September 2014**
Minimum required value of BCF pooled budget: 2014/15	**£3,428,000**
2015/16	**£12,198,000**
Total agreed value of pooled budget: 2014/15	**£7,848,000**
2015/16	**£12,198,000**

b) | **Authorisation and Sign-Off**

Signed on behalf of the Clinical Commissioning Group	
By	Dr Howard Freeman
Position	Chairman of Merton CCG
Date	18 September 2014

Signed on behalf of the Council	
By	Simon Williams
Position	Director of Adult Social Services
Date	18 September 2014

Signed on behalf of the Health and Wellbeing Board	
By Chair of Health and Wellbeing Board	Councillor Caroline Cooper-Marbiah
Date	18 September 2014

(c) | **Related Documentation**

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	Synopsis and links
Merton JSNA	http://www.merton.gov.uk/health-social-care/publichealth/jsna.htm
Merton JHWS	http://www.merton.gov.uk/democratic_services/w-agendas/w-fpreports/1222.pdf

2   VISION FOR HEALTH AND CARE SERVICES

(a)   **Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20**

1. Merton's Vision

The vision of Merton's Health and Wellbeing Board is to improve health and social care outcomes for the population of Merton by:

- Ensuring commissioned services are tailored to the needs of individual patients;

- Addressing the diverse health needs of Merton's population; and

- Reducing geographical, age and deprivation-related variation.

This vision is built around and evidenced by the Merton Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy (JHWS), as set out below.

> Ultimately our vision should deliver:
> *the right care, at the right time, in the right place with the right outcomes.*

2. Merton's Objectives

Merton's Health and Wellbeing Board has agreed that the Better Care Fund Vision will be delivered through four principal objectives:

1 REDUCING (GROWTH OF) EMERGENCY ADMISSIONS

2 REDUCING LENGTH OF HOSPITAL STAY

3 REDUCING PERMANENT ADMISSIONS TO CARE HOMES

4 IMPROVING SERVICE USER & CARER EXPERIENCE

3. What informs the Vision?

The JSNA informs us that the population of Merton is young in comparison with the rest of England. Over 65 year-olds make up just under 12% of the population, which is projected to increase by 21% by 2021, although the numbers of 85 year-olds and over is set to rise by nearly 41%.

In 2011, 35% of the population were from BAME groups (Black, Asian and Minority Ethnic). The extent of ethnic diversity has increased markedly over the last 5-10 years with new emerging communities (particularly Polish, Urdu and Tamil) and is expected to rise over the next 10-20 years. The level of ethnic diversity across Merton is recognised to increase the complexity of delivering services in the following ways:

- Wider and diverse range of long-term conditions and complexity of need such as rates of smoking, obesity, ischemic heart disease and diabetes.

- Diverse needs with respect to accessing care and self-management resources, such as language and cultural barriers.

- Care that addresses cultural differences to care such as for mental health conditions including dementia.

Deprivation levels are low and residents have a higher life expectancy than the England average. For adults, levels of obesity, smoking and healthy eating are estimated to be better than the England average, although the estimated level of physical activity among adults is worse. There are however stark inequalities in health and lifestyle within Merton, for example, life expectancy for men living in the least deprived areas of the borough is almost nine years higher than for men living in the most deprived areas.

The difference for women is thirteen years. Circulatory disease and cancer are the top reasons for early death and, consequently, circulatory diseases (including stroke and cancer plus diabetes) are among the main causes of long-term illness and disability.

Since 2008, there has been an increase in unemployment with 7.8% of residents claiming out-of-work related benefits. This however does remain lower than London and England as a whole. In addition, where people live and the quality of their home has a substantial impact on their health, wellbeing and social outcomes, and there is a high level of housing needs amongst households in Merton.

In terms of geographical variation, Merton is broadly divided into two localities; East and West Merton, where there are significant variations in age, deprivation, care needs and subsequently life expectancy. In East Merton life expectancy is 9 years lower for males than in West Merton and for women, 13 years. In East Merton, the population is younger, but the needs of the population who are aged 50-65 years are rising. In West Merton, the population is more affluent but is ageing, with rising burden of long term conditions and complex needs. There is therefore a need to proactively identify or screen for and preventatively manage care needs and long term conditions as well as providing services to respond to crisis and exacerbations of conditions.

Merton's Health and Wellbeing Strategy has four broad objectives: giving every child a good start in life, enabling residents to live healthily, delivering services that offer choice and independence, and addressing the wider influencers of health such as housing and the environment. The Better Care Fund is especially concerned with the third of these areas but takes account of the whole strategy.

4. The South West London Five-Year Strategy

"People in south west London can access the right health services when and where they need them. Care is delivered by a suitably trained and experienced workforce, in the most appropriate setting with a positive experience for patients. Services are patient centred and integrated with social care, focus on health promotion and encourage people to take ownership of their health. Services are high quality but also affordable."

In June 2014, the six south west London CCGs submitted their 5 year strategy for health services across south west London. This strategy, which is the culmination of joint working since January 2014, seeks to address the rising demand for healthcare in south west London, and the quality and financial gaps that exist at present in its provision. The clinical input to the strategy was developed by seven clinical design groups (CDGs), with integrated care being both a CDG in its own right and a major component of the strategy as a whole. Patient feedback was sought as part of this process and used by the CDGs in developing the initiatives in the five-year strategy.

For integrated care services in particular, the vision across South West London is to develop services that:

- Help people to self-manage their condition and helps understand how, when and who to access care from when their condition deteriorates.
- Help to keep people with one or multiple LTCs and complex needs stable.
- Allow people to get timely and high quality access to care when they are ill, delivered in the community where appropriate.

- Support people in hospital to be discharged back home as soon as they no longer require hospital care, with appropriate plans in place for care to continue at home.
- Provide people discharged from hospital with the right level of support delivered at home or in the community to prevent readmission and promote independence.
- Support and provides education to both family and carers to ensure their health and well-being needs are met, and includes support to maintain finances and staying in work, where relevant.

Help people requiring end of their life care to be supported to receive their care and to die in their preferred place.

Social Care Strategy

A commissioning strategy was published in 2010 and is due for revision later in 2014. This is based on the Use of Resources framework used nationally and pioneered in Merton and a few other councils. There are six areas where the framework seeks to add value for customers and funders:

- Prevention: ensuring that everyone can use universal services for as long as possible and not be forced prematurely into segregated social care services.
- Recovery: offering everyone the chance to regain and maintain as much independence as possible following episodes of crisis, be it physical illness, mental illness or other crises such as homelessness
- Long term support: for those needing such support, offering it at home or ordinary community settings wherever possible, and maximising choice and control over the support received
- Process; ensuring processes used add value to the customer and minimising those which don't
- Partnership: ensuring that all agencies supporting residents work in partnership and that the customer experiences this support in an integrated manner
- Contribution: enabling and expecting everyone to make a contribution to their own or others' support

These values and principles underpin the work on integration as well as new duties such as the Care Act.

(b) **What difference will this make to patient and service user outcomes?**

5. The South West London Vision

For patients and service users, our aim by 2018/19 is to provide improved access to services that meet relevant quality standards, with a greater proportion of care provided by multi-disciplinary teams closer to individuals' home. We aim to expand and improve services provided outside hospital, up-skill the workforce, increase specialisation in the community and high quality care out of hospital whenever appropriate. Patients will benefit from services that are more proactive rather than reactive, and that will co-ordinate the efforts of multiple providers in seeking to improve the health and wellbeing of people across south west London.

Across south west London, we want people to experience an uninterrupted journey through services, ensure that patients' families and carers receive education and support, and improve connections to the voluntary sector. In addition, integrated services will make better provision for mental health care to enhance overall wellbeing, independence and 'social capital'.

The drive to achieve the London Quality Standards, and other relevant standards, will result in patients experiencing improved outcomes from healthcare services in south west London. The further separation of elective and non-elective surgery is expected to support a reduction in average lengths of stay and infection rates, and to lead to an improvement in outcomes.

A key driver for the 5 year strategy is to address the health inequalities that exist across south west London. Improvements to services will result in more consistent outcomes for patients, regardless of whom they are and where they live.

6. What will locality services look like in Merton in April 2015?

From a Merton perspective, the following table sets out the vision for services from April 2015 and how they will operate from the point of view of all interested parties and illustrates how the overall model of care within Merton will change to reflect the developing needs of the population. This table sets out how the practical implementation of the schemes will be felt on the ground and has been drawn up and agreed by all stakeholders through the Merton Model Development Group, Project Team and the Merton Integration Board.

Figure 1: How Merton Localities will operate from 1 April 2015

Ref	Stakeholder/Service	What will success look like?
2.1	Patients, Service Users and Carers	More coordinated care through key workers. Smoother discharge through single access pathway. More opportunity to be treated in the community and at home.
2.2	GPs and Primary Care	Leading monthly MDT meetings in every practice and working closely with key workers.
2.3	Key worker	Key worker role and responsibilities established and localities working to this model through health liaison workers and/or other professionals.
2.4	Social Work	The 'Proactive' teams working in three localities to a single pathway coordinated with healthcare teams. Single, agreed support planning process developed and operated across localities with teams working consistently to the agreed process and operating procedures. A single assessment process delivered at least through a 'trusted assessor' arrangement. Role of social care OTs and social care hospital discharge teams reviewed.
2.5	Community Health	Planned care functions delivered in three localities working to a single pathway in coordination with social work teams. Single, agreed support planning process developed and operated across localities with teams working consistently to the agreed process and operating procedures. A single assessment process delivered at least through a 'trusted assessor' arrangement.
2.6	Advanced practice-based MDT meetings	All localities using an agreed risk stratification tool and running monthly, practice-level MDT meetings that are fully constituted and defined. All MDTs operating to an increased level of efficiency and effectiveness.
2.7	MILES, reablement and step up beds	Processes for straightforward referral to reablement in place following restructuring of Merton Independent Living and Engagement Service (MILES) teams into three localities.

Figure 1: How Merton Localities will operate from 1 April 2015 (cont'd)

Ref	Stakeholder/Service	What will success look like?
2.8	Mental Health, incl. dementia and memory clinics	Formal links to MH services in place with MH workers potentially based within localities. Integrated pathways to dementia hubs and memory clinics.
2.9	Location	Teams are still not likely to be co-located but estates plans will be in place to deliver co-location in 2015/16.
2.10	End of Life	End of life services integrated into the locality pathways.
2.11	Process	Agreed, single access and assessment processes in operation. Key worker processes agreed and operational. Some degree of integration within processes to MH services. Trusted assessor agreements in place.
2.12	Acute Trusts	Fewer inappropriate admissions, as patients being managed by integrated teams in the community. Coordinated discharge function with single pathway of access to all locality services.
2.13	Voluntary Sector	Integrated into locality pathways and overall patient and service user processes.
2.14	Equipment	Local access to equipment, including swift prescribing and delivery to prevent unnecessary delays to discharges.
2.15	Management	Collectively managed resources identified.

7. An illustration: Mrs Jones' Story

Mrs Jones is an 83 year old retired schoolteacher who lives alone and has no relatives living locally. She has had COPD for the past 10 years and has increasing problems with breathlessness and mobility. Over the weekend she develops a cough and fever and then has a fall whilst feeding her cat.

She calls the London Ambulance Service who take her to St George's Accident and Emergency department where she is has a full geriatric assessment. This reveals that she has no fractures and access to her GP records helps the team identify that she is suffering from an exacerbation of COPD causing confusion and reduced mobility. This requires treatment with antibiotics and steroids and means she will be less able to look after herself for a period of time.

It is agreed that hospital admission is not needed; however Mrs Jones does not feel confident or safe to return home alone. The Rapid Response Team arranges for her to spend a couple of nights in a 'step-up' bed under the care of the locality based multi-disciplinary team.

She is introduced to the community nurse who will act as her key worker and together they agree a care plan. This includes support from the voluntary sector to ensure her home is warm when she returns and provide domestic support until she is well enough to do this herself. A clinical management plan, aimed to reduce exacerbations and identify any deterioration early, is developed with the help of her GP.

Once Mrs Jones is feeling better in her own home, the voluntary sector continues to support her by introducing her to an exercise class for older people, which helps her maintain her fitness and her mobility and where she makes some new friends.

(c) **What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF-funded work contribute to this?**

8. The five-year view

8.1 The Merton Perspective

Merton's five-year planning process is being developed in partnership with the SW London Commissioning Collaborative. These plans have been published in draft format and are currently open for consultation. The proposals in the SWL five-year plans are broadly summarised in the following paragraph.

8.2 The South-West London Perspective

The strategy as a whole will require fundamental changes to how services are delivered across south west London. Over the next five years, there will be an increasing shift in services from the acute to community services, with the development of more proactive services. Below are the anticipated changes by clinical area, as defined in the strategy by the seven clinical design groups:

- **Children's services** - Investment in community children's services during in advance of rolling-out integrated children's services and the Paediatric Assessment Unit model. The impact on acute capacity would then be assessed with a view to a future consolidation of acute children's services.

- **Integrated care** - Focus on the implementation of BCF plans during 2014/15 and 2015/16, with work in parallel to consider contracting, workforce and IT enablers for improving integration across south west London. Implementation of seven-day working in the community from 2016/17.

- **Maternity services** - All units to achieve 98-hours of consultant obstetric presence by the end of 2014/15, with full compliance achieved by 2018/19. Midwifery-related LQS to be achieved by the end of 2015/16.

- **Mental health** - Series of initiatives to develop capacity in community services, including developing a single point of access, increased access to IAPT and greater provision of home treatment, to be implemented between 2014/15 and 2016/17, with a view to reducing acute in-patient activity from 2017/18.

- **Planned care** - Creation of an implementation plan for a multi-speciality elective centre (MSEC), with Urology services deployed in an elective centre from 2016/17, one further specialty from 2017/18 and three more from 2018/19. Planning to include consideration of appropriate quality measures and approaches to contracting.

- **Primary care** - Fully networked model of primary care, in line with NHS England plans, to be achieved by 2016/17, with implementation plans for estates improvements and workforce transformation to commence in the same year. Greater emphasis to be placed on MDT working, prevention and supporting self-management.

- **Urgent and emergency care** - Implementation of seven-day working across urgency and emergency care services in SWL by 2015/16, supported by an ambulatory emergency care model. LQS to be achieved in all emergency departments by 2016/17. Further improvements in efficiency and effectiveness, including greater connectivity with other settings, to be pursued through implementation of new IT systems.

3   CASE FOR CHANGE

Please set out a clear, analytically-driven understanding of how care can be improved by integration in your area, explaining the risk stratification exercises you have undertaken as part of this.

9.   Methodology

In setting out Merton's Case for Change, a four-step process was followed to ensure that the schemes ultimately being delivered by the integration process matched the needs of the target population. By taking this approach, the Health and Wellbeing Board can be assured that activity is focused on the target groups that will demonstrate the greatest benefits to patients, service users and the overall health and social care economy in Merton. The methodology was as follows:

9.1 Step 1: Clarifying the health and social care needs of the population.

Purpose: To ensure clarity about the opportunities to improve the health outcomes of patients and service users in Merton

Approach: Analysis of patients at risk of admission and the target population that will benefit from BCF schemes.

9.2 Step 2: Ensuring BCF Schemes will address the needs of the target population

Purpose: To review the schemes already identified within the original BCF Plan to ensure that they continued to meet the identified needs of the target population, including evaluation of MDTs, care-planning, care coordination and self-management schemes.

Approach: Check to ensure evidence-specific areas are reflected in plans and supported by established risk-stratification methodology. Amend or restructure these, as necessary.

9.3 Step 3: Aligning schemes with anticipated benefits and engagement of providers

Purpose: To identify where the greatest impact might be had on Merton's patient and service user population to demonstrate the impact that integration would have on the overall health economy.

Approach: Share analysis of the health and social care needs of the population with providers, identify any restructuring of schemes and agree the methodology to quantify the anticipated benefits of BCF with providers. This ensures that the schemes will be workable by all partners.

9.4 Step 4: Modelling the benefits

Purpose: To make sure that the agreed methodology is capable of demonstrating the desired benefits of a reduction in NELs of 3.5% (plus 2.2% forecast growth) in Merton.

Approach: Demonstrate that the modelling is robust and capable of meeting the requirement for a reduction in NEL admission and triangulated with QIPP.

---

10. Step 1: Clarifying the health and social care needs of our population

10.1 The Starting Position

In assessing how integration can improve care delivery in Merton, it was first acknowledged that Merton already had a very low rate of NEL admissions.

Figure 2: Non-elective admissions per 1,000 registered population
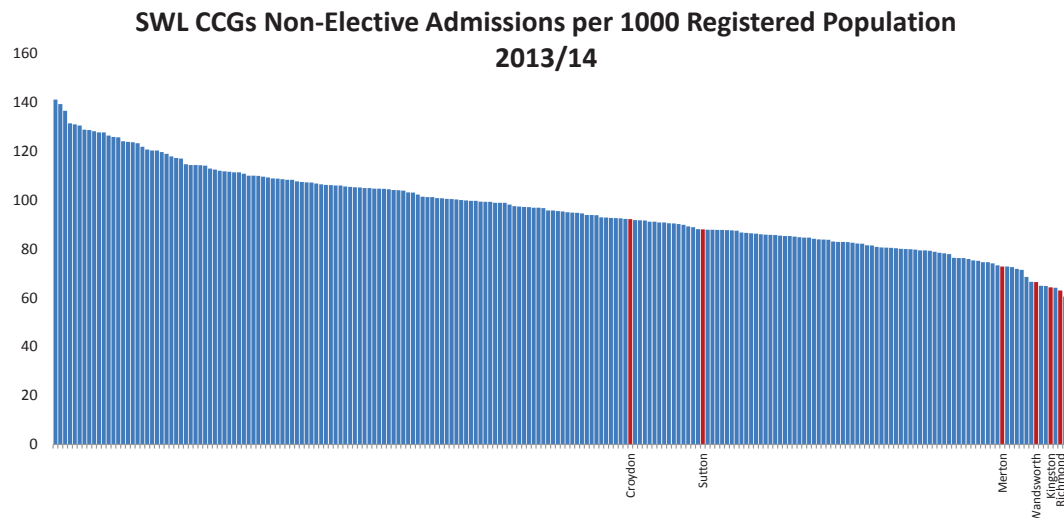
Consultation with the clinical community (both primary care and providers) supported the view that Merton CCG already managed patients well and, therefore, there was limited further opportunity to impact on non-elective admissions.

Nevertheless, as a consequence of the changed focus of the BCF Resubmission on reducing NEL admissions, a review of data around the overall patient population was undertaken in order to ensure that the existing BCF schemes are structured to address the needs of the population.

10.2. Analysis of population based on Risk stratification profiles

Using 'Sollis' Risk Stratification methodology across all 25 Merton practices in the three localities, it is evident that there are high admissions for the cohort of patients classified as 'Very High Risk' (VHR) and 'High Risk' (HR) of emergency admission in the next year.

Figure 3: Distribution of admission across risk profile groups

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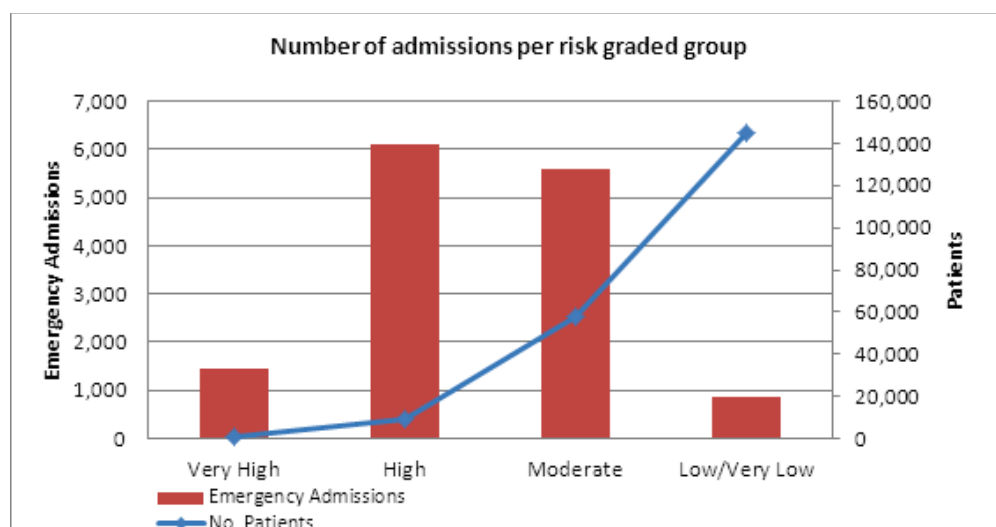
Analysis of the age groups and condition profiles was undertaken to gain an understanding of which groups of patients' admissions could potentially be prevented. This revealed that the number and combination of long term conditions had little impact on the rate of emergency admissions in the VHR and HR groups.

Figure 4: Rate of admissions compared to numbers of long term conditions.

Number of long term conditions	Number of patients	Number of emergency admissions	Rate of admissions
0	378	627	1.7
1	502	1068	2.1
2	447	764	1.7
3	556	955	1.7
4	596	1056	1.8
5+	1589	3081	1.9

10.3 Analysis of the Very High Risk (VHR) and High Risk (HR) Groups

Analysing the VHR group, the majority had multiple long-term conditions and the trend for over 60s was very noticeable:

Figure 5: Analysis of Very High Risk patients.
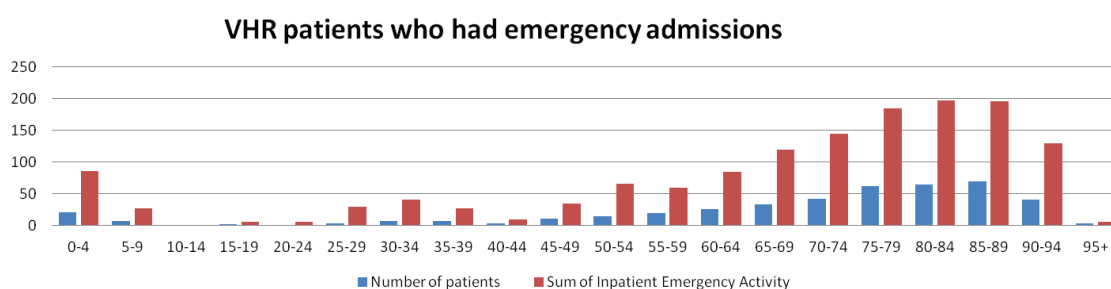
By comparison with the VHR patients, the distribution of HR patients is more evenly spread across age ranges, although the expected increase at the over 65 age is still marked. Those people in the high risk group have a more varied long-term condition profile and the age profile of those that are admitted is widely distributed.

Figure 6: Distribution of High Risk patients with at least one admission.
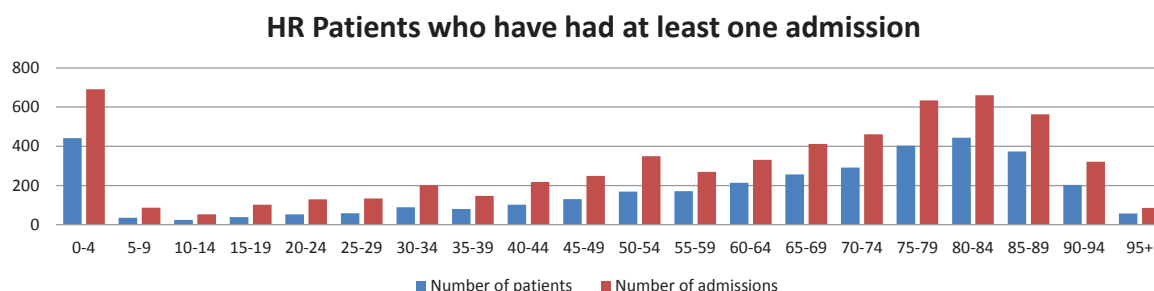
10.4 Analysis of Emergency admissions profile

The Sollis Risk Stratification tool used by Merton CCG does not currently show the reason for admission, nor the HRG under which patients were admitted. Therefore, we were not able to analyse the acuity or clinical needs of patients based on their risk profile. A full analysis of the data generated using the Sollis tool will be undertaken once the scheduled upgrade, due by the 30 September 2014, has been completed. We do not, however, anticipate this analysis to significantly impact the structure of our schemes, nor on the projected benefit derived from the schemes.

As an alternative to the Risk Stratification data, analysis of emergency admissions for Merton registered patients was conducted using Secondary Uses Services (SUS) data in order to gain an understanding of which types of emergency admissions could be impacted through BCF schemes.

This analysis was done by GPs who identified a number of HRG (Healthcare Resource Group) codes which could be impacted by BCF. This list of HRG codes was deemed to potentially be preventable admissions as, due to the type of intervention, they were considered to be susceptible to treatment outside hospital if alternative responses were available in the community. (The full list and projected impact is shown in figure 12 in section 13.3)

Figure 7: Opportunity for preventing emergency admissions across all ages and all specialities
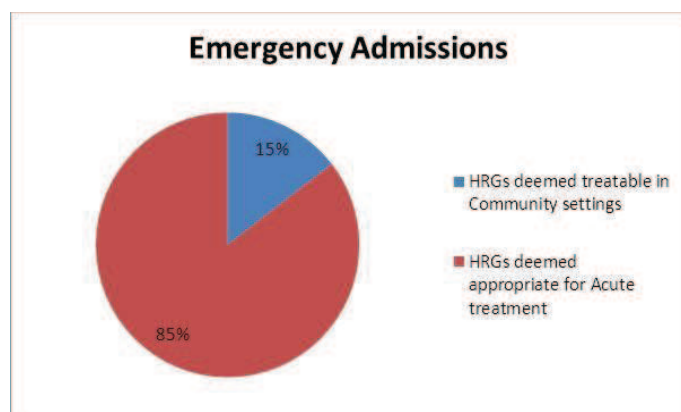
However, clinical consultation with GPs recommended that there was limited/no opportunity to impact emergency admissions for those patients that were admitted to specialities other than Emergency Medicine, Geriatric Medicine and General Medicine as, due to the nature of the speciality to which patients were admitted, they were highly likely to have required a secondary care intervention such as surgery.

Figure 8: All non-elective activity by speciality
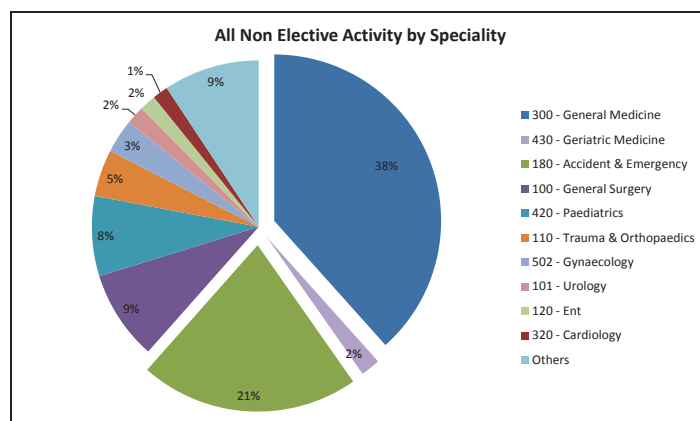
It was therefore concluded that the opportunity to impact emergency admissions was better represented by admissions for people over 65 admitted to the specialities of Accident and Emergency medicine, Geriatric Medicine and General Medicine.

This opportunity equates to 1289 potentially avoidable admissions.

Figure 9: Opportunity for preventing emergency admissions for 65+ in A&E medicine, GM and Geriatrics
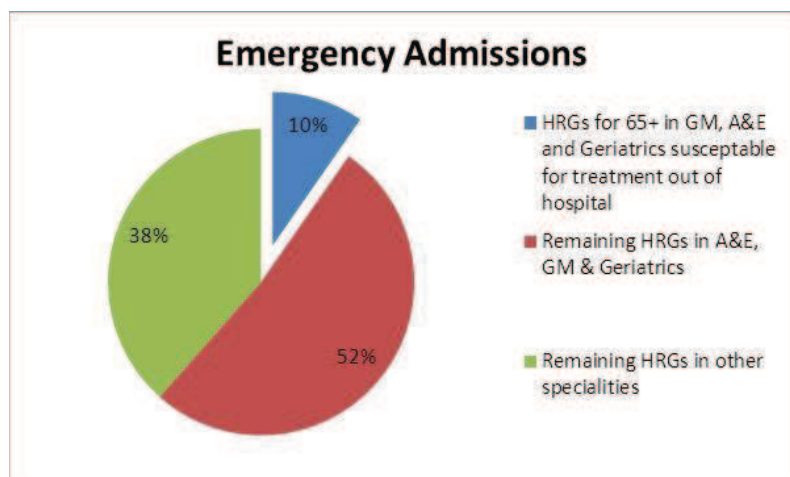
11. Step 2: Ensuring BCF Schemes will address the needs of the target population

11.1 The ACG 'Sollis' Risk Stratification Tool used by Merton

All twenty-five GP practices in Merton undertake risk-stratification profiling to identify patients at high or very high risk of:

    (a) Deterioration and subsequent escalation in the community (potential Acute spend).

    (b) Patients who are frequent attenders in Acute services (existing Acute spend).

Merton uses the ACG SOLLIS system and practices have been trained in using this to identify the high risk cohort of the population.

11.2 Components for Success of BCF

A review of the components with the greatest evidence for success was undertaken to ensure that the BCF schemes had the greatest opportunity to deliver improvements for Merton patients and service users. The following components were all identified as being evidence-specific areas and are reflected in the Schemes within the Plan:

(a) Multi-Disciplinary Teams

MDTs are already operating in all 25 Merton practices on a monthly basis with a core team of GP, practice nurse, social worker and named clinician from Community Services. There has been specific investment from the BCF to support three Health Liaison Social Workers (one in each locality) to deliver meaningful, integrated support from a social work side to the MDT meetings. All relevant services, including mental health services, are involved in MDTs and the continuing successful outcomes from MDTs demonstrate that Merton's approach is robust.   Practices have also all provided DDimer testing kits to rule out deep vein thrombosis at the GP surgery to avoid admission.

The project is also developing the role of the voluntary sector within MDTs, as it has been identified that non-clinical support for the target groups can often support people

to stay home for longer. Project **Work Package 6.2** has been set up specifically to assess and review the effectiveness of the MDTs operating across Merton and to spread best practice and support a consistent implementation.

(b) Case Management

As part of the initial steps towards integration in Merton in February 2013, it was agreed that there would be an alignment of services within LB Merton to a 'reactive' and a 'proactive' agenda, aligning and integrating social care and health care responses with urgent and planned care. Care plans are created for the patients identified as being at highest risk of NEL admission.

The delivery of this ambition is incorporated within the project as **Work Package 2.3**, specifically delivering the initiatives that will support 'Proactive' responses. The full project structure can be seen in Section 4(c) of this document and full analysis of case management within Scheme 1.2 in Annexe 1.2.

(c) Care Co-ordination

Virtual case management forms the core activity of MDTs. A key worker, with an appropriate professional background is assigned and is ultimately responsible for co-ordinating the care of the individual and providing first-line support to the person and carer in terms of communication, initially assessing ongoing need, developing expectations of care and reflecting this in their care plan.

The key worker is also responsible for communicating progress or further need back to appropriate professionals, including clinicians who need to be connected in with ongoing actions, as well as to the wider MDT team.

Ideally, this takes place through a shared record system, using the NHS number as a unique primary identifier, and through the appropriate channels in relation to the level urgency (telephone, secure email, meetings etc.).

As part of the data sharing scheme, further investigation is taking place regarding the potential wider implementation of the 'Coordinate my Care' record system for these patients.

The successful establishment of the three locality teams in Merton with effect from July 2014 (Project **Work Package 2.3.1**) ensures that the proactive management of patients and service users in the target groups can be even more effectively delivered and the opening of the Holistic Assessment and Rapid Investigation Service (HARI) from April 2015 (Project **Work Package 2.1**) will support clinicians to keep their patients healthier in the community.

(d) Self-Management

It is a desired outcome for the MDT process to support patients and service users to live independently. A number of related project work packages address this need to support people in Merton to manage their own conditions, including:

- Project **Work Package 2.3.2** (Dementia): integration of dementia care services including Memory Clinics within localities.

- Project **Work Package 2.3.3** (End of Life): coordination of End of Life within locality teams, including jointly delivered EoL services.

- Project **Work Package 2.3.4** (AgeWell Prevention): delivery of integrated outcomes of LB Merton voluntary sector preventative support programme. Incorporated into the project as a result of alignment with the LB Merton Service Delivery Plan for Adult Social Care.

- Project **Work Package 2.3.5** (Expert Patient Programme), which delivers recurrent funding for a total of eight Expert Patient Programme (EPP) courses per annum, enabling 120 patients to benefit from the course each year.

- Project **Work Package 2.3.6**   (Falls Prevention), incorporated into the project as a result of alignment with the CCG's two-year Operating Plan.

- Project **Work Package 2.3.7**   (Podiatry Services), incorporated into the project as a result of alignment with the CCG's two-year Operating Plan.

All of the above schemes support the delivery of self-management schemes within the overall development of proactive services as part of the BCF Plan schemes.

12. Step 3: Aligning schemes with anticipated benefits and engagement of providers

12.1 Regrouping Schemes

In order to ensure that the schemes match the revised objectives and align with how the impact/benefits of the schemes have been quantified, it has been necessary to regroup some of the schemes from the original BCF Plan in April. In order to meet the focus of the schemes on 'Reactive' and 'Proactive' initiatives, the original community services schemes have been regrouped into two schemes based on the reactive and proactive models.

In the Part 2 template, the initiatives that make up the schemes have been regrouped and renamed accordingly in order to match the new structure.

Figure 10: Regrouping of schemes for BCF Plan Resubmission

Original Schemes from April 2014		Revised Schemes from September 2014		How will we measure the impact/benefit?
1	Community Beds and Rehabilitation	1.1	Reactive Schemes in the Community	Number of people being treated in the community rather than in Acute settings for selected groups of conditions when they require an urgent response.
2	Prevention of Admission Initiatives			
3	Integrated Locality Teams	1.2	Proactive Schemes in the Community	Number of people being Case managed and therefore not requiring an admission.
4	Seven-Day Working			
5	Protecting and Modernising Social Care	1.3	Protecting and Modernising Social Care	The number of people receiving social care services
6	Carers' Breaks	1.4	Carers' Breaks	Number of people receiving carers breaks
7	Investing into Integration Infrastructure	1.5	Investing into Integration Infrastructure	Effectiveness of case management

As with the objective of the schemes from April, the schemes continue to support Merton's commitment to meet the National Requirements (see also Section 7), as well as the need to restructure community services in the Borough in order to ensure that they are fit for purpose.

12.2 Stakeholder engagement

A focused review of risk stratification data, Acute activity data and the evidential basis and the principles of Merton's schemes culminated in a half-day workshop on 14 August 2014, which was attended by providers and commissioners. At this workshop, it was agreed by all that benefits relating to reduction in emergency admissions should be quantified under two broad headings and in line with the joint health and social care schemes already under way in Merton.

The impact of BCF schemes have therefore been modelled based on the projected impact of:

(i)   Case Management – proactive care.

(ii)   Prevention of admission – reactive care.

(iii)   Protecting social care

13. Step 4: Modelling the Benefits

13.1 The combined purpose of the schemes

The Merton BCF schemes are designed to better manage people by:

(i)   All services proactively planning responses to peoples anticipated health and social care needs.

(ii)   Identifying people who are predicted to experience urgent deterioration in their health and provide access to urgent community response that prevent them being admitted to hospital to receive that care.

(iii)   Protecting social care in order to prevent deterioration in people's health and independence causing a reliance on health care.

13.2 Benefits expected from Case Management - Proactive model

Risk Stratification data was reviewed to support the development of the 'reactive' model. This data provides an indication of the number of patients that should be proactively managed and forecasts an impact on emergency admissions for these patients.

A benefits/impact model was developed to forecast the impact on emergency admissions activity ascribable to case management by locality based MDT teams which operate in all of Merton's 25 GP practices. The impact on emergency admissions was forecast and validated with the support of Merton CCG's Clinical Director for Integration, Adults and Vulnerable People.

The methodology builds on 2014/15 QIPP plans. The 2015/16 QIPP/BCF forecasts that 10% of those identified through Risk Stratification as being at Very High Risk or High Risk of admission in the next year will have 1 admission prevented. This reduction was estimated based on:

1.   Current benchmarked non-elective admissions performance for Merton.

2.   Clinical review of evidence base regarding impact of Case Management, Risk Stratification, Care Co-ordination and Self-management.

3.   Audit investigating the potential impact of case management on patients who had 3+ admissions in past 12 months.

The estimate was generated based on the schemes that are planned, the timing of implementation of the schemes and impact of previous QIPP schemes aimed at reducing emergency admissions.

Figure 12: Admissions avoidable through one reduction

Age Group	Number of patients	Number of admissions	Prevent one admission for 10% of those at Very High Risk or High Risk
18 - 74	1789	3543	178.9
75+	1721	2976	172.1
Total admissions prevented (reduce 1 admission for 10% of those at Very High and High Risk)			**351**

Whilst the BCF Case Management (proactive care schemes) are driven by the integration agenda, the One Merton Group is capitalising on primary care incentives that encourage member practices to use risk stratification to identify those patients at the highest risk of admission, as well as patients over 75. The locality MDT model has been developed and resourced to support GPs in proactively managing patients at highest risk of emergency admission.

13.3 Benefits expected from Prevention of Admission – Reactive Care

The following data was reviewed to support the development of the 'reactive' model:

- An initial analysis of 2013/14 emergency admissions to hospital at speciality level and HRG level.

- Identification of types of admissions that could reasonably be treated by planned 2014/15 QIPP schemes, notably by the implementation of the Community Prevention of Admission Team (CPAT) and the Holistic Assessment and Rapid Investigation (HARI) service, the implementation of which has been clinically lead by a Darzi Fellow and GPs.

The benefits model for reactive care is therefore based on the current QIPP (2014/15) modelling which provides a granular detail regarding the number and type of emergency admissions at HRG level that BCF reactive schemes aim to prevent. This is a currency that providers know, use and can monitor.

The impact of reactive response was quantified by Merton GPs advising what proportion of admissions to hospital for the identified list of HRGs could be prevented. This estimate forecasts the impact of planned community responses implemented through BCF schemes.

The reactive modelling and forecast impact is set out below:

Figure 13: Reactive modelling and forecast impact.

HRGs amenable to treatment outside Acute settings	Sum of Total Spell Count	Average of % reduction due to BCF Schemes (CPAT & HARI)	Sum of Reduction in spell count
AA25Z - Cerebral Degenerations or Miscellaneous Disorders of Nervous System	57	70%	40
AA27Z - Medical Care of Patients with Alzheimer's Disease	5	70%	4
AA31Z - Headache or Migraine	142	50%	71
BZ24C - Non-Surgical Ophthalmology with length of stay 1 day or less	4	50%	2
DZ11C - Lobar, Atypical or Viral Pneumonia without CC	26	50%	13

HRGs amenable to treatment outside Acute settings	Sum of Total Spell Count	Average of % reduction due to BCF Schemes (CPAT & HARI)	Sum of Reduction in spell count
DZ12B - Bronchiectasis without CC	1	50%	1
DZ15F - Asthma without CC without Intubation	27	60%	16
DZ19C - Other Respiratory Diagnoses without CC	34	50%	17
DZ21A - Chronic Obstructive Pulmonary Disease or Bronchitis with length of stay 1 day or less discharged hom	69	50%	35
DZ21A - Chronic Obstructive Pulmonary Disease or Bronchitis with length of stay 1 day or less discharged home	8	50%	4
DZ21K - Chronic Obstructive Pulmonary Disease or Bronchitis without NIV without Intubation without CC	16	50%	8
DZ22C - Unspecified Acute Lower Respiratory Infection without CC	11	50%	6
DZ28Z - Pleurisy	26	50%	13
EB03I - Heart Failure or Shock without CC	100	40%	40
EB07I - Arrhythmia or Conduction Disorders without CC	106	40%	42
FZ37F - Inflammatory Bowel Disease with length of stay 1 day or less	2		0
FZ37J - Inflammatory Bowel Disease with length of stay 2 days or more without Major CC without Interventions	28	30%	8
FZ43B - Non-Malignant Stomach or Duodenum Disorders with length of stay 2 days or more without Major CC	23	30%	7
FZ43C - Non-Malignant Stomach or Duodenum Disorders with length of stay 1 day or less	9	30%	3
FZ44B - Malignant Stomach or Duodenum Disorders with length of stay 2 days or more without Major CC	20	30%	6
FZ45B - Non-Malignant Large Intestinal Disorders with length of stay 2 days or more without Major CC	15	30%	5
FZ45C - Non-Malignant Large Intestinal Disorders with length of stay 1 day or less	30	30%	9
FZ47B - Non-Malignant General Abdominal Disorders with length of stay 2 days or more without Major CC	72	30%	22
FZ47C - Non-Malignant General Abdominal Disorders with length of stay 1 day or less	22	30%	7
FZ49C - Disorders of Nutrition with length of stay 1 day or less	110	70%	77

HRGs amenable to treatment outside Acute settings	Sum of Total Spell Count	Average of % reduction due to BCF Schemes (CPAT & HARI)	Sum of Reduction in spell count
HA81C - Sprains, Strains, or Minor Open Wounds without CC	8	70%	6
JC27Z - Nursing Procedures & Dressings 1	49	70%	34
KB02F - Diabetes with Hyperglycaemic Disorders 69 years and under without CC	5	30%	2
KB03B - Diabetes with Lower Limb Complications without Major CC	7	30%	2
KC05C - Fluid and Electrolyte Disorders 70 years and over without CC	1	40%	0
LA04F - Kidney or Urinary Tract Infections with length of stay 2 days or more without CC	45	60%	27
LA04G - Kidney or Urinary Tract Infections with length of stay less 1 day or less	21	70%	15
LA09H - General Renal Disorders with length of stay 1 day or less	92	60%	55
LB16C - Lower Urinary Tract Findings without CC	2	60%	1
LB18Z - Attention to Suprapubic Bladder Catheter	8	70%	6
LB19B - Ureteric / Bladder Disorders 19 years and over without CC	1	70%	1
LB37B - Miscellaneous Urinary Tract Findings without CC	4	70%	3
LB38B - Unspecified Haematuria without Major CC	5	30%	2
PA14C - Lower Respiratory Tract Disorders without Acute Bronchiolitis with length of stay 1 day or more with	2	50%	1
PA14D - Lower Respiratory Tract Disorders without Acute Bronchiolitis with length of stay 1 day or more with	5	50%	3
PA14E - Lower Respiratory Tract Disorders without Acute Bronchiolitis with length of stay 0 days	8	50%	4
PA18B - Minor Infections without CC		70%	0
PA20B - Fever unspecified without CC	22	30%	7
PA21B - Infectious and Non-Infectious Gastroenteritis without CC	26	30%	8
PA26B - Other Gastrointestinal or Metabolic Disorders without CC	11	40%	4
PA65C - Upper Respiratory Tract Disorders with length of stay 1 day or more without CC	4	70%	3
Grand Total	**1289**	**49%**	**635**

The benefits expected due to 'Prevention of Admission – Reactive Care' equates to 635 reduced admissions in 2015/16. This reduction equates to 5% of overall Emergency activity based on 2012/13 activity data.

Figure 14: QIPP/BCF Reactive schemes as a proportion of overall emergency activity.
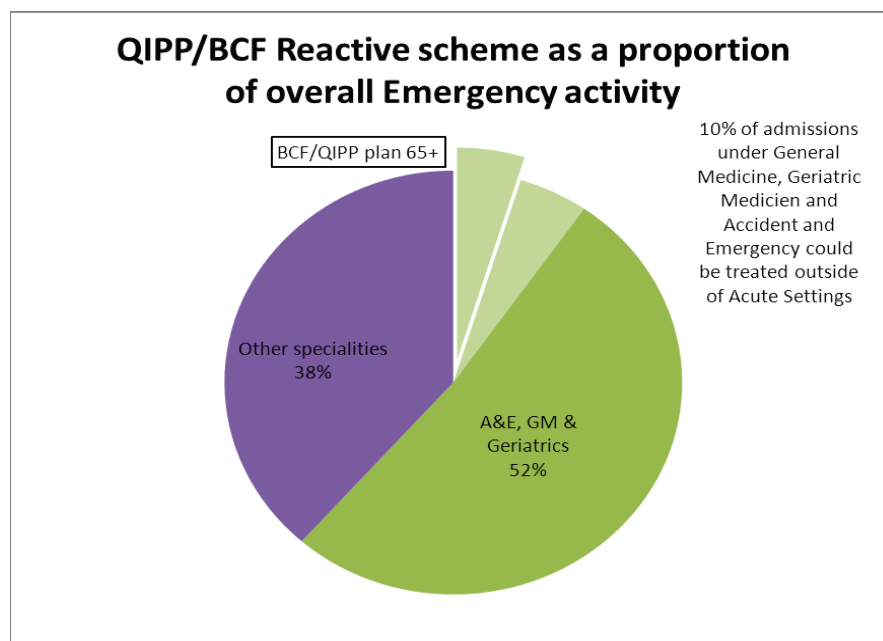
13.4   Benefits expected from reducing Excess Bed Days

Whilst Merton does not forecast to gain any further benefit by maintaining the current low rate of Delayed Discharges of Care, we do forecast to benefit from curbing the growth in excess bed days due to implementation of the In-Reach service in 2014. This benefit is quantified in the 2014/15 QIPP plans, which forecast stemming previous growth (1.95%) in excess bed days across the Acute hospitals for those over 65 admitted under the specialities of Geriatric medicine, General medicine and Accident

The 2015/16 QIPP/BCF forecasts maintaining this curtailed growth (1.95%) in excess bed days across the Acute hospitals for the same specialities and age group. This equates to 112 Excess Bed days prevented in 2015/16.

13.5   Benefits expected due to Protecting Social Care

Protecting and modernising social care is essential to ensure that people are appropriately supported and cared for in their community. Without the necessary support, people are more likely to require intervention from health services, be inappropriately admitted to institutional settings or be admitted to hospital. The Merton Protecting social care scheme enables Case Management and Prevention of admission schemes to derive benefits. Without protection of social care, emergency admissions are forecast to increase well above the current predicted growth rate of 2.2%. Without modernising social care permanent admissions to care homes would increase in line with the population for older people. The Protecting and modernising social care scheme will:

- Contribute to the planned reduction in emergency admissions to hospital
- Maintain current excellent performance in supporting discharge from hospital in a timely manner

The impact of protecting social care on emergency admissions has been considered and accounted for within the Pro-active and Reactive schemes. Additional quantified benefits in our plan relate to reducing the rate of permanent admissions to care homes for 2014/15 and 2015/16. The performance trend for the past 5 years shows that Merton achieved, on average, 100 permanent placements per year. Although during 2013/14 there was an unusual increase. Our plan is therefore based on the 2012/13 out-turn as it sets a more reliable, although ambitious, baseline for 2014/15 and 2015/16. Merton forecasts that due to BCF, the actual number of admissions will stay relatively constant at about 100 per year. When population growth is factored in, reducing the rate from 420.8 in 12/13, to 403 for 14/15 and 395 for 15/16 translates to a benefit of 5 prevented admissions during 14/15 and 6 admissions during 15/16.

13.6 Triangulation

The impact of BCF schemes and the CCG QIPP schemes have been triangulated to ensure the anticipated impact/savings are only accounted for once.

In 2014/15 these benefits related to the individual schemes have been accounted for through the CCG QIPP project structure.

It is anticipated that in 2015/16, the combined BCF schemes will be monitored under BCF project structure, however savings ascribed due to the impact on emergency admissions and excess bed days will continue to be accounted for through CCG QIPP plans.

In order to ensure the BCF and QIPP methodology aligns, QIPP and BCF project leads have moderated the forecast impact on activity on emergency admissions to ensure that double counting of anticipated benefits does not occur. The benefits model has then shared with our Acute providers and we have maintained a continuous dialogue with stakeholders to ensure validity of the model and to ensure providers are in agreement with assumptions regarding the predicted impact of schemes.

13.7 Merton BCF Model Summary

Figure 15, below, sets out the summary of the BCF modelling for Merton. Using the assumption that the 2014/15 QIPP Schemes will curtail growth of emergency admissions to 2.2% or below, Merton BCF/QIPP schemes are anticipated to deliver a 3.5% reduction in Emergency admissions in 2015/16 and therefore meet the requirements of the 3.5% reduction in non-elective admissions required to meet Merton's commitment to the Better Care Fund.

Figure 15: BCF Benefits Summary

Merton BCF Benefits Summary	Criteria	2014/15 Activity	2015/16 Activity	2014/15 Spell Cost	2015/16 Spell cost	2014/15 Benefits	2015/16 Benefits
Case Management (Proactive care)	Reduce 1 admission for 10% of VHR and HR patients	200	351	£2,209	£1,490	£441,800	£522,990
Prevention of Admission (Reactive care)	SGH, ESH, KH, CH	171	635	£938	£1,490	£160,398	£946,150
In-Reach (QIPP)	Excess Bed Days	112	112	£179	£179	£20,048	£20,048
Protecting Social Care	Reduction in permanent residential admissions	5	6	£32,240	£32,240	£161,200	£193,440
Protecting Social Care	Increased effectiveness of reablement	132	72	£2,138	£2,138	£282,175	£153,914
Protecting Social Care	Reduction in delayed transfers of care	0	0	£179	£179	£0	£0
Total Benefits		N/A	N/A	N/A	N/A	**£1,065,621**	**£1,836,542**
Total Reduction in Emergency admissions due to BCF	Aligned with 2014/15 QIPP	**371**	**986**	N/A	N/A		

13.8   Delivering the Change

In order to deliver the change, Primary Care Improvement is linked with the Merton Model component of the Better Care Fund to ensure that the most appropriate risk profiling methodology is implemented across Merton's 25 practice-based MDTs.

Best practice will be shared at locality meetings and a consistent model of risk stratification implemented across all Merton practices by 1 April 2015 to ensure that the benefits targets for the Better Care Fund are achieved.

13.9   Mitigating Risks within the Merton BCF Benefits Model

Although it is acknowledged that the approach of benefits modelling based on benefits derived from pro-active and reactive care risks double-counting prevented emergency admissions, this risk has been mitigated by:

- Quantifying the impact of proactive care based on the number of people, rather than the number of admissions, these people currently experience. It is anticipated that the types of admissions and the HRG classification of those being prevented are not the same as those that are being prevented due to reactive intervention.

- The impact of reactive care is quantified based on the 65+ cohort only and only admissions under the specialities of Geriatrics and General medicine.

4 PLAN OF ACTION

(a) Please map out the key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies

14. Project delivery milestones

The project is following a fully-realised plan under Prince2 methodology. The following diagram illustrates the principal milestones in the delivery of the Plan.

Figure 16: Key Milestones of the Project Plan

Date	Interfaces		BCF Delivery	Interfaces			Date
	HR & Training	System Resilience		Engagement	Data & Information Governance	Primary Care	
April 2014			Project established	Stakeholder Engagement			April 2014
July 2014	Finalise roles and responsibility of Key Workers		Primary Care, Social Services and Community Services all operating three locality model; CPAT Model Agreed; In-Reach Model Agreed; Holistic Assessment & Rapid Investigation Service Spec Agreed; Model for Intermediate Care (Step Up/Step Down) Beds Agreed	Primary Care Engagement; Patient & Service User Engagement	Tech Fund 2	Risk Stratification Alignment Begins	July 2014
October 2014		Ensure NHS 111 Provider and NHS Pathways understand operational changes.	HARI Operating limited service from Wilson Walk-In Centre	Stakeholder Engagement			October 2014
January 2014		Additional System Resilience Investment in Community Health Services (including CPAT) to meet Winter Pressures.	Restructuring of MILES (LB Merton Reablement Services)		Tech Fund 2		January 2014
April 2015	All staffing complete for new ways of working		Localities Operating Full Services under single management.; HARI Operating full service from Nelson Hospital		Data Strategy Agreed across SW London	Unified Risk Stratification in Operation	April 2015
2015/16			Dementia Services integrated into Locality Teams; Extension of End-of-Life Services into Locality Teams		Data Strategy Implemented across SW London		2015/16

(b) Please articulate the overarching governance arrangements for integrated care locally

15. Local governance arrangements

15.1 Working together in Merton

Merton has a history of integrated working between local health and social care, which has rapidly accelerated since February 2013 with the formation of the Merton Integrated Care Project Board, and the subsequent enactment of the *Health and Social Care Act 2012* in April 2013. Governance structures have therefore been developed and implemented that enable close working between health and social care locally. Some of these predate the announcement of the BCF.

15.2 Merton Health and Wellbeing Board

In common with other areas, the **Merton Health and Wellbeing Board** (HWB) has a statutory responsibility for ensuring that commissioning intentions of both Merton Council and Merton Clinical Commissioning Group are aligned, coherent, and meet the priorities set out in the **Joint Health and Wellbeing Strategy**. The Merton HWB has a statutory (mandatory minimum) membership, defined in the *Health and Social Care Act 2012*, that includes senior leaders from across health and social care services and meets on a bi-monthly basis.

Figure 17 sets out the over-arching governance arrangements for integration in Merton.

Figure 17: Overarching governance structure for Integrated care locally
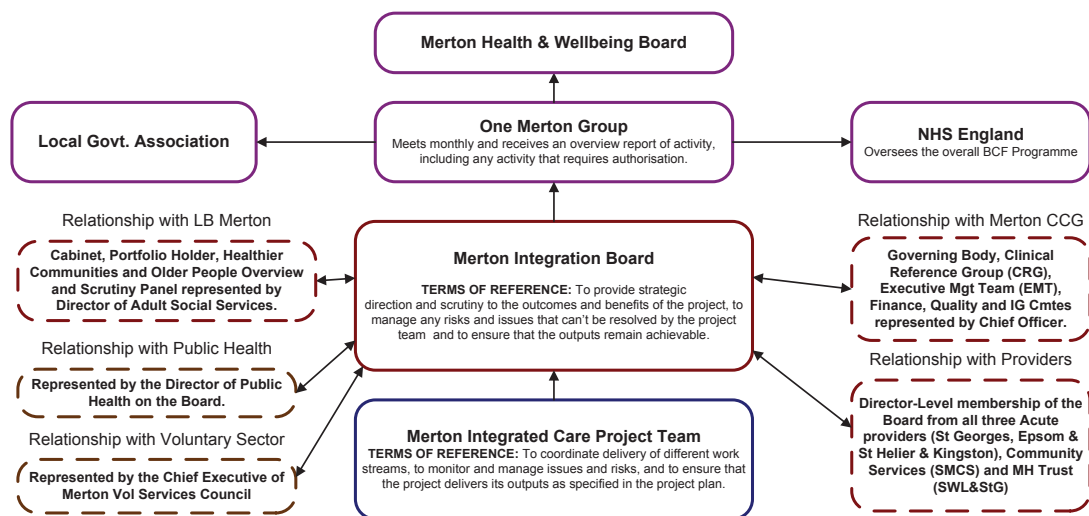
15.3 The One Merton Group (OMG)

The **One Merton Group (OMG)** is an executive level joint group that reports to the Merton HWB. The OMG has a remit to provide strategic direction to integrated services locally. It brings together senior representatives from:

- Merton Council (Director of Community and Housing and Director of Children's and Families),
- Merton Clinical Commissioning Group (Chief Officer and Director of Commissioning and Planning), and
- Public Health (Director of Public Health).

The OMG meets monthly.

15.4 Merton Integration Board (MIB)

The **Merton Integration Board** has a remit to facilitate the practical aspects of integrated working locally and reports to the OMG. It brings together stakeholders to co-design local integrated services; this includes providing direction to, and coordinating the output of the Project Team and the six workstream subgroups:

- Finance and Performance
- The Merton Model
- IT and Data
- Workforce Strategy
- Engagement
- Integrated Quality Commissioning

The Merton Integrated Care Project Board membership includes representatives from Merton Council, Merton CCG, the community services provider (Sutton and Merton Community Services), local acute and mental health providers and a voluntary sector representative. The Merton Integration Board meets on a monthly basis and the full membership of this is set out in Figure 17 below in order to demonstrate that the Board represents the stakeholders at an appropriate level.

Figure 18: Representation on the Merton Integration Board

Organisation	Representative
Epsom & St Helier Hospital	Head of Clinical Programmes
Voluntary Sector	Chief Executive, Merton Voluntary Service Council
Kingston Hospital	Director of Organisational Development
LB Merton	Director of Community and Housing
Merton CCG	Chief Officer Director of Commissioning and Planning
Public Health Merton	Director of Public Health
Royal Marsden (SMCS)	Divisional Director, SMCS Assistant Chief Nurse
St George's Hospital	Divisional Chair for Community Services Director of Strategy
St George's MH Trust	Service Director

(c) Please provide details of the management and oversight of the delivery of the Better care Fund plan, including management of any remedial actions should plans go off track.

16 Project delivery structure

The delivery of the Better Care Fund Plan is managed through the 'Merton Integrated Care Project Team', which meets every fortnight, alternating with a meeting of the 'Merton Model Development Group', which is the largest and most complex of the work streams.

The Project Team manages the continuing delivery of outputs as well as risks and issues and is chaired by the Project Manager. Any risks and issues that cannot be resolved by the project team are escalated to the Merton Integration Board.

Figure 19: Project and Work Package Structure
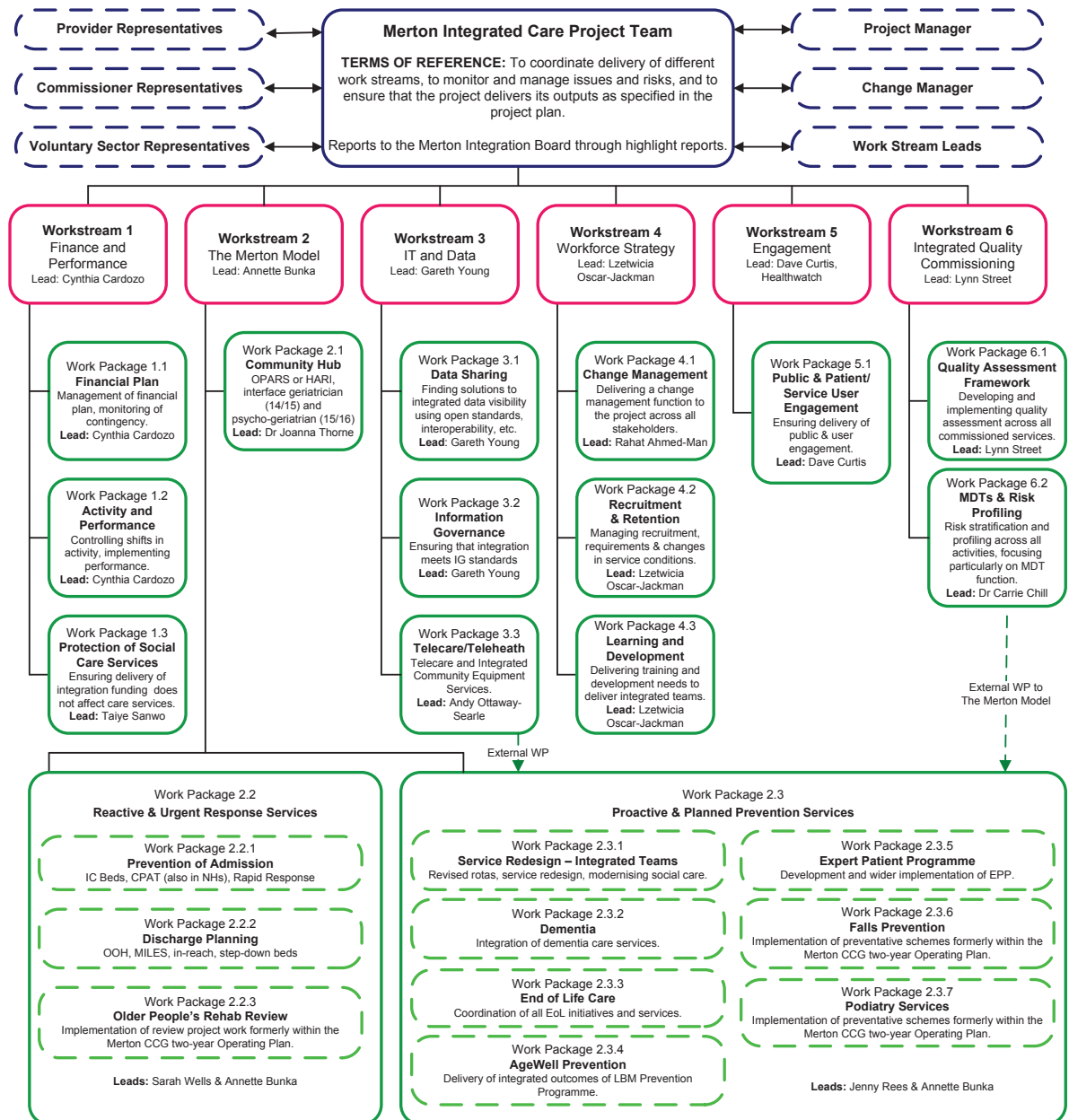
(d) **List of planned BCF schemes**

Please list below the individual projects or changes which you are planning as part of the Better Care Fund. Please complete the *Detailed Scheme Description* template (Annexe 1) for each of these schemes.

16   List of BCF Schemes (September 2014)

It should be noted that delivery of the components of these schemes commenced in April 2014, as part of the original BCF Project Delivery. Due to the need to refocus the BCF as part of the resubmission, these schemes have been regrouped to meet the structure set out in Part 2 of the Plan and consequently comprise components that are not planned are already wholly or partly delivered.

Figure 20: List of BCF Schemes (September 2014)

Revised Schemes from September 2014		Brief Description of Scheme	Annexe Ref	Page
1	Proactive schemes to support reduction in non-elective admissions through community services.	The scheme comprises a number of components that aim to reduce the number of admissions to hospital that could reasonably be treated by alternative community services/responses. The components are focused on a seven day a week and 24/7 model of delivery where appropriate, embedding out-of-hours capacity and appropriately skilled 'night' staff to ensure a reactive approach to care in the community Escalating care needs or crises are identified and responded to swiftly by dedicated multi-professional teams with increased capacity for rehabilitation and reablement.	1.1	52
2	Reactive schemes to support reduction in non-elective admissions through community services.	This scheme comprises a number of components using risk stratification to provide primary and community providers with an indication of the number of patients that can be proactively managed and therefore forecasts an impact on admissions for these patients. A risk stratification model was developed to examine the impact on emergency admissions activity forecast and validated with the support of Merton CCG's Clinical Director for Integration, Adults and Vulnerable People. This is quantified on the basis of number of people being managed with a key worker through integrated MDTs, which operate in all of Merton's 25 GP practices.	1.2	56

Figure 20: List of BCF Schemes (September 2014)(cont'd)

Revised Schemes from September 2014		Brief Description of Scheme	Annexe Ref	Page
3	Protecting and Modernising Social Care	Protecting social care is essential to ensure that people are appropriately supported and cared for in their community. Without the necessary support, people are more likely to require intervention from health services and the more likely they are to be admitted to hospital. The Merton Protecting social care scheme enables Case Management and Prevention of admission schemes to derive benefits. Without protection of social care, emergency admissions are forecast to increase well above the predicted growth rate of 2.2%.	1.3	59
4	Carers' Breaks	This scheme will increase the capacity of the Night Nursing Service, providing additional skilled support which is available to carers between the hours of 7pm and 7am in order to prevent unnecessary emergency admissions. This will primarily be through remote advice provided from a hub, extended to mobile / visit support in appropriate cases. The scheme is integrated with Merton Social Services.	1.4	61
5	Investing into Integration Infrastructure (Enabler)	To create an environment where data and records can be shared between appropriate professionals to prevent patients and service users having to repeat their stories multiple times and to provide a more efficient and effective process for data exchange. This scheme provides funding towards a multi-agency project to develop information sharing across health and social care across south west London, commissioned from South London Commissioning Support Unit. Organisations must put processes and systems in place to ensure that NHS number 'completeness' is maintained at or above 97.5% as the primary identifier in communications. It includes funding to facilitate the use of the Coordinate My Care system as a platform to hold common care plans developed by the integrated locality teams, ahead of larger-scale information sharing progress.	1.5	63

5   RISKS AND CONTINGENCY

(a)   Risk log

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers and any financial risks for both the NHS and local government.

17   Extract of Risk Register

NOTE:	to make the template more useable, column headings 2, 3 and 4 have been replaced by abbreviations. The full headings are as follows:
Lkhd	**How likely is the risk to materialise?** *Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely*
Impt	**Potential impact** *Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact (And if there is some financial impact please specify in £000s, also specify who the impact of the risk falls on)*
Ovrl	**Overall risk factor** *(likelihood multiplied by potential impact)*

There is a risk that:	Lkhd	Impt	Ovrl	Mitigating Actions
NELs cannot be reduced by at least 3.5% because the plan is not realistic.	2	4	8	As set out in Section 3, a full and robust analysis based on the best available evidence has been drawn up in order to reach a conclusion that the 3.5% target is achievable. If the local health and social care economy is unable to meet the target, the P4P money will continue to support Merton residents with healthcare services, as per the guidance.
NEL reductions do not have a material impact on the overall care economy for reasons such as low-value HRGs being targeted.	1	4	4	During the analysis of available evidence to prepare the Case for Change, appropriate HRGs were selected and the impact of reduction of these is set out in Figure 1 of Section 3 demonstrating £622,234 in 2014/15 and £1,039,571 in 2015/16.
Incorrect base data is used to assess the level of NEL reduction resulting in errors and incorrect assumptions.	1	4	4	The base data has been checked and verified so errors and incorrect assumptions are unlikely.
The NEL reduction target is not considered ambitious enough by NHS England or the reason for the level of ambition is not considered satisfactory.	2	3	6	Merton has set out a case to meet the NHS England challenge of a 3.5% reduction in NELs alongside a projected 2.2% growth in demand. Merton is already a high-performing locality in respect of NELs and the target is both realistic and achievable.

There is a risk that:	Lkhd	Impt	Ovrl	Mitigating Actions
Schemes are not financially evidence-based or modelled for full benefits realisation.	2	4	8	A full and robust analysis based on the best available financial evidence has been drawn up in order to reach a conclusion that the benefits are achievable. Owner: Board.
Schemes are not implemented due to lack of project management.	1	4	4	A full project management environment has been in place throughout the project in order to ensure that the schemes will be delivered according to the plan. Owner: Board.
The National Conditions will not be met from the project's outputs.	1	4	4	The project is set up to address the requirements of the National Conditions. Owner: Board.
The BCF fails to deliver forecast shifts to activity in 2015/16.	1	4	4	Robust project management including a separate work stream focused solely on Finance and Performance. CCG has worked extensively with acute providers to ensure that there are robustly modelled plans. Providers have assured CCG QIPP plans. Owner: Board
Shifting of resources towards community providers destabilises one (or more) acute providers due to the cumulative impact of multiple BCF plans across the area.	5	2	10	Impact will be monitored through SWL Collaborative Commissioning and overall 5 year strategic plan. Owner: HWB.
Introduction of Care Bill results in a significant increase in the cost of provision of care from 2016 onwards and impacts on current planning	3	2	6	Local system will keep impact and costs under review. DH has promised that under New Burdens deal that all new duties will be fully funded so primary mitigation is to hold government to this promise. Secondary mitigation to tailor services to resources. Owner: HWB.
Complexity of measuring success of individual initiatives leading to an impact on the pay by performance element of the BCF	3	1	3	Each scheme is being measured to an aggregate level to ensure appropriate savings can be attributed to each scheme. Owner: Board.
Failure to deliver data sharing project between health and social care undermines integrated service delivery	4	3	12	Separate work stream solely focused on this work stream with commitment from all partner organisations for this to happen. Nevertheless, the complexity of the local system and the fact that Merton is not a principal commissioner of any Acute services means there remains a risk that this will not be delivered meaningfully in a reasonable timescale. The SWLCC is currently commissioning work on this. Owner: Board.

There is a risk that:	Lkhd	Impt	Ovrl	Mitigating Actions
Tension arises between partners on the definition of 'protection for social services with a health impact'	1	4	4	Local definition of protection of social services. Regular meetings of senior teams in CCG and council, led and attended by CCG Chief Officer and council Director of Community and Housing. All schemes in plan fully debated and understood. Transparency over financial plans on both sides including savings. Shared performance metrics so impact of schemes and performance of whole system can be monitored. Owner: Board.
Existing programmes, such as QIPP and social care efficiency programmes, lead to 'double-counting' of savings	1	4	4	All schemes have been reviewed to ensure that the data sets used triangulate with each scheme to ensure that there is no double counting. The finance and performance group will also monitor these schemes on a monthly basis. Additional scrutiny will take place by an external agency on QIPP/BCF assurance. Owner: Board.
Increasing demand on services (through demographic factors such as an ageing population as well as increased service expectation) means that targets cannot be met	2	4	8	All schemes have been reviewed to ensure that the data sets that are being used to triangulate with each scheme to ensure that there is no double counting. The finance and performance group also monitors these schemes on a monthly basis where all providers are present. Owner: Board.
Health and social care working practice may not change as rapidly as required by QIPP/BCF plans	2	3	6	There is a separate workforce and culture work stream as part of this project and will address this issue - including training and development. Owner: Board.
PPI Engagement will not be meaningful if the project is not clear what it wants to engage on.	1	3	3	Healthwatch Merton and MCVS are fully involved with the project at Board and project team level and will supporting the project to deliver meaningful and relevant PPI. The project team is clear about what will benefit most from meaningful engagement. Owner: Board.
The project can't develop a meaningful, integrated Quality Assessment Framework for services being delivered due to different priorities and reporting structures.	1	4	4	There is an entire work stream dedicated to this requirement. A series of meetings has taken place to develop a meaningful joint quality monitoring regime. Owner: Board.

There is a risk that:	Lkhd	Impt	Ovrl	Mitigating Actions
Telehealth desired outcomes can't be delivered because meaningful evidence can't be demonstrated to clinicians to ensure there is take-up.	2	2	4	A work package is dedicated to this. Project Manager is taking a full interest in developing a business case and a pilot programme will be run to demonstrate benefits to Merton GPs in localities.

(b)   **Contingency plan and risk sharing**

Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place (i) between commissioners across health and social care and (ii) between providers and commissioners.

18   Agreement on risk-sharing: between Commissioners

While the introduction of the BCF presents a considerable opportunity to facilitate greater integration between health and social care services, it also creates greater interdependencies between organisations with different statutory obligations. These obligations are set out in the Health and Social Care Act 2012 for Merton CCG, and for Merton Local Authority by the Care Act 2014.

In recognition of these obligations, and the level of investment that is to be made both as individual organisations and from a joint pool, risk-management and risk-sharing agreements are being developed collaboratively. For the purposes of risk sharing, it has been agreed that, in the case of non-performance, the financial risk of £894k will be shared on an equitable basis. Given that Merton CCG and LA have agreed all the investments in advance, if the target reduction is not achieved, Merton CCG and LA will jointly review the investments schemes to agree which schemes should either be modified or terminated, such that the funding is released to pay the providers.

This is currently being formalised with a contractual agreement for risk sharing between Merton Local Authority and Merton CCG.

19   Agreement on risk-sharing: between Commissioners and Providers

It is unlikely that there will be a risk to Acute Providers, given that any non-elective activity above the 2008-09 threshold (or adjusted) is paid at 30% as per PbR and the consensus from Providers is that they make a loss on non-elective activity above the threshold. Acute Providers will continue to be paid as per contractual agreement on activity performance. There is also currently a capacity issue at our main Provider (St George's) and therefore any reduction in admissions would help release beds for specialist activity.

Potential risks could sit with our Community and Mental Health Providers where, investments will be given to schemes that deliver the reduction in emergency admissions. These schemes will have agreed KPIs and penalty clauses where targets are not met.

System-wide risks of the integration agenda will be reviewed among all partners. Where the impact of deliverables risks any one of the partners being at financial risk, the parties will work together through the Merton Integration Board to mitigate that risk.

6   ALIGNMENT

(a)   Please describe how these plans align with other initiatives related to care and support underway in your area

20   Alignment with other plans

Broadly, the long-term vision for integrated health and social care services for Merton will align with the other Merton strategies illustrated below.

Figure 21: Illustration of interdependencies between strategies
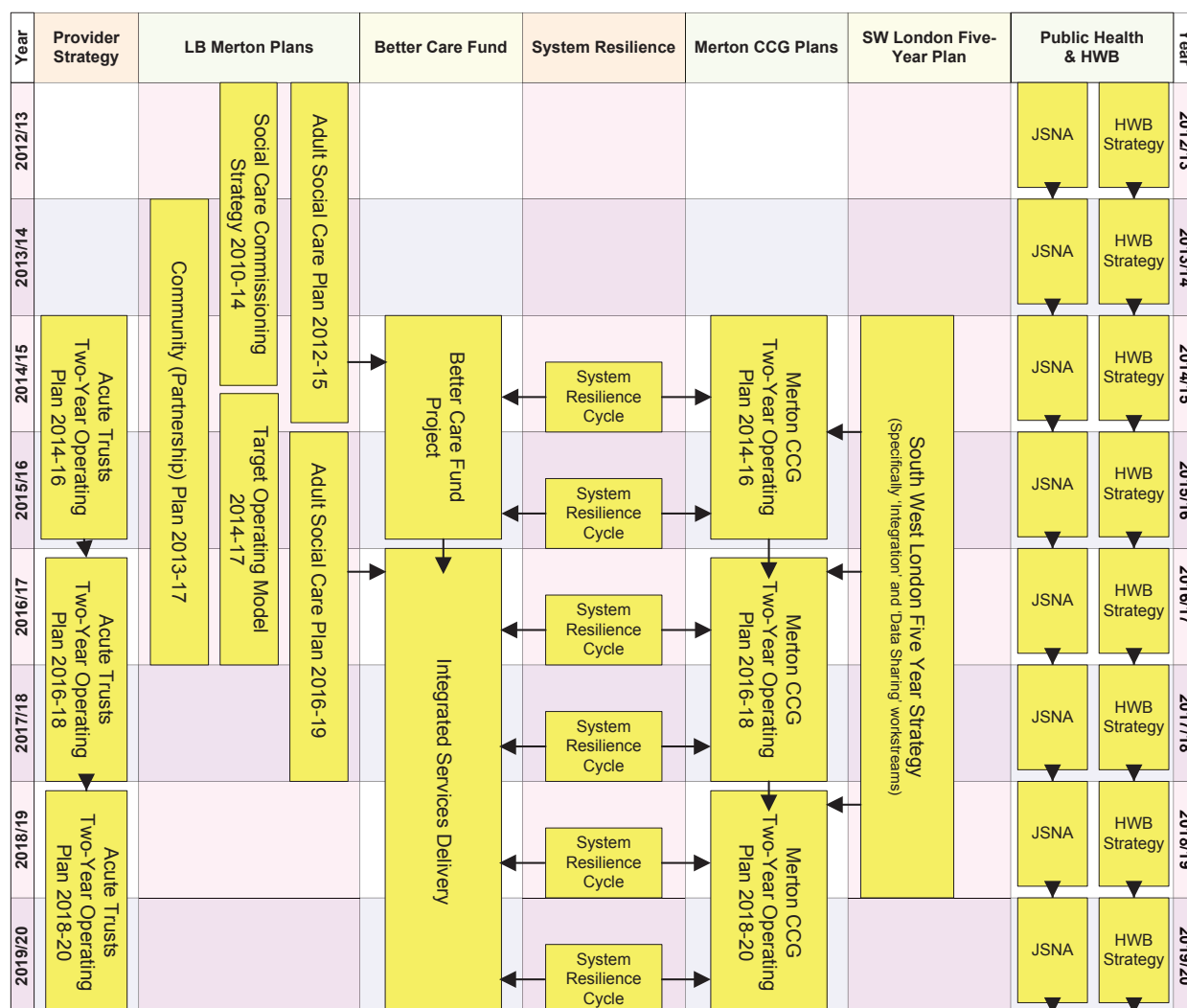
(b)   Please describe how your BCF plan of action aligns with existing 2 year operating and 5 year strategic plans, as well as local government planning documents

21   Alignment with two-year and five year operating plans

The BCF provides a framework for these successful, joint initiatives to become appropriate, integrated services with a suitable funding structure and outcomes to support them and the Merton partners welcome this initiative to improve service delivery for patients and service users in the Borough.

For Merton CCG, the Better Care Fund Plan and the implementation of the service changes and schemes, forms the core of a wider two-year operational plan linking with our key delivery areas as well as the vision and strategy for south west London as outlined in our five-year strategic plan.

As outlined in Merton CCG's two-year operational plan our key delivery areas which align with our BCF plan include:

1. Older and Vulnerable Adults
2. Mental Health
3. Keeping Healthy and Well
4. Early Detection and Management
5. Urgent Care
6. Children and Maternity

Merton CCG is committed to focusing efforts on a wider transformational service redesign that will deliver a financially sustainable health system over two years and has recognised that a sustainable health system can only be achieved in partnership across our health and social care economy.

The two-year Operational Plan also reflects the need to develop integrated services and an associated programme is also being initiated to ensure that the Plan's objectives are delivered within a formal framework.

The BCF (as the Merton Integration Plan) also aligns with the LB Merton Service Plan for Adult Social Services and Figure 18 demonstrates how the three strategies are interrelated. Figure 19 subsequently explains how the natural synergies between the 'Merton Model' work stream within the BCF Project (where the delivery of the schemes sit) and the 'Older and Vulnerable Adults' work stream of the two-year operating plan were combined to ensure a coordinated delivery of outputs across both strategies.

Figure 22: Interdependencies between BCF, CCG Two-Year Operating Plan and LB Merton Service Plan
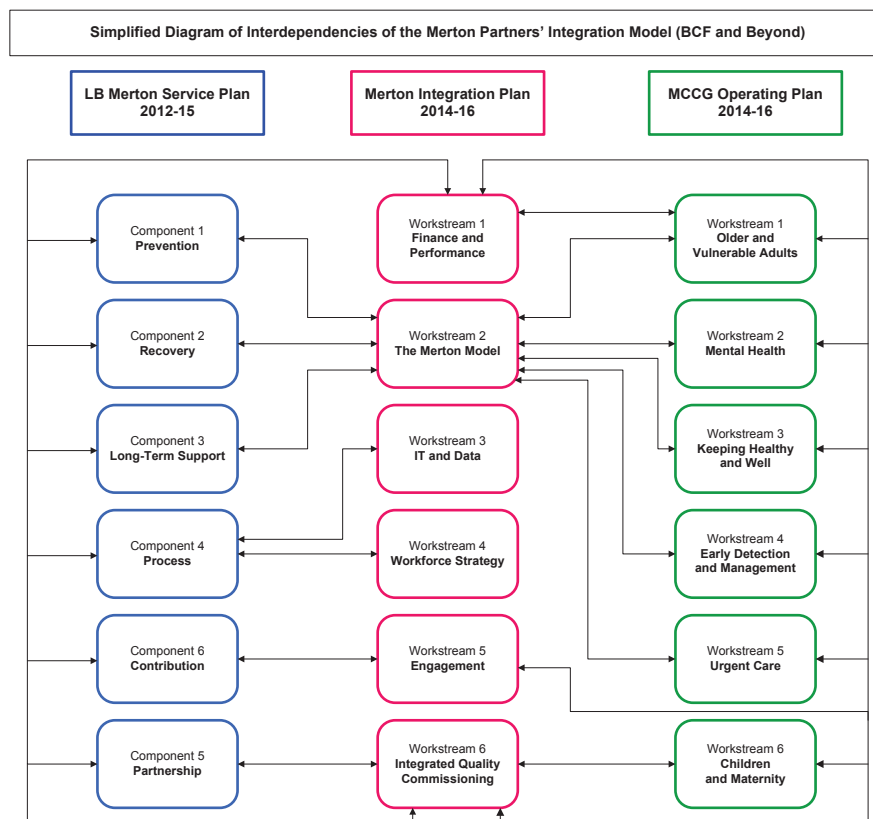
Figure 23: Combining work streams across the BCF Plan and the Two-Year Operating Plan

Better Care Fund Workstream 2: 'The Merton Model'	New Better Care Fund Workstream 2: **'The Merton Model'**	Operating Plan Workstream 1: 'Older & Vulnerable Adults'
	2.1: Investigation and Rehabilitation	
2.1: Community Hub (HARI)		
	2.2: Reactive & Rapid Response	
2.2.1: Intermediate Care: Prevention of Admission		
		OP 1.3: Intermediate Care Beds
		OP 1.6: Improved Care In Nursing Homes
2.2.2: Intermediate Care: Discharge Planning		
2.2.1: St Helier ICOPP Pathway		
		OP 1.1: Older People's Rehab Review
	2.3: Proactive, Planned & Preventative	
2.3.1: Service Redesign: Integrated Localities		
2.3.2: Dementia Integration		
		OP 1.7: Memory Clinics
2.3.3: End-of-Life Services		
		OP 1.2: End-of-Life Services
2.3.4: AgeWell Prevention		
2.3.5: Expert Patient Programme		
		OP 1.5: Falls Prevention
		OP 1.4: Podiatry Services

(c) Please describe how your BCF plans align with your plans for primary care co-commissioning.

22 Co-commissiong

CCGs in SWL submitted a joint expression of interest for primary care co-commissioning in June of this year. CCG leads, alongside their local authority counterparts recognise that the lack of aligned incentives between commissioning acute, community and social care services with primary care, presents risks to the successful implementation of BCF plans. Stakeholders, including patients and the public, who have engaged on a SWL level, have stressed the importance of improved access to good quality primary care. Co-commissioning primary care is therefore an important element of the BCF.

Since submitting the primary care co-commissioning EOI, CCGs have come together to form the SWL Transforming Primary Care Delivery Group. This includes the NHSE London LAT. This group has overall responsibility to lead the implementation of the Transforming Primary Care strategic plan for SWL. In addition, CCGs are working with NHSE to develop further plans for primary care co-commissioning, currently reviewing which functions are developed locally and under joint commissioning arrangements.

SWL CCGs have identified the following specific benefits of co-commissioning primary care:

- Local knowledge and intelligence of need and patterns of services in general practice, including already commissioned LES contracts to allow more effective commissioning at the local level

- Better coordination and alignment of already commissioned CCG services with general practice services

- Greater achievement of objectives and plans for transforming primary care in SWL through the 5-year strategic plan and the opportunity to affect change at 'scale and pace'

- Better alignment of current CCG primary care schemes with overall commissioning intentions for primary care. This includes, reducing variation in quality of primary care through implementation of the primary care service specifications (formerly primary care standards), closer monitoring and better relationships with primary care providers and alignment of already CCG commissioned initiatives with core contracting

- Contract design based on local population needs and intelligence, with greater involvement in contract monitoring and management
- Increased scale and pace of enabling factors to transform primary care including estates and workforce

All of these benefits will contribute to the success of the implementation of the BCF and integrated care plans. In particular, better implementation and outcomes for integrated multidisciplinary teams and blurring organisational boundaries where appropriate.

Commissioners in SWL are interested to assume responsibility for joint commissioning of primary care in order to align commissioning and incentives so that:

- There is appropriate support and suitable incentives to build multidisciplinary working with the right level and processes for accountability, improving the care of people with LTCs and complex needs

- Models of general practice provided and improved access to primary care services focus on the needs of the local population, in line with the HWB strategy and social care (as well as the health) needs of the population

- Primary care capacity and changes in service provision and skill mix to support this, align with local plans for expanding community services

- Primary, community and social care providers work together to reduce health and social care inequalities

Commissioning intentions for primary care are aligned with those for acute and community provision.

7   NATIONAL CONDITIONS

Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections

(a)   Protecting Social Care Services

(i)   Please outline your agreed local definition of protecting adult social care services (not spending)

Merton's definition of Protecting Adult Social Care Services is as follows:

"Enables social care to continue to operate in a way that ensures that the whole system works effectively, and that core social care services are not undermined. This will be done through the integration agenda, sharing a pooled budget, reconfiguring services and rearranging the workforce."

(ii)   Please explain how local schemes and spending plans will support the commitment to protect social care.

Merton is committed to mitigate the impact of savings that the council has to find in the following ways:

- Funding for core services which are essential to the whole system, at the same time modernising them.

- Working together to find efficiencies that also benefit social care.

- Continued joint investment in prevention.

The framework for this the efficiency and investment framework was developed and piloted in Merton and is now used nationally.

The following specific activities will facilitate the protection of social care services:

- The scheme on prevention, Ageing Well, is one protection element. By adding £80k of funding in 2015/16, the BCF will protect the Ageing Well programme, for which the Council is planning to reduce funding in future years. Outcomes for the programme will be agreed between the BCF partners

- The council will ensure 24 hour access to Domiciliary Care Packages. The council will meet the demand from health sources, offering timely and prompt service in the community as an alternative to hospital admission and on discharge

- LB Merton is planning to achieve efficiency measures where the effect upon capacity of hours delivered will be minimal. The additional funding from BCF will help protect the service and also includes funding for night sits, and the extra demand for visits resulting from successful avoidance of hospital admission

- The New Duties scheme is as per the national guidance whereby the amount is proportional to the nationally announced figure. It is expected to be spent mainly on staff to undertake the additional assessments required

- Expanding the council's capacity to arrange care packages during the weekend (8am-5pm) and in the weekday evenings adding a care package from (5pm-8pm). This scheme is also expected to include greater responsiveness from the MASCOT Telecare service

- The 7-day working proposal is to expand the hours of the community rehabilitation team, which works with people in intermediate care beds in specific nursing homes, and also in people's homes. This will mean that both the health and social care elements of the reactive stream will move to 7 days. This provides the basis for integrating these two services (and others in the reactive stream) on an even footing

Merton has agreed with host commissioners that it will be involved in contract review meetings and local communications between partner providers to ensure there is a continued focus on Merton despite the fact that it is not a host commissioner for acute trusts

(iii) **Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.).**

The agreed figure for protecting and modernising social care within the BCF is £3,577,000. This includes funding for care packages, funding for Merton Independent Living and Reablement Service (MILES), and funding for implementation of the Care Act.

(iv) **Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met.**

The Care Act brings new duties and pressures into the health and social care system, in particular:

- assessing people who fund their own care.

- assessing carers who have new rights for assessments and services.

- implementing national eligibility criteria.

- ensuing that safeguarding arrangements reflect the new statutory basis and the new definition of those for whom we have a duty to safeguard.

- implementing the new threshold of £118k below which the council must make some financial contribution.

- taking the overview of the market and having contingency plans for provider failure.

- applying the over arching principles a of Wellbeing and Prevention in how support is commissioned and delivered.

Our intention is to ensure that these issues are embedded in our arrangements for integration. For example, our shared assessment processes in proactive case management will need to have regard to national criteria, assessments of carers should look at their needs across health and social care, and support to providers already comes from the CCG as well as the council. Our shared governance and project structures ensure that planning can take place in the right places.

(v) **Please specify the level of resource that will be dedicated to carer-specific support.**

Merton has allocated £551,000 for carer support during 2015/16.

(vi)   Please explain to what extent has the local authority's budget been affected against what was originally forecast with the original BCF plan?

The London Borough of Merton faces a challenging financial environment. It has an agreed Medium Term Financial Strategy which has already delivered significant savings but has more to find through to 2018 to ensure financial balance. Whilst the political administration has promised to protect support for vulnerable people, in reality, adult social care has to deliver further significant savings. The part of the BCF for protecting and modernising social care will help to ensure that services vital for the whole system will be maintained and that these services will play a full part in achieving whole system objectives such as reducing non elective submissions.

(b) Seven Day Services to Support Discharge

Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and to prevent unnecessary admissions at weekends

Strategic Commitment

Merton already performs in the upper quartile for NEL admissions; therefore to improve performance further, there must be a step-change in the way that services are provided. There is a shared commitment between LB Merton and Merton CCG to reorganise and expand existing services to operate for seven days of the week, and an appreciation of the interdependencies between health and social care services in achieving these aims.

Locally Agreed Plans

Achieving truly integrated seven day services is core to Merton's plans for future services. The approach will see the development of complementary services in health and social care, integrated to provide patients and service users a seamless service as the BCF is fully implemented. To meet this objective, a specific pillar of the BCF will focus on transitioning services to seven-day working; meaning admissions to an acute setting can initially be avoided and discharge is not delayed merely because it is a weekend. Fundamentally the service model will change contractual arrangements with community and social providers will need to change and the ways the community and indeed the primary care workforce will change.

Although Merton currently has a low level of delayed transfers of care, moving to a seven-day model of working offers the opportunity of significant advances in this respect. The seven day working model of care is expected to be fully operational by the end of 2014/15, and the period of implementation will be used to understand emerging levels of integration between services and drive improvements where required. Underpinning the changes is the move to three integrated MDTs organised into geographic localities. Through the BCF, Merton is making considerable investments to support the development of these locality teams, and they will become the vehicle that delivers seamless, integrated and consistent care for seven days.

The role of the Merton Integration Board is to provide practical support for the local integration of services. Through this representation and reporting, the key points in the Joint Health and Wellbeing Strategy can be met in a practical sense. Our operational subgroup, enabled by the finance and performance, quality and workforce and culture subgroups, will be responsible for further planning, mobilising and delivering our plans for seven-day services. In addition, the integrated care project board, and the executive teams will assess our progress to deliver this, directly against our performance on the national metrics.

Social Care Plans

LB Merton is proposing that social care services undergo a full restructuring to ensure that 'the right staff with the right skills are available in the right place at the right time'. This change will allow for additional capacity to arrange care packages in the evening and on weekends, preventing the historical delays associated with discharging from acute settings Friday through to Sunday. Reorganisation will enable additional social care staff to be based at St Helier and St George's, while services such as intensive home care and night sits will facilitate timely discharges and receiving individuals with social care needs back into the community over seven-days.

Through making services available for greater periods of the week, social care related additional bed days in hospital can be reduced. In order to aid integration, teams will be structured into three localities, mirroring the organisation of health services.

Health Plans

Merton CCG already commissions some services that operate for seven days, such as community nursing (provided by SMCS). Along with this service being expanded, two new seven-day services will be commissioned: community rehabilitation and intermediate beds located within nursing homes. The later service will be offered to patients with a high potential to return to their home after a short spell of intermediate care to rehabilitate intensively to an acceptable level of functioning in the home environment.

The aim of these services is that acute trusts will experience no difference when discharging patients no matter what day of the week it is. Services such as intensive rehabilitation in people's homes and additional rehabilitation in intermediate settings will facilitate timely discharge from the acute setting. Expanding community nursing keeps people in their homes for longer, avoiding potential emergency admissions where there is no other alternative.

(c) | **Data Sharing**

| **(i)** | **Please set out the plans you have in place for using the NHS Number as the primary identifier for correspondence across all health and care services.** |

NHS commissioned services are using the NHS number as the primary identifier for correspondence. Primary care, through contract changes effective from 1 April 2014, also uses the NHS number to communicate with other services.

Local Authorities do not currently use the NHS Number as the primary identifier for correspondence across all health and care services but have plans in place to do so. Although our current social care database is not capable of allowing both the Carefirst number and NHS number to be used in conjunction as primary identifiers LBM has recently tendered for their social care system and are in the process on implementing Framework-i. This system will use the NHS number as primary identifier and will be live on a phased basis between June and September 2015. A complimentary training process for IG will accompany this change.

In the meantime, we have been through a comprehensive data matching process within our current system, CareFirst, and currently have 83.1% compliance for NHS numbers in Adult Social Care as at September 2014.

The NHS number has also been added as a field on the Initial Contact forms designed to accommodate the new Adult Social Care Collections (Zero Based Review – ZBR) and we will work through the remaining data over the coming months with an ambition to be fully compliant when we launch the new system.

Once this is in place we have an ongoing process for keeping the NHS numbers up to date they will run regular reports that will identify missing NHS numbers. These reports will be circulated to the relevant managers for action as part of our regular data quality monthly reporting. They will also consider developing an NHS number for completeness performance indicator

Alongside the technical work needed to get the NHS number uploaded into our Social Care System we have also designed a programme of work designed to support information sharing based around this information.

This will include:

- Using the NHS number as the basis for information sharing prior to an Multi-Disciplinary Team meeting to allow practitioners who have a legitimate relationship with a service user to prepare accordingly.

- Working with our newly formed locality teams to see how information can be shared better within those teams. Any information sharing in these settings will be based around the NHS number and legitimate relationships between the practitioners and patients and service users.

- Development of Information Sharing Agreements and Fair Processing Notices where these are relevant

- Specific training for staff looking at information governance but with a focus on helping staff understand their responsibility re: using the NHS number to facilitate information sharing and how to do that within the legal framework.

| **(ii)** | **Please explain your approach for adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK)).** |

Our Commitment to APIs and Open Standards

The following organisations are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK)):

- Merton Council
- Merton Clinical Commissioning Group
- Sutton and Merton Community Services (part of The Royal Marsden NHS Foundation Trust)
- St George's Healthcare NHS Trust
- Epsom and St Helier University Hospitals NHS Trust
- Kingston Hospital NHS Foundation Trust
- South West London and St George's Mental Health NHS Trust.

LBM and Merton CCG recognise that interoperability between different systems is essential to delivering integrated health and social care systems and the partners are committed to pursuing an information architecture that is built on open application programming interfaces (APIs). An initial list of systems holding relevant data has been compiled by the SLCSU working on behalf of the SW London CCGs and Boroughs. This work will form the basis of some further work by the SW London CCGs Commissioning Collaborative proposing a solution across South West London.

Merton will support and contribute to this process.

NHS Mail is widely used across our partnered NHS organisations, supported by N3 Connectivity, for the secure transmission of patient confidential data, and LB Merton have implemented third party email gateway security solutions: Proofpoint, GC Mail and CJSM, the latter two of which are specifically compatible with NHS Mail.

(iii)   Please explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practice and in particular requirements set out in Caldicott 2.

The following organisations are committed to ensuring that the appropriate Information Governance Controls will be in place.

- Merton Council

- Merton Clinical Commissioning Group

- Sutton and Merton Community Services (part of The Royal Marsden NHS Foundation Trust)

- St George's Healthcare NHS Trust

- Epsom and St Helier University Hospitals NHS Trust

- Kingston Hospital NHS Foundation Trust

- South West London and St George's Mental Health NHS Trust

We are committed to ensuring that appropriate IG controls will be in place. We are committed to obtaining and maintaining a minimum of level two on all IG Toolkit requirements. We are committed to upholding the values of Caldicott 2, and to fulfilling our duty to share.

- The confidentiality of service user information will be respected

- The duty to share will be met in order to ensure that members of the care team have access the data that is necessary for the delivery of safe and effective care

- Information that is shared for indirect care purposes should be anonymised.

- The rights of service users to object to their data being shared will be respected

We have designed our organisational structure in such a way to give sufficient precedence and priority to information governance, through the IT and data sharing group.

This IT and data sharing group has developed a programme of work based around the following key themes:

- Information Sharing Agreements

- MDT meetings

- Co-ordinate My Care Pilot

- NHS Numbers

- Commissioning and Contracts

- Training

- Consent

- System Access

- Paper records

- Communication

Taken together we believe these themes will deliver improved data sharing amongst health and social care professionals which will, in turn contribute to better outcomes for service users.

(d) | **Joint assessment and accountable lead professional for high risk populations**

(i) **Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them.**

The following four component activities with the central professional; the key worker, who acts as the accountable lead professional, is the mainstay of the principle of our out-of-hospital strategy, the expansion of our community-based service model and development of inter-relationships between community services, social care services and primary care.

Figure 24: The key activities and central professional underpinning integrated working

As stated comprehensively in Section 3, all 25 GP practices in Merton are already undertaking risk-stratification profiling using the Sollis tool to proactively identify patients at high risk of deterioration and subsequent escalation in the community or who are frequent attenders in acute services.

Currently, 3510 adults registered with Merton GPs are at Very High and High risk of admission. During 2013/14, these adults had 6519 emergency admissions to hospital.

(ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population.

GP practices and GP leads in Merton are using the risk stratification profiling as per the following flow chart, linking in with multi-disciplinary teams:

Figure 25: GP Risk Stratification, as used in Merton
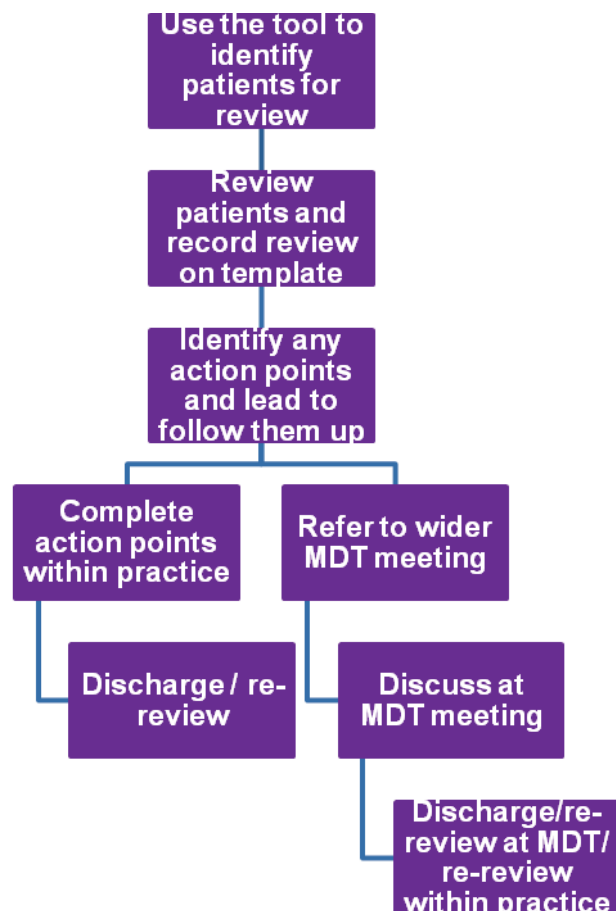
Virtual case management forms the core activity of multi-disciplinary meetings where primary care and community clinicians, alongside social care professionals review ways in which to deliver care to patients, and jointly agree action plans.

A **key worker**, with an appropriate professional background is assigned and is ultimately responsible for co-ordinating the care of the individual and providing first-line support to the person and carer in terms of communication, initially assessing ongoing need, developing expectations of care and reflecting this in their care plan.

The key worker is also responsible for communicating progress or further need back to appropriate professionals, including clinicians who need to be connected in with ongoing actions, as well as to the wider MDT team. Ideally this will ultimately take place through a shared record system, using the NHS number as a unique primary identifier, and through the appropriate channels in relation to the level urgency (telephone, email, meetings etc.). The latter data sharing component of this way of working is expected to take longer to achieve.

(iii) **Please state what proportion of individuals at high risk already have a joint care plan in place.**

Merton does not currently have access to this information. However, we have conducted an audit of Very High and High Risk patients at one practice and this audit demonstrated that 100% of those patients who had 3 or more admissions in the past year had care plans in place.

Merton CCG is currently planning implementation of software that will enable this information to be provided. The expected timescale for implementation is November 2014.

8 ENGAGEMENT

Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections

(a) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future.

As part of the process of designing a new approach to integrated care in Merton, we have held a number of events which have included consulting and engaging staff, clinicians, the voluntary sector, service users and carers. Users and carers have been involved from the early stages in the design of our integration project, and an evolved learning approach is one our guiding principles which underpins the way we design integrated care.   The following activities took place or are taking place to engage patients, service users and the public in the development and design of integrated services:

August 2013: 'What would brilliant look like?'

This event was attended by 50 service users and carers as well as the voluntary sector to identify what would define a brilliant integrated care system in Merton.   Feedback and suggestions from this event were captured and this input has been used to develop the local model.

October 2013: Engage Merton

We ran an event called 'Engage Merton' in partnership with Healthwatch Merton. More than 60 patients, members of the public, service users, carers, clinicians and other stakeholders were involved in discussions about the Commissioning Intentions for 2014-2015 and the Engagement Strategy and Implementation Plan for 2013-2015. The findings from the event enabled us to set priorities, form Commissioning Plans and develop an Engagement Strategy.

The event identified 'seldom heard' groups including, housing associations, individuals from the traveller community, members of the public without internet access, amongst many others, and developed ideas for engaging with these groups going forward. Feedback also provided us with greater insight into how the voluntary sector can support the integration agenda in Merton. This can be seen in Appendix 1.

November 2013: Integrated Care Model Simulation

We ran a simulation of the process, involving service users and carers, GPs, social workers, clinicians as well as managers from acute hospitals, community and mental health providers. During the simulation a group of service users and carers acted as advisors to each of the professionals who were playing the role of a 'key worker.'

They were also part of a group participating as voluntary and community groups. This event helped to test the 'Merton model', acted as a learning event for professional development, and gained knowledge from the perspectives of all the people who were involved.

April 2014: 'Introducing the Better Care Fund Integration'

A catered, half-day stakeholder event was held in April 2014, attended by more than 30 organisational stakeholders (commissioners, providers, voluntary sector, etc.). The event introduced the submission, as agreed by the Health and Wellbeing Board, and initiated the Merton-wide stakeholder management plan, as part of the overall project framework.

September 2014: 'Joining Health and Social Care' – Your Experiences

A full-day event facilitated by Healthwatch Merton at which 40 service users, patients, carers and members of the public were asked about their experiences and opinions of six areas of integration focus: dementia, carers, end-of-life care, crisis, discharge from hospital and keeping well at home. The format of small groups and facilitators rotating around the tables delivered excellent results and these are currently being reviewed in order to shape the continued development of integrated services in Merton.

(b)   **Service provider engagement**

Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

(i) NHS Foundation Trusts and NHS Trusts

Merton CCG and LB Merton have been progressive in their approach to engaging and involving service providers in how services should be developed and redesigned to meet the integration agenda and meet the rising demand for health and social care. Given that Merton does not host an acute provider and shares a community provider with Sutton, a complex multi-stakeholder environment results creating even more weight to ensuring that health and social care providers are involved in parallel with designing services.

Whilst commissioners in Merton will provide the momentum, strategy and framework for service-level change, Merton CCG and LB Merton are acutely aware that service providers bring good insight into frontline issues and solutions. In addition it is recognised that workforce planning and step-changes in multi-professional working across health and social care organisational boundaries, can only be overcome through a carefully managed and continuing engagement between commissioners and providers.

We therefore hosted two engagement events on 16 July 2014 and 21 July 2014, which was attended by Directors from our Acute and Community providers to present our BCF schemes and changes we were planning. We hosted a further event on the 14th of August to engage our main acute providers (St. Georges Healthcare NHS Trust and Epsom and St. Helier University Hospitals NHS Trust) with the methodology we used to quantify the impact of our schemes of Acute emergency activity.

We have maintained a constant dialogue with identified leads at our main Acute providers and they have agreed to our forecasts relating to impact on emergency admissions.

As part of the 2013/14 contracting process, we shared our projected impact on emergency admissions at HRG level with St. Georges NHS Trust and Epsom and St. Helier University Hospitals NHS Trust. This will be repeated as part of the 2015/16 contracting process; however, as part of the BCF resubmission our providers have been part of the process of forecasting the predicted impact.

(ii) Primary Care Providers

GPs have been kept informed about progress with the BCF Plan through regular communications and through the GP Practice Leads Forum.

(iii) Social Care and Providers from the Voluntary and Community Sector

The voluntary and community sector, including providers, are represented at all levels in the integration and BCF governance structures, including the Merton Integration Board, Project Team, Merton Model Development Group and in developing work packages, as appropriate.

(c) **Implications for Acute Providers**

Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

- What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?

- Are local providers' plans for 2015/16 consistent with the BCF plan set out here?

The introduction of the BCF is likely to have far reaching implications in terms of the way that health and social care is provided in the future. Many of the resultant changes are likely to be felt most intensely by acute providers. Recognising this Merton, through bodies such as the Merton Integration Board, has engaged with providers to ensure that there is a shared awareness of the likely changes.

When the changes to integrated care are fully implemented, the whole-system effects are expected to provide benefits to acute providers in the area. A reduction in the numbers of emergency attendances and admissions will relieve pressure on trusts' A&E departments, better enabling them to meet the 4-hour A&E target and also reduce the amount of activity that is funded at the marginal rate (currently 30% of tariff).

The Merton HWBB projected reduction of non-elective FFCE activity on our acute providers is shown in the table below. This takes into account projected 2.2% growth and will enable Merton HWBB to deliver an overall 3.5% reduction on non-elective FFCEs.

Figure 26: Forecast impact of Merton BCF schemes on our main acute providers

Total forecast impact on Acute provider NEL FFCEs 2015/16 in general and acute due to Merton BCF Schemes					
	St George's NHS Trust	**Epsom & St Helier NHS Trust**	**Kingston NHS FT Trust**	**Croydon NHS Trust**	**Merton HWBB reduction of NEL FFCEs**
Proactive Schemes	223	102	13	13	351
Reactive Schemes	404	184	23	24	635
Total Impact	**627**	**285**	**35**	**38**	**986**

These calculations have been shared with providers as part of the BCF submission process and will be used as part of the 2015/16 contracting process to reflect planned QIPP savings.

Current forecasts to quantify the benefits of reduction of non-elective FFCEs for the BCF submission have applied the national average tariff for non-elective admissions of £1490. However, further work is required to validate this forecast, as our Acute providers have identified that currently, a significant amount of this activity occurs under the short stay general medicine tariff of c£380 per admission. We will continue to work with our providers to estimate the financial value of the reduced activity, and these calculations will be used in the 2015/16 contract.

Figure 27: Financial impact of Merton BCF schemes on our main acute providers

Total financial impact on Acute provider NEL FFCEs 2015/16 in general and acute due to Merton BCF Schemes					
	St George's NHS Trust	**Epsom & St Helier NHS Trust**	**Kingston NHS FT Trust**	**Croydon NHS Trust**	**Merton HWBB reduction of NEL FFCEs**
National tariff for FFCEs	£1,490	£1,490	£1,490	£1,490	£1,490
Prevention of forecast 2.2% growth	242	110	14	15	381
3.5% reduction	385	176	22	23	605
Total Financial Impact	**£933,824**	**£426,422**	**£52,753**	**£55,992**	**£1,468,991**

As many of the schemes included within the BCF are interdependent between Merton CCG and LB MERTON, a risk-sharing agreement has been reached. This will ensure that both partners are able to take greatest advantage from the fund, and that in the case of non-performance one organisation would not be disproportionately disadvantaged, as well as taking joint responsibility for the whole health and social care economy.

Please note that CCGs are asked to share their non-elective admissions planned figures (general and acute only) from two operational year plans with local acute providers. Each local acute provider is then asked to complete a template providing their commentary – see Annex 2 – Provider Commentary.

Scheme ref no.
Merton 1.1

Scheme name
Reactive Community Schemes to Prevent Admission

What is the strategic objective of this scheme?
The strategic objective of this scheme is to put in place a number of coordinated initiatives to support the prevention of admission teams in Merton to meet the objective of keeping people out of Acute hospitals and treating them in the community. The scheme comprises a number of coordinated components that have the objectives of   - Further reducing the number of delayed transfers of care.   - Reducing non-elective emergency admissions.   - Evidencing the effectiveness of reablement.   - Reducing admissions to residential and nursing care.   - Improving the overall patient and service user experience.

Overview of the scheme
Please provide a brief description of what you are proposing to do including: - What is the model of care and support?   - Which patient cohorts are being targeted?
The impact of reactive response is quantified on the basis of the number of admissions to hospital that could reasonably be treated by alternative community services/responses implemented under BCF. Analysis and modelling is based on Acute HRG codes.
This is based on the current QIPP modelling that provides a granular detail regarding the number and type of emergency admissions at HRG level that BCF reactive schemes aim to prevent. This is a currency that providers know, use and can monitor.
In summary, the reactive modelling is set out below: - The 2014/15 QIPP forecasts a 49% reduction on admission to St George's Hospital, Epsom & St Helier Hospital, Kingston Hospital and to Croydon Hospital with one of the 10% of HRGs deemed to be treatable in the community due to implementation of community response services such as the CPAT or HARI services.   - The 2015/16 QIPP/BCF benefits from the full year effect of these schemes as implementation is forecast to be completed by 2014/15 year end.
The service model is able to reduce the likelihood of avoidable emergency admission in times of deterioration or crises by ensuring that appropriate and responsive care and support is available in the community, including access to specialist care
In addition, the service model is able to reduce service users' length of stay in acute services, encouraging a smooth discharge with appropriate support in the community to deliver high quality care, promote rehabilitation and reablement, preventing readmission into acute services or subsequent admission into care homes.

Services are particularly focused on a 7 day a week and 24/7 model of delivery where appropriate, and therefore embeds out-of-hours capacity and appropriately skilled 'night' staff to ensure a reactive approach to care in the community, relieving the pressure on emergency departments. In particular, seamless communication and interactions with local urgent care services, NHS 111 and primary care will be delivered. This will also include the rapid deployment of social care provision in the community where required

Escalating care needs or crises are identified and responded to swiftly by dedicated multi-professional teams with sufficient capacity to enable people to stay at home unless acute specialist care or intermediate or respite care is required. These community teams work closely with acute care colleagues to avoid emergency and unplanned care admissions

The capacity of rehabilitation and reablement services, professionals and skill will be increased in the community, to ensure that needs addressing independence and functionality are addressed, preventing admission to hospital, ensuring discharge from hospital is timely or preventing premature permanent admission to care homes

Rehabiltation and reablement capacity is supported by intensive short-stay intermediate care (non-home based) to reduce likelihood of admission to hospital or promote earlier discharge from hospital. This service will be kept to an essential minimum (continuing to promote home-based care where appropriate) and referral criteria will be strictly controlled by service leads to ensure that only people with a potential to return to independence are managed through this service. This is to prevent 'bed-blocking'

Greater specialist support to be delivered in the community in collaboration with primary care, by enhancing relationships and communication between acute care professionals, primary care and community-based professionals. This includes responsive and timely specialist advice and support given to primary care professionals to prevent admissions and promote discharge from hospital, and the ability for GPs to 'fast-track' diagnostics (including community-based diagnostics) and clinical review for 'at risk' individuals

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Service:	Delivered by:	Commissioned by:
Community Prevention of Admission Team (CPAT): nursing team across the whole of Merton – supplemented by System Resilience funding over the winter.	Sutton & Merton Cmty Services (CH Provider)	Merton CCG
Holistic Assessment and Rapid Investigation Service (HARI): rapid access (24 hour) to clinical and medical investigations in a community hospital setting.	TBC (contract awarded)	Merton CCG
Merton Independent Living and Enablement Service (MILES): short-term reablement service delivered by in-house reablement team. Currently being reviewed.	LB Merton	LB Merton
Community Intermediate Care Beds: step-up and step down facilities to be used for rapid response to emergency and crisis situations.	Various nursing home providers.	Merton CCG

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme

- to drive assumptions about impact and outcomes

The basis for this work largely comes from the well referenced national documents that have set out research to manage emergency admissions. These are primarily:

- The National Audit Office, Emergency admissions to hospital; managing the demand (October 2013): http://www.nao.org.uk/wp-content/uploads/2013

- The Kings Fund, Emergency hospital admissions for ambulatory care sensitive conditions; identifying the potential for reductions (April 2012): http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/data-briefing-emergency-hospital-admissions-for-ambulatory-care-sensitive-conditions-apr-2012.pdf

- The Kings Fund, Avoiding hospital admissions, what does the research evidence say? (December 2010): http://www.kingsfund.org.uk/sites/files/kf/Avoiding-Hospital-Admissions-Sarah-Purdy-December2010_0.pdf

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Through the Merton BCF programme structure, the Finance and Performance Group monitors the strategic programme indicators (non-elective FFCEs and the HWBB indicators) as well as operational indicators such as service activity and effectiveness.

The group also commissions ad-hoc audits to evaluate specific areas of service delivery in order to gain an understanding of the correlation between operational indicators and strategic indicators in order to evaluate the impact of individual schemes.

What are the key success factors for implementation of this scheme?

- Out of Hours Brokerage Officers to source and set up care packages.

- Occupational Therapists to implement reablement programmes and techniques and/or provide equipment, minor adaptations and Telecare prior to service packages and /or admissions to residential/nursing or hospital beds.

- Out of hours admin support to update the data base on a real time basis.

- Additional carers to provide short term intensive home care and night sits.
- Mobile Response Officer to provide back up and immediate installation of telecare monitoring system.
- Carers and users feedback.
- Implementation of three geographical localities and integrated MDT working to provide 'wrap-around' care.
- Implementation of 7 day working in social care.

Scheme ref no.
Merton 1.2

Scheme name
Proactive Community Schemes to Prevent Admission

What is the strategic objective of this scheme?

For the proactive model, risk stratification provides primary and community providers with an indication of the number of patients that should be proactively managed and therefore forecasts an impact on admissions for these patients. This model provides the BCF project team with an indication of the required scale of community case management by MDT teams. A risk stratification model was developed to examine the impact on emergency admissions activity forecast and validated with the support of Merton CCG's Clinical Director for Integration, Adults and Vulnerable People. This is quantified on the basis of number of people being managed through integrated MDTs, which operate in all of Merton's 25 GP practices.

In summary, the proactive modelling is based on the following:

- The 2014/15 QIPP forecasts a 49% reduction on Ambulatory Sensitive Conditions.

- The 2015/16 QIPP/BCF forecasts that 10% of Very High Risk and High Risk patient will benefit from a reduction of one admission due to Case Management

Overview of the scheme
Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?

- Which patient cohorts are being targeted?

- A service model where coordination of the journey and experience of people (service users) identifies those who are vulnerable or could benefit from care, and which focuses on prevention, self-management, education and training, increase in quality of living and life expectancy promoting overall wellbeing.

- A service model where skilled workers coordinate ongoing proactive care in their multi-professional locality teams, each 'facing' acute care trusts in neighbouring localities (West Merton – St. George's Hospital, Raynes Park – Kingston Hospital and East Merton – St. Helier's Hospital). Each locality team will work with their locality network of GP practices, with access to specialist support in the community as required. Multi-professional teams are 'blended' to provide appropriate disciplines, skill mix, leadership and accountability to provide a proactive approach to care.

- Risk stratification and case management activities across multi-disciplinary teams will deliver proactive care, identifying and managing individuals at risk of deterioration, admission to acute care services or care homes, supporting care which addresses the needs of the 'whole person'.

- Each identified person will have a strong relationship with their GP or key worker who is able to lead as their care-coordinator, helping them to receive timely and consistent support and care from a multi-professional and multi-organisational team.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Service:	Delivered by:	Commissioned by:
Holistic Assessment and Rapid Investigation Service (HARI): rapid access (24 hour) to clinical and medical investigations in a community hospital setting.	TBC (contract awarded)	Merton CCG
Merton Independent Living and Enablement Service (MILES): short-term reablement service delivered by in-house reablement team. Currently being reviewed.	LB Merton	LB Merton

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme

- to drive assumptions about impact and outcomes

The basis for this work largely comes from the well referenced national documents that have set out research to manage emergency admissions. These are primarily:

- The National Audit Office, Emergency admissions to hospital; managing the demand (October 2013): http://www.nao.org.uk/wp-content/uploads/2013

- The Kings Fund, Emergency hospital admissions for ambulatory care sensitive conditions; identifying the potential for reductions (April 2012): http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/data-briefing-emergency-hospital-admissions-for-ambulatory-care-sensitive-conditions-apr-2012.pdf

- The Kings Fund, Avoiding hospital admissions, what does the research evidence say? (December 2010): http://www.kingsfund.org.uk/sites/files/kf/Avoiding-Hospital-Admissions-Sarah-Purdy-December2010_0.pdf

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

- **Clinical** – patients and service users will not be admitted to an inpatient hospital ward unless medically necessary, enabling customers to have their needs met in the least intrusive manner, and as close to their familiar home environment as possible.

- **Operational** – joint working between health and social care staff with enhanced hours presence will enable a more productive response to customers, who will be given the right care and support at the most effective time. The project will reduce

the spikes in activity caused currently by Monday to Friday working.

- Discharges from acute settings happen across seven days of the week, based on medical suitability for discharge and not the availability of packages of care in the community.

- Rehabilitation and reablement packages are agreed ahead of discharge and begin as soon as the person is within the community setting, regardless of the day of the week that this falls upon – overall the length of stay in the acute setting is reduced and outcomes are improved.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Through the Merton BCF programme structure, the Finance and Performance Group monitors the strategic programme indicators (non-elective FFCEs and the HWBB indicators) as well as operational indicators such as service activity and effectiveness.

The group also commissions ad-hoc audits to evaluate specific areas of service delivery in order to gain an understanding of the correlation between operational indicators and strategic indicators in order to evaluate the impact of individual schemes.

What are the key success factors for implementation of this scheme?

- Out of Hours Brokerage Officers to source and set up care packages.
- Occupational Therapists to implement reablement programmes and techniques and/or provide equipment, minor adaptations and Telecare prior to service packages and /or admissions to residential/nursing or hospital beds.
- Out of hours admin support to update the data base on a real time basis.
- Additional carers to provide short term intensive home care and night sits.
- Mobile Response Officer to provide back up and immediate installation of telecare monitoring system.
- Carers and users feedback.
- Implementation of three geographical localities and integrated MDT working to provide 'wrap-around' care.
- Implementation of 7 day working in social care.

Scheme ref no.
Merton 1.3

Scheme name
Protecting and Modernising Social Care

What is the strategic objective of this scheme?
To ensure that social care services are not compromised by a reduction in direct funding for social care.

Overview of the scheme
Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Protecting social care is essential to ensure that people are appropriately supported and cared for in their community. Without the necessary support, people are more likely to require intervention from health services and the more likely they are to be admitted to hospital. The Merton Protecting social care scheme enables Case Management and Prevention of admission schemes to derive benefits. Without protection of social care, emergency admissions are forecast to increase well above the predicted growth rate of 2.2%.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
N/A

The evidence base
Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
N/A

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Through the Merton BCF programme structure, the Finance and Performance Group monitors the strategic programme indicators (non-elective FFCEs and the HWBB indicators) as well as operational indicators such as service activity and effectiveness.

The group also commissions ad-hoc audits to evaluate specific areas of service delivery in order to gain an understanding of the correlation between operational indicators and strategic indicators in order to evaluate the impact of individual schemes.

What are the key success factors for implementation of this scheme?

Continued ability of Merton Adult Social Care to fund its agreed programme.

Scheme ref no.
Merton 1.4
Scheme name
Carers' Breaks
What is the strategic objective of this scheme?
To support carers to continue to keep service users and patients in their own homes and to reduce avoidable admissions to care homes.
Overview of the scheme   Please provide a brief description of what you are proposing to do including: - What is the model of care and support?   - Which patient cohorts are being targeted?
This scheme will increase the capacity of the Night Nursing Service, providing additional skilled support which is available to carers between the hours of 7pm and 7am in order to prevent unnecessary emergency admissions. This will primarily be through remote advice provided from a hub, extended to mobile / visit support in appropriate cases. The scheme is integrated with Merton Social Services.
The delivery chain   Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
Additional support commissioned by Merton CCG from Community Healthcare provider.
The evidence base   Please reference the evidence base which you have drawn on   - to support the selection and design of this scheme   - to drive assumptions about impact and outcomes
Evidence of impact of short breaks: http://lx.iriss.org.uk/category/short-break-research-area/evidence-impact-short-breaks-respite-care   Evidence for the Impact of Short Breaks on Carer Well-Being   https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/221938/DCSF-RR222.pdf
Investment requirements   Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Through the Merton BCF programme structure, the Finance and Performance Group monitors the strategic programme indicators (non-elective FFCEs and the HWBB indicators) as well as operational indicators such as service activity and effectiveness.

The group also commissions ad-hoc audits to evaluate specific areas of service delivery in order to gain an understanding of the correlation between operational indicators and strategic indicators in order to evaluate the impact of individual schemes.

What are the key success factors for implementation of this scheme?

Reduction in NEL admission ascribable to carer breakdown.

Patient and service user satisfaction.

Scheme ref no.
Merton 1.5
Scheme name
Investing into Integration Infrastructure (Enabler)
What is the strategic objective of this scheme?
To create an environment where data and records can be shared between appropriate professionals to prevent patients and service users having to repeat their stories multiple times and to provide a more efficient and effective process for data exchange.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support?   - Which patient cohorts are being targeted?
This scheme provides funding towards a multi-agency project to develop information sharing across health and social care across south west London, commissioned from South London Commissioning Support Unit. Organisations must put processes and systems in place to ensure that NHS number 'completeness' is maintained at or above 97.5% as the primary identifier in communications.   It includes funding to facilitate the use of the Coordinate My Care system as a platform to hold common care plans developed by the integrated locality teams, ahead of larger-scale information sharing progress.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
Development of a delivery chain for this is being coordinated with the South West London Commissioning Collaborative and, as such a delivery chain has not yet been agreed. Solutions will be developed among all commissioners.
The evidence base Please reference the evidence base which you have drawn on   - to support the selection and design of this scheme   - to drive assumptions about impact and outcomes
Development of the evidence base is being coordinated with the South West London Commissioning Collaborative and, as such, evidence will be reviewed among all commissioners.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Progress monitored through Merton Integration Board.

What are the key success factors for implementation of this scheme?

- NHS Number becomes the primary method of data sharing for customers/patients between teams within the three integrated MDT localities.
- Meeting or exceeding of the targets set out as part of the *Better Care Fund* for NHS Number completeness.
- Seamless data sharing within integrated locality teams and between health and social care partners.

ANNEXE 2 – Provider commentary

For further detail on how to use this Annexe to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	Merton
Name of Provider organisation	St George's Healthcare NHS Trust
Name of Provider CEO	Miles Scott
Signature (electronic or typed)	Signature on embedded PDF: St George's Sign Off (PDF).pdf

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	16,882
	2014/15 Plan	17,294
	2015/16 Plan	16,517
	14/15 Change compared to 13/14 outturn	+412
	15/16 Change compared to planned 14/15 outturn	-777
	How many non-elective admissions is the BCF planned to prevent in 14-15?	371
	How many non-elective admissions is the BCF planned to prevent in 15-16?	977

For Provider to populate:

	Question	**Response**
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	The planned non-elective admissions reduction of 1,348 (data as above) has been discussed with St. George's Healthcare NHS Trust. Our view is that this is ambitious in comparison to the plans of neighbouring CCGs. Merton already has a population admission rate in the lowest quartile nationally, and there have been changes to the threshold for local emergency admissions over the last 3 years which may make an ambitious target for reduction difficult to deliver. We support this ambition but are concerned that this does present a risk to delivery. Merton CCG has been clear that the mechanism for delivery of the planned reduction in non-elective admissions is entirely through out of hospital

		services.
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	Yes.

ANNEXE 2 – Provider commentary

For further detail on how to use this Annexe to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	Merton
Name of Provider organisation	Epsom and St Helier University Hospitals NHS Trust
Name of Provider CEO	Chrisha Alagaratnam
Signature (electronic or typed)	Signature on embedded PDF: EStH Sign Off (PDF).pdf

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	16,882
	2014/15 Plan	17,294
	2015/16 Plan	16,517
	14/15 Change compared to 13/14 outturn	+412
	15/16 Change compared to planned 14/15 outturn	-777
	How many non-elective admissions is the BCF planned to prevent in 14-15?	371
	How many non-elective admissions is the BCF planned to prevent in 15-16?	977

For Provider to populate:

	Question	**Response**
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	Yes
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	N/A
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	The Trust fully supports the principles of the Better Care Fund and the schemes developed by partner agencies in Merton, led by Merton CCG and the London Borough of Merton to implement integrated

care for the local population. Merton has worked collaboratively with the Acute Trust and other partners to establish clear objectives and agreed metrics across the schemes. There is a programme management approach to monitor the impact at point of delivery in the community settings and we are working with the leads to establish how best to correlate these with acute emergency activity data. We would encourage a focus on data quality and data capture across the schemes, enhanced by clinical audit and user experience feedback.

The Trust is reassured by the detail of the benefits modelling and evaluation. We will build on this work to develop a monitoring framework that contributes to understanding the schemes that demonstrate the greatest impact.

Merton has calculated the target reduction in non-elective admissions at 5.7% which includes a growth of 2.2%. We would like to note that we have seen a 5% growth in year of attendances at St Helier A&E, including the urgent care centre.

Further consideration may need to be given to the changing landscape with the closure of some London A&E departments and the potential impact on other A&E departments.

Contractually, the acute contract will remain as it is under PbR and any discussions regarding risk share and / or performance rewards will be from the default PbR position.

ANNEXE 2 – Provider commentary

For further detail on how to use this Annexe to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	Merton
Name of Provider organisation	SW London and St Georges Mental Health NHS Trust
Name of Provider CEO	David Bradley
Signature (electronic or typed)	David Bradley

For HWB to populate:

Total number of non-elective FFCEs in general & acute	2013/14 Outturn	16,882
	2014/15 Plan	17,294
	2015/16 Plan	16,517
	14/15 Change compared to 13/14 outturn	+412
	15/16 Change compared to planned 14/15 outturn	-777
	How many non-elective admissions is the BCF planned to prevent in 14-15?	371
	How many non-elective admissions is the BCF planned to prevent in 15-16?	977

For Provider to populate:

	Question	Response
1.	Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?	Yes
2.	If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?	
3.	Can you confirm that you have considered the resultant implications on services provided by your organisation?	Yes

The following pages are not part of the formal narrative submission but, for ease, set out a conveniently printable facsimile of the data contained within the 'Part Two' template: 'Technical Submission'.

The official, formal documentation should always be considered as the 'master' version and the following data is provided for convenience only.

TAB: PAYMENT FOR PERFORMANCE

1. Reduction in non elective activity	
	Numbers
Baseline of Non Elective Activity (Q4 13/14 - Q3 14/15)	17,117
Change in Non Elective Activity	-600
% Change in Non Elective Activity	-3.5%

2. Calculation of Performance and NHS Commissioned Ringfenced Funds	
	Figures in £
Financial Value of Non Elective Saving/ Performance Fund	894,000
Combined total of Performance and Ringfenced Funds	3,252,601
Ringfenced Fund	2,358,601
Value of NHS Commissioned Services	5,746,000
Shortfall of Contribution to NHS Commissioned Services	0

2015/16 Quarterly Breakdown of P4P				
	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
Cumulative Quarterly Baseline of Non Elective Activity	4,216	8,457	12,676	17,117
Cumulative Change in Non Elective Activity	-126	-253	-421	-600
Cumulative % Change in Non Elective Activity	-0.7%	-1.5%	-2.5%	-3.5%
Financial Value of Non Elective Saving/ Performance Fund (£)	187,740	189,230	250,320	266,710

TAB 1: HWB FUNDING SOURCES

Source	Gross Contribution (£000)	
	2014/15	**2015/16**
Local Authority Social Services		
Merton	3,428	944
Total Local Authority Contribution	**3,428**	**944**
CCG Minimum Contribution		
NHS Merton CCG		11,254
Total Minimum CCG Contribution	**-**	**11,254**
Additional CCG Contribution		
NHS Merton CCG	**4,420**	
Total Additional CCG Contribution	**4,420**	**-**
Total Contribution	**7,848**	**12,198**

TAB 2: SUMMARY OF HWB SCHEMES

Summary of Total BCF Expenditure (figures in £000)				
	From 3. HWB Expenditure Plan		Please confirm the amount allocated for the protection of adult social care	
	2014/15	**2015/16**	**2014/15**	**2015/16**
Acute	-	-		
Mental Health	-	-		
Community Health	3,231	3,813		
Continuing Care	-	-		
Primary Care	-	-		
Social Care	3,183	6,452	1,877	3,577
Other	1,434	1,933		
Total	**7,848**	**12,198**		**3,577**

Summary of Commissioned Out-of-Hospital Services Spend from MINIMUM BCF Pool		
	From 3. HWB Expenditure Plan	
		2015/16
Mental Health		
Community Health		3,813
Continuing Care		
Primary Care		
Social Care		
Other		1,933
Total		**5,746**

Summary of Benefits			
	From 4. HWB Benefits		From 5. HWB P4P Metric
	2014/15 vs outturn	**2015/16 vs outturn**	**2015/16**
Reduction in permanent residential admissions	(322)	(193)	
Increased effectiveness of reablement	(282)	(154)	
Reduction in delayed transfers of care	(0)	(0)	
Reduction in non-elective (general + acute only)	(442)	(1,441)	894
Other	(20)	(20)	
Total	**(1,066)**	**(1,808)**	**894**

- Merton has accounted for the benefit of preventing the 2.2% forecast growth in non-elective admissions in addition to the benefit of the 3.5% planned reduction of non-elective admissions

TAB 3: HWB EXPENDITURE PLAN

Scheme Name	Area of Spend	Please specify if Other	Commissioner	Provider	Source of Funding	2014/15 (£000)	2015/16 (£000)
Case Management - Proactive Care: Incontinence	Social Care		Local Authority	Charity/ Voluntary Sector	CCG Minimum Contribution	20	20
Case Management - Proactive care: Health Liason officers (x 3)	Social Care		Local Authority	Local Authority	CCG Minimum Contribution	150	150
Case Management - Proactive Care: Telecare	Social Care		Local Authority	Local Authority	CCG Minimum Contribution	400	400
Case Management - Proactive Care: Seven day working	Social Care		Local Authority	Local Authority	CCG Minimum Contribution	240	500
Case Management - Proactive Care: Agewell	Social Care		Local Authority	Charity/ Voluntary Sector	CCG Minimum Contribution	-	80
Prevention of Admission - Reactive care: Equipment	Social Care		Local Authority	Private Sector	CCG Minimum Contribution	200	200
Prevention of Admission - Reactive care: Miles Reablement	Social Care		Local Authority	Local Authority	CCG Minimum Contribution	900	1,400
Prevention of Admission - Reactive care: Miles Reablement	Social Care		Local Authority	Local Authority	CCG Minimum Contribution	100	100
Case Management - Proactive Care: Medication management	Social Care		Local Authority	Private Sector	CCG Minimum Contribution	20	20
Protecting Social Care: Domiciliary Packages	Social Care		Local Authority	Private Sector	CCG Minimum Contribution	800	2,000
Prevention of Admission - Reactive Care: Equipment	Social Care		Local Authority	Private Sector	CCG Minimum Contribution	57	57
Protecting social care: Developing personal and health care budgets	Social Care		Local Authority	Local Authority	CCG Minimum Contribution	-	400
Investing into infrastructure: Data Sharing	Social Care		Local Authority	CCG	CCG Minimum Contribution	28	42
Protecting Social Care: Non-recurrent change fund	Social Care		Local Authority	Local Authority	CCG Minimum Contribution	15	15

TAB 3: HWB EXPENDITURE PLAN

Scheme Name	Area of Spend	Please specify if Other	Commissioner	Provider	Source of Funding	2014/15 (£000)	2015/16 (£000)
Case Management - Proactive Care: Project costs	Social Care		Local Authority	Local Authority	CCG Minimum Contribution	30	30
Case Management - Proactive Care: Project costs	Social Care	MCCG Project Costs	Local Authority	Local Authority	CCG Minimum Contribution	223	94
Case Management - proactive care: Integrated locality teams	Other	Community/ Mental Health/ Voluntary	CCG	NHS Community Provider	CCG Minimum Contribution	607	960
Prevention of admission - reactive care: 7 Day working	Other	Community/ Mental Health/ Voluntary	CCG	NHS Community Provider	CCG Minimum Contribution	110	240
Prevention of admission - reactive care: CPAT	Community Health		CCG	NHS Community Provider	CCG Minimum Contribution	943	1,106
Prevention of admission - reactive care: Community Beds and rehabilitation	Community Health		CCG	NHS Community Provider	CCG Minimum Contribution	2,288	2,707
Investing into infrastructure: Data Sharing	Other	Community/ Primary Care/ Social Care/ Voluntary	CCG	NHS Community Provider	CCG Minimum Contribution	166	182
Protecting Social Care; Carers breaks	Other	Voluntary	CCG	Charity/ Voluntary Sector	CCG Minimum Contribution	551	551
Protecting Social Care: Disabled Facilities Grant	Social Care		Local Authority	Local Authority	Local Authority Social Services	-	944
Total						**7,848**	**12,198**

TAB 4: HWB FINANCIAL BENEFITS PLAN

2014/15								
Benefit achieved from	If other please specifiy	Scheme Name	Organisation to Benefit	Change in activity measure	Unit Price (£)	Total (Saving) (£)	How was the saving value calculated?	How will the savings against plan be monitored?
Reduction in non-elective (general + acute only)		Case management - proactive care	NHS Commissioner	(200)	2,209	(441,800)	10% Reduction of Ambulatory Care Sensitive Admissions	Monitoring of SUS data for Avoidable Ambulatory Care Sensitive conditions
Reduction in permanent residential admissions		Prevention of admission- Reactive care	NHS Commissioner	(171)	938	(160,398)	Impact at HRG level modelled which demonstrated a 49% reduction on conditions that are amenable to treatment outside Acute Settings	Monitoring a set of HRG codes classified as conditions that are amenable to treatment outside Acute Settings
Other	Excess bed days	Prevention of admission- Reactive care	NHS Commissioner	(112)	179	(20,048)	Preventing growth in the number of excess bed days	Monitoring Excess bed days activity across our four major Acute Trusts
Reduction in permanent residential admissions		Protecting Social Care	Local Authority	(5)	32,240	(161,200)	Preventing growth in the number of permanent residential admissions	Monitoring number of new permanent residential admissions and average length of residential admissions
Increased effectiveness of reablement		Protecting Social Care	Local Authority	(132)	2,137	(282,084)	Combined benefit of increasing the number of people offered reablement and the effectiveness of reablement. i.e quantified the value of reablement based on the cost of alternative care	Monthly monitoring of number of people offered Reablement and annual audit of effectiveness of reablement
Reduction in delayed transfers of care		Protecting Social Care	Local Authority	(1)	179	(179)	Preventing growth in the rate of DTOC	Monthly monitoring of number of DTOCs

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TAB 4: HWB FINANCIAL BENEFITS PLAN

	2015/16							
Benefit achieved from	**If other please specifiy**	**Scheme Name**	**Organisation to Benefit**	**Change in activity measure**	**Unit Price (£)**	**Total (Saving) (£)**	**How was the saving value calculated?**	**How will the savings against plan be monitored?**
Reduction in non-elective (general + acute only)		Case management - proactive care	NHS Commissioner	(351)	1,409	(494,559)	%of VHR and HR patients amenable to Case Management	Monitoring admissions data of Very High Risk and High Risk individuals via the Risk Stratification tool
Reduction in non-elective (general + acute only)		Prevention of admission- Reactive care	NHS Commissioner	(635)	1,490	(946,150)	%of admissions for conditions that are amenable to case management	Monitoring a set of HRG codes classified as conditions that are amenable to treatment outside Acute Settings
Other	Excess bed days	In-Reach	NHS Commissioner	(112)	179	(20,048)	Preventing growth in the number of excess bed days	Monitoring Excess bed days activity across our four major Acute Trusts
Reduction in permanent residential admissions		Protecting Social Care	Local Authority	(6)	32,240	(193,440)	Preventing growth in the number of permanent residential admissions	Monitoring number of new permanent residential admissions and average length of residential admissions
Increased effectiveness of reablement		Protecting Social Care	Local Authority	(72)	2,137	(153,864)	Combined benefit of increasing the number of people offered reablement and the effectiveness of reablement. i.e quantified the value of reablement based on the cost of alternative care	Monthly monitoring of number of people offered Reablement and annual audit of effectiveness of reablement
Reduction in delayed transfers of care		Protecting Social Care	Local Authority	(1)	179	(179)	Preventing growth in the rate of DTOC	Monthly monitoring of number of DTOCs

TAB 5: HWB PAY FOR PERFORMANCE (P4P) METRIC

Non - Elective admissions (general and acute)										
Metric		Baseline (14-15 figures are CCG plans)				Pay for performance period				
		Q4 (Jan 14 - Mar 14)	Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)	Q4 (Jan 15 - Mar 15)	Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)
Total non-elective admissions in to hospital (general & acute), all-age, per 100,000 population	Quarterly rate	2,031	2,043	2,032	2,139	1,945	1,956	1,926	2,026	1,919
	Numerator	4,216	4,241	4,219	4,441	4,090	4,114	4,051	4,262	4,090
	Denominator	207,588	207,588	207,588	207,588	210,322	210,322	210,322	210,322	213,187
				P4P annual change in admissions		-600				
				P4P annual change in admissions (%)		**-3.5%**	Average cost of a NEL			
				P4P annual saving		£894,000		**£1,490**		

TAB 5: HWB PAY FOR PERFORMANCE (P4P) METRIC

Non-Elective Admissions Mapped against CCGs										
Contributing CCGs	**CCG baseline activity (14-15 figures are CCG plans)**				**% CCG registered population that has resident population in Merton**	**% Merton resident population that is in CCG registered population**	**Contributing CCG activity**			
	Q4 (Jan 14 - Mar 14)	**Q1** (Apr 14 - Jun 14)	**Q2** (Jul 14 - Sep 14)	**Q3** (Oct 14 - Dec 14)			**Q4** (Jan 14 - Mar 14)	**Q1** (Apr 14 - Jun 14)	**Q2** (Jul 14 - Sep 14)	**Q3** (Oct 14 - Dec 14)
NHS Croydon CCG	9,042	8,244	8,410	8,376	0.5%	0.8%	43	39	40	40
NHS Kingston CCG	3,223	3,158	3,180	3,106	3.6%	3.0%	116	114	114	112
NHS Lambeth CCG	7,181	6,970	7,432	7,128	0.8%	1.3%	58	56	60	57
NHS Merton CCG	3,962	3,965	3,935	4,170	87.8%	82.0%	3,477	3,480	3,454	3,660
NHS Sutton CCG	4,266	3,807	3,860	4,140	3.4%	2.8%	145	129	131	141
NHS Wandsworth CCG	5,999	6,722	6,688	6,859	6.3%	10.1%	377	423	421	431
Total						100%	**4,216**	**4,241**	**4,219**	**4,441**

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TAB 6: HWB SUPPORTING METRICS

Residential Admissions				
Metric		**Baseline (2013/14)**	**Planned 14/15**	**Planned 15/16**
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Annual rate*	**517.6**	**403.2**	**395.3**
	Numerator	125	100	100
	Denominator	23,765	24,800	25,299
	Annual change in admissions		-25	0
	Annual change in admissions %		-20.0%	0.0%

Reablement				
Metric		**Baseline (2013/14)**	**Planned 14/15**	**Planned 15/16**
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Annual rate*	**83.3**	**85.7**	**85.7**
	Numerator	45	60	78
	Denominator	55	70	91
	Annual change in proportion		2.4	0.0
	Annual change in proportion %		2.9%	0.0%

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TAB 6: HWB SUPPORTING METRICS

Delayed transfers of care													
Metric		**13-14 Baseline**				**14/15 plans**				**15-16 plans**			
		Q1 (Apr 13 - Jun 13)	**Q2** (Jul 13 - Sep 13)	**Q3** (Oct 13 - Dec 13)	**Q4** (Jan 14 - Mar 14)	**Q1** (Apr 14 - Jun 14)	**Q2** (Jul 14 - Sep 14)	**Q3** (Oct 14 - Dec 14)	**Q4** (Jan 15 - Mar 15)	**Q1** (Apr 15 - Jun 15)	**Q2** (Jul 15 - Sep 15)	**Q3** (Oct 15 - Dec 15)	**Q4** (Jan 16 - Mar 16)
Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+).	*Quarterly rate*	**288.2**	**264.1**	**247.1**	**161.5**	**287.8**	**263.7**	**247.0**	**161.4**	**287.4**	**263.5**	**246.4**	**161.3**
	Numerator	456	418	391	261	465	426	399	264	470	431	403	267
	Denominator	158,248	158,248	158,248	161,566	161,566	161,566	161,566	163,542	163,542	163,542	163,542	165,579
					Annual change in admissions			*28*		Annual change in admissions			*17*
					Annual change in admissions %			*1.8%*		Annual change in admissions %			*1.1%*

Patient – Service User Experience Metric				
Metric		**Baseline 2013-14**	**Planned 14/15 (if available)**	**Planned 15/16**
1A (ASCOF) Social care-related quality of life Enhancing quality of life for people with care and support needs.	*Metric Value*	18.8	18.8	18.8
	Numerator	36,307	36,307	36,307
	Denominator	1,932	1,932	1,932
Improvement indicated by:	Increase			

TAB 6: HWB SUPPORTING METRICS

Local Metric				
Metric		**Baseline 2013-14**	**Planned 14/15 (if available)**	**Planned 15/16**
BCF 2: 2B(2) -Proportion of older people (65 and over) who were offered a Reablement or Intermediate Care Service during the period October to December	*Metric Value*	0.9	2.0	2.5
	Numerator	30	70	91
	Denominator	3,345	3,480	3,620
Improvement indicated by:	Increase			

== ENDS ==

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Committee: Health and Wellbeing Board

Date: 30 September 2014

Wards: All

Subject: Merton Mental Health Needs Assessment

Lead officer: Dr. Kay Eilbert Director of Public Health

Lead member: Councillor Caroline Cooper-Marbiah, Cabinet Member for Adult Social Care and Health.

Forward Plan reference number:

Contact officer: Dr. Anjan Ghosh, Consultant in Public Health

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Recommendations:

A. That members of the Health and Wellbeing Board agree the two reports:

1. Merton Adult Mental Health Needs Assessment (MMHNA)

2. Supplementary Report on stakeholder event feedback

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1   PURPOSE OF REPORT AND EXECUTIVE SUMMARY

The Merton Adult Mental Health Needs Assessment was commissioned by the Merton Health and Well Being Board (MHWBB) as part of the wider Merton Mental Health Review, to analyse current and future mental health needs to inform commissioning of health, well-being and social care services within Merton.

Executive summary of the MMHNA is included in the appendix 1.

2.   DETAILS

The MMHNA (Merton Mental Health Needs Assessment) aims to:
- describe the size and nature of adult mental health conditions
- describe the nature and extent of health inequalities in both the distribution of mental health illnesses in the population, and in uptake of and access to services
- identify evidence-based interventions and best practice to tackle mental health issues
- describe current health and social care provision and how this compares with best practise interventions
- identify gaps in service provision and make recommendations about how to address them, particularly in relation to reducing health inequalities and inequity.

The MMHNA includes an in-depth data analysis, consultations with services users, carers and service providers, and a review of the literature.

1

A workshop was held on 28th July 2014, with service users, carers, voluntary sector and community organisations, and statutory organisations including key providers, commissioners and mental health professionals in Merton. Hosted by the London Borough of Merton (LBM) and NHS Merton Clinical Commissioning Group (MCCG) and facilitated by Merton Healthwatch, this event obtained views and facilitated discussion about the Merton Adult Mental Health Needs Assessment (MMHNA) findings. In addition to the recommendations from the MMHNA, feedback in this report will support the future commissioning of mental health services in the Borough.

3.   NEXT STEPS

Following the agreement of the HWBB, the two reports will be uploaded on the Public Health Merton council web page. The recommendations and feedback from the reports will be utilised to inform the development of a commissioning plan by the Merton Clinical Commissioning Group, with support from Public Health Merton and other LBM partners.

It is planned to have regular workshops with users and carers regarding mental health services to ensure commissioners hear live messages, and progress on commissioning and service delivery is shared.

4.   ALTERNATIVE OPTIONS

None

5.   CONSULTATION UNDERTAKEN OR PROPOSED

A range of partner organisations participated in the development of the MMHNA through a Task and Finish Group. The MMHNA itself had a qualitative component which involved consultations with service users, carers and providers of mental health services. A large stakeholder event was held as well, in which the MMHNA recommendations were discussed and further feedback was obtained.

As mentioned earlier, an on-going programme of engagement with stakeholders is planned.

6.   TIMETABLE

The next steps include the development of a commissioning plan and further stakeholder workshops. The timescales for this are to be determined.

7.   FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

Costs of the work was managed within existing budgets.

8.   LEGAL AND STATUTORY IMPLICATIONS

2

None

9. **HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS**

None

10. **CRIME AND DISORDER IMPLICATIONS**

None

11. **RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS**

None

12. **BACKGROUND PAPERS**

1. Full report of the Merton Adult Mental Health Needs Assessment

2. Report on the feedback from the stakeholder workshop

APPENDIX 1: EXECUTIVE SUMMARY OF THE MMHNA

Background

The Merton Adult Mental Health Needs Assessment was commissioned by the Merton Health and Well Being Board (MHWBB) as part of the wider Merton Mental Health Review, to analyse current and future mental health needs to inform commissioning of health, well-being and social care services within Merton.

Aims, objectives and methodology

The MMHNA (Merton Mental Health Needs Assessment) aims to:
- describe the size and nature of adult mental health conditions
- describe the nature and extent of health inequalities in both the distribution of mental health illnesses in the population, and in uptake of and access to services
- identify evidence-based interventions and best practice to tackle mental health issues
- describe current health and social care provision and how this compares with best practise interventions
- identify gaps in service provision and make recommendations about how to address them, particularly in relation to reducing health inequalities and inequity.

The MMHNA includes an in-depth data analysis, consultations with services users, carers and service providers, and a review of the literature.

The picture of adult mental health in Merton

Overall Merton does well on many measures of mental health. Merton CCG has lower spend and better outcomes for mental health overall. While the per capita spend on mental health in Merton is much lower than for other CCGs in our ONS cluster (Hounslow, Harrow, Ealing, Redbridge and Barnet) and England, the outcomes overall are good- suggesting that the investments are good value for money.

While Merton is a relatively young borough, the proportion of older people is going to increase. By 2017 there is forecast to be an increase of 2,900 people (11%) in the over 65 age group with an increase of around 1,500 in the over 90 age group[1]. Modelled prevalence indicates that the numbers of people with Common Mental Health Disorders (CMDs) and Severe Mental Illnesses (SMIs) will increase in the next five years, and so will the number of dementia cases. This will place constant and increasing demands on mental health services and underscores the importance of prevention work in mental health.

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[1] Merton Joint Strategic Needs Assessment, 2013-14

Key points

Overall:
- Data suggests that there is under-diagnosis and/or under-recording of depression and dementia in primary care in Merton
- Where Merton is doing particularly well:
  - Recording the diagnosis of a mental health condition
  - Assigning patients to a mental health cluster
  - Having significantly lower A&E attendances for patients with psychiatric disorders
  - Having significantly lower number of bed days,
  - Having a significantly higher rate of carers of mental health clients receiving assessments
- Where Merton not doing so well:
  - Providing newly diagnosed depression patients with severity assessment at the outset of their treatment
  - Having a significantly lower rate than England average of recovery for IAPT treatment (percentage of people completing IAPT who have moved to recovery)
- Merton has a significantly higher than national average percentage of mental health service users that are in-patient in a psychiatric hospital and a significantly lower rate than England average, of people on Care Programme Approach (CPA)
- Merton also has a significantly lower rate of mental health clients receiving community, residential or nursing home care and a significantly lower rate of people in contact with specialist mental health services
- The number of people with mental health conditions is expected to increase in Merton over time for all conditions (Common Mental Disorders, Borderline Personality Disorder, Antisocial Personality Disorder, Psychotic Disorder, and Two or more psychiatric disorder)
- Merton CCG has the lowest reported prevalence of mental health disorders among SW London and statistically similar CCGs
- There are considerable variations in the prevalence of mental health conditions by GP practices and also comparing practices in East and West Merton
- Proportion of adults in contact with secondary mental health services living independently, with or without support is below the London average and the lowest among SW London boroughs. It is second lowest among statistical neighbours

For Common Mental Health Disorders (CMDs):
- Public Health England estimates that Merton has one of the highest percentages of 16-74 years olds estimated to have a common mental health disorder
- Merton has significantly lower than national averages for adults with depression known to GPs, new cases of depression; and lower than national average long term mental health problems, and depression and anxiety among GP survey respondents
- The rate of initial assessment of depression in Merton was significantly lower than the England average while the percentage of adults with a new diagnosis of depression with a follow-up assessment after 4-12 weeks was significantly higher
- Merton performs significantly lower than average at case finding for depression and has a significantly lower than average percentage of people with long term conditions visiting GP who felt that they have had enough support from local services in the last 6 months

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For Severe Mental Illness (SMI):

- Merton has a significantly lower than average number of people with SMI known to GPs
- The rate of contact with services, and day care attendances are significantly lower than average
- Merton has a significantly higher than average percentage of mental health service users who were inpatients in a psychiatric hospital
- Schizophrenia emergency admission rate was significantly higher in Merton than the national average although the data quality had some concerns
- For the percentage of people in contact with mental health services with a crisis plan in place was significantly less in Merton compared with the England average
- Merton rates were significantly lower than the England averages for social care mental health clients receiving services during the year, mental health clients in residential or nursing care, mental health clients receiving home care during the year, and mental health clients receiving day care or day services
- 2012-13 QOF data suggests that there is room for improvement and considerable variance between GP practices overall and between practices in East and West Merton in terms of proxies for caring for the physical health of patients with schizophrenia

For dementia:

- The NHS dementia calculator gives the current diagnosis rate as 47% (2013/14) and a dementia gap of 1,057 cases for 2014/15
- In 2012-13, there were 870 Merton residents on the dementia register out of a total registered population of 217,803. This gives an overall GP recorded prevalence of 0.4% for Merton CCG. The England prevalence is 0.57%
- There is considerable variance between practices and East and West Merton for the observed to expected prevalence ratio

For mental health inequalities in Merton:

- Black ethnicities were over-represented in the in-patient population and Asians under-represented in both the in-patient and Community Mental Health Services (CMHS) populations. This could be indicative of the underlying risks of mental illnesses in different ethnicities- especially in the case of black ethnicities and/or more repeat admissions in this group, but in the case of Asians this very likely indicates an inequity in access, perhaps due to cultural taboos or other reasons
- A majority of in-patients and CMHS patients belonged to the most deprived areas of Merton and most patients came from East Merton
- The majority of patients from West Merton belonged to the least deprived areas
- In terms of referral rates to CMHS, white, black and other ethnicities have comparable referrals rates while the rate in Asians is statistically significantly much lower. For in-patients, Black ethnicities have the highest admission rates in Merton and this is statistically significantly different from admission rates for other ethnicities. Asians have the lowest rate and this too is statistically significantly different from admission rates in white and black ethnicities
- Apart from organic disorders where the least deprived patients have the highest proportion of cases, for all other the major diagnostic groups the more deprived patients have the higher proportion of cases, indicating a positive correlation between mental illnesses and deprivation

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- In all the major primary diagnostic groups there are a higher proportion of patients from East Merton compared with West Merton

For patients in Merton:
- The three top causes for in-patient admission were schizophrenia, followed by psychoactive substances and then mood affective disorders
- The three top causes for CMHS referrals were mood affective disorders, followed by psychoactive substances and then schizophrenia
- Psychoactive substances were the second most common cause for both in-patient admissions and CMH patients in adults overall from 2008-13, as well as the second most common cause for admissions in working age adults. Additionally this category was the most common cause for referrals to CMH in working age adults. In both in-patient admissions and CMHS referrals for substance misuse, a significant majority were due alcohol

Qualitative data: Focus Groups and Semi-structured interviews

Qualitative work was undertaken to ascertain the experiences and views of adult mental health services users, carers and providers in Merton. The study took place between August and October 2013. In all 31 informants participated in the study.

For the most part, service users were critical of mental health services in the borough. This is by no means unusual and is typical of much of the user experience documented in the mental health literature.

Concerns raised in the study included the continuing attitudes towards mental illness, experience of care and cuts in services. Other issues included the closure of drop-in/day centres, perceived powerlessness to influence care and services dominated by a medical approach to treatment. Carers highlighted their lack of involvement in the decision making process. BAME service users and carers reported particular challenges which highlight the importance of developing cultural competence within mainstream services along with more targeted provision specifically. This is a priority for further investigation.

Key themes emerging from the experience of service users and carers included:
- relationships with health professionals and the need for more involvement and empowerment
- communication, including listening, talking and understanding
- cultural competence of the service
- comparisons with services in neighbouring boroughs, especially Sutton and Wandsworth, which are seen as providing better care and a wider range of services

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What are the gaps in Merton?

1. **Equity issue: Under-representation of Asians and over-representation of black minority ethnic groups**
Analysis of the data clearly indicates which groups are the most vulnerable in Merton and which groups needs to be therefore targeted more effectively. Black ethnicities are over-represented (in-patients) and Asians significantly under-represented (both in-patients and Community Mental Health Services-CMHS) in our mental health services. In the case of Asian communities this under-representation suggests inequity in access and cultural taboos and stigma associated with mental illness. In Black ethnicities the over-representation could be due to the underlying risks of mental illness in different ethnicities, but it is possible that a number of patients are being diagnosed later and with more severe symptoms, who could have otherwise been managed in the community. More targeted work is required with these communities and there is a need to develop services that are more accessible to BME groups- especially Asians.

2. **Services that address the dual diagnosis of substance misuse and mental ill-health and hidden harms**
Psychoactive substances are the most common cause for community mental health referrals and the second most common cause for in-patient admissions in working age adults in Merton. The overwhelming majority of these were for alcohol related problems. The issue of dual diagnosis is a significant one for Merton - with so many admissions and referrals due to psychoactive substances, increased focus is required on prevention and early detection in addition to treatment. The 'hidden harms' aspects of this are likely to be considerable, i.e. the impact on children living with parent(s) with dual diagnosis. There could be potential safe-guarding risks, crime-related issues and a wider reputational risk to both London Borough of Merton and the NHS. The hidden harms aspect is not just about dual diagnosis but extends to parents with mental illnesses (and not substance misuse) as well.

3. **Personality disorders (PD)**
Around 8-9% of all in-patient cases and patients in CMHS are seen because of personality disorders. Anecdotal evidence suggests that there are significant numbers of undiagnosed cases of PD in the community, and there needs to be more and better access to psychological treatment (DBT/MBT) for cases of PD and dual diagnosis with PD. Considerable preparatory work is required to get PD cases ready for such therapies.

4. **Primary care variation by practice, variable quality outcomes and under-diagnosis**
Findings suggest that in primary care there is considerable variation by practice, variable quality of outcomes and under-diagnosis. The 2012-13 QOF data for both depression and dementia suggest that at primary care level, there is under-diagnosis of both in Merton, and that there is considerable variation between GP practices especially when comparing the GPs in East Merton (where the data indicates even more under-diagnosis) with those in West Merton.

While the latest HSCIC data on further assessment of depression severity is reported for 2011-12 and is for Sutton and Merton PCT, it suggests that we have the lowest percentage of patients undergoing further assessment of depression in SW London, lower than some

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statistical neighbours and lower than England. 2012-13 QOF data suggests considerable variation by GP practices in Merton, and that in East Merton especially for MH 17 - The percentage of patients on lithium therapy with a record of serum creatinine and TSH in the preceding 9 months, and MH 18 - The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range within the preceding 4 months- there are more practices which have low percentages compared to GP practices elsewhere in Merton.

NHS Dementia Prevalence Calculator indicates that the current detection rate of dementia in Merton is 47% (CQUIN data Q3 2013-14) which is better than many of our geographical and statistical neighbours but still means that there are estimated to be 1,057 undiagnosed dementia cases in Merton in 2014-15. There is an on-going refresh of the Merton dementia strategy to deal effectively with this.

5. **Primary Care management of the physical health of Merton residents with schizophrenia**
Findings suggest that more work is required to ensure the physical health of Merton residents with schizophrenia is better managed at primary care level. While emergency hospital admissions for schizophrenia in Merton are among the lowest in London and lower than all our SW London and statistical neighbours, the 2014 NEPHO SMI profile for Merton indicates that Merton has a significantly higher than average percentage of mental health service users who were inpatients in a psychiatric hospital and that Merton has a significantly higher than average (England) percentage of mental health service users who were inpatients in a psychiatric hospital. Local data indicates that admissions and referrals for schizophrenia are also increasing. This could be reflecting an increase in the prevalence of psychosis in Merton. HSCIC data indicates that in Merton the follow-up of non-attendance at annual review among patients with psychoses is among the lowest in SW London (especially considering that Kingston and Richmond PCTs achieved 100%), lower than Ealing and Harrow PCTs among statistical neighbours, and lower than England. For 2012-13 QOF indicators MH 16 (The percentage of patients aged from 25 to 64 with schizophrenia, bipolar affective disorder and other psychoses whose notes record that a cervical screening test has been performed in the preceding 5 years) and MH19 (The percentage of patients aged 40 years and over with schizophrenia, bipolar affective disorder and other psychoses who have a record of total cholesterol: HDL ratio in the preceding 15 months) the GP practices in Merton do not perform very well and there is considerable variation between practices and by East-West Merton.

6. **Referrals to community mental health services**
In terms of referrals to community mental health services in Merton, 44% were from GPs & the next largest sources of referrals were internal (16%) and then Accident & Emergency services (12%). While it is encouraging that GP referrals were the highest, this could be improved further. Furthermore it appears that GPs in East Merton are making fewer referrals than West Merton GPs. There were fewer referrals from the Merton Local Authority (including Adult Social Care, Education & other departments) combined (2.6%) than Merton residents who self-referred (2.9%) . This perhaps indicates that more training and awareness raising is required for front-line staff (in all sectors including Metropolitan Police) on detecting the signs of mental ill health, local services and pathways, and how and where to refer someone to. The DH policy "No Health Without Mental Health" states

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that frontline workers, across the full range of services, are to be trained to understand better about mental health, the principles of recovery and be able to tackle any stigma related to mental health[2].

7. IAPT services

In terms of IAPT services, Merton has the lowest proportion of cases that moved to recovery in SW London and compared with the London average. From August 2012-August 2013, the recovery rate for Merton was 35.7% against a local target of 43% and a national target of 50%. This has been the case for some years as the NEPHO 2014 community MH profile indicates that in 2012/13 the IAPT recovery rate at 37.9% was significantly worse than England (45.9%). The percentage of referrals waiting less than 28 days for IAPT services are significantly lower than average but in contrast for waiting times greater than 90 days Merton has significantly higher than average percentages. This could mean that more referrals are waiting over 90 days than they are less than 28 days. Merton CCG is undertaking a specific project to look at the IAPT service and how it can be made more effective.

8. Smoking and mental health

Smoking and mental health have very strong and significant links. SWLStG MH NHS Trust has had a CQUIN on smoking since 2010-11 and this ends in March 2014. Data provided by the Trust suggests that an effective smoking cessation service had been established although it was unclear from the data what the disaggregated figures for Merton were. This service is meant to be mainstreamed into SWLStG MHT but there is a risk to the service till it is assured that this has indeed happened.

9. Gaps expressed by service users in consultations

Although the consultations in the qualitative study identified a variety of both positive and negative experiences of mental health services in Merton, the views expressed by service users and carers were for the most part critical. Service users' main concerns in this study were around continuing attitudes to mental illness, experience of care, and cuts in services. Their most prominently expressed issues with Merton's mental health provision were the loss of drop-in/day centres, perceived powerlessness in influencing their care and services that where dominated by a medical approach to treatment.

10. Gaps expressed by carers in consultations

The most important issues for carers were their poor involvement in decisions about the care, properly informed sessions, providing support in the areas of training in managing specific situations. There is no up-to-date carer's strategy for Merton and this needs to be addressed. The triangle of care model must be sustained.

11. Cultural competence of services

BME service users and carers reported particular challenges in different areas, exposing the importance of developing cultural competence within the mainstream services along with targeted provision specifically tailored to their unique needs. The data stated earlier,

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[2] Department of Health published a cross-government strategy on mental health "No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages" in 2011.

(https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/135457/dh_124058.pdf.pdf)

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which shows that black ethnicities were over-represented and Asians significantly under-represented, back this expressed need. Furthermore this is specifically emphasized in the DH policy, "No Health without Mental Health"[3] and the implementation framework[4] which state that services should actively promote equality and must be accessible, acceptable, and culturally appropriate to all the communities. Public Bodies must meet their obligations under the Equality Act 2010.

Service providers offered insights into the main strategies they employed to deliver more user-responsive services. These were:

a. Adopting a more open and candid approach with users informed by the policy recommendations of the Francis report.
b. Established feedback and stepped complaints procedures
c. Developing different ways of working, and
d. Fostering partnership working.

Staff training and education underpinned all four approaches.

Health and social care recommendations

1. Promoting Mental Health and Wellbeing

1.1. **Promoting public mental health**
There is growing emphasis to promote mental wellbeing of the whole population, as well as an on-going commitment to reducing health inequalities in health (there are separate recommendations on health inequalities included in recommendation 4).

a.   It is recommended that steps are taken to promote positive mental health and wellbeing and prevent mental ill-health, taking a life-course approach.

b.   This encompasses taking a whole community approach to recovery, addressing factors that influence mental wellbeing for everyone, whether or not they have a diagnosis; and creating environments and cultures that support wellbeing from schools and colleges, to work places and on the streets.

1.2. **Smoking cessation and healthy lifestyles**
a.   As of 31st March 2014, the CQUIN on smoking cessation services for SWLStG MHT will cease to exist. It must be ensured that the Trust embeds this service in line with NICE public health guidance PH48 and that an on-site stop smoking services continues to be provided.

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[3] Department of Health published a cross-government strategy on mental health "No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages" in 2011.
(https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/135457/dh_124058.pdf.pdf)

[4] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/156084/No-Health-Without-Mental-Health-Implementation-Framework-Report-accessible-version.pdf.pdf

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b. Smoking cessation support to Merton residents with mental ill-health must also be provided by community-based and primary care service and mental health should be mainstreamed within general smoking prevention and cessation programmes in the borough.

c. It is recommended that all patients on GP Practice's SMI register who smoke should be routinely referred to LiveWell for smoking cessation advice.

d. It must be ensured that people with diagnosed mental illnesses, especially psychosis or schizophrenia and those taking antipsychotics are offered a combined healthy eating and physical activity programme by their mental healthcare provider[5].

e. The percentage of adults participating in recommended levels of physical activity is lower in Merton than the London and England averages and this percentage must be increased as the link between physical activity and mental health and wellbeing is well established.

1.3. **Promoting mental wellbeing early in life**
a. The most important opportunities for prevention of mental illness and promotion of mental health wellbeing lie in childhood, many of them in the context of the family. *The most important modifiable risk factor for mental health problems in childhood, and thus in adult life in general, is parenting*[6].

b. The key way to reduce risk in very early childhood is to promote healthy parenting focusing on the quality of parent-infant/child relationships, parenting styles including behaviour management, and infant and child nutrition (including breast-feeding and healthy eating). Parental mental illness and parental lifestyle behaviours such as smoking, and drug and alcohol misuse are important risk factors for childhood mental health problems[7].

c. Schools offer another important opportunity for promotion and prevention. School, school ethos, bullying and teacher wellbeing all have an influence on children's current and future mental health[8]. Mental health promotion programmes that can modify these factors, and also mitigate mental health problems initiated from within the family, must be provided in schools in Merton.

1.4. **Enabling more people with mental ill-health to remain in or move into work**
People with mental ill health frequently experience high levels of unemployment. Conversely people who are not in employment are more susceptible to mental ill health.

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[5] NICE Clinical Guideline CG 178: Psychosis and schizophrenia in adults: treatment and management, Feb 2014
http://www.nice.org.uk/nicemedia/live/14382/66534/66534.pdf

[6] http://www.fph.org.uk/parenting

[7] Göpfert M, Webster J, Seema MV, (eds). Parental psychiatric disorder: distressed parents and their families. Cambridge, CUP 2004

[8] Weare K. Promoting mental, emotional, and social health: a whole school approach. Psychology Press, 2000

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For people with mental ill health who are unable to attend mainstream education, training or work, London Borough of Merton should ensure that commissioned services are effective in providing alternative educational or occupational activities according to their individual needs and capacity to engage with such activities, with an ultimate goal of returning to mainstream education, training or employment.

1.5. **Providing good quality housing**
   a. There is an extensive body of academic, policy-related and community based literature that describes the powerful nature of housing as a social determinant of population health. The relationship that exists between poor housing (or a lack of housing) and poor mental and physical health is well-documented[9][10]. The spectrum of accommodation in Merton, from high to low dependency and independent accommodation for people with mental health need should be reviewed, in order to establish the current needs, to enable forward planning for the future provision of housing and support options for people with mental health needs.

   b. LBM should consider how Merton can benefit from the Department of Health recently allocating up to £43 million from the Care and Support Specialised Housing (CASSH) Fund[11] to support the construction of a small number of housing projects for people with mental health problems or learning disabilities. These projects will be designed in close conjunction with mental health and learning disability policy experts and representatives of relevant charities. Their ambition is to receive bids from potential developers by 2015 and seeing some homes available by 2017.

1.6. **Workplace wellbeing**
   a. All employers in Merton (including in LBM and MCCG) should be sensitive to the potential mental health issues underlying sickness absence. They should ensure adequate occupational health provision, and through employee assistance programmes, employees are supported to prevent the build-up of unmanageable stress, and healthy workplaces are actively promoted. Evidence states that workplace screening for depression and anxiety disorders is cost-effective, with the benefits gained through the reduction in levels of absenteeism, and improved productivity through reduction in presenteeism.

   b. Public Health Merton is currently developing a Merton workforce strategy based on absence research that is looking at the reasons behind the sickness absence rates in the London Borough of Merton (Council). Work related stress comes up in the findings as an important reason. It is recommended that the findings of this report are taken into account while considering measures to create a healthy workplace.

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[9] Jacobs DE, Wilson J, Dixon SL, Smith J, Evens A. *The Relationship of Housing and Population Health: A 30-Year Retrospective Analysis Environmental Health Perspectives*. 2009;117(4):597–604

[10] Canadian Institute for Health Information. *Improving the Health of Canadians: Mental Health and Homelessness*. Ottawa: Canadian Institute for Health Information; 2007.

[11] Closing the gap: priorities for essential change in mental health, February 2014; Department of Health. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281250/Closing_the_gap_V2_-_17_Feb_2014.pdf

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2. Parental and child mental health

The following generic recommendations are sourced from national policy documents[12][13] and it is suggested that the Merton Local Safeguarding Children's Board (LSCB) partners should assure themselves and the LSCB that these are embedded in local practice.

2.1 **The Local Safeguarding Children's Board (LSCB) should assure that**:

Structures are in place for joint training and joint supervision to ensure that all children's and adult services practitioners working with families affected by mental health difficulties and/or drug and alcohol problems have a thorough understanding of the impact of these difficulties on children and the opportunity to reflect together on their joint responsibilities in tackling concerns.

2.2 **Adult mental health services should:**

a. increase awareness of the role of adult mental health professionals in safeguarding the children of adult service users.

b. orient early identification and assessment to ensure children and young people living with parental mental illness, learning disability, substance misuse and domestic violence, are not left in dangerous and abusive situations. Early identification depends on ensuring children and young people have opportunities to discuss their experiences with a trusted adult

c. review recording systems to ensure that information about children is set out clearly and in sufficient detail to establish children's needs and risks, to identify young carers and to assess whether there is a need for early support

d. collate data and report to the LSCB on the numbers of children affected by adult mental health difficulties

e. ensure that managers are aware of all cases in which adults with mental health difficulties have children, or where there are children in the household, and that all these cases have appropriate and recorded oversight.

2.3 **Commissioners of adult mental health services should:**

a. ensure that the role of adult mental health services in safeguarding and protecting children is set out comprehensively and explicitly in all relevant tender documents and in contracts

b. have systems in place to monitor the extent to which adult mental health services meet their responsibilities to safeguard and protect children

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[12] What about the children? Joint working between adult and children's services when parents or carers have mental ill health and/or drug and alcohol problems; Ofsted March 2013, Ref no. 130066.

[13] Cleaver H, Unell I and Aldgate J; Children's Needs- Parenting Capacity, Child Abuse: Parental mental illness, learning disability, substance misuse, and domestic violence; 2nd Edition, TSO (The Stationery Office); Norwich, 2011.

c. Ensure stable funding for voluntary and community based programmes is required to provide the necessary long-term support to ensure children living with families with complex needs are safe

2.4 **Adult mental health services and drug and alcohol services should**:
   a. ensure that practitioners consistently challenge decisions by children's social care to take no further action if in their judgement action is warranted, using escalation processes where necessary

   b. review recording systems to ensure that children and young people who are undertaking inappropriate caring responsibilities for parents or siblings are identified, and that their needs are explicitly considered and referred for support when necessary

   c. ensure that adult assessments consider the need for early support for parents, carers and children and that action is taken to put this in place.

2.5 **Local authorities (Adult and Child Social Services), mental health services and drug and alcohol services should:**
   Ensure that staff liaise with each other and agree a joint plan of action when parents or carers do not attend appointments with adult services.

2.6 **Local authorities (Adult and Child Social Services) and mental health services should**:
   a. improve the quality of assessments of the impact of mental health difficulties on children, ensuring that children's social workers and adult mental health practitioners work together to assess and agree effective action plans

   b. review arrangements for discharging patients from hospitals to ensure that discharge meetings involve children's social workers where appropriate; that the needs of the children are considered and that discharge plans set out clearly when/if parents or carers will be ready to resume the care of their children.

3. Tackling Dementia in Merton

3.1. **Supporting the Dementia Hub**
   With the launch of the Dementia Hub in Merton[14] it must be ensured that relevant services are aware of this centre and how patients with dementia can be referred to it. This is particularly applicable to GP practices as GPs have a pivotal role to play in the early detection and referral of residents of Merton with dementia.

3.2. **Dementia awareness and training**
   Dementia awareness and training sessions with relevant services, especially in primary care must be organised in a rolling programme that is repeated at regular intervals.

3.3. **Dementia strategy refresh**

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[14] http://www.alzheimers.org.uk/site/custom_scripts/branch.php?branch=true&branchCode=13596&areaBC=EALO

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The current five year dementia strategy (for Sutton and Merton) which is due to end in 2015, must be refreshed to reflect the current organisational changes in health and social care, and the dementia strategy implementation plan must be updated.

3.4. **Preventing dementia**

Awareness must be raised of evidence-based measures to prevent dementia (the six pillars of a brain-healthy lifestyle: regular exercise, healthy diet, mental stimulation, quality sleep, stress management and an active social life[15]) to relevant services, professionals and lay public in Merton. Community-based projects or pilots to prevent dementia and promote dementia awareness should be considered.

4. *Improving services for people with a dual diagnosis of substance misuse and mental ill-health*

4.1. **Early identification of dual diagnosis and prevention work**

Developing &/or strengthening services should be considered, to ensure that dual diagnosis of substance misuse and mental ill health is identified early and that there are clear eligibility criteria, referral and care pathways, and robust outcome measures for dual diagnosis

4.2. **Joint service provision and pathways for dual diagnosis**

a. Joint commissioning of mental health and drug or alcohol services needs to become the norm in the areas of general health, mental health, substance misuse (including alcohol), social care, education, community safety, crime (including domestic violence) and safeguarding in both children and adults, linking promotion and prevention much more closely with treatment and care for substance use and mental health.

b. To ensure 4.2a above, all contracts with providers need to stipulate effective joint working and clear pathways, to meet the needs of people with co-existing mental health needs and substance misuse problems.

4.3. **"Hidden harms" of substance misuse**

LBM is planning a needs assessment on Hidden Harm in Merton. It is recommended that appropriate services are jointly developed; to tackle hidden harm and support this needs assessment, considering its recommendations in the development of this work. A dual diagnosis in one or both parents or caregivers has significant impacts on children living with them. The hidden harms aspect is not just about dual diagnosis but extends to parents with mental illnesses (and not substance misuse) as well.

4.4. **Personality disorders (PD)- with and without dual diagnosis**

Around 8-9% of all in-patient cases and patients in CMHS are seen because of personality disorders. Anecdotal evidence suggests that there are significant numbers of undiagnosed cases of PD in the community, and there needs to be more and better access to psychological treatment (DBT/MBT) for cases of PD and dual diagnosis with PD. Considerable preparatory work is required to get PD cases ready for such therapies.

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[15] http://www.helpguide.org/elder/alzheimers_prevention_slowing_down_treatment.htm

5. Addressing Health inequalities and inequity

5.1. Black and Minority Ethnic groups

The findings from this report indicate that black communities are over-represented in in-patient services (but not in CMHS) and Asians are significantly under-represented in both in-patient and community mental health services. A range of early intervention and support services should be considered that are culturally sensitive to Merton's BME groups that promote mental health wellbeing and reduce stigma. The services should be targeted and outcome specific.

5.2. Local care pathways

It should be ensured that local care pathways promote access to the services by wider communities including socially excluded groups such as black and minority ethnic groups, older people, those in prison or in contact with the criminal justice system and ex-service personnel.

5.3. Services for older people

a. It has been estimated that at any given time in a typical 500-bed district general hospital, 220 beds are occupied by older people with mental health problems: 102 with dementia and 96 with depression[16]. Services and pathways should be developed to address the specific needs of older adults in Merton and these services should be appropriate for this age group, helping to reduce the demand on acute beds by increasing care for the frail and elderly in community settings, providing a holistic assessment in the community, and ensuring that both mental and physical health are addressed..

b. Rather than the current generic system in Merton, a specialist liaison psychiatry service for older people based in acute hospitals could be developed. Mental health liaison services can help increase productivity in acute hospitals by improving older people's clinical outcomes while reducing length of stay and re-admission rates[17].

c. Development in this area should be linked with the on-going integration work in Merton under the Better Care Fund.

6. Improving engagement with and support for service users and carers

6.1. Education and Training of front-line staff

It must be ensured that frontline workers, across the full range of services, are trained to understand better about mental health, the principles of recovery and are able to tackle any stigma related to mental health. Furthermore training must be provided on the

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[16] Anderson D, Banerjee S, Barker A, Connelly P, Junaid O, Series H, Seymour J (2009). The Need to Tackle Age Discrimination in Mental Health: A compendium of evidence. London: Faculty of Old Age Psychiatry, Royal College of Psychiatrists. Available at:
www.rcpsych.ac.uk/pdf/Royal%20College%20of%20Psychiatrists%20%20The%20Need%20to%20Tackle%20Age%20Discrimination%20in%20Mental%20Health%20Services%20-%20Oct09.pdf

[17] Naylor C, Bell A (2010); Mental Health And The Productivity Challenge, Improving quality and value for money; The King's Fund and Centre for Mental Health.

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services that exist in Merton, the care pathways and how to refer a person to the appropriate mental health services.

6.2. **Education and Training of healthcare professionals in primary care**

Healthcare professionals in primary care including GPs need training and education in order to better recognise mental ill health, engage and support patients on this, and accord parity of esteem to mental ill health. Consultations with service users revealed that primary care professionals were perceived by some to have an inadequate understanding of mental illness, and service users reporting a negative experience on the whole.

6.3. **Carer needs**

Consultations with carers revealed that pro-active information-sharing and guidance, their involvement in decisions about the care provided, properly informed sessions and providing support/training in managing specific conditions were the most important issues for them. Feedback from the carers indicated that these arrangements and provisions were not as good as they needed to be. It needs to be ensured that these provisions are improved for carers. There is no up-to-date carer's strategy for Merton and this needs to be addressed. The triangle of care model must be sustained.

6.4. **Enabling access to services for Merton residents with mental health conditions**

Service users and carers in our consultations felt that not having the Freedom Pass severely limited their ability to get around and could contribute to a worsening of their problems. Many mental health service users are not in employment or on low incomes and they struggle with the cost of transport. It is recommended that the London Borough of Merton takes steps to enable Merton residents with mental ill-health to access services that are so vital for their wellbeing, bearing in mind that the Freedom Pass is no longer available.

7. *Primary care and IAPT services*

7.1. **Variation in quality and under-diagnosis in Primary Care**

Variations in quality and under-diagnosis need to be understood in greater depth (i.e. how much is due to differences in coding and how much is actual) and minimised in primary care, particularly in GP practices in East Merton. In the consultations in this needs assessment both service users and carers expressed the view that health services continue to give less attention to mental illnesses than to physical illnesses and primary care professionals had an inadequate understanding of mental illness. Health professionals in primary care (including GPs) need training and education in order to better recognise mental ill health, engage and support patients on this, and accord parity of esteem to mental ill health.

7.2. **Physical health of Merton residents with mental ill-health**

The physical health of Merton residents with mental health conditions needs to be monitored regularly. NICE guidance CG 178 recommends that GPs and other primary healthcare professionals should monitor the physical health of people with psychosis or schizophrenia when responsibility for monitoring is transferred from secondary care, and

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then at least annually. The physical health of patients with schizophrenia in particular needs to be better managed in Primary Care.

7.3. **Transfer of care from secondary to primary care**
The transition between secondary care and primary care in relation to all mental illnesses but specially schizophrenia must be well managed.

7.4. **Primary Care integration**
There must be more integration of mental health related services in primary care between health, social care, housing, employment, legal services and community services. This includes greater integration between physical and mental health, and the early identification of illness and comorbidity, reduced stigma, and social inclusion.

7.5. **Psychological therapies**
There are a number of issues around the current IAPT service that are being addressed by the Merton CCG. These include consistently low recovery rates against local and national targets, and the profile of cases being seen tending to belong to the more severe spectrum of mental disorders. Merton CCG is undertaking a specific programme of work that is reviewing the IAPT service and considering how to make it more effective.

8. *Improving rehabilitation and stepped down provision*

8.1. There is a need to undertake a more detailed piece of work to understand the current step-down provision from acute services when patients are well enough to be discharged from an acute bed but not well enough to live independently at home. This work will help to consider alternative options and to design a provision that is fit for purpose, mindful of the principle of "Right Care at the Right Place" and commissioning services closer to home and in the least restrictive environment.

8.2. Co-ordinated working with LB Merton will be required to understand the demand and capacity for step-down placements for social care needs, including housing.

9. *Areas where more research required*

While this report covers a wide expanse of issues pertinent to adult mental health in Merton, there are some areas that are not covered and need more work. These areas are learning disabilities, the interface between children and adult mental health services (especially the transition) and in general there is need for a CAMHS health needs assessment.

Beyond the MMHNA: Next steps

The MMHNA will be reported to the MHWBB in September 2014, and form part of the evidence base for commissioning future mental health services for Merton residents.

A workshop was held with service users, carers, voluntary sector and community organisations, and statutory organisations including key providers, commissioners and mental health professionals in Merton. Hosted by the LBM and MCCG and facilitated by Merton Healthwatch, this workshop obtained views and facilitated discussion about the MMHNA findings. Feedback from participants (see supplementary report) will also support the future commissioning of mental health services in the Borough.

It is planned to have regular workshops with users and carers regarding mental health services to ensure commissioners hear live messages, and progress on commissioning and service delivery is shared.

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Merton
Adult Mental Health Needs Assessment
2013-14
Public Health Merton

London Borough of Merton

Author
Dr. Anjan Ghosh, Consultant in Public Health,
Public Health Merton

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Executive Summary

Background

The Merton Adult Mental Health Needs Assessment was commissioned by the Merton Health and Well Being Board (MHWBB) as part of the wider Merton Mental Health Review, to analyse current and future mental health needs to inform commissioning of health, well-being and social care services within Merton.

Aims, objectives and methodology

The MMHNA (Merton Mental Health Needs Assessment) aims to:
- describe the size and nature of adult mental health conditions
- describe the nature and extent of health inequalities in both the distribution of mental health illnesses in the population, and in uptake of and access to services
- identify evidence-based interventions and best practice to tackle mental health issues
- describe current health and social care provision and how this compares with best practise interventions
- identify gaps in service provision and make recommendations about how to address them, particularly in relation to reducing health inequalities and inequity.

The MMHNA includes an in-depth data analysis, consultations with services users, carers and service providers, and a review of the literature.

The picture of adult mental health in Merton

Overall Merton does well on many measures of mental health. Merton CCG has lower spend and better outcomes for mental health overall. While the per capita spend on mental health in Merton is much lower than for other CCGs in our ONS cluster (Hounslow, Harrow, Ealing, Redbridge and Barnet) and England, the outcomes overall are good- suggesting that the investments are good value for money.

While Merton is a relatively young borough, the proportion of older people is going to increase. By 2017 there is forecast to be an increase of 2,900 people (11%) in the over 65 age group with an increase of around 1,500 in the over 90 age group[1]. Modelled prevalence indicates that the numbers of people with Common Mental Health Disorders (CMDs) and Severe Mental Illnesses (SMIs) will increase in the next five years, and so will the number of dementia cases. This will place constant and increasing demands on mental health services and underscores the importance of prevention work in mental health.

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[1] Merton Joint Strategic Needs Assessment, 2013-14

Key points

Overall:
- Data suggests that there is under-diagnosis and/or under-recording of depression and dementia in primary care in Merton
- Where Merton is doing particularly well:
    - Recording the diagnosis of a mental health condition
    - Assigning patients to a mental health cluster
    - Having significantly lower A&E attendances for patients with psychiatric disorders
    - Having significantly lower number of bed days,
    - Having a significantly higher rate of carers of mental health clients receiving assessments
- Where Merton not doing so well:
    - Providing newly diagnosed depression patients with severity assessment at the outset of their treatment
    - Having a significantly lower rate than England average of recovery for IAPT treatment (percentage of people completing IAPT who have moved to recovery)
- Merton has a significantly higher than national average percentage of mental health service users that are in-patient in a psychiatric hospital and a significantly lower rate than England average, of people on Care Programme Approach (CPA)
- Merton also has a significantly lower rate of mental health clients receiving community, residential or nursing home care and a significantly lower rate of people in contact with specialist mental health services
- The number of people with mental health conditions is expected to increase in Merton over time for all conditions (Common Mental Disorders, Borderline Personality Disorder, Antisocial Personality Disorder, Psychotic Disorder, and Two or more psychiatric disorder)
- Merton CCG has the lowest reported prevalence of mental health disorders among SW London and statistically similar CCGs
- There are considerable variations in the prevalence of mental health conditions by GP practices and also comparing practices in East and West Merton
- Proportion of adults in contact with secondary mental health services living independently, with or without support is below the London average and the lowest among SW London boroughs. It is second lowest among statistical neighbours

For Common Mental Health Disorders (CMDs):
- Public Health England estimates that Merton has one of the highest percentages of 16-74 years olds estimated to have a common mental health disorder
- Merton has significantly lower than national averages for adults with depression known to GPs, new cases of depression; and lower than national average long term mental health problems, and depression and anxiety among GP survey respondents
- The rate of initial assessment of depression in Merton was significantly lower than the England average while the percentage of adults with a new diagnosis of depression with a follow-up assessment after 4-12 weeks was significantly higher
- Merton performs significantly lower than average at case finding for depression and has a significantly lower than average percentage of people with long term conditions visiting GP who felt that they have had enough support from local services in the last 6 months

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For Severe Mental Illness (SMI):

- Merton has a significantly lower than average number of people with SMI known to GPs
- The rate of contact with services, and day care attendances are significantly lower than average
- Merton has a significantly higher than average percentage of mental health service users who were inpatients in a psychiatric hospital
- Schizophrenia emergency admission rate was significantly higher in Merton than the national average although the data quality had some concerns
- For the percentage of people in contact with mental health services with a crisis plan in place was significantly less in Merton compared with the England average
- Merton rates were significantly lower than the England averages for social care mental health clients receiving services during the year, mental health clients in residential or nursing care, mental health clients receiving home care during the year, and mental health clients receiving day care or day services
- 2012-13 QOF data suggests that there is room for improvement and considerable variance between GP practices overall and between practices in East and West Merton in terms of proxies for caring for the physical health of patients with schizophrenia

For dementia:

- The NHS dementia calculator gives the current diagnosis rate as 47% (2013/14) and a dementia gap of 1,057 cases for 2014/15
- In 2012-13, there were 870 Merton residents on the dementia register out of a total registered population of 217,803. This gives an overall GP recorded prevalence of 0.4% for Merton CCG. The England prevalence is 0.57%
- There is considerable variance between practices and East and West Merton for the observed to expected prevalence ratio

For mental health inequalities in Merton:

- Black ethnicities were over-represented in the in-patient population and Asians under-represented in both the in-patient and Community Mental Health Services (CMHS) populations. This could be indicative of the underlying risks of mental illnesses in different ethnicities- especially in the case of black ethnicities and/or more repeat admissions in this group, but in the case of Asians this very likely indicates an inequity in access, perhaps due to cultural taboos or other reasons
- A majority of in-patients and CMHS patients belonged to the most deprived areas of Merton and most patients came from East Merton
- The majority of patients from West Merton belonged to the least deprived areas
- In terms of referral rates to CMHS, white, black and other ethnicities have comparable referrals rates while the rate in Asians is statistically significantly much lower. For in-patients, Black ethnicities have the highest admission rates in Merton and this is statistically significantly different from admission rates for other ethnicities. Asians have the lowest rate and this too is statistically significantly different from admission rates in white and black ethnicities
- Apart from organic disorders where the least deprived patients have the highest proportion of cases, for all other the major diagnostic groups the more deprived patients have the higher proportion of cases, indicating a positive correlation between mental illnesses and deprivation

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- In all the major primary diagnostic groups there are a higher proportion of patients from East Merton compared with West Merton

For patients in Merton:
- The three top causes for in-patient admission were schizophrenia, followed by psychoactive substances and then mood affective disorders
- The three top causes for CMHS referrals were mood affective disorders, followed by psychoactive substances and then schizophrenia
- Psychoactive substances were the second most common cause for both in-patient admissions and CMH patients in adults overall from 2008-13, as well as the second most common cause for admissions in working age adults. Additionally this category was the most common cause for referrals to CMH in working age adults. In both in-patient admissions and CMHS referrals for substance misuse, a significant majority were due alcohol

Qualitative data: Focus Groups and Semi-structured interviews

Qualitative work was undertaken to ascertain the experiences and views of adult mental health services users, carers and providers in Merton. The study took place between August and October 2013. In all 31 informants participated in the study.

For the most part, service users were critical of mental health services in the borough. This is by no means unusual and is typical of much of the user experience documented in the mental health literature.

Concerns raised in the study included the continuing attitudes towards mental illness, experience of care and cuts in services. Other issues included the closure of drop-in/day centres, perceived powerlessness to influence care and services dominated by a medical approach to treatment. Carers highlighted their lack of involvement in the decision making process. BAME service users and carers reported particular challenges which highlight the importance of developing cultural competence within mainstream services along with more targeted provision specifically. This is a priority for further investigation.

Key themes emerging from the experience of service users and carers included:
- relationships with health professionals and the need for more involvement and empowerment
- communication, including listening, talking and understanding
- cultural competence of the service
- comparisons with services in neighbouring boroughs, especially Sutton and Wandsworth, which are seen as providing better care and a wider range of services

What are the gaps in Merton?

1. **Equity issue: Under-representation of Asians and over-representation of black minority ethnic groups**
    Analysis of the data clearly indicates which groups are the most vulnerable in Merton and which groups needs to be therefore targeted more effectively. Black ethnicities are over-represented (in-patients) and Asians significantly under-represented (both in-patients and Community Mental Health Services-CMHS) in our mental health services. In the case of Asian communities this under-representation suggests inequity in access and cultural taboos and stigma associated with mental illness. In Black ethnicities the over-representation could be due to the underlying risks of mental illness in different ethnicities, but it is possible that a number of patients are being diagnosed later and with more severe symptoms, who could have otherwise been managed in the community. More targeted work is required with these communities and there is a need to develop services that are more accessible to BME groups- especially Asians.

2. **Services that address the dual diagnosis of substance misuse and mental ill-health and hidden harms**
    Psychoactive substances are the most common cause for community mental health referrals and the second most common cause for in-patient admissions in working age adults in Merton. The overwhelming majority of these were for alcohol related problems. The issue of dual diagnosis is a significant one for Merton - with so many admissions and referrals due to psychoactive substances, increased focus is required on prevention and early detection in addition to treatment. The 'hidden harms' aspects of this are likely to be considerable, i.e. the impact on children living with parent(s) with dual diagnosis. There could be potential safe-guarding risks, crime-related issues and a wider reputational risk to both London Borough of Merton and the NHS. The hidden harms aspect is not just about dual diagnosis but extends to parents with mental illnesses (and not substance misuse) as well.

3. **Personality disorders (PD)**
    Around 8-9% of all in-patient cases and patients in CMHS are seen because of personality disorders. Anecdotal evidence suggests that there are significant numbers of undiagnosed cases of PD in the community, and there needs to be more and better access to psychological treatment (DBT/MBT) for cases of PD and dual diagnosis with PD. Considerable preparatory work is required to get PD cases ready for such therapies.

4. **Primary care variation by practice, variable quality outcomes and under-diagnosis**
    Findings suggest that in primary care there is considerable variation by practice, variable quality of outcomes and under-diagnosis. The 2012-13 QOF data for both depression and dementia suggest that at primary care level, there is under-diagnosis of both in Merton, and that there is considerable variation between GP practices especially when comparing the GPs in East Merton (where the data indicates even more under-diagnosis) with those in West Merton.

    While the latest HSCIC data on further assessment of depression severity is reported for 2011-12 and is for Sutton and Merton PCT, it suggests that we have the lowest

percentage of patients undergoing further assessment of depression in SW London, lower than some statistical neighbours and lower than England. 2012-13 QOF data suggests considerable variation by GP practices in Merton, and that in East Merton especially for MH 17 - The percentage of patients on lithium therapy with a record of serum creatinine and TSH in the preceding 9 months, and MH 18 - The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range within the preceding 4 months- there are more practices which have low percentages compared to GP practices elsewhere in Merton.

NHS Dementia Prevalence Calculator indicates that the current detection rate of dementia in Merton is 47% (CQUIN data Q3 2013-14) which is better than many of our geographical and statistical neighbours but still means that there are estimated to be 1,057 undiagnosed dementia cases in Merton in 2014-15. There is an on-going refresh of the Merton dementia strategy to deal effectively with this.

5. **Primary Care management of the physical health of Merton residents with schizophrenia**

Findings suggest that more work is required to ensure the physical health of Merton residents with schizophrenia is better managed at primary care level. While emergency hospital admissions for schizophrenia in Merton are among the lowest in London and lower than all our SW London and statistical neighbours, the 2014 NEPHO SMI profile for Merton indicates that Merton has a significantly higher than average percentage of mental health service users who were inpatients in a psychiatric hospital and that Merton has a significantly higher than average (England) percentage of mental health service users who were inpatients in a psychiatric hospital. Local data indicates that admissions and referrals for schizophrenia are also increasing. This could be reflecting an increase in the prevalence of psychosis in Merton. HSCIC data indicates that in Merton the follow-up of non-attendance at annual review among patients with psychoses is among the lowest in SW London (especially considering that Kingston and Richmond PCTs achieved 100%), lower than Ealing and Harrow PCTs among statistical neighbours, and lower than England. For 2012-13 QOF indicators MH 16 (The percentage of patients aged from 25 to 64 with schizophrenia, bipolar affective disorder and other psychoses whose notes record that a cervical screening test has been performed in the preceding 5 years) and MH19 (The percentage of patients aged 40 years and over with schizophrenia, bipolar affective disorder and other psychoses who have a record of total cholesterol: HDL ratio in the preceding 15 months) the GP practices in Merton do not perform very well and there is considerable variation between practices and by East-West Merton.

6. **Referrals to community mental health services**

In terms of referrals to community mental health services in Merton, 44% were from GPs & the next largest sources of referrals were internal (16%) and then Accident & Emergency services (12%). While it is encouraging that GP referrals were the highest, this could be improved further. Furthermore it appears that GPs in East Merton are making fewer referrals than West Merton GPs. There were fewer referrals from the Merton Local Authority (including Adult Social Care, Education & other departments) combined (2.6%) than Merton residents who self-referred (2.9%) . This perhaps indicates that more training and awareness raising is required for front-line staff (in all sectors

including Metropolitan Police) on detecting the signs of mental ill health, local services and pathways, and how and where to refer someone to. The DH policy "No Health Without Mental Health" states that frontline workers, across the full range of services, are to be trained to understand better about mental health, the principles of recovery and be able to tackle any stigma related to mental health[2].

7. **IAPT services**

In terms of IAPT services, Merton has the lowest proportion of cases that moved to recovery in SW London and compared with the London average. From August 2012-August 2013, the recovery rate for Merton was 35.7% against a local target of 43% and a national target of 50%. This has been the case for some years as the NEPHO 2014 community MH profile indicates that in 2012/13 the IAPT recovery rate at 37.9% was significantly worse than England (45.9%). The percentage of referrals waiting less than 28 days for IAPT services are significantly lower than average but in contrast for waiting times greater than 90 days Merton has significantly higher than average percentages. This could mean that more referrals are waiting over 90 days than they are less than 28 days. Merton CCG is undertaking a specific project to look at the IAPT service and how it can be made more effective.

8. **Smoking and mental health**

Smoking and mental health have very strong and significant links. SWLStG MH NHS Trust has had a CQUIN on smoking since 2010-11 and this ends in March 2014. Data provided by the Trust suggests that an effective smoking cessation service had been established although it was unclear from the data what the disaggregated figures for Merton were. This service is meant to be mainstreamed into SWLStG MHT but there is a risk to the service till it is assured that this has indeed happened.

9. **Gaps expressed by service users in consultations**

Although the consultations in the qualitative study identified a variety of both positive and negative experiences of mental health services in Merton, the views expressed by service users and carers were for the most part critical. Service users' main concerns in this study were around continuing attitudes to mental illness, experience of care, and cuts in services. Their most prominently expressed issues with Merton's mental health provision were the loss of drop-in/day centres, perceived powerlessness in influencing their care and services that where dominated by a medical approach to treatment.

10. **Gaps expressed by carers in consultations**

The most important issues for carers were their poor involvement in decisions about the care, properly informed sessions, providing support in the areas of training in managing specific situations. There is no up-to-date carer's strategy for Merton and this needs to be addressed. The triangle of care model must be sustained.

11. **Cultural competence of services**

BME service users and carers reported particular challenges in different areas, exposing the importance of developing cultural competence within the mainstream services along

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[2] Department of Health published a cross-government strategy on mental health "No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages" in 2011. (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/135457/dh_124058.pdf.pdf)

with targeted provision specifically tailored to their unique needs. The data stated earlier, which shows that black ethnicities were over-represented and Asians significantly under-represented, back this expressed need. Furthermore this is specifically emphasized in the DH policy, "No Health without Mental Health"[3] and the implementation framework[4] which state that services should actively promote equality and must be accessible, acceptable, and culturally appropriate to all the communities. Public Bodies must meet their obligations under the Equality Act 2010.

Service providers offered insights into the main strategies they employed to deliver more user-responsive services. These were:

a. Adopting a more open and candid approach with users informed by the policy recommendations of the Francis report.
b. Established feedback and stepped complaints procedures
c. Developing different ways of working, and
d. Fostering partnership working.

Staff training and education underpinned all four approaches.

Health and social care recommendations

1. Promoting Mental Health and Wellbeing

1.1. **Promoting public mental health**
There is growing emphasis to promote mental wellbeing of the whole population, as well as an on-going commitment to reducing health inequalities in health (there are separate recommendations on health inequalities included in recommendation 4).

   a. It is recommended that steps are taken to promote positive mental health and wellbeing and prevent mental ill-health, taking a life-course approach.

   b. This encompasses taking a whole community approach to recovery, addressing factors that influence mental wellbeing for everyone, whether or not they have a diagnosis; and creating environments and cultures that support wellbeing from schools and colleges, to work places and on the streets.

1.2. **Smoking cessation and healthy lifestyles**
   a. As of 31st March 2014, the CQUIN on smoking cessation services for SWLStG MHT will cease to exist. It must be ensured that the Trust embeds this service in line with NICE public health guidance PH48 and that an on-site stop smoking services continues to be provided.

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[3] Department of Health published a cross-government strategy on mental health "No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages" in 2011. (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/135457/dh_124058.pdf.pdf)
[4] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/156084/No-Health-Without-Mental-Health-Implementation-Framework-Report-accessible-version.pdf.pdf

b. Smoking cessation support to Merton residents with mental ill-health must also be provided by community-based and primary care service and mental health should be mainstreamed within general smoking prevention and cessation programmes in the borough.

c. It is recommended that all patients on GP Practice's SMI register who smoke should be routinely referred to LiveWell for smoking cessation advice.

d. It must be ensured that people with diagnosed mental illnesses, especially psychosis or schizophrenia and those taking antipsychotics are offered a combined healthy eating and physical activity programme by their mental healthcare provider[5].

e. The percentage of adults participating in recommended levels of physical activity is lower in Merton than the London and England averages and this percentage must be increased as the link between physical activity and mental health and wellbeing is well established.

1.3. **Promoting mental wellbeing early in life**
   a. The most important opportunities for prevention of mental illness and promotion of mental health wellbeing lie in childhood, many of them in the context of the family. *The most important modifiable risk factor for mental health problems in childhood, and thus in adult life in general, is parenting*[6].

   b. The key way to reduce risk in very early childhood is to promote healthy parenting focusing on the quality of parent-infant/child relationships, parenting styles including behaviour management, and infant and child nutrition (including breast-feeding and healthy eating). Parental mental illness and parental lifestyle behaviours such as smoking, and drug and alcohol misuse are important risk factors for childhood mental health problems[7].

   c. Schools offer another important opportunity for promotion and prevention. School, school ethos, bullying and teacher wellbeing all have an influence on children's current and future mental health[8]. Mental health promotion programmes that can modify these factors, and also mitigate mental health problems initiated from within the family, must be provided in schools in Merton.

1.4. **Enabling more people with mental ill-health to remain in or move into work**
   People with mental ill health frequently experience high levels of unemployment. Conversely people who are not in employment are more susceptible to mental ill health. For people with mental ill health who are unable to attend mainstream education, training or work, London Borough of Merton should ensure that commissioned services

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[5] NICE Clinical Guideline CG 178: Psychosis and schizophrenia in adults: treatment and management, Feb 2014 http://www.nice.org.uk/nicemedia/live/14382/66534/66534.pdf
[6] http://www.fph.org.uk/parenting
[7] Göpfert M, Webster J, Seema MV, (eds). Parental psychiatric disorder: distressed parents and their families. Cambridge, CUP 2004
[8] Weare K. Promoting mental, emotional, and social health: a whole school approach. Psychology Press, 2000

are effective in providing alternative educational or occupational activities according to their individual needs and capacity to engage with such activities, with an ultimate goal of returning to mainstream education, training or employment.

1.5. **Providing good quality housing**
   a. There is an extensive body of academic, policy-related and community based literature that describes the powerful nature of housing as a social determinant of population health. The relationship that exists between poor housing (or a lack of housing) and poor mental and physical health is well-documented[9][10]. The spectrum of accommodation in Merton, from high to low dependency and independent accommodation for people with mental health need should be reviewed, in order to establish the current needs, to enable forward planning for the future provision of housing and support options for people with mental health needs.

   b. LBM should consider how Merton can benefit from the Department of Health recently allocating up to £43 million from the Care and Support Specialised Housing (CASSH) Fund[11] to support the construction of a small number of housing projects for people with mental health problems or learning disabilities. These projects will be designed in close conjunction with mental health and learning disability policy experts and representatives of relevant charities. Their ambition is to receive bids from potential developers by 2015 and seeing some homes available by 2017.

1.6. **Workplace wellbeing**
   a. All employers in Merton (including in LBM and MCCG) should be sensitive to the potential mental health issues underlying sickness absence. They should ensure adequate occupational health provision, and through employee assistance programmes, employees are supported to prevent the build-up of unmanageable stress, and healthy workplaces are actively promoted. Evidence states that workplace screening for depression and anxiety disorders is cost-effective, with the benefits gained through the reduction in levels of absenteeism, and improved productivity through reduction in presenteeism.

   b. Public Health Merton is currently developing a Merton workforce strategy based on absence research that is looking at the reasons behind the sickness absence rates in the London Borough of Merton (Council). Work related stress comes up in the findings as an important reason. It is recommended that the findings of this report are taken into account while considering measures to create a healthy workplace.

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[9] Jacobs DE, Wilson J, Dixon SL, Smith J, Evens A. *The Relationship of Housing and Population Health: A 30-Year Retrospective Analysis Environmental Health Perspectives*. 2009;117(4):597–604
[10] Canadian Institute for Health Information. *Improving the Health of Canadians: Mental Health and Homelessness*. Ottawa: Canadian Institute for Health Information; 2007.
[11] Closing the gap: priorities for essential change in mental health, February 2014; Department of Health. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281250/Closing_the_gap_V2_-_17_Feb_2014.pdf

2. *Parental and child mental health*

The following generic recommendations are sourced from national policy documents[12] [13] and it is suggested that the Merton Local Safeguarding Children's Board (LSCB) partners should assure themselves and the LSCB that these are embedded in local practice.

2.1 The Local Safeguarding Children's Board (LSCB) should assure that:

Structures are in place for joint training and joint supervision to ensure that all children's and adult services practitioners working with families affected by mental health difficulties and/or drug and alcohol problems have a thorough understanding of the impact of these difficulties on children and the opportunity to reflect together on their joint responsibilities in tackling concerns.

2.2 Adult mental health services should:

a. increase awareness of the role of adult mental health professionals in safeguarding the children of adult service users.

b. orient early identification and assessment to ensure children and young people living with parental mental illness, learning disability, substance misuse and domestic violence, are not left in dangerous and abusive situations. Early identification depends on ensuring children and young people have opportunities to discuss their experiences with a trusted adult

c. review recording systems to ensure that information about children is set out clearly and in sufficient detail to establish children's needs and risks, to identify young carers and to assess whether there is a need for early support

d. collate data and report to the LSCB on the numbers of children affected by adult mental health difficulties

e. ensure that managers are aware of all cases in which adults with mental health difficulties have children, or where there are children in the household, and that all these cases have appropriate and recorded oversight.

2.3 Commissioners of adult mental health services should:

a. ensure that the role of adult mental health services in safeguarding and protecting children is set out comprehensively and explicitly in all relevant tender documents and in contracts

b. have systems in place to monitor the extent to which adult mental health services meet their responsibilities to safeguard and protect children

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[12] What about the children? Joint working between adult and children's services when parents or carers have mental ill health and/or drug and alcohol problems; Ofsted March 2013, Ref no. 130066.
[13] Cleaver H, Unell I and Aldgate J; Children's Needs- Parenting Capacity, Child Abuse: Parental mental illness, learning disability, substance misuse, and domestic violence; 2nd Edition, TSO (The Stationery Office); Norwich, 2011.

c. Ensure stable funding for voluntary and community based programmes is required to provide the necessary long-term support to ensure children living with families with complex needs are safe

2.4 **Adult mental health services and drug and alcohol services should**:
   a. ensure that practitioners consistently challenge decisions by children's social care to take no further action if in their judgement action is warranted, using escalation processes where necessary

   b. review recording systems to ensure that children and young people who are undertaking inappropriate caring responsibilities for parents or siblings are identified, and that their needs are explicitly considered and referred for support when necessary

   c. ensure that adult assessments consider the need for early support for parents, carers and children and that action is taken to put this in place.

2.5 **Local authorities (Adult and Child Social Services), mental health services and drug and alcohol services should:**
   Ensure that staff liaise with each other and agree a joint plan of action when parents or carers do not attend appointments with adult services.

2.6 **Local authorities (Adult and Child Social Services) and mental health services should**:
   a. improve the quality of assessments of the impact of mental health difficulties on children, ensuring that children's social workers and adult mental health practitioners work together to assess and agree effective action plans

   b. review arrangements for discharging patients from hospitals to ensure that discharge meetings involve children's social workers where appropriate; that the needs of the children are considered and that discharge plans set out clearly when/if parents or carers will be ready to resume the care of their children.

3. *Tackling Dementia in Merton*

3.1. **Supporting the Dementia Hub**
   With the launch of the Dementia Hub in Merton[14] it must be ensured that relevant services are aware of this centre and how patients with dementia can be referred to it. This is particularly applicable to GP practices as GPs have a pivotal role to play in the early detection and referral of residents of Merton with dementia.

3.2. **Dementia awareness and training**
   Dementia awareness and training sessions with relevant services, especially in primary care must be organised in a rolling programme that is repeated at regular intervals.

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[14]

http://www.alzheimers.org.uk/site/custom_scripts/branch.php?branch=true&branchCode=13596&areaBC=EALO

3.3. **Dementia strategy refresh**
The current five year dementia strategy (for Sutton and Merton) which is due to end in 2015, must be refreshed to reflect the current organisational changes in health and social care, and the dementia strategy implementation plan must be updated.

3.4. **Preventing dementia**
Awareness must be raised of evidence-based measures to prevent dementia (the six pillars of a brain-healthy lifestyle: regular exercise, healthy diet, mental stimulation, quality sleep, stress management and an active social life[15]) to relevant services, professionals and lay public in Merton. Community-based projects or pilots to prevent dementia and promote dementia awareness should be considered.

4. *Improving services for people with a dual diagnosis of substance misuse and mental ill-health*

4.1. **Early identification of dual diagnosis and prevention work**
Developing &/or strengthening services should be considered, to ensure that dual diagnosis of substance misuse and mental ill health is identified early and that there are clear eligibility criteria, referral and care pathways, and robust outcome measures for dual diagnosis

4.2. **Joint service provision and pathways for dual diagnosis**
a. Joint commissioning of mental health and drug or alcohol services needs to become the norm in the areas of general health, mental health, substance misuse (including alcohol), social care, education, community safety, crime (including domestic violence) and safeguarding in both children and adults, linking promotion and prevention much more closely with treatment and care for substance use and mental health.

b. To ensure 4.2a above, all contracts with providers need to stipulate effective joint working and clear pathways, to meet the needs of people with co-existing mental health needs and substance misuse problems.

4.3. **"Hidden harms" of substance misuse**
LBM is planning a needs assessment on Hidden Harm in Merton. It is recommended that appropriate services are jointly developed; to tackle hidden harm and support this needs assessment, considering its recommendations in the development of this work. A dual diagnosis in one or both parents or caregivers has significant impacts on children living with them. The hidden harms aspect is not just about dual diagnosis but extends to parents with mental illnesses (and not substance misuse) as well.

4.4. **Personality disorders (PD)- with and without dual diagnosis**
Around 8-9% of all in-patient cases and patients in CMHS are seen because of personality disorders. Anecdotal evidence suggests that there are significant numbers of undiagnosed cases of PD in the community, and there needs to be more and better

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[15] http://www.helpguide.org/elder/alzheimers_prevention_slowing_down_treatment.htm

access to psychological treatment (DBT/MBT) for cases of PD and dual diagnosis with PD. Considerable preparatory work is required to get PD cases ready for such therapies.

5. *Addressing Health inequalities and inequity*

5.1. **Black and Minority Ethnic groups**
The findings from this report indicate that black communities are over-represented in in-patient services (but not in CMHS) and Asians are significantly under-represented in both in-patient and community mental health services. A range of early intervention and support services should be considered that are culturally sensitive to Merton's BME groups that promote mental health wellbeing and reduce stigma. The services should be targeted and outcome specific.

5.2. **Local care pathways**
It should be ensured that local care pathways promote access to the services by wider communities including socially excluded groups such as black and minority ethnic groups, older people, those in prison or in contact with the criminal justice system and ex-service personnel.

5.3. **Services for older people**
a. It has been estimated that at any given time in a typical 500-bed district general hospital, 220 beds are occupied by older people with mental health problems: 102 with dementia and 96 with depression [16]. Services and pathways should be developed to address the specific needs of older adults in Merton and these services should be appropriate for this age group, helping to reduce the demand on acute beds by increasing care for the frail and elderly in community settings, providing a holistic assessment in the community, and ensuring that both mental and physical health are addressed..

b. Rather than the current generic system in Merton, a specialist liaison psychiatry service for older people based in acute hospitals could be developed. Mental health liaison services can help increase productivity in acute hospitals by improving older people's clinical outcomes while reducing length of stay and re-admission rates[17].

c. Development in this area should be linked with the on-going integration work in Merton under the Better Care Fund.

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[16] Anderson D, Banerjee S, Barker A, Connelly P, Junaid O, Series H, Seymour J (2009). The Need to Tackle Age Discrimination in Mental Health: A compendium of evidence. London: Faculty of Old Age Psychiatry, Royal College of Psychiatrists. Available at:
www.rcpsych.ac.uk/pdf/Royal%20College%20of%20Psychiatrists%20%20The%20Need%20to%20Tackle%20Age%20Discrimination%20in%20Mental%20Health%20Services%20-%20Oct09.pdf
[17] Naylor C, Bell A (2010); Mental Health And The Productivity Challenge, Improving quality and value for money; The King's Fund and Centre for Mental Health.

6. *Improving engagement with and support for service users and carers*

6.1. **Education and Training of front-line staff**

It must be ensured that frontline workers, across the full range of services, are trained to understand better about mental health, the principles of recovery and are able to tackle any stigma related to mental health. Furthermore training must be provided on the services that exist in Merton, the care pathways and how to refer a person to the appropriate mental health services.

6.2. **Education and Training of healthcare professionals in primary care**

Healthcare professionals in primary care including GPs need training and education in order to better recognise mental ill health, engage and support patients on this, and accord parity of esteem to mental ill health. Consultations with service users revealed that primary care professionals were perceived by some to have an inadequate understanding of mental illness, and service users reporting a negative experience on the whole.

6.3. **Carer needs**

Consultations with carers revealed that pro-active information-sharing and guidance, their involvement in decisions about the care provided, properly informed sessions and providing support/training in managing specific conditions were the most important issues for them. Feedback from the carers indicated that these arrangements and provisions were not as good as they needed to be. It needs to be ensured that these provisions are improved for carers. There is no up-to-date carer's strategy for Merton and this needs to be addressed. The triangle of care model must be sustained.

6.4. **Enabling access to services for Merton residents with mental health conditions**

Service users and carers in our consultations felt that not having the Freedom Pass severely limited their ability to get around and could contribute to a worsening of their problems. Many mental health service users are not in employment or on low incomes and they struggle with the cost of transport. It is recommended that the London Borough of Merton takes steps to enable Merton residents with mental ill-health to access services that are so vital for their wellbeing, bearing in mind that the Freedom Pass is no longer available.

7. *Primary care and IAPT services*

7.1. **Variation in quality and under-diagnosis in Primary Care**

Variations in quality and under-diagnosis need to be understood in greater depth (i.e. how much is due to differences in coding and how much is actual) and minimised in primary care, particularly in GP practices in East Merton. In the consultations in this needs assessment both service users and carers expressed the view that health services continue to give less attention to mental illnesses than to physical illnesses and primary care professionals had an inadequate understanding of mental illness. Health professionals in primary care (including GPs) need training and education in order to better recognise mental ill health, engage and support patients on this, and accord parity of esteem to mental ill health.

7.2. **Physical health of Merton residents with mental ill-health**

The physical health of Merton residents with mental health conditions needs to be monitored regularly. NICE guidance CG 178 recommends that GPs and other primary healthcare professionals should monitor the physical health of people with psychosis or schizophrenia when responsibility for monitoring is transferred from secondary care, and then at least annually. The physical health of patients with schizophrenia in particular needs to be better managed in Primary Care.

7.3. **Transfer of care from secondary to primary care**

The transition between secondary care and primary care in relation to all mental illnesses but specially schizophrenia must be well managed.

7.4. **Primary Care integration**

There must be more integration of mental health related services in primary care between health, social care, housing, employment, legal services and community services. This includes greater integration between physical and mental health, and the early identification of illness and comorbidity, reduced stigma, and social inclusion.

7.5. **Psychological therapies**

There are a number of issues around the current IAPT service that are being addressed by the Merton CCG. These include consistently low recovery rates against local and national targets, and the profile of cases being seen tending to belong to the more severe spectrum of mental disorders. Merton CCG is undertaking a specific programme of work that is reviewing the IAPT service and considering how to make it more effective.

8. *Improving rehabilitation and stepped down provision*

8.1. There is a need to undertake a more detailed piece of work to understand the current step-down provision from acute services when patients are well enough to be discharged from an acute bed but not well enough to live independently at home. This work will help to consider alternative options and to design a provision that is fit for purpose, mindful of the principle of "Right Care at the Right Place" and commissioning services closer to home and in the least restrictive environment.

8.2. Co-ordinated working with LB Merton will be required to understand the demand and capacity for step-down placements for social care needs, including housing.

9. *Areas where more research required*

While this report covers a wide expanse of issues pertinent to adult mental health in Merton, there are some areas that are not covered and need more work. These areas are learning disabilities, the interface between children and adult mental health services (especially the transition) and in general there is need for a CAMHS health needs assessment.

Beyond the MMHNA: Next steps

The MMHNA will be reported to the MHWBB in September 2014, and form part of the evidence base for commissioning future mental health services for Merton residents.

A workshop was held with service users, carers, voluntary sector and community organisations, and statutory organisations including key providers, commissioners and mental health professionals in Merton. Hosted by the LBM and MCCG and facilitated by Merton Healthwatch, this workshop obtained views and facilitated discussion about the MMHNA findings. Feedback from participants (see supplementary report) will also support the future commissioning of mental health services in the Borough.

It is planned to have regular workshops with users and carers regarding mental health services to ensure commissioners hear live messages, and progress on commissioning and service delivery is shared.

Introduction

Mental illness is generally applied to conditions on a spectrum ranging from those almost entirely managed in Primary Care to conditions that are almost exclusively managed by specialists. The link between mental health problems and social exclusion is intricate and well documented. Mental ill-health can be both the cause and the consequence of social exclusion leading to a vicious cycle of homelessness, unemployment, and worsening physical and mental health.

One in four people in the UK will experience a mental health problem in the course of a year. The cost of mental health problems to the economy in England have recently been estimated at £105 billion each year and treatment costs are expected to double in the next 20 years (NEPHO). In 2004, 22.8% of the total burden of disease in the UK was attributable to mental disorder (including self-inflicted injury), compared with 16.2% for cardiovascular disease and 15.9% for cancer, as measured by Disability Adjusted Life Years (DALYs)[18]. Depression alone accounts for 7% of the disease burden, more than any other health condition. It is predicted that by 2030, neuropsychiatric conditions will account for the greatest overall increase in DALYs[19].

The Department of Health launched the strategy 'No Health Without Mental Health' (DH 2011) which takes a cross government approach, including promoting mental wellbeing, reducing stigma and a focus on improving outcomes for people with mental illness.

Health inequalities in mental health
Research shows that different ethnic groups have very different experiences of mental distress and recovery. They may have higher rates of incidence than other groups, different routes into and out of treatment services, and different outcomes afterwards.

There is evidence that much of the variation amongst ethnicities can be attributed to associated factors, such as income, employment, lifestyle and physical health. Other factors associated with ethnicity include discrimination, experiences of migration and traumatic events. Culturally determined beliefs about age and gender roles, the meaning of health and wellbeing and levels of stigma associated with mental ill health and treatment services are influential[20].

However, different rates of mental ill health remain for some groups even after taking many of these factors into account. For example, White populations have the highest rates for suicidal thoughts, self-harm and alcohol dependence[21]; and rates of schizophrenia are

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[18] World Health Organization (2008) Global Burden of Disease Report. WHO
http://www.who.int/healthinfo/global_burden_disease/estimates_country/en/index.html
[19] World Health Organization (2004) Projections of Mortality and Global Burden of Disease 2004–2030. WHO
[20] Choosing Health: Supporting the physical health needs of people with severe mental illness – commissioning framework, Department of Health, August 2006.
[21] McManus S, Meltzer H, Brugha T, et al (2009) Adult psychiatric morbidity in England, 2007. Results of a household survey. Health and Social Information Centre, Social Care Statistics.
http://discover.ukdataservice.ac.uk/catalogue?sn=6379

higher among Black Caribbean and Black Africans compared with the White British population and after adjustment for socioeconomic status and age[22].

Another way in which ethnicity impacts mental ill health is through the different ways in which groups of people tend to access and experience services. In general, people from black and minority ethnic groups are more likely to enter the mental health services at a time of crisis or breakdown. They are more likely to be referred via the courts or the police rather than by a GP, and more likely to receive medication rather than talking therapies such as psychotherapy. Afro-Caribbean people in particular are more likely to be detained in hospital under the Mental Health Act and more likely to experience poor outcomes from treatment[23].

Similar to the differences in disorder between ethnicities, there is some evidence that mental ill health can vary based on gender and sexuality. For instance, eating disorders are more common among women throughout life and there is a higher probability of PTSD (Post Traumatic Stress Disorder) in all female age groups excluding 16– 24 years[24]. Analysis of a large UK-wide sample of adults found that people who identify as non-heterosexual have higher rates of unhappiness, anxiety and depression. They are also more likely to suffer from obsessive–compulsive disorder, phobic disorder, psychosis and acts of self-harm [25]. Research has found that the rate of suicide attempts is twice as high in non-heterosexual individuals and particularly high for non-heterosexual men[26]. Use of alcohol, drugs and cigarettes are also higher among some gay, lesbian and bisexual groups[27].

The reasons for the differences in mental ill health by ethnicity, gender, sexuality, and wider determinants are complex, poorly understood and confounded by many factors- such as the impact of social stigma and discrimination.

The key inequalities experienced by people with mental health problems are:
* Low levels of employment: less than 25% of people with mental ill-health work though many would like to do so. Of those with severe and enduring mental illness, 58% are capable of employment. During long-term unemployment, mental health can deteriorate thus further reducing the chance of gaining work
* Social exclusion might arise through stigma, discrimination and difficulties in maintaining social and family networks
* Barriers to accessing health services: the Social Exclusion Report (2004) indicated that 44% of people with mental ill health were dissatisfied with their GP because their physical health problems/symptoms were dismissed as a mental health issue

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[22] Kirkbride JB, Barker D, Cowden F, et al (2008) Psychoses, ethnicity and socioeconomic status. Br J Psychiatry 193:18–24. http://www.ncbi.nlm.nih.gov/pubmed/18700213
[23] Mental Health Foundation.
 http://www.mentalhealth.org.uk/help-information/mental-health-a-z/B/BMEcommunities/
[24] Health & Social Care Information Centre. Adult Psychiatric Morbidity Survey - 2007.
http://discover.ukdataservice.ac.uk/catalogue?sn=6379
[25] Chakraborty, A. et al. Mental health of the non-heterosexual population of England. British Journal of Psychiatry, Vol.198, February 2011, pp. 143-48.
http://bjp.rcpsych.org/content/198/2/143.abstract?ijkey=9a44090b64de0d1e6b721de2c486615518710560&keytype2=tf_ipsecsha
[26] King, M. et al. A systematic review of mental disorder, suicide, and deliberate self-harm in lesbian, gay and bisexual people. BMC Psychiatry, Vol. 18, August 2008, 8:70.
[27] Chakraborty, A. et al. Mental health of the non-heterosexual population of England. British Journal of Psychiatry, Vol.198, February 2011, pp. 143-48.

- Poorer physical health and increased mortality from some diseases. This may result from misdiagnosis of physical ailments; reluctance or inability to access health services; and unhealthier lifestyles, for example poor diet, less exercise and higher levels of smoking

The last two bullet points above point to key inequalities in physical health for people with serious mental health problems are:

- On average, a person with schizophrenia is at risk of dying on average twenty years prematurely[28] [29].
- Studies which examine prevalence of smoking within individual mental disorders have found a prevalence of 40% to 50% in people with depressive and anxiety disorders and 70% in people with schizophrenia[30]. The 2010 Health Survey for England found that smoking prevalence amongst people with a long standing mental health disorder was 37%[31] compared to 20% in the general population[32].
- Approximately 30% of people misusing drugs have mental health problems. In one study, half of alcohol dependant adults said they had a mental health problem[33].
- People with Severe Mental Illnesses have twice the risk of diabetes compared with the general population[34], 2-3 times the risk of hypertension and 3 times the risk of dying from coronary heart disease[35].

The inequalities described above are present and often more severe amongst people in Black, Asian and Minority Ethnic (BAME) groups with mental health problems. Additional inequalities include[36]:

- Increased risk of hospital admission and coercive care under the provisions of the Mental Health Act 1983
- Greater difficulty accessing mental health assessment and treatment
- Higher levels of dissatisfaction with mental health services
- Greater likelihood of considering their diagnosis inappropriate
- Greater likelihood of having medical problems misattributed to mental health

A recent report by Rethink "Lethal Discrimination", published in September 2013[37] found that:

[28] Brown S, Kim M, Mitchell C and Inskip H., 2010. Twenty-five year mortality of a community cohort with schizophrenia. British Journal of Psychiatry 196 pp 116–121.

[29] Parks J, Svendsen D, Singer P et al., 2006. Morbidity and Mortality in People with Serious Mental Illness. 13th technical report. Alexandria, Virginia: National Association of State Mental Health Program Directors.

[30] Olivier D, Lubman DI, Fraser R. Tobacco smoking within psychiatric inpatient settings: biopsychosocial perspective. Aust & NZ J Psych 2007; 41: 572-580

[31] The NHS Information Centre. Health Survey for England 2010. Published Dec 2011.

[32] McManus S, Meltzer H & Campion J. Cigarette smoking and mental health in England. Data from the Adult Psychiatric Morbidity Survey 2007. National Centre for Social Research, Dec. 2010

[33] Mental Health and Social Exclusion: Social Exclusion Unit Report, June 2004. Office of the Deputy Prime Minister, London.

[34] Royal College of Psychiatrists, 2013 'Whole person care: from rhetoric to reality. Achieving parity between mental and physical health', Occasional paper OP88.

[35] Osborn, DPJ., 2007 Physical activity, dietary habits and coronary heart disease risk factor knowledge amongst people with severe mental illness: a cross sectional comparative study in primary care. Social Psychiatry Psychiatric Epidemiology pp 787-93.

[36] Mental health crisis care: commissioning excellence for black and minority ethnic groups: A briefing for clinical commissioning groups, March 2013; Mind UK. http://www.mind.org.uk/media/494422/bme-commissioning-excellence-briefing.pdf

[37] Rethink, 2013. http://www.rethink.org/get-involved/campaigns/lethal-discrimination

- More than 40% of all tobacco is smoked by people with mental illness, but they are less likely to be given support to quit.
- Fewer than 30% of people with schizophrenia are being given a basic annual physical health check.
- People gain an average of 13lbs in the first two months of taking antipsychotic medication and this continues over the first year. Despite this, in some areas 70% of people in this group are not having their weight monitored.
- Many health professionals are failing to take people with mental illness seriously when they raise concerns about their physical health.

Cost of mental ill health in London
The Greater London Authority published a paper early this year, 'London Mental Health: The invisible costs of mental health'[38]. The paper attempts to analyse the wider economic and social impacts of mental ill health and quantify in economic terms impacts including those that are beyond the usual measures of economic output (Gross value Added- or GVA) and include amongst other things, the "non-market" impacts such as quality of life from mental ill health. The wider impacts of mental ill health result in around **£26 billion** each year in total economic and social costs to London.

In adults in London, a simple comparison of the QALY (Quality Adjusted Life Years[39]) index values between those with at least moderate anxiety or depression and those without shows that the former group have QALY index values around 0.29 lower. Some of this difference can be attributed to a higher incidence of other health problems in those with depression or anxiety. The London figures suggest that individuals with anxiety or depression have around 1.3 other health problems (out of a maximum of 4), compared to just 0.4 among those without- giving an indication of co-morbidities being higher in those with anxiety or depression. When the QALY loss is adjusted for these co-morbidities, the estimated loss of QALYs due to depression and anxiety is 0.13 rather than 0.29. In other words an adult in perfect health will enjoy a QALY of 1 for each year s/he spends in that state. In comparison a person with depression or anxiety (and no other illness) will experience a QALY of 0.87 for each year s/he spends in that state.

The human component (that is the intrinsic enjoyment of life) of a QALY has been valued at around £42,000 per QALY in current prices. Therefore, the human costs resulting from the average QALY loss of 0.13 are valued at around £5,000 per year. Given that an estimated 1.1m adults (15.9% of those aged 16 and over) in London have a common mental disorder, the overall scale of quality of life losses due to poor mental health is therefore substantial at around **£5.75bn** for the estimated 138,000 QALYs lost each year in London.

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[38] London Mental Health: The invisible costs of mental ill health; Greater London Authority, January 2014 http://www.london.gov.uk/sites/default/files/Mental%20health%20report.pdf
[39] This is a measure of the quality of life a person experiences. It is a validated measure based on respondents in the 2011 Health Survey of England rating five components of health related quality of life (mobility, self-care, usual activities, pain/ discomfort, anxiety/ depression) on a three point scale (No Problems (1), Moderate Problems (2), Extreme Problems (3))- resulting in a QUALY score for different health states. For example, a person with no problems on any of the dimensions would have an index value of 1 (referred to as one 'quality adjusted life year' or QALY- a year of life in perfect health), but if they were to develop moderate anxiety or depression their index value would fall to around 0.85, suggesting the health related quality of life they experience had declined by around 15%.

Impact of worklessness due to CMDs (Common Mental health Disorders)
Increased level of worklessness has costs at the individual level, as being out of work is associated with lower income and therefore reduced consumption and quality of life. There are also costs at the societal level, as fewer people working means that there is less output produced in the economy. Based on 22% of 5.6 million working age adults in London experiencing some form of anxiety or depression, this produces an estimate of lost output related to poor mental health in London of around **£3.5bn**. Alternative ways of measuring this show the lost output due to CMDs varies from **£5.49bn to £7.55bn** in London each year.

Increased sickness absence
More than a third of sickness absence days are due to stress, anxiety and depression, making these conditions more common causes than musculoskeletal disorders or infectious diseases. The estimated lost output from mental ill health related sickness absence ranges from **£0.92 to £1.08bn** per year in London.

Reduced productivity
Reduced productivity due to individuals attending work despite ill health is often referred to as presenteeism. Reports looking at the cost of mental ill health, such as the Sainsbury Centre for Mental Health (2007), have often assumed that 1.5 times as many working days are lost due to presenteeism as are lost due to mental ill health related absences. Value of the lost output for London each year for this is estimated around **£1.62bn to £1.89bn**.

Lost output due to premature death
In London in 2011 there were 583 suicides of individuals aged 15 or over[40]. Department for Transport (DfT) research[41] suggests that the lost output resulting from a suicide is worth around £0.58m on average. This means that the total cost of suicides in London in 2011 was around **£0.34bn** in terms of lost output alone. Additionally the total estimated annual cost of lost time due to transportation delays resulting from suicide attempts is around **£16.5m**.

Value of informal care
One of the more significant external economic costs of mental ill health in London comes through informal care provision. The 2009/10 GfK[42] NOP Survey of Carers in Households[43] reports that around 10% of adults in London, approximately 670,000 people are carers. The survey also reports that, for the whole of England, mental health problems are the reason for the care in around 13% of instances. Assuming this pattern broadly holds for London, there are an estimated 88,000 people providing informal care to others due to a mental health issue.

The same survey reports that carers spend an average of 32 hours each week providing care. This equates to around 1,700 hours per carer per year. If valued using the median care assistant wage in London, this represents care worth almost £14,000 per carer and an

[40] ONS. Suicides in the UK, 2011. –
http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-288089
[41] Department for Transport, 2011. The Accidents Sub-Objective. –
http://www.dft.gov.uk/webtag/documents/archive/1208/unit3.4.1.pdf
[42] GfK NOP is the name of the private company that did this survey.
[43] HSCIC, 2010. Survey of Carers in Households. –
http://www.esds.ac.uk/doc/6768/mrdoc/pdf/6768_survey_of_carers_in_households_2009_10_england.pdf

estimated **£1.21bn** for the overall cohort of individuals providing informal care for people suffering with mental health problems.

Crime related
The economic costs of crime, lost outputs due to crime, property damage, theft and anticipatory spending related to crime related to mental ill health amounts to approximately **£1bn** a year in London.

Additionally the real resource cost to society from mental ill health (the actual public expenditure on mental ill health) ranges from **£6bn to £7bn**.

Economic and social costs: totals
The total economic and social costs of mental ill health in London are clearly substantial at an estimated £25bn to £27bn annually. **This equates to approximately £2,990 to £3,210 per person in London per year** and is equivalent to around 8.9 to 9.5% of London's GVA[44]. (This includes the cost of mental ill health in children and young people).

Co-morbidities in mental illness- physical ill health and mental ill health
Comorbidity is the presence of two or more conditions in a person at the same time. This could also mean more than one mental illness. The Institute of Public Care (PANSI) estimates that just under a quarter of adults (23.0%) meet the criteria for at least one psychiatric condition. Of those with at least one condition: 68.7% meet the criteria for only one condition, 19.1% meet the criteria for two conditions and 12.2% meet the criteria for three or more conditions. This means that in London, as many as 484,800 adults may have more than one mental health condition[45].

People experiencing a physical health condition are also more likely to suffer mental ill health. Thirty per cent of the population have one or more chronic or long-term physical conditions, such as diabetes, arthritis or HIV/AIDS. The presence of a long-term physical health condition increases the risk of mental ill health by two to three times over that of the general population. The reverse is also true. Mental ill health may often increase the risk of physical illness. People struggling with mental disorder may engage in riskier behaviours or may be less able to care for themselves as a result of their illness. The result is that people with mental health conditions are two to four times more likely to die prematurely, mainly from physical causes like cardiovascular disease[46].

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[44] It should be noted that the comparison with GVA is not strictly accurate as it is not a like for like comparison. As set out in the text, the estimate of the total economic and social costs of mental ill health to London incorporate some 'nonmarket' aspects which are not included in the calculation of GVA. In this instance, framing the economic and social costs as a proportion of London's GVA acts simply to provide some idea of the scale of costs.

[45] London Mental Health: The invisible costs of mental ill health; Greater London Authority, January 2014 http://www.london.gov.uk/sites/default/files/Mental%20health%20report.pdf

[46] 'Long-term conditions and mental health: The cost of co-morbidities.' The King's Fund and Centre for Mental Health 2012 – http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/long-term-conditions-mental-healthcost-comorbidities-naylor-feb12.pdf

The landmark 1980 study by Richard Hall et al[47] found that 46% of the psychiatric patients had physical ailments causing or exacerbating their mental symptoms.

A significant proportion of people with a range of physical health needs also have co-existing mental health needs or their mental state is made worse by their physical condition[48].

Examples of this are:
- A serious physical illness can affect every area of life, such as relationships, work, spiritual beliefs and how people socialise.
- This can result in increased levels of anxiety and depression
- Some drug treatments, such as steroids, affect the way the brain works and so cause anxiety and depression directly.
- Some physical illnesses, such as an under-active thyroid, affect the way the brain works. They cause anxiety and depression directly.
- Recent research[49] has shown that a history of celiac disease makes the risk of developing schizophrenia 3.2 times higher.
- Cancer – 33% patients depressed and these patients remain in hospital 40% longer and have 35% greater costs. Meta-analysis of PCTs revealed sustained beneficial gain from short focused CBT in terms of mental health, functional adjustment (return to work), and physical symptoms. Also evidence of increased survival rates and increased coping and quality of life-years.

One particular type of co-morbidity is the abuse of alcohol and drugs. Similar to physical illness, substance misuse and mental ill health have a two-way relationship. The presence of mental ill health increases the likelihood of substance misuse via self-medication and increased risk taking. Conversely, substance misuse can result in a host of behavioural and cognitive issues, such as depression or psychosis, that are characteristic of mental ill health. It is well documented that misuse of alcohol and drugs is higher among those with mental disorder, as are rates of smoking. For example, rates of drug dependence amongst people with social phobia are six times as high as those of the general population. People with obsessive compulsive disorder have a fourfold increase in the risk of developing alcohol dependence, and generalised anxiety disorder is associated with a 9% increase in the risk of being a smoker[50].

Smoking and mental health
A systematic review and meta-analysis of 26 observational longitudinal studies published in the British Medical Journal recently[51], investigated change in mental health after smoking cessation compared with continuing to smoke. Follow-up mental health scores were measured between seven weeks and nine years after baseline. The study found that anxiety, depression, mixed anxiety and depression, and stress significantly decreased

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[47] Physical illness manifesting as psychiatric disease: II. Analysis of a state hospital inpatient population. Hall, Richard C; et al, Archives of General Psychiatry, Vol 37(9), Sep 1980, 989-995.
[48] Royal College of Psychiatrists Physical Illness and Mental Health
[49] Coeliac disease and schizophrenia: population based case control study with linkage of Danish national registers; Eaton,W. Mortensen, P.B., Agerbo, E. Byrne, M., Mors, O., Ewald, H. (2004) British Medical Journal 328 438-439.
[50] Adult Psychiatric Morbidity Survey, 2007. http://discover.ukdataservice.ac.uk/catalogue?sn=6379
[51] Taylor G, McNeill A, Girling A, et al.; Change in mental health after smoking cessation: systematic review and meta-analysis; BMJ 2014; 348:g1151 (Published 13 February 2014).

between baseline and follow-up in quitters compared with continuing smokers. Both psychological quality of life and positive affect significantly increased between baseline and follow-up in quitters compared with continuing smokers. The study concluded that smoking cessation is associated with reduced depression, anxiety, and stress and improved positive mood and quality of life compared with continuing to smoke. The effect sizes are equal or larger than those of antidepressant treatment for mood and anxiety disorders.

Common Mental health Disorders (CMDs) and Severe Mental Illnesses (SMIs)

In the UK, Mental Health conditions are clinically classified using ICD-10 - the WHO (World Health Organisation) International Classification of Disease. This is used in the clinical diagnosis of mental illnesses. Mental health conditions can also be broadly divided into common mental health disorders (CMDs) and Severe Mental Illnesses (SMIs). Common mental health disorders, such as depression, generalised anxiety disorder, panic disorder, obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD) and social anxiety disorder, may affect up to 15% of the population at any one time. Depression and anxiety disorders can have a lifelong course of relapse and remission. There is considerable variation in the severity of common mental health disorders, but all can be associated with significant long-term disability. For example, depression is estimated to be the second greatest contributor to disability-adjusted life years throughout the developed world. It is also associated with high levels of morbidity and mortality, and is the most common disorder contributing to suicide[52]. There is no universal definition of severe mental illness. However, the term usually refers to illnesses where psychosis occurs. Psychosis describes the loss of reality a person experiences so that they stop seeing and responding appropriately to the world they are used to. Schizophrenia and bipolar disorder are the two main forms of severe mental illness. However, this does not mean that other conditions are not regarded as serious - there are others such as schizo-affective disorder, severe clinical depression and personality disorders.

Locally there is limited definitive data on prevalence and incidence of mental health conditions. A review of adult mental health services was started in August 2013 in order to shape the adult mental health services in Merton. The first stage of the review is this health needs assessment of adult mental health in Merton (MMHNA).

Aims and objectives of the health needs assessment

The MMHNA (Merton Mental Health Needs Assessment) is an epidemiological, corporate and comparative one that aims to:
- Describe the size and nature of adult mental health illnesses and conditions, and provide a comprehensive picture of adult mental health in Merton, based on the analysis of all available and relevant data, and consultations with key stakeholders, providers and users
- Describe the nature and extent of health inequalities in the

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[52] Common mental health disorders, Identification and pathways to care; NICE clinical guideline 123; Issued: May 2011

- distribution of mental health illnesses and conditions in the population of Merton, identifying local risk groups and risk factors, profiling such risk factors and describing how they relate to mental health
- the uptake of services and any variations of uptake (by geography, ethnicity etc.) and explore any equity issues (access)
- Identify evidence-based interventions and best practise in tackling issues related to mental health, including public mental health
- Describe the current health and social care services available in Merton that impact on adult mental health and how these match up against best practise and interventions identified
- Identify the gaps in provisions for health and social care in Merton in relation to adult mental health and make recommendations as to how these could be addressed, particularly around reducing health inequalities and inequity

Methodology

The traditional model of epidemiological, corporate and comparative healthcare needs assessment has been developed by Stevens and Rafferty[53]. Epidemiological need looks at the severity and size of the health problem. Corporate need looks at the perceptions of the service providers and comparative need looks at the different service providers and users managing the health issue[54]. This health needs assessment includes all three approaches.

Epidemiological: primarily entailing the analysis of all available and relevant data. This may include auditing the primary and secondary health care and social care data from the past few years relating to adult mental health in order to establish any historical patterns and identifiable risk factors.

Corporate: through qualitative work in the form of focus groups and semi-structured interviews with mental health services users, carers and service providers.

Comparative: through mapping the services in Merton and assessing how well the mental health needs of the adult population in Merton are met by this and identifying the gaps.

The steps proceeding with this health needs assessment are described in the figure below.

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[53] Stevens A. Rafferty J. Health Care Needs Assessment: The Epidemiologically Based Needs Assessment Reviews, Vol. 1. Oxford: Radcliffe Medical Press
[54] Hooper J, Longworth P. Health needs assessment workbook. Health Development Agency. January 2002

Figure 1: Methodology of the MMHNA

Health Needs Assessment

What is the problem?

↓

What is the size and nature of the problem?

↓

What are the services currently available?

↓

Identify interventions (consultation phase)

↓

Identify interventions by reviewing scientific knowledge

↓

What and where are the gaps?

↓

What are the recommendations and possibly what are the resource implications?

Population Health Status Assessment

Define the population concerned

↓

Define the aspects of health that need to be covered/ considered) i.e. determinants and measures

↓

Identify and review existing data sources

↓

Select the most appropriate existing data

↓

Make good use of the data and analyse appropriately

↓

Consider if specific issues require specially collected data

↓

Consider use of comparators

↓

Issues of confidentiality and disclosure

↓

Interpret results

Epidemiological analysis methodology

This was done through the collation and analysis of all available and relevant national, regional and local data.

Routinely collected data

Routinely collected national data were obtained from HSCIC (Health and Social Care Information Centre), POPPI (Projecting Older People Population Information), PANSI (Projecting Adult Needs and Services Information), NEPHO (North East Public Health Observatory), NHS Dementia Calculator and ONS (Office for National Statistics).

Ad-hoc data

Ad-hoc local data sets were obtained from the main local NHS Mental Health provider-South West London and St. Georges NHS Mental Health Trust (SWLStG MHT). This comprised of five years of inpatient data for admissions or discharges between 01/04/2008 and 31/03/2013. Community mental health services (CMH/ CMHS) data sets (referrals and contacts) include any Merton residents either referred or discharged from all non-inpatient services between 01/04/2008 and 31/03/2013. Referral source has been included such as those from a GP or via A&E Departments. A summary of IAPT (Improved Access to Psychological Services) performance were also obtained for the period between 01/08/2012 and 31/08/2013 to match a number of KPIs usually submitted to the Information Centre. The in-patient and community data were analysed separately. An analysis strategy was developed in consultation with the Mental Health Review's Task and Finish Group. The first stage was a descriptive analysis of the datasets, followed in the second stage by univariate analysis of specific risk factors and some bivariate/ multivariate analysis. The data were cleaned and further defined to create datasets that were analysed using a statistical software package, STATA SE13.

The primary and secondary diagnoses are by ICD-10 codes (see appendix) where "F-codes" are the ICD-10 codes directly related to mental health conditions (i.e. schizophrenia, neurotic disorders etc.). Additionally there are admissions and referrals primary diagnoses data coded with non-F ICD codes (i.e. other letters of the alphabet)- these include certain infections (including parasitic), neoplasms (cancers), blood disorders, endocrinal or metabolic conditions, neurological conditions, injuries, poisonings and conditions primarily affecting other parts of the body can also manifest with mental health symptoms. The overall analysis includes these non-F-codes as well, although the numbers are small.

Limitations of the data

Mental health conditions are a complex area and the data are often patchy and based on estimates and projections rather than actual numbers. This is in part due to the complexity of the service provision for mental health and also because of confidentiality and data sharing arrangements. We have attempted to bring together multiple sources of data, with valuable local data helping to create a more comprehensive picture for Merton adult mental health.

Limitations of the analysis

Some assumptions and caveats were made in order to calculate crude measures in this report:

- It was assumed that the de-duplicated records in both the datasets reflected the underlying numbers of patients with mental health conditions in a given year.
- It was assumed that in the case of the duplicate records, the patient was seen for the same primary diagnosis each time.
- It was assumed that the same patient would not be admitted as an in-patient and be seen by CMHS in the same year. This was necessary in order to calculate the diagnosed case prevalence even though it could well be the case, which means that the calculated prevalence is likely to double count some patients and therefore over-estimate the diagnosed case prevalence.
- Almost 50% of the CMHS data had no primary diagnosis, and therefore the distribution of known primary diagnosis codes was applied to the missing data to get an expected

number for the missing primary diagnoses- this assumed that the missing diagnoses would have the same distribution as the known cases.

Qualitative work methodology

Qualitative work was undertaken to ascertain the experiences and views of adult mental health services users, carers and providers in Merton.

The specific objectives were to:
a. ascertain the mental health need of the adult and elderly population in the borough
b. identify gaps in service provision; and
c. make recommendations for the provision of effective and efficient services.

The study took place between August and October 2013 and drew on qualitative methods of inquiry - in-depth, semi-structured one-to-one interviews and focus group discussions complemented by document analysis and a targeted review of the mental health literature. The approach was informed by the exploratory nature of the study objectives. In all, 31 informants participated in the study.

Figure 2: Qualitative study design

Participants
Information was obtained from three stakeholder groups:
a. Adult mental health service users resident in Merton
b. Carers of service users
c. Mental health service providers (statutory and voluntary sector).

Informants were selected using a non-probability, purposive approach. A maximum variation strategy was taken to achieve as diverse a range as possible of people within the groups with information relevant to the study objectives.[55] An initial group of informants were

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[55] Ritchie J, Lewis J, Elam G (2003). Designing and selecting samples. In: Ritchie J and Lewis J (eds.). Qualitative research practice: a guide for social science students and researchers. Sage: London.

identified by Merton Public Health team, and additional ones by snowballing.[56] Access to service users and carers was facilitated by Healthwatch Merton and two service user groups: Focus-4-1 and Rethink.

Composition of service users and carers
In all there were 16 services users and 6 carers that participated in the consultation. Due to small numbers, the gender and ethnicity breakdowns are expressed for the two groups combined and as percentages. Not all participants gave us their ages. The mean age of service users was 42 years (50% did not give their age) and the mean age of carers was 63 years.

Figure 3: Gender breakdown of service users and carers
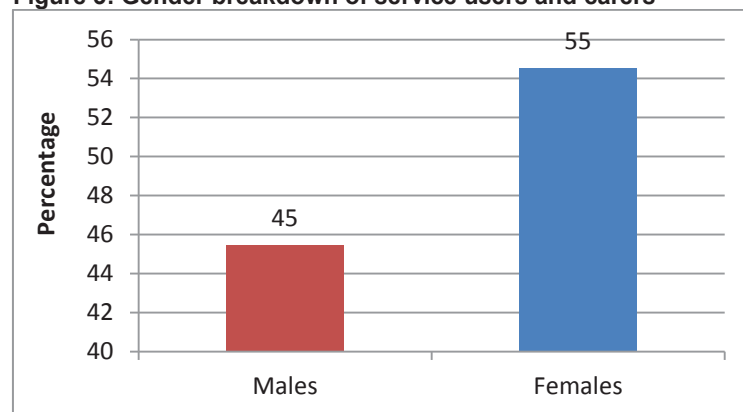
Figure 4: Ethnicity breakdown of service users and carers
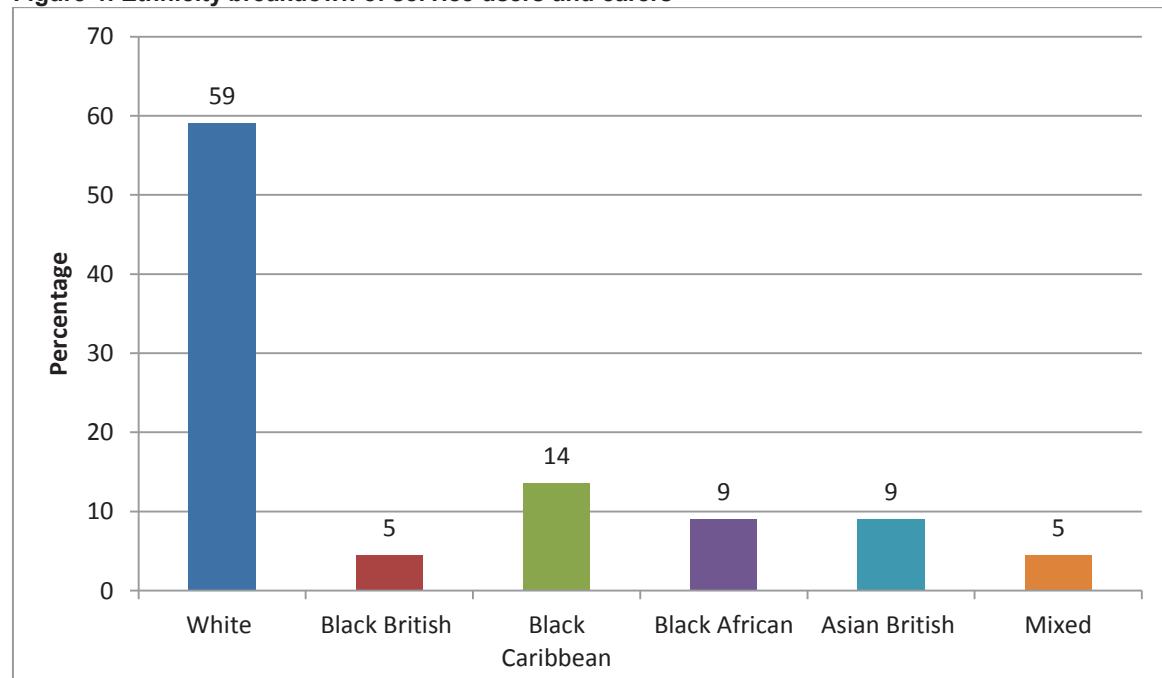
55% of service users and carers were females and 45% males. Majority of the service users and carers were white and the next biggest group were black minorities.

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[56] Hansen EC (2006). Successful qualitative health research: a practical introduction. Open University Press: Berkshire.

Focus-4-1 is based in Mitcham (east Merton) and promotes services for Black and Asian Minority Ethnic (BAME) groups, while Rethink is located in Wimbledon (west Merton) and serves a largely White population. There are substantial social and health inequalities between some of the most deprived communities in the east of the borough compared to the communities in the west[57] and the two groups were purposively chosen to ensure that these differences were represented in the study.

Interview schedules

Separate interview schedules for each stakeholder group were developed in collaboration with the Merton Public Health team. The topics for discussion were guided by a targeted review of the mental health literature (see Appendix for details). In particular, the service users schedule drew on the key dimensions of patient-centred care identified in NICE guidance.[58] The discussion topics for carers were informed by a Bristol Mind study on effective involvement in mental health services.[59]

Data collection

Thirty one informants were interviewed. Their distribution is shown in Table 1 below (see Appendix for further details). The focus groups lasted about 90 minutes and were supported by a carer (Focus-4-1) and mental health worker (Rethink). The interviews lasted about 40 minutes and were conducted face-to-face (except for two done by phone). Participants received an information sheet about the study and gave written or verbal consent before being interviewed. Brief socio-demographic information (age, gender and ethnicity) was obtained from the service users and carers to give perspective to their comments. All interviews were audio recorded and additional hand written notes taken by the interviewer.

Table 1: Distribution of informants

Stakeholder group	Number	Data collection method
Focus-4-1 service users	8	Focus group
Rethink service users	9	Focus group
Carers	6	Interview
Statutory services	6*	Interview
Voluntary sector providers	2**	Interview

* Two providers contacted did not respond.
** Four providers contacted did not respond or cancelled appointments.

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[57] Merton Joint Strategic Needs Assessment 2013. http://www.mertonjsna.org.uk/causes-of-poor-health/mental-health.aspx
[58] National Collaborating Centre for Mental Health (2012). Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services. National Institute for Health & Clinical Excellence National Clinical Guidance Number 136. The British Psychological Society and The Royal College of Psychiatrists.
[59] Davies R, Shocolinsky-Dwyer R, Mowat J, Evans J, Heslop P, Onyett S, Soteriou T (2008). Effective involvement in mental health services: assertive outreach and the voluntary sector. Bristol Mind.

Data analysis

After familiarisation with the data through review, reading and listening, thematic analysis was undertaken informed by Ritchie and Spencer's guidelines for framework analysis – an approach that is particularly suited to investigations with clearly specified questions, a limited time frame, and a pre-designed sample.[60] In addition, framework analysis provides insights quickly enough for public authorities to be able to use them in their decision-making.[61]

The discussion areas were grouped into overarching themes and informants' responses identified, examined and coded within the relevant theme. For the purposes of the analysis and given the limited timeframe, coding focused mainly on information relevant to the pre-identified themes. Comparisons were made within and across the data looking for patterns and relationships that could help organize the information more meaningfully. Exemplar quotes that best illustrated the aggregate information within each theme were extracted for anonymised reporting.

The data was first analysed within each stakeholder group and then triangulated across groups. Triangulation aimed to corroborate and strengthen the credibility of findings from one source[62], otherwise to challenge it and gain a more granular understanding of the evidence.[63]

Limitations of the study

Some limitations of the study are acknowledged. First, despite the strategy to maximise the diversity of the sample, non-response to requests for interviews by voluntary sector providers (which in fairness was mostly because of the tight timelines of the project and it's timing over summer) meant that views from the sector were relatively under-represented, especially carers. The total sample size of this study is 31- and further subdivided into users, carers and providers. Therefore the transferability of the findings needs to be treated with a degree of caution, although the objective of a qualitative study is to add more depth and understanding to the underlying issues- which this study achieved. Due to limited resources, a pragmatic approach was taken to analysis of the data. Only one researcher carried out the coding and interpretation. Not all responses were fully reported to avoid disclosing the identity of informants. However, a great deal of care was taken in developing the final analysis from the initial descriptive codes.

Literature review methodology

A review of the literature was undertaken to address the following areas:
- Best practice, national guidelines and policies in adult mental health
- Economic appraisals and cost-effectiveness evaluations of interventions to prevent mental ill health

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[60] Ritchie J, Spencer L (1994). Qualitative data analysis for applied policy research. In: A.Bryman and R. G. Burgess [eds.] Analyzing qualitative data, pp.173-194. London: Routledge.

[61] Srivastava A, Thomson SB (2009). Framework analysis: a qualitative methodology for applied policy research. JOAAG, 4(2): 72-79.

[62] Creswell JW, Plano Clark VL (2007). **Designing and conducting mixed methods research.** Thousand Oaks, CA: Sage Publications.

[63] Gorard S, Taylor C (2004). Combining research methods in educational and social research. Berkshire; Open University Press.

Given the volume of literature on mental health and the relatively broad scope of the review, a systematic review was not attempted- a pragmatic approach was taken to this aspect of the health needs assessment.

A search of the bibliographic databases was undertaken to uncover existing evidence in relation to the effectiveness and possibly the cost-effectiveness of prevention related interventions. The research questions were broken down into concepts. Based on these concepts a search strategy was created and the bibliographic databases EMBASE, PUBMED, OVID, and CINAHL were searched. Additional searches on Google were undertaken. NICE guidelines were obtained from the NICE website. It was not possible to undertake any further searches on other data bases or manual searches.

Inclusion and Exclusion Criteria

The main inclusion criterion was the date of publication (2008 onwards), adult's mental health, England/ UK. Additionally articles in 'English language', 'systematic reviews or literature reviews or meta-analysis or randomised controlled trials' were eligible for inclusion. Any relevant NICE or other guidelines were eligible for inclusion too.

The results are reported in two areas in this report-
- The section on the literature review
- The section on policies, strategies, NICE Guidance & best practice

The picture of adult mental health in Merton

What does mental health in Merton look like overall?

> ***Key Points***
> - *Overall Merton is a borough with lower spend and better mental health outcomes, compared with other statistically comparable CCGs*
> - *Overall levels of mental health and illness, treatment, outcomes in Merton are generally either similar to the England average or better*
> - *Data suggests that there is under-diagnosis and under-recording of depression and dementia in primary care in Merton*
> - *Where Merton is doing particularly well:*
>   - *Recording the diagnosis of a mental health condition*
>   - *Assigning patients to a mental health cluster*
>   - *Having significantly lower A&E attendances for patients with psychiatric disorders*
>   - *Having significantly lower number of bed days,*
>   - *Having a significantly higher rate of carers of mental health clients receiving assessments*
> - *Where Merton not doing so well:*
>   - *Providing newly diagnosed depression patients with severity assessment at the outset of their treatment*
>   - *Having a significantly lower rate than England average of recovery for IAPT treatment (percentage of people completing IAPT who have moved to recovery)*
> - *Merton has a significantly higher than national average percentage of mental health service users that are in-patient in a psychiatric hospital and a significantly lower rate than the England average, of people on a Care Programme Approach (CPA)*
> - *Merton also has a significantly lower rate of mental health clients receiving community, residential or nursing home care and a significantly lower rate of people in contact with specialist mental health services*
> - *The number of people with mental health conditions is expected to increase in Merton over time for all conditions (Common Mental Disorders, Borderline Personality Disorder, Antisocial Personality Disorder, Psychotic Disorder, and Two or more psychiatric disorder)*
> - *Merton CCG has the lowest reported prevalence of mental health disorders among SW London and statistically similar CCGs*
> - *There are considerable variations in the prevalence of mental health conditions by GP practices and also comparing practices in East and West Merton*
> - *Proportion of adults in contact with secondary mental health services living independently, with or without support is below the London average and the lowest among SW London boroughs. It is second lowest among statistical neighbours*

Overall Merton does well on many measures of mental health. Merton CCG has lower spend and better outcomes for mental health overall. While the per capita spend on mental health in Merton is much lower than for other CCGs in our ONS cluster (Hounslow, Harrow, Ealing, Redbridge and Barnet) and England, the outcomes overall are good- suggesting that the investments are good value for money.

The Merton Community Mental Health Profile (NEPHO June 2014) (Figure 5)[64] provides an overview of levels of mental health and illness, treatment, outcomes. More detailed profiles on Common Mental Health Disorders (CMDs)[65] and Severe Mental Illness (SMIs)[66] have also recently been released (June 2014) broken down by risk and related factors, prevalence, services, quality and outcomes, and finance (see later). These profiles provide useful comparative information to supplement local data. However, it is important to note that they do not reflect geographical (other than in some indicators by GP practice), gender or ethnic variations across Merton.

Merton Community Mental Health Profile
The Community Mental Health Profile indicates that the overall levels of mental health and illness, treatment, outcomes in Merton are generally either similar to the England average or better. However there are a number of indicators where Merton is significantly and unfavourably different from England. All the indicators have to be interpreted in local context, as an indicator where Merton appears to be faring better than England could be partly explained by factors like under diagnosis or under-recording.

Levels of mental health and illness
These are based on 2012/13 QOF data and GP practice survey. For depression prevalence and incidence in adults, Merton has significantly lower figures than England, as it does for GP survey recorded depression and anxiety prevalence, prevalence of mental health problem (all ages) and percentage reporting a long-term mental health problem. While these indicate that depression and anxiety in Merton may be lower than many other places, a more detailed look at mood affective disorders further on in this report shows that the recorded prevalence is lower than expected, indicating under-diagnosis and under-recording in general practice.

Treatment
In this group of indicators for most part Merton is performing similar to or better than England. Where Merton is doing particularly well is in recording the diagnosis of a mental health condition, assigning patients to a mental health cluster, having significantly lower A&E attendances for patients with psychiatric disorders, significantly lower number of bed days, and a significantly higher rate of carers of mental health clients receiving assessments. However where Merton does not do very well is providing newly diagnosed depression patients with severity assessment at the outset of their treatment, where Merton has a significantly lower percentage than the England average. Merton also has a significantly higher than national average percentage of mental health service users that are in-patient in a psychiatric hospital.

Merton also has a significantly lower rate of mental health clients receiving community, residential or nursing home care in 2012/13, and a significantly lower rate of people in

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[64] http://fingertips.phe.org.uk/profile-group/mental-health/profile/cmhp/data#gid/8000053/pat/44/ati/19/page/9/par/E40000003/are/E38000105

[65] http://fingertips.phe.org.uk/profile-group/mental-health/profile/common-mental-disorders/data#gid/8000041/pat/6/ati/102/page/9/par/E12000007/are/E09000024

[66] http://fingertips.phe.org.uk/profile-group/mental-health/profile/severe-mental-illness/data#gid/8000027/pat/6/ati/102/page/9/par/E12000007/are/E09000024

contact with specialist mental health services in 2013/14 (although the latter is a snap-shot of quarter 1). The interpretations of these figures are context specific. Merton has lower numbers of people with mental health problems recorded (QOF) than England, therefore it follows that there will lower rates of contact with specialist mental health services. A low number of people in contact with mental health services may indicate low prevalence, but may also reflect poor recognition and diagnosis of mental health conditions and availability of services, access issues, and higher thresholds for referrals. Similarly with rates of community, residential or nursing care, lower rates could be related to the significantly higher percentages of mental health service users in in-patient care.

Outcomes

In terms of outcomes, Merton's suicide rate for 2010-12 is similar to the England average and the rate of emergency admissions for self-harm significantly lower than the England average (in fact less than half). Merton has a significantly lower rate than England average, of people on Care Programme Approach (CPA) although this is snap-shot of 2013/14 Q1. Although this rate is lower than average, of those adults on CPA, a significantly higher percentage are in settled accommodation than the national average. In Merton, the rate of recovery for IAPT treatment (percentage of people completing IAPT who have moved to recovery) is significantly lower.

The relatively low funding of mental health services in Merton creates the necessity for a tightly managed system which enables people to be treated in community wherever possible, and in inpatient care wherever required. Merton mental health services thus manage demand for inpatient services to operate with a lower than average bed occupancy for its population. This reflects a well performing Home Treatment Team, and good interfaces with community and inpatient services to support discharge planning.

A similar prioritisation process underpins the primary/secondary care interface, where Adult Mental Health and GPs actively manage the care pathway to ensure that people receive their treatment/support at the right level through regular practice based meetings. This results in a prioritised system where people do not remain under a CPA level of care longer than they require and therefore relatively few Merton residents, benchmarked against other CCGs, are under CPA at any one time. However, those that are on CPA at any one time will have complex needs, and a higher than average proportion of these will require admission. This high proportion relates to the low denominator of people on CPA, given that the absolute numbers of people requiring admission is low.

Figure 5: Merton Community Mental Health Profile: wider determinants, risk factors and levels of illness

The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the black line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A dark blue circle means that this area is significantly lower than England for that indicator; a pale blue circle means that this area is significantly higher than the England average for that indicator.

- ● Significantly lower than England average
- ● Not significantly different from England average
- ● Significantly higher than England average
- ○ Significance not calculated

Domain	Indicator	Period	Local value	Eng. value	Eng. lowest	Eng. highest
Levels of mental health and illness	1 Depression: QOF prevalence (18+)	2012/13	4.7	5.8	2.9	11.5
	2 Depression: QOF incidence (18+)	2012/13	0.9	1.0	0.5	1.9
	3 Depression and anxiety prevalence (GP survey)	2012/13	9.2	12.0	8.1	19.5
	4 Mental health problem: QOF prevalence (all ages)	2012/13	0.78	0.84	0.48	1.46
	5 % reporting a long-term mental health problem	2012/13	3.6	4.5	2.5	8.2
Treatment	6 Patients with a diagnosis recorded	2013/14 Q1	51.7	17.8	1.1	63.2
	7 Patients assigned to a mental health cluster	2013/14 Q1	88.0	69.0	1.9	94.8
	8 Patients with a comprehensive care plan	2012/13	88.6	87.3	79.9	95.0
	9 Patients with severity of depression assessed	2012/13	88.2	90.6	77.4	97.8
	10 Antidepressant prescribing (ADQs/STAR-PU)	2012/13	3.8	6.0	2.7	9.0
	11 People with a mental illness in residential or nursing care per 100,000 population	2012/13	14.9	32.7	0.0	124.3
	12 Service users in hospital: % mental health service users who were inpatients in a psychiatric hospital	2013/14 Q3	3.4	2.4	0.7	12.3
	13 Detentions under the Mental Health Act per 100,000 population	2013/14 Q1	17.1	15.5	0.0	44.5
	14 Attendances at A&E for a psychiatric disorder per 100,000 population	2012/13	180.0	243.5	3.0	925.5
	15 Number of bed days per 100,000 population.	2013/14 Q1	2270	4686	685	11073
	16 People in contact with mental health services per 100,000 population	2013/14 Q1	1139	2176	116	5442
	17 Carers of mental health clients receiving of assessments	2012/13	168.0	68.5	0.0	343.4
	18 Spend (£s) on mental health in specialist services: rate per 100,000 population	2012/13	16425	26756	14296	49755
	19 % secondary care funding spent on mental health	2011/12	10.4	12.1	7.1	19.1
Outcomes	20 People on Care Programme Approach per 100,000 population	2013/14 Q1	482	531	17	1895
	21 % CPA adults in settled accommodation	2013/14 Q1	78.9	61.0	5.0	94.6
	22 % CPA adults in employment	2013/14 Q1	9.1	7.0	0.0	22.7
	23 Emergency admissions for self harm per 100,000 population	2012/13	88.7	191.0	49.8	595.6
	24 Suicide rate	2010 - 12	8.2	8.5	4.8	19.6
	25 Hospital admissions for unintentional and deliberate injuries, ages 0-24 per 10,000 population	2012/13	93.4	116.0	68.6	201.7
	26 Rate of recovery for IAPT treatment	2012/13	37.9	45.9	22.6	80.3

Indicator Notes

1 % adults (18+) with a record of unresolved depression recorded since 2006 (2012/13) 2 % adults (18+) with a new diagnosis of depression recorded in 2012/13 3 % respondents to the GP survey who reported moderate or extreme anxiety or depression, 2012/13 4 % adults with a serious mental illness (schizophrenia, bipolar disorder or other psychoses, or on lithium therapy), 2012/13 5 % people in people the GP practice survey reporting a long-term mental health problem, 2012/13 6 % patients in contact with mental health services with a diagnosis recorded, Q1 2013/14 7 % patients in contact with mental health services assigned to a cluster, Q1 2013/14 8 % patients with a serious mental illness who have a comprehensive care plan recorded, 2012/13 9 % new depression cases with a severity assessment at outset of treatment), 2012/13 10 Average daily doses of antidepressants prescribed per patient (STAR-PU), 2012/13 11 Merton mental health clients aged 18-64 receiving community, residential or nursing home care in 2012/13 per 100,000 population 12 Standardised admissions of all people in contact with specialist mental health services/ 100,000 population 2012/13 13 Detentions under the mental health act\100,000 population, Q1 2013/14 14 Attendances at A&E for a psychiatric disorder, 2012/13 15 In-year bed days for mental health\1,000 population, 2012/13 16 17 People in contact with specialist mental health services\100,000 population, 2013/14 Q1 17 Carers of mental health clients aged 18-64 who were assessed during 2012/13 per 100,000 population 18 Spend on all publicly funded mental health services for adults aged 16-64, rate per 100,000 adults, 2010/11 19 Spend for specialist mental health services as a % of all secondary care services, 2011/12 20 People on CPA per 100,000 population 2013/14 Q1 21 % people with mental illness on CPA, aged 18-69, in settled accommodation, 2013/14 Q1 22 % people with mental illness on CPA, aged 18-69, in employment, 2013/14 Q1 23 Directly standardised rate for emergency hospital admissions for self harm, 2012/13 24 to Directly standardised mortality rate for suicide and undetermined injury, 2010-2012 25 Admissions for unintentional or deliberate injuries in <24s, 2012/13 26 % people completing IAPT who have moved to recovery, 2012/13

Source: NEPHO 2014 http://fingertips.phe.org.uk/profile-group/mental-health/profile/cmhp/data

Spend and Outcome data for Merton

Programme budgeting is a well-established technique for assessing investment in programmes of care rather than services. All PCTs in England have submitted an annual programme budgeting return since 2003/4. The tool and factsheets use this Programme Budgeting data and overall indicators of health outcome by programme (where available) to present PCTs and CCGs with an analysis of the impact of their expenditure. This allows easy identification of those areas which require priority attention, where relative potential shifts in investment opportunities will optimise local health gains and increase quality. In all there are 23 programme budget areas, of which mental health is one. At CCG level the latest data is for 2011-12.

Overall Merton CCG compares favourably in terms of the spend and outcome data for the Mental Health (MH) programme – see figure 6 below where the red arrow denotes that programme. While this is a considered one of the big spend areas in the health budgets of all CCGs (along with circulatory disease and cancer), the MH programme in MCCG is an area of low spend and better outcomes, the best possible combination.

The SPOT (spend and outcomes) tool[67] enables more detailed analysis of the mental health programme budget for MCCG in comparison with other CCGs, and ONS clusters. The mental health (MH) programme is further categorised into six areas of spend:
- Mental Health Disorders
- Organic Mental Disorders
- Psychotic Disorders
- Other Mental Health Disorders
- Substance Misuse
- Child and Adolescent Mental Health Disorders

For each of these areas of spend, the figures 7-12 depict the spend and outcomes of Merton CCG relative to other CCGs. Merton CCG is the largest light green dot (with red arrow) in each of these figures. Each dot represents a CCG. CCGs in the same ONS Cluster and/or SHA are highlighted.

For Mental Health Disorders - MCCG has lower spend and better outcomes
Organic Mental Disorders - MCCG has lower spend and better outcomes
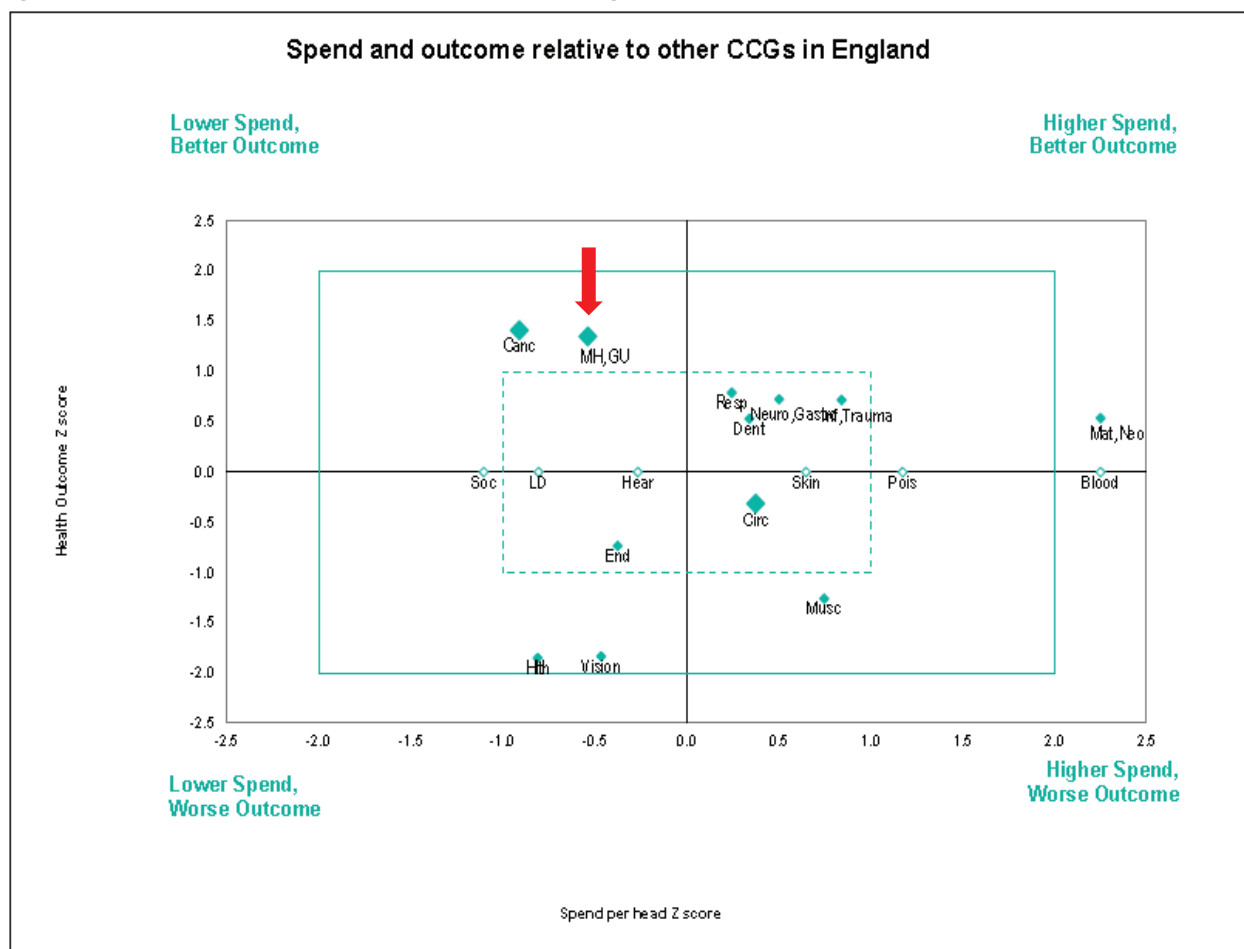Psychotic Disorders - MCCG has lower spend and better outcomes
Other Mental Health Disorders - MCCG has higher spend and better outcomes
Substance Misuse - MCCG has a much lower spend and better outcomes
Child and Adolescent Mental Health Disorders- MCCG has a much lower spend and better outcomes

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[67] http://www.yhpho.org.uk/default.aspx?RID=49488

Figure 6: Merton CCG spend and outcomes for all programmes, 2011-12

Spend and outcome relative to other CCGs in England

Lower Spend,
Better Outcome

Higher Spend,
Better Outcome

Lower Spend,
Worse Outcome

Higher Spend,
Worse Outcome

Health Outcome Z score

Spend per head Z score

◇ No outcome indicators readily available
◆ Outcome indicators available

Programme Area Abbreviations

Infectious Diseases	Inf	Hearing	Hear	Disorders of Blood	Blood
Cancers & Tumours	Canc	Circulation	Circ	Maternity	Mat
Respiratory System	Resp	Mental Health	MH	Neonates	Neo
Endocrine, Nutritional & Metabolic	End	Dental	Dent	Neurological	Neuro
Genito Urinary System	GU	GI System	Gastro	Healthy Individuals	Hlth
Learning Disabilities	LD	Musculoskeletal	Musc	Social Care Needs	Soc
Adverse effects & poisoning	Pois	Trauma & Injuries	Trauma		

Interpreting the chart:

Spend: By population, Population: Unified Weighted

Each dot represents a programme budget category. The three largest spending programmes nationally (Mental Health, Circulatory Diseases and Cancer) are represented by larger dots.

The outcome measures on the chart have been chosen because they are reasonably representative of the programme as a whole. This means that for some programmes no outcome data is available.

The source data for the outcome measures shown on the chart can be found in the Spend and Outcome Tool.

A programme lying outside the solid +/- 2 z scores box, may indicate the need to investigate further. If the programme lies to the left or right of the box, the spend may need reviewing, and if it lies outside the top or bottom of the box, the outcome may need reviewing. Programmes outside the box at the corners may need a review of both spend and outcome.

Programmes lying outside the dotted/thin +/- 1 z score box may also warrant further exploration.

Z score:

A z score essentially measures the distance of a value from the mean (average) in units of standard deviations. A positive z score indicates that the value is above the mean, whereas a negative z score indicates that the value is below the mean. A z score below -2 or above +2 may indicate the need to investigate further.

Figure 7: Mental Health Disorders, 2011-12

Spend and Outcome relative to other CCGs
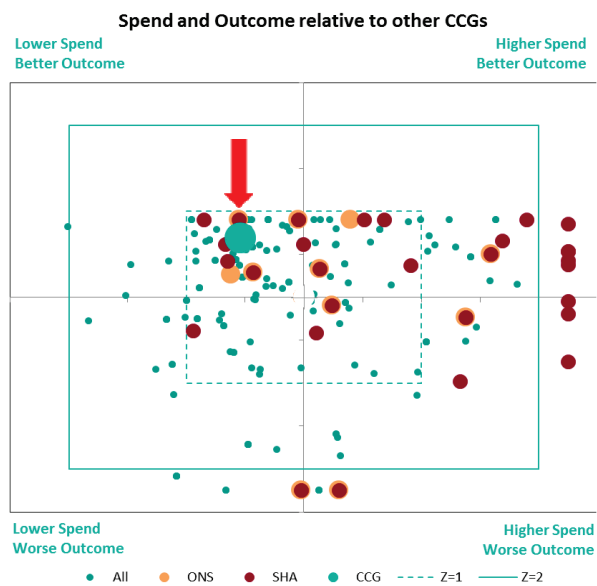
Figure 10: Other MH Disorders, 2011-12

Spend and Outcome relative to other CCGs
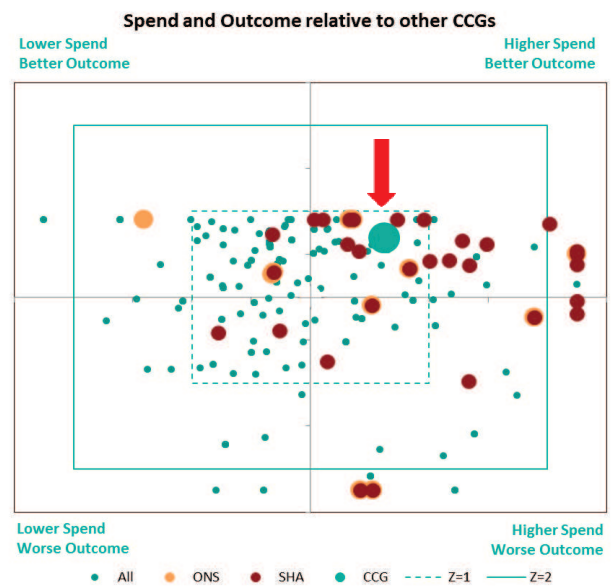
Figure 8: Organic Mental Disorders, 2011-12

Spend and Outcome relative to other CCGs
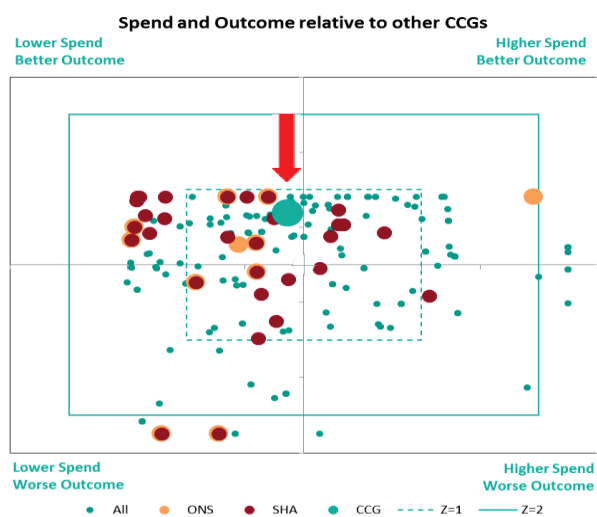
Figure 11: Substance Misuse, 2011-12

Spend and Outcome relative to other CCGs
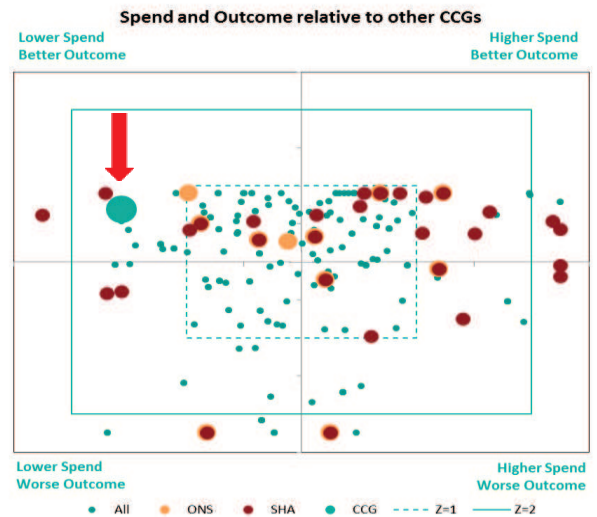
Figure 9: Psychotic Disorders, 2011-12

Spend and Outcome relative to other CCGs
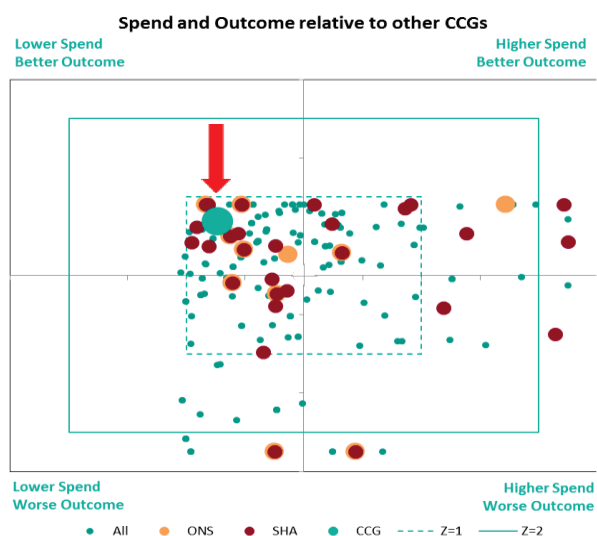
Figure 12: Child and Adolescent Mental Health Disorders, 2011-12

Spend and Outcome relative to other CCGs

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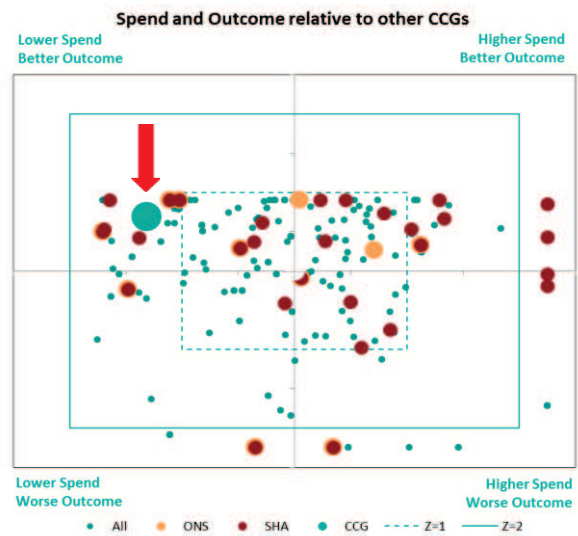
Spend per capita on mental health

As noted on the section before this, Merton CCG has lower spend and better outcomes for mental health, suggesting good value for money and returns on investments. The per capita spend is much lower than the comparator ONS cluster and England.

Table 2: Merton CCG per capita spend on mental health, compared with ONS cluster and England

Merton CCG			ONS Cluster 2011-12	England 2011-12
2009-10	**2010-11**	**2011-12**		
£183	£188	£185	£219	£212

Source: Spend and Outcomes Factsheets, NHS England, Public Health England, Right Care

Spend on mental health

Merton CCG

Table 2 above depicts the spend per capita. Despite plans in the Local Joint Mental Health Strategy (2010 - 2015) to create a shift in mental health spend from secondary care to primary care; NHS Merton still invests very little at the primary care end of the mental health care spectrum (see table 3).

Table 3: Merton CCG spend on mental health, 2012-13

MH Services	Merton (£000)	%Total spend
Primary Care	1,200	5.9%
Secondary Care	19,000	94.1%
Total (£000)	**£20,200**	

London Borough of Merton

Merton Council finances the social care elements of Merton's adult mental health services. These include adult placements, day care, direct payments to Merton residents with mental health conditions, home care, nursing and residential care. When the financial data for the periods from 2008-09 to 2012-13 are examined, the total gross spend has been decreasing year on year, but when the income[68] (which is falling year on year) is deducted from these gross amounts, we find a drop from 2009-12 but then the spend increases again slightly in 2012/13 (see table 4).

Table 4: London Borough of Merton Gross Mental Health Placements Spend, 2008-13

	Financial Years				
	2008/09 £	**2009/10** £	**2010/11** £	**2011/12** £	**2012/13** £
Adult Placement	595,140	625,605	541,394	513,795	504,127
Day Care*	526,207	562,323	473,291	357,905	383,508
Direct Payment	74,356	164,118	116,871	99,106	105,804
Home care	81,385	129,615	132,025	142,915	188,731
Nursing	218,682	220,696	153,913	73,554	69,054
Residential	1,038,782	1,112,575	952,358	980,256	709,543
Other	61,037	57,133	29,832	29,257	23,763
Total Gross	**2,595,589**	**2,872,065**	**2,399,684**	**2,196,788**	**1,984,530**
Less Income		-716,445	-742,751	-597,964	-361,205
Total Net		2,155,620	1,656,933	1,598,824	1,623,325

* Includes day care contracts

[68] Income: these are contributions from customers if they have been assessed to pay. In earlier years(2009/10 and 2010/11) this also included government grants.

What is the size of mental ill health in Merton?

The prevalence of mental health conditions is calculated in various ways. The Adult psychiatric morbidity household survey in England, 2007[69] helped to generate national estimates of prevalence for various mental health conditions. The survey uses statistically robust methods to sample households and assesses psychiatric disorders where possible to actual diagnostic criteria. These are applied to local populations to estimate the expected numbers in that local population, of individuals having these mental health conditions. When the national prevalence is applied to the Merton population, the numbers are likely to under-estimate the true prevalence, as the national prevalence is not adjusted for ethnicity and certain ethnic groups are known to have higher prevalence of certain mental illnesses. Nevertheless this is a very useful metric and is the best available estimate. For depression and dementia, QOF (Quality and Outcomes Framework) data are able to provide an accurate record of the number of actual diagnoses of depression and dementia made by GP practices and this can be compared with the expected numbers.

Mental health conditions in working age (18-64 year old) in Merton

The table below shows the modelled number of people with mental health conditions in Merton, London and England for two periods- 2012 and 2018. The number of people with mental health conditions increases in time at all administrative levels and for all conditions.

Table 5: Expected Prevalence of Mental Health Conditions in working age adults (18-64) in Merton, London and England in 2012 and 2018

Working age adults (18-64)	2012			2018		
	Merton	London	England	Merton	London	England
Common Mental Disorder	22,182	894,822	5,336,014	24,996	964,009	5,481,450
Borderline Personality Disorder	620	25,019	149,207	698	26,924	153,215
Antisocial Personality Disorder	480	19,400	115,574	547	21,091	119,118
Psychotic Disorder	551	22,233	132,586	621	23,946	136,183
Two or more Psychiatric Disorders	9,910	399,958	2,384,591	11,193	432,647	2,451,198

Source: Projecting Adult Needs and Service Information (PANSI) web site 08.10.2013
Based on the Adult psychiatric morbidity in England, 2007: Results of a household survey, published by the Health and Social Care Information Centre in 2009.

The table below indicates the national prevalence for common mental disorders and for two or more psychiatric disorders. These are applied to the Merton ONS mid-year population estimates for each of the years from 2012-2020.

Table 6: Estimated prevalence in working age men and women in England

Prevalence	% males	% females
Common mental disorder	12.5	19.7
Two or more psychiatric disorders	6.9	7.5

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[69] http://www.hscic.gov.uk/pubs/psychiatricmorbidity07

Figure 13 below shows the estimated number of 18-64 year olds in Merton predicted to have a common mental disorder or two or more psychiatric disorders from 2012 to 2020 (provisional). It shows that the number of working age adults in Merton with a common mental health disorder will increase progressively from 2012 to 2020. The number of working age Merton adults with two or more psychiatric disorders will also increase over this period but more gradually.

Figure 13: Estimated numbers of people in Merton predicted* to have a common mental disorder or two or more psychiatric disorders projected from 2012 to 2020
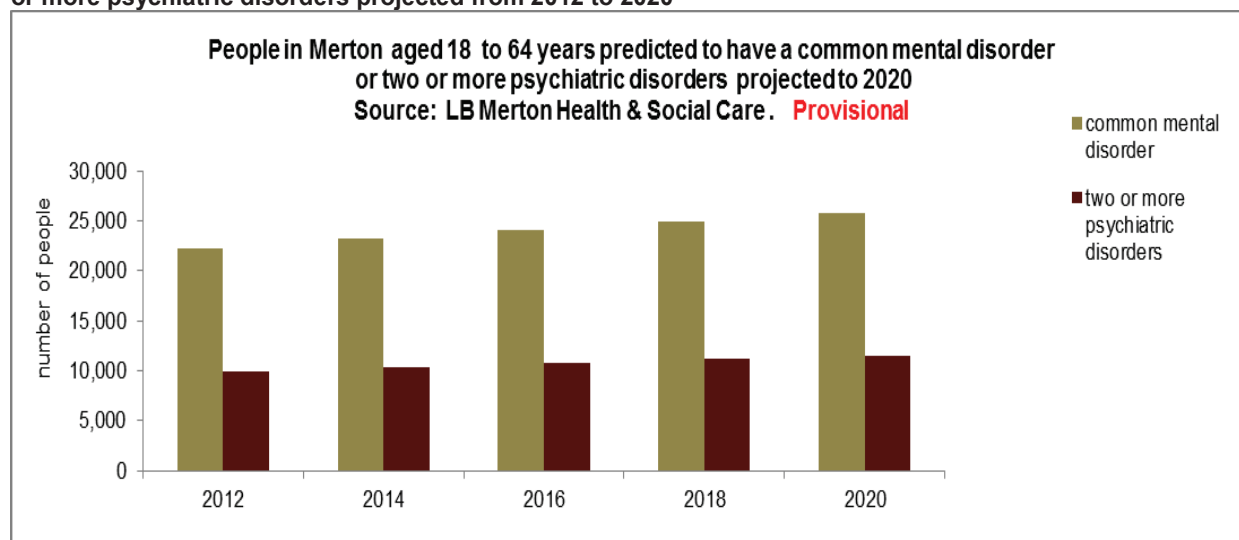
The prevalence rates have been applied to ONS population projections for the 18-64 population to give estimated numbers predicted to have a mental health problem, projected to 2020.

Figure 14 shows the estimated numbers of working age adults in Merton predicted to have personality and psychotic disorders from 2012 to 2020. The table depicts the national prevalence for these conditions in men and women. Borderline personality disorder and psychotic disorders are predicted to rise during this eight year period.

Figure 14: Estimated numbers of working age people in Merton predicted* to have a personality or psychotic disorder projected from 2012 to 2020
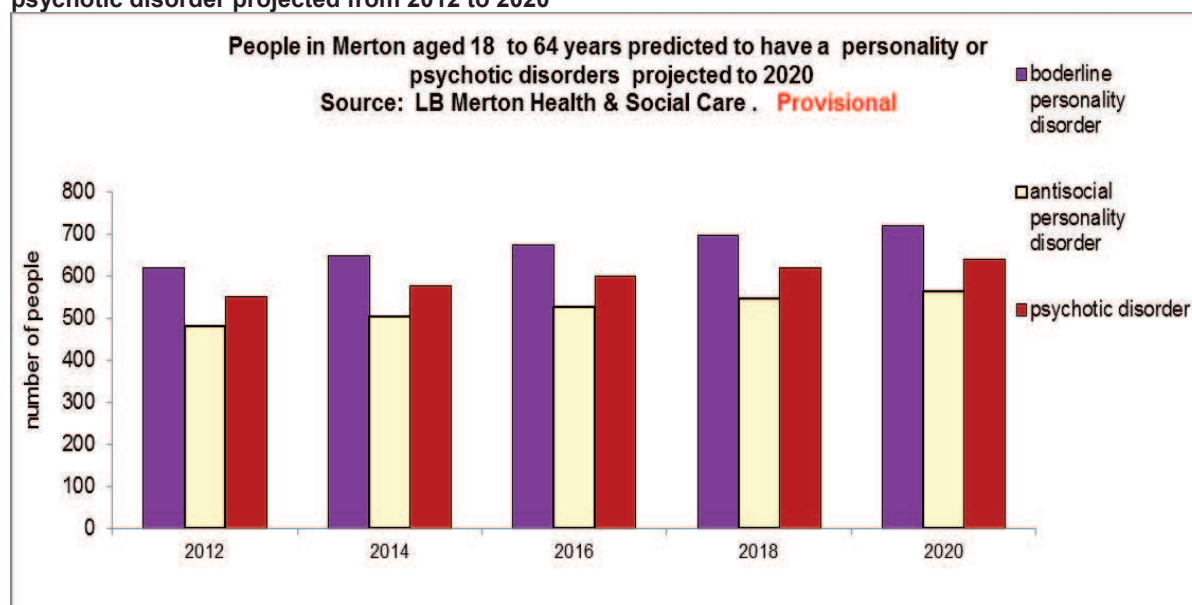
*The prevalence rates have been applied to ONS population projections for the 18-64 population to give estimated numbers predicted to have a mental health problem, projected to 2020.

Table 7: Estimated prevalence in working age men and women in England

Prevalence	% males	% females
Borderline personality disorder	0.3	0.6
Antisocial personality disorder	0.6	0.1
Psychotic disorder	0.3	0.5

Quality and Outcomes Framework (QOF)

The Quality and Outcomes Framework (QOF) rewards GP practices financially for the provision of quality care and helps to standardise improvements in the delivery of clinical care. Practice participation in QOF is voluntary but most practices on General Medical Services (GMS) contracts, as well as many on Personal Medical Services (PMS) contracts, take part in QOF. It was introduced as part of the new GMS contract in 2004.

In terms of mental health reported prevalence by CCG - the percentage of registered patients on the mental health register, in 2012-13 Merton CCG had the lowest prevalence among SW London CCGs as well as statistically similar CCGs (figure 15).

Figure 16 depicts the mental health reported prevalence by practices in East and West Merton, and also comparing data from 2010/11 with 2012/13. Most practices in East Merton had higher prevalence than practices in West Merton, across both periods. Only two practices in East Merton have seen a sharp drop in prevalence, and most practices have had increases from 2010/11 to 2012/13.

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Figure 15: Mental health reported prevalence by CCG - the percentage of registered patients on the mental health register

Mental health prevalence by CCG, Merton and comparators- QOF 2012-13

Source: NHS Information Centre, HSCIC https://indicators.ic.nhs.uk/webview/
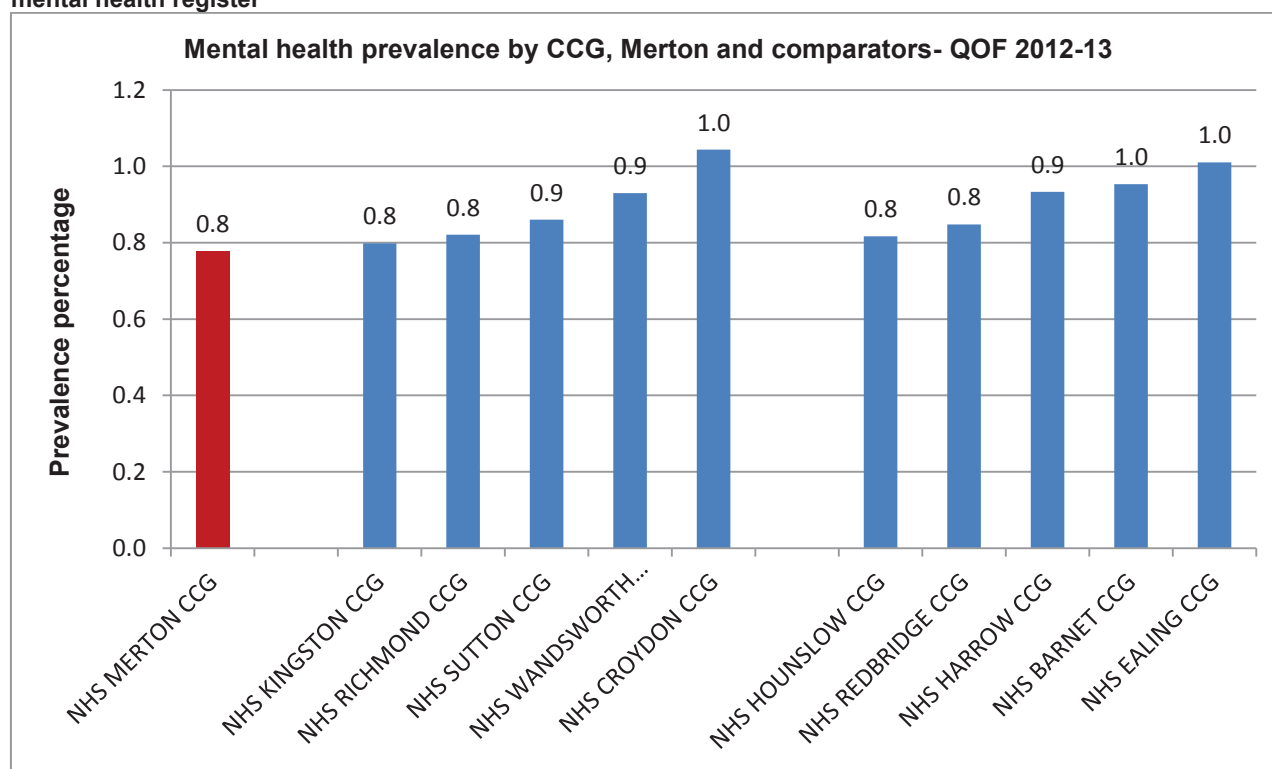
Figure 16: Mental health reported prevalence by practice in Merton - the percentage of registered patients on the mental health register, QOF 2010/11 & 2012/13

Source: NHS Information Centre, HSCIC https://indicators.ic.nhs.uk/webview/
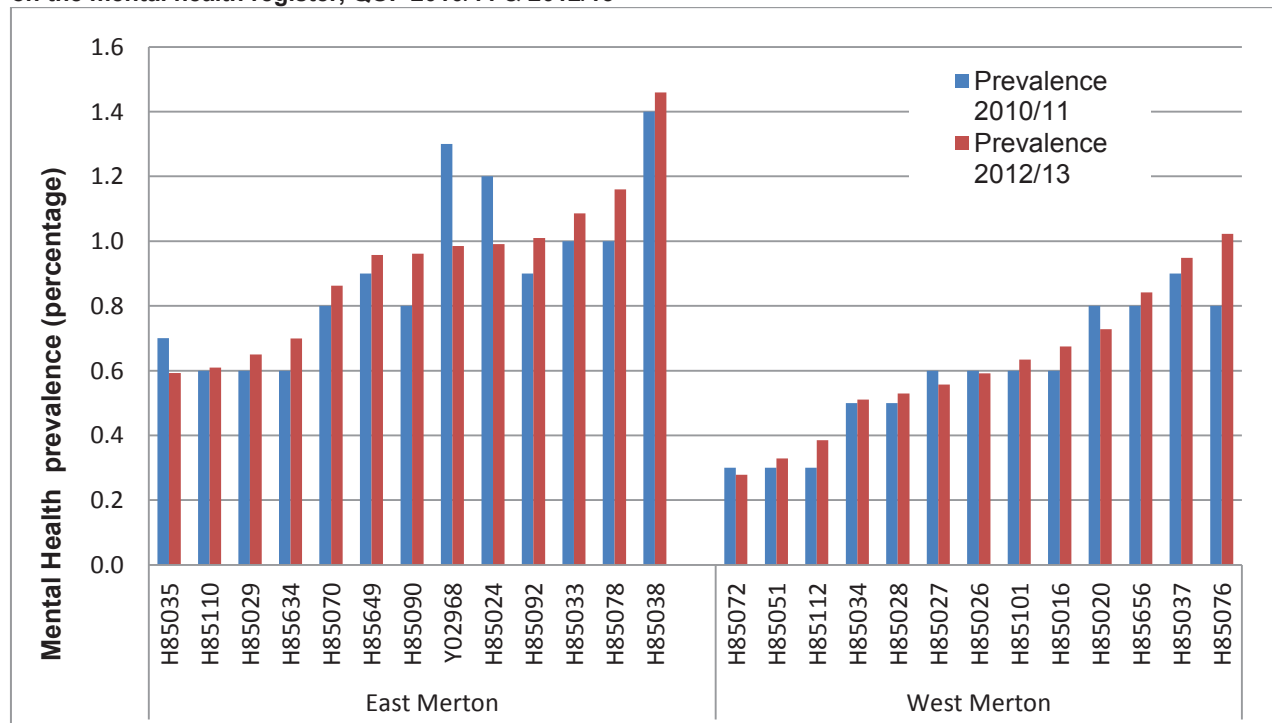
QOF indicator MH 10 relates to "the percentage of patients on the register who have a comprehensive care plan documented in the records agreed"- Practices across both areas

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of Merton have a very similar profile with most practices in the 70-90% range. Three practices in East Merton have low rates in the region of 60%.

Figure 17: MH 10-The percentage of patients on the register who have a comprehensive care plan documented in the records agreed

Source: NHS Information Centre, HSCIC https://indicators.ic.nhs.uk/webview/
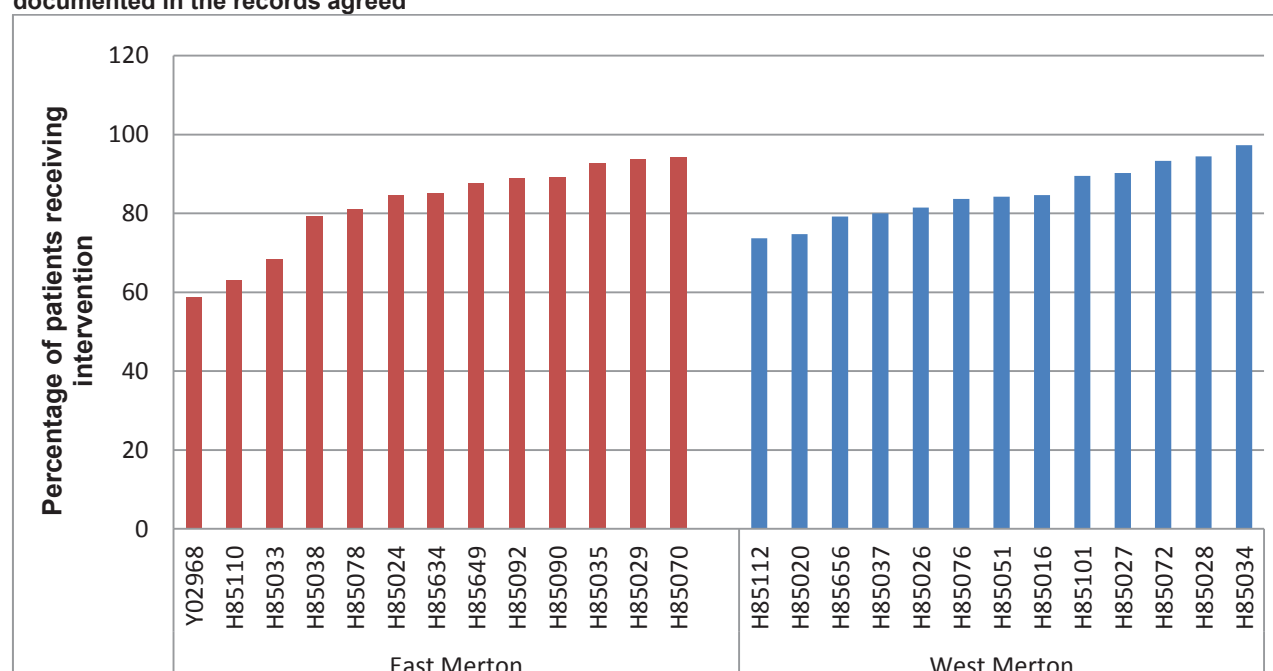
Health & social care outcomes related to mental health

The Health and Social Care Information Centre is the national database for all data relating to health and social care. Some of the indicators in it relate to mental health. The latest data is mostly for 2011-12 but in some cases for 2010-11. Also for Merton the data is in some cases reported as Sutton & Merton PCT (SMPCT) rather than as Merton CCG. However the comparative values give a reasonable idea of where Merton stands in relation to England, London, statistical and neighbouring boroughs. While the relevant HSCIC outcomes are reported in this document under the mental health conditions to which they apply, these are proxy indicators for the quality of care provided especially in the community, and help to benchmark Merton against national, regional and local comparators.

Comprehensive care plan for patients on mental health register
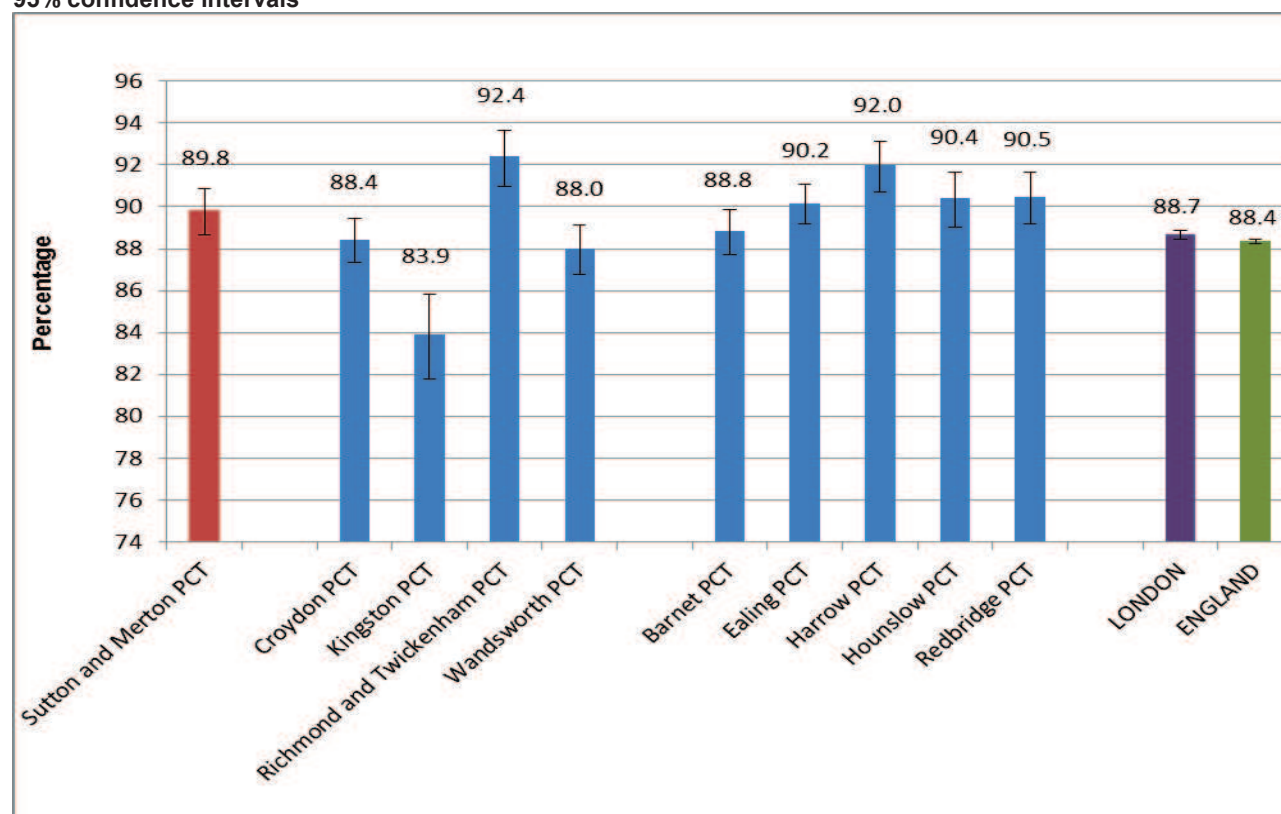
Patients on the mental health register should have a documented primary care consultation that acknowledges, especially in the event of a relapse, a comprehensive plan for care. This consultation may include the views of their relatives or carers where appropriate. For the patients who have a Severe Mental Illness and are seen in a primary care setting, it is important that the primary care team takes responsibility for discussing and documenting a care plan in their primary care record. In 2011-12 SMPCT had the second highest percentage in SW London, higher than England and marginally higher than London. It was second lowest compared with statistical neighbours (figure 18 below).

* 95% confidence intervals (CI) indicate the precision with which the percentages are calculated. They also indicate the range of values in which there is a 95% likelihood that the true value for the patient population lies - the narrower the range, the more precise the calculation. The intervals are the widest for the smaller sample sizes. These are shown by the vertical lines at the top of the bar graphs. When the percentages are compared, if the CI intervals do not overlap this represents a statistically significant difference.

ASCOF 1F: Proportion of adults in contact with secondary mental health services in paid employment

This indicator measures working age adults who are receiving secondary mental health services and who are on the Care Programme Approach recorded as being employed, as a percentage of working-age adults who are receiving secondary mental health services and who were on the Care Programme Approach (aged 18 to 69). Merton is above England and London on this indicator, third lowest among SW London boroughs and higher than all statistical neighbours (figure 19).

ASCOF 1H: Proportion of adults in contact with secondary mental health services living independently, with or without support

This indicator measures adults who are receiving secondary mental health services on the Care Programme Approach recorded as living independently, with or without support, as a percentage of adults who are receiving secondary mental health services and who are on the Care Programme Approach (aged 18 to 69). While Merton is above the England average, it is below the London average and the lowest among SW London boroughs. It is second lowest among statistical neighbours (figure 20 below).

Figure 19: ASCOF 1F: Proportion of adults in contact with secondary mental health services in paid employment, 2012-13*
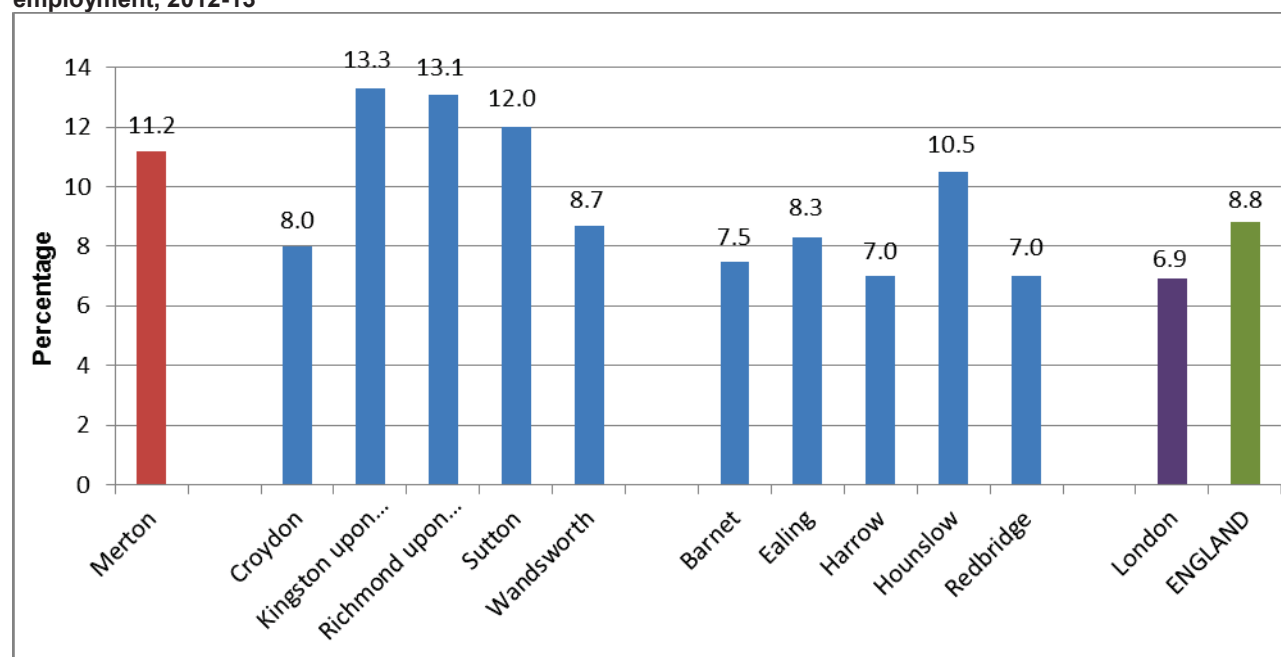
Source: NHS Information Centre, HSCIC https://indicators.ic.nhs.uk/webview/
*ASCOF data does not include confidence intervals.

Figure 20: ASCOF 1H: Proportion of adults in contact with secondary mental health services living independently, with or without support, 2012-13*
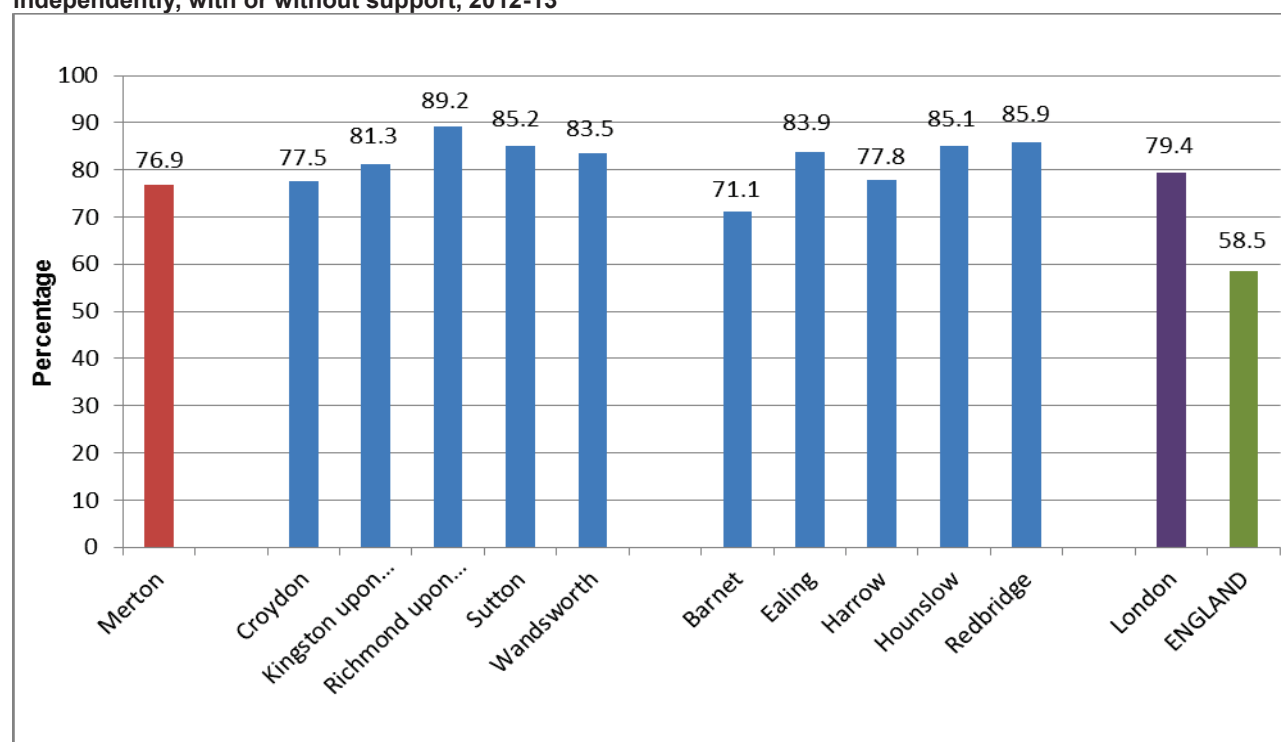
Source: NHS Information Centre, HSCIC https://indicators.ic.nhs.uk/webview/
*ASCOF data does not include confidence intervals.

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Common Mental Health Disorders (CMDs)

Key Points
- *Public Health England estimates that Merton has one of the highest percentages of 16-74 years olds estimated to have a common mental health disorder*
- *Merton has significantly lower than national averages for adults with depression known to GPs and new cases of depression; and lower than national average long term mental health problems, and depression and anxiety among GP survey respondents*
- *The overall GP recorded depression prevalence is 4.7% for Merton CCG. the England prevalence is 5.8%*
- *In terms of the ratio of observed to expected depression prevalence, Merton has an overall ratio of 0.8 which suggests a level of under-diagnosis and there is considerable variance in diagnosis levels in Merton GP practices and between East and West Merton*
- *The rate of initial assessment of depression in Merton was significantly lower than the England average while the percentage of adults with a new diagnosis of depression with a follow-up assessment after 4-12 weeks was significantly higher*
- *Merton performs significantly lower than average at case finding for depression and has a significantly lower than average percentage of people with long term conditions visiting GP who felt that they have had enough support from local services in the last 6 months*
- *the IAPT (Improved Access to Psychological Therapies) referral rate (18+ yrs of age) in Merton was significantly higher than the national average as was the referral rate specifically for depression*
- *For mixed anxiety and depression the IAPT referral rate was significantly lower than average*
- *IAPT use by BME groups in Merton was significantly higher than the national average as was access to IAPT services expressed as a percentage of those estimated to have anxiety and depression*
- *The rate of beginning IAPT treatment was significantly higher than the national average while the rate of completion of treatment was significantly lower- suggesting low recovery rates, which indeed is the case in Merton*
- *For IAPT services in Merton, the percentage of referrals waiting less than 28 days are significantly lower than average but in contrast, for waiting times greater than 90 days Merton has significantly higher than average percentages*

CMDs include different types of depression and anxiety. They cause appreciable emotional distress and interfere with daily function, but do not usually affect insight or cognition. According to the Adult Psychiatric Morbidity Survey (APMS) 2007[70]:
- More than half of those with a CMD presented with mixed anxiety and depressive disorder (9.0%).
- Women were more likely than men to have a CMD (19.7% and 12.5% respectively), and rates were significantly higher for women across all categories of CMD, with the exception of panic disorder and obsessive compulsive disorder.

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[70] http://www.hscic.gov.uk/catalogue/PUB02931/adul-psyc-morb-res-hou-sur-eng-2007-rep.pdf

- Overall, the proportion of people aged 16-64 meeting the criteria for at least one CMD increased between 1993 and 2000, but did not change between 2000 and 2007 (15.5% in 1993, 17.5% in 2000, 17.6% in 2007). The largest increase in rate of CMD between 1993 and 2007 was observed in women aged 45-64, among whom the rate rose by about a fifth.
- Rates of CMD varied by age: those aged 75 and over were the least likely to have a CMD (6.3%of men, 12.2% of women). In women, the rate peaked among 45-54 year olds, with a quarter (25.1%) of this group meeting the criteria for at least one CMD. Among men the rate was highest in 25-54 year olds (14.6%of 25-34 year olds, 15.0%of 35-44 year olds, 14.5% of 45-54 year olds).
- A quarter (24%) of people with a CMD were receiving treatment for an emotional or mental problem, mostly in the form of medication. The level and nature of treatment varied by type of CMD: over half (57%) the adults with a phobia were in receipt of treatment, but only 15%of those with mixed anxiety and depressive disorder. Half (48%) the people with two or more CMDs were receiving treatment for a mental or emotional problem.

Common Mental Health Disorders Profile for Merton (figure 21)

Risk and related factors
Social, economic and environmental conditions influence the mental and physical health of individuals and communities such as deprivation, employment, crime, and alcohol and drug misuse. In Merton indicators are generally significantly better than England; however Public Health England has identified household overcrowding, percentage of households living in rented accommodation, percentage of people who cannot speak English/ speak it well, population turnover (internal migration), and migrant GP registrations as areas with significantly higher than national average values for Merton.

Prevalence
Public Health England estimates that Merton has one of the highest percentages of 16-74 year olds estimated to have a common mental health disorder (31%). The statistical significance of this metric has not been calculated and the figure is likely to be revised as it is not accurate[71]. As mentioned earlier, Merton has significantly lower than national averages for adults with depression known to GPs, new cases of depression; and lower than national average long term mental health problems, and depression and anxiety among GP survey respondents. This might indicate a low prevalence in Merton but could also indicate under-diagnosis and under-recording.

Services
As a snapshot (Q3, 2013/14), the IAPT referral rate (18+ yrs of age) in Merton was significantly higher than the national average as was the referral rate specifically for depression. For mixed anxiety and depression the IAPT referral rate was significantly lower than average. IAPT use by BME groups in Merton was significantly higher than the national average as was access to IAPT services expressed as a percentage of those estimated to have anxiety and depression. The rate of beginning IAPT treatment was significantly higher

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[71] NHS Merton Clinical Commissioning Group has corresponded with Public Health England on this figure, and it has been established that there was an error in the way it was calculated.

than the national average while the rate of completion of treatment was significantly lower-suggesting low recovery rates, which indeed is the case in Merton.

Quality and Outcomes
As mentioned earlier in this report, the rate of initial assessment of depression in Merton was significantly lower than average, expressed as the percentage of adults with a new diagnosis of depression with an assessment of severity at treatment outset, while the percentage of adults with a new diagnosis of depression with a follow-up assessment after 4-12 weeks was significantly higher. This suggests that Merton GP practices are better at follow-up assessment of depression after 4-12 weeks than they are in the initial assessment of depression. Merton performs significantly lower than average at case finding for depression, the metric for which is the percentage of patients on diabetes and/or CHD register for whom case finding for depression has been undertaken during the preceding 15 months. This suggests that the mental health of patients with physical health problems is not adequately addressed in primary care. This is further corroborated by the finding that Merton has a significantly lower than average percentage of people with long term conditions visiting GP who felt that they have had enough support from local services in the last 6 months.

For IAPT services in Merton, the percentage of referrals waiting less than 28 days are significantly lower than average but in contrast, for waiting times greater than 90 days Merton has significantly higher than average percentages. This means that more referrals are waiting over 90 days than they are less than 28 days. As mentioned earlier, IAPT recovery rate in Merton is significantly lower than national average. The DNA (Did Not Attend) rate is also significantly lower than average.

In terms of social care based on 2012/13 figures[72], Merton has a significantly lower than national average percentage of service users who are extremely or very satisfied with their care and support. The percentage of services users who say that services have made them feel safe and secure is also significantly lower than average. Public Health England has expressed some concerns with the quality of the data.

Finance
In general Merton has a lower spend on mental health compared with the national average. Where Merton's spend is considerably higher than average is the percentage spend on "other" mental health. It is also higher for secondary care spend on "other" mental health and the spend on IAPT services.

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[72] http://fingertips.phe.org.uk/profile-group/mental-health/profile/common-mental-disorders/data#gid/8000043/pat/6/ati/102/page/1/par/E12000007/are/E09000024

Figure 21 : Merton Common Mental Health Disorders Profile (CMDs)

- ● Significantly lower than England average
- ● Not significantly different from England average
- ● Significantly higher than England average
- ○ Significance not calculated

England Average
England Worst — 25th Percentile — 75th Percentile — England Best

Risk and related factors

	Period	Local value	Eng. value	Eng. worst	Range	Eng. best
Socioeconomic deprivation: overall IMD score	2012	15.0	21.5	5.8		47.4
Older people living in income deprived households: % of people over 60	2012	17.2	18.1	7.4		56.2
People with CHD and/or diabetes: % patients on the GP register	2012/13	5.8	7.3	4.3		10.4

Prevalence

	Period	Local value	Eng. value	Eng. worst	Range	Eng. best
People estimated to have any common mental health disorder: Estimated % of population aged 16-74	2013/14	31.04 ^	15.85	4.84		31.04
Adults with depression known to GPs: Patients with depression as % of all patients on the GP register	2012/13	4.7	5.8	2.9		11.5
New cases of depression: Adults with a new diagnosis of depression as % of all patients on the GP register	2012/13	0.9	1.0	0.5		1.9
Long term mental health problems among GP survey respondents: % people completing GP patient survey who report long-term mental health problem	2013/14	3.7	4.6	2.6		8.8
Depression and anxiety among GP survey respondents: % of people completing GP patient survey reporting they feel moderately or extremely anxious or depressed	2013/14	9.4	12.1	7.2		19.4

Services

	Period	Local value	Eng. value	Eng. worst	Range	Eng. best
Adults with depression known to GPs: Patients with depression as % of all patients on the GP register	2012/13	4.7	5.8	2.9		11.5
New cases of depression: Adults with a new diagnosis of depression as % of all patients on the GP register	2012/13	0.9	1.0	0.5		1.9
Antidepressant prescribing: Average daily quantities (ADQs) per STAR-PU	2012/13	3.8	6.0	2.7		9.0
Use of '1st choice' antidepressants: % of prescription items that were '1st choice' generic SSRIs	2012/13	67.6	63.4	53.4		74.2
Hypnotics prescribing: Average daily quantities (ADQs) per STAR-PU	2012/13	3.30	4.18	1.90		7.98
IAPT referrals: Rate (quarterly) per 100,000 population aged 18+	2013/14 Q3	1052	624	3		1719
IAPT referrals for depression: Rate (quarterly) per 100,000 population aged 18+	2013/14 Q3	92.5	73.1	0.0		738.2
IAPT referrals for mixed anxiety and depression: Rate (quarterly) per 100,000 population aged 18+	2013/14 Q3	16.5	75.1	0.0		684.5
IAPT use by BME groups: % of referrals (in quarter) which are for people of black and minority ethnic groups	2013/14 Q3	41.5	16.1	0.9		75.1
Access to IAPT services: People entering IAPT (in month) as % of those estimated to have anxiety/depression	Dec 2013	14.6	9.5	0.0		50.4
Entering IAPT treatment: Rate (quarterly) beginning IAPT treatment per 100,000 population aged 18+	2013/14 Q3	697	416	0		1020
Completion of IAPT treatment: Rate (quarterly) completing treatment per 100,000 population aged 18+	2013/14 Q3	174	223	17		605
IAPT diagnosis coding completeness: % (in quarter) of IAPT referrals with a provisional diagnosis code	2013/14 Q3	21.0	43.2	0.5		100

Quality and Outcomes

	Period	Local value	Eng. value	Eng. worst	Range	Eng. best
Assessment of depression: % of adults with a new diagnosis of depression with assessment of severity at treatment outset	2012/13	75.1	79.8	62.3		94.4
Follow-up assessment of depression: % of adults with a new diagnosis of depression with follow-up assessment after 4-12 weeks	2012/13	61.6	56.0	44.4		71.3
Case finding for depression: % of patients on diabetes and/or CHD register for whom case finding for depression has been undertaken during the preceding 15 months	2012/13	84.5	85.9	80.2		91.7
Exception rate for depression: % of patients on depression register excluded from quality indicators	2012/13	5.4	5.3	3.1		9.7
Support for people with LTCs: % of people with long term conditions visiting GP who feel they have had enough support from local services in last 6 months	2012/13	57.0	64.0	54.3		71.0
Waiting < 28 days for IAPT: % of referrals (in month) waiting	Dec 2013	23.9	61.9	5.7		98.4
Waiting > 90 days for IAPT: % of referrals (in month) waiting > 90 days for first treatment	Dec 2013	35.2	11.2	0.8		73.3
IAPT recovery: % of people (in month) who have completed IAPT treatment who are "moving to recovery"	Dec 2013	42.3	43.7	19.8		96.3
IAPT reliable recovery: % of people (in quarter) who have completed IAPT treatment who achieved "reliable improvement"	2013/14 Q3	48.7	61.3	29.5		74.0
IAPT DNAs: % of IAPT appointments (in quarter) where patient did not attend and gave no advance warning	2013/14 Q3	6.6	12.0	2.2		29.6
Paired data completeness: % of referrals (in quarter) with paired PHQ9 and ADSM scores	2013/14 Q3	100	96.9	65.8		100

Finance

	Period	Local value	Eng. value	Eng. worst	Range	Eng. best
Specialist mental health services spend: rate (£000s) per 100,000 aged 18+ (mapped from PCT)	2012/13	16425	26756	14296		49755
% spend on specialist mental health services: % of all secondary care service spend categorised as mental health (mapped from PCT)	2012/13	8.8	11.9	8.1		19.1
Spend on other mental health services: rate (£000s) per 100,000 population aged 18+ (mapped from PCT)	2012/13	13687	13772	3903		30893
% spend on other mental health: % of all mental health spend categorised as other mental health (mapped from PCT)	2012/13	83.3	51.5	13.1		87.7
Primary care prescribing spend on other mental health: rate (£000s) per 100,000 aged 18+ (mapped from PCT)	2012/13	483	857	268		1419
Secondary Care spend on other mental health: rate (£000s) per 100,000 aged 18+ (mapped from PCT)	2012/13	10832	6762	103		27077
Community care spend on other mental health: rate (£000s) per 100,000 aged 18+ (mapped from PCT)	2012/13	0	2739	0		15718
Spend on Psychological Therapy Services (IAPT): rate (£000s) per 100,000 aged 16 - 64 (mapped from PCT)	2010/11	648	487	1		1621
Spend on Psychological Therapy Services (Non IAPT): rate (£000s) per 100,000 aged 16 - 64 (mapped from PCT)	2010/11	252	534	11		1809
Cost of GP prescribing for antidepressant drugs: Net Ingredient Cost (quarterly) per STAR-PU	2013/14 Q3	150.8	287.4	119.0		548.5
Cost of GP prescribing for hypnotics and anxiolytics: Net Ingredient Cost (quarterly) per STAR-PU	2013/14 Q3	435	586	225		1196

Indicators included in spine-charts are drawn from a range of sources, are based on differing populations and are presented for a number of time periods. Detail relating to each indicator is included within the tool under 'definitions'.

http://fingertips.phe.org.uk/profile-group/mental-health/profile/common-mental-disorders

Source: NEPHO 2014 http://fingertips.phe.org.uk/profile-group/mental-health/profile/cmhp/data

Mood affective disorders including depression

Analysis of depression in Merton from QOF 2012-13 data

In 2012-13, there were 7,997 Merton residents on the depression register (18+ years of age) out of a total registered 18+ years of age population of 171,358. This gives an overall GP recorded prevalence of 4.7% for Merton CCG. The England prevalence is 5.8%. Figure 22 compares the observed prevalence in Merton CCG with comparator CCGs. Among geographically neighbouring CCGs Merton has the second highest recorded prevalence, second only to Sutton, and has a higher prevalence than all statistically comparable CCGs.

**Figure 22: Observed prevalence of depression in Merton CCG and comparator CCGs, QOF 2012-13* ¥**
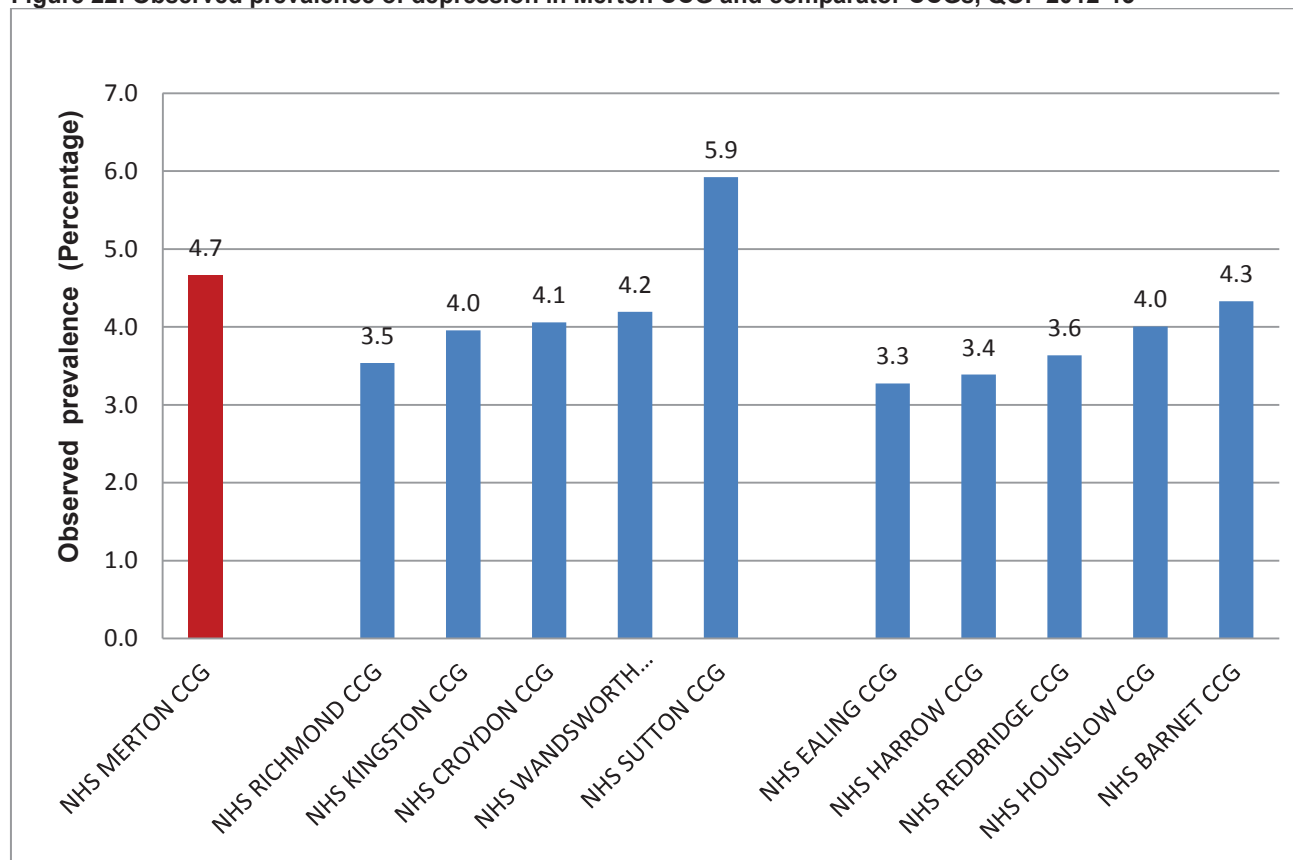
*Prevalence percentages are rounded off to the nearest tenth. ¥England prevalence is 5.8%.

By applying the national QOF recorded age-specific (18+ years of age) prevalence for depression to individual GP practice populations in the 18+ years of age group, the expected number of cases for Merton overall and by GP practice can be ascertained. Dividing the observed by the expected numbers gives a ratio that is indicative of the level of over- or under-diagnosis. A value of 1 indicates that the level of diagnosis is roughly in line with what is expected. A value less than 1 indicates that there are less cases being diagnosed than expected. A value higher than 1 indicates that more cases are being diagnosed than predicted, which can suggest over-diagnosis. A simple rule of thumb is that the closer the metric is to 1, the more suggestive this is of effective diagnosis in primary care. Figure 23 below depicts the ratio of observed to expected prevalence for Merton CCG and comparator CCGs. Merton has an overall ratio of 0.8 which suggests a level of under-diagnosis, but

when compared with other geographical and neighbouring CCGs, only Sutton CCG has a better ratio (1.0)

Figure 23: Ratio of Observed to expected prevalence of depression in Merton CCG and comparator CCGs, QOF 2012-13
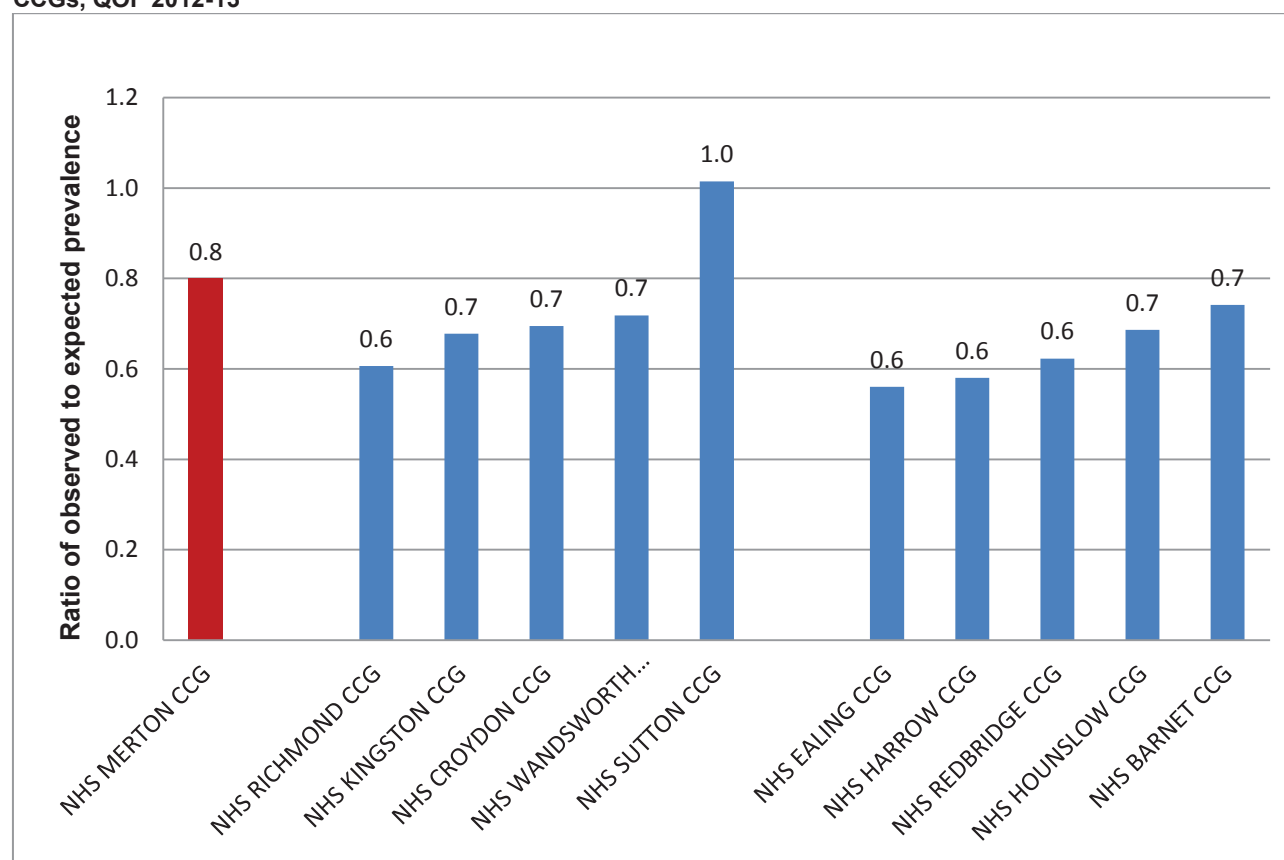
Plotting the observed to expected prevalence ratios for individual practices in Merton and grouping them into east & west Merton practices illustrates the considerable variance in diagnosis levels between different practices. It is now well established that there are major health inequalities in the borough between east and west Merton[73]. Figure 24 further illustrates this point in relation to the diagnosis of depression. While in both east and west Merton there are considerable differences between practices in the levels of diagnosis, more practices in the east are below that optimal value (i.e. 1.0) than in the west. Furthermore a lot more practices in the east are below the Merton average of 0.8 (the green line) than in the west. This suggests that there are many more undiagnosed cases of depression in 18+ years of age adults in east Merton than in west Merton although there is under-diagnosis in both areas.

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[73] Merton JSNA 2012-13, and 2013-14

Figure 24: Ratio of Observed to expected prevalence of depression in Merton GP practices, 18+ years, QOF 2012-13
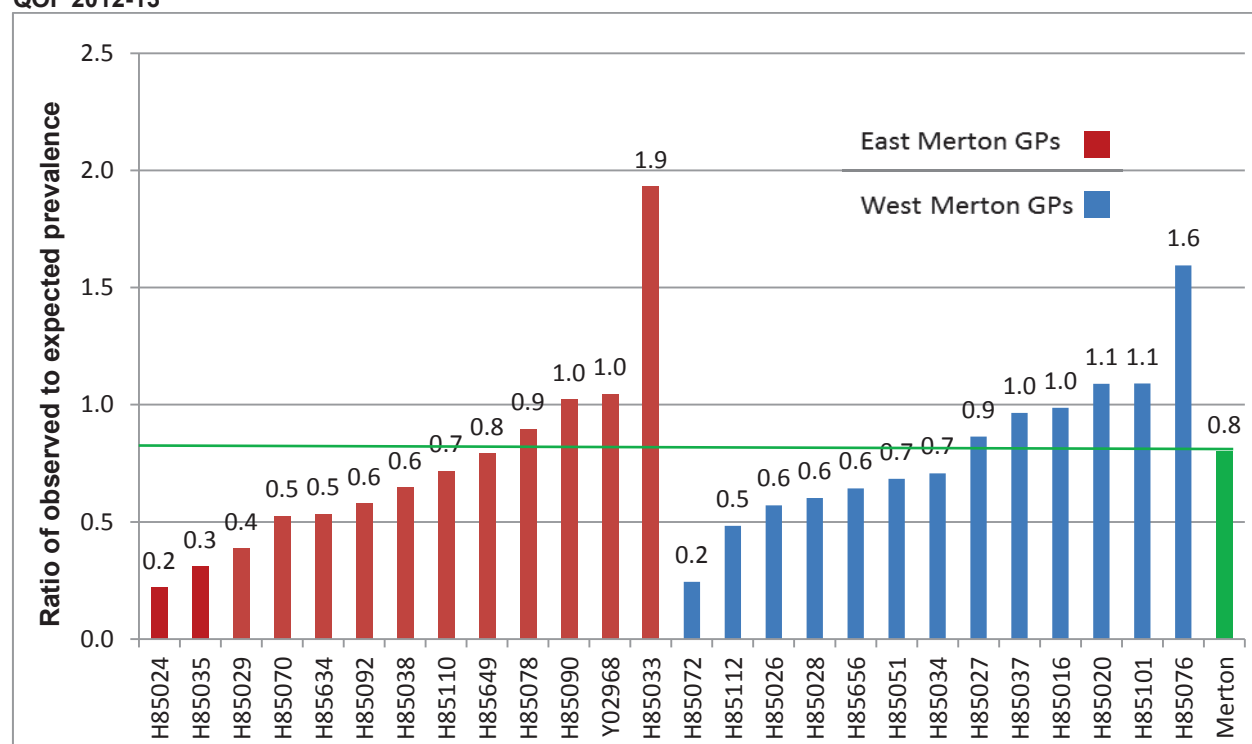
Depression and severe depression in older people (65+ years) in Merton
The table 8 shows the modelled numbers of older people with depression in Merton, London and England for two periods- 2012 and 2018. Once again the numbers increase in time at all administrative levels and for all conditions. The table 9 indicates the estimated national prevalence of depression in men and women by age groups. This is used to estimate the local numbers.

Table 8: Expected Prevalence of depression and severe depression in older people (65+) in Merton, London and England in 2012 and 2018

Older People (65+)	2012			2018		
	Merton	London	England	Merton	London	England
Depression	2,085	80,909	781,879	2,310	88,718	881,279
Severe Depression	656	25,679	248,600	736	28,099	278,826

Source: Projecting Older People Information System (POPPI) web site 08.10.2013

Table 9: Estimated prevalence of depression in men and women in England

Rates for men and women diagnosed with depression:		
Age range	% Males	% Females
65-69	5.8	10.9
70-74	6.9	9.5
75-79	5.9	10.7
80-84	9.7	9.2
85+	5.1	11.1

Further assessment of depression severity

Further assessment of depression severity is important to help ensure high standards of
primary health care and treatment delivered to NHS patients diagnosed with depression. The
rationale for such follow-up measurement is derived from the recognition that depression is
often a chronic disease, yet treatment is often episodic and short-lived. If treatment with
antidepressants is initiated, then patients should be being followed up regularly for several
months. Early cessation of treatment is associated with a greater risk of relapse. In 2011-12
S&M PCT had the lowest percentage of patients undergoing further assessment of
depression in SW London, lower than England and only marginally higher than London.
Compared with statistical neighbours it was third highest after Harrow and Ealing PCTs.

Figure 25: Further assessment of depression severity, 2011-12, 18+ (%), with 95% confidence intervals*
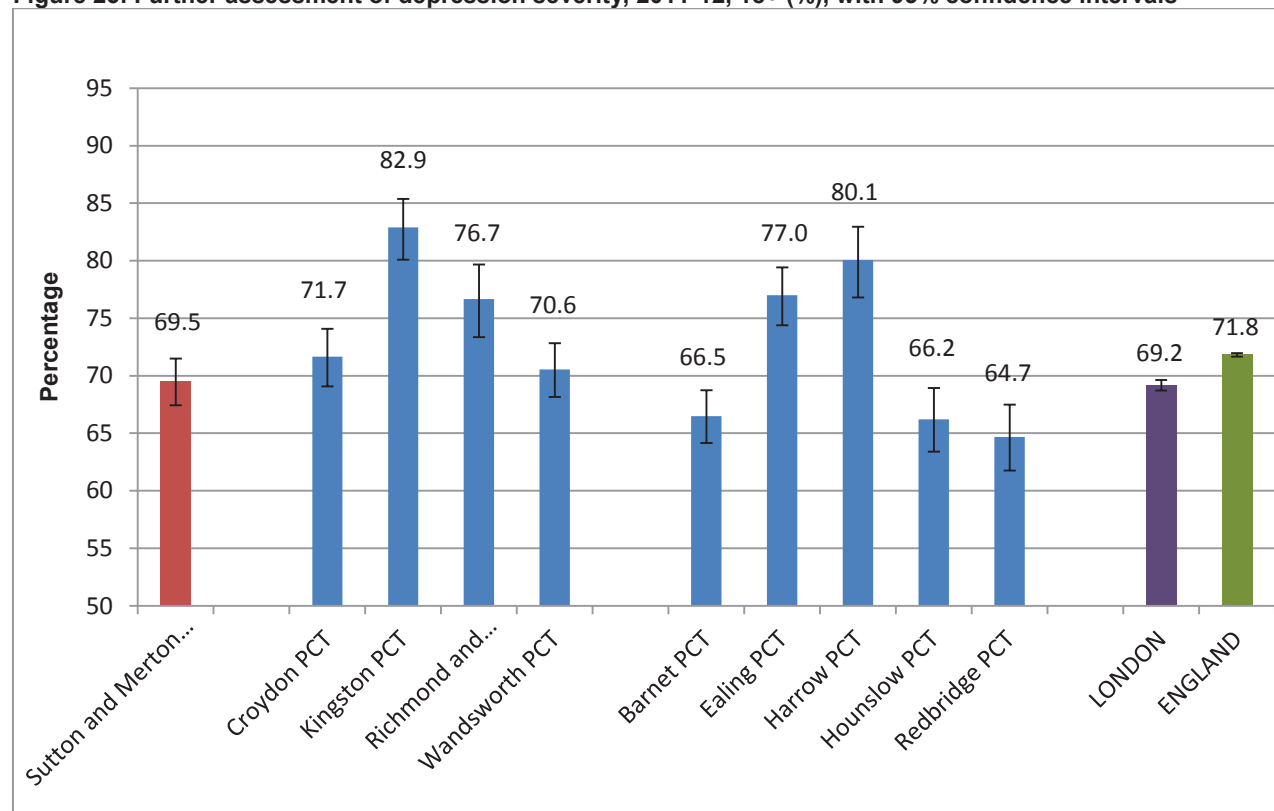
Source: NHS Information Centre, HSCIC https://indicators.ic.nhs.uk/webview/
* 95% confidence intervals (CI) indicate the precision with which the percentages are calculated. They also
indicate the range of values in which there is a 95% likelihood that the true value for the patient population lies -
the narrower the range, the more precise the calculation. The intervals are the widest for the smaller sample
sizes. These are shown by the vertical lines at the top of the bar graphs. When the percentages are compared, if
the CI intervals do not overlap this represents a statistically significant difference.

Depression severity assessment at outset of treatment

Depression severity assessment at outset of treatment is essential to decide on appropriate
interventions and improve the quality of care. A measure of severity at the outset of

treatment enables a discussion with the patient about relevant treatment interventions and options, guided by the stepped care model of depression. Recent research has shown that patients value the use of severity measures and that doctors' treatment and referral rates are related to the scores on the measures[74]. In 2011-12 S&M PCT had the second lowest percentage in SW London, and it was marginally higher than England and higher than London, and comparable with other SW London PCTs although it was second lowest above Wandsworth. It was third highest with Hounslow, among statistical neighbours.

Figure 26: Depression severity assessment at outset of treatment, 2011-12, 18+ (%), with 95% confidence intervals*

Source: NHS Information Centre, HSCIC https://indicators.ic.nhs.uk/webview/
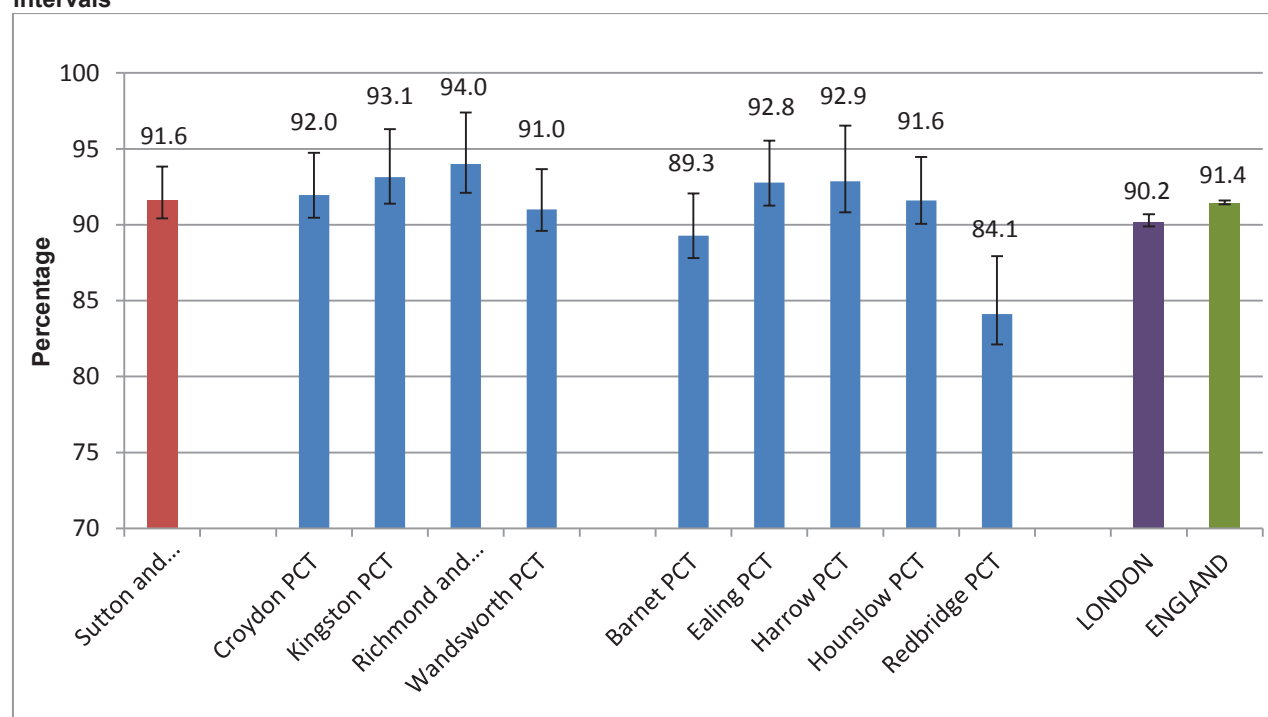** 95% confidence intervals (CI) indicate the precision with which the percentages are calculated. They also indicate the range of values in which there is a 95% likelihood that the true value for the patient population lies - the narrower the range, the more precise the calculation. The intervals are the widest for the smaller sample sizes. These are shown by the vertical lines at the top of the bar graphs. When the percentages are compared, if the CI intervals do not overlap this represents a statistically significant difference.*

Of the nine quality indicators for mental health in the QOF, MH17 & MH18 relate to the treatment of depressive illnesses. The results in 2012-13 for these indicators are presented by practice grouped into East and West Merton:

MH 17 - The percentage of patients on lithium therapy with a record of serum creatinine and TSH in the preceding 9 months- Almost all practices in West Merton and half of East Merton practices achieve 100%. The other half of practices in East Merton has relatively low percentages considering that so many achieved 100%, with one practice not reporting.

MH 18 - The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range within the preceding 4 months- Again more practices in West Merton

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[74] HSCIC Meta data on indicator;
https://indicators.ic.nhs.uk/download/NCHOD/Specification/Spec_31Q_669PC_12_V1.pdf

achieved 100% than in East Merton and there is a clear split in the East between the half of practices achieving 100% and a much lower percentage (mostly less than 60%) in the other half.

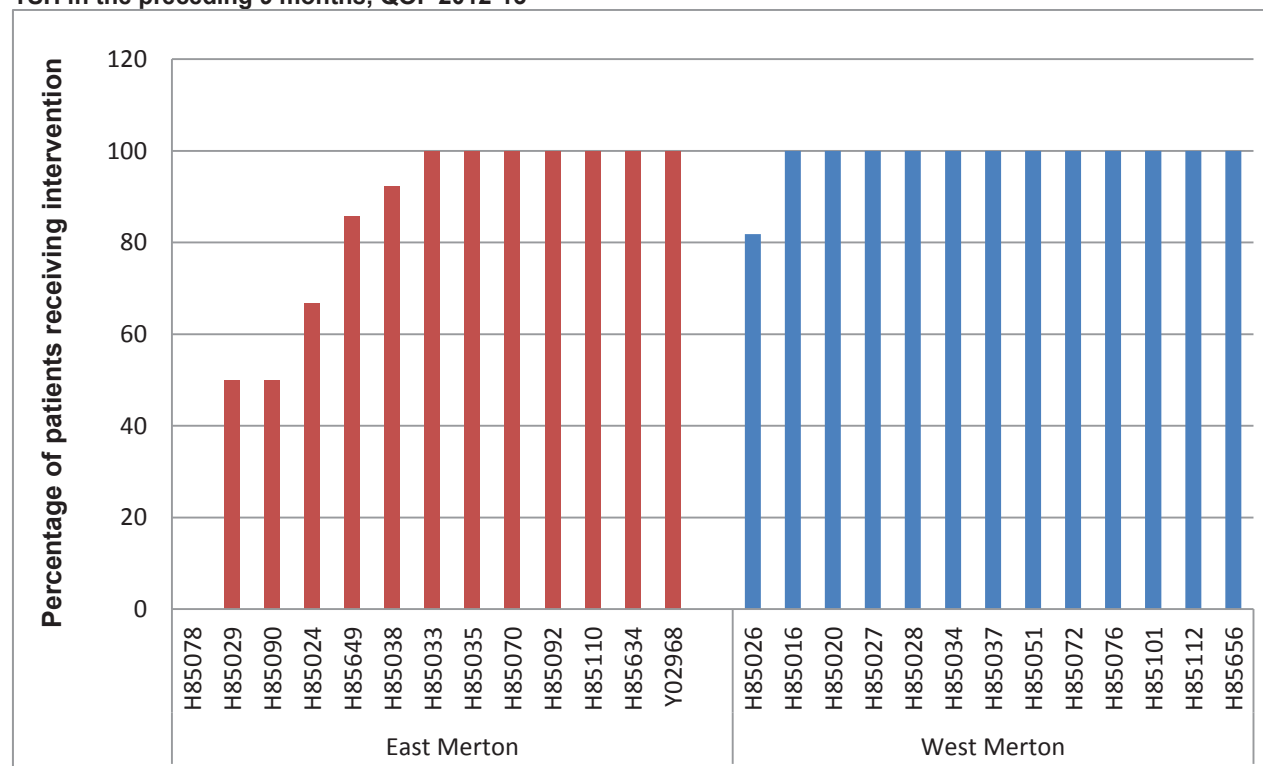**Figure 27: MH 17 - The percentage of patients on lithium therapy with a record of serum creatinine and TSH in the preceding 9 months, QOF 2012-13**

Source: NHS Information Centre, HSCIC https://indicators.ic.nhs.uk/webview/

Figure 28: MH 18 - The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range within the preceding 4 months, QOF 2012-13

Source: NHS Information Centre, HSCIC https://indicators.ic.nhs.uk/webview/
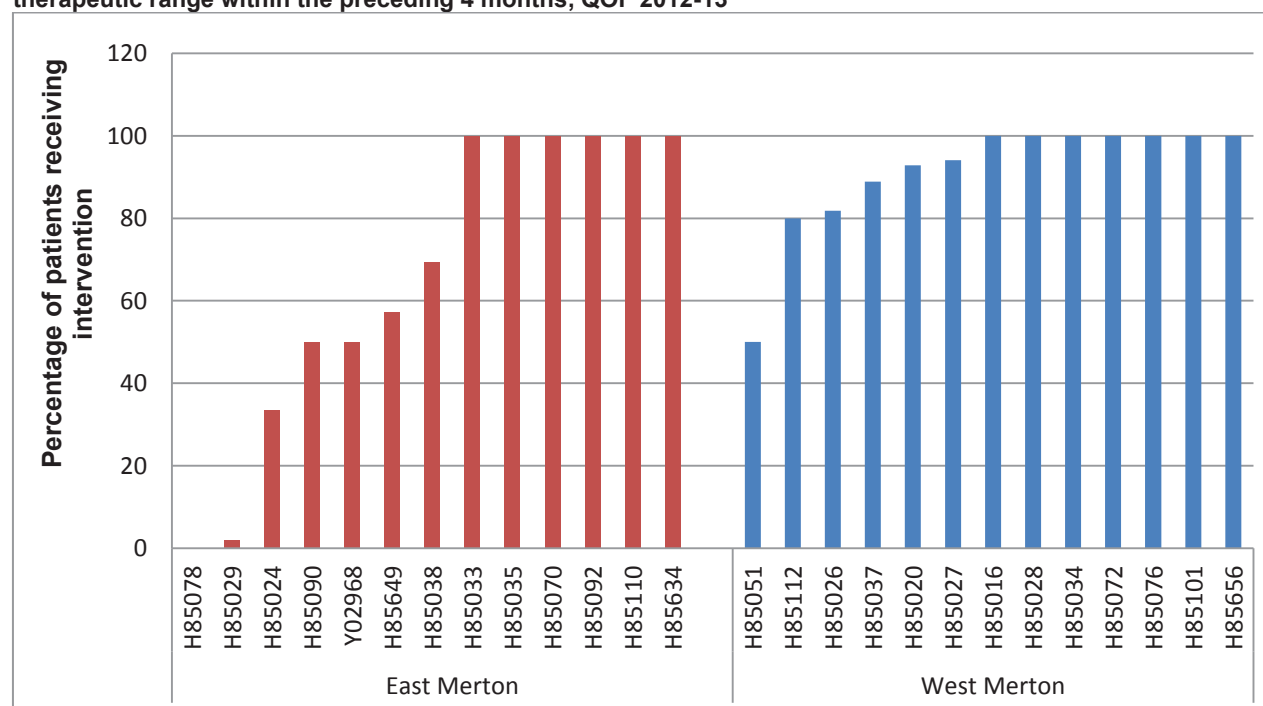
Neurotic, anxiety and stress disorders

Emergency hospital admissions for neurosis

For emergency hospital admissions for neurosis, Merton rates are lower than England and London, and lower than Sutton and Wandsworth among geographical neighbours, and lower than Hounslow, Redbridge and Ealing among statistical ones. None of these differences are however statistically significant.

Figure 29: Emergency hospital admission rate (indirectly standardised) for neurosis, people aged 15-74 years, 2011/12, with 95% confidence intervals*
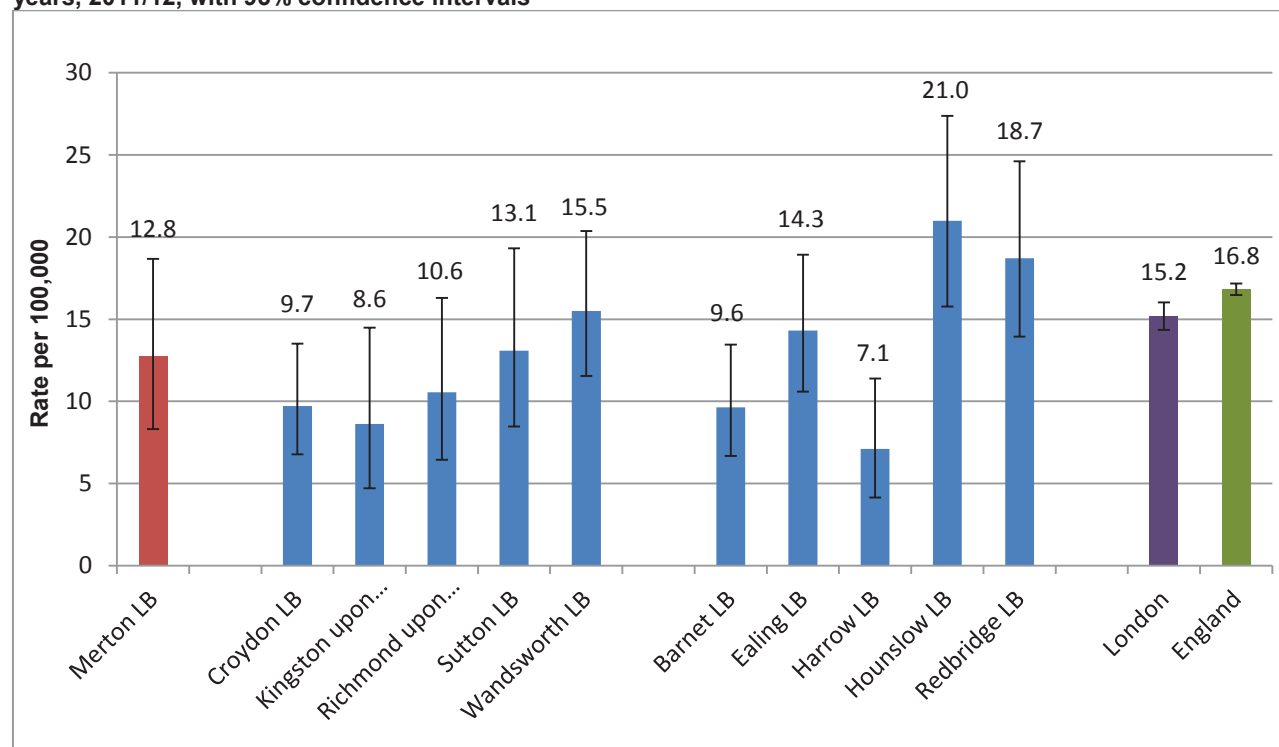
Source: NHS Information Centre, HSCIC https://indicators.ic.nhs.uk/webview/
* 95% confidence intervals (CI) indicate the precision with which the rates are calculated. They also indicate the range of values in which there is a 95% likelihood that the true value for the patient population lies - the narrower the range, the more precise the calculation. The intervals are the widest for the smaller sample sizes. These are shown by the vertical lines at the top of the bar graphs. When the rates are compared, if the CI intervals do not overlap this represents a statistically significant difference

Severe Mental Illness (SMI)

Key Points

- *Merton has a significantly lower than average number of people with SMI known to GPs. Merton also has a lower ratio than the England average of the QOF registered prevalence as a ratio of estimated prevalence. These point to relative under-diagnosis or under-recording of SMI in Merton compared with national the average*
- *For new cases of psychosis served by the Early Intervention teams, Merton rates are significantly higher than the national average, as they are for the rate of people being treated by the Early Intervention teams*
- *The rate of contact with services, and day care attendances are significantly lower than average*
- *Merton has a significantly higher than average percentage of mental health service users who were inpatients in a psychiatric hospital and significantly lower rates of mental health hospital admissions and discharges*
- *Admissions under the Mental Health Act in Merton were significantly higher than the national average- in fact more than double. Detentions on admission to hospital were also significantly higher than the national average*
- *Schizophrenia emergency admission rate was significantly higher in Merton than the national average although there were some concerns about data quality*
- *Merton rates were significantly lower than the England averages for social care mental health clients receiving services during the year, mental health clients in residential or nursing care, mental health clients receiving home care during the year, and mental health clients receiving day care or day services*
- *Merton rates were significantly higher than the England averages for mental health clients with new social care assessments during the year, and carers (of an adult with mental health conditions) assessed during the year*
- *The percentage of people in contact with mental health services with a crisis plan in place was significantly less in Merton compared with the England average*
- *Merton had significantly higher rate of delayed discharge than the England average- in fact more than 3.5 times*
- *For follow-up of non-attendance at annual review among patients with psychoses, in 2010-11 Sutton & Merton Primary Care Trust had the second lowest percentage in SW London, and it was lower than England and marginally higher than London*
- *2012-13 QOF data suggests that there is room for improvement, and considerable variance between GP practices overall and between practices in East and West Merton in terms of proxies for caring for the physical health of patients with schizophrenia*

Merton Severe Mental Illness Profile for Merton (figure 30)

Risk and related factors

Merton has a significantly lower than national average percentage of people with learning disabilities on a GP register- which means that a significantly lower percentage of people with learning disabilities are known to GPs in Merton than the England average.

Prevalence
Merton has a significantly lower than average number of people with SMI known to GPs, expressed as a percentage on the GP register. Merton also has a lower ratio than the England average of the QOF registered prevalence as a ratio of estimated prevalence. These metrics point to relative under-diagnosis or under-recording of SMI in Merton compared with national the average.

Services
In terms of new cases of psychosis served by the Early Intervention teams, Merton rates are significantly higher than the national average, as they are for the rate of people being treated by the Early Intervention teams. In Merton the rate of contact with services, and day care attendances are significantly lower than average. Merton has a significantly higher than average percentage of mental health service users who were inpatients in a psychiatric hospital but significantly lower rates of mental health hospital admissions and discharges. Admissions under the Mental Health Act in Merton were significantly higher than the national average- in fact more than double. Detentions on admission to hospital in Merton were also significantly higher. A&E attendances for a psychiatric disorder were significantly lower than the national average. However the schizophrenia emergency admission rate was significantly higher in Merton than the national average although there were some concerns about data quality.

For social care related metrics Public Health indicates that there were some concerns on data quality for all the metrics. Having said that, in 2012/13 Merton rates were significantly lower than the England averages for social care mental health clients receiving services during the year, mental health clients in residential or nursing care, mental health clients receiving home care during the year, and mental health clients receiving day care or day services. Merton rates were significantly higher than the England averages for mental health clients with new social care assessments during the year, and carers (of an adult with mental health conditions) assessed during the year.

Quality and outcomes
On most indicators Merton had comparable or better figures compared with England averages. However the percentage of people in contact with mental health services with a crisis plan in place was significantly less in Merton compared with the England average. Having said that, Merton had a low rate of emergency readmissions over the same period (local Trust data- if there were less people with a crisis plan in place, then emergency readmissions would be higher), which suggests that this could be a recording problem. For days of delayed discharge as a rate per 1000 bed days, Merton had significantly higher rate of delayed discharge than the England average- in fact more than 3.5 times. This could reflect a lack of accommodation available for patients due to be discharged.

In terms of social care in 2012/13, the percentage of social care mental health clients receiving direct payments in Merton was significantly higher than the national average (more than 6 times), as was the percentage of social care mental health clients receiving direct payments or having a personal budget (almost 3 times). In Merton 100% of carers received services or advice or information, as a percentage of mental health clients receiving community services- this was significantly higher than England average (approx. 5 times).

Finance

In terms of spend in Merton related to SMI, on all the metrics Merton spent less than the England average.

Figure 30: Merton Severe Mental Illness (SMI) Profile

- ● Significantly lower than England average
- ● Not significantly different from England average
- ○ Significantly higher than England average
- ○ Significance not calculated

England Average

England Worst | 25th Percentile | 75th Percentile | England Best

Risk and related factors

	Period	Local value	Eng. value	Eng. worst	Range	Eng. best
Socioeconomic deprivation: overall IMD score	2012	15.0	21.5	5.8		47.4
Number of people with learning disabilities known to GPs: % on register	2012/13	0.3	0.5	0.2		0.9

Prevalence

	Period	Local value	Eng. value	Eng. worst	Range	Eng. best
Psychotic disorder: Estimated % of people aged 16+	2012	0.42 ^	0.40	0.18		0.77
Number of people with SMI known to GPs: % on register	2012/13	0.78	0.84	0.48		1.46
Comparison of QoF and estimated prevalence: QoF register prevalence as a ratio of estimated prevalence	2012	1.86	2.02	1.32		3.76

Services

	Period	Local value	Eng. value	Eng. worst	Range	Eng. best
Number of people with SMI known to GPs: % on register	2012/13	0.78	0.84	0.48		1.46
Comparison of QoF and estimated prevalence: QoF register prevalence as a ratio of estimated prevalence	2012	1.86	2.02	1.32		3.76
GP prescribing of drugs for psychoses and related disoders: Items (quarterly) per 1,000 population	2013/14 Q3	34.2	44.5	21.3		95.4
People in contact with services: Rate per 100,000 population (end of quarter snapshot)	2013/14 Q3	1097	2256	396		5247
People on Care Programme Approach: Rate per 100,000 population (end of quarter snapshot)	2013/14 Q3	449	523	54		1728
Service users on CPA: % people in contact with MH servives who are on care programme approach (end of quarter snapshot)	2013/14 Q3	40.9	23.2	1.3		84.0
Use of mental health services by BME groups: % of people in contact with mental health services who are in black and minority ethnic groups	2012/13	25.9	8.6	0.3		55.2
New cases of psychosis served by Early Intervention teams: Rate (annual) per 100,000 population	2013/14	37.4	24.9	0.0		134.1
Rate of people being treated by Early Intervention teams: Rate per 100,000 population (end of quarter snapshot)	2013/14 Q3	60.2	37.4	0.0		144.6
Rate of people receiving assertive outreach services: Rate per 100,000 population (end of quarter snapshot)	2013/14 Q3	- *	26.6	0.0		104.3
Contacts and daycare attendances: Rate (quarterly) per 100,000 population	2013/14 Q3	7963	10597	290		33069
Service users in hospital: % mental health service users who were inpatients in a psychiatric hospital (end of quarter snapshot)	2013/14 Q3	3.4	2.4	0.7		12.3
Mental health admissions to hospital: Rate (quarterly) per 100,000 population	2013/14 Q3	47.5	70.2	28.5		207.5
Mental health discharges from hospital: Rate (quarterly) per 100,000 population	2013/14 Q3	44.4	70.5	19.8		170.2
Attendances at A&E for a psychiatric disorder: Rate per 100,000 population	2012/13	180.0	243.5	3.0		925.5
People subject to Mental Health Act: Rate per 100,000 population (end of quarter snapshot)	2013/14 Q3	34.2	37.5	6.2		110.2

Quality and outcomes

	Period	Local value	Eng. value	Eng. worst	Range	Eng. best
Patients with SMI who have comprehensive care plan: % with plan (patients receiving intervention)	2012/13	83.0	81.3	72.2		93.0
Patients on lithium therapy with record of serum creatinine and TSH: % with record in the preceding 9 months (patients receiving intervention)	2012/13	94.2	92.3	81.5		98.8
Patients on lithium therapy with levels in therapeutic range: % within preceding 4 months (patients receiving intervention)	2012/13	84.9	79.8	56.0		93.5
Exceptions from SMI checks: % of adults on SMI register exempt from checks	2012/13	14.8	15.5	10.1		23.7
Patients with SMI with alcohol consumption check: % with record in preceding 15 months (patients receiving intervention)	2012/13	82.2	82.0	71.8		89.2
Patients with SMI with BMI check: % with record in preceding 15 months (patients receiving intervention)	2012/13	81.3	81.1	73.1		87.4
Patients with SMI with blood pressure check: % with record in preceding 15 months (patients receiving intervention)	2012/13	86.0	84.9	77.3		90.8
Female patients with SMI who had cervical screening test: % tested in preceding 5 years (patients receiving intervention)	2012/13	71.7	72.5	61.1		82.6
Patients with SMI with cholesterol check: % with record in preceding 15 months (patients receiving intervention)	2012/13	40.8	42.4	32.2		49.8
Patients with SMI with blood glucose or HbA1c check: % with record in preceding 15 months (patients receiving intervention)	2012/13	64.7	66.3	55.9		74.4
Smokers on GP registers offered cessation advice or referral: % in previous 15 months	2011/12	93.3	92.9	89.2		96.5
Gate kept admissions: % (quarterly) admissions to acute wards that were gate kept by the CRHT teams	2013/14 Q4	100	98.3	82.6		100
Service users with crisis plans: % of people in contact with mental health services with a crisis plan in place (end of quarter snapshot)	2013/14 Q3	3.1	10.2	0.0		44.9
CPA review: % of people on CPA for more than 12 months who have had a review (end of quarter snapshot)	2013/14 Q3	91.3	83.6	23.3		99.4

Finance

	Period	Local value	Eng. value	Eng. worst	Range	Eng. best
Specialist mental health services spend: rate (£000s) per 100,000 aged 18+ (mapped from PCT)	2012/13	16425	26756	14296		49755
% spend on specialist mental health services: % of all secondary care service spend categorised as mental health (mapped from PCT)	2012/13	8.8	11.9	8.1		19.1
Primary care prescribing spend on mental health: rate (£000s) per 100,000 aged 18+ (mapped from PCT)	2012/13	1231	2021	746		3933
Cost of GP prescribing for psychoses and related disorders: Net Ingredient Cost (£) per 1,000 population (quarterly)	2013/14 Q3	578	667	294		1476
Secondary Care spend on mental health: rate (£000s) per 100,000 aged 18+ (mapped from PCT)	2012/13	11533	12518	440		34267
Community care spend on mental health: rate (£000s) per 100,000 aged 18+ (mapped from PCT)	2012/13	0	5094	0		19965
Spend on psychosis services: rate (£000s) per 100,000 population aged 18+ (mapped from PCT)	2012/13	462	4789	458		15576
% spend on psychosis: % of all mental health spend categorised as psychosis (mapped from PCT)	2012/13	2.8	17.9	1.7		48.5
Primary care prescribing spend on psychosis: rate (£000s) per 100,000 aged 18+ (mapped from PCT)	2012/13	417	541	159		1388
Secondary Care spend on psychosis: rate (£000s) per 100,000 aged 18+ (mapped from PCT)	2012/13	32	3051	0		13513

Indicators included in spine-charts are drawn from a range of sources, are based on differing populations and are presented for a number of time periods. Detail relating to each indicator is included within the tool under 'definitions'.

Source: NEPHO 2014 http://fingertips.phe.org.uk/profile-group/mental-health/profile/cmhp/data

Psychosis

Psychoses are disorders that produce disturbances in thinking and perception severe enough to distort perception of reality. The main types are schizophrenia and affective psychosis, such as bi-polar disorder. According to the Adult Psychiatric Morbidity Survey (APMS) 2007[75] the overall prevalence of psychotic disorder was found to be 0.4% (0.3% of men, 0.5% of women). In both men and women the highest prevalence was observed in those aged 35 to 44 years (0.7% and 1.1% respectively). The age standardised prevalence of psychotic disorder was significantly higher among black men (3.1%) than men from other ethnic groups (0.2%of white men, no cases observed among men in the South Asian or 'other' ethnic group). There was no significant variation by ethnicity among women.

Prevalence of psychosis in 2011-12
HSCIC data on prevalence of psychosis for 2011-12 indicates that Sutton and Merton PCT had among the lowest prevalences in SW London, with only Kingston and Hounslow PCTs being lower. It had a lower prevalence than England and London.

Figure 31: Prevalence Psychosis, 2011-12 all ages (%), with 95% confidence intervals*
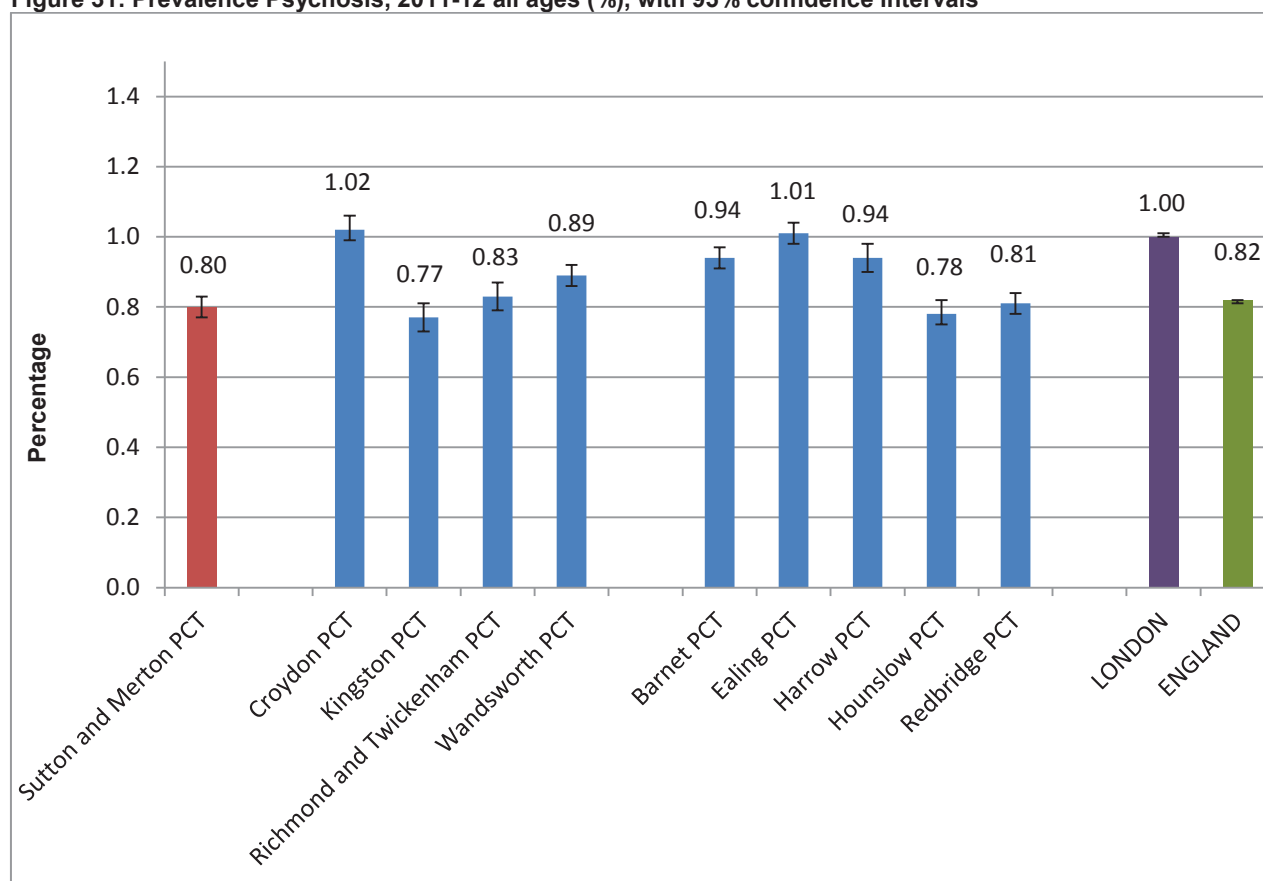
Source: NHS Information Centre, HSCIC https://indicators.ic.nhs.uk/webview/
* 95% confidence intervals (CI) indicate the precision with which the percentages are calculated. They also indicate the range of values in which there is a 95% likelihood that the true value for the patient population lies - the narrower the range, the more precise the calculation. The intervals are the widest for the smaller sample sizes. These are shown by the vertical lines at the top of the bar graphs. When the percentages are compared, if the CI intervals do not overlap this represents a statistically significant difference.

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[75] http://www.hscic.gov.uk/catalogue/PUB02931/adul-psyc-morb-res-hou-sur-eng-2007-rep.pdf

Health reviews and treatment checks on patients with psychoses
Health reviews and treatment checks for psychoses are intended to reduce the levels of risk to health for patients with psychoses and ensure high standards of primary care and treatment delivered to them. In many cases, the bulk of care for patients with long-term mental health problems will be provided by specialist services, however, there are some aspects of management such as physical health which often lie within the general practitioner's responsibility. Patients with serious mental health problems are at considerably increased risk of physical ill-health than the general population. It is therefore good practice for a member of the general practice team to review each patient's physical health on an annual basis. In 2010-11 S&M PCT had a high percentage of patients with psychoses undergoing health reviews and treatment checks, comparable with London and England and second highest among PCTs in SW London after Richmond & Twickenham; and also second highest compared with statistical neighbours.

Figure 32: Health review and treatment checks on patients with psychoses, 2010-11, all ages % with 95% confidence intervals*

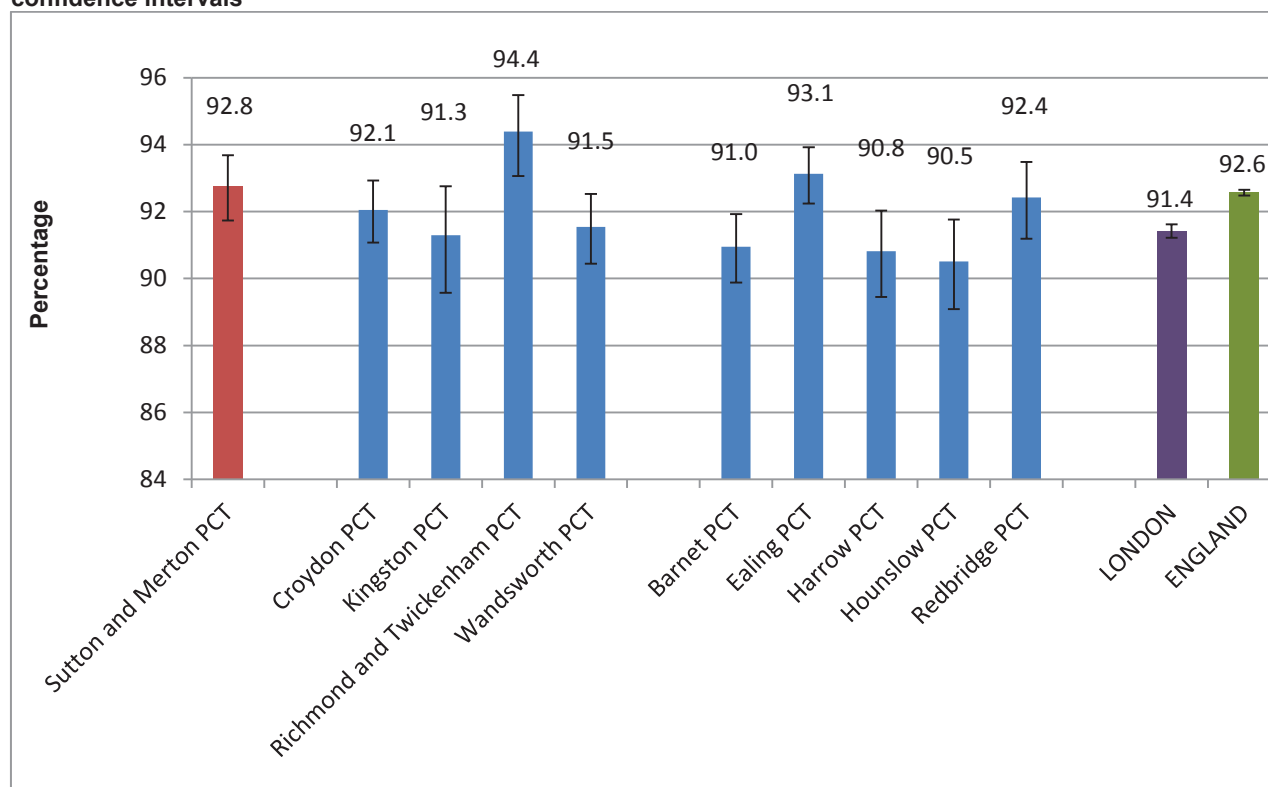*Source: NHS Information Centre, HSCIC https://indicators.ic.nhs.uk/webview/*
* 95% confidence intervals (CI) indicate the precision with which the percentages are calculated. They also indicate the range of values in which there is a 95% likelihood that the true value for the patient population lies - the narrower the range, the more precise the calculation. The intervals are the widest for the smaller sample sizes. These are shown by the vertical lines at the top of the bar graphs. When the percentages are compared, if the CI intervals do not overlap this represents a statistically significant difference.

Follow-up of non-attendance at annual review among patients with psychoses
Poor compliance with medication among patients with psychoses may lead to relapse, hospitalisation and poorer outcomes. There is also evidence to suggest that non-attendance at appointments may be interpreted by some practices as part of a patient having a Severe Mental Illness, rather than recognising that not turning up for an appointment may be a sign of relapse. Follow-up of non-attendance at annual review among patients with psychoses

requires proactive intervention from the practice to contact the patients and enquire about their health status. In 2010-11 S&M PCT had the second lowest percentage in SW London, and it was lower than England and marginally higher than London. S&M PCT had the third highest percentage compared with statistical neighbours.

Figure 33: Follow-up of non-attendance at annual review among patients with psychoses, 2010-11, all ages (%)

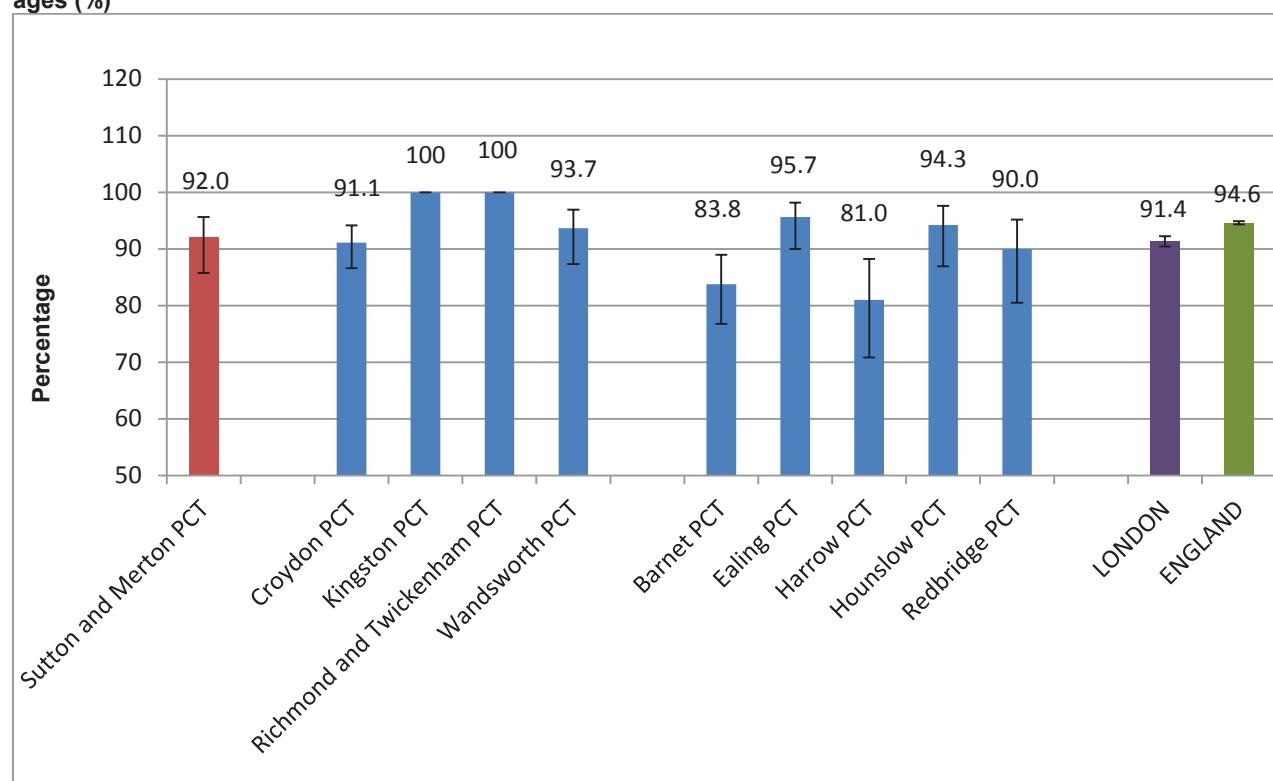Source: NHS Information Centre, HSCIC https://indicators.ic.nhs.uk/webview/
* 95% confidence intervals (CI) indicate the precision with which the percentages are calculated. They also indicate the range of values in which there is a 95% likelihood that the true value for the patient population lies - the narrower the range, the more precise the calculation. The intervals are the widest for the smaller sample sizes. These are shown by the vertical lines at the top of the bar graphs. When the percentages are compared, if the CI intervals do not overlap this represents a statistically significant difference.

Schizophrenia, schizotypal and delusional disorders

Age standardised hospital episode rate (DSR per 100,000) for schizophrenia
This indicator is a useful measure of inequality - people from a black and minority ethnic group are more likely to be diagnosed with schizophrenia, be detained and treated compulsory under the Mental Health Act (1983) and be over-prescribed psychotropic medication[76]. A higher rate could be indicative of less effective community based care-this is a proxy measure for the quality of community care. Merton has a lower rate than England, London, statistical and geographical neighbours- and the differences are statistically significant.

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[76] Evidence cited in King's Fund (2003) Ethnic diversity and mental health in London: Recent developments in London King's Fund: London.

Figure 34: Age standardised hospital episode rate (DSR) for schizophrenia, people aged 15-74 years, 2011/12, with 95% confidence intervals*

Source: NHS Information Centre, HSCIC https://indicators.ic.nhs.uk/webview/
* 95% confidence intervals (CI) indicate the precision with which the rates are calculated. They also indicate the range of values in which there is a 95% likelihood that the true value for the patient population lies - the narrower the range, the more precise the calculation. The intervals are the widest for the smaller sample sizes. These are shown by the vertical lines at the top of the bar graphs. When the rates are compared, if the CI intervals do not overlap this represents a statistically significant difference.
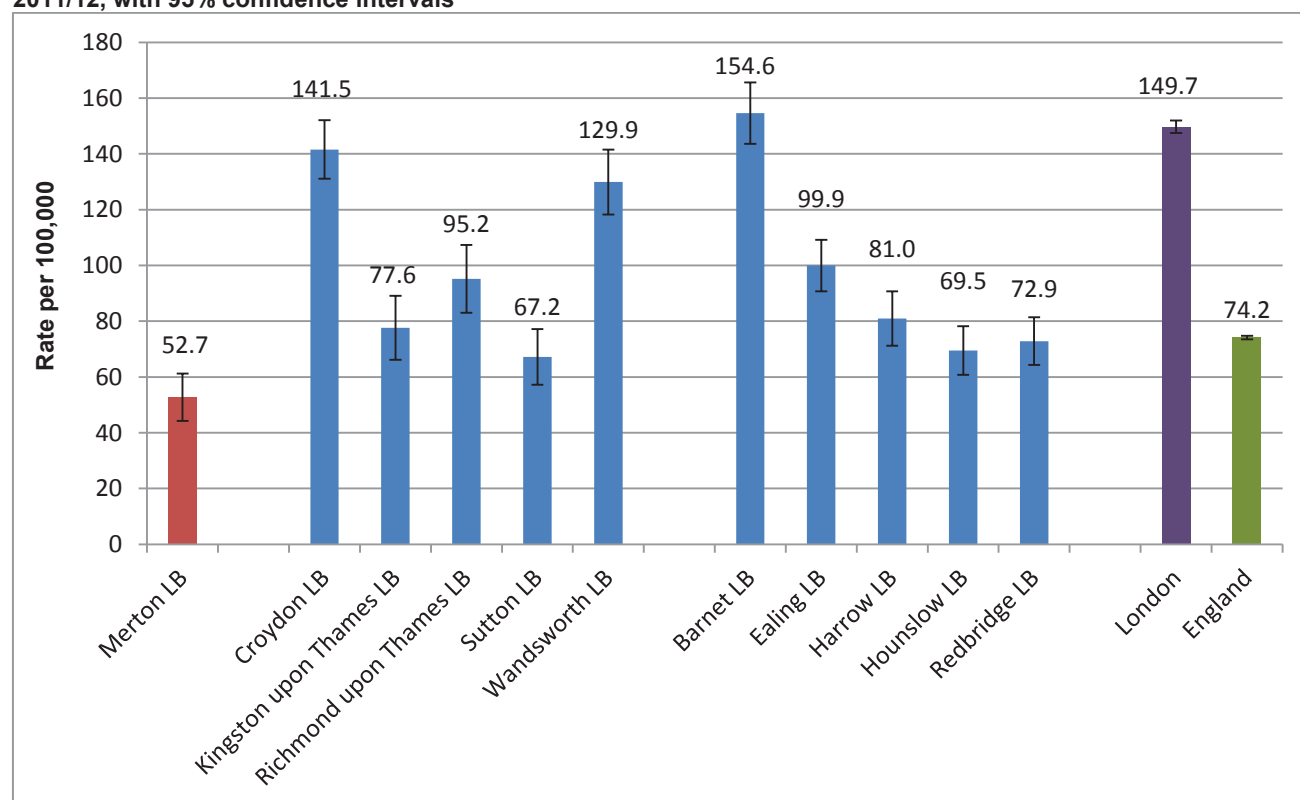
Emergency hospital admissions for schizophrenia

These are other proxy measures for the quality of community care. For emergency hospital admissions for schizophrenia, Merton does well compared with all other geographical and statistical comparators as it has the lowest levels and suggests that more of the potentially avoidable admissions are most likely being avoided and seen effectively in the community. The differences with England, London and some geographical and statistical comparators are statistically significant.

Of the nine quality indicators for mental health in the QOF, MH11, MH12, MH13, MH16, MH19 & MH20 relate to the schizophrenia, bipolar affective disorders and other psychoses. These are also proxy indicators for the quality of primary care. The results in 2012-13 for these indicators are presented by practice grouped into East and West Merton (graphs after description):

MH 11 - The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 15 months- Most practices in both East & West Merton achieve the 80% mark, but three East Merton practices have relatively low percentages and also some have 90+%.

MH 12 - The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of BMI in the preceding 15 months- For this again the profiles in East and West Merton are similar, with more practices in East Merton achieving higher percentages.

MH 13 - The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 15 months- in this measure virtually all practices across Merton achieve high numbers, with more practices in East Merton achieving percentages close to 90%.

MH 16 - The percentage of patients (aged from 25 to 64) with schizophrenia, bipolar affective disorder and other psychoses whose notes record that a cervical screening test has been performed in the preceding 5 years- this is low for all practices in Merton, with the comparatively lower percentages in West Merton reflecting the older age profile in that part of Merton.

MH 19 - The percentage of patients aged 40 years and over with schizophrenia, bipolar affective disorder and other psychoses who have a record of total cholesterol: HDL ratio in the preceding 15 months- This is low all across Merton with very few practices achieving more than 50%.

MH 20 - The percentage of patients aged 40 years and over with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood glucose or HbA1c in the preceding 15 months- most practices in Merton were less than 75% on this measure, with many more in East Merton achieving less than 70%.

Figure 36: MH 11- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 15 months, QOF 2012-13

Source: NHS Information Centre, HSCIC https://indicators.ic.nhs.uk/webview/

Figure 37: MH 12 - The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of BMI in the preceding 15 months, QOF 2012-13
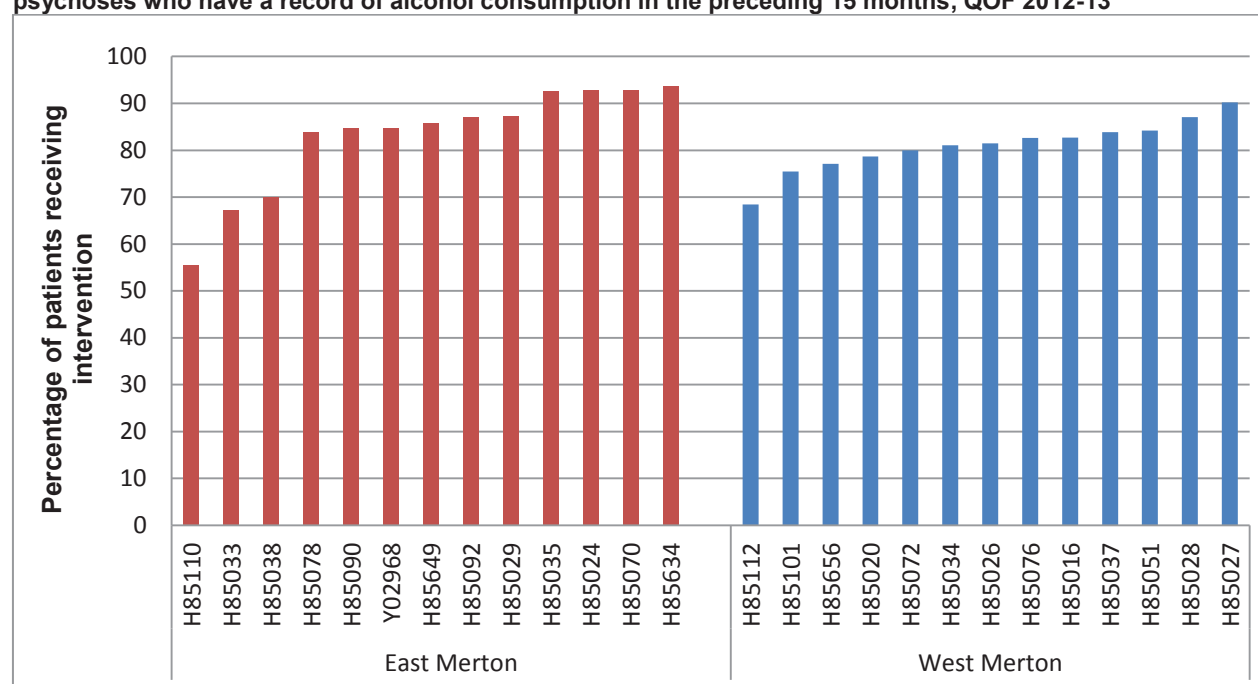
Figure 38: MH 13 - The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 15 months, QOF 2012-13

Figure 39: MH 16 - The percentage of patients (aged from 25 to 64) with schizophrenia, bipolar affective disorder and other psychoses whose notes record that a cervical screening test has been performed in the preceding 5 years, QOF 2012-13

Source: NHS Information Centre, HSCIC https://indicators.ic.nhs.uk/webview/
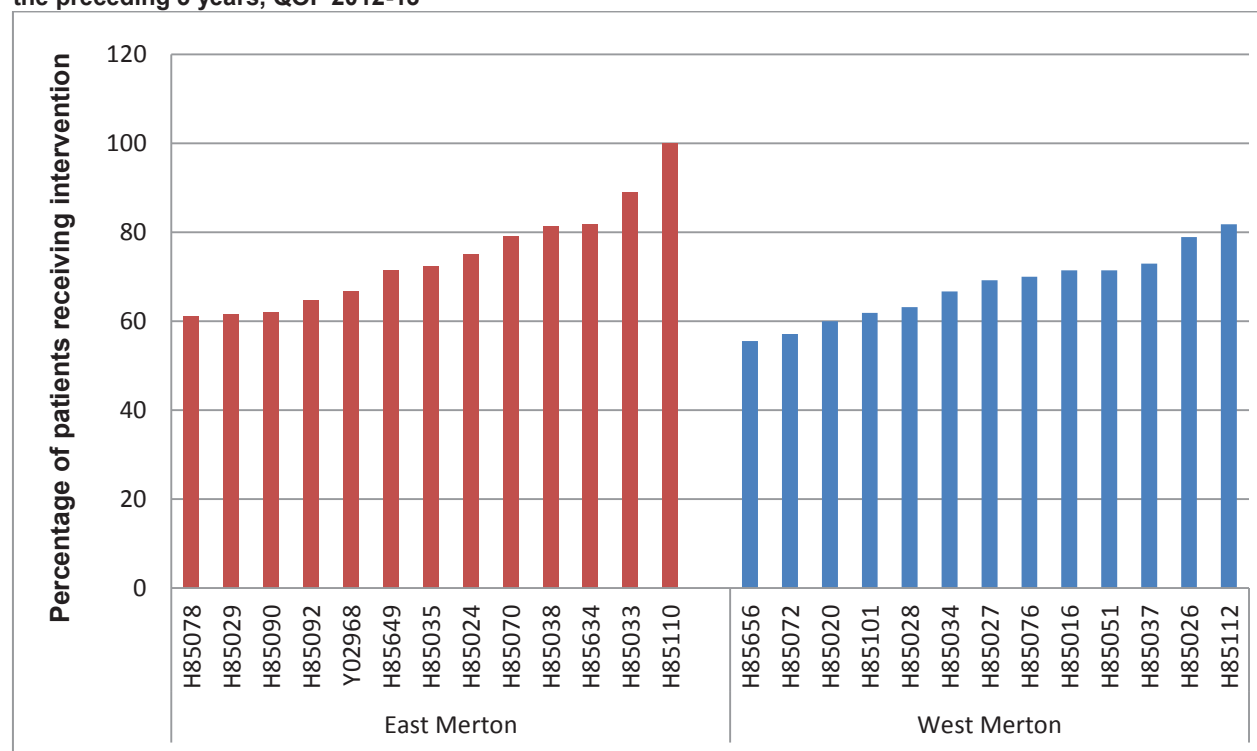
Figure 40: MH 19 - The percentage of patients aged 40 years and over with schizophrenia, bipolar affective disorder and other psychoses who have a record of total cholesterol: HDL ratio in the preceding 15 months, QOF 2012-13

Source: NHS Information Centre, HSCIC https://indicators.ic.nhs.uk/webview/
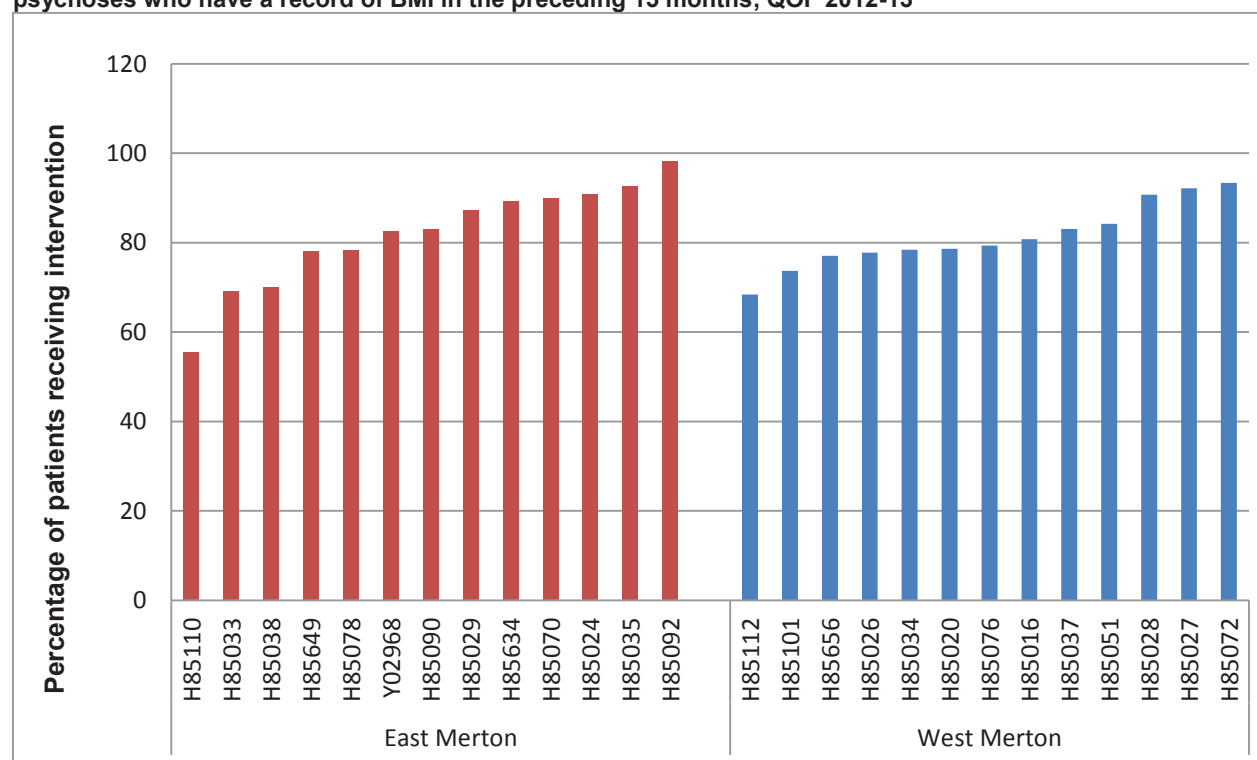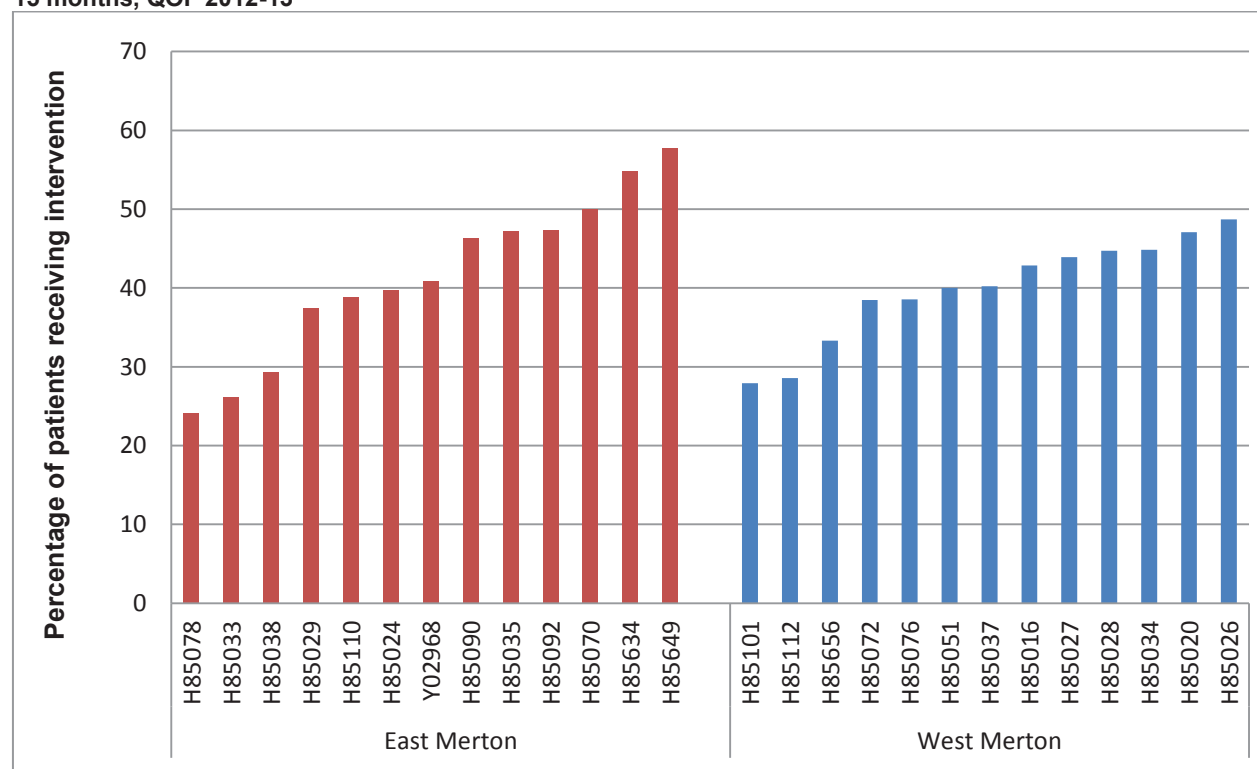
Figure 41: MH 20 - The percentage of patients aged 40 years and over with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood glucose or HbA1c in the preceding 15 months, QOF 2012-13
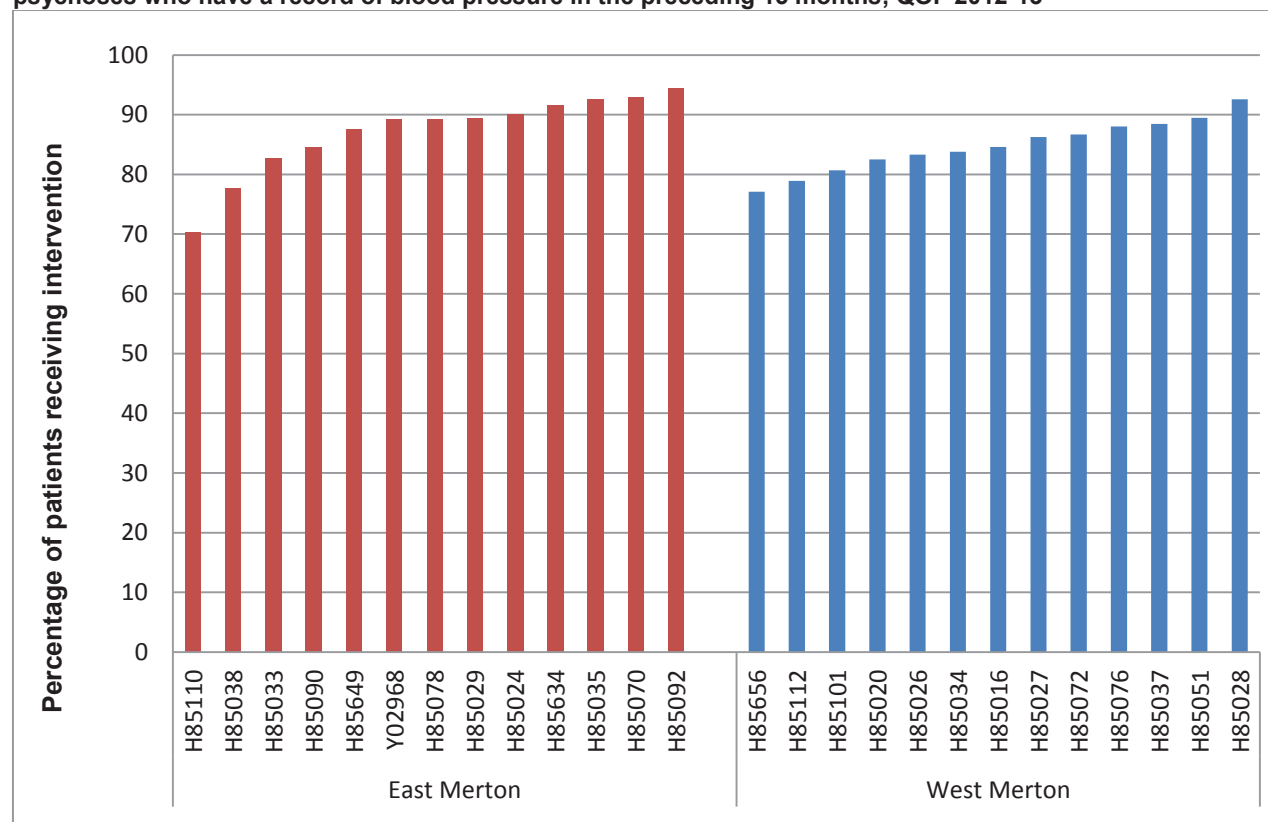

Source: NHS Information Centre, HSCIC https://indicators.ic.nhs.uk/webview/
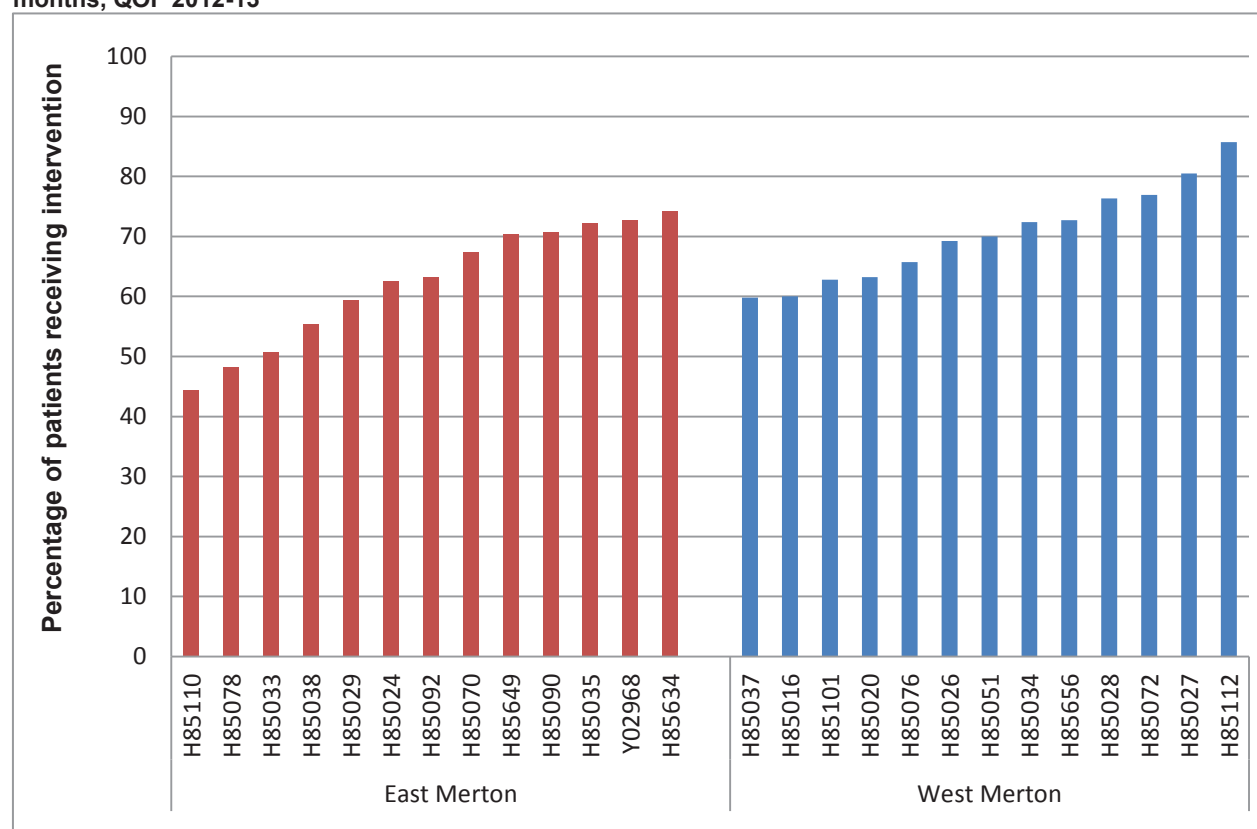
Psychoactive substances

Psychoactive substances are the most common cause for CMH referrals and the second most common cause for in-patient admissions in working age adults in Merton. The overwhelming majority of these were for alcohol related problems. The next most common psychoactive substance was multiple drug use.

Personality disorders

Personality disorders are longstanding, ingrained distortions of personality interfering with the ability to make and sustain relationships. *Antisocial personality disorder (ASPD)* and *borderline personality disorder (BPD)* are two types with particular public and mental health policy relevance.

ASPD is characterised by disregard for and violation of the rights of others. People with ASPD have a pattern of aggressive and irresponsible behaviour which emerges in childhood or early adolescence. They account for a disproportionately large proportion of crime and violence committed. ASPD was present in 0.3% of adults aged 18 or over (0.6% of men and 0.1% of women)[77].

BPD is characterised by high levels of personal and emotional instability associated with significant impairment. People with BPD have severe difficulties with sustaining

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[77] Adult Psychiatric Morbidity Survey (APMS) 2007

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relationships, and self-harm and suicidal behaviour is common. The overall prevalence of BPD was similar to that of ASPD, at 0.4% of adults aged 16 or over (0.3% of men, 0.6% of women)[78].

Organic disorders including dementia

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Key Points
- *In Merton it is estimated that 7.2% of women and 5.3% of men aged over 65 have dementia (2007), by 2021 this is predicted to reduce to 6.7% for women and increase to 5.6% for men*
- *The NHS dementia calculator gives the current diagnosis rate as 47% (2013/14) and a dementia gap of 1,057 cases for 2014/15*
- *In 2012-13, there were 870 Merton residents on the dementia register out of a total registered population of 217,803. This gives an overall GP recorded prevalence of 0.4% for Merton CCG. The England prevalence is 0.57%*
- *The ratio of observed to expected prevalence of dementia is 0.7 for Merton, suggesting a level of under-diagnosis*
- *There is considerable variance between practices and East and West Merton for the observed to expected prevalence ratio*

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Dementia in Merton

By far the biggest issue for mental health services for people over the age of 65 is dementia. Dementia has a significant impact on individuals and their families, presents major challenges for health and social services and remains a misunderstood and stigmatised disease. It is a syndrome, a term for a group of diseases and conditions that are characterised by the decline and eventual loss of cognitive functions such as memory, thinking and reasoning and by changes in personality and mood.

Old age is the largest risk factor for dementia and prevalence doubles every five years after the age of 65. Some 68% of all people with dementia are aged over 80 and most will also have co-morbid conditions and illnesses that result in physical impairment.

Alzheimer's disease (AD) accounts for 62% of all dementias, with vascular dementia and mixed dementia accounting for 27%. Dementia is a leading cause of disability and death in people aged over 65. A progressive disease, it is usually terminal some five to eight years after diagnosis. Women with dementia outnumber men by two to one.

In the UK people from Black, Asian and Minority Ethnic groups (BAME) make up just 1.7% of the total population affected by dementia. This group is expected to increase by 15% over the next decade. The younger age profile is reflected in the larger proportion of people from BAME groups with early onset dementia, 6.1% compared to 2.2% for the UK[79].

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[78] Adult Psychiatric Morbidity Survey (APMS) 2007
[79] Dementia UK – The full report, Alzheimer's Society 2007

It is estimated that 63.5% of people with dementia live in the community, of whom two thirds are supported by carers and one third live alone. Approximately 36.5% live in care homes. The majority of residents in care homes for older people have a dementia.

In Merton it is estimated that 7.2% of women and 5.3% of men aged over 65 have dementia (2007), by 2021 this is predicted to reduce to 6.7% for women and increase to 5.6% for men. It is estimated that the rate of diagnosis in Merton is only 39% (Alzheimer's Society 2013), and this is consistent with the low levels of recorded dementia in GP practices across Merton. The NHS dementia calculator gives the current diagnosis rate as 47% (2013/14) and a dementia gap of 1,057 cases for 2014/15.

Table 10 below shows the number of cases and estimated prevalence of dementia in 2012/13, broken down by estimates in community settings and in residential care. The table

Table 10: Dementia numbers and forecasts using adjusted national dementia prevalence, Merton compared with statistical and geographical neighbours

Dementia numbers & forecasts by local authority using adjusted national dementia prevalence	Merton	Croydon	Kingston upon Thames	Richmond upon Thames	Sutton	Wandsworth	Barnet	Ealing	Harrow	Hounslow	Redbridge
Total number of people with dementia in 2012/13 (estimated)	1927	3841	1898	2075	2146	2277	4364	2976	2559	2069	2602
People with dementia living in the **community** in 2012/13 (estimated)	1228	1970	1169	1311	1370	1354	2525	1918	1723	1497	1788
People with dementia living in **residential care** in 2012/13 (estimated)	699	1871	729	764	776	923	1839	1058	836	572	814
Dementia register - The number of people diagnosed under Quality & Outcomes Framework (QoF), 2012/13	870	1662	731	989	838	1031	2293	1479	870	978	1121
Diagnosis rate - The percentage of the estimated prevalence that have been diagnosed, 2012/13	45.16	43.27	38.52	47.67	39.05	45.28	52.54	49.7	33.99	47.28	43.07
Dementia gap - the undiagnosed cases in 2014/15	1057	2179	1167	1086	1308	1246	2071	1497	1689	1091	1481
Dementia diagnosis rate (adjusted) - The percentage of the estimated prevalence that have been diagnosed, 2013/14, (source: CQUIN CCG data)	47	44	39.3	49	40.2	45.6	52.6	49.5	33.1	46.9	43.1

Source: NHS Dementia Prevalence calculator, version 3, 03/07/2014, The adjusted national dementia prevalence uses General practice patient list numbers

also shows the actual numbers diagnosed in the corresponding period according to QOF records. These two numbers enable the calculation of a *diagnosis rate* which is a percentage derived by dividing the numbers diagnosed by the estimated prevalence in 2012/13. In Merton this is 45.2% for 2012/13 which implies that each year approximately 55% of cases of dementia in the borough go undiagnosed. The table also gives a current estimate of the diagnosis rate for 2013/14 as 47%. The diagnosis rate allows the estimation of the number of *undiagnosed* cases which is called the **dementia gap**. The table shows that in Merton it is estimated that there will be 1,057 undiagnosed cases in 2014-15. This is the lower than all other geographical neighbours and all statistical neighbours.

Dementia prevalence is difficult to model, estimate and capture. The national standard for prevalence figures in use is from the Dementia UK report of 2007. However these figures are not considered sensitive enough for small populations at general practice level resulting in practice level prevalence being skewed. In order to overcome this, the calculator applies the 2007 prevalence to general practice registered populations by age and gender to estimate local prevalence.

Analysis of dementia in Merton from QOF 2012-13 data
In 2012-13, there were 870 Merton residents on the dementia register out of a total registered population of 217,803. This gives an overall GP recorded prevalence of 0.4% for Merton CCG. The England prevalence is 0.57%. Figure 42 compares the observed prevalence in Merton CCG with comparator CCGs. Among geographically neighbouring CCGs Merton has a lower recorded prevalence than the CCGs of Richmond, Sutton and Croydon, but higher than Kingston and Wandsworth. Merton CCG and has a higher prevalence than all statistically comparable CCGs except Barnet.

Figure 42: Observed prevalence of depression in Merton CCG and comparator CCGs, QOF 2012-13* ¥
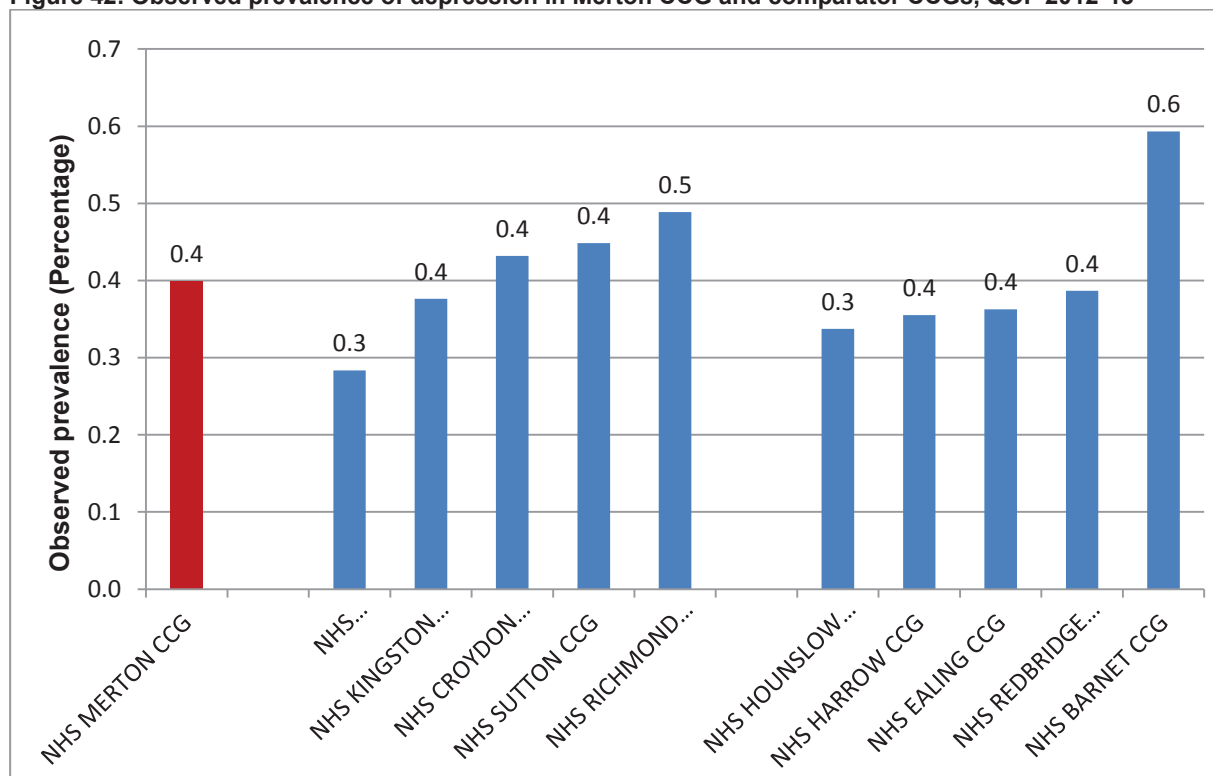
*Prevalence percentages are rounded off to the nearest tenth. ¥ England prevalence is 0.57%.

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By applying the national QOF recorded prevalence for depression to individual GP practice populations, the expected number of cases for Merton overall and by GP practice can be ascertained. Dividing the observed by the expected numbers gives a ratio that is indicative of the level of over- or under-diagnosis. A value of 1 indicates that the level of diagnosis is roughly in line with what is expected. A value less than 1 indicates that there are less cases being diagnosed than expected. A value higher than 1 indicates that more cases are being diagnosed than predicted, which can suggest over-diagnosis. Figure 43 below depicts the ratio of observed to expected prevalence for Merton CCG and comparator CCGs. Merton has an overall ratio of 0.7 which suggests a level of under-diagnosis. When compared with other geographical and neighbouring CCGs, Merton has a higher level of diagnosis than Kingston and Wandsworth, but is lower than Richmond, Sutton and Croydon CCGs. Among statistically similar CCGs, Merton is on par with Redbridge and only Barnet CCG is higher.

Figure 43: Ratio of Observed to expected prevalence of dementia in Merton CCG and comparator CCGs, QOF 2012-13
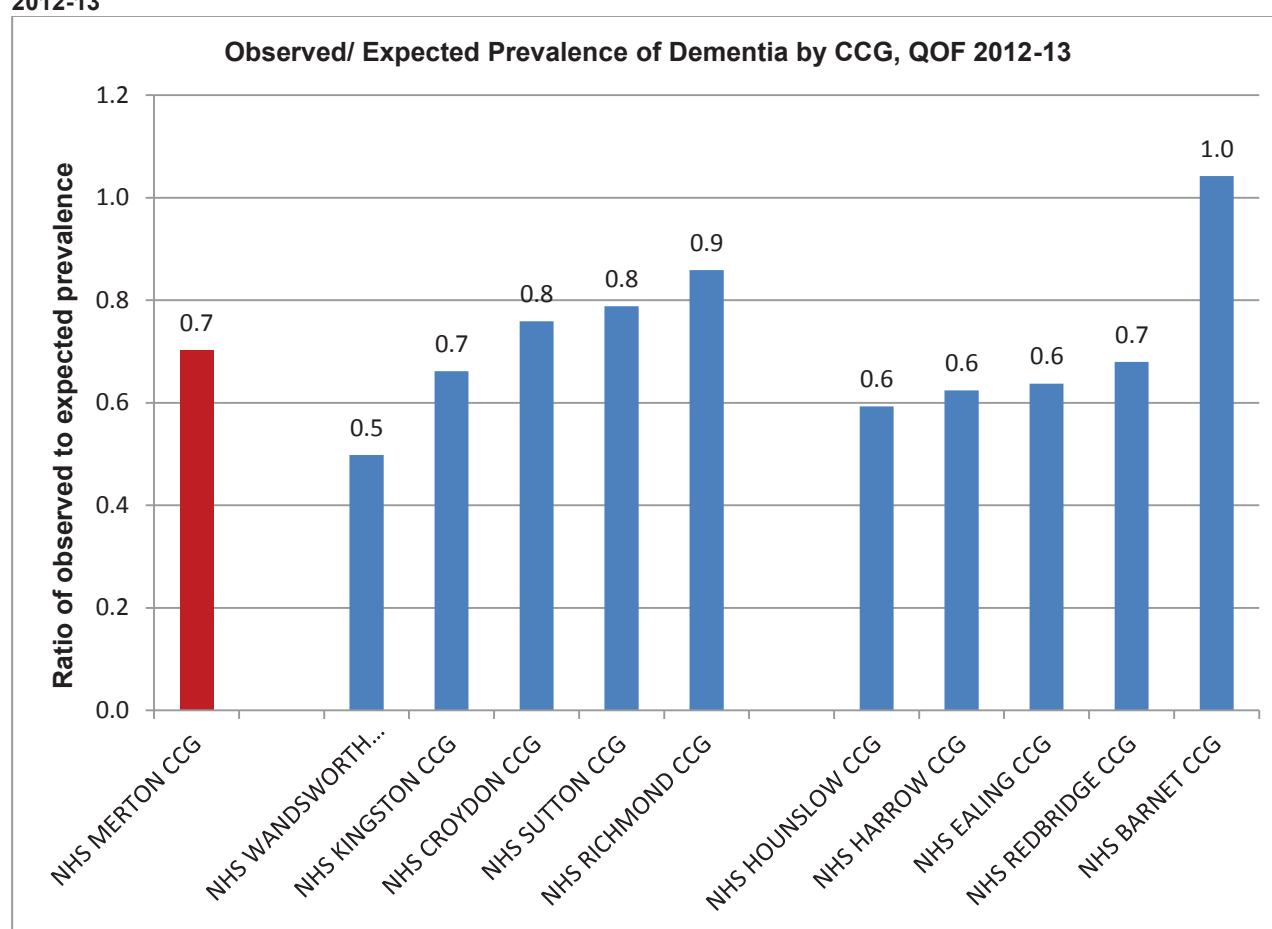
Plotting the observed to expected prevalence ratios for individual practices in Merton and grouping them into east & west Merton practices illustrates the considerable variance in diagnosis levels between different practices (figure 44). The figure further illustrates this point in relation to the diagnosis of depression. The optimal level of diagnosis would be the ratio value of 1. While in both east and west Merton there are considerable differences between practices in the levels of diagnosis, more practices in the east are below that optimal value (i.e. 1.0) than in the west. Furthermore the practices in the east which are below the Merton average of 0.7 (the green line)

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have much lower levels of diagnosis than in the west. For those practices above the Merton average, the practices in the west are on the whole diagnosing more cases than the east. This suggests that there are many more undiagnosed cases of dementia in east Merton than in west Merton although there is under-diagnosis in both areas.

Figure 44: Ratio of Observed to expected prevalence of dementia in Merton GP practices, QOF 2012-13
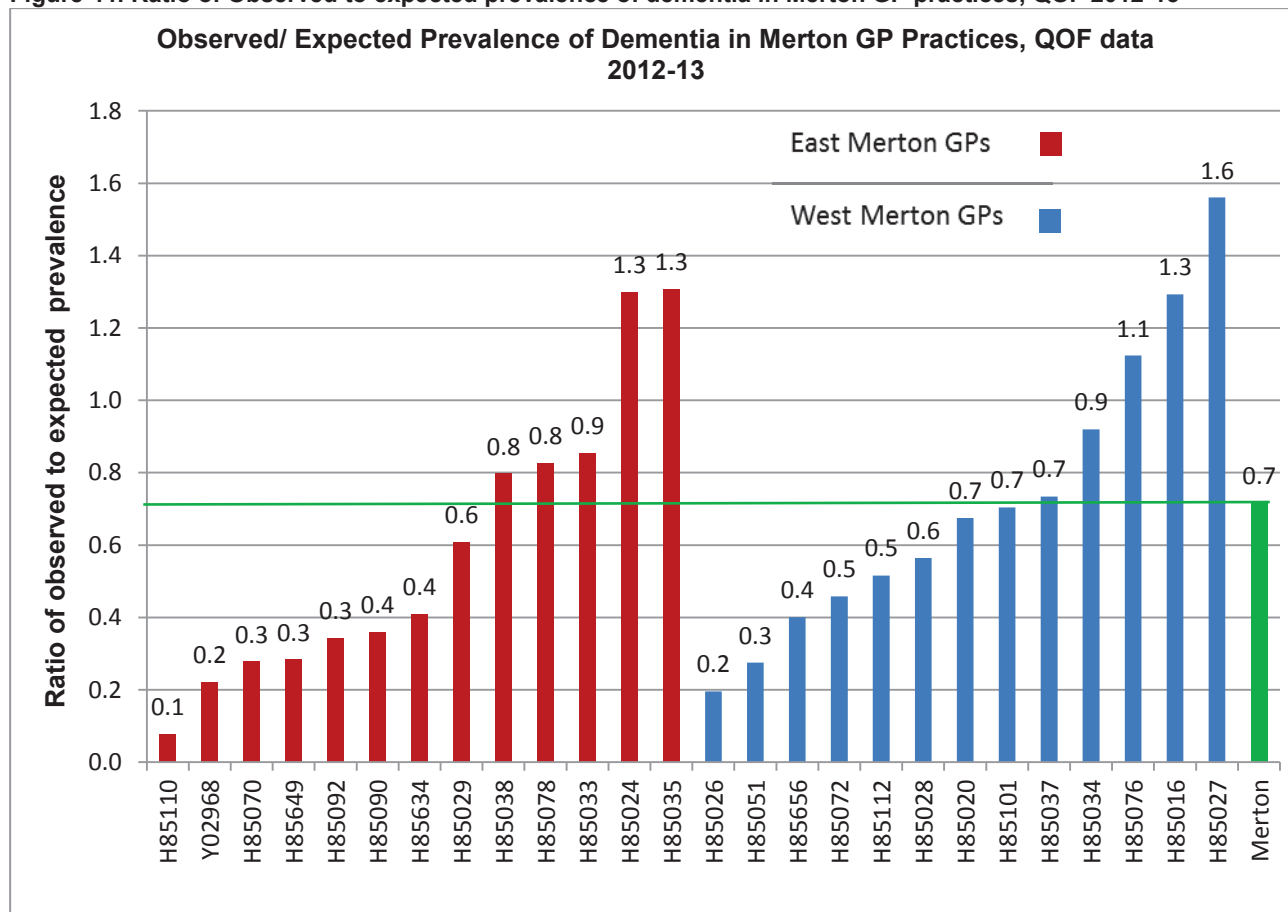
Care review among patients with dementia

The face to face dementia review should focus on support needs of the patients and their carers. As the illness progresses, and more agencies are involved, the review should additionally focus on assessing the communication between health and social care and non-statutory sectors as appropriate, to ensure that potentially complex needs are addressed. Communication and referral issues highlighted in the review need to be followed up as part of the review process. While none of the values across SW London, England or London for this indicator in figure 45 are statistically significantly different from each other, nevertheless for 2011-12, S&M PCT had a percentage marginally higher than England, similar to London and lower than Richmond & Twickenham, and Kingston PCTs in SW London. It was comparable and not significantly different from statistical neighbours.

Figure 45: Care review among patients with dementia, 2011-12, all ages (%), 95% confidence intervals*
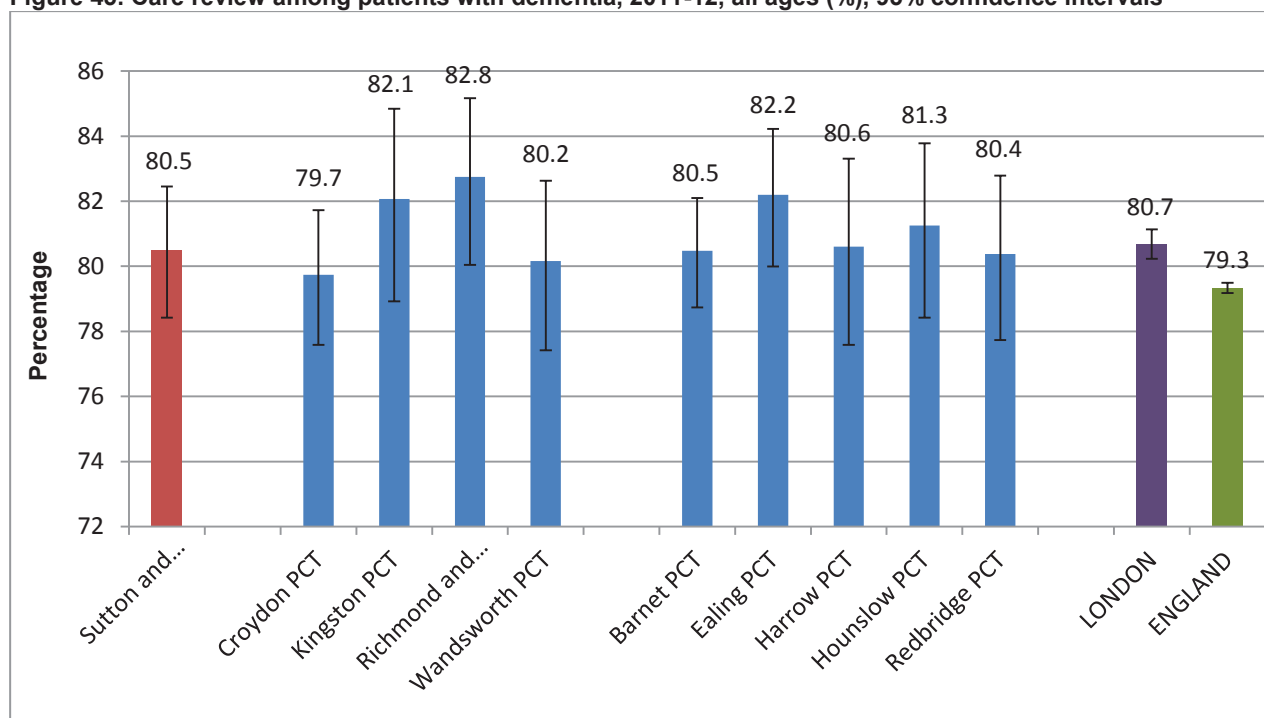
Source: NHS Information Centre, HSCIC https://indicators.ic.nhs.uk/webview/

* 95% confidence intervals (CI) indicate the precision with which the percentages are calculated. They also indicate the range of values in which there is a 95% likelihood that the true value for the patient population lies - the narrower the range, the more precise the calculation. The intervals are the widest for the smaller sample sizes. These are shown by the vertical lines at the top of the bar graphs. When the percentages are compared, if the CI intervals do not overlap this represents a statistically significant difference.

Who are the patients in Merton and where are the health inequalities?

Key Points
- *A majority of the in-patients and community mental health services (CMHS) referrals were working age adults in Merton*
- *A majority of the admissions were in male adults. It is the opposite for CMHS, where there were more female referrals than male referrals*
- *Black ethnicities were over-represented in the in-patient population and Asians under-represented in both the in-patient and CMHS populations. In the case of Asian communities this under-representation could be due to inequity in access, and the cultural taboos and stigma associated with mental illness. In Black ethnicities the over-representation could be due to the underlying risks of mental illness in different ethnicities, but it is possible that a number of patients are being diagnosed later and with more severe symptoms, who could have otherwise been managed in the community.*
- *A majority of in-patients and CMHS patients belonged to the most deprived areas of Merton and most patients came from East Merton*
- *The majority of patients from West Merton belonged to the least deprived areas*

Age of patients

Figure 46 below depicts the age ranges of in-patients in South West London and St. George's Mental Health NHS Trust (SWLStG MHT) between 2008-13. A majority of the in-patients were working age adults (16-64 years of age). Among the patients referred to Community Mental Health Services (CMHS) between 2008-13, again a majority were working age adults with the most referrals received in patients in the 30-39 year age group. There are no referrals from the 40-49 age group (figure 47).

Figure 46: SWLStG MHT in-patients by age range in Merton (percentage), 2008-13
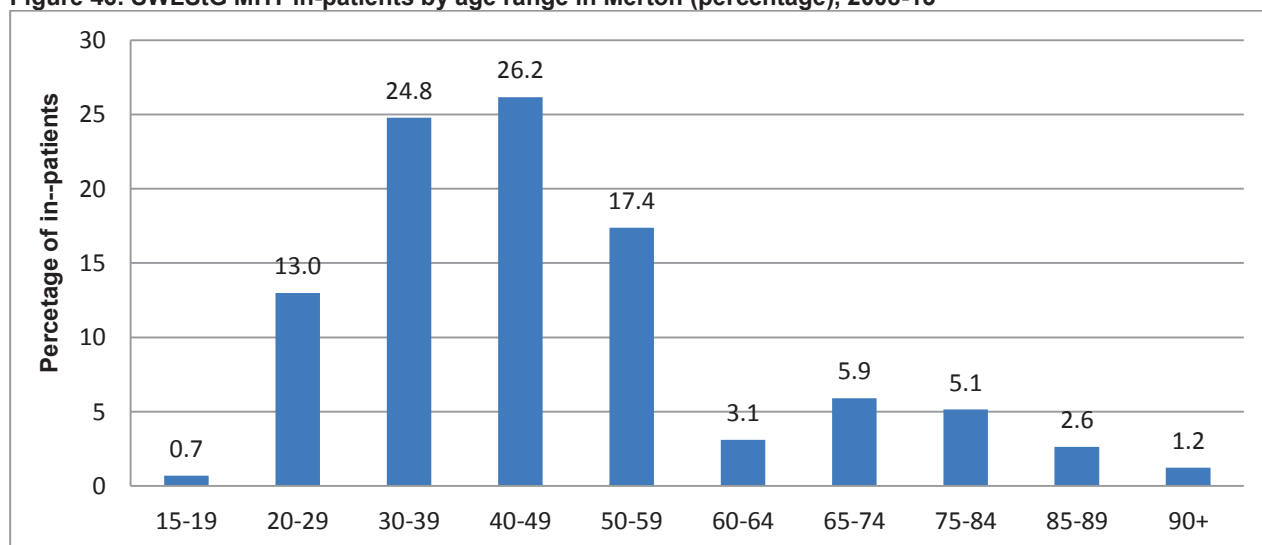
Figure 47: CMHS patients by age range in Merton (percentage, 2008-13
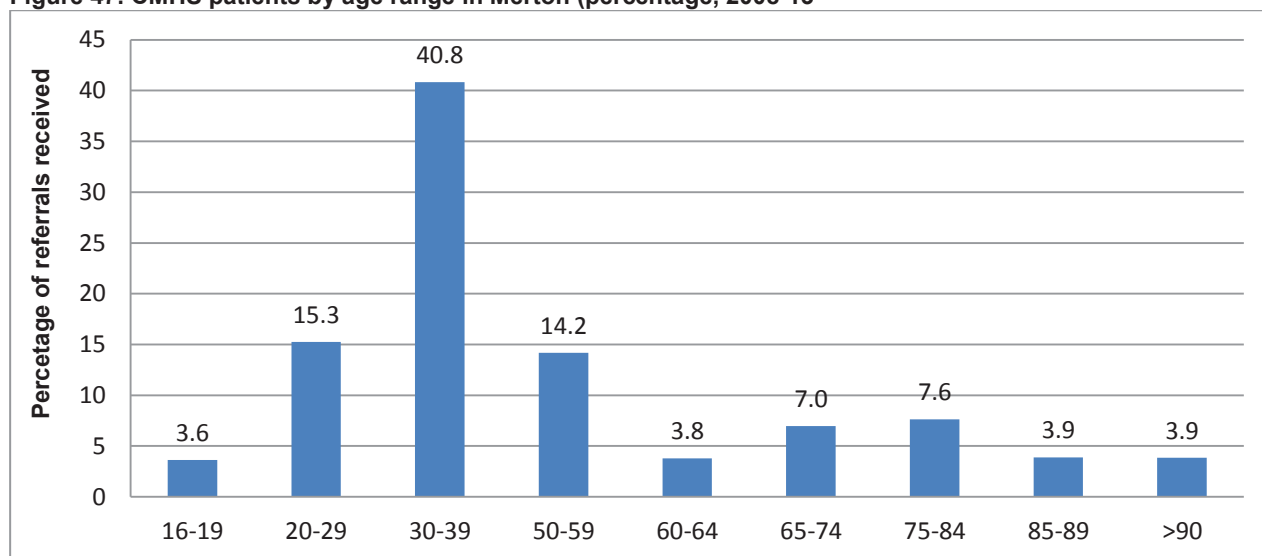
Gender of patients

Figure 48 below depicts the in-patients gender distribution. A majority of the admissions were in male adults. Interestingly it is the opposite in the case of referrals received for CMHS, where there are more female referrals than male referrals (figure 49).

Figure 48: Merton in-patients by gender in Merton, 2008-13
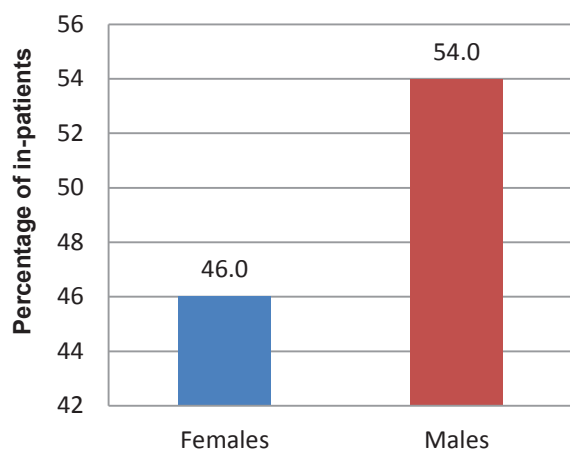
Figure 49: CMHS patients by gender in Merton, 2008-13
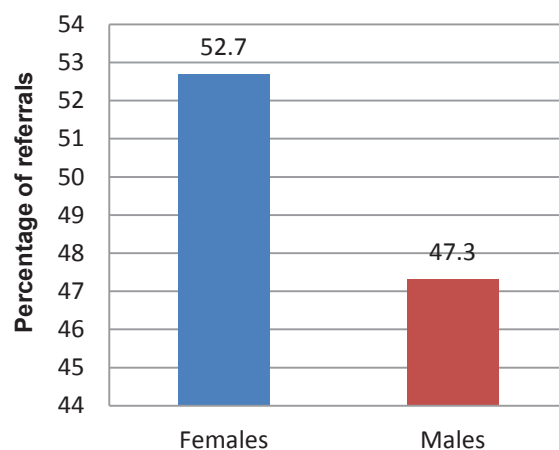
Among in-patients there are 56% working age males and 44% working age females. In older age adults 42% are males and 58% are females. This is partly explained by the higher life-expectancy in females and also reflects perhaps the differing distribution of mental health conditions between males and females[80]. In CMHS patients, for working age adults there are almost the same proportion of males and females, while in older adults there are a much higher proportion of females than males.

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[80] http://www.who.int/mental_health/prevention/genderwomen/en/

Figure 50: Merton in-patients by gender in working group and older adults (percentage), 2008-13
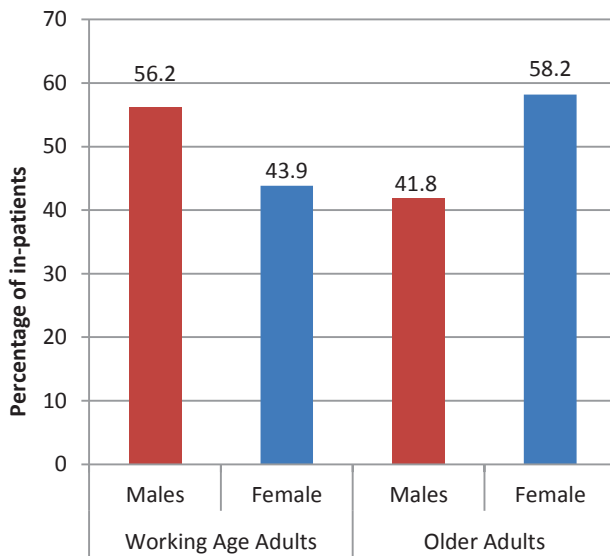
Figure 51: Merton CMHS patients by gender in working group and older adults (percentage), 2008-13
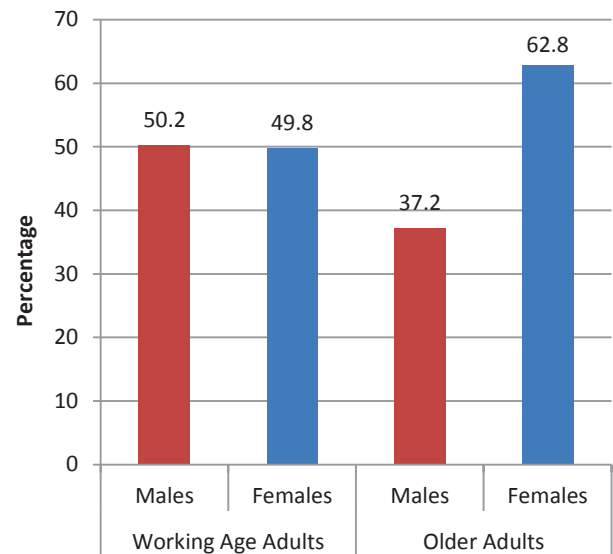
Ethnicity

Of the SWLStG MHT in-patients over 2008-13, a majority of admissions (67%) were in the white ethnicity group, followed by black (16%), Asian (11%), other ethnicities including mixed (5%) and 1% were not known. Of the CMHS referrals received over 2008-13, a majority of referrals (67%) were in the white ethnicity group, followed by equal proportions of black (10%), Asian (10%), other ethnicities including mixed (6%) and 7% were not known.

Figure 52: SWLStG in-patient occupancy by ethnicity for all causes in Merton, 2008-13
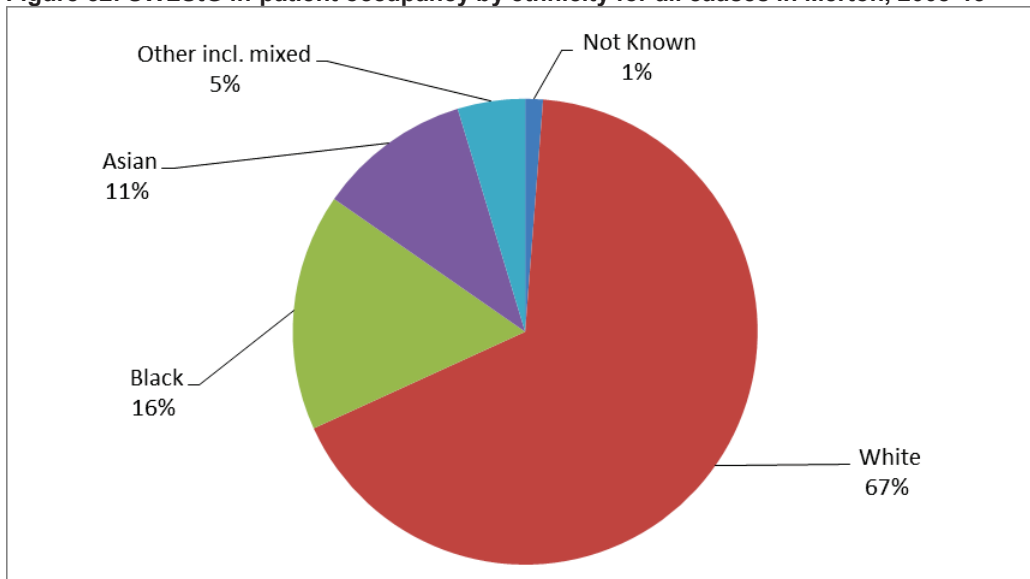
Figure 53: Merton CMHS patients by ethnicity for all causes in Merton, 2008-13
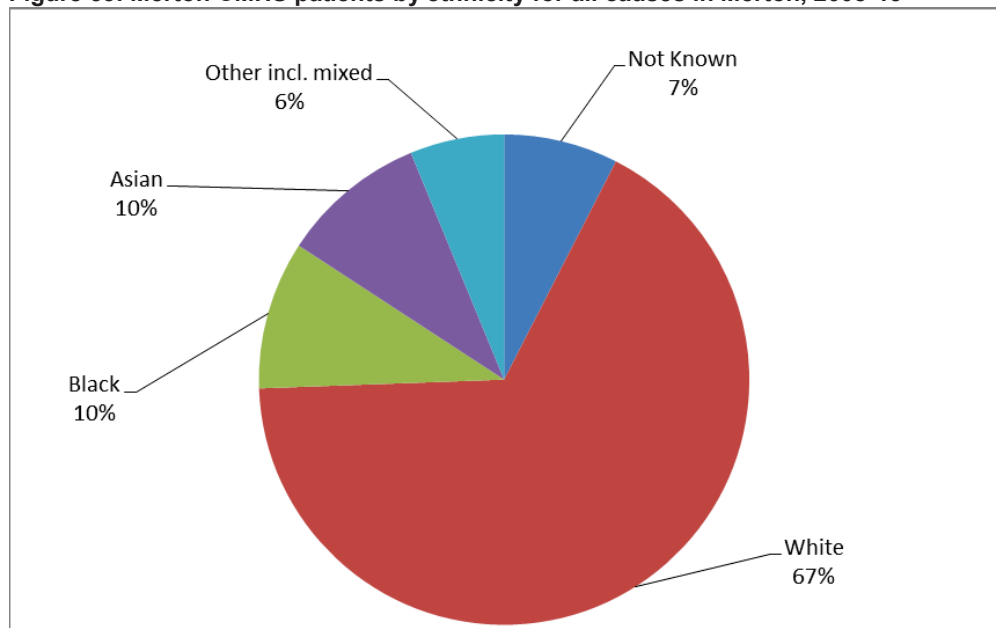
The ethnicity distribution for in-patients and CMHS patients corresponds quite closely to the underlying ethnicity distribution for the white ethnicity group in Merton (Figure 54). However while the underlying black population in Merton is 10%, the in-patient population had 16% blacks (the CMHS black proportion is same as the underlying black population proportion). While there are 18% Asians in the general population the in-patient population had 11% Asians and the CMHS only 10%. In other words blacks were over-represented in the in-patient population and Asians under-represented in both the in-patient and CMHS populations. In the case of Asian communities this under-representation suggests inequity in access and cultural taboos and stigma associated with mental illness. In Black ethnicities the in-patient over-representation could be due to the underlying risks of mental illness in different ethnicities, but it is possible that a number of patients are being diagnosed later and with more severe symptoms, who could have otherwise been managed in the community.

Figure 54: Merton ethnicity breakdown, 2011 Census data, ONS

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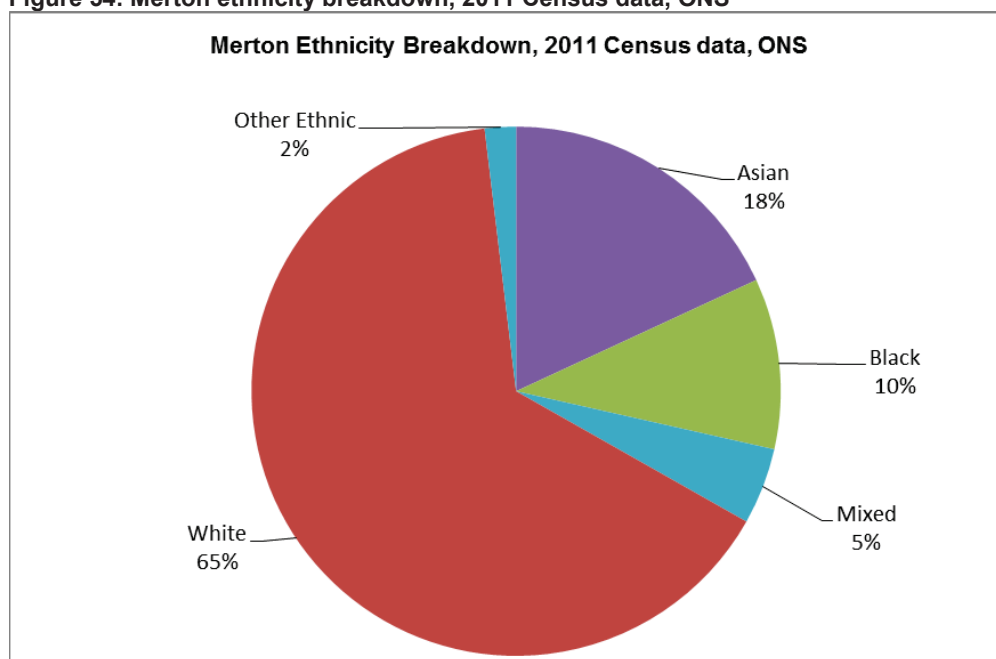
A more detailed breakdown is shown in table 11 below.

Table 11: Breakdown of Merton in-patient & CMHS ethnicities for SWLStG MHT, 2008-13

Ethnicity Group	SWLStG in-patients Percentage	CMHS referrals Percentage
Not Known	1.2	8.4
White British	55.6	54.9
White Irish	3.0	1.8
White Other	8.4	9.2
Black African	7.2	3.9
Black Caribbean	6.6	4.1
Black British	0.4	0.3
Black Other	2.2	1.6
Indian	3.1	2.2
Pakistani	0.9	1.6
Bangladeshi	1.0	0.7
Sri Lankan	1.4	0.8
Other Asian	3.9	3.6
Mixed White & Black African	0.3	0.4
Mixed White & Black Caribbean	1.4	1.2
Mixed White and Asian	0.3	0.4
Mixed Other	0.8	1.1
other Ethnicity	1.4	3.1
Chinese	0.5	0.3
Asian or Asian British	0.3	0.2
Mixed Asian	-	0.2

Examining the ethnicity groups of in-patients and CMHS patients by East and West Merton reveals differences in terms of the percentages in each ethnicity group admitted from each area. From the East there are fewer whites, more blacks and Asians, and roughly the same number of other ethnicities. This is in line with the diversity in east Merton but comparing the patient distributions of ethnicities with the distribution in the overall population, by East and West Merton, in in-patients there is over-representation of white and black ethnicities from the East and an under-representation of Asian ethnic groups. In CMHS populations there is under-representation of both black and Asians compared with the general population, although this is more pronounced for Asians. For West Merton the representations of whites are in line with the underlying population

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while blacks are over-represented and Asians are under-represented. While part of the over-representation can be explained by underlying differences in the patterns of mental illness by ethnicity and also by repeat admissions, this analysis further re-enforces a point made earlier that the under-representation of Asians is very likely to be an equity issue and furthermore, the over-representation of blacks could be because of increased admissions due to cases being diagnosed later (see figures 55, 56 and 57).

Figure 55: Merton in-patients (percentage) by ethnicity in East and West Merton, 2008-13
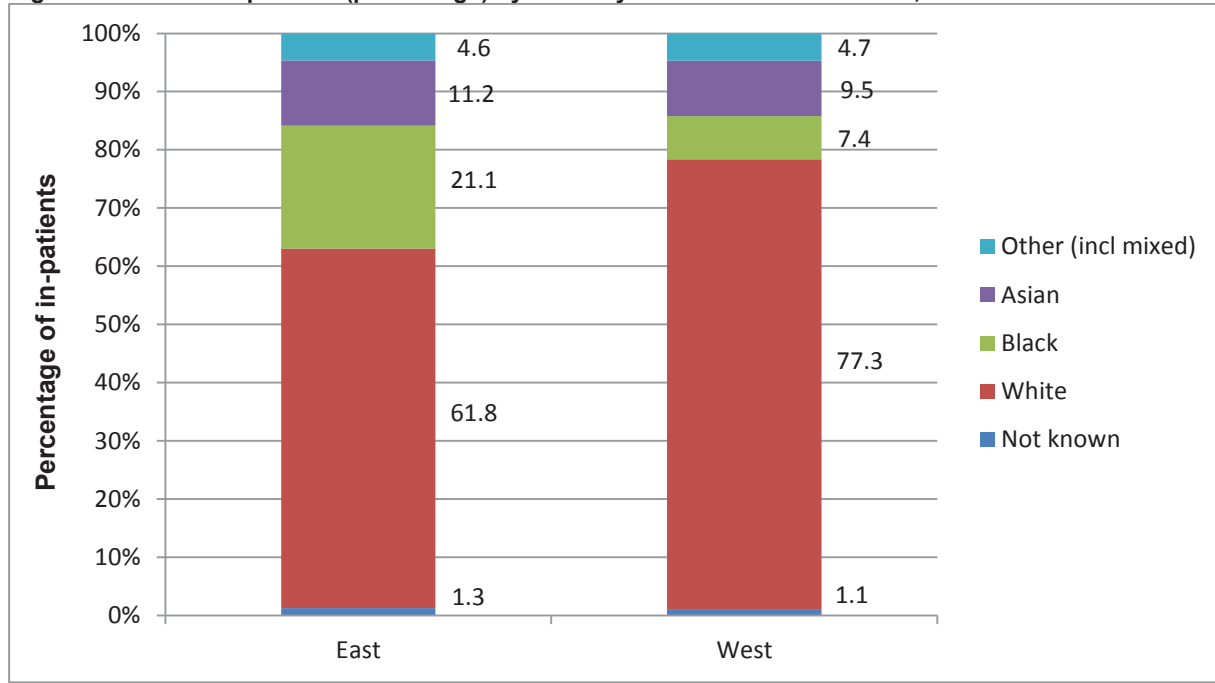
Figure 56: Merton CMHS patients (percentage) by ethnicity in East and West Merton, 2008-13
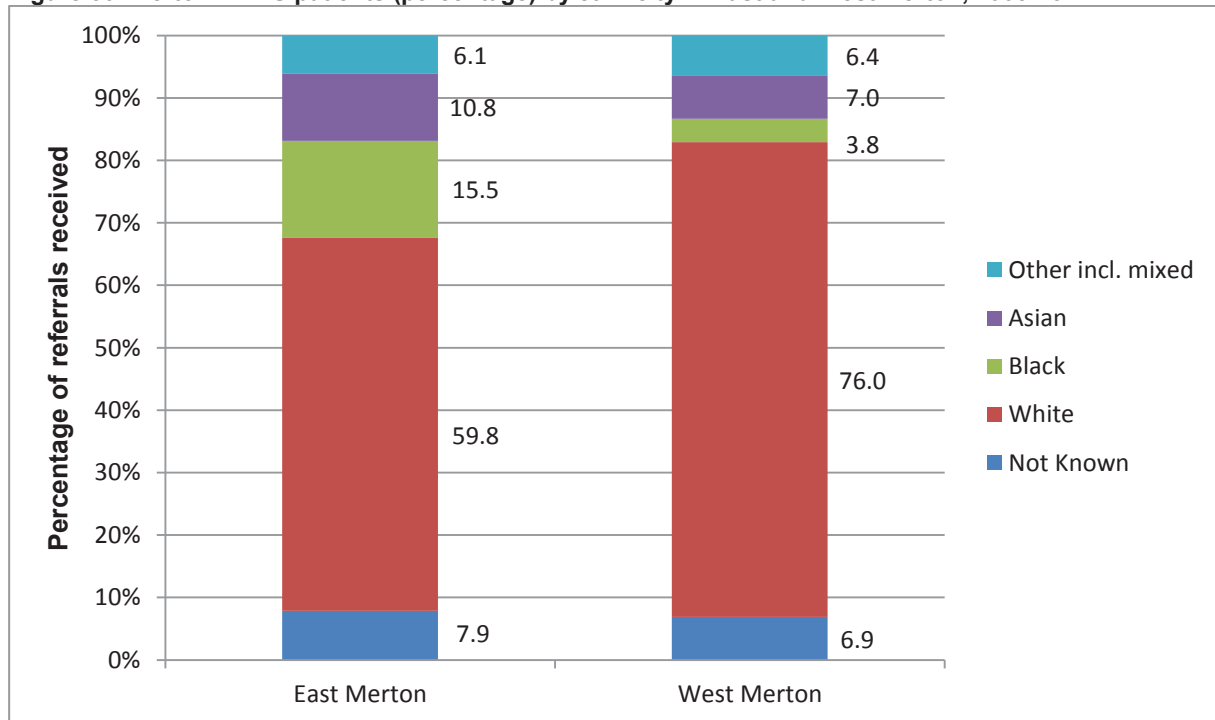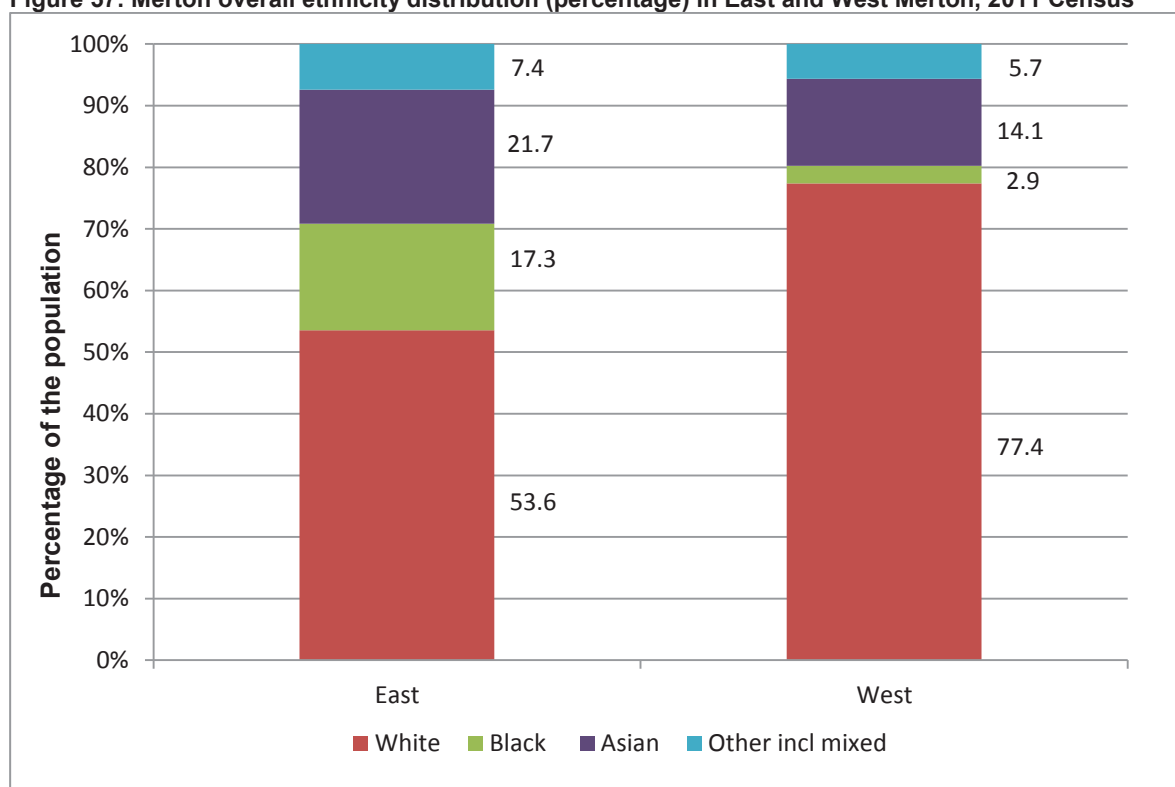
Admissions by deprivation quintile

When the in-patient occupancies were broken down by IMD (Index of Multiple Deprivation) quintile where IMD 1 is the least deprived and IMD 5 is the most deprived, a majority of the in-patients belonged to IMD 4 (37%) followed by IMD 3 (26%), IMD 1 (16%), IMD 2 (15%) & IMD 5 (3%). Similarly for CMHS patients, most referrals were from the second most deprived quintile (IMD4-31%) and then IMD 3 (26%), IMD 1 (22%) IMD 2 (15%) and IMD 5 (3%). The low numbers in IMD 5 are perhaps because Merton is in general a wealthy borough and there not many people in IMD 5 as such but more in IMD 4 in terms of deprivation (figure 58, 59).

As mentioned earlier the health inequalities between East and West Merton are well established, and also that East Merton is much more deprived than the West[81]. Examining the data by patient's place of residence reveals that 64% of the in-patient population was from East Merton, 33% from West Merton and 3% not attributable. It was more evenly split for CMHS, with 42% from East Merton, 37% from West and 21% not attributable (figures 60 and 61).

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[81] Merton Joint Strategic Needs Assessment 2013-14

Figure 58: In-patients in Merton by IMD deprivation quintiles, 2008-13 (1= least deprived)
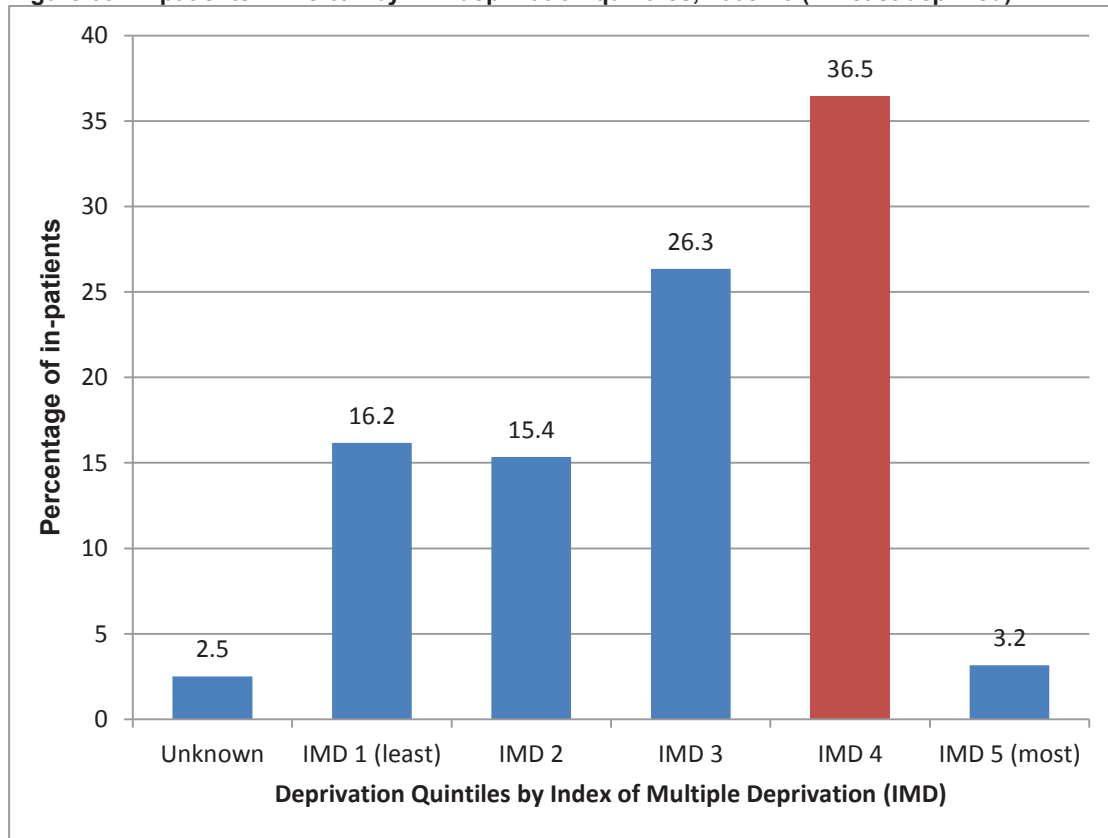
Figure 59: CMHS patients in Merton by IMD deprivation quintiles, 2008-13 (1- least deprived)

100
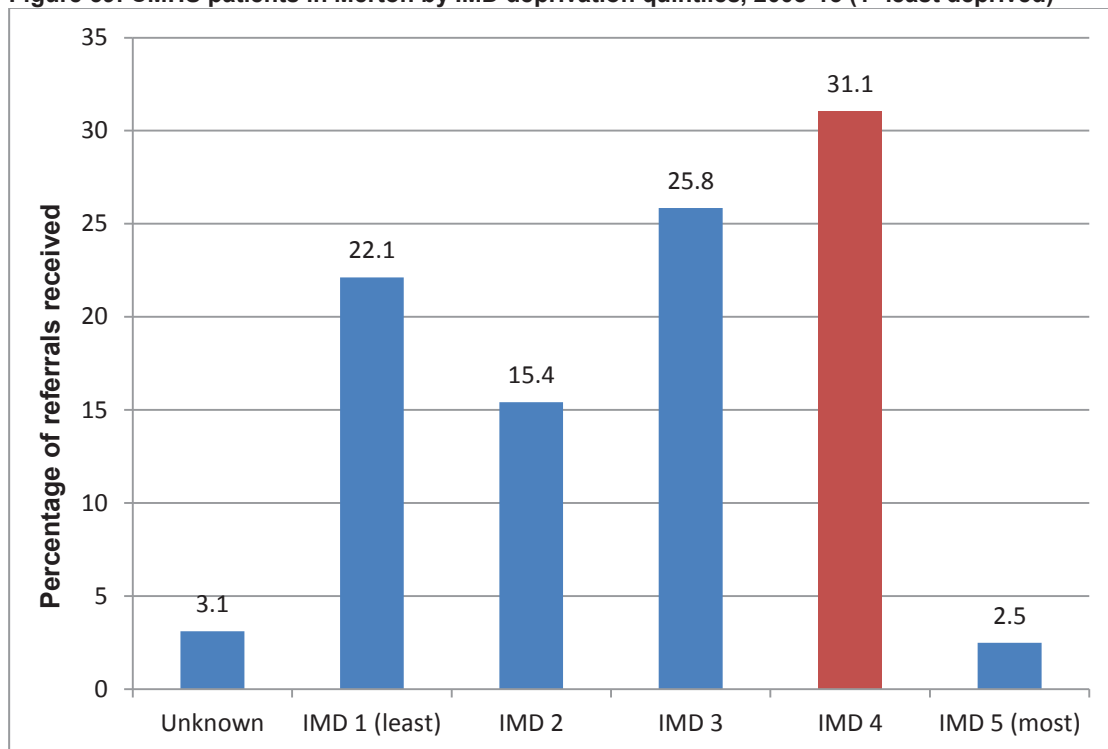
Figure 60: In-patients from East and West Merton, 2008-13

In-patients by East West Merton, numbers and percentages, 2008-13

not attributable
3%
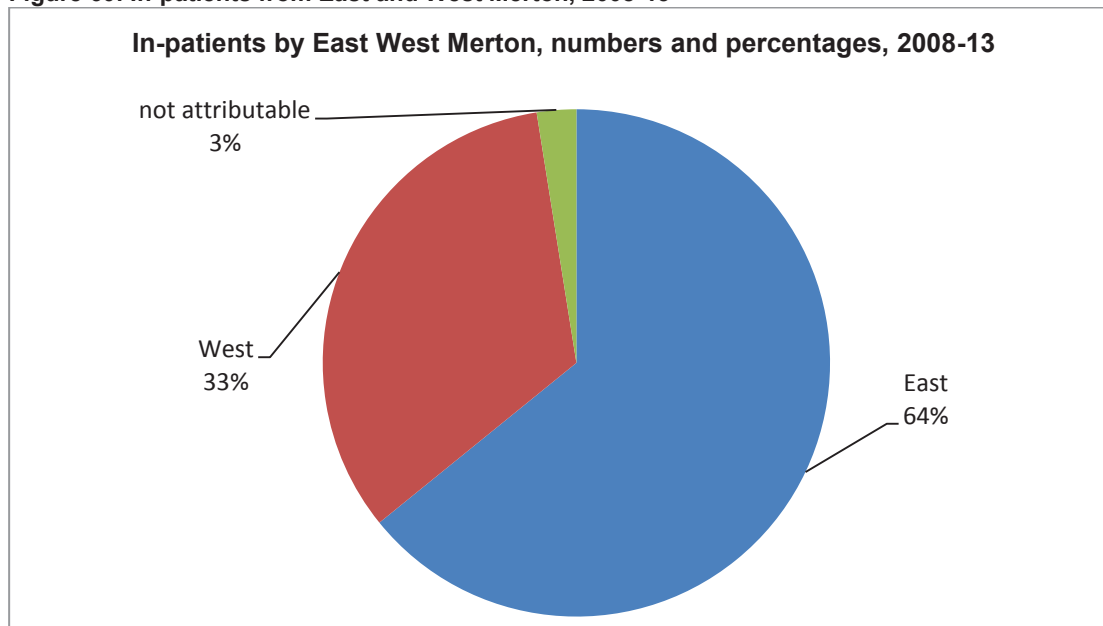
West
33%

East
64%

Figure 61: CMHS patients from East and West Merton, 2008-13

Community MH Services patients by East and West Merton, 2008-13

not attributable
21%
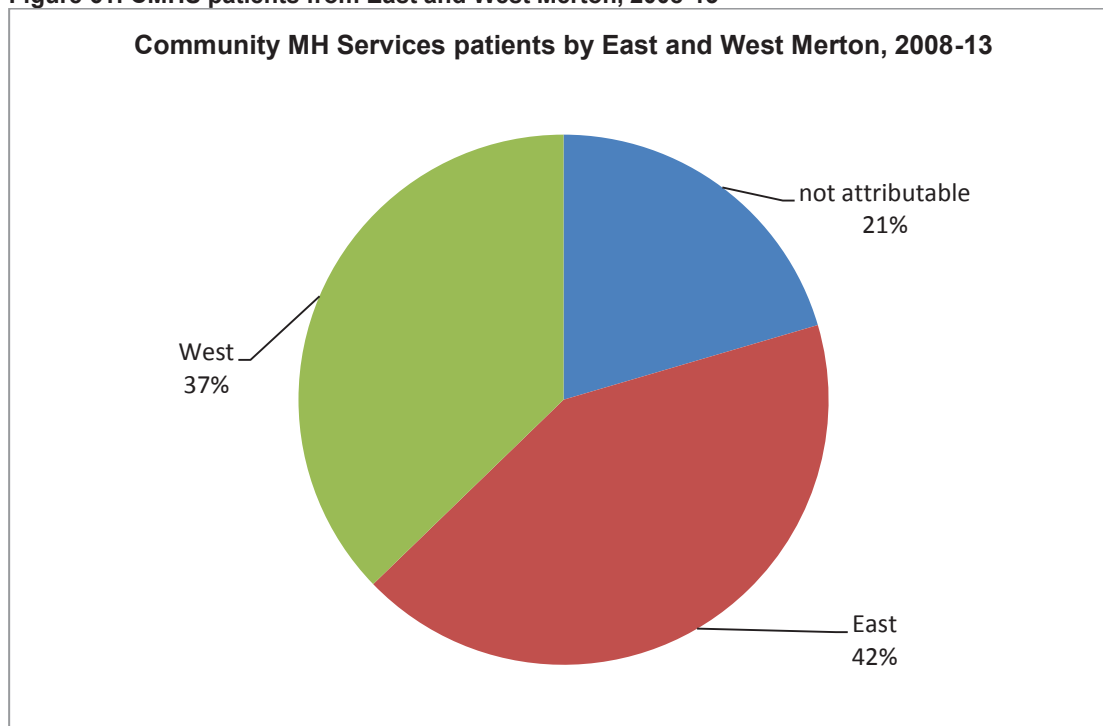
West
37%

East
42%

When the deprivation quintiles are examined separately for East and West Merton, there is a sharp contrast in the proportion of patients belonging to each deprivation quintile, to the extent that they are almost a mirror image of each other. Whereas in East Merton the highest proportion of patients belongs to IMD quintile 4 (second-most deprived) and progressively less patients belong to the less deprived quintiles and the least proportion of patients belong to the least deprived quintile. In the case of West Merton, it is the exact opposite, with the most patients belonging to the least deprived quintile and the least number of patients belonging to the highest deprivation quintiles. This is observed for both in-patients and CMHS patients.

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Figure 62: Percentage of in-patients by deprivation quintile (1= least deprived) in East and West Merton, 2008-13
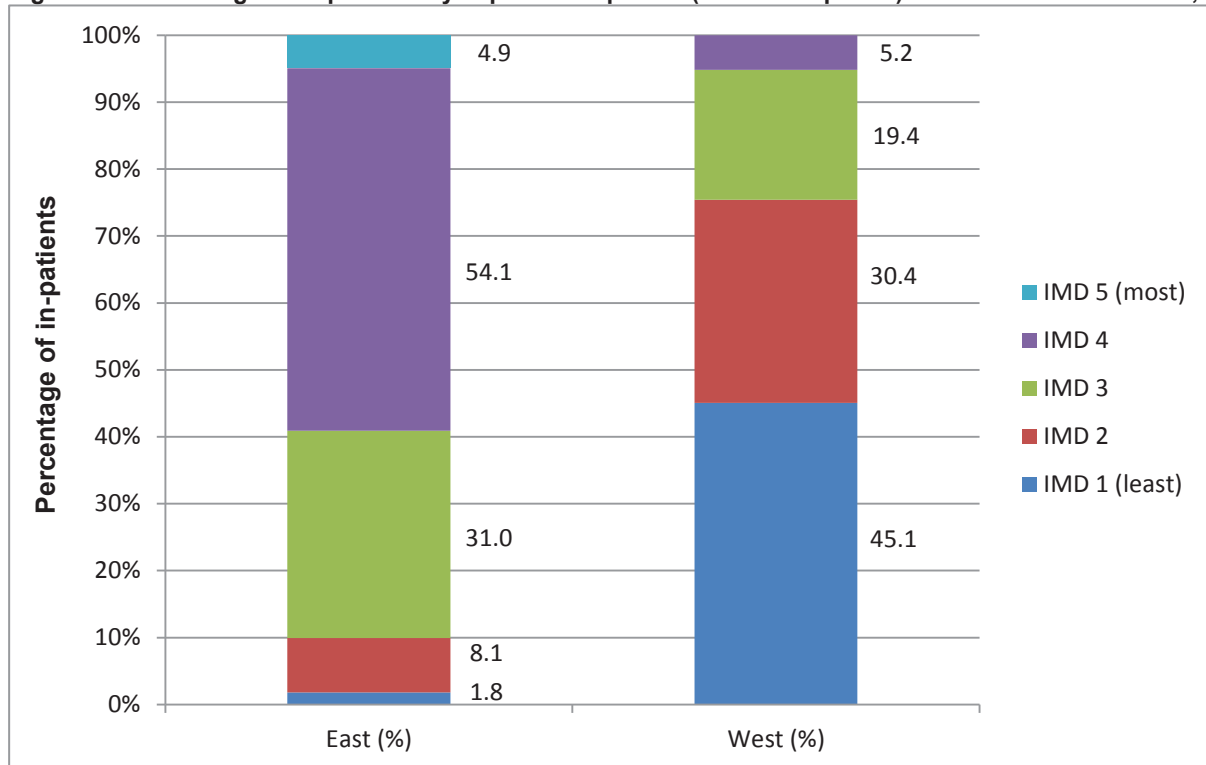
Figure 63: Percentage of Community MH Services patients by deprivation quintile (1= least deprived) in East and West Merton, 2008-13

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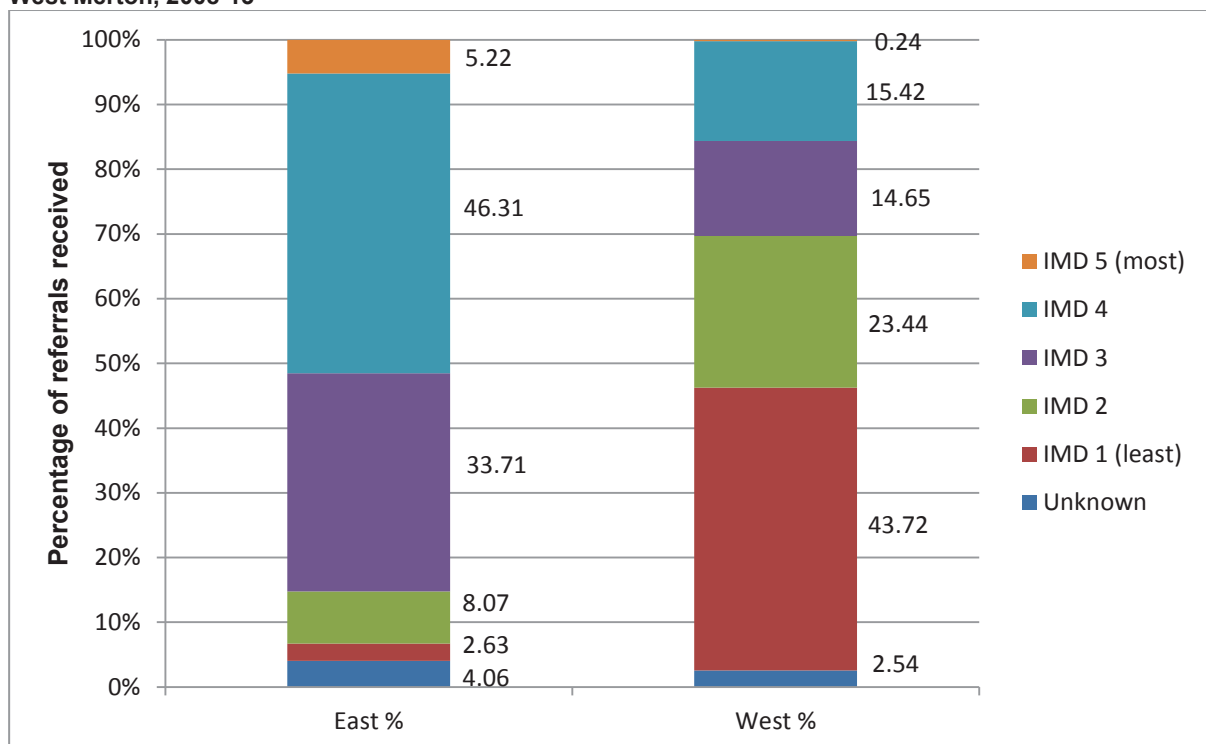
What are the overall trends and main causes of admissions and referrals in Merton?

> *Key Points*
> - *The in-patient admissions show a decreasing trend from 2008-13. Overall there was a drop in the mean length of stay for in-patients in Merton from 2008-13*
> - *In terms of referral rates to CMHS, white, black and other ethnicities have comparable referrals rates while the rate in Asians is statistically significantly much lower. For in-patients, Black ethnicities have the highest admission rates in Merton and this is statistically significantly higher than the admission rates for other ethnicities. Asians have the lowest rate and this too is statistically significantly different from admission rates in white and black ethnicities*
> - *The three top causes for in-patient admission were schizophrenia, followed by psychoactive substances and then mood affective disorders*
> - *The three top causes for CMHS referrals were mood affective disorders, followed by psychoactive substances and then schizophrenia*
> - *In working age adults the most common cause of admission was schizophrenia while in older adults it was mood affective disorders. The next most common in working age adults was psychoactive substances while in older adults it was schizophrenia*
> - *For CMHS, in working age adults the most common diagnosis is psychoactive substances, while in older adults it is organic disorders. The next most common in working age adults is mood affective disorders while in older adults it is affective disorders*
> - *Psychoactive substances were the second most common cause for both in-patient admissions and CMH patients in adults overall from 2008-13, as well as the second most common cause for admissions in working age adults. Additionally this category was the most common cause for referrals to CMH in working age adults. In both in-patient admissions and CMHS referrals for substance misuse, a significant majority were due alcohol*
> - *For Merton in-patients, black ethnicities were admitted in the highest proportion after white ethnicities for schizophrenia, mood disorders and organic disorders. Asians were represented in higher proportions than black ethnicities among patients with neurotic, anxiety and stress disorders, and psychoactive substances. White ethnicities had a particularly high proportion of admissions for psychoactive substances, organic disorders and personality disorders*
> - *For Merton CMHS patients, after white ethnicities the next highest ethnic proportion is of black ethnicities in schizophrenia and adult personality disorders. Asians are represented in higher proportions than black ethnicities in patients with neurotic, anxiety and stress disorders, organic disorders and by small margins in psychoactive and mood disorders*
> - *Apart from organic disorders where the least deprived patients have the highest proportion of cases, for all other major diagnostic groups the more deprived patients have the higher proportion of cases, indicating a positive correlation between mental illnesses and deprivation*
> - *In all the major primary diagnostic groups there are a higher proportion of patients from East Merton compared with West Merton*
> - *Majority of referrals to CMHS were from GPs. The percentage of referrals from the Local Authority was very low.*

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Overall admission and referral trends

While the mental health services in Merton will be described at length in a subsequent section of this document, it would be useful to consider the way the SWLStG MHT services are organised in Merton (see figure 64 below). The first point of contact for a person with mental health concerns is their GP. For anxiety and depression related problems the GP may refer the person to Merton's IAPT services. For SMI (Severe Mental Illness) the person may be referred to the Merton Assessment Team (MAT) which triages cases and determines which service is most appropriate for the person (community mental health services- Recovery & Support Team, Early Intervention Service or Complex Needs Service; or the Crisis & Home Treatment team) and can lead to a hospital admission.

In total there were 1,024 in-patient admissions over the period 2008-2013 in the SWLStG MHT Springfield University Hospital. The total number of adult patients referred to CMHS for all causes in the period 2008-13 was 29,441. As with in-patients, these include many patients that were seen on more than one occasion.

Table 12: Summary of SWLStG MHT in-patients and CMHS referrals in Merton for period 2008-13

Metric	Number of patients
Overall number of patients that were admitted during the period 2008-13, due to any cause	1,024
Overall number of referrals to CMHS in adults during the period 2008-13, due to any cause	29,441

Figure 64: Care pathway of adult mental health services in Merton

Adult Mental Health Care Pathway for Merton
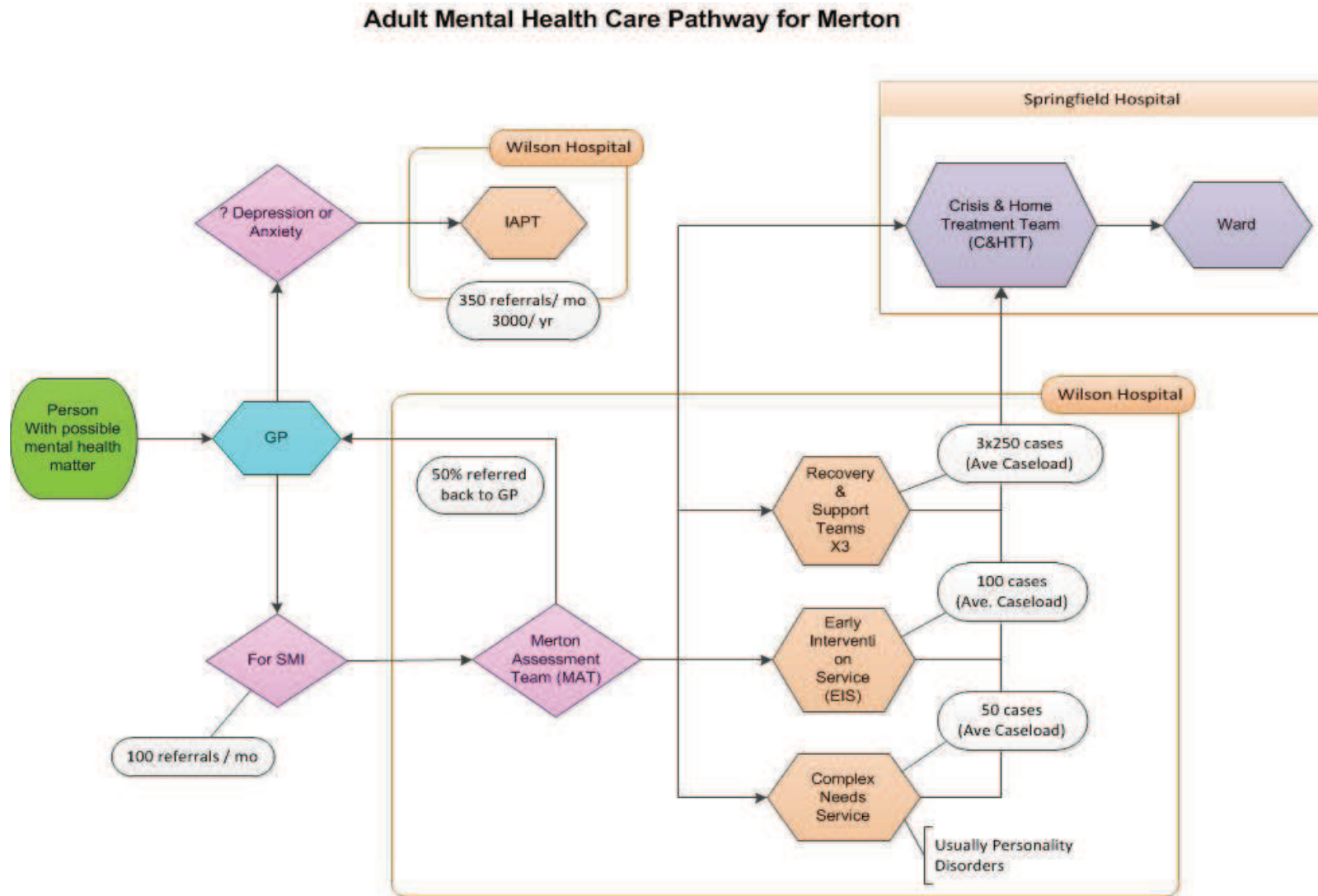
Admission and referral trends

The in-patient admissions trend overall over 2008-13 shows a decreasing trend from 2008-09 to 2012-13. The decrease is more pronounced during the period 2009-2011, and then a relatively more gradual decrease occurs over the 2011-2013. The reductions probably reflect the changes in the way mental health services were provided and the increasingly effective triaging done by the Merton Assessment Team, so that more cases are seen in the community and fewer more serious cases were admitted to hospital.

Figure 65: Overall in-patient admissions in Merton, 2008-2013

Total SWLStG MHT in-patient admissions for Merton CCG 2008-13
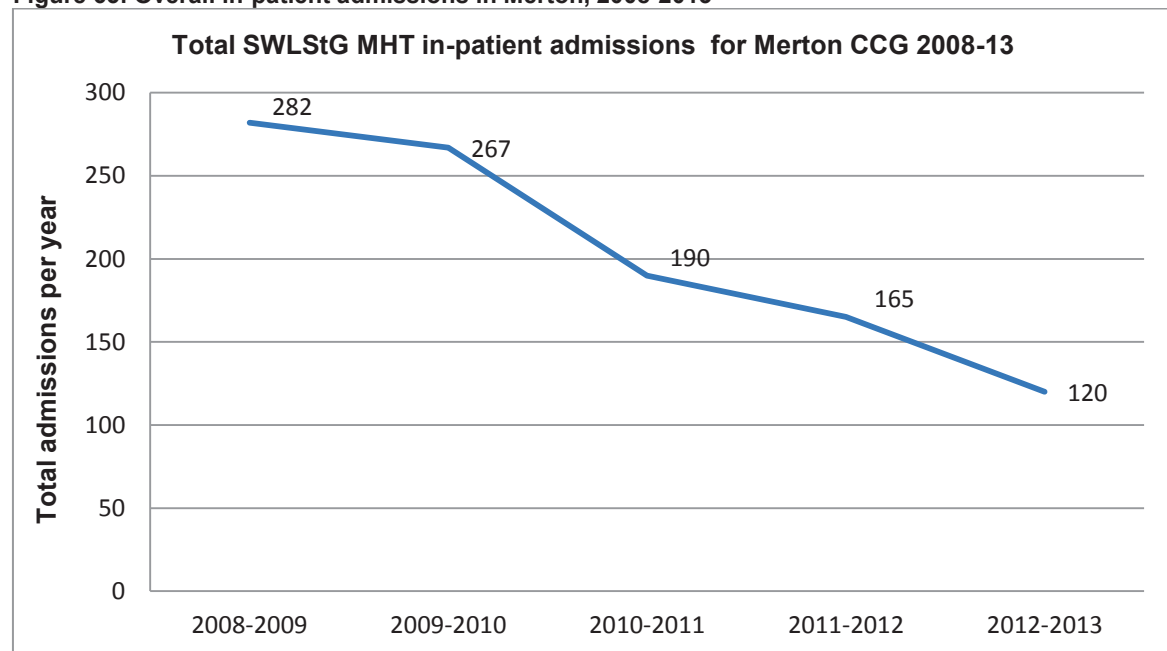
The trends for CMHS patients overall over 2008-13 show sharp increases from 2008-09 to 2009-10, then a more gradual increase over the next financial year (2010-11), after which the number of referrals drop significantly over 2011-12 and then more gradually over 2012-13 (figure 66).

Figure 66: Overall CMHS patients referred to CMHS in Merton, 2008-2013
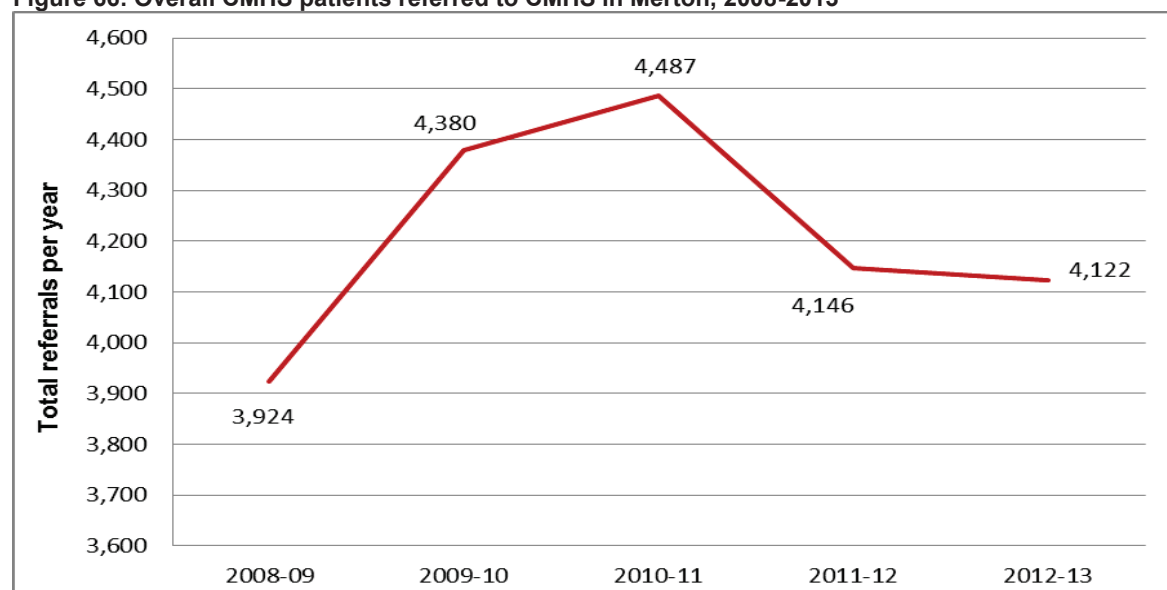
Mean length of stay for in-patients

The figure below shows the mean length of stay in days for admissions in that particular year. It shows that there was a drop in mean length of stay from 2008/09 to 2010/11 after which the mean length of stay has increased slightly year on year.

Figure 67: Trends in mean length of stay (days) for admissions in Merton, SWLStG MHT 2008-13
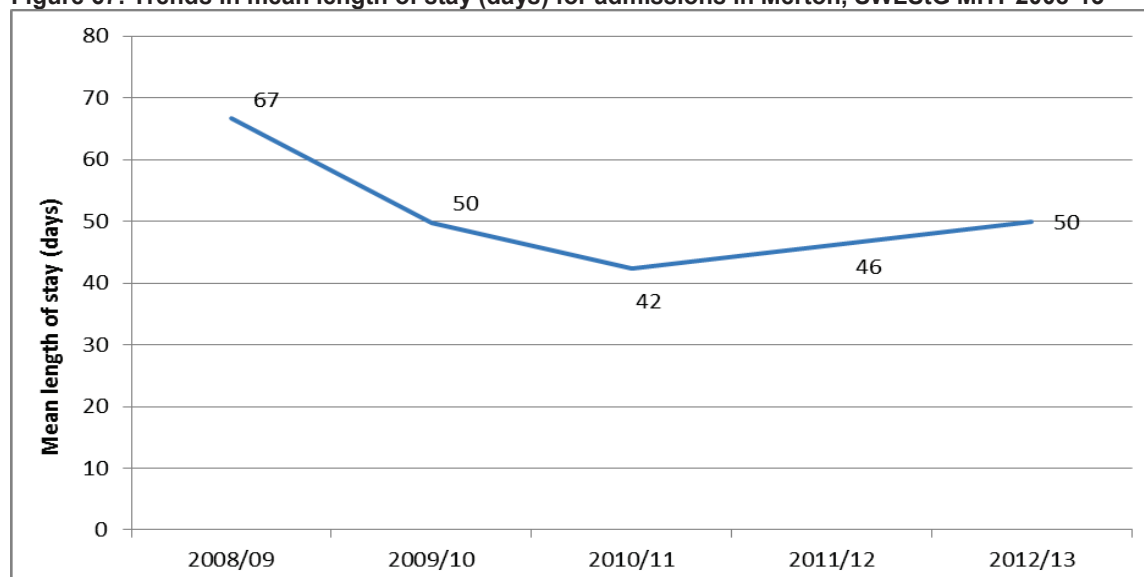
Over 2010-13, while there has been a reduction in the number of admissions there has been an increase in the mean length of stay. One interpretation of this is that while fewer admissions are taking place and more people are being seen in the community mental health services, the cases that are being admitted have a greater severity of symptoms due to which their length of stay in hospital is increasing.

Admission and referral rates by ethnicity and age group

A crude rate was developed for both in-patient admissions and CMHS referrals by ethnicity and also by age group. This was done by calculating the average number of admissions and referrals over 2008-13 and then dividing these by the ONS 2011 Census Merton population break-down by ethnicity (for rates by ethnic groups) and the average age-specific ONS population projections for Merton from 2008 to 2012 (for the age-specific rates). All the rates are expressed per 1000 population in that group- for example, a referral rate of X for say the 20-29 year age group means that there were X referrals per year for every thousand 20-29 year olds in Merton.

Referral and admission rates by ethnicity

While in absolute terms it appears that a large number of admissions/ referrals were from the white population, this is also explained by the fact that there are many more white people in Merton. By creating admission and referrals rates, this brings greater clarity and perspective.

Figure 68 shows the referral rates for CMHS in Merton by ethnicity, with 95% confidence intervals. White, black and other ethnicities have comparable referrals rates while the rate in Asians is statistically significantly much lower.

Figure 68: Merton CMHS average referral rates (per 1000 population) per year by ethnicity with 95% confidence intervals$^{\$}$, 2008-13*
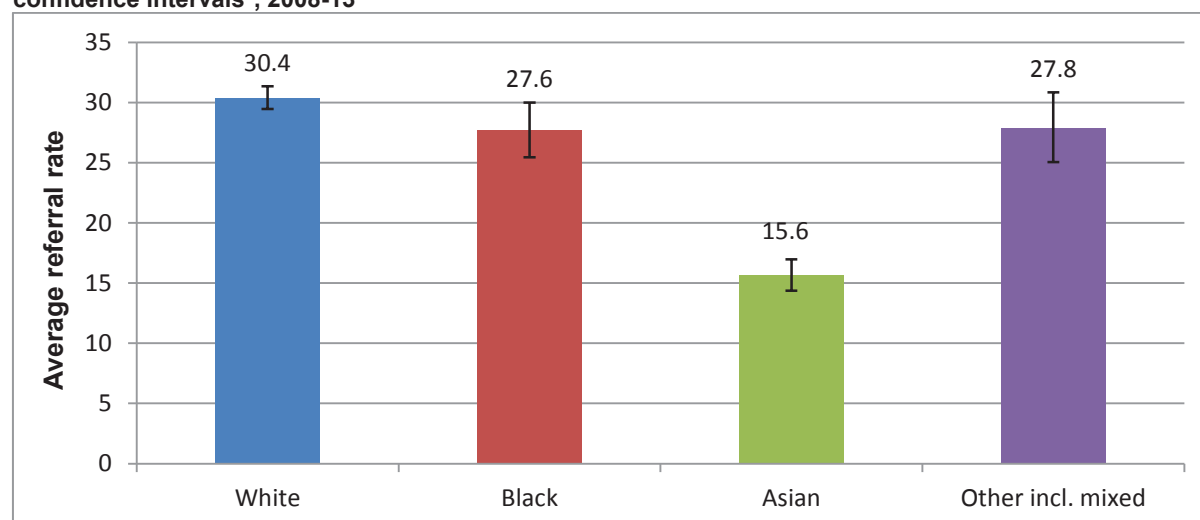
$^{\$}$ *95% confidence intervals (CI) indicate the precision with which the rates are calculated. They also indicate the range of values in which there is a 95% likelihood that the true value for the patient population lies - the narrower the range, the more precise the calculation. The intervals are the widest for smaller sample sizes. These are shown by the vertical lines at the top of the bar graphs. When the rates are compared, if the CI intervals do not overlap this represents a statistically significant difference.*

*Rates were calculated from average numbers of referrals for 2008-13 and ONS 2011 ethnicity populations for Merton.

Figure 69 shows the admission rates for SWLStG MHT in-patients in Merton by ethnicity, with 95% confidence intervals. Black ethnicities have the highest admission rates in Merton and this is statistically significantly different from admission rates for other ethnicities. Asians have the lowest rate and this too is statistically significantly different from admission rates in whites and blacks, but not other including mixed.

Figure 69: Merton in-patient average admission rates (per 1000 population) per year by ethnicity with 95% confidence intervals$^{\$}$, 2008-13*
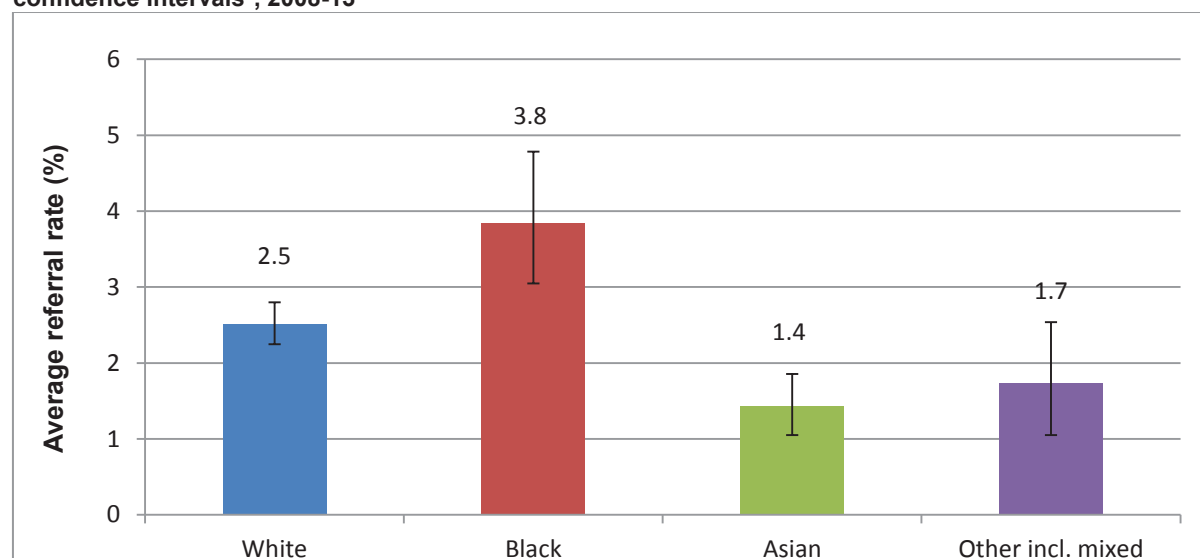
$^{\$}$ *95% confidence intervals (CI) indicate the precision with which the rates are calculated. They also indicate the range of values in which there is a 95% likelihood that the true value for the patient population lies - the narrower the range, the more precise the calculation. The intervals are the widest for smaller sample sizes. These are shown by the vertical lines at the top of the bar graphs. When the rates are compared, if the CI intervals do not overlap this represents a statistically significant difference.*

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Cause of admission

The cause of admission for in-patients that occupied a bed at any point during the period 2008-13 is depicted in the figure 70. Overall, the majority of in-patients were admitted with a primary diagnosis of schizophrenia, followed by psychoactive substances > mood affective disorders>Personality & behavioural disorders> neurotic, anxiety and related disorders> Organic disorders (which includes dementia)> others.

Figure 70: Merton in-patients by primary diagnosis, 2008-13

Adult personality & behavioural disorders 8.0%
Other 0.8%
Organic including symptomatic disorders 3.4%
Behavioural syndromes 1.2%
Psychoactive substances 25.6%
Neurotic, anxiety and stress disorders 4.6%
Mood affective disorders 20.7%
Schizophrenia, schizotypal and delusional disorders 35.7%

Figure 71: Merton CMHS patients by primary diagnosis, 2008-13

Adult personality & behavioural disorders 7%
Other 3%
Organic including symptomatic disorders 13%
Behavioural syndromes 2%
Psychoactive substances 21%
Neurotic, anxiety and stress disorders 11%
Mood affective disorders 24%
Schizophrenia, schizotypal and delusional disorders 19%

The picture is somewhat different for CMHS patients (figure 71) where the order of primary diagnosis from most common to least is:
Mood affective disorders> psychoactive substances > schizophrenia> Organic disorders (which includes dementia)> neurotic, anxiety and related disorders> Personality & behavioural disorders> others

Cause of admission by working age and older adults
There are interesting differences when the primary diagnosis for in-patients is analysed separately for working age (16-64 yrs. of age) and older (65+ yrs. of age) adults. In working age adults the most common cause of admission is schizophrenia (37.9%) while in older adults it is mood affective disorders (42.1%). The next most common in working age adults is psychoactive substances (28.9%) while in older adults it is schizophrenia (23%). The third most common in working age adults is mood disorders (17%) while in older adults it is organic disorders including dementia (21.2%)- organic disorder only form (as expected) a small fraction of the admissions in working age adults. Neurotic disorders share roughly the same proportion of admissions in both age groups (4.5%, 5.0%). But while personality disorders are a significant proportion of working age adult admissions (9.2%) there are none in older age adults.

Figure 72: Merton in-patients by primary diagnosis in working age adults, 2008-13
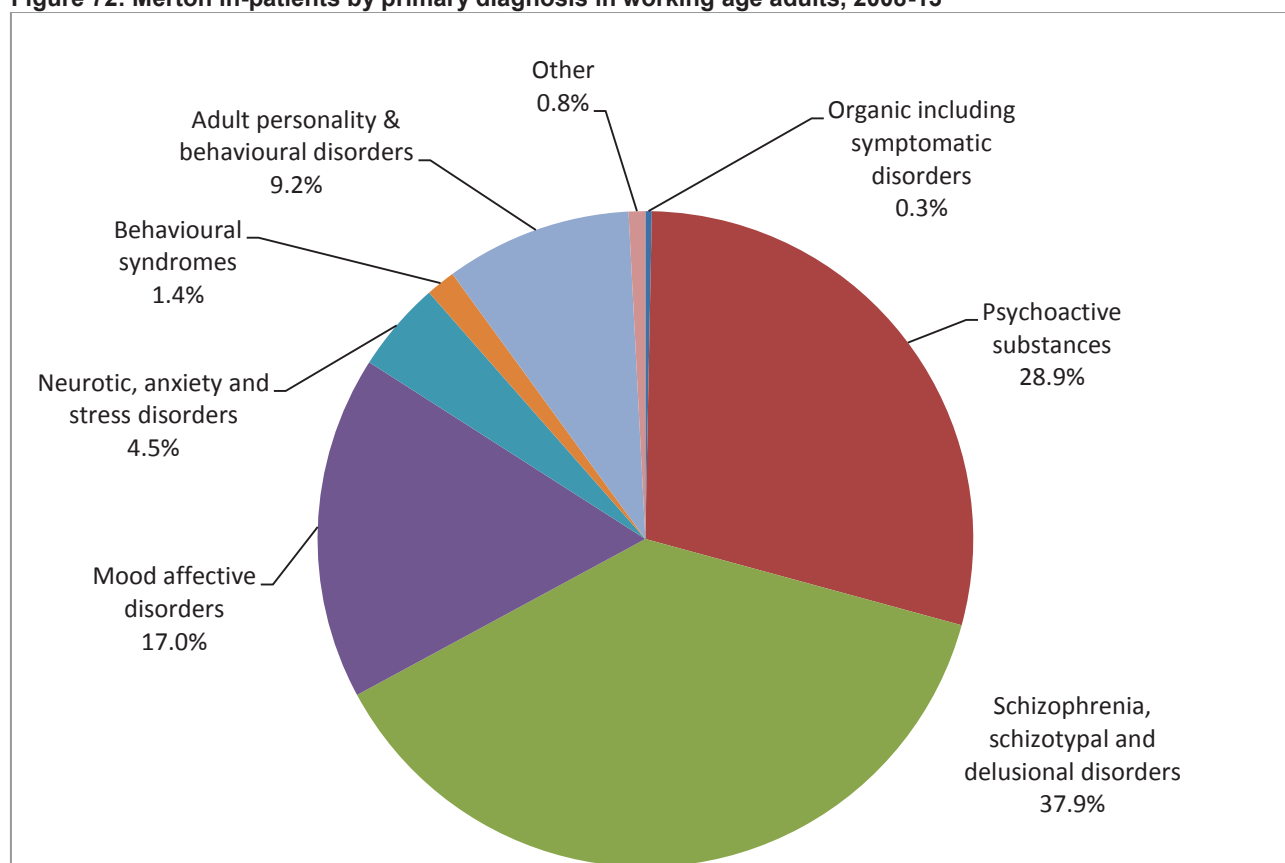
Figure 73: Merton in-patients by primary diagnosis in older age adults, 2008-13
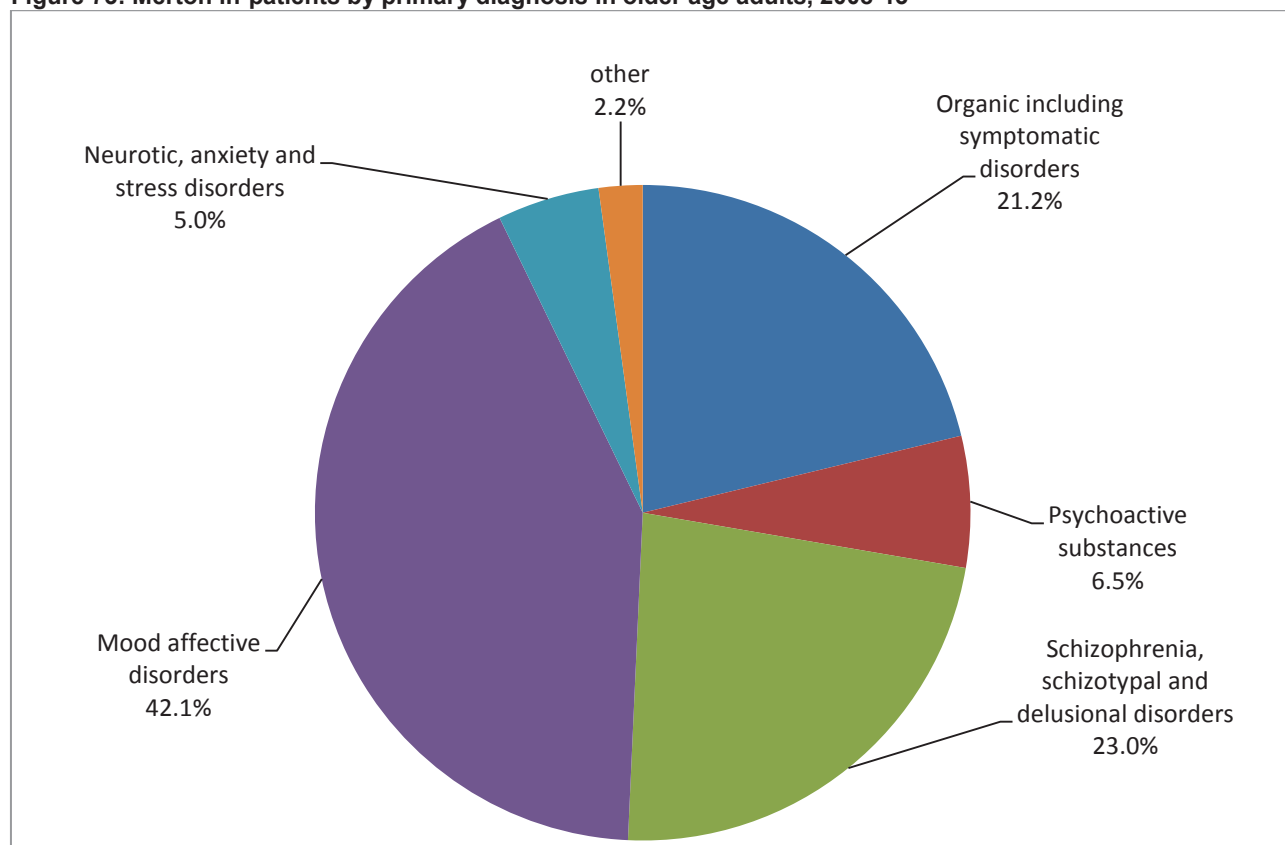
There are interesting differences when the primary diagnosis for CMHS patients is analysed separately for working age (16-64 yrs. of age) and older (65+ yrs. of age) adults. In working age adults the most common diagnosis is psychoactive substances (25.8%) while in older adults it is organic disorders (53.3%). The next most common in working age adults is mood affective disorders (24.2%) while in older adults it is affective disorders (22.3%). The third most common in working age adults is schizophrenia (21.7%) while in older adults it is schizophrenia (9.9%). Next most common in working age and older adults is neurotic, anxiety and stress disorders (12.1%, 8.1%) Adult personality disorders still form a significant part of the conditions for working age adults, but for older adults it is less so, and psychoactive substances only form a small proportion of conditions affecting older adults relative to working age. Organic disorders only form (as expected) a small fraction of the admissions in working age adults.

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Figure 74: Merton CMHS patients by primary diagnosis in working age adults, 2008-13

Other
4.0%

Organic including symptomatic disorders
0.9%

Adult personality & behavioural disorders
8.7%

Behavioural syndromes
2.6%

Neurotic, anxiety and stress disorders
12.1%

Psychoactive substances
25.8%

Mood affective disorders
24.2%

Schizophrenia, schizotypal and delusional disorders
21.7%
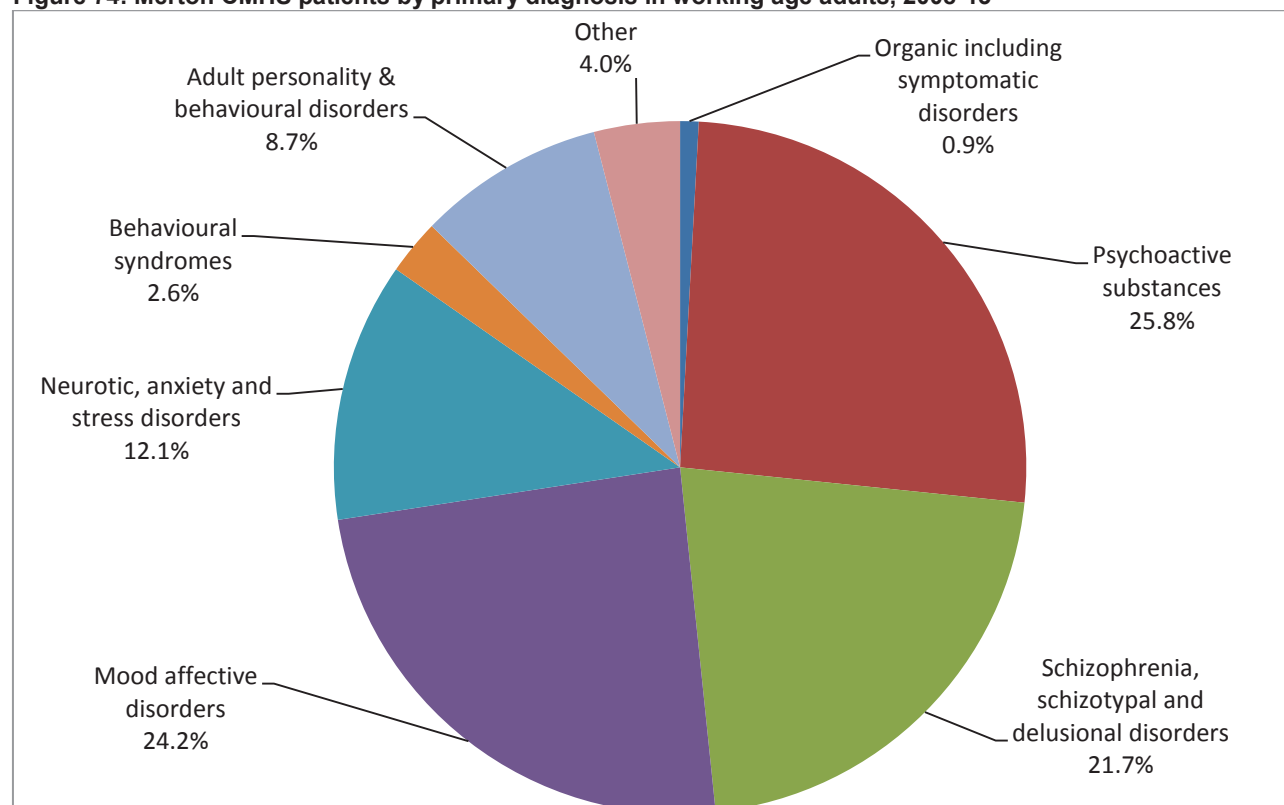
Figure 75: Merton CMHS patients by primary diagnosis in older age adults, 2008-13

Adult personality & behavioural disorders
1.5%

Other
0.3%

Behavioural syndromes
0.2%

Neurotic, anxiety and stress disorders
8.1%

Mood affective disorders
22.3%

Schizophrenia, schizotypal and delusional disorders
9.9%

Psychoactive substances
4.3%

Organic including symptomatic disorders
53.3%

112
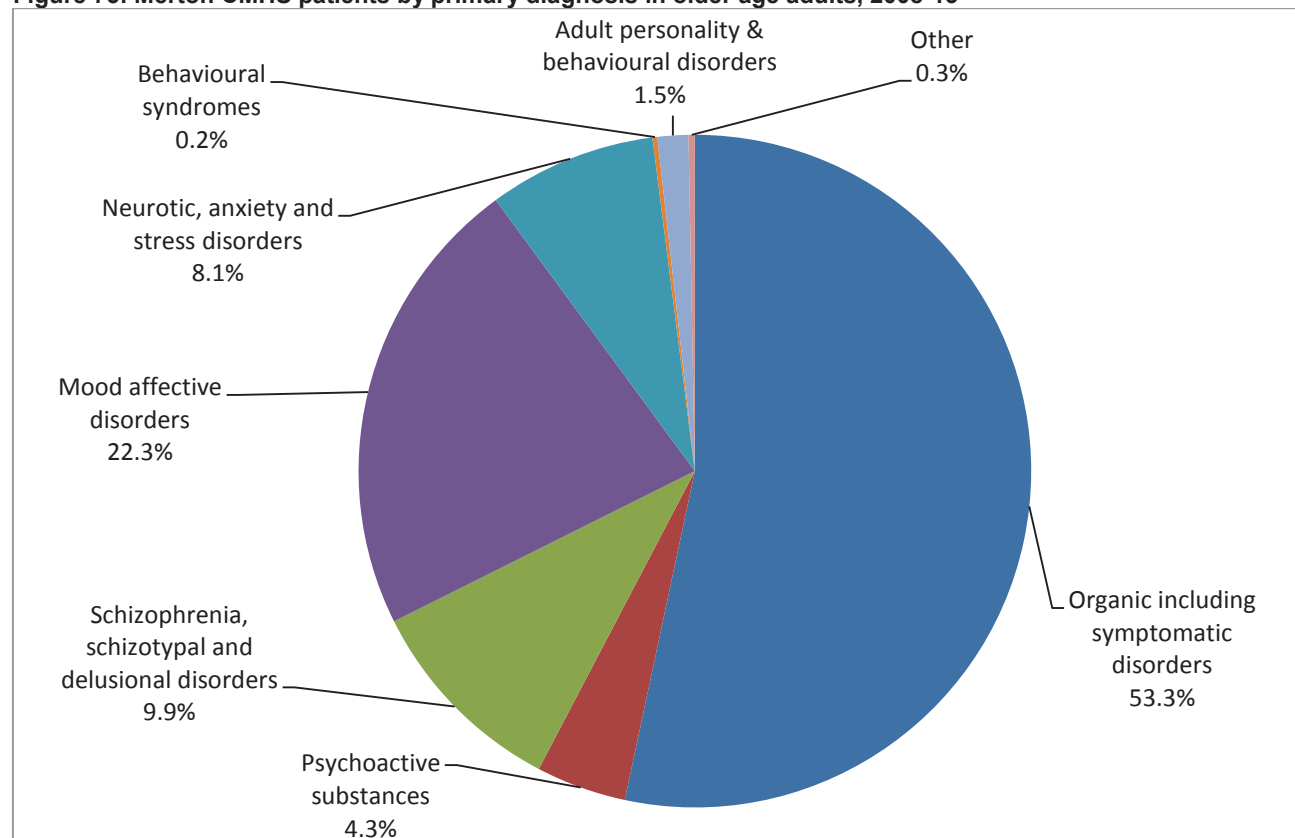
Subset analysis: Psychoactive substances

Psychoactive substances were the second most common cause for both in-patient admissions and CMH patients in adults overall from 2008-13, as well as the second most common cause for admissions in working age adults. Additionally this category was the most common cause for referrals to CMH in working age adults. However psychoactive substances cover a wide range of substances from alcohol to cocaine to cannabis. Therefore this subset was further analysed to drill down into the different types of substances that Merton residents were seen by the mental health services for.

Figure 76 below shows the breakdown of psychoactive substance in-patient admissions and reveals that 70% of such admissions were due to alcohol, out of which the majority were due to alcohol dependence syndrome. Multiple drug use was the second most common reason for admission in this group.

Figure 76: Merton in-patient admissions for psychoactive substances, 2008-13
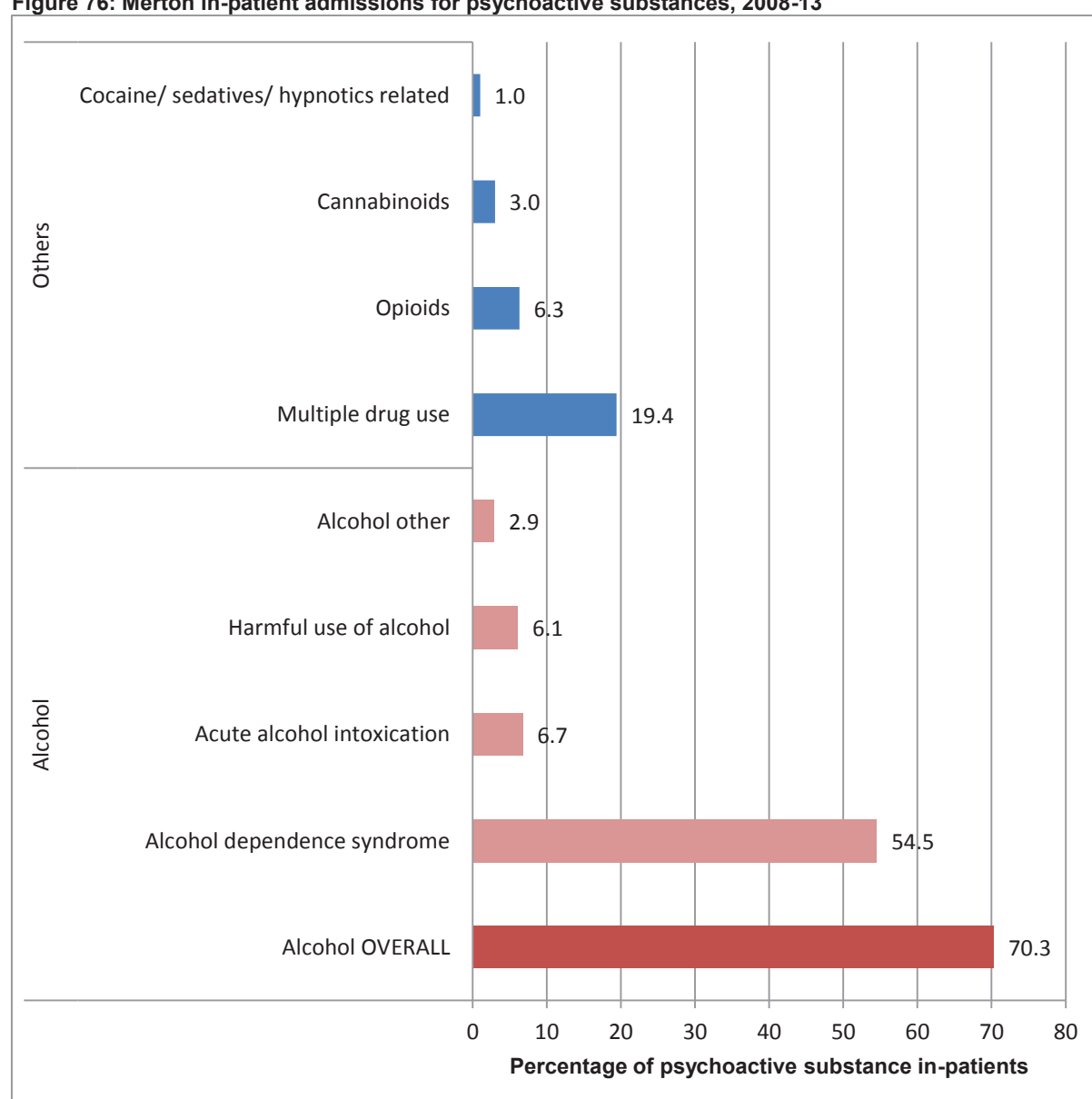
A similar picture is revealed for CMH patients with diagnosis of psychoactive substances, where a majority were due to alcohol (66%) and again alcohol dependence was the most common reason in the alcohol group. 18% patients in the psychoactive substances group had a diagnosis of multiple drug use of which majority were due to dependence syndromes. Opioid dependence was the next biggest group (9%).

Figure 77: Merton CHM patients with diagnosis of psychoactive substances, 2008-13
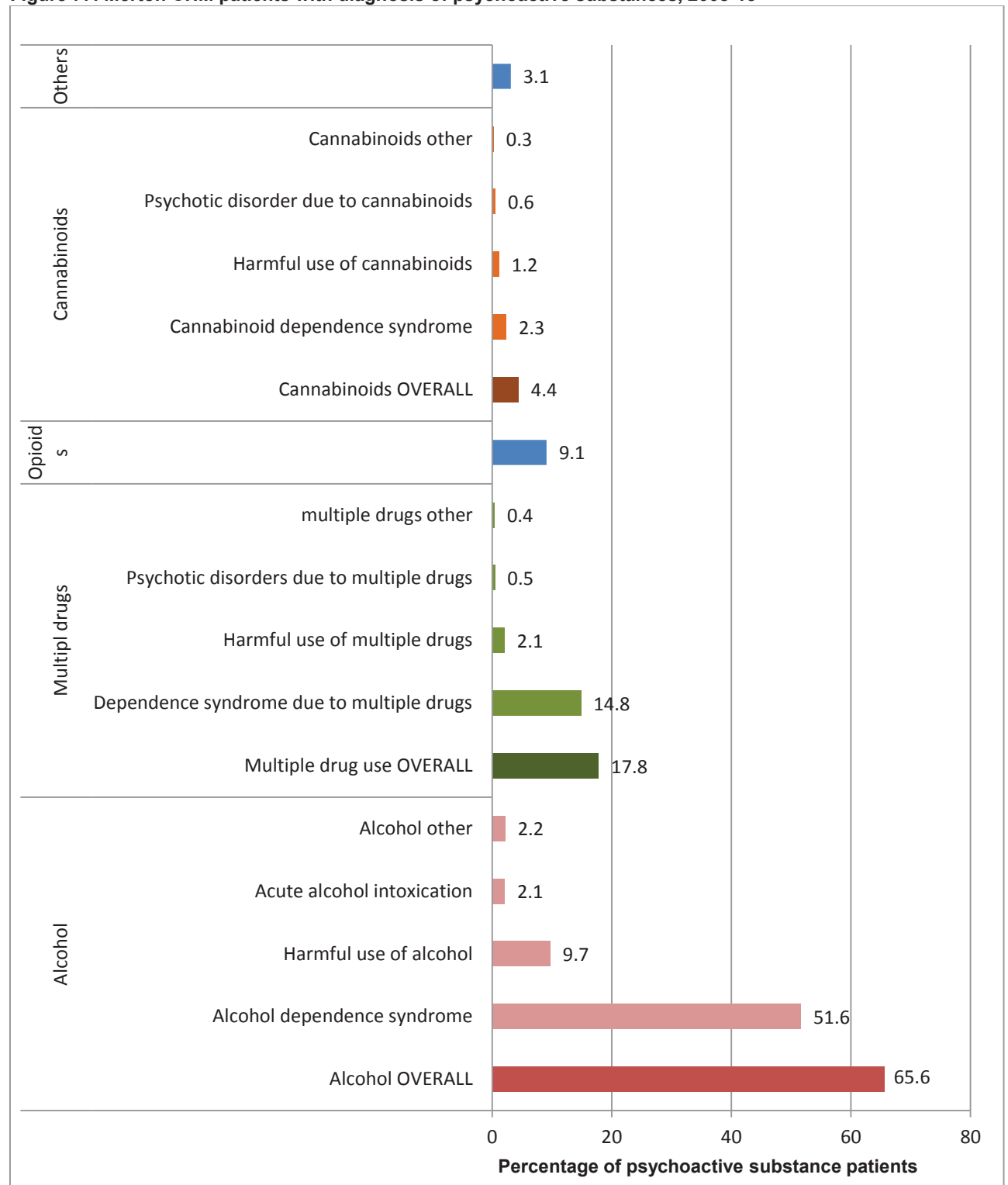
Cause of admission by gender

When primary diagnosis is examined separately for in-patients by gender, the order of primary diagnosis is as follows:

Males- schizophrenia 40.7%> psychoactive substances 32.2%> mood affective disorders 16%> Personality & behavioural disorders 4.1%> neurotic, anxiety and related disorders 3.2%> Organic disorders (which includes dementia) 3%

Females- schizophrenia 29.7%> mood affective disorders 26.2%> psychoactive substances 17.8%> Personality & behavioural disorders 12.7%> neurotic, anxiety and related disorders 6.2%> Organic disorders (which includes dementia) 4%
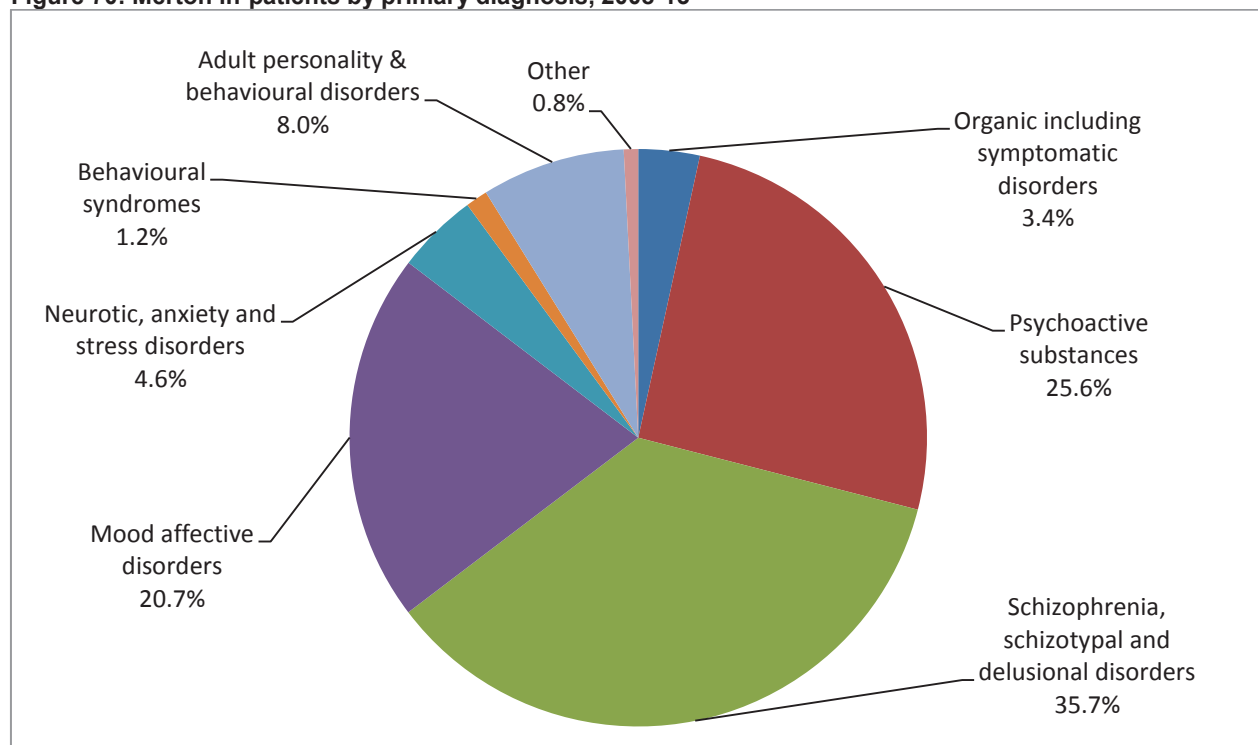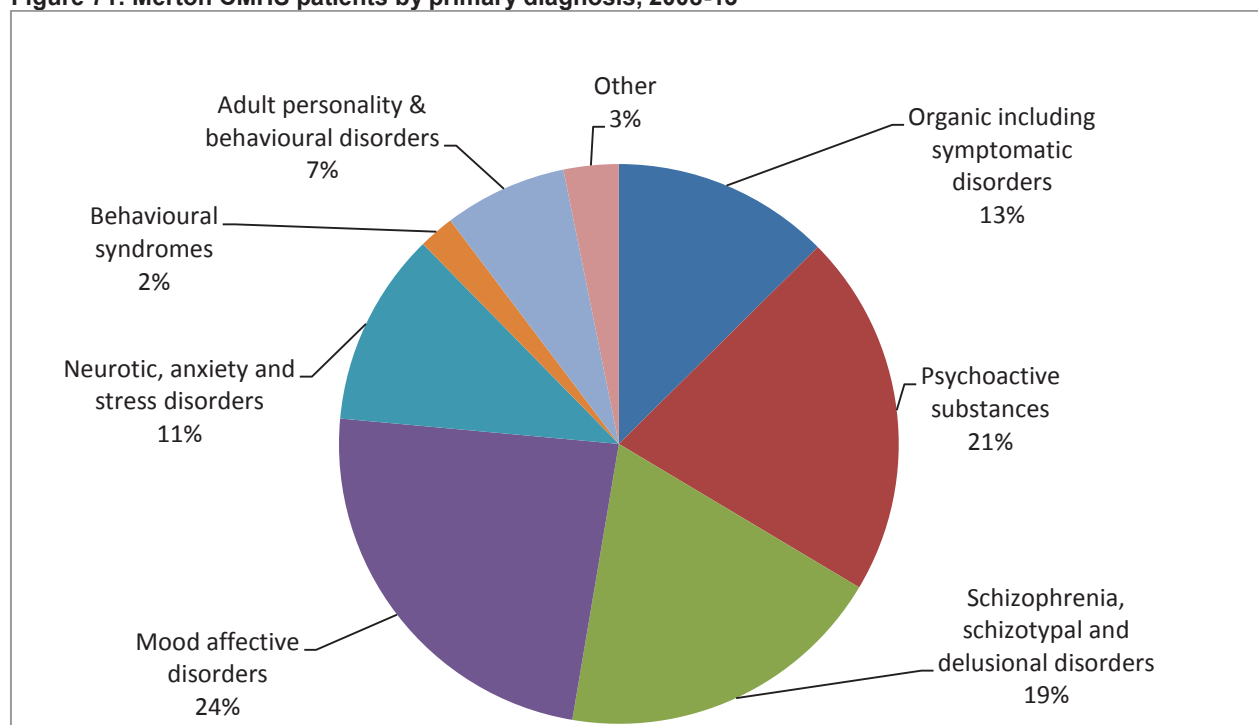
Figure 78: Merton in-patient primary diagnosis by gender- males, 2008-13
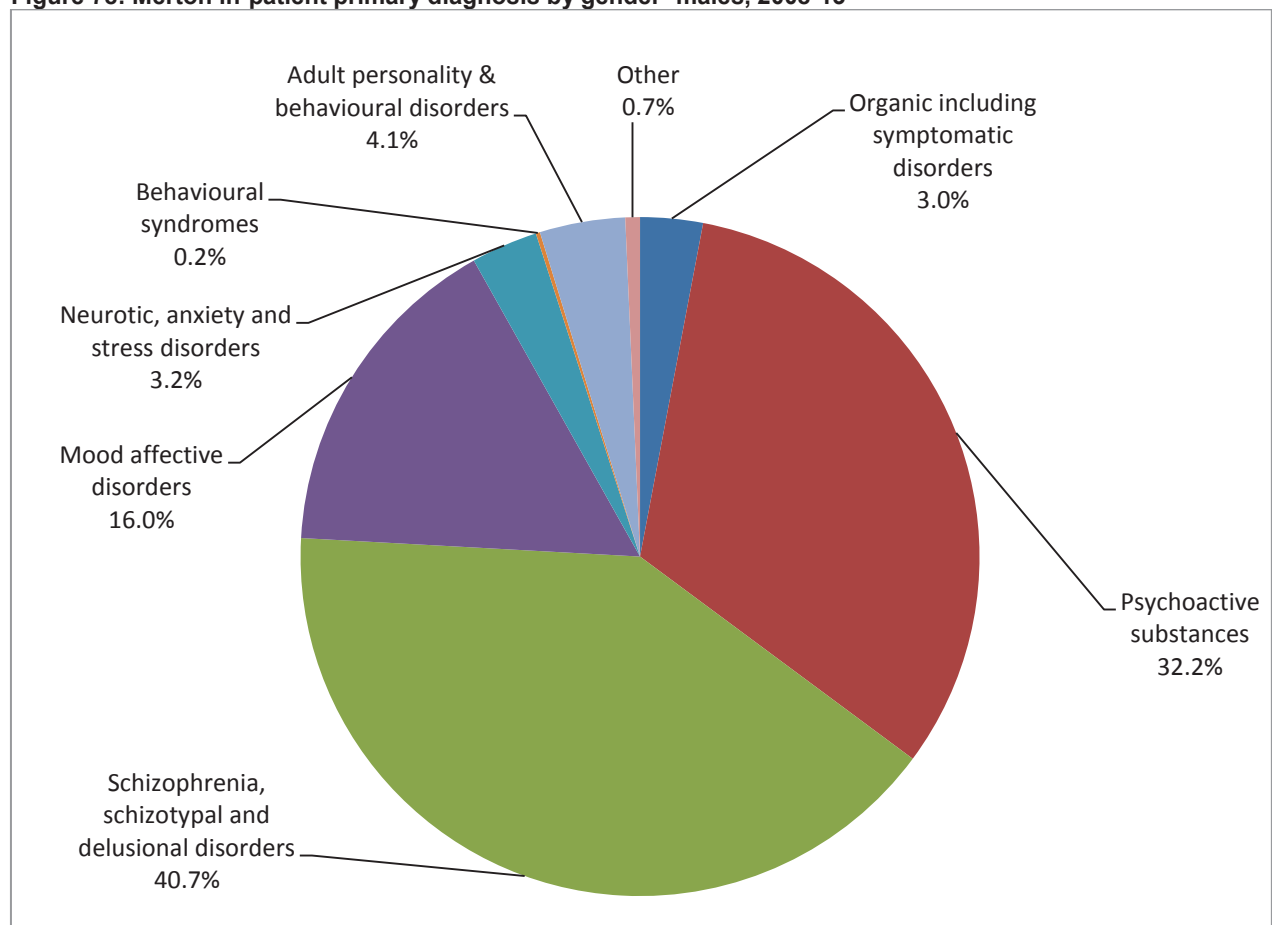
Figure 79: Merton in-patient primary diagnosis by gender- females, 2008-13
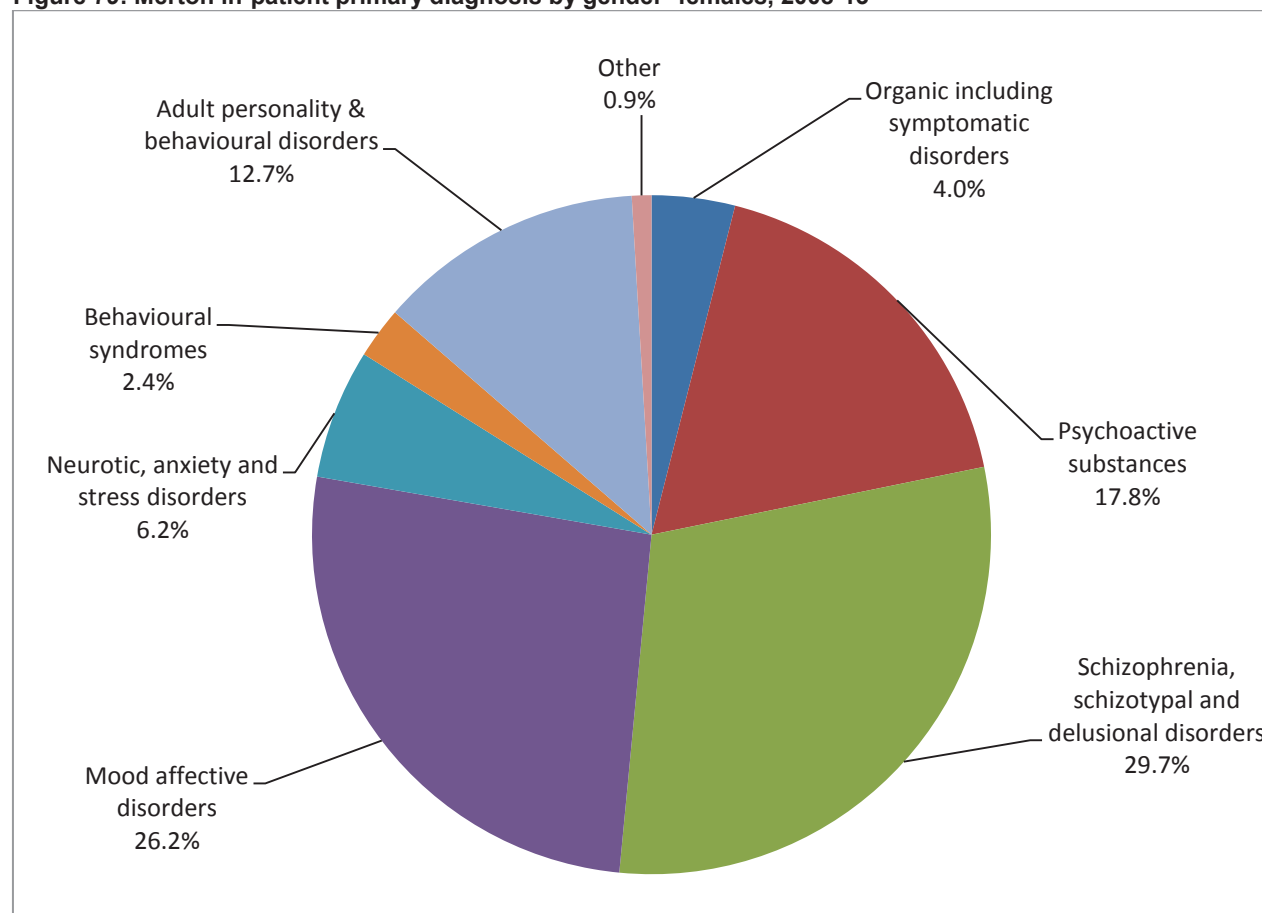
When primary diagnosis is examined separately for CMHS patients by gender, the order of primary diagnosis is as follows:

Males- psychoactive substances 28.9%> schizophrenia 23.8%> mood affective disorders 19%> Organic disorders (which includes dementia) 9.8%> neurotic, anxiety and related disorders 9.7%> Personality & behavioural disorders 4.2%>

Females- mood affective disorders 28%> Organic disorders (which includes dementia) 15.1%> schizophrenia 14.9%> psychoactive substances 13.9%> neurotic, anxiety and related disorders 12.6%> Personality & behavioural disorders 9.8%

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Figure 80: Merton CMHS patients by primary diagnosis- males, 2008-13

Adult personality &
behavioural disorders
4.2%

Other
4.2%

Organic including
symptomatic
disorders
9.8%

Behavioural
syndromes
0.5%

Neurotic, anxiety and
stress disorders
9.7%

Mood affective
disorders
19.0%

Psychoactive
substances
28.9%

Schizophrenia,
schizotypal and
delusional disorders
23.8%
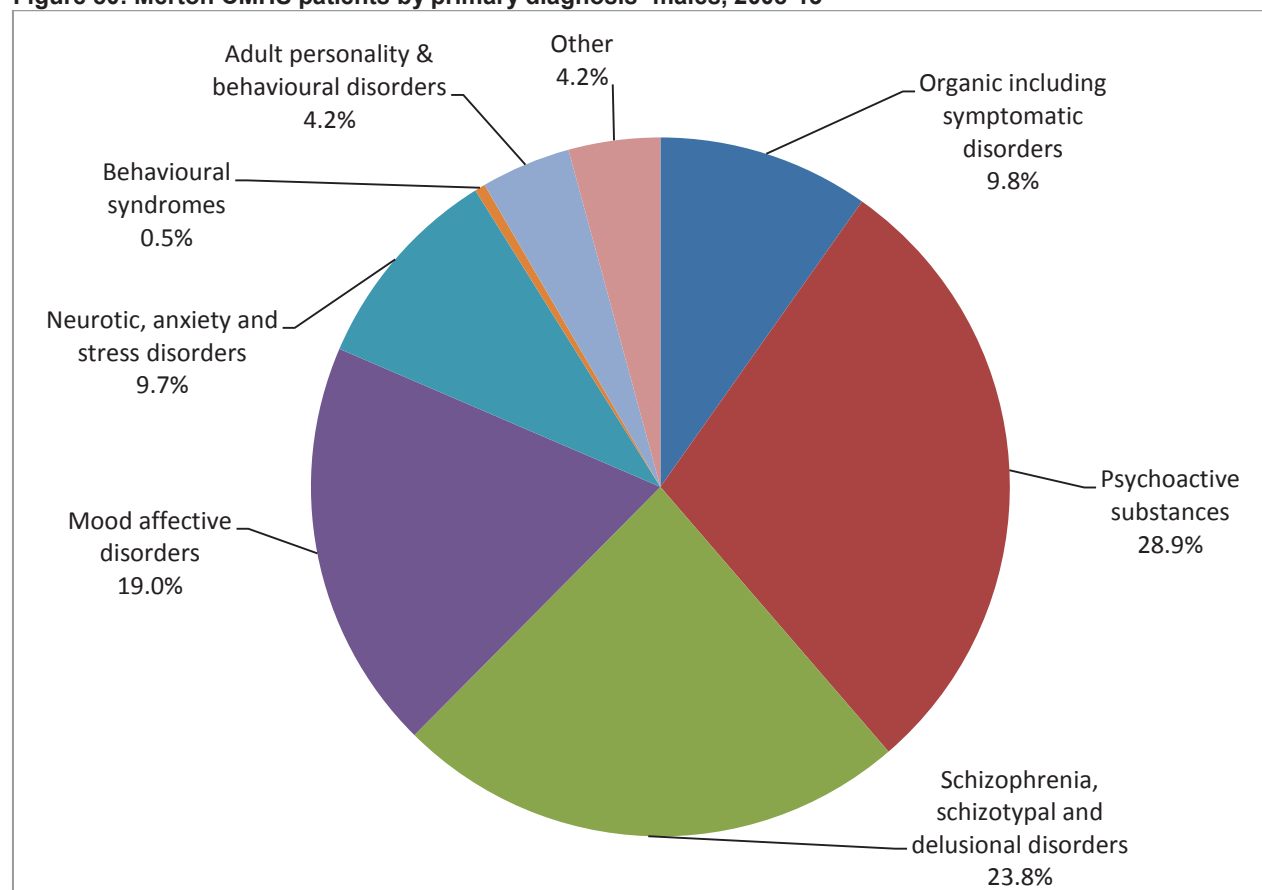
Figure 81: Merton CMHS patients by primary diagnosis- females, 2008-13

Adult personality &
behavioural disorders
9.8%

Other
2.2%

Organic including
symptomatic
disorders
15.1%

Behavioural
syndromes
3.5%

Neurotic, anxiety and
stress disorders
12.6%

Psychoactive
substances
13.9%

Mood affective
disorders
28.0%

Schizophrenia,
schizotypal and
delusional disorders
14.9%

117
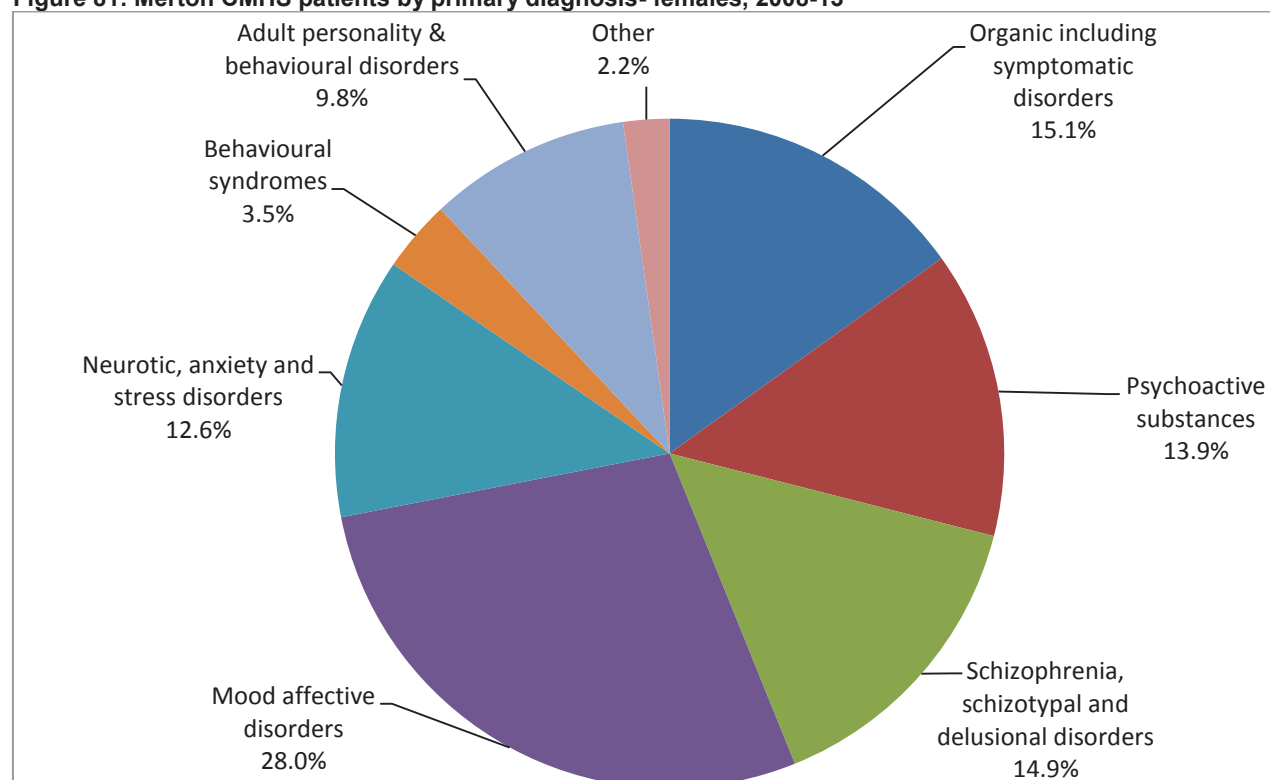
Cause of admission by ethnicity

When the data is analysed for primary diagnosis by ethnicity some interesting patterns emerge specifically for minority ethnic groups.

Figure 82: Merton in-patients by primary diagnosis and ethnicity, 2008-13
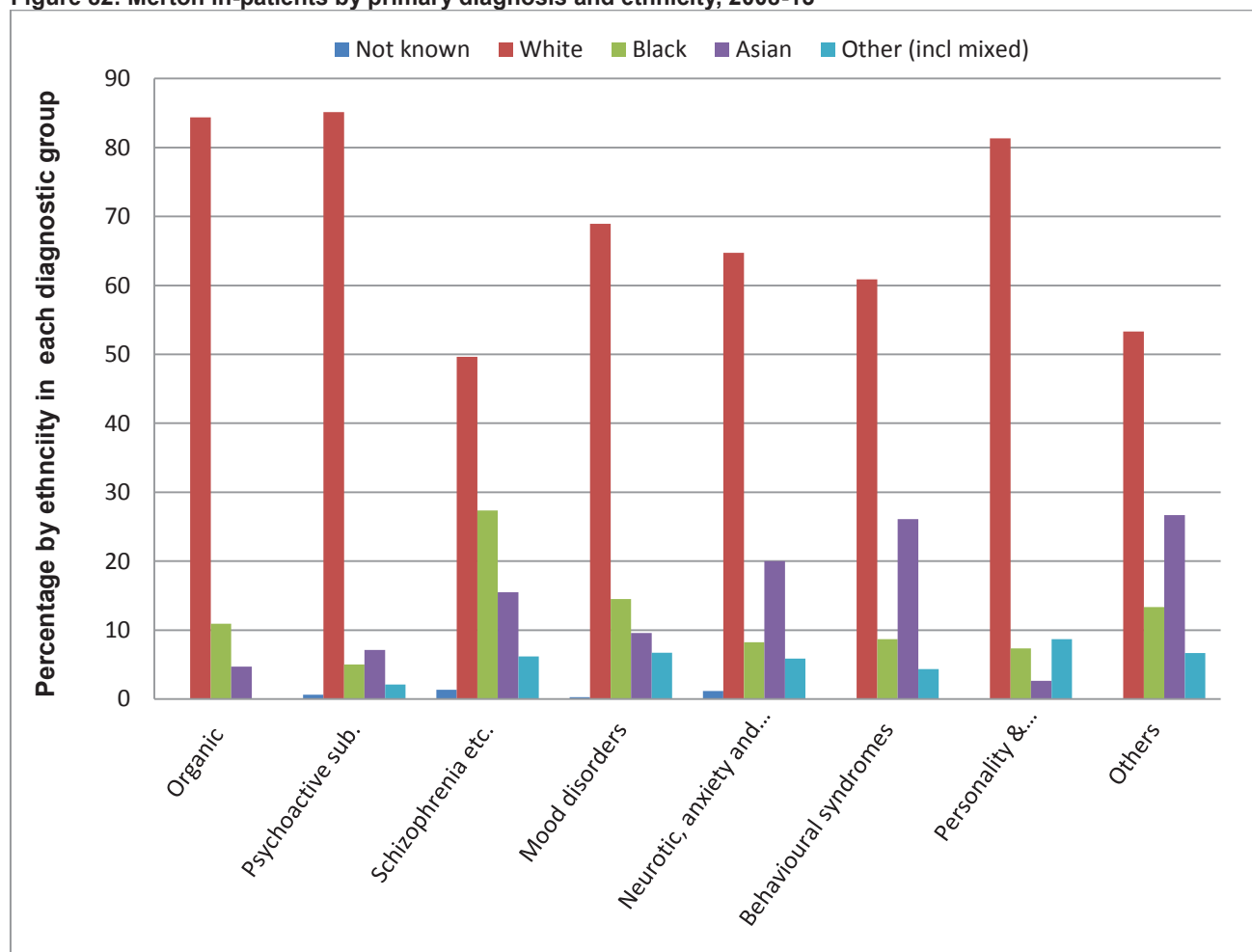
Overall, the diagnostic groups with the most in-patients are schizophrenia, psychoactive substances, mood disorders, personality and behavioural disorders, neurotic disorders and organic disorders. Within these groups, the black ethnicities are in the highest proportion after whites in schizophrenia, mood disorders and organic disorders. Asians are represented in higher proportions than blacks among patients with neurotic, anxiety and stress disorders, and psychoactive substances. Whites are in the highest proportion in all in-patients, but the contrast is particularly stark in psychoactive substances. Whites also have a very high representation in organic disorders and personality disorders.

Overall, the diagnostic groups with the most patients in CMHS are mood disorders, psychoactive substances, schizophrenia, organic disorders, neurotic disorders and personality and behavioural disorders. Within these groups after whites, the next highest ethnic proportion is of black ethnicities in schizophrenia and adult personality disorders. Asians are represented in higher proportions than blacks in patients with neurotic, anxiety and stress disorders, organic disorders and by small margins in psychoactive and mood disorders.

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Figure 83: Merton CMHS patients by primary diagnosis and ethnicity, 2008-13
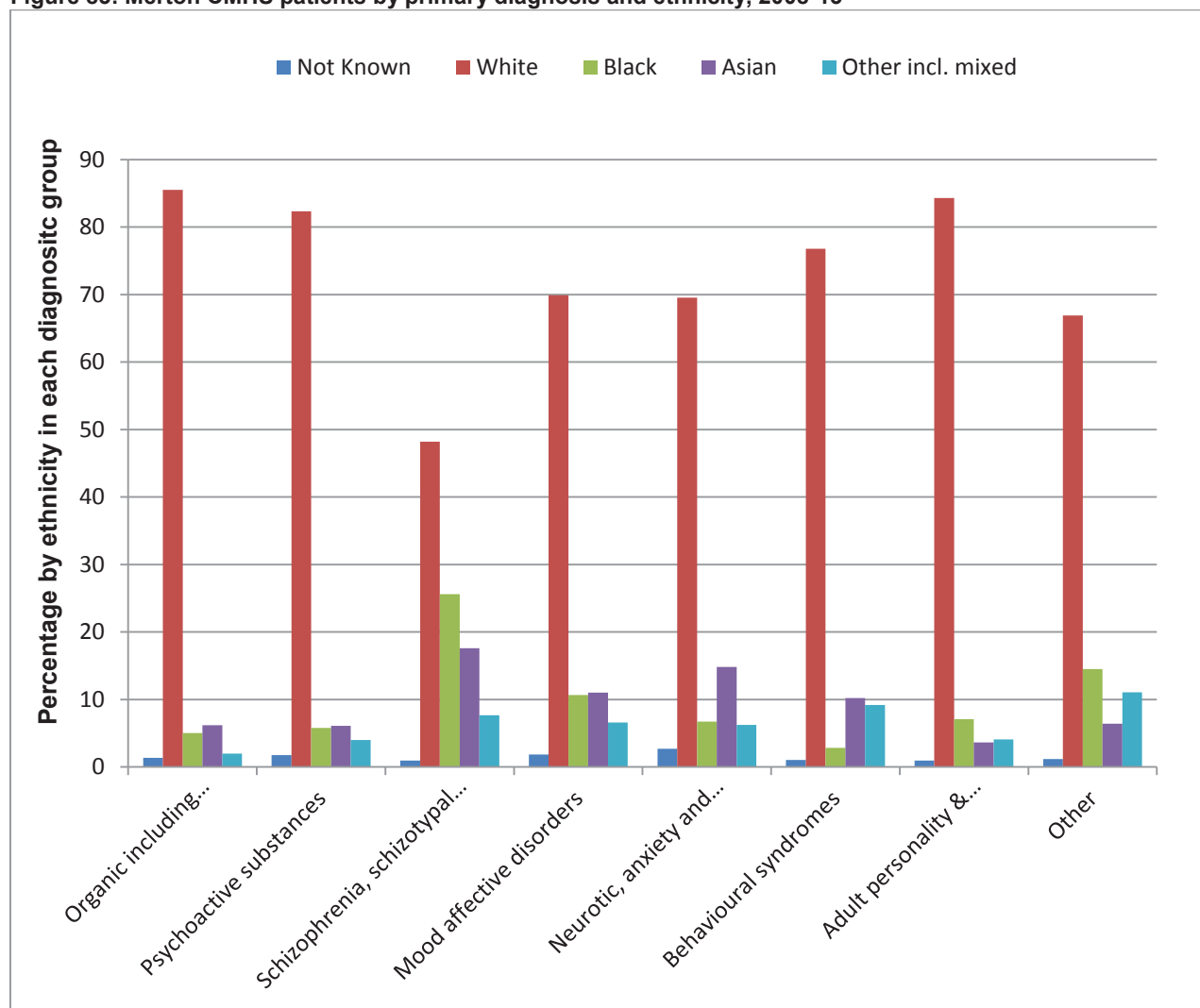
Cause of admission by deprivation quintile

As observed earlier, the highest admissions and CMHS referrals were from the IMD 4 quintile which is the second most deprived quintile in Merton. Figure 84 & 85 break down the in-patient admissions and CMHS referrals by IMD quintiles in each primary diagnosis category. For schizophrenia and psychoactive substances a similar pattern emerges- whereby as one goes from the least to the most deprived quintiles (with the exception of IMD 5) the percentage of in-patients progressively increase. Apart from organic disorders where the least deprived quintile has the highest proportion of cases, for all other the major diagnostic groups the more deprived quintiles have the higher proportion of cases. So as expected there appears to be a positive correlation between mental illnesses and deprivation. Organic disorders include dementia, and this affects older people much more than working age adults. The older populations in Merton tend to be in the wealthier western parts of Merton. Therefore it is unsurprising that the highest proportion of in-patients is from the least deprived IMD quintile in this diagnostic group. However IMD 3 & 4 combined has a higher proportion.

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Figure 84: Merton in-patients by deprivation in each primary diagnosis group, 2008-13
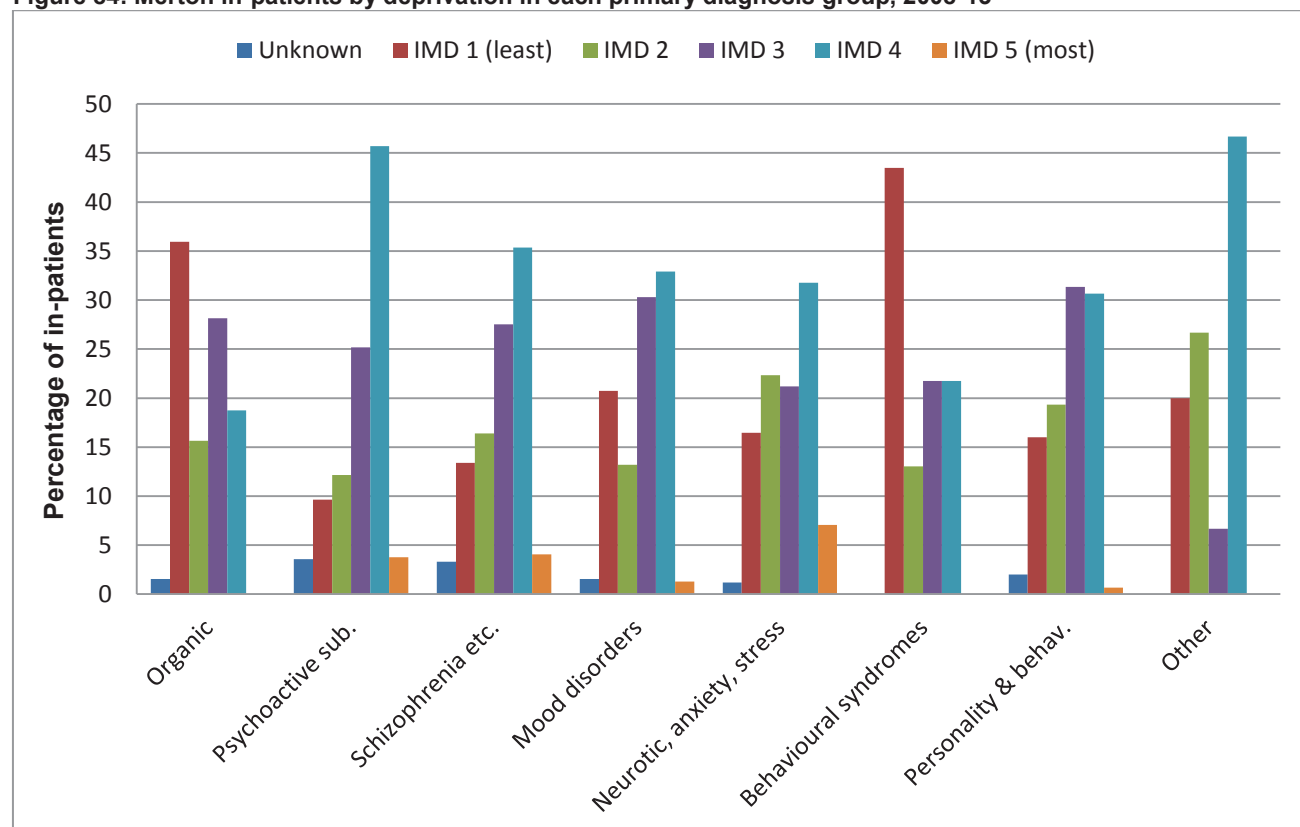
Figure 85: Merton CMHS patients by deprivation in each primary diagnosis group, 2008-13

120
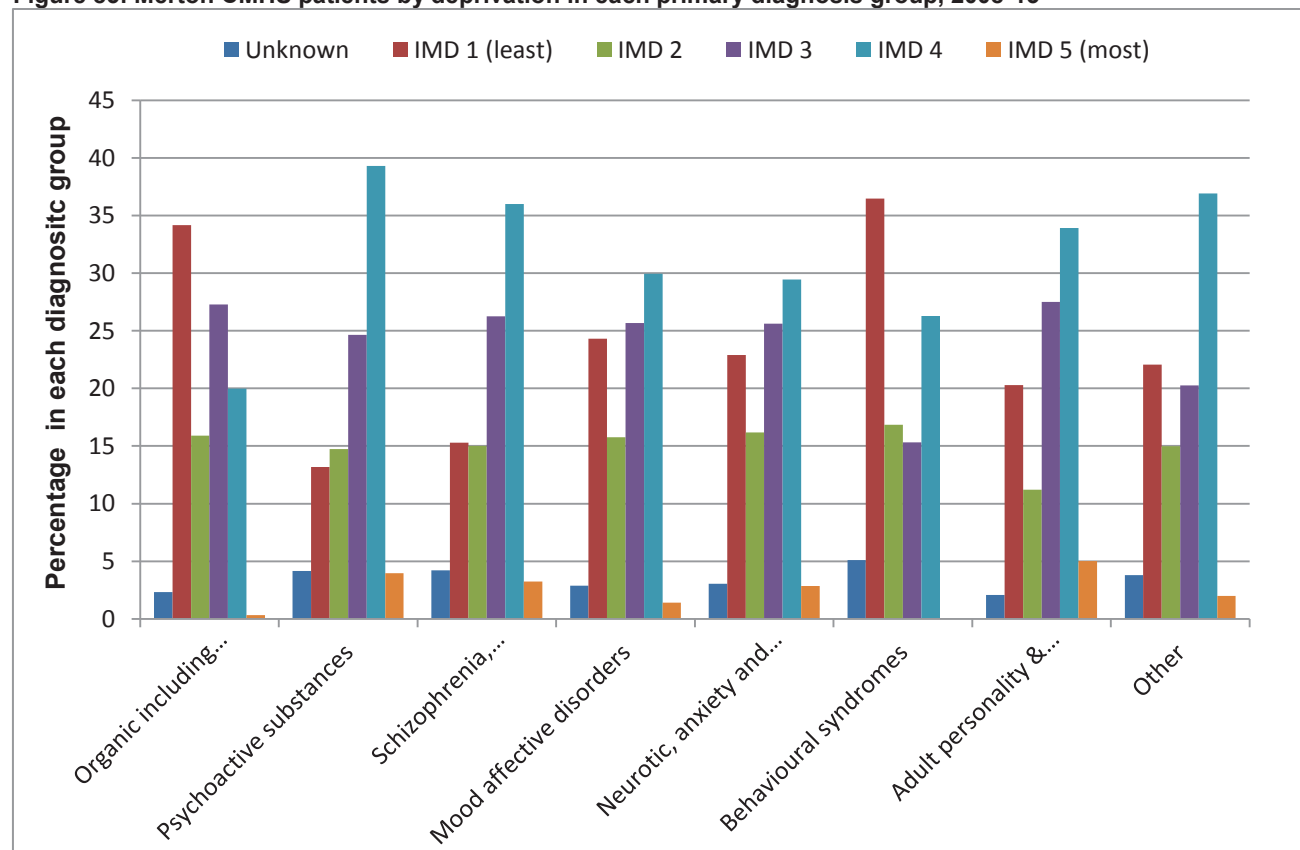
Cause of admission by East versus West Merton

When in-patient records are analysed within each primary diagnosis by whether the patient is from East or West Merton, in all the major primary diagnostic groups there are a higher proportion of patients from East Merton compared with West Merton.

Figure 86: In-patients in each primary diagnosis group by East and West Merton, 2008-13
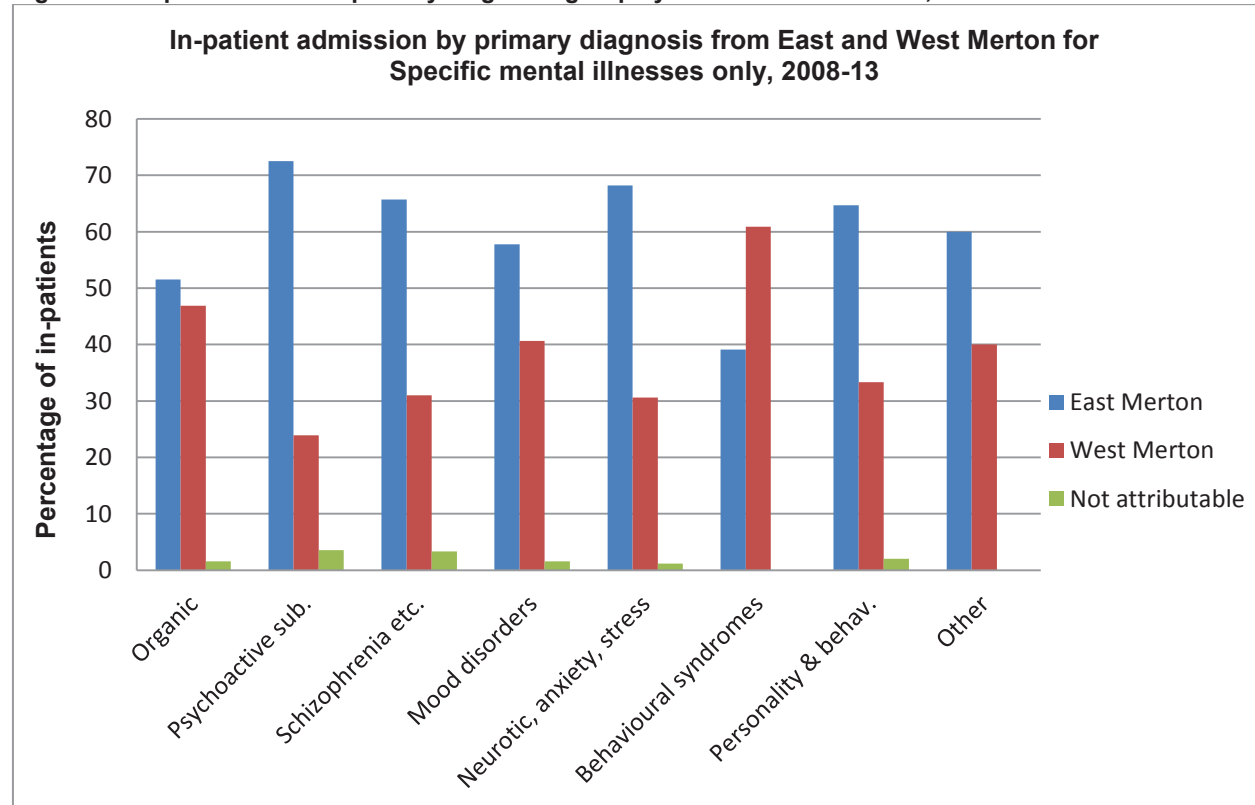
For the CMHS this is not the case however- a large proportion of cases are not attributable to any locality so this might be skewing the data. As it stands, there are more referrals for organic disorders and mood disorders from West than East Merton. For schizophrenia, psychoactive substances, neurotic, anxiety and stress disorders and personality disorders, East dominates West Merton.

Community MH Services patients by condition from East and West Merton (percentage in each group), 2008-13

Where did referrals to CMHS come from?

It was possible to analyse all the referrals by where they were sent from. Figure 88 highlights the main sources of referrals for all causes in adults from 2008 to 2013. GP were the main source of the referrals to CMHS with 44% of the referrals coming from them. The profile of these referrals is analysed further below. The next largest source of referrals was internal- these were within the SWLStG Mental Health NHS Trust services either from one CMHS team to another or from in-patient service to CMHS. The third largest source of referrals was the Accident & Emergency departments at Acute NHS Trusts. There were really small proportions of referrals from social services and other departments in the Local Authority – less than the number of self-referrals. Perhaps this needs to be explored further and this might highlight the need to raise awareness of mental health issues and the referral pathways to front-line staff in the Local Authority. GP referrals while being in the majority could be increased further.

Figure 88: Merton CMHS source of referrals (percentage), 2008-13*
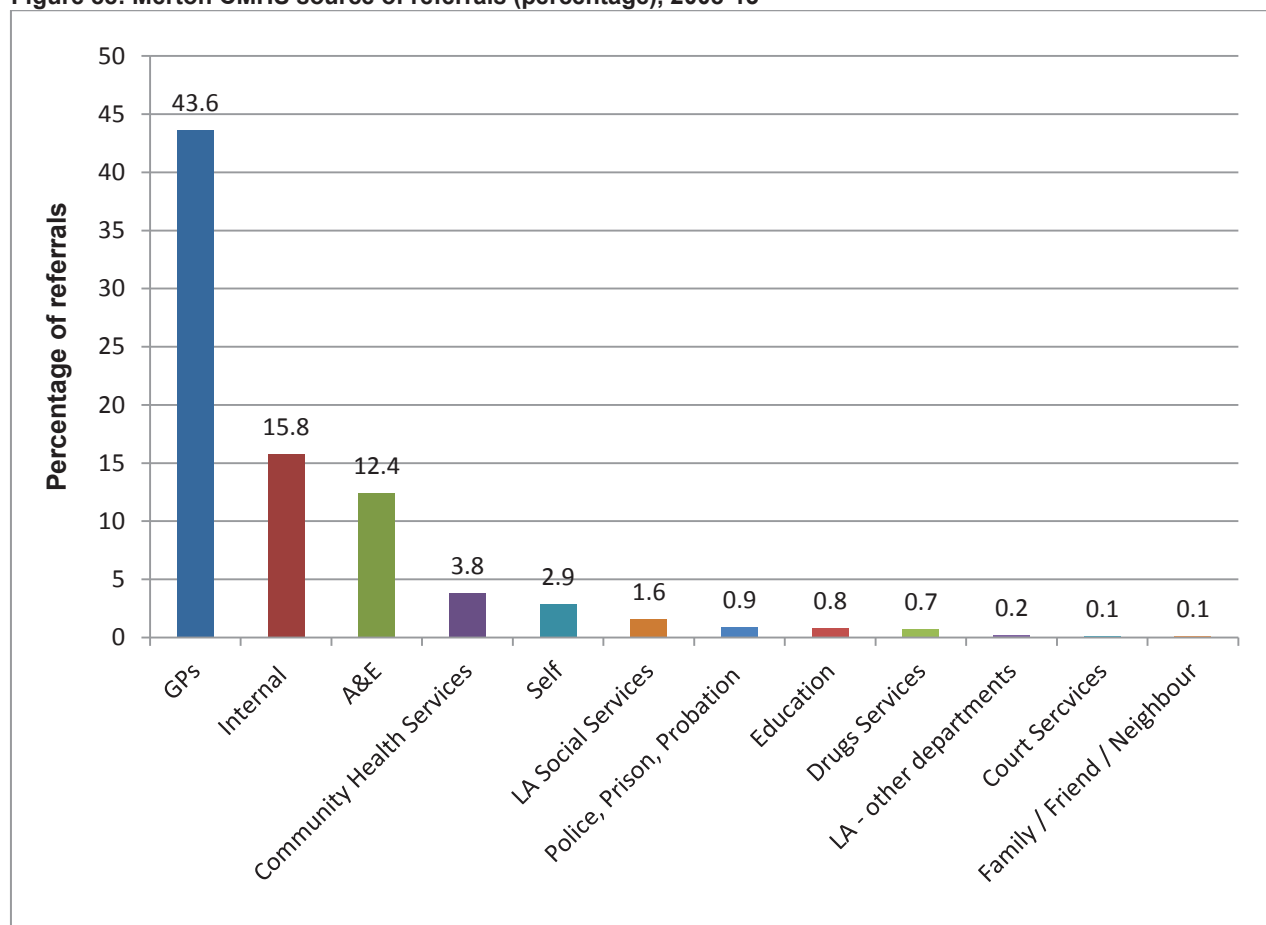
*Graph does not include all referral sources, only main ones of interest.

GP referrals to CMHS

In terms of the referrals made by GPs to CMHS in Merton from 2008 to 2013, there were more than five times the number of referrals in working age adults compared with older age groups (figure 89). This difference is more than the overall differences in the number of referrals for working age adults compared with older adults. There were more females referred than males (similar to the overall picture) and there were marginally more referrals from West Merton than East Merton which is the reverse of the overall trend where there were more referrals from East than West Merton. Predictably most referrals were from white ethnicities with Asians being the next highest. In terms of the deprivation quintiles of the referrals- most were from the second most deprived (IMD 4) with only marginally less from the least deprived quintile (IMD1) - this contrasts with the overall picture where the least deprived quintile has the least number of referrals.

What this tells us is that GPs are making more referrals from the wealthier and working age populations and more of these referrals are in females and whites. Also that there are more referrals by GPs in West Merton- while this is only marginal, it becomes significant when the overall referrals are viewed and we see that more came from East Merton.

Figure 89: CMHS referrals from GPs by age group, 2008-13
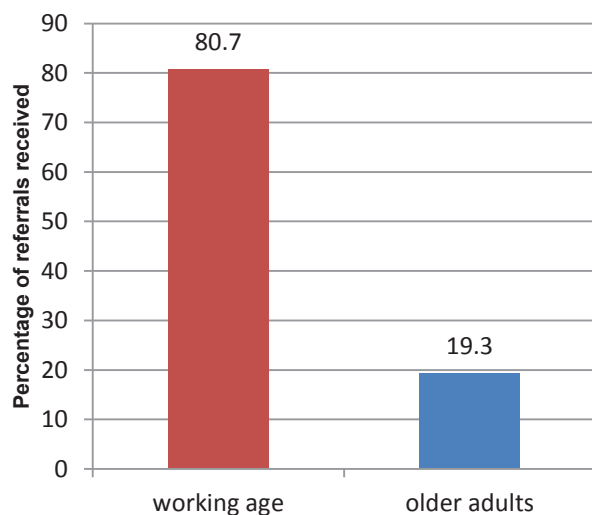
Figure 92: CMHS referrals from GPs by ethnicity, 2008-13
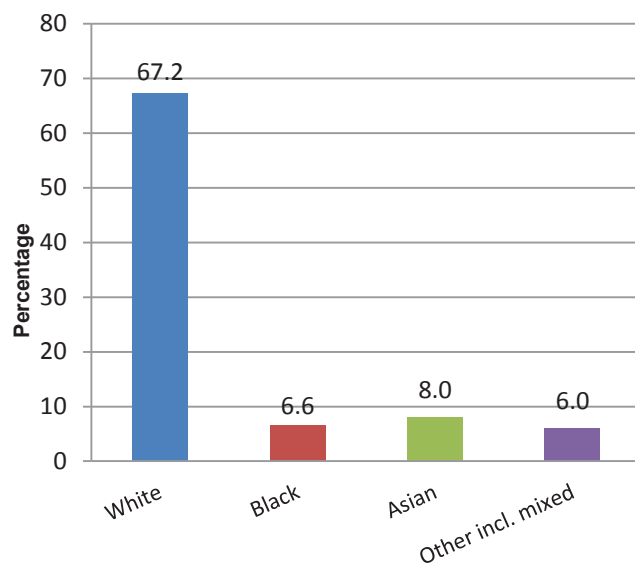
Figure 90: CMHS referrals from GPs by sex, 2008-13
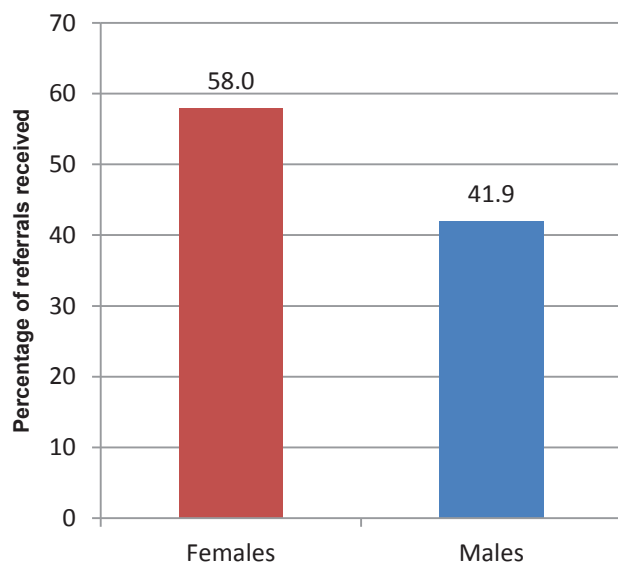
Figure 93: CMHS referrals from GPs by deprivation quintile (1=least deprived), 2008-13
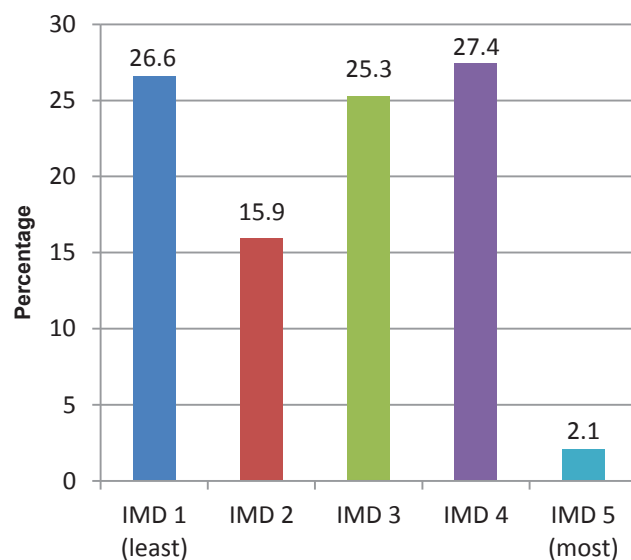
Figure 91: CMHS referrals from GPs by E-W Merton, 2008-13

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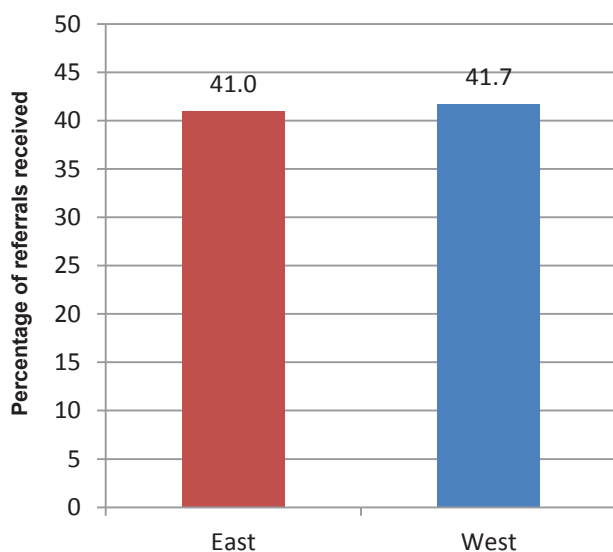
IAPT (Improved Access to Psychological Therapies) services data

IAPT services are provided by a number of statutory and voluntary sector providers in Merton, the main provider being the SWLStG MH NHS Trust. Comparing the data for Merton (in 2012 this was reported as Sutton & Merton combined) of a number of key performance indicators for 2012, with neighbouring IAPT services reveals a number of facts.

Table 13: Sutton & Merton PCT IAPT activity compared with 3 neighbouring London IAPT services (April 2012 – March 2013) (Source: NHS Information Centre)

KPIs	Sutton & Merton	Lambeth	Lewisham	Wandsworth	London average
KPI 1: The number of people in the local population who have depression and/or anxiety disorders (taken from the Psychiatric Morbidity Survey)	**46,764**	44,168	37,757	44,013	33,333
KPI 3a: The number of people who have been referred for psychological therapies during the reporting period	**8001**	8300	7455	4962	4632
KPI 3b: The number of active referrals who have waited more than 28 days from referral to first treatment/first therapeutic session (at the end of the reporting period)	**777**	2608	6048	3023	2430
PHQ13-5: People who have entered (i.e. received) treatment as a proportion of people with anxiety or depression in the population (%)	**10.48**	10.73	11.63	5.77	8.36
KPI 4: The number of people who have entered (i.e. received) psychological therapies during the reporting period	**4988**	4763	4362	2562	2779
KPI 5: The number of people who have completed treatment (minimum two contacts) during the reporting period	**3408**	3154	3197	1815	1583
KPI 6a: The number of people who are "moving to recovery" (of those who have completed treatment, those who at initial assessment achieved "caseness" and at final session did not) during the reporting period	**1175**	1277	986	662	567
PHQ13_06: Number of people not at caseness at their last session, as a proportion of people who were at caseness at their first session (%)	**37.94**	44.62	35.91	39.64	41.13
KPI 7: The number of people moving off sick pay or benefits during the reporting period	**269**	191	169	149	107

Compared with neighbouring IAPT services, S & M had the highest number of people with depression &/or anxiety disorders, second highest (after Lambeth) numbers of cases referred and the highest numbers moving off sick pay and benefits- the last KPI was also higher than the London average. It also had one of the lowest proportion of cases that moved to recovery (as a percentage), second lowest only to Lewisham.

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Data for Merton alone (as opposed to Sutton and Merton) was obtained for SWLStG MH NHS Trust for the period from 01/08/2012 to 31/08/2013- as accessed on 16/10/2013. Table 14 depicts the KPIs for this period.

Table 14: Merton SWLStG MHT IAPT services KPIs from August 2012- August 2013

Activity	KPI	2012/2013 v3 KPIs	Local Target	National Target
Referrals Received	KPI 3a - The number of people who have been referred for psychological therapies	4574	13%	15%
	KPI 3b to Treatment - The number of active referrals who have waited more than 28days from referral to treatment (first therapeutic session)	922		
Entering Treatment	KPI 4 - The number of people who have entered psychological therapies	2509		
Received/ Completed Treatment	KPI 5 - The number of people who have completed treatment with at least one therapeutic session and a treatment session	1516		
Moving to Recovery	KPI 6 - The number of people who are 'moving to recovery'	498		
	KPI 6b - The number of people who have completed treatment not at clinical caseness at treatment commencement	119		
Moving off Sick Pay	KPI 7 - The number of people moving off sick pay and benefits	73		
	Recovery Rate	35.65%	43%	50%

Merton IAPT services assignment of steps, Aug 2012-13

Step	Contacts
No Step Assigned	1058
Step 2	6817
Step 3	5768

Of the referrals received by the IAPT services from 01 August 2012- 31 August 2013 the majority of referrals were from GPs (64%). Figure 94 depicts the main sources of referrals and the percentages of referrals from these sources. After GPs the next largest percentage of referrals was self-referrals. The proportions of referrals received from any other agencies in the statutory and voluntary sector including the local authority, were very low and this is perhaps an area that needs to be improved.

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Figure 94: Merton IAPT services- percentage of referrals by referral source, Aug 2012- Aug 2013
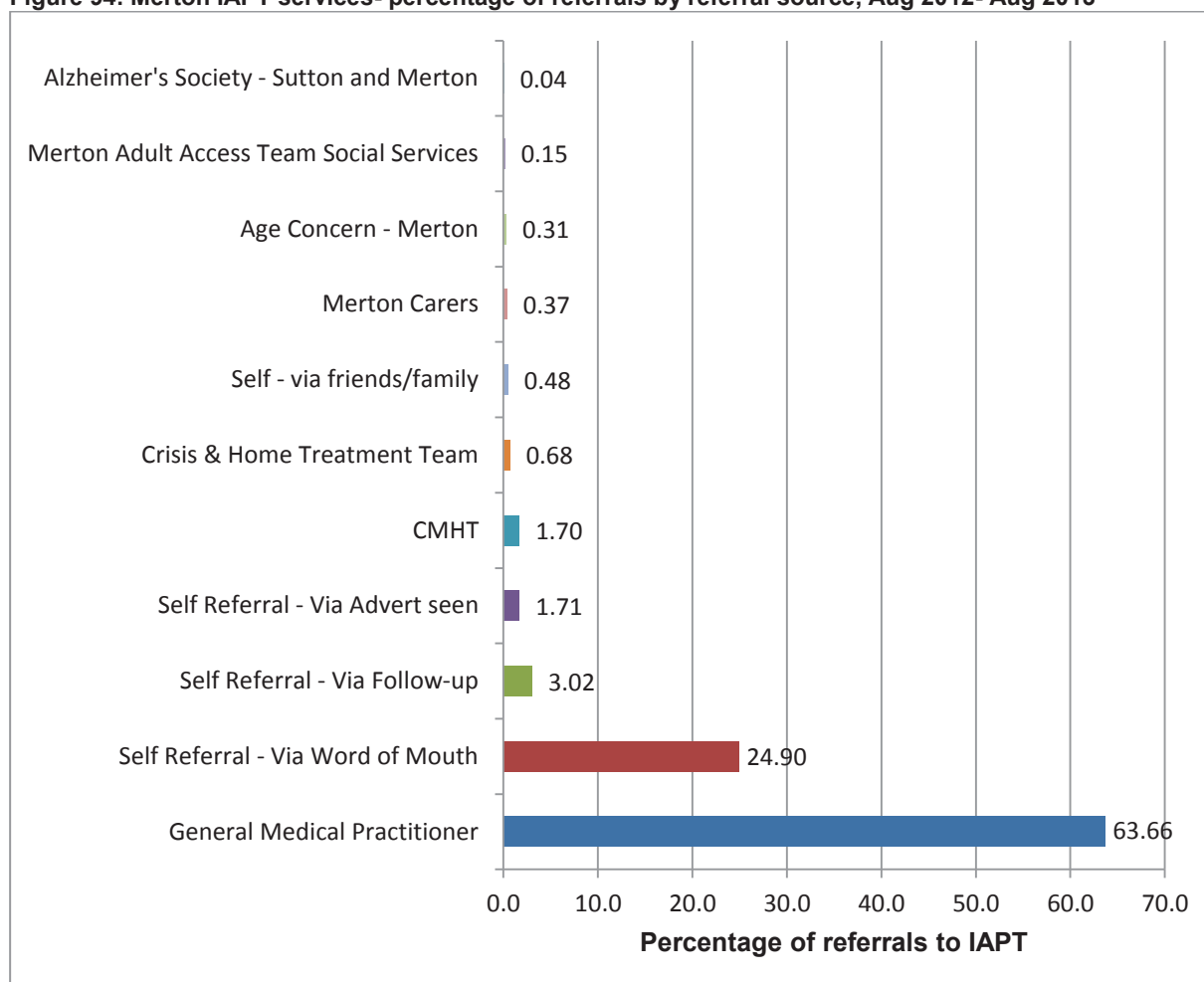
Smoking data SWLStG MHT

There is a strong association between smoking and mental health disorders. Overall, smoking prevalence among psychiatric patients is two to three times higher than among the general population, ranging from 40-50% among people with depressive and anxiety disorders to 70% or higher among patients with schizophrenia[82].

If someone has a mental health problem and smokes, s/he is more likely to have poor general health – it is one of the main reasons why people with a mental illness tend to die younger. Smoking can interfere with some medication (antidepressants, antipsychotics, benzodiazepines and opiates etc.) and a patient might have to take a higher dose than s/he otherwise would have if they were not smoking[83].

SWLStG MHT started a smoking cessation project in 2010 that continues to date. Since 2010-11 there have been CQUINs (Commissioning for Quality Innovation) related to smoking. The rationale behind the CQUIN smoking cessation targets (indicators) for 2010/11 was to improve the health of the local population by delivery of effective stop smoking advice to smokers, especially those with

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[82]Olivier D, Lubman DI, Fraser R. Tobacco smoking within psychiatric inpatient settings: biopsychosocial perspective. Aust & NZ J Psych 2007; 41: 572-580, http://www.ash.org.uk/files/documents/ASH_120.pdf
[83] http://www.rcpsych.ac.uk/mentalhealthinfo/problems/smokingandmentalhealth.aspx

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higher rates of smoking [84]. The 2010/11 CQUIN smoking cessation indicators focused on establishing the number of smokers, training staff to deliver brief interventions to these smokers and then referring those who were willing to the SCAs (Smoking Cessation Advisers), thus increasing access to support. Once the smokers had been referred, the SCAs needed to encourage them to start a course of Nicotine Replacement Therapy (NRT) in order to facilitate their quit attempt. Targets for these included:

5a - Training to give effective stop smoking advice to professionals
75% of all appropriate clinical and professional staff to be trained
5b – Data recording of smoking status
75% of all admissions to be recorded on client files and in house system
5c – Provision of service: Number of referrals to Stop Smoking Service
50% of smokers to be referred to the PCT Stop Smoking Service (Trust SCAs)
5d – Provision of service: Number of NRT (Nicotine Replacement Therapy) referrals
45% of referred smokers to be prescribed NRT

By March 2011 the targets had been reached for the training (5a), data recording (5b) and provision of service, NRT (5d) targets with the following figures-
5a - over 90% of all appropriate clinical staff trained to Level 1 Smoking Cessation competence
5b - 80% of smoking status recorded
5d - 49% of all smokers referred to a SCA prescribed NRT.

In November 2011 the Trust had 10,400 service users (this is from across all the boroughs the Trust has patients from- Merton, Sutton, Wandsworth, Richmond & Kingston) who were appropriate to be included in its smoking cessation work (i.e. over 16yrs old and never diagnosed with dementia). Clinicians established and recorded the smoking status for 8,457 (81%) of these; just over 50% were recorded as smokers.

In 2013/14, the SWLStG Smoking Cessation Team continues to achieve all their CQUIN targets (100% for Q1 and Q2).

Table 15: SWLStG MHT CQUIN 2013/14, Q1 & Q2 data

		Q1	Q2
CQUIN 2013/14 **Smoking Cessation Indicator 5**	5b) % of service users completing full 12 weeks support	16.4% (Target 6%)	44.7% (Target 7%)
	5c) % of smoking status recorded, referrals, quit dates set	84.6% 22.4% 35% (Targets: 80%, 20% & 17.5%)	85.7% 24.7% 32% (Targets: 80%, 20% & 17.5%)

The qualitative element of the indicators this year (5a) required the implementation of service user feedback surveys. Now part of everyday working practice, this system enables smokers engaged in the Trust's 12 week expert smoking cessation support package to tell the Trust what they think of the support they receive, if they value it and any improvements they would like to see.

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[84] Schedule 4 Part 2: National Incentive Framework for Commissioning for Quality and Innovation (CQUIN) Payment Framework 2010/11

Feedback from service users continues to be very positive regarding:

- Feeling listened to
- Talking about what they want to talk about
- Understanding things said during sessions
- Feeling that the session that day was useful

Figure 95: SWLStG MHT service user feedback for Sutton & Merton, April-Sept 2013
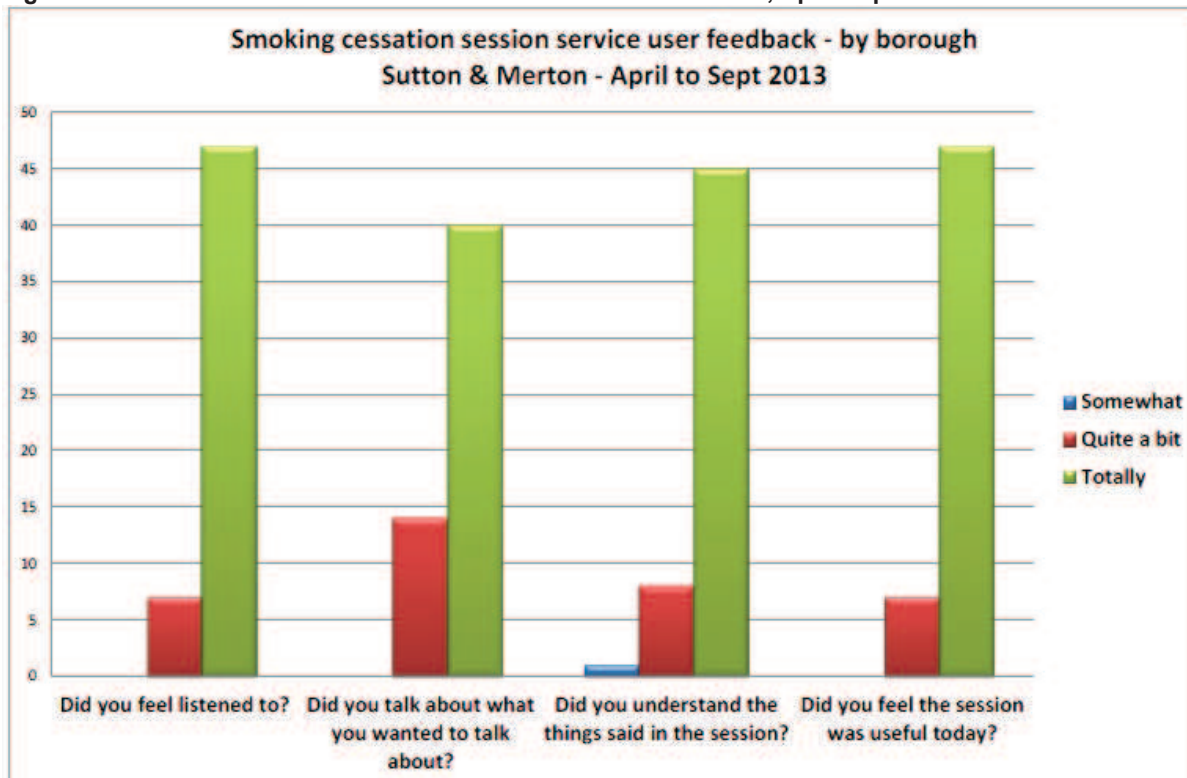
This year, the SCAs have been monitoring the number of service users who have completed the full 12 weeks expert support package they offer. The percentage of service users who completed the full 12 weeks support package improved quarter on quarter in 2013-14:

Q1 – 27.6%

Q2 – 44.8%

Q3 – 58.6%

This data is for all the 5 boroughs SWLStG MH NHS Trust serves.

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Primary Care Mental Health Prescriptions in Merton

Merton CCG mental health prescribing data was obtained for all practices in the period between quarters 1-4 for 2009-10 to 2012-13 and quarters 1 & 2 for 2013-14. Over that period the total spend on mental health prescribing was £7,268,955. Table 16 below shows the overall volumes of prescriptions by number of prescriptions (Total Items Rx in the table), the total number of pills dispensed (Quantity in table) and total actual cost.

Table 16: Merton CCG prescribing for mental health, 2009/10 - Q2 2013/14

Drug Group	Total Items (Rx)	Quantity	Total Cost
Antipsychotics	105763	1449189	£3,279,667.05
Antidepressants	479574	3483636	£2,440,088.31
Dementia	38946	181315	£1,341,562.03
Anxiolytics	69458	532780	£162,107.89
Antimanic	11234	293732	£45,529.91
Grand Total	704975	5940652	£7,268,955.19

Merton GPs are organised into three locality groups- East Merton, Raynes Park and West Merton. When the grand totals are broken down by these GP Locality Groups, East Merton has the highest volume and cost for mental health prescribing, followed by West Merton and then Raynes Park. This is expected, considering the epidemiological data suggests that most of the burden of mental illness is in East Merton.

Table 17: Merton CCG prescribing for mental health by GP Locality Group, 2009/10 - Q2 2013/14

GP Locality Group	Total Items (Rx)	Quantity	Total Cost
East Merton	324,774	2,616,312	£3,047,206.8
Raynes Park	145,932	1,331,762	£1,797,816.2
West Merton	234,269	1,992,578	£2,423,932.2

When the prescribing volumes for mental health are viewed for each year separately, the trends in prescribing for the different drug groups can be established. In terms of costs, antipsychotics had the highest cost for the Merton CCG but since 2011/12 there has been a sharp decline in these costs. It is not the highest volume item in terms of prescriptions- which is by far the anti-depressants and the second costliest drug group for MCCG. Prescription volumes both in terms of cost and prescriptions are on a downward trend overall. There was a sharp drop in dementia drug prescription costs since 2011/12 as well.

Figure 96: Merton CCG Total Prescription Costs in £100,000's, 2009/10 - Q2 2013/14
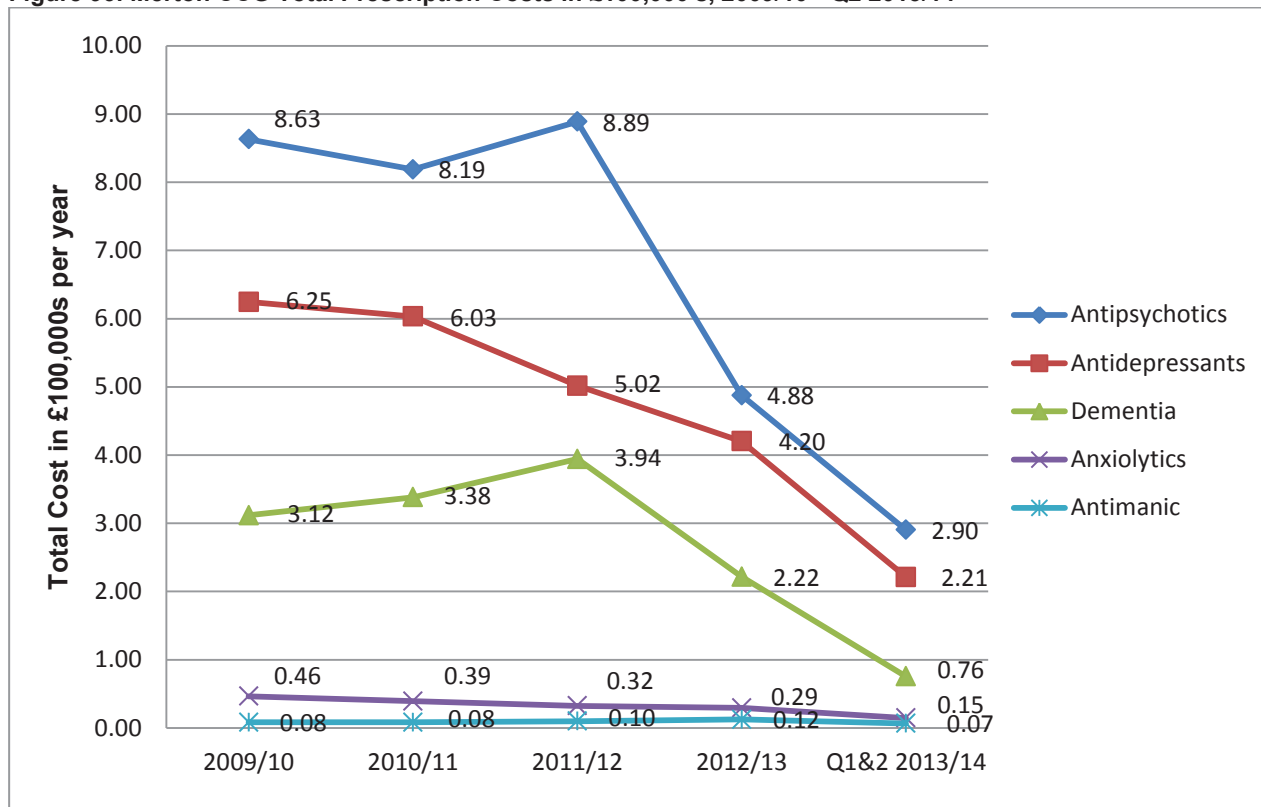
Figure 97: Merton CCG Total Prescription Volume (Items) in 1000's, 2009/10 - Q2 2013/14

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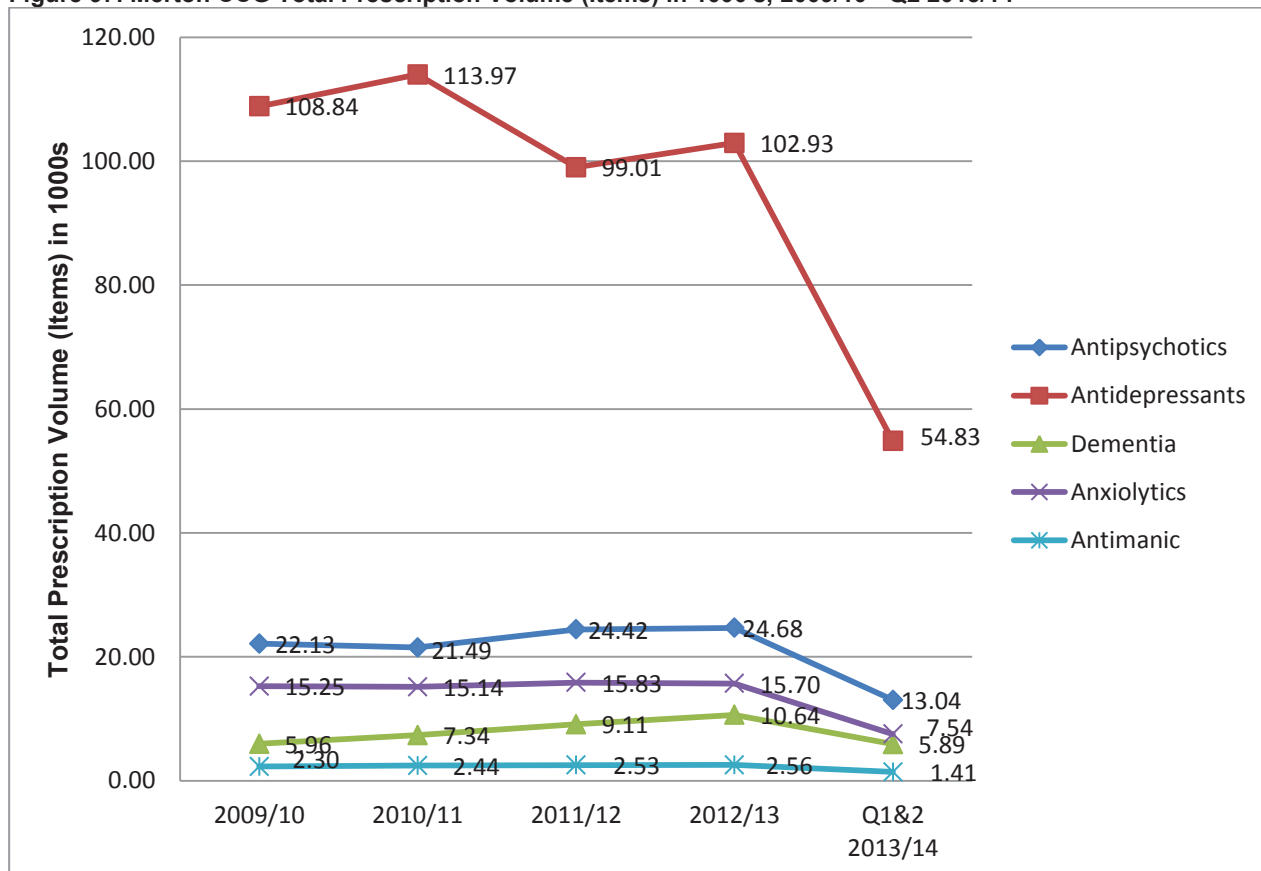
Parental and child mental health

Evidence from small studies of people with mental health difficulties shows that a high proportion of adults in acute psychiatric hospital settings may be parents – at least 25% and probably substantially more, especially among young women, although shortcomings have been identified in the quality of this research. [85] Research published in 2011 by the National Society for the Prevention of Cruelty to Children (NSPCC) estimates that 144,000 babies less than 1 year old live with a parent who has a common mental health problem.[86]

The National Treatment Agency for Substance Abuse collects national data on the take-up of drug and alcohol services and requires local areas to report on the number of service users who are parents. It estimates that around 200,000 adults are currently receiving treatment for substance misuse problems and of these, one third are parents and have children living with them, although details of the number of children are not known.[87] A recent survey of parental alcohol and drug use reported that 8% of parents had taken illegal drugs over the past year and 7% drink alcohol every day.[88] The NSPCC's review of evidence estimates that 19,500 babies less than 1 year old are living with a parent who has used Class A drugs in the last year; 93,500 babies less than 1 year old live with a parent who is a problem drinker.[89]

The extent to which these difficulties impact on parenting capacity varies enormously. Research shows that the impact can be mitigated by a second parent, or care by extended family involvement and early community support. [90] However, without this support children may be neglected and/or emotionally harmed. Alcohol misuse by parents, particularly by fathers, can also result in violence and risks of physical harm to children. Analyses by Ofsted of serious case reviews between 2007 and 2011 where children had either died or been seriously harmed, showed that mental health difficulties, drug and alcohol problems and domestic abuse were the most common characteristics of the families involved.[91] Studies in the field of child protection suggest that the prevalence of identified mental illness, which in many cases exists alongside other parental difficulties, increases with the level of enquiry. At the referral stage prevalence is low. A study[92] of 2,248 referrals to children's social care found, on re-analysing their data, that parental mental illness was recorded in 10.4% of referrals, a finding similar to the 13% identified by another key study.[93] However, prevalence increases with greater knowledge of the family circumstances.

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[85] G Parker, B Beresford, S Clarke, K Gridley, R Pitman, G Spiers, K Light, *Research reviews on prevalence, detection and interventions in parental mental health and child welfare: Summary report*,
Social Policy Research Unit, York University, 2008; http://php.york.ac.uk/inst/spru/pubs/1125/.
[86] C Cuthbert, G Rayns, K Stanley, *All babies count, prevention and protection for vulnerable babies: a review of the evidence*, National Society for the Prevention of Cruelty to Children, 2011;.
www.nspcc.org.uk/inform/resourcesforprofessionals/underones/all_babies_count_wda85568.html.
[87] *Supporting information for the development of joint local protocols between drug and alcohol partnerships, children and family services*, National Treatment Agency for Substance Misuse, supported by Department for Education, 2011; www.nta.nhs.uk/publications.aspx.
[88] *Over the limit. The truth about families and alcohol,* 4Children, 2012; www.4children.org.uk/Resources/Detail/Over-the-Limit.
[89] C Cuthbert, G Rayns, K Stanley, *All babies count, prevention and protection for vulnerable babies: a review of the evidence*, National Society for the Prevention of Cruelty to Children, 2011;
www.nspcc.org.uk/inform/resourcesforprofessionals/underones/all_babies_count_wda85568.html.
[90] E Sawyer and S Burton, *Building resilience in families under stress,*
National Children's Bureau, 2012; www.ncb.org.uk/resources/publications.
[91] *Ages of concern: learning lessons from serious case reviews* (110080), Ofsted, 2011;
www.ofsted.gov.uk/resources/110080.
[92] Cleaver, H. and Walker, S. with Meadows, P. (2004) *Assessing Children's Needs and Circumstances: The Impact of the Assessment Framework*. London: Jessica Kingsley Publishers.
[93] Gibbons, J., Conroy, S. and Bell, C. (1995) *Operating the Child Protection System: A Study of Child Protection Practices in English Local Authorities*. London: HMSO.

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Parental mental illness was identified in a quarter of cases coming to conference.[94] Parental mental illness had been noted in some 43% of cases where children are the subject of care proceedings.[95] [96]

Research on child sexual abuse also suggests a greater association with parental mental illness. A study of child sexual abuse[97] found 71% of families, where there were suspicions of abuse, were in a 'poor psychological state' using the General Health Questionnaire[98] and there was a further increase when suspicions were confirmed. These findings are in line with a study[99] of families attending a specialised treatment and assessment day clinic for child sexual abuse. They found 86% of mothers (assessed using the General Health Questionnaire) showed symptoms of depression or anxiety and, for a considerable proportion, the symptoms had been of long duration.

Caution, however, must be exercised in relation to these findings because studies of physical abuse and neglect have tended not to use standardised measures of mental health and it is not possible to compare like with like.

The Children Act 2004 places a duty on partner organisations to safeguard and promote the welfare of children, and current statutory guidance sets clear and explicit expectations that adult and children's services should work cooperatively together to safeguard and promote the welfare of children.[100] The Children Act 1989 defines children 'in need' under section 17 as those whose vulnerability is such that they are unlikely to reach or maintain a satisfactory level of health or development, or their health and development will be significantly impaired without the provision of services. If children's parents or carers have serious mental health difficulties and /or drug or alcohol problems then consideration needs to be given as to how and whether this will affect their ability to care for their children, to determine if the children are 'in need'.[101]

However, historically, joint working between adult and children's services has not been strong. The issues, challenges and barriers to effective cooperation are well documented in inspections, research and serious case reviews. Reports by Ofsted of serious case reviews from 1 April 2007 to 31 March 2011 highlighted repeated examples of ways in which the risks resulting from the parents' own needs were underestimated – including when parents had mental health difficulties and/or drug and alcohol problems.[102]

Nationally, Ofsted reports[103] that the extent to which adult and children's services worked effectively together to assess concerns and support and challenge parents and carers varied considerably. Overall, the quality of joint working was much stronger between children's social care

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[94] Farmer, E. and Owen, M. (1995) *Child Protection Practice: Private Risks and Public Remedies*. London: HMSO.
[95] Hunt, J., Macleod, A. and Thomas, C. (1999) *The Last Resort: Child Protection, the Courts and the 1989 Children Act*. London: The Stationery Office.
[96] Brophy, J., Jhutti-Johal, J. and Owen, C. (2003) 'Assessing and documenting child ill-treatment in minority ethnic households.' *Family Law* 33, 756–764.
[97] Sharland, E., Seal, H., Croucher, M., Aldgate, J. and Jones, D. (1996) *Professional Intervention in Child Sexual Abuse.* London: HMSO.
[98] Goldberg, D.P. and Williams, P. (1988) *A User's Guide to the General Health Questionnaire.* Windsor: NFER-Nelson.
[99] Monck, E., Bentovin, A., Goodall, G., Hyde, C., Lwin, R., Sharland, E. with Elton,
A. (1995) *Child Sexual Abuse: A Descriptive and Treatment Study.* London: HMSO.
[100] Children Act 2004 sections 10 and 11; www.opsi.gov.uk/acts/acts2004/ukpga_20040031_en_1
[101] Children Act 1989 section 17(10); www.opsi.gov.uk/acts/acts1989/ukpga_19890041_en_1.
[102] Ofsted publications: www.ofsted.gov.uk/resources/results/serious%20case%20reviews.
[103] What about the children? Joint working between adult and children's services when parents or carers have mental ill health and/or drug and alcohol problems; Ofsted March 2013, Ref no. 130066.

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and drug and alcohol services than between children's social care and adult mental health services.

Furthermore, the report found that considerations on the impact of parents' or carers' difficulties on children was more strongly embedded in drug and alcohol services than in adult mental health services. Mental health services did not consistently consider the impact of the adult mental health difficulties on children. Questions about children were included in recording systems, but the clarity and detail of these varied and they were not always consistently completed.

SWLStG MH NHS Trust undertake internal assessments of their patients for safeguarding issues, and in that regard record if a patient is a parent (having dependent children). Table XX below depicts the number of adult patients (Column B) needing such an assessment of risk (called SF) (Column C), and the number where this assessment was completed (Column D). This gives the percentage completion rate (Column E). In March 2013 this completion rate was 74% and this rose to 92% the following year. As of 29/08/2014 it stands at 88% completion, and this dip is explained by the Trust as due to the fact that they recently extended this indicator to include patients not on the Care programme approach, as well as patients on the Care Programme Approach. Column F depicts the number of patients who were identified as parents with any dependent children and Column G the number of such parents where the SF was completed. In all adult patients with dependent children, a safeguarding risk assessment was completed. As on 29.8.14 the Trust was treating 5,538 adults, of which 88% had been assessed as to whether or not they had dependent children. Of the 4867 adults assessed, 515 were identified as having dependent children.

Table 18: SWLStG MHT data on safeguarding assessments and patients identified as having dependent children

Date (A)	Number of Adults (B)	All Clients			Clients marked as Pregnant/Parent/Carer/Primary Carer		
		Clients needing SF (C)	Number SF complete (D)	% complete (E)	Clients needing SF (F)	Number SF complete (G)	% complete (H)
31/03/2013	4894	4894	3601	74%	420	420	100%
31/03/2014	5160	5160	4754	92%	481	481	100%
29/08/2014	5538	5538	4867	88%	515	515	100%

The number of parents in Column F is a subset of the total patient population in Column B.
Therefore the percentage of mental health patients with dependent children in each year is:
As of 31/03/2013 - 8.6%
As of 31/03/2014 – 9.3%
As of 29/08/2014 – 9.2%
This percentage is of course dependent on the completion rate in Column E, but gives a reasonable indication of the number and percentage of mental health patients in Merton at any given time, that have dependent children.

Nationally, in assessments where there were issues of parent or carer mental ill health professionals did not routinely approach the assessment as a shared activity between children's

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social workers and adult mental health practitioners, in which each professional drew on the other's expertise. As a result, the majority of assessments did not provide a comprehensive and reflective analysis of the impact on the child of living with a parent or carer with mental health difficulties. In most cases seen when parents or carers had been admitted to hospital, joint working was poor in ensuring that plans for discharge took the children's needs into account. As a result, children had sometimes been returned too early to the care of parents or carers who were unable to meet their needs at that time. This is the national picture and may or may not reflect ground realties in Merton.

In most of the long-term cases there was a history of involvement by children's social care. These cases were complex and challenging. Parents' and carers' difficulties were not easily, and sometimes never, resolved and progress was often not sustained. Cases were opened and closed, and families were supported for a time, sometimes over substantial periods and sometimes intermittently. This raised questions about the sustainability of change, and the timeliness and robustness of previous decision-making and planning.

Impact of parenting[104]

Parenting can be defined as those activities and behaviours of caregiving adults that are needed by children to enable them to function successfully as adults, within their culture.[105]

In order to achieve this, those who are responsible for parenting must provide the child with basic care, ensure their safety, provide emotional warmth, provide appropriate stimulation, offer guidance and boundaries and provide the child with stability.

To suggest that all parents who suffer from mental illness, learning disability, problem alcohol/drug use or are subjected to or perpetrate domestic violence present a danger to their children is misleading and dangerous. Indeed, much research indicates that, with adequate support, parents who are experiencing a single disorder are often able to be effective and loving parents and present little risk of significant harm to children. A four-year follow-up study[106] of children, found two-thirds of those in families where there was parental mental illness suffered no long-term behavioural or emotional difficulties. In fact, many parents with mental illness regard the bond between themselves and their children as especially strong and close[107] and negative effects can be offset with adequate support.

Although a single issue such as mental illness may not detrimentally affect parenting capacity, there is considerable evidence that many parents also experience other difficulties.[108] [109] For example, adults with mental health problems are more likely than those without to abuse drugs or

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[104] Cleaver H, Unell I and Aldgate J; Children's Needs- Parenting Capacity, Child Abuse: Parental mental illness, learning disability, substance misuse, and domestic violence; 2nd Edition, TSO (The Stationery Office); Norwich, 2011.

[105] Jones, D.P.H. (2009) 'Assessment of parenting', in Horwath, J. (ed.) *The Child's World: The Comprehensive Guide to Assessing Children in Need.* 2nd edition. London: Jessica Kingsley Publishers.

[106] Rutter, M. and Quinton, D. (1984) 'Parental psychiatric disorder; effects on children.' *Psychological Medicine* 14, 853–880.

[107] Ackerson, B.J. (2003) 'Coping with the dual demands of severe mental illness and parenting: The parents' perspective.' *Families in Society* 84, 1, 109–119.

[108] Cleaver, H. and Walker, S. with Meadows, P. (2004) *Assessing Children's Needs and Circumstances: The Impact of the Assessment Framework*. London: Jessica Kingsley Publishers.

[109] Velleman, R. and Reuber, D. (2007) *Domestic Violence and Abuse Experienced by Children and Young People Living in Families with Alcohol Problems: Results of a Cross European Study.* ENCARE. (www.apua.info/File/fb9c3027-2698-48b3994c-349a0e491c7c/ALC_VIOL_ParentalAlcoholProblems_EN.pdf) accessed 03.03.2011.

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alcohol; similarly, those who abuse drugs have a markedly increased lifetime occurrence of diagnosable psychopathology.[110] [111] It is the 'multiplicative' impact of combinations of factors that have been found to increase the risk of harm to children. For example, the risk of child abuse increased 14-fold when parents had themselves been abused in childhood, if the parent was under twenty-one, had been treated for mental health problems or had a partner with violent tendencies.[112] [113] Research has shown that mothers who experience depression after childbirth, compared to those who do not, are 20% more dependent on alcohol. Alcohol dependence linked to depression is generally associated with poorer, less consistent parenting. Research suggests that in such cases women's capacity to empathise with and respond to their children's needs is overwhelmed by their own needs where *'alcohol dependence is present alongside depression, there is greater concern about the 'dangerousness' of the situation'.*[114]

Impact on children

A disorganised lifestyle will have a differential impact on children depending on their age, development and personality. A lack of supervision leaves babies, young children and disabled children particularly vulnerable, but older children are also at risk of neglect. For example, some parents who are opiate dependent allow others to inject heroin in their homes, despite believing that their drug dependence and associated lifestyle are potentially harmful to their children.[115] Parental mental health has well-documented impacts on the development of children from pre-birth onwards.

In most cases parental problems influence how parents relate to their child. Weissman and Paykel[116] observed that *'at the simplest level, the helplessness and hostility which are associated with acute depression interfere with the ability to be a warm and consistent mother'*. A psychopathic personality disorder may manifest itself in a *'callous unconcern for others, a low threshold for frustration, a discharge of aggression and an inability to feel remorse'.*[117] Similarly, excessive drinking or drug misuse can result in the parent being emotionally unavailable to the child. Mothers who have a problem with drugs are less responsive to their babies, less willing to engage in meaningful play and more likely to respond in a manner that curtails further engagement.[118] Parents with learning disabilities may not readily recognise their baby's cues nor

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[110] Spotts, J.V., and Shontz, F. C. (1991) 'Drugs and personality: Comparison of drug users, nonusers, and other clinical groups on the 16PF.' *International Journal of Addiction* 26, 10, 1019–1054.

[111] Beckwith, L., Howard, J., Espinosa, M. and Tyler, R. (1999) 'Psychopathology, mother-child interaction, and infant development: Substance-abusing mothers and their offspring.' *Development and Psychopathology* 11, 4, 715–725.

[112] Dixon, L., Browne, K.D., Hamilton-Giacritsis, C. (2005a) 'Risk factors of parents abused as children national analysis of the intergenerational continuity of child maltreatment (part 1).' *Journal of Psychology and Psychiatry* 46, 1, 47–57.

[113] Dixon, L., Hamilton-Giacritsis, C. and Browne, K.D. (2005b) 'Risk factors and behavioural measures of abused as children: a meditational analysis of the intergenerational continuity of child maltreatment (part 11).' *Journal of Child Psychology and Psychiatry* 46, 1, 58–68.

[114] Woodcock, J. and Sheppard, M. (2002) 'Double trouble: Maternal depression and alcohol dependence as combined factors in child and family social work.' *Children & Society* 16, 4, 232–245.

[115] Hogan, D.M. (2003) 'Parenting beliefs and practices of opiate-addicted parents: Concealment and taboo.' *European Addiction Research* 9, 113–119.

[116] Weissman, M.M. and Paykel, E.S. (1974) *The Depressed Woman: A Study of Social Relationships*. Chicago: University of Chicago Press.

[117] Stroud, J. (1997) 'Mental disorder and the homicide of children.' *Social Work and Social Sciences Review: An International Journal of Applied Research* 6, 3, 149–162.

[118] Kroll, B. and Taylor, A. (2003) *Parental Substance Misuse and Child Welfare.* London: Jessica Kingsley Publishers.

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have sufficient understanding to know how to respond appropriately to reassure the baby and encourage further interaction.[119]

All these issues pose a considerable risk to the process of attachment and more general relationships between children and their parents. Insecure patterns of attachment may mean that children develop shaky internal working models, which can have adverse consequences for later relationships. [120] Moreover, when children experience a degree of rejection this may have implications for the child's sense of connectedness. This, in turn, can affect intellectual, emotional, social and psychological functioning.[121] [122] Attachment begins during the first year of life, and the major characteristic of this relationship is the presence of a consistent person who is able to reduce the baby's anxiety in stressful situations. Babies who become securely attached feel sufficiently confident to explore their world.[123] The process of attachment is not confined to a single adult. Babies can develop secure attachments to more than one adult as long as they are constant figures in the baby's life.[124] [125] [126]

Separation of children and parents

When parents' problems become extreme, they may result in children being separated from one or both parents. For example, drug dealing to sustain a 'habit' may lead to the parent's imprisonment, domestic violence to a mother's escape to a refuge, or an acute episode of mental illness to hospitalisation. If the other parent or a close relative can provide a stable environment and the time and attention the children require, the risk of negative outcomes is much reduced. However, the luxury of a second caring parent or relative is not always available. For these children the hospitalisation or imprisonment of one parent results in the child being 'looked after' by the local authority. Although professionals are reluctant to place children in local authority care because of the well-publicised difficulties surrounding placement, there is growing evidence to suggest that *'foster care provides a positive service to many children. Often it is both valued and, as far as research has been able to assess, valuable'.*[127]

Recurrent separations have the potential to disrupt the continuity of care provided to children and the formation of harmonious stable family relationships. Approximately three-quarters of children (76%) living with domestic violence, a similar proportion (73%) of those living with parental substance misuse and half the children (48%) living with a parent with a learning disability were assessed as not having a stable family environment in which to develop and maintain a secure attachment to a parent figure. [128] [129]

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[119] Cleaver, H. and Nicholson, D. (2007) *Parental Learning Disability and Children's Needs: Family Experiences and Effective Practice*. London: Jessica Kingsley Publishers.

[120] Howe, D. (1995) *Attachment Theory for Social Work Practice*. London: Macmillan.

[121] Owusu-Bempah, K. (1995) 'Information about the absent parent as a factor in the well-being of children of single-parent families.' *International Social Work* 38, 253–275.

[122] Owusu-Bempah, K. and Howitt, J. (1997) 'Self-identity and black children in care', in Davies, M. (ed.) *The Blackwell Companion to Social Work*. London: Blackwell.

[123] Bowlby, J. (1973) *Attachment and Loss, Volume 11, Separation, anxiety and anger.* London: Hogarth Press.

[124] Rutter, M. (1985) 'Resilience in the face of adversity. Protective factors and resistance to psychiatric disorder.' *British Journal of Psychiatry* 147, 598–611.

[125] Thoburn, J. (1996) 'Psychological parenting and child placement: "But we want to have our cake and eat it"', in Howe, D. (ed.) *Attachment and Loss in Child and Family Social Work*. Aldershot: Avebury.

[126] Bowlby, J. (1973) *Attachment and Loss, Volume 11, Separation, anxiety and anger.* London: Hogarth Press

[127] Wilson K. (2006) 'Foster care in the UK', in McAuley, C., Pecora, P.J. and Rose, W. (eds) *Enhancing the Well-Being of Children and Families through Effective Interventions*. London: Jessica Kingsley Publishers.

[128] Cleaver, H., Nicholson, D., Tarr, S. and Cleaver, D. (2007) *Child Protection, Domestic Violence and Parental Substance Misuse: Family Experiences and Effective Practice*. London: Jessica Kingsley Publishers.

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The fear of separation or fear of children being removed from parental care may be a critical factor in a parent with a mental illness not presenting to a mental health service, possibly resulting in the parent then being seen at the point of crisis resulting in the very thing occurring that the parent was wishing to avoid. This cycle can be circumvented if parents with mental illnesses have confidence in the services.[130]

For recommendations related to parent and child mental health, please refer to the main health and social care recommendation at the end of this report.

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[129] Cleaver, H. and Nicholson, D. (2007) *Parental Learning Disability and Children's Needs: Family Experiences and Effective Practice*. London: Jessica Kingsley Publishers.
[130] From personal communications with the Merton Children Schools and Families department.

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Qualitative data: Focus Groups and Semi-structured interviews

Summary of key learning from consultations

Although the consultations in this study identified a variety of both positive and negative experiences of mental health services in Merton, the views expressed by service users and carers were for the most part critical. This is by no means unusual and is typical of much of the user experience documented in the mental health literature.

Service users' main concerns in this study were around continuing attitudes to mental illness, experience of care, and cuts in services. Their most prominently expressed issues with Merton's mental health provision were the loss of drop-in/day centres, perceived powerlessness in influencing their care and services that were dominated by a medical approach to treatment.

The most important issues for carers were their poor involvement in decisions about the care, properly informed sessions and providing support/ training in managing specific situations.

BME service users and carers reported particular challenges in different areas, exposing the importance of developing cultural competence within the mainstream services along with targeted provision specifically tailored to their unique needs. BME groups are under-represented in research[131] and their experiences and expectations of services will continue to be priorities for further investigation.

When service users and carers talked about their experiences of primary, acute and hospital care, their views were largely framed by four perspectives:
a. Relationships with health professionals.
b. Communication – consisting of listening, talking and understanding.
c. Cultural competence of the service (particularly in the case of BME service users)
d. Comparisons with services in adjoining boroughs (especially Sutton and Wandsworth) which were generally seen as providing better care and a wider range of services).

Service providers offered insights into the main strategies they employed to deliver more user-responsive services. These were:
a. Adopting a more open and candid approach with users informed by the policy recommendations of the Francis report.
b. Established feedback and stepped complaints procedures
c. Developing different ways of working, and
d. Fostering partnership working.

Staff training and education underpinned all four approaches.

Regarding perceptions of an ideal mental health service, central to the narratives of both service user and carers were issues of relationship, involvement, and empowerment. For service providers, priority areas for attention were largely related to more effective collaboration and better integration of services across domains of care.

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[131] Bee P, Playle J, Lovell K, Barnes P, Gray R, Keeley P (2008). *Service user views and expectations of UK-registered mental health nurses: A systematic review of empirical research.* International Journal of Nursing Studies, 45 (3). pp. 442-457

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When **service users** were asked what a good service would look like, high on the list of essential qualities were informed and understanding staff, longer periods of follow-up, a broad range of services and better integration between different teams of workers.

Carers were invited to describe what a good mental health service for them would look like. Prominent among the services and design features they expressed a desire to have were day centres, meaningful consultation on service commissioning and delivery, pro-active information-sharing and guidance, a more user and carer-responsive approach and less emphasis on medical (i.e. drug) treatment and hospitalisation.

Providers were asked what they would like to see included in the current services being delivered. Many responded by identifying a need for better integration of services across domains of care. They further recognised that this would require closer partnership working.

Details of findings from the consultations

A number of prominent themes emerged from the analysis of informants accounts of their experiences and perceptions of engaging with (services users and carers) or delivering services (mental health providers). They are presented below arranged by the responses of the three stakeholder groups.

Service Users
Three aggregate themes emerged from the focus group discussions with service users:
1. Attitudes to mental illness
2. Experience of care
3. Loss of services

1. *Attitudes to mental illness*
Two distinct sub-themes were identified from participants' responses: stigma and discrimination, and parity of esteem.

Stigma and discrimination
This issue was raised by almost all the participants and this was experienced in four settings: society, family, workplace and the health services. In *society*, few participants were convinced that mental health-related stigma and discrimination had improved. The picture of poor progress was echoed by most of the service users, with several observing that the situation had even worsened. In *family settings*, several participants, mainly from BME backgrounds, related personal experiences of the shame their mental health problems had brought on their families.
"My family…it's like they don't talk about mental health. Like they told the rest of my family and friends that I'm on a sabbatical for the last three years, because it (mental illness) brings shame on the family."

In the *workplace* many participants admitted that they would be reluctant to disclose their condition to their employer. In the *health services* the attitudes and behaviours of professionals in the health services were generally was felt to be satisfactory by most informants.

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Parity of esteem

"You just make an appointment and get to your GP and that's what they're there for. But the GPs aren't always good with mental health problems, especially if you don't understand [how to explain the problem yourself]."

There was a general view that the health service still gave less attention to mental illness than to physical problems. While stigma and discrimination were blamed for the disparity in care, the *invisibility* of mental problems was mentioned as an important underpinning factor. Except for acute episodes, mental illness was not felt to have the obvious external signs of physical disorders that attracted early attention by the health service. Hence, people presenting at the clinic seeking care were not deemed to have a serious problem that needed to be treated as a priority. There was general agreement that it was more straightforward getting an appointment for a physical problem than for a mental health complaint.

2. *Experience of care*
   Participants' views about mental health services in Merton highlighted two subordinate themes of interest: access to services and quality of care.

   Access to services
   Two types of barriers were mentioned by service users in terms of access: *accessing the right type of care* and *transportation*.

   Accessing the right type of care
   In terms of the first barrier, while participants had no problems getting appointments with their GPs, they did not feel this was always the most appropriate point of contact in many circumstances, and would have preferred to have direct specialist access. Primary care professionals were also perceived by some to have an inadequate understanding of mental illness.

   "I don't think they're fully trained or they don't know (primary care professionals)...or mental health issues is too much for them to cope with."

   Some service users had resorted to using A&E services but were left frustrated by the process. The Crisis line (telephone service) was also not regarded as helpful.

   "I've used the Crisis line. They told me to take a milky drink and go to bed.... And it doesn't help, and in the end I have to go to A&E at one a.m. in the morning because I'm feeling so bad, and then I get sent away."

   Participants also stressed that they lacked good information about services they could access and were not adequately signposted by health workers.

   Some informants mentioned the difficulty they had in accessing Improving Access to Psychological Therapies (IAPT) services. Their complaints were related to the length of time it could take to get an appointment following referral by their GP, up to 6 months in one instance, and being dropped from the service if they missed scheduled appointments. The IAPT service seemed to be specially mentioned because it was one that many users found helpful. Other

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service users identified the closure of hospital wards as compounding the situation, as well as reduced number of health professionals.

"Well, I did have a psychiatrist, in those days, and suddenly, you go in and say, and suddenly your psychiatrist is taken away. And you would like to see a psychiatrist, so I don't know how you go about seeing one, and suddenly you no longer have that psychiatrist. …before I would see a psychiatrist every 6 months or a year…but now, em, they've started saying sorry, you have to sort your own problems out."

Transportation & Discretionary Freedom Passes
Transportation was the other main barrier to access that was an issue of clear concern and generated a great deal of discussion about the decision to withdraw Discretionary Freedom Passes. Participants felt this would severely limit their ability to get around and lead to a worsening of their problems. It was pointed out that many mental health service users were not in employment or on low incomes and they would struggle with the cost of transport. While the Council had given reassurance that people would be able to retain their freedom passes if they had any mobility problems, the process did not appear to work well. Several informants noted that the information they were given about people who would be exempted from withdrawal was different to their actual experience.

"*Freedom pass…it's been withdrawn for a lot of people with mental health problems. I phoned the Council and they said that if I had a mobility problem of any sort, I would retain it."*

"They (the Council) had a consultation. I think a lot of people were told they wouldn't lose theirs so long as they got a letter from their GP saying they was unable to drive. But it wasn't the case; a lot of people had their bus passes withdrawn."

Quality of care
There were four sub-themes in relation to quality of care: *relationship with care giver, communication, involvement in decisions on care,* and *service integration*.

Relationship with care giver
At primary care level, opinions about services were mixed and strongly linked to people's relationship with their care givers. Some service users had good relationships with their GPs, and cited examples of the impact that effective support from primary care had on their engagement with other parts of the health service. However, many more reported less positive experiences.

"Well the thing is, when I got ill, I was put into hospital, then I came out to see my GP and he just gave me a sick note and he said 'There you are', and I said 'What is this?', and he told me, he didn't explain to me what it was. I was diagnosed of having polymorphic psychosis of [with] symptoms of schizophrenia, and I said to him 'What is this?', and he said 'Well, it's many forms of….', and he didn't know; he had to look it up in a text book. So…and, and then I went to see my psychiatrist, and I was on the books for a couple of years; then they referred me back to my GP, and this has been four years and I've seen my doctor twice in the last four years, and this is just for my yearly reviews, and he just say's 'How are you? Anything different?', ticks a box, and that's it."

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Communication

Communication was frequently mentioned and service users who said they were given time to talk, paid attention and listened to, held more positive views about the service as a whole. They described themselves as feeling respected, not judged or patronised. Conversely, those who did not talked of having to *'fight'* and *'shout'* to be heard.

Involvement in decisions on care

Responses to whether service users had significant input into decisions about their care were **all negative**. Meetings with health professionals were described as being a *'monologue'* rather than dialogue, and many informants felt that they were indifferent to their concerns.

The tendency for health professionals to over-emphasis medication and ignore peoples' preference for non-drug forms of therapy was mentioned several times to illustrate service users lack of power to influence their care.

"I don't think to get referred is that easy from your GP.... [They] just medicate you. It's not always the answer, is it? I mean medication sometimes with a bit of other help, or... but I don't think medication is always the answer."

Service integration

Participants voiced concerns about the poor liaison between their GPs, hospitals and key workers (care coordinators). One reason for this was felt to be an inadequate number of mental health workers which was having an impact on the quality of care.

> When asked what a good service would look like, high on the list of essential qualities were informed and understanding staff, longer periods of follow-up, a broad range of services and better integration between different teams of workers.

3. **Loss of services**

Cuts in Merton's mental health services generated considerable discussion. Participants were unanimous in their view that the closures had affected services that they frequently accessed and found helpful in various ways. Several examples were mentioned including Fanon, Beehive, Cottage Day and Mind. Social interaction and motivation to get out and about were some of the features of the services that were particularly valued. Fanon, a BME-focused service, was noted by BME users for its culturally sensitive approach.

"I used to go to Chapel Orchard, which was the day centre specifically for people with mental health problems, and that was open seven days a week. And that was really good, because I stayed in bed for one year; I had nowhere to go. And then I was referred to this place, and that shut down. And a lot of people had breakdowns after it shut down. So there was nowhere for them to go. And then I was introduced to Fanon, went to Fanon for a few years, and that shut down. There's St Marks which is a church open group, erm, every Thursday, but that's shutting down in September, yeah, it's shutting down in September. So the only groups left is Imagine, Focus-4-1 and Wimbledon Guild, on a Wednesday evening."

There was dissatisfaction with some of the services that had replaced the lost ones. Various reasons were given for this including insufficient activity sessions. Several informants mentioned not feeling *'safe'*, using the term to describe service settings that were unfamiliar

and in which they did not feel comfortable. In the case of third sector providers, they were seen as being too expensive to access.

"The problem with Imagine is that it has one-off days you can go to; like a library…they have a hall you can go to, where you socialise or whatever and your needs are sort of met. But the problem with Imagine is that it's not like Fanon. Fanon was like a safe haven to go to. So if you're in the stress or something, you've got five days a week you can go there. But Imagine is…is like an office, you go to an office and then they talk about how they can help you, but they're not really engaging with you during the week, or, they're not really, erm, meeting your needs; they're not meeting your needs. And it's funny how they took away Fanon, but Imagine is still running. So my question is, not question, but my fear is that they're putting across that the way forwards for services especially in Merton, they're putting across that it's going to be built up in offices and places where people don't go to, to engage with each other and know each other and feel that they are part of something…………So this is.. this is the…the..the sort of thing where things turn into other things. But Imagine was supposed to take over Fanon, but it never."

Table 19 summarises service users' views about what they felt had worked well and what had not.

Table 19: What has worked well and what has not

What has worked well	Positive service attributes/ mechanisms	Negative service attributes/ mechanisms
Service level		
Day centres	Easy access, understanding staff, something to do, somewhere to go, reduced loneliness through social contact and providing motivation to go out.	Loss of services that were valued.
GP care	Take time to listen, readily refer to IAPT.	Poor communication/relationship building.
IAPT	Easy access, non-drug therapy.	-
Hospital/community care		Resort too readily to medication, inadequate follow up by key worker, difficult to transit between services.
Physical activity (football, tennis, etc)	Opportunity to get out and about.	
Recovery College	Using the Five Ways to Wellbeing approach and Mindfulness techniques.	
Rethink	Open, non-judgemental, social contact.	
Fanon	Open, non-judgemental, culturally sensitive.	
Structural level		
Revocation of Freedom Pass		Limited ability to go out and do things with others.
Unemployment		Lack of opportunities

Carers

Seven themes were identified from the interviews with carers:

1. Attitudes to mental illness
2. Engagement with services

3. Needs assessment
4. Support mechanisms
5. Respite
6. Culturally competent services
7. Expectations

1. *Attitudes to mental illness*

Similar to service users, carers observed that ignorance about, and negative attitudes to mental illness were still very much pervasive. They all concurred that it was much easier to disclose a physical illness than a mental one.

2. *Engagement with services*

Two subordinate themes framed the perspectives through which carers' described their experience of engaging with Merton's mental health services: their *relationship with health professionals* and the *quality of care* provided.

Relationship with health professionals

Effective information sharing was considered an important aspect of the relationship with health professionals- the general opinion expressed was that carers did not feel that they were adequately informed about the service users they cared for. Information-sharing is a two-way process of communication, and carers stressed the need to be '*listened to'* when they tried to make inputs. While there was an acknowledgement of professionals' concerns about patient confidentiality and the pressures they were under, especially when having to manage acute episodes, a desire to be better drawn into the management process was expressed.

The other important aspect of this relationship was *professional's attitudes*- most often psychiatrists, community teams and GPs. In all cases, there were wide differences in views, similar to the varying responses given by service users, with opinions ranging from '*fantastic'* to '*useless'*.

Quality of care

Discontinuity of care was seen as an important aspect of quality of care. Carers said that under the current system, there were so many care providers involved that it made it more difficult to coordinate care across primary, community and hospital services.

Inflexibility in service response was another important aspect. A common observation was that there seemed to be a standard response regardless of service users' circumstances and the context of presentation. Health professionals were perceived as not willing to consider all possible treatment options. It was suggested that if carers were better equipped with coping skills, they could offer feasible alternatives to hospitalisation.

"You see always, if I cried for help and called the police, of if I called the doctor, it was the same scenario. No matter what happened, whoever I called for help, it always ended up in him being carted off in an ambulance to Springfield hospital. It was always, Oh I knew the moment I picked the phone to call the GP, he would arrive, probably with the police in tow, or with the, you know, the ambulance, at least, in tow. The moment he got a call to my address, he would come with an entourage of other people, and my son would be taken away from the home. So you try and try and try as much as you could to keep the sick person at home, knowing the consequences of ringing, asking for help. But you

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need help. But there was sort of no, nothing in the middle where I could go and talk to somebody who could give me some advice on some strategies, coping strategies, so that it didn't became that critical that he had to be carted away from the home. And it was quite dramatic and I still cry just talking about it, but I thought it was bigger than that."

Health professionals' personal qualities: When asked to assess the quality of service provision, most responses particularly emphasised the characteristics of the health professionals involved in delivering the care. Personal attributes of professionals were therefore a principal proxy indicator of care quality. As described in the relationship sub-theme above, there were varying perceptions about the quality of care depending on whether an informant had encountered 'good' professionals or not. The divergent perceptions were summed up in comments of one carer who described the situation as *'a bit of hit or miss'*.

3. Needs assessment

Most of the carers seemed uncertain of what was meant or replied in the negative when asked if a formal assessment of their needs had ever been undertaken and how frequently follow up assessments were carried out. However, following further probing over the course of the interview, some recalled informal enquiries made about their requirements, but did not seem to associate this with a needs assessment. The initial contact with the mental health service was an especially crucial period and most of the carers recalled being left in the dark about what was happening at a time when they would have welcomed guidance and support.

"But no professional in the mental health told me that any services were out there for me; looked after me. They were looking after my son fine in the hospital, but nobody ever…, I just went down there at visiting time to visit him and came home. There was nothing given to me by way of a pack or one-to-one with anybody. It was always about my son and how he was progressing or digressing [regressing]. But they never once asked me how I was coping with his issue and the broader aspect of my life as a whole; juggling work, juggling other children, juggling my son being ill, you know. It was very traumatic for me."

4. Support mechanisms

Several effective mechanisms were identified by carers that supported them in their role. Non-statutory services and self-help groups (such as Carer Support Merton and Rethink) were a key source of support and provided a range of services including counselling, information, help with filling forms and signposting to useful local services. They also offered vital social and emotional support. Social activities are varied and include games (scrabble, quizzes, bingo), creative writing, day trips, and theatre trips.

5. Respite

Breaks for carers were an important issue. The pressure of the role was stressed and how carers struggled just to keep up that they had little time to focus on their own needs. Comparisons were made between looking after people with physical health conditions and those with mental health conditions to emphasize the added burden mental health carers faced, and consequently the importance of adequate respite.

6. Culturally competent services

Cultural competence was a prominent cross-cutting theme that was interwoven with all the other themes such as **stigma**; **seeking help; support mechanisms** where the effectiveness of

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support is enhanced if the support service had an understanding of the carer's cultural values and behaviours; & **respite** where BME carers were seen as losing out on respite benefits because they were outside of the influential social networks, were less knowledgeable about how to access information and how to effectively navigate the system.

7. *Expectations*

Carers were invited to describe what a good mental health service for them would look like. Prominent among the services and design features they expressed a desire to have were day centres, meaningful consultation on service commissioning and delivery, pro-active information-sharing and guidance, a more user and carer-responsive approach and less emphasis on medical (i.e. drug) treatment and hospitalisation.

"We've taken away what was important to the service user without actually engaging them in the consultation processes, and if you ask them what they want; they need centres, they need somewhere to go, somewhere to talk. Not the hospital, because often going to the hospital means having to be an inpatient of the hospital and that's not where the service user wants. Not professionals per se that I don't make judgements for and then decide what's good for them and put them away; but independent people like myself who are not particularly qualified but have the tee shirt, been there, done that, know what it's like to be a carer; can identify what it's like to be a service user, because you've cared for one yourself, you know where they're coming from, you realise when they're getting ill and you realise when they are just lonely and distressed or frustrated, and that they're crying out for help."

Service providers

Interviews with statutory and voluntary sector service providers were used to discuss pre-identified service issues and, crucially, explore provider perspectives on the themes emerging from the other two stakeholder groups. Informants' responses were grouped under four overarching themes:

1. Attitudes to mental illness
2. Service responsiveness
3. Changing health seeking behaviour
4. Service cuts and capacity
5. Service gaps

1. *Attitudes to mental illness*

"*It is more respectable to say I have an alcohol or drug problem, than to say I am schizophrenic."*

Informants observed that in many parts of society, unlike mental illness, attitudes to drunken behaviour and drug use were increasingly tolerant, with such behaviours broadly accepted and/or excused. Nevertheless, service providers generally held slightly more positive views to users and carers about improvement in societal and family attitudes regarding mental illness. It was further suggested that there may be variations in attitudes depending on the age group affected and the type of mental illness.

2. *Service responsiveness*

The interviews identified four approaches services employed to address the needs of service users and carers: responding to policy guidance, feedback and complaints procedures, different ways of working, and fostering partnership working. Training and education underpinned all four approaches.

Responding to policy guidance

Statutory providers talked about a number of strategies that were recently established to deliver a more responsive and patient-centred service. *Staff training, openness* and *honesty* were frequently mentioned terms, reflecting the language of key NHS policy guidance: *Being open* and *Duty of candour*. The Francis report[132] was also mentioned.

Feedback and complaints procedures

Alongside implementing the guidance, statutory providers described other forms of responding to users' complaints, typically by establishing a feedback and complaints system, usually with a designated complaint's officer that users' could access by phone, email or directly visiting the service. The process was stepped so that complaints could be escalated if not satisfactorily resolved informally or at lower levels. They also mentioned running patient and carer surveys at intervals to obtain feedback on the services.

Different ways of working

Service providers mentioned that they were beginning to explore non-traditional forms of service delivery as a way of improving engagement and uptake of services by users. An example from a GP surgery described how the practice was taking interventions outside the walls of the surgery (Zumba classes for the elderly in a nearby park).

Fostering partnership working

This approach was well illustrated in the work of the IAPT service where it was used to enhance access to BME groups. An informant observed:

"We also work very closely with various key organisations in our area. So, erm, for example, we've got a very high Tamil population, erm, in Merton. Erm, we've also got a very large Polish population in Merton; and with their key organisations. For example we have a Shree Ghanapathy temple in Wimbledon, and we work very closely with them, we run depression groups directly in their premises. We also work with the Polish Families Association population in Colliers Wood, and we are trying to..., we are aware that that is a very under-represented population in the area, despite that we've got a very large population there. They don't make use of the services that we have to offer as much as they ought to do, and this is something that we are currently looking at."

Another informant highlighted collaborations between primary care and the voluntary sector, citing an example of several voluntary sector providers using surgery settings to deliver activities.

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[132] The Francis report describes the findings of an inquiry that had been set up to examine the commissioning, supervisory and regulatory organisations in relation to their monitoring role at Mid Staffordshire NHS Foundation Trust between January 2005 and March 2009. The Inquiry looked at why the serious problems at the Trust were not identified and acted on sooner, to identify important lessons to be learnt for the future of patient care. http://www.midstaffspublicinquiry.com/home

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3. *Changing health seeking behaviour*

From a provider perspective, the IAPT service was a key mechanism for encouraging earlier engagement with the mental health service. It was favourably viewed by service users for its ease of access and non-drug approaches to treatment, and the service provider further highlighted the different ways the service worked to improve access especially for BME people and ensure that service users presented early. These include pro-active education and training for GPs and practice managers to alert them to the presenting complaints that might signal mental distress.

4. *Service cuts and capacity*

There was a common view that the demand for mental health services would increase, given both the profile of the local population and the wider economic pressures and cost-cutting drive. Voluntary sector providers were especially concerned that cuts in services and the lack of adequate options would have adverse impacts on service users.

5. *Service gaps*

Providers were asked what they would like to see included in the current services being delivered. Many responded by identifying a need for better integration of services across domains of care. They further recognised that this would require closer partnership working.

The table below summarises the gaps identified by service providers.

Table 20: Gaps identified by service providers

Statutory sector providers	Voluntary/community providers
• Integration between primary care and community services • Improved partnership working with voluntary sector to help deliver services in community settings. • Specialist liaison psychiatry for older adults (rather than the current generic system). • Targeting low referral GP practices	• More holistic approaches that emphasise all aspects of care, not just the medical. • Better coordination of services and collaboration with the statutory sector. • Effective voluntary sector representation on commissioning groups. • Targeted services for BME groups • Strengthening early interventions (i.e. for schools & young people). • Peer volunteering • improve housing support

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Adult Mental Health services in Merton

How services are structured in Merton

South West London and St George's Mental Health NHS Trust

The local mental health trust for Merton is the South West London and St George's Mental Health Trust. The Trust has its main in-patient base at Springfield Psychiatric Hospital in Tooting, with local community mental health services based at The Wilson Hospital, and a community 'spoke' also provided in the west of the Borough. The Wilson Hospital site is temporary and due for redevelopment.

The demand for in-patient beds for working age adults will normally vary within a range of 20-27 beds, and this is normally absorbed within Jupiter, the dedicated Merton ward. The demand for older person's beds is significantly less and is absorbed within Crocus, which also accommodates in-patient demand from Wandsworth and Sutton.

Figure 98: Journey of a service user from referral to the Mental Health Trust to return to primary care
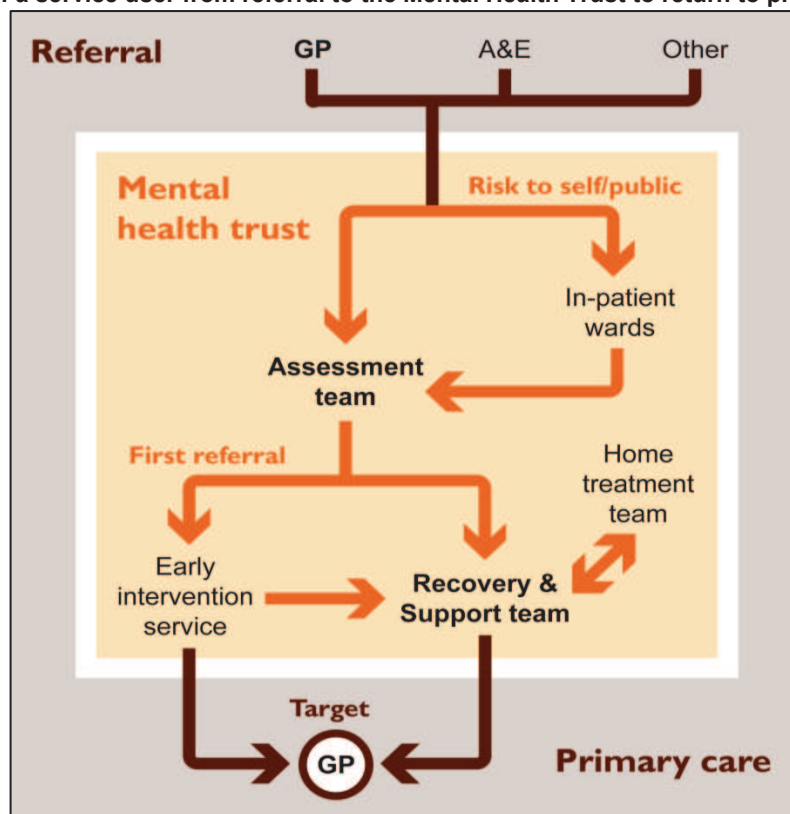
The care pathway for working age adults being referred to secondary care in Merton incorporates a single Assessment service for all referrals; with three locality based Recovery and Support Teams, and Early Intervention Service, a Personality Disorder Service and a Crisis and Home Treatment Team in place for those people with more complex needs (see figure above).

When someone is referred to the Trust their first contact is with the Assessment Team, who assesses their needs and either advises the GP about their treatment and physical care, or signposts to the appropriate secondary care service. Referrals to the Mental Health Trust could come through GPs, the in-patient wards or other health services like Accident and Emergency.

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People are admitted to the in-patient wards where their needs/risk require 24/7 care, and can be detained under the Mental Health Act if they present a risk to themselves or the public that could not be managed in the community. As soon as patients are admitted, the Trust begins to consider their discharge and the services they can use after discharge from the ward. Information is given to patients and services signposted where possible.

If someone experiences a psychosis for the first time, they will receive intensive treatment from the Early Intervention Service using a psycho-social model for a 2-3 year period to help the service user to best manage their illness and to prevent their illness progressing further. Service users will then either be referred onto the Recovery & Support team or, if they have stabilised, back to their GP.

IAPT (improved Access to Psychological Therapies) service
In 2009 NHS Sutton & Merton (which was a combined Primary Care Trust) established a local IAPT service in line with the IAPT programme's design principles and operating standards. The current provider of this IAPT service is SWLStG Mental Health NHS Trust.

S&M IAPT provide assessment and treatment for the common mental health problems such as depression, generalised anxiety disorder, panic disorder, social phobia, obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD), bulimia nervosa, and other diagnosable mental health disorders defined by NICE (the National Institute for Health and Clinical Excellence). They also provide a service to people with long term medical conditions and depression and/or anxiety and people experiencing difficulties retaining or returning to employment.

The service applies a stepped care model of care which provides each client with the level of treatment that is appropriate to their current needs.

Initial triage assessment which is often carried out over the telephone, this is a structured interview specifically designed to identify current mental health problems. A further assessment may be required in some cases. The following may then be offered:
- Signposted to a service that more closely matches their needs
- Psycho-educational group programme (LI)
- Guided CBT or computerised CBT (LI)
- CBT (group / individual) (HI)
- Dynamic Interpersonal Therapy (HI)
- Referred on to a specialist service

The Sutton & Merton IAPT team consist of 40 WTE psychological therapists, made up of 25 wte high intensity workers and 15 wte low intensity workers (psychological well-being practitioners).

The service reports locally on IAPT KPIs, access data and patient experience data. Two KPIs are included in Merton CCGs operating plan:
- The local 'enter treatment' target is 13% (6079 people seen) for 2013-14, leading to the 15% National target in 2015
- The local recovery rate target is 45% for 2013-14, leading to the 50% National target in 2015

Although S&M IAPT do work in partnership with local organisations to increase access for their diverse communities (e.g. Age UK, carers organisations, Tamil and Polish community groups)

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more needs to be done with BME communities to ensure equity of access. BME communities make up 35% of Merton's total population. Recent data (Q2 13-14) states that 25% of Merton referrals are from BME communities.

Recovery & Support Team

The three Recovery & Support teams provide on-going care for people with SMI (Severe Mental Illnesses) in Merton. The team is mainly staffed by Community Psychiatric Nurses, Social Workers, doctors, psychologists, employment workers and Recovery & Support workers (RSWs).

The nurses, social workers and occupational therapists undertake the role of the Care Co-ordinators and establish an overview of the service user's care; ensuring appropriate linkages are made into other services such as supported housing or social services.

Care Co-ordinators will work with service users on enabling recovery and agreed outcomes within agreed timescales and specific goals for their service users. The intention is to ensure people's independence wherever possible and for them to be supported in the least restrictive manner consequent to their needs. Care Co-ordinators see their service users about once every two weeks on average although this will vary with service user need. Recovery & Support Workers (RSWs) will undertake many of the practical tasks in delivering care under the supervision of the care coordinator, and may see service users more frequently. . Most service users are seen in their homes but they may also come to the team base, especially if they need blood tests for their medication.

The Mental Health Trust tries to maintain consistency in providing care workers for service users but due to the impact of people changing jobs and restructuring within the organisation, this is not always possible.

Recovery College

The South West London Recovery College, operated by the Mental Health Trust, runs self-management courses to give service users to develop the skills to manage their own recovery. Carers and staff can also attend the courses. The Recovery College approach is to help people recognise and develop their personal resourcefulness and the message is 'hope' – that service users can recover a meaningful life.

There are short introductory courses (half a day) and longer term ones (3-10 weeks, half day weekly sessions), e.g. about spirituality and five ways to wellbeing. There are also more practical courses such as an introduction to the internet.

The college runs on a hub and spoke model with courses delivered both at Springfield Hospital as the hub and at a variety of places within the community - libraries, adult education and community halls across south west London. The community venue in Merton is Vestry Hall in Mitcham.

Merton Adult Substance Misuse Services

London Borough of Merton commissions The Mental Health Trust and Merton Adult Crack Service (MACS), a Voluntary Sector organisation to provide structured treatment for adults (over 18s) presenting with substance misuse problems. The services are located at The Wilson hospital and Wimbledon Chase and provide a range of interventions including full comprehensive assessment, prescribing and psycho-social interventions including structured Group-Therapy. The services also provide aftercare, work with the Criminal Justice System, and referral into in-patient detoxification,

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and residential rehabilitation services where required/appropriate. Access to "recovery capital (ETE and Housing) may also be achieved through these services.

Drop-in for Merton residents with mental ill health
There are no LBM commissioned day centres in Merton for residents with mental ill health. LBM has commissioned Imagine Merton to provide multiple drop-ins- one drop-in is located in Wimbledon and the other in Mitcham. The Mitcham drop-in is specifically for BME groups and the remit of these drop-ins is to offer support in terms of employment, advocacy, peer support and to undertake needs assessments of clients. The service works closely with the IAPT team and CMH in Merton.

How care is structured

Care Plan Approach (CPA)
Each service user normally has a Care Plan Approach (CPA) Review every six months. The care coordinator will organize this meeting and involve the service user, carer (if appropriate) and any other professionals or agencies involved in the care to review the care plan in a collaborative manner, and agree the future care plan, or indeed, discharge.

Each service user on CPA also has a personalised care plan that should include identifying and achieving their recovery goals. These goals are agreed with the service users – they are about moving their life forward and building the life they want to live

Care clusters and care packages
New mental health care clusters and care packages were introduced in April 2013, as a process of bringing greater definition to care groups, and payment for the inputs delivered to these. but have not yet been agreed at a national level as the model for contracting. The care clusters have yet to be fully implemented nationally, are divided between three super clusters – psychosis, non-psychosis and organic. Care packages are written descriptions of the care that service users in each of the care clusters will receive.

The care packages include information about the amount of time spent by different Mental Health Trust staff with the service user, therapeutic services that should be offered (e.g. "physical health monitoring and intervention") and enabling services (such as the Recovery College – mentioned above). However, given the individuality of patient need, many patients do not neatly fit the prescribed clusters and their care plans will also vary as a result.

Age affects the type of caseload for mental health services. In older adults there is higher demand for acute services by patients with organic mental health conditions. These include conditions such as dementia and Alzheimer's. In working age adults there is a high demand for acute services by patients with schizophrenia or mood disorders.

Local services in Merton to support dementia care

NHS
For medical diagnosis, treatment and management of dementia the NHS provides services through primary care (GPs) and secondary/ tertiary/ specialised services through the South West London and St. George's Mental Health NHS Trust.

The Mental Health Trust also provides community support through a Community Mental Health Team, which assesses and treats people (normally, though not exclusively over 75) with both dementia and functional mental illnesses such as depression, schizophrenia or bipolar disorder. The service also operates:

- Intensive Home Treatment Service to support people in their own homes over a crisis, as an alternative to hospital admission
- Challenging Behaviour Service which works with nursing homes to help them review and deliver care to residents with challenging behaviour using cognitive approaches, and minimizing the need for psychotropic medication or admission to hospital
- A Memory Clinic at Clare House, St George's Hospital, which provides an initial assessment and diagnosis of dementia, and review, in partnership with the Alzheimer's Society

Merton Council Social care
The Merton Council provides a variety of services for people with mild to moderate dementia, who need opportunities for additional social support and contact, and respite for carers- these needs are predominantly met through non-specialist day centres.

Merton Dementia Hub, Mitcham
The main dementia service commissioned in 2013 by Merton Council is the Merton Dementia Hub situated in Mitcham with additional outreach services held across the borough by the Alzheimer's Society. The Alzheimer's Society works in partnership with the Merton older peoples CMHT (Community Mental health Trust) Memory Clinic. They are available to meet and talk with patients and their carers providing advice and support about how best to live well and strong with dementia. The Alzheimer's Society provides a range of activities and by working in partnership with the Memory Clinic enables everyone to engage into the many activities they provide. The emphasis of the Dementia Hub is very much on early diagnosis improving prognosis promoting a dementia friendly Borough, providing a weekly 'one stop shop' facility through a dedicated team.

The Dementia Hub aims to:
- Raise awareness & understanding
  The information worker raises awareness and promotes the benefits of diagnosis amongst professionals and the local community. This includes presentations to community groups and information provision in community settings such as libraries, supermarkets, local shops and places of worship. Developing volunteer capacity across the borough will enhance this activity, particularly within specific communities.

- Provide Early Diagnosis and support
  The Dementia Adviser service supports individuals to obtain a diagnosis and works with newly diagnosed individuals to identify their specific needs and preferred sources and styles of support. An individual support plan then allows identification and signposting to the most appropriate services. Service users are encouraged to return for further planning support when

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they feel their needs have changed, with the service being accessible to them throughout their dementia journey.

Facilitated peer support was identified through the consultation for the NDSE (National Dementia Strategy for England) as important to many people affected by dementia following a diagnosis and the Hub offers peer support appropriate for people at this stage as well as further on in the dementia journey. Training provided for carers through CrISP (Carers Support and Information programme) sessions helps in understanding the condition, developing coping strategies and knowing sources of support.

- Support Living Well with Dementia
  Both Dementia Adviser Service (DAS) and Dementia Support Workers (DSWs) develop support plans with people and the DSWs continue with those who need more support to achieve their identified outcomes. They give an individualised service, often through home visits, and provide continuity of service by being available as a person's condition progresses and their needs change.

Continuing information and support is provided also through peer support activities such as the Dementia Cafes. These, along with activities like Singing for the Brain, also address the social needs of people with dementia and their carers. They can be an opportunity for both parties to enjoy a more social activity together.

The Hub provides:
Dementia Support Service, which is a service for people with dementia and their carers, providing:
- Information, including a welcome pack with details of local support and services, information sheets, Alzheimer's Society leaflets and our newsletter
- Telephone and email support and home visits if required
- Signposting to other local support services
- Encouragement to become socially active
- Information and support available weekly at St George's Hospital Memory clinic

Peer Support Service
- *Support groups for carers*: Friendly informal meetings where carers can support each other and share experiences, information and advice
- *Younger persons' group*: A group designed specifically for people under 65 with a diagnosis of dementia
- *The Friday Club*: A meeting place for people with dementia, carers and family members to meet in a relaxed atmosphere to get information and support, to talk freely about dementia and enjoy a range of activities

Information Service
Raising awareness and understanding of dementia in the community through talks, presentations, information stands, forums, media articles and access to a library of factsheets, books and DVDs.

Workshops
(CRISP) Carers' Information and Support Programme
A series of workshops for people caring for a family member or friend with dementia.

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Singing for the Brain
A stimulating group activity, for people in the early to moderate stages of dementia and their carers, which can help with general well being and confidence.

Life After Diagnosis (LAD)
Support for people with a new diagnosis of dementia.

Other Dementia services commissioned by the Council are-
Day Centres (Woodlands and Eastways Day Centres) to provide:
- Social support to people with dementia and long-term mental health problems
- Short breaks for carers (respite) for carers
- Information and support to carers

South Thames Crossroads: Provides practical support and respite care to carers
Carers Support Merton: Provides support for Carers

Figure 99 below describes the Merton roadmap of Dementia services.

Figure 99: Roadmap of Merton's Dementia services
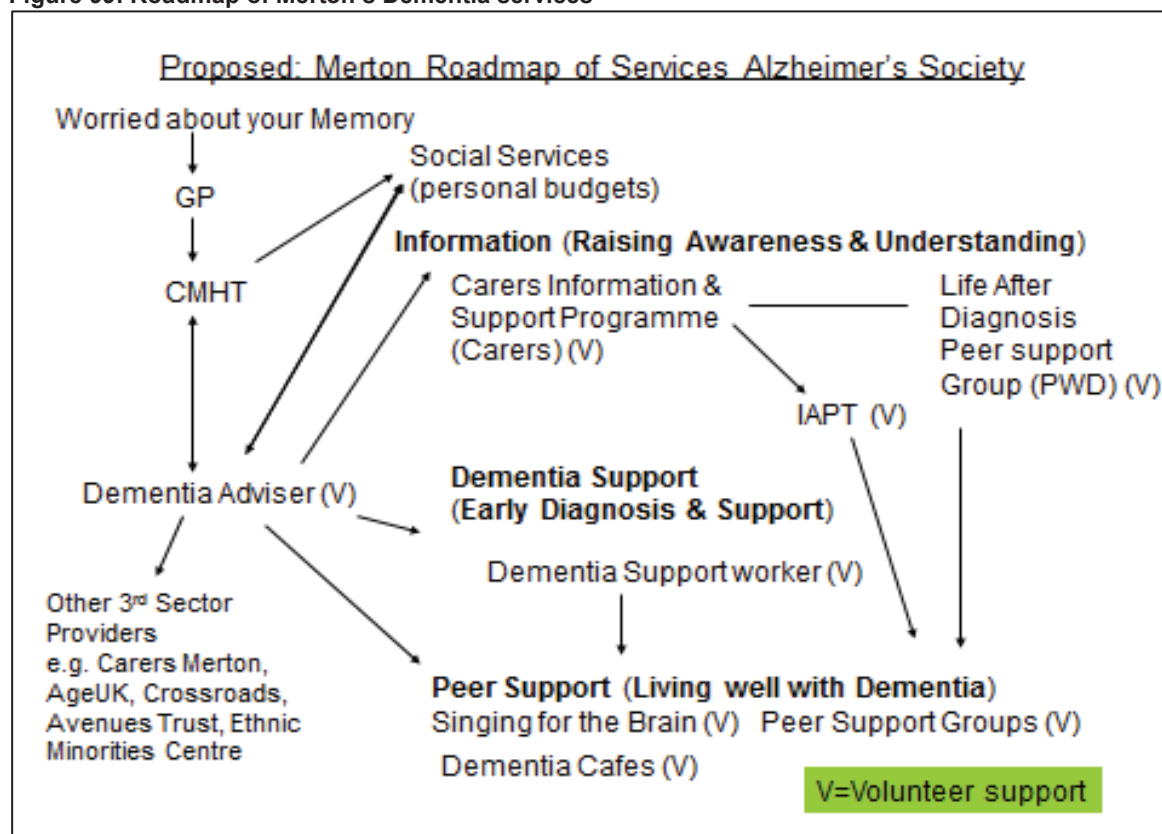
Prevention and support for mental ill-health in the elderly
Community involvement and voluntary action are essential to the quality of life in Merton, and the voluntary and community sector makes a valuable contribution to the borough's economic, environmental and social development. The Merton 'Compact' is a partnership agreement between Merton Council, the Merton CCG and the voluntary and community sector. The 'Compact' is a

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national framework for how councils should work with the voluntary sector. The partnership offers joint services including:

Ageing Well Programme
The Adult Social Care Ageing Well Programme was launched on 30 April 2013. The key features of the programme are:

- Enables people to live for longer in their own homes and delaying or reducing spend on Council funded social care
- Is based on the evidence of triggers that cause people to go into care homes – such as incontinence, dementia, isolation, loss of mobility, and depression/anxiety.
- Is outcomes-focused and takes an asset based approach
- Builds social connectedness - instead of relying on services which keep older people segregated from others, it actively encourages people to mix
- Promotes stronger local neighbourhoods, putting older people in touch with local people and opportunities
- Its effectiveness will be measured by a set of metrics - a combination of inputs by voluntary groups, individuals or objective assessment of "wellbeing" among older people against certain key factors and whether the services are actually having a "preventive" effect
- Cross-borough coverage for outcomes, whether by one organisation or through collaboration between organisations
- Consultations with older people on what they actually want

The services funded by the Ageing Well Programme are:
Age UK Merton – Life after Stroke; continence awareness and support service
Carers Support Merton - Neighbourhood peer support groups/networks; self-financed activities for carers as respite; Carry on caring workshops; emotional support and coaching
Merton & Morden Guild of Social Service - 'Fit for Life' exercise programme; falls prevention programme; opportunities for volunteering
Merton Community Transport - Volunteer community car service
Merton Mencap – 'Evolutions' support service for non-FACs eligible people with autism; activities club and carers community advice service
Merton Vision - Buddying programme, emotional support and counselling, training to use equipment
Volunteer Centre Merton - Supported Volunteering Programme for mental health service users and people with learning, physical or sensory disabilities
Wimbledon Guild of Social Welfare - Community coaching sessions; menu of services; informal drop-in café

Smoking cessation
People with mental health conditions have a higher rates of smoking which contributes to shorter life expectancies.

Local smoking cessation services
A major factor in reducing smoking prevalence is to ensure ready access to Stop Smoking Services and support. The smoking cessation services in Merton are delivered by Hounslow and Richmond Community Healthcare NHS Trust. This is integrated into the LiveWell health improvement programme, resulting in a service that can support smokers to stop and also provide

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support around other health behaviours e.g. increasing physical activity levels to reduce potential weight gain that is sometimes seen by those who stop smoking.
https://www.live-well.org.uk/merton/

Smoking cessation services in SWLStG MH NHS Trust
South West London and St George's Mental Health NHS Trust's (SWLStG) smoking cessation project was established in 2010 to deliver the CQUIN1 local goal 2010/11 Indicators (detailed in an earlier section). The ultimate aim of the project, and the intention of the CQUIN targets, was to improve access to, and the quality of, smoking cessation support for service users with a view to improving their physical health. Over the past three years, the Trust has built up an in-house smoking cessation service for its service users who are now easily able to access the help and support they need if they choose to stop smoking or even just reduce the number of cigarettes they smoke each day.

As of 01/04/2014 the CQUIN on smoking cessation will cease and it is expected that the SWLStG MHT will have integrated the service into the overall provision for its service users.

Types of housing for people with mental health conditions
A mental health condition does not necessarily mean that a person will require housing services. A lot of people continue to function sufficiently well, so that it does not come to the attention of others and they carry on with their lives, work and maintain accommodation. For other people a mental health condition can have a devastating effect on their lives and impact on all aspects particularly employment, finances and housing. People may lose their homes as a result of illness, but recover well and have sufficient skills to manage anew tenancy and live independently or they may not make such a quick recovery and require different accommodation to what they had previously

If a person with a mental illness becomes homeless they may be considered to be vulnerable and therefore have a priority need for accommodation in accordance with the Housing Act 1996 Part 7 (as amended by the Homelessness Act 2002). In reaching a decision as to whether a person with a mental illness is in priority need, regard to advice from medical professionals, social care or current providers of care and support is considered and close working between the housing service and mental health agencies is crucial

The Council also takes a proactive approach to the prevention of homelessness and offers a range of options to resolve a persons housing needs. This includes rent rescue, advice on security of tenure, defending possession proceedings , increasing housing supply by working closely with private sector Landlords, improving housing conditions through advice and enforcement, and welfare and money advice

In situations where the Council accepts that a person with a mental illness is owed a housing duty because they are unintentionally homeless, in priority need, eligible for assistance and have a local connection with the borough, they will be provided with temporary accommodation until a permanent housing solution can be found. This might be an offer of a social housing tenancy through a registered provider (Housing Association) or a private sector Landlord.

Alternatively assistance may be required to help a person with a mental health condition to live in the community and a range of supported accommodation exists in Merton run by specialist housing

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and support providers. These dwellings can be accessed through a supported housing panel set up to assess and process referrals into these services

These include
- Ability Housing 24 self contained flats in the Mitcham area
- Family Mosaic 8 bedsits in Colliers Woods
- Shared Lives 47 units at various locations

As stated previously many people with mental health conditions live in ordinary accommodation, that they own or rent and they continue to do this even if there are times when they become unwell. Where people live is, based on their preferences, needs and an assessment of what support is required to help them keep safe and well.

Table 21: Details of housing schemes funded through London Borough of Merton

Provider	Scheme Name	Short Term Or Long Term	Number of Units
Ability	Layton House	Short Term Housing Related Support	23
Ability	Merton Move-on	Long Term Housing Related Support	41
Ability	Malcolm Road	Long Term Housing Related Support: Very long term. (The Mental Health Accommodation Panel rarely makes placements here).	4
Casa Support	Norfolk Rd	Long Term Housing Related Support: The service users in this scheme invariably occupy the accommodation under permanent residence. (The Mental Health Accommodation Panel does not ordinarily make placements here).	2
Casa Support	Grenfell Rd	Long Term Housing Related Support: The service users in this scheme invariably occupy the accommodation under permanent residence. (The Mental Health Accommodation Panel does not ordinarily make placements here).	2
Comfort Care	ex HST	Long Term Housing Related Support Now spot purchase. (The Mental Health Accommodation Panel no longer make placements here).	10
Family Mosaic	Waldemar Rd	Long Term Housing Related Support	8
Metro Support Trust	Quicks and Latimer	Long Term Housing Related Support: The service users in this scheme invariably occupy the accommodation under permanent residence. (The	3

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		Mental Health Accommodation Panel does not ordinarily make placements here).	

In terms of 'day resources', London Borough of Merton funds the following:

Table 22: Day resources funded by London Borough of Merton

Provider	Scheme Name	Price	Units
Rethink	Independent Mental Health Advocacy	£28,000 per annum	Not Specified
Voiceability	Independent Mental Capacity Advocacy	IMCA @ £20,000 per annum DoLS @ £20 per hour up to 200 hours and £17.50 per hour above 200 hours.	Not Specified
Imagine	General Advocacy & Support for Mental Health Clients	£210,000 per annum	Not Specified
Alzheimer's Society	Dementia Hub (wide range of services including outreach support)	£231,554 per annum	Not Specified

The care programme approach (CPA) was introduced in 1990 (reviewed in 2008) to provide a framework for effective mental health care for people with severe mental health problems.

Its four main elements are:

- Systematic arrangements for assessing the health and social needs of people accepted into specialist mental health services

- The formation of a care plan which identifies the health and social care required from a variety of providers

- The appointment of a (care co-ordinator) to keep in close touch with the service user and to monitor and co-ordinate care reviews and where necessary agree changes to the care plan.

- Reviews and where necessary, agree changes to the care plan

The CPA meeting should include the individual and all relevant people contributing to meeting their needs e.g. carer, care co-ordinator, housing provider, resettlement worker.

If a change to accommodation is identified in a CPA meeting, the care co-ordinator is pivotal to the process of helping the person access other accommodation. They make a referral to the Housing Needs Service for advice and assistance on gaining appropriate accommodation. If a person with a mental health condition is so severe that the person cannot be housed in mainstream/ supported

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housing, a health-funded placement is required. These placements are mostly funded through the NHS Merton Clinical Commissioning Group (MCCG).

Registered, residential and nursing home placements are "purchased" usually through Adult Social Care and include:

- A local step down facility, Norfolk Lodge- This is an 11 bedded unit for male patients. The unit provides step down after inpatient stays where the person requires further rehabilitation before moving to supported or independent accommodation and also where people are homeless and have no other arranged accommodation and will require support to access the right next step
- Burntwood Villas- a 15 bedded facility across three houses which provides step down for males and females with complex needs and challenging behaviour

Additionally the CCG procures and funds other health needs level mental health placements for those who require a high level of support. NHS England also funds a small number of high level secure placements.

There is also an annual quota of rehousing in general needs housing association stock for people with a mental health condition. The Community care act 1990 puts a duty on the council to consider and where possible meet accommodation needs as part of any care package.

Mental health nominations are to assist a small number of people who are not eligible for rehousing through any other route. Care Managers can nominate persons who require accommodation as part of their care package or who have other general needs where:

- Move on from supported accommodation is needed
- A person is living with relatives and needs independent housing and where other routes to appropriate accommodation have been explored and exhausted

What does the literature say?

Mental health promotion and prevention

Health systems aim to improve health and health-related well-being, but are always constrained by the resources available to them. They also need to be aware of the resources available in adjacent systems which can have such an impact on health, such as housing, employment and education. Careful choices therefore have to be made about how to utilise what is available. One immediate corollary is to ask whether investment in the prevention of mental health needs and the promotion of mental wellbeing might represent a good use of available resources. An economic evaluation was undertaken by London School of Economics and Political Sciences on behalf of the Department of Health in 2011 that modelled different interventions[133].

Health visiting and reducing post-natal depression

Context

Moderate to severe post-natal depression affects around one in eight women in the early months following childbirth[134] [135]. The condition has an adverse impact on the mother-infant relationship, a woman's quality of life, and the behavioural, emotional and intellectual development of children; it also increases the likelihood that fathers become depressed after birth[136]. The National Institute for Health and Clinical Excellence (NICE) recommends the screening of post-natal depression as part of routine care, and the use of psychosocial interventions and psychological therapy for women depending on the severity of depressive symptoms[137]. However, research suggests that in practice a significant proportion of women with post-natal depression are missed in primary care[138] [139]. The economic costs of post-natal depression are conservatively estimated at £45m for England and Wales[140].

Intervention

Health visitors are well placed to identify mothers suffering from postnatal depression and to provide preventative screening and early interventions. A range of UK trials with interventions provided by health visitors have been positive: women were more likely to recover fully after 3 months[141]; targeted ante-natal intervention with high-risk groups was shown to reduce the average time mothers spent in a depressed state; and a combination of screening and psychologically

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[133] Knapp M, McDaid D, Parsonage M; Mental Health Promotion and Prevention: The Economic Case; Department of Health, January 2011

[134] Petrou S, Cooper P, Murray L, Davidson LL (2006) Cost-effectiveness of a preventive counselling and support package for postnatal depression. International Journal of Technology Assessment in Health Care 22:443–453.

[135] O'Hara MW, Swain AM (1996) Rates and risk of postpartum depression: a meta-analysis. International Review of Psychiatry 8:37–54.

[136] Paulson JF, Bazemore SD (2010) Prenatal and postpartum depression in fathers and its association with maternal depression: a meta-analysis. Journal of the American Medical Association 303(19):1961-1969.

[137] NICE (2007) Antenatal and postnatal mental health: clinical management and service guideline, Clinical Guideline 45, developed by the National Collaborating Centre for Mental Health, London.

[138] Kessler D, Bennewith O, Lewis G, Sharp D (2002) Detection of depression and anxiety in primary care: follow up study. British Medical Journal 325:1016.

[139] Murray L, Woolgar M, Cooper P (2004) Detection and treatment of postpartum depression. Community Practitioner 77:13–17.

[140] Derived from Petrou S, Cooper P, Murray P, Davidson LL (2002) Economic costs of post-natal depression in a high-risk British cohort. British Journal of Psychiatry 181:505–512.

[141] Holden JM, Sagovsky JL, Cox JL (1989) Counselling in a general practice setting: controlled study of health visitor intervention in treatment of postnatal depression. British Medical Journal 298:223–226.

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informed sessions with health visitors was clinically effective 6 and 12 months after childbirth[142]. The biggest direct costs of the interventions were associated with training (estimated at £1,400 per health visitor), plus the additional time spent by health visitors with mothers for screening and counselling.

Impact

When quality of life benefits to women are incorporated, the health visiting intervention provides a positive net benefit with an incremental cost-effectiveness ratio (ICER) of around £4,500 per quality-adjusted life year (QALY).

Key points

- Findings of a significant improvement in quality of life for mothers and of cost-effectiveness of the health visiting intervention mirror those of Morrell[143]. Our model suggests wider application of this approach.
- On a one-year horizon, health visiting interventions to reduce post-natal depression do not reduce net costs, but do increase productivity for those who return to work.
- The intervention may produce cost savings in the medium- and long-term but this possibility remains to be evaluated.

Early detection for psychosis

Context

The first symptoms of psychosis typically present in the late teenage and early adult years. It is estimated that each year in England 15,763 people exhibit early (prodromal) symptoms before the onset of full psychosis[144]. However, early detection services are not routinely provided and provision is currently very limited. Progression of the disease is associated with higher costs to public services (including health, social care, and criminal justice), lost employment, and greatly diminished quality of life for the patient and their family. A 2008 analysis estimated the average annual direct costs per average patient with schizophrenia at £10,605, and total costs (including lost employment) at £19,078. The corresponding costs for bipolar disorder and related conditions were £1,424 and £4,568. Total costs for these conditions combined were estimated at £3.9bn for services and £9.2bn for services and lost employment.

Intervention

Early detection services aim to identify the early symptoms of psychosis, reduce the risk of transition to full psychosis and shorten the duration of untreated psychosis for those who do develop it. Such services include the provision of sessions of cognitive behavioural therapy, psychotropic medication, and contact with psychiatrists; this contrasts with treatment as usual which typically consists of GP and counsellor contacts. There is some evidence that such services can reduce the rate of transition to full psychosis. One year of early detection intervention has been estimated to cost £2,948 (2008/9 prices) per patient, compared with £743 for standard care[145]. The

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[142] Morrell CJ, Warner R, Slade P et al (2009) Psychological interventions for postnatal depression: cluster randomised trial and economic evaluation: the PONDER trial. Health Technology Assessment 13(30).

[143] Morrell CJ, Warner R, Slade P et al (2009) Psychological interventions for postnatal depression: cluster randomised trial and economic evaluation: the PONDER trial. Health Technology Assessment 13(30).

[144] McCrone P, Dhanasiri S, Patel A, Knapp M, Lawton-Smith S (2008) Paying the Price: the Cost of Mental Health Care in England to 2026. London: King's Fund.

[145] Valmaggia LR, McCrone P, Knapp M et al (2009) Economic impact of early intervention in people at high risk of psychosis. Psychological Medicine 39:1617–1626.

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costs of community mental health care and inpatient admissions (formal and informal) were included.

Impact

The savings associated with early detection are, in the model, entirely driven by reduced numbers of people making a transition to psychosis. The assumed 'success rate' in the model is 15 percentage points (20% compared to 35%). If the difference was only 5 percentage points, the annual saving in years 2–5 would fall to around £16m, but would increase to around £79m if the success rate were 25 percentage points. Using these two extreme scenarios, the annual savings over years 6–10 are approximately £14m and £68m, respectively. The assumed difference of 15 percentage points is in fact similar to the impact reported elsewhere[146] [147] [148].

Key points
- Early detection services for patients with prodromal symptoms of schizophrenia are cost-saving overall, and also cost-saving from the perspective of the NHS from year 2.
- Further evidence is needed on the impact of different models of early detection services.

Early intervention for psychosis

Context

The number of young people each year aged 15–35 who experience a first episode of psychosis is estimated at 6,900 in England. Psychosis related to schizophrenia is associated with higher costs to public services (including health, social care, and criminal justice), lost employment, and greatly diminished quality of life for the individual with the illness and their family. Estimates of the costs of schizophrenia and bipolar disorder are given in the report on early detection for psychosis (see previous model).

Intervention

Early intervention teams aim to reduce relapse and readmission rates for patients who have suffered a first episode of psychosis, and to improve their chances of returning to employment, education or training, and more generally their future quality of life. Such intervention involves a multidisciplinary team that could include a range of professionals (psychiatrists, psychologists, occupational therapists, community support workers, social workers, vocational workers). The emphasis is on an assertive approach to maintaining contact with the patient and on encouraging a return to normal vocational pursuits. In the UK evidence has shown that early intervention can reduce relapse and readmission to hospital and to improve quality of life[149] [150].

The annual direct cost per patient of this type of service in terms of input from an early intervention team plus other community psychiatric services and inpatient care has been estimated at £10,927

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[146] McGlashan T, Zipursky R, Perkins D et al (2006) Randomized, double-blind trial of olanzapine versus placebo in patients prodromally symptomatic for psychosis. American Journal of Psychiatry 163:790–799.
[147] McGorry P, Yung A, Phillips L et al (2002) Randomized controlled trial of interventions designed to reduce the risk of progression to first-episode psychosis in a clinical sample with subthreshold symptoms. Archives of General Psychiatry 59:921–928.
[148] Morrison A, French P, Walford L, et al (2004) Cognitive therapy for the prevention of psychosis in people at ultra-high risk: randomised controlled trial. British Journal of Psychiatry 185:291–297.
[149] Craig TKJ, Garety P, Power P et al (2004) The Lambeth Early Onset (LEO) Team: randomised controlled trial of the effectiveness of specialised care for early psychosis. British Medical Journal 329:1067–1070.
[150] Garety PA, Craig TKJ, Dunn G et al (2006) Specialised care for early psychosis: symptoms, social functioning, and patient satisfaction: randomised controlled trial. British Journal of Psychiatry 188:37–45.

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at 2008/09 prices, considerably less than that of standard care at £16,704[151]. The reduction in overall service costs is primarily due to the lower demand for inpatient care when specialist early intervention is provided; the first year of the actual early intervention team's input (including contacts with psychiatrists, social workers and community mental health nurses) is estimated to cost £2,282 per patient, which is higher than the £1,284 for standard care.

Impact

The model looks at whether investments in specialist early intervention services can be cost-saving in terms of use of health care services, criminal justice services, suicide, homicide and lost employment. The target group is young people aged 15 to 35 years old in the general population experiencing a first episode of psychosis.

Table 20 shows the impact on annual costs/savings of full coverage by early intervention services of a one-year cohort of patients, compared to standard care. Savings are reduced after three years (when discharge to standard care is assumed to occur) because it is conservatively assumed that, from then on, the inpatient admission rates for early intervention services are the same as for standard care.

Table 23: Impact of early intervention services on annual costs/pay-offs, based on a one-year cohort of patients (2008/09 prices)

	Year 1	Years 2–5	Year 6–10
Per person	(£)	(£)	(£)
Services	-5,777	-2,408	-60
Productivity losses		-2,052	-1,912
Intangibles (negative impact on quality of life)		-314	-628
Total	-5,777	-4,774	-2,600
By sector	(£m)	(£m)	(£m)
NHS	-39.1	-16.0	0
Other public sector	-0.8	-0.6	-0.4
Productivity losses	0	-14.2	-13.2
Intangible	0	-2.2	-4.3
Total	-39.9	-32.9	-17.9

Key points

- The expansion of the coverage of early intervention services to all patients experiencing a first episode of psychosis is cost-saving overall, and also cost-saving from the perspective of the NHS alone, from year 1.

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[151] McCrone P, Knapp M, Dhanasiri S (2009) Economic impact of services for first episode psychosis: a decision model approach. Early Intervention in Psychiatry 3:266–273.

- Savings are estimated to decrease over time because there is no current evidence to suggest that reductions in inpatient stays are maintained when patients are discharged from the early intervention team.

Screening and brief intervention in primary care for alcohol misuse

Context

In 2010 it was estimated that 6.6 million adults in England consumed alcohol at hazardous levels and 2.3 million at harmful levels[152]. Hazardous drinking is defined as weekly alcohol consumption of 21–50 and 14–35 units for men and women, respectively, and harmful drinking 50 and 35 units, respectively.

The total costs of alcohol misuse in England, based on inflation-adjusted Department of Health data[153], can be estimated in 2009/10 prices at around £23.1bn, comprising: £3.0bn in NHS costs, £7.2bn in output losses and £12.9bn from the costs of crime. In practice, these figures understate the costs falling on the NHS as more than £1bn allocated to crime covers medical treatment for injuries suffered by the victims of alcohol-related violence. Harmful alcohol misuse is disproportionately costly: analysis for this study estimates that the overall average annual costs of a harmful drinker are around 3.4 times that of a hazardous drinker.

Intervention

Effective strategies to reduce alcohol-related harm require a combination of measures, covering both population-level approaches (such as price increases and advertising controls) and interventions aimed at individuals [154]. In the latter category, evidence indicates that brief interventions in primary care settings achieve an average 12.3% reduction in alcohol consumption per individual[155]. However, this is a short-term effect and evidence about its duration is less clear cut.

An inexpensive intervention in primary care combines universal screening by GPs of all patients, followed by a 5-minute advice session for those who screen positive. The total cost of the intervention averaged over all those screened is £17.41 per head in 2009/10 prices[156].

Impact

Given the £17.41 cost of the intervention, the results demonstrate that savings after seven years exceed costs by a factor of nearly 12 to 1 (Table 21). Purely in terms of public expenditure, the intervention offers good value for money over the same period as combined savings in the NHS and criminal justice system exceed the costs of the intervention by a factor of more than 3 to 1. Estimated savings in the NHS alone exceed costs by more than 2 to 1.

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[152] Riley C (2010) The Cost of Alcohol Misuse. Unpublished report prepared for the Department of Health.

[153] Department of Health (2008) Safe, Sensible, Social – Consultation on Further Action: Impact Assessments. London: Department of Health.

[154] National Institute for Health and Clinical Excellence (2010) Alcohol Use Disorders: Preventing the Development of Hazardous and Harmful Drinking. London: NICE.

[155] Kaner E, Dickinson H, Beyer F et al (2007) Effectiveness of brief alcohol interventions in primary care populations. Cochrane Database of Systematic Reviews 2007, Issue 2.

[156] Purshouse R, Brennan A, Latimer N et al (2009) Modelling to Assess the Effectiveness and Cost-Effectiveness of Public Health Related Strategies and Interventions to Reduce Alcohol Attributable Harm in England. Report to the NICE Public Health Development Group.

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Table 24: Cost/pay-offs per head for screening and brief advice based on a representative sample of 1,000 adults attending their next GP consultation (2009/10 prices)

	Year 1 (£)	Years 2–5 (£)	Years 6–7 (£)	Total (£)
NHS	-10.55	-24.61	-3.91	-39.07
Crime	-28.49	-66.02	-10.49	-105.00
Productivity losses	-16.20	-38.24	-6.05	-60.48
Total	-55.23	-128.87	-20.45	-204.55

Key points
- There is a robust economic case: low-cost interventions in primary care offer good value for money in reducing alcohol-related harm.
- The main constraint on national implementation is one of scale; options to consider include targeted approaches (e.g. focusing on young males), screening people only when they change GP rather than at next consultation, or using practice nurses rather than GPs to provide the screening and/or follow-up advice.

Workplace screening for depression and anxiety disorders

Context
Substantial potential economic costs arise for employers from productivity losses due to depression and anxiety in the workforce. The main costs occur due to staff absenteeism and presenteeism (lost productivity while at work). From the perspective of the public purse, failure to intervene also risks higher future health and social care costs.

If these conditions are not treated, additional costs are also likely to arise from related physical health problems. In the longer term, wider costs may also be incurred, such as from acute care, the impact on family members and premature death. There may also be additional recruitment and training costs for employers if their employees permanently withdraw from the workforce.

Intervention
Workplace-based enhanced depression care consists of completion by employees of a screening questionnaire, followed by care management for those found to be suffering from, or at risk of developing, depression and/or anxiety disorders. Those identified as being at risk of depression or anxiety disorders are offered a course of cognitive behavioural therapy (CBT) delivered in six sessions over 12 weeks. This intervention has been shown in a number of studies to be effective in tackling depression and reducing productivity losses in various workplaces. In a similar approach in Australia, productivity improvements outweighed the costs of the intervention[157].

It was estimated that £30.90 (at 2009 prices) covered the cost of facilitating the completion of the screening questionnaire, follow-up assessment to confirm depression, and care management

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[157] Hilton M (2007) Assessing the Financial Return on Investment of Good Management Strategies and the WORC Project. Brisbane: University of Queensland.

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costs[158]. For those identified as being at risk, the cost of six sessions of face-to-face CBT is £240. Computerised CBT courses are cheaper, and may be less stigmatising to individual workers, but less is known about their longer-term effectiveness.

Impact

The results show that from a business perspective the intervention appears cost-saving, despite the cost of screening all employees (Table 22). Benefits are gained through both a reduction in the level of absenteeism and improved levels of workplace productivity through a reduction in presenteeism. However, the impact may differ across industries; the case may be less strong where staff turnover is high and skill requirements low. From a health and personal social services perspective the model is cost-saving, assuming the costs of the programme are indeed borne by the enterprise.

Table 25: Total net costs/pay-offs from business and societal perspectives for a company with 500 employees (2009 prices)

	Year 1 (£)	Year 2 (£)
Intervention cost	20,676	0
Health (including social care)	0	-10,522
Absenteeism (productivity losses)	-17,508	-23,006
Presenteeism (productivity losses)	-22,868	-30,050
Total	-19,700	-63,578

Key points

- The intervention is cost-saving from the perspectives of both business and the health system, on the assumption that all costs are borne by business.
- The costs of the intervention are more than outweighed by gains to business due to a reduction in both presenteeism and levels of absenteeism.
- Public sector employers also have the potential to benefit from investing in universal workplace depression and anxiety screening interventions.

Promoting well-being in the workplace

Context

The workplace provides a convenient location for addressing the physical and mental health of a large proportion of the adult population. Problems inside and beyond work can be identified and tackled, and there is also scope for general health promotion. Aside from the potential benefits to public health, this type of well-being intervention can improve an organisation's productivity, image and workplace safety. It may also reduce the vulnerability of employees to work-related mental health problems.

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[158] Wang PS, Patrick A, Avorn J et al (2006) The costs and benefits of enhanced depression care to employers. Archives of General Psychiatry 63:1345–1353.

Deteriorating well-being in the workplace is potentially costly for businesses as it may increase absenteeism and presenteeism (lost productivity while at work), and in the longer term potentially leads to premature withdrawal from the labour market. From a health system perspective, improved well-being potentially will help avoid the use of services for some mental and physical health problems.

Intervention

There are a wide range of approaches to mental health promotion in the workplace, including healthy workplace schemes[159]. These include flexible working arrangements; career progression opportunities; ergonomics and environment; stress audits; and improved recognition of risk factors for poor mental health by line managers. Other measures targeted at general well-being can include access to gyms, exercise and sports opportunities and changes to the canteen food. One study found that Scottish health care workers who were helped to adopt more active commuting habits showed significantly improved mental health[160].

A multi-component health promotion intervention of the sort modelled in the current study consists of personalised health and well-being information and advice; a health risk appraisal questionnaire; access to a tailored health improvement web portal; wellness literature; and seminars and workshops focused on identified wellness issues. A quasi-experimental evaluation of this type of programme has reported significantly reduced stress levels, reduced absenteeism and reduced presenteeism, compared with a control group[161]. Promotion of long-term mental well-being may be associated with reduced longer term risk of poor mental health, although the evidence for this remains weak[162] [163].

The cost of a multi-component intervention is estimated at £80 per employee per year.

Impact

From a business perspective the model appears cost saving compared to taking no action (Table 23). In year 1, the initial costs of £40,000 for the programme are outweighed by gains arising from reduced presenteeism and absenteeism of £387,722. This represents a substantial annual return on investment of more than 9 to 1. In addition there are likely to be benefits to the health system from reduced physical and mental health problems as a result of the intervention, but these are not quantified here.

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[159] http://www.london.gov.uk/priorities/health/focus-issues/health-work-and-wellbeing
[160] Mutrie N, Carney D, Blamey A et al (2002) "Walk in to Work Out": a randomised controlled trial of a self help intervention to promote active commuting. Journal of Epidemiology and Community Health 56:407–412.
[161] Mills P, Kessler R, Cooper J, Sullivan S (2007) Impact of a health promotion program on employee health risks and work productivity. American Journal of Health Promotion 22:45–53.
[162] Westerhof GJ, Keyes CL (2010) Mental illness and mental health: the two continua model across the lifespan. Journal of Adult Development 17:110–119.
[163] Keyes C (2007) Promoting and protecting mental health as flourishing: a complementary strategy for improving national mental health. American Psychologist 62:95–108.

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Table 26: Total net costs/pay-offs from a business perspective for a company with 500 employees (2009 prices)

	Year 1 (£)
Intervention cost	40,000
Absenteeism (productivity losses)	-110,527
Presenteeism (productivity losses)	-277,195
Total	-347,722

Key points
- A strong case can be made to businesses that workplace well-being interventions can be significantly cost-saving in the short term, but some smaller companies may need public support to implement such schemes.
- The public sector, including the NHS, can also benefit as an employer from improved investment in workplace well-being programmes.

Debt and mental health

Context

Even before the current global financial crisis, it was estimated that 8% of the population had serious financial problems and another 9% showed signs of financial stress[164]. These problems have wide-ranging implications. In particular, research has demonstrated a link between debt and mental health; individuals who initially have no mental health problems but find themselves having unmanageable debts within a 12-month period have a 33% higher risk of developing depression and anxiety-related problems compared to the general population who do not experience financial problems[165].

The vast majority of these mental health problems take the form of depression and anxiety-related disorders. These conditions are associated with significant costs arising from health service use, legal fees, debt recovery and lost productivity. On average, the lost employment costs of each case of poor mental health are £11,432 per annum, while the annual costs of health and social service use are £1,508[166].

Only about half of all people with debt problems seek advice[167], and without intervention almost two-thirds of people with unmanageable debt problems will still face such problems 12 months later.

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[164] Fearnley J (2007) Gauging Demand for Free to Access Money Advice: a Discussion Paper. London: Money Advice Trust.
[165] Skapinakis P, Weich, S et al (2006) Socio-economic position and common mental disorders. Longitudinal study in the general population in the UK. British Journal of Psychiatry 189:109–117.
[166] McCrone P, Dhanasiri,S et al (2008) Paying the Price. The Cost of Mental Health Care in England to 2026. London: Kings Fund.
[167] Pleasence P, Buck A et al (2004) Causes of Action: Civil Law and Social Justice. London: Legal Services Commission.

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Intervention
The current evidence suggests that there is potential for debt advice interventions to alleviate financial debt, and hence reduce mental health problems resulting from debt. For the general population, contact with face-to-face advice services is associated with a 56% likelihood of debt becoming manageable[168], while telephone services achieve 47%[169]. In comparison, around one-third of problem debt may be resolved without any intervention.

The costs of this type of intervention vary significantly, depending on whether it is through face-to-face, telephone or internet-based services. The Department for Business, Innovation and Skills suggests expenditure of £250 per client for face-to-face debt advice; telephone and internet-based services are cheaper. Funding for debt advice comes from a range of sources including government, NHS, charities and creditors.

Impact
Even under conservative assumptions, investment in debt advice services can both lower expected costs and reduce the risk of developing mental health problems. The intervention appears to be cost-effective from most societal and public expenditure perspectives. However, face-to-face services will only be the most cost-effective option if a high proportion of the costs of providing the service is recovered from creditors. This is feasible: one major not-for-profit debt advice service covers more than 90% of its costs in this way. In other scenarios, where cost recovery is lower, either telephone or web-delivered services will be most cost-effective. Table 24 shows the impact on costs/savings of face-to-face intervention for a hypothetical population of 100,000, compared with no intervention, assuming that one third of the cost of the debt advice is borne by the NHS, with the rest paid for by creditors.

In practice, this type of intervention could be targeted at specific groups who may be particularly vulnerable to financial debt and mental health problems, for example low-income communities.

Table 27: Impact on costs/pay-offs of face-to-face debt intervention (with NHS paying one-third of the costs of the debt advice services) (2009 prices)

	Year 1 (£)	Year 2 (£)	Year 3 (£)	Year 4 (£)	Year 5 (£)
Health and social care	151,512	-13,209	-13,017	-12,829	-12,643
Legal	-87,908	-	-	-	-
Productivity losses	-7,827	-100,128	-98,677	-97,426	-95,837
Net costs/pay-offs	55,777	-113,336	-111,694	-110,075	-108,480

Key points
- In nearly all modelled scenarios, at least one type of debt management intervention has better outcomes and lower costs over a two-year period compared to no action.
- For greatest cost-effectiveness, careful consideration needs to be given to models of financing and to the mix between face-to-face, telephone and web-based provision.

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[168] Williams K, Sansom A (2007) Twelve Months Later: Does Advice Help? The Impact of Debt Advice: Advice Agency Client Study. London: Ministry of Justice.
[169] Pleasence P, Balmer NJ (2007) Changing fortunes: results from a randomized trial of the offer of debt advice in England and Wales. Journal of Empirical Legal Studies 4:465–475.

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Collaborative care for depression in individuals with Type II diabetes

Context

Depression is commonly associated with chronic physical health problems. NICE has estimated that 20% of individuals with a chronic physical problem are likely to have depression[170], while US data indicate that 13% of all new cases of Type II diabetes will also have clinical depression[171]. These patterns are important as evidence shows that co-morbid depression exacerbates the complications and adverse consequences of diabetes[172], in part because patients may more poorly manage their diabetes. Not only does this increase the risk of disability and premature mortality, it also has substantial economic consequences.

In the UK, compared to people with diabetes alone, individuals with co-morbid depression and diabetes are four times more likely to have difficulties in self-managing their health and seven times more likely to have days off work[173]. In the US, health care costs for those with severe depression and diabetes are almost double those with diabetes alone[174].

Intervention

'Collaborative care' can be delivered in a primary care setting to individuals with co-morbid diabetes and depression. Like 'usual care', collaborative care includes GP advice and care, the use of antidepressants and cognitive behavioural therapy (CBT) for some patients. The difference is that for collaborative care a GP practice nurse acts as a case manager for patients receiving care; GPs also incur additional time costs liaising with practice nurses.

Using a NICE analysis, it is estimated that the total cost of six months of collaborative care is £682, compared with £346 for usual care. A two-year evaluation in the US found that, on average, collaborative care achieved an additional 115 depression-free days per individual; total medical costs were higher in year 1, but there were cost savings in year 2[175].

Impact

Table 25 shows the estimated costs/savings for 119,150 new cases of Type II diabetes in England in 2009, assuming 20% screen positive for co-morbid depression. Completing and successfully responding to collaborative care leads to an additional 117,850 depression-free days in year 1 and 111,860 depression-free days in year 2. According to the model, the intervention results in substantial additional net costs in year 1 due to the costs of the treatment. In year 2, however, there are net savings for the health and social care system due to lower costs associated with depression in the intervention group, plus further benefits from reduced productivity losses. Using a lower 13% rate of co-morbid diabetes and depression, total net costs in year 1 would be more than £4.5m, while net savings in year 2 would be more than £450,000.

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[170] NICE (2009) Depression in Adults with Chronic Physical Health Problem: Treatment and Management. London: NICE.

[171] Katon WJ, Von Korff M, Lin EHB et al (2004) The Pathways study: a randomized trial of collaborative care in patients with diabetes and depression. Archives of General Psychiatry 61:1042–1049.

[172] Lloyd CE (2010) Diabetes and mental health: the problem of co-morbidity. Diabetic Medicine 27:853–854.

[173] Das Munshi J, Stewart R, Ismail K et al (2007) Diabetes, common mental disorders, and disability: findings from the UK National Psychiatric Morbidity Survey. Psychosomatic Medicine 69:543–550.

[174] Simon GE, Katon W, Lin EHB et al (2007) Cost effectiveness of systematic depression treatment among people with diabetes mellitus. Archives of General Psychiatry 64:65–72.

[175] Katon W, Unützer J, Fan M et al (2006) Cost-effectiveness and net benefit of enhanced treatment of depression for older adults with diabetes and depression. Diabetes Care 29:265–270.

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The study also estimated the incremental cost per Quality-Adjusted Life Year (QALY) gained, which over two years was £3,614. This is highly cost-effective in an English context.

Table 28: Costs/pay-offs of collaborative care for new cases of Type II diabetes screened positive for depression in England (2009 prices)

	Year 1 (£)	Year 2 (£)
Health and social care	7,298,860	-385,240
Productivity losses	-331,170	-314,330
Net cost/pay-off	6,967,690	-699,570

These estimates of the potential benefits are, however, very conservative. The model does not factor in productivity losses due to premature mortality, nor further quality of life gains associated with avoidance of the complications of diabetes, such as amputations, heart disease and renal failure. Nor does the analysis include long-term cost savings from reduced complications. These are potentially substantial: research in 2003 showed that for diabetes-relates cases the average initial health care costs of an amputation were £8,500 and for a non-fatal myocardial infarction £4,000[176]. If, on average, costs of just £150 per year could be avoided for the intervention group, then investment in collaborative care would overall be cost-saving from a health and social care perspective after just two years.

Key points
- The intervention is cost-effective in an English context after two years, but has high net additional costs in the short term due to implementation costs.
- A wider-ranging analysis is merited to demonstrate the potential longer-term savings in health and social care costs due to reduced complications of diabetes.

Befriending of older adults

Context
Befriending initiatives, often delivered by volunteers, provide an 'upstream' intervention that is potentially of value both to the person being befriended and the 'befriender'. For those receiving the intervention, particularly older people, it promotes social inclusion and reduces loneliness[177]; for the befriender, there is the personal satisfaction of contributing to the local community by offering support and skills. Specific potential benefits include the improved mental well-being of the person receiving the intervention, a reduced risk of depression, and associated savings in health care costs.

Intervention
In a typical befriending intervention, a befriender visits a person in their home, usually on a one-to-one basis, where that individual has requested and agreed to such a contact. The intervention is not usually structured and nor does it have formally-defined goals. Instead an informal, natural

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[176] Clarke P, Gray A, Legood R, Briggs A, Holman R (2003) The impact of diabetes-related complications on healthcare costs: results from the United Kingdom Prospective Diabetes Study. Diabetic Medicine 20:442–450.
[177] Cacioppo JT, Hughes ME, Waite LJ, Hawkley LC, Thisted RA (2006) Loneliness as a specific risk factor for depressive symptoms: cross-sectional and longitudinal analysis. Psychology and Aging 26:140–151.

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relationship develops between the participants, who will usually have been matched for interests and preferences. This relationship facilitates improved mental health, reduced loneliness and greater social inclusion. A recent research review confirmed that, compared with usual care and support (which may mean no intervention at all), befriending has a modest but significant effect on depressive symptoms, at least in the short term [178]. Another evaluation showed decreased depression and anxiety in 5% of people receiving socio-emotional interventions, including befriending[179]. The contact is generally for an hour per week or fortnight. The cost to public services of 12 hours of befriending contact is estimated at £85, based on the lower end of the cost range for befriending interventions[180].

Impact

Using existing estimates of savings associated with reduced treatment of depression[181], the model found total gross cost savings to the NHS were around £40 (at 2008/9 prices) in year 1 for every £85 invested in the intervention. Thus, befriending schemes do not appear to be cost-saving from a public expenditure perspective.

If the analysis includes the quality of life benefits associated with reduced depressive symptoms, then befriending schemes have the potential to create further improvements worth £270 per person and are likely to be cost-effective with an incremental cost effectiveness ratio (ICER) of around £2,900.

Key points
- Befriending interventions are unlikely to achieve cost savings to the public purse, but they do improve an individual's quality of life at a low cost.
- The targeting of at-risk groups (e.g. older people discharged from hospital or mothers at risk of post-natal depression) would potentially offer better returns on an investment in befriending, and this could be explored through further research.

[178] Mead N, Lester H, Chew-Graham C, Gask L, Bower P (2010) Effects of befriending on depressive symptoms and distress: systematic review and meta-analysis. British Journal of Psychiatry 196:96–101.
[179] Department of Health (2009) Partnerships for Older People Projects Final Report. London: Department of Health.
[180] Knapp M. Henderson C, Perkins M, Roman A (2009) Brighter Futures Group final report (unpublished). Maidstone: Kent County Council.
[181] Beecham J, Knapp M, Fernandez JL et al (2008) Age Discrimination in Mental Health Services, Discussion Paper. London: PSSRU, LSE.

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Policies, strategies, NICE Guidance & best practice

There is a vast array of NICE publications on mental health and related conditions. It is not possible to list them all here but the reader is advised to look these up at the NICE website.
See: http://www.nice.org.uk/guidance/index.jsp?action=byTopic&o=7281

However there are some key points on what works to improve mental health and well-being of people with mental health problems:

- Employment support for people with mental health problems
- Information and support for people with mental health problems to improve access to work and social opportunities (for example through day care or primary care services)
- Promotion of positive mental health in schools
- Improved diagnosis and management of common mental disorders in primary care, for example anxiety and depression
- Equitable access to mental health services, for example for BAME communities
- Supporting community involvement for people who are at risk of social isolation or where they are disaffected

Department of Health published a cross-government strategy on mental health "No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages" in 2011.
(https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/135457/dh_124058.pdf.pdf)
This strategy focuses on six shared objectives:
   i. More people will have good mental health.
   ii. More people with mental health problems will recover.
   iii. More people with mental health problems will have good physical health.
   iv. More people will have a positive experience of care and support.
   v. Fewer people will suffer avoidable harm.
   vi. Fewer people will experience stigma and discrimination.

The objectives are based on 3 guiding principles.
1. Freedom
2. Fairness
3. Responsibility

The strategy aims to bring about significant change in people's lives. Bringing the changes, for everyone, across the country and in the most effective way, will mean that:
1. Mental health has 'parity of esteem' with physical health within the health and care system.
2. People with mental health problems, their families and carers, are involved in all aspects of service design and delivery.
3. Public services improve equality and tackle inequality.
4. More people have access to evidence-based treatments.
5. The new public health system includes mental health from day one.
6. Public services intervene early.
7. Public services work together around people's needs and aspirations.
8. Health services tackle smoking, obesity and co-morbidity for people with mental health problems.

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9. People with mental health problems have a better experience of employment.
10. We tackle the stigma and discrimination faced by people with mental health problems.

DH Analysis of the Impact on Equality (AIE) of the strategy.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/135459/dh_123989.pdf.pdf
This document explains and analyses the impact of Equality on six shared objectives identified in the Strategy. The Equality Act 2010 covers nine protected characteristics, and there is a public sector duty to advance equality and reduce inequality for people with these protected characteristics.

There are three aspects to reduce mental health inequality:
1. tackling the inequalities that lead to poor mental health;
2. tackling the inequalities that result from poor mental health – such as lower employment rates, and poorer housing, education and physical health; and
3. tackling the inequalities in service provision – in access, experience and outcomes.

Department of Health "No Health Without Mental Health: Implementation framework".
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/156084/No-Health-Without-Mental-Health-Implementation-Framework-Report-accessible-version.pdf.pdf

The national policy integrates mental health and physical health and suggests that there should be a collaborative programme of action to achieve the ambition that mental health is on a par with physical health:
1. Local planning and priority setting should reflect the mental health needs of the population. Mental health and wellbeing is integral to the work of CCGs, health and wellbeing boards and other local organisations.
2. To translate the vision into reality, people with mental health, their families and carers should be fully involved in planning, priority setting and delivery of services.
3. Services actively promote equality and are accessible, acceptable, and culturally appropriate to all the communities. Public Bodies meet their obligations under the Equality Act 2010. People including children, young person, older people, and people from ethnic minority should have access to Psychological Therapies.
4. All people receive evidence-based mental health promotion. Schools and colleges promote good mental health for all children and young people, alongside targeted support for those at risk of mental health problems.
5. The Public Health Outcomes Framework (PHOF) includes mental health measures. Local public health services deliver clear plans for mental health.
6. All organisations should recognise the value of promoting good mental health.
7. Public services should recognise and identify people at risk of mental health problems and take appropriate, timely action, including using innovative service models. Early recognition and intervention will enable stopping serious consequences from occurring.
8. Public health campaigns should include people' mental health as well physical health. Services tackle and support people with dual diagnosis and substance misuse to achieve better outcomes and reduce cost.
9. Services working together support people with mental health problems to maintain, or to return to employment.

10. Frontline workers, across the full range of services, are to be trained to understand better about mental health, the principles of recovery and be able to tackle any stigma related to mental health.

No health without public mental health: The case for action, Royal College of Psychiatrists, 2010
http://www.rcpsych.ac.uk/pdf/Position%20Statement%204%20website.pdf

This report describes the key points and features that should be part of a public mental health strategy:

1. There is no public health without public mental health. Investment is needed to promote public mental health. This will enhance population well-being and resilience against illness, promote recovery, and reduce stigma and the prevalence of mental illness.

2. The Royal College of Psychiatrists strongly supports the findings of the Marmot Strategic Review of Health Inequalities in England post 2010. It recognises that inequality is a key determinant of illness, which then leads to even further inequality. Government policy and actions should effectively address inequalities to promote population mental health, prevent mental ill health and promote recovery.

3. Physical health is inextricably linked to mental health. Poor mental health is associated with other priority public health conditions such as obesity, alcohol misuse and smoking, and with diseases such as cancer, cardiovascular disease and diabetes. Poor physical health also increases the risk of mental illness.

4. Interventions which apply across the life course need to be provided. Since the majority of mental illnesses have childhood antecedents, childhood interventions which protect health and well-being and promote resilience to adversity should be implemented. If mental health problems occur there should be early and appropriate intervention. Strategies to promote parental mental health and effectively treat parental mental illness are important since parental mental health has a direct influence on child mental health.

5. Older people also require targeted approaches to promote mental health and prevent mental disorder, including dementia. Action is needed to promote awareness of the importance of mental health and well-being in older age as well as ways to safeguard it. Ageist attitudes need to be challenged and values promoted that recognise the contributions older people make to communities, valuing unpaid, voluntary work as we do economic productivity.

6. An effective public health strategy requires both universal interventions, applied to the entire population, and interventions targeted at those people who are less likely to benefit from universal approaches and are at higher risk, including the most socially excluded groups. Such groups include children in care or subject to bullying and abuse, people of low socioeconomic status, those who are unemployed or homeless, those with addictions or intellectual disability, and other groups subject to discrimination, stigma or social exclusion. Health promotion interventions are particularly important for those recovering from mental illness or addiction problems. Those with poor mental health as well as poor physical health require effective targeted health promotion interventions.

7. The prevention of alcohol-related problems and other addictions is an important component of promoting population health and well-being. The College supports the development of a minimum alcohol pricing policy and a cross-government, evidence-based addictions policy.

8. Smoking is the largest single cause of preventable death and health inequality. It occurs at much higher rates in those with mental illness, with almost half of total tobacco consumption and smoking-related deaths occurring in those with mental disorder. Therefore, mental health needs to be mainstreamed within smoking prevention and cessation programmes.

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9. A suicide prevention strategy should remain a government priority and should include strategies to address and reduce the incidence of self-harm.
10. Collaborative working is required across all government departments in view of the cross-government benefits of public mental health interventions across a range of portfolios, such as education, housing, employment, crime, social cohesion, culture, sports, environment and local government. Actions to combat stigma related to mental illness should be included in these strategies.
11. Doctors can be important leaders in facilitating local and national implementation of public mental health strategies. Many psychiatrists already adopt a public mental health approach in their work and influence national and local strategy. Psychiatrists should be supported in assessing the needs of their local population for health promotion.
12. Psychiatrists should be engaged in the commissioning process and inform commissioners of the expected prevalence of specific disorders to anticipate levels of service provision and unmet need, and to help prioritise resource allocation. Support and training are required to facilitate this.
13. Commissioners should take into account the effects of mental health and mental illness across the life course as well as the economic benefits of protecting and promoting mental health and well-being.
14. Commissioners should consider the existing arrangements and adequacy of services for comorbid disorders and unexplained medical symptoms where cost-effective interventions could be provided.

Closing the Gap: Priorities for essential change in mental health, Department of Health, February 2014 (V2)
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281250/Closing_the_gap_V2_-_17_Feb_2014.pdf

This document aims to bridge the gap between the governments' long-term ambition (as stated in No Health Without Mental Health) and shorter-term action. It seeks to show how changes in local service planning and delivery will make a difference, in the next two or three years, to the lives of people with mental health problems.

It sets out 25 areas where people can expect to see, and experience, the fastest changes. These are the priorities for action: issues that current programmes are beginning to address and where the strategy is coming to life. The 25 areas are:
1. Commissioning high-quality mental health services with an emphasis on recovery in all areas, reflecting local need
2. Leading an information revolution around mental health and wellbeing
3. Establishing clear waiting time limits for mental health services
4. Tackling inequalities around access to mental health services
5. Over 900,000 people benefitting from psychological therapies every year
6. Improving access to psychological therapies for children and young people across the whole of England
7. The most effective services will get the most funding
8. Giving adults the right to make choices about the mental health care they receive
9. Radically reducing the use of all restrictive practices and take action to end the use of high risk restraint, including face down restraint and holding people on the floor
10. Using the Friends and Family Test to allow all patients to comment on their experience of mental health services – including children's mental health services

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11. Identifying poor quality services sooner and taking action to improve care and where necessary protect patients
12. Supporting carers better and being more closely involved in decisions about mental health service provision
13. Integrating mental health care and physical health care better at every level
14. Changing the way frontline health services respond to self-harm
15. Ensuring that no-one experiencing a mental health crisis is turned away from services
16. Offering better support to new mothers to minimise the risks and impacts of postnatal depression
17. Supporting schools to identify mental health problems sooner
18. Ending the cliff-edge of lost support as children and young people with mental health needs reach the age of 18
19. People with mental health problems will live healthier lives and longer lives
20. More people with mental health problems will live in homes that support recovery
21. Introducing a national liaison and diversion service so that the mental health needs of offenders will be identified sooner and appropriate support provided
22. Offering anyone with a mental health problem who is a victim of crime enhanced support
23. Supporting employers to help more people with mental health problems to remain in or move into work
24. Developing new approaches to help people with mental health problems who are unemployed to move into work and seek to support them during periods when they are unable to work
25. Stamping out discrimination around mental health

NICE Clinical Guideline CG 178: Psychosis and schizophrenia in adults: treatment and management, Feb 2014
http://www.nice.org.uk/nicemedia/live/14382/66534/66534.pdf

This guideline covers the treatment and management of psychosis and schizophrenia and related disorders in adults (18 years and older) with onset before 60 years. The term psychosis' is used in this guideline to refer to the group of psychotic disorders that includes schizophrenia, schizoaffective disorder, schizophreniform disorder and delusional disorder.

A summary of the key recommendations are:

Care across all phases
- Health care professionals should work in partnership with people with schizophrenia and their carers, offer help; treatment and care in an atmosphere of hope and optimism; take time to build supportive and empathic relationships.
- Healthcare professionals inexperienced in working with people with psychosis or schizophrenia from diverse ethnic and cultural backgrounds should seek advice and supervision from healthcare professionals who are experienced in working transculturally.
- Mental health services should work with local voluntary black, Asian and minority ethnic groups to jointly ensure that culturally appropriate psychological and psychosocial treatment, consistent with this guideline and delivered by competent practitioners, is provided to people from diverse ethnic and cultural backgrounds.
- People with psychosis or schizophrenia, especially those taking antipsychotics, should be offered a combined healthy eating and physical activity programme by their mental healthcare provider.

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- Offer people with psychosis or schizophrenia who smoke help to stop smoking, even if previous attempts have been unsuccessful. Be aware of the potential impact of reducing nicotine on the metabolism of other drugs, particularly clozapine and olanzapine.
- Consider one of the following to help people stop smoking:
    - nicotine replacement therapy (usually a combination of transdermal patches with a short-acting product such as an inhalator, gum, lozenges or spray) for people with psychosis or schizophrenia **or**
    - bupropion[1] for people with a diagnosis of schizophrenia **or**
    - varenicline for people with psychosis or schizophrenia.
- For people in inpatient settings who do not want to stop smoking, offer nicotine replacement therapy to help them to reduce or temporarily stop smoking.

Support for carers
- Offer carers of people with psychosis or schizophrenia an assessment (provided by mental health services) of their own needs and discuss with them their strengths and views. Develop a care plan to address any identified needs, give a copy to the carer and their GP and ensure it is reviewed annually.
- Advise carers about their statutory right to a formal carer's assessment provided by social care services and explain how to access this.
    - Give carers written and verbal information in an accessible format about:
    - diagnosis and management of psychosis and schizophrenia
    - positive outcomes and recovery
    - types of support for carers
    - role of teams and services
    - getting help in a crisis.
- When providing information, offer the carer support if necessary.
- As early as possible negotiate with service users and carers about how information about the service user will be shared. When discussing rights to confidentiality, emphasise the importance of sharing information about risks and the need for carers to understand the service user's perspective. Foster a collaborative approach that supports both service users and carers, and respects their individual needs and interdependence.
- Offer a carer-focused education and support programme, which may be part of a family intervention for psychosis and schizophrenia, as early as possible to all carers. The intervention should:
    - be available as needed
    - have a positive message about recovery.

Preventing psychosis
- Refer a person without delay to a specialist mental health service or an early intervention in psychosis service for assessment of risk of developing psychosis if the person is distressed, has a decline in social functioning and has:
    - transient or attenuated psychotic symptoms or
    - other experiences or behaviour suggestive of possible psychosis or
    - a first-degree relative with psychosis or schizophrenia
- If a person is considered to be at increased risk of developing psychosis:
    - offer individual cognitive behavioral therapy (CBT) with or without family intervention **and**

- offer interventions recommended in NICE guidance for people with any of the anxiety disorders, depression, emerging personality disorder or substance misuse.
- Do not offer antipsychotic medication:
    - to people considered to be at increased risk of developing psychosis **or**
    - with the aim of decreasing the risk of or preventing psychosis.

First episode psychosis

- Early intervention in psychosis services should be accessible to all people with a first episode or first presentation of psychosis, irrespective of the person's age or the duration of untreated psychosis.
- Assess for post-traumatic stress disorder and other reactions to trauma because people with psychosis or schizophrenia are likely to have experienced previous adverse events or trauma associated with the development of the psychosis or as a result of the psychosis itself. For people who show signs of post-traumatic stress, follow the recommendations in Post-traumatic stress disorder (NICE clinical guideline 26).
- Write a care plan in collaboration with the service user as soon as possible following assessment, based on a psychiatric and psychological formulation, and a full assessment of their physical health. Send a copy of the care plan to the primary healthcare professional who made the referral and the service user.
- For people who are unable to attend mainstream education, training or work, facilitate alternative educational or occupational activities according to their individual needs and capacity to engage with such activities, with an ultimate goal of returning to mainstream education, training or employment.
- The secondary care team should maintain responsibility for monitoring service users' physical health and the effects of antipsychotic medication for at least the first 12 months or until the person's condition has stabilised, whichever is longer. Thereafter, the responsibility for this monitoring may be transferred to primary care under shared care arrangements.
- Discuss any non-prescribed therapies the service user wishes to use (including complementary therapies), and the use of alcohol, tobacco, prescription and non-prescription medication and illicit drugs with the service user, and carer if appropriate.

Subsequent acute episodes of psychosis or schizophrenia and referral in crisis

- Offer crisis resolution and home treatment teams as a first-line service to support people with psychosis or schizophrenia during an acute episode in the community if the severity of the episode, or the level of risk to self or others, exceeds the capacity of the early intervention in psychosis services or other community teams to effectively manage it.
- Crisis resolution and home treatment teams should be the single point of entry to all other acute services in the community and in hospitals.
- Offer:
    - CBT to all people with psychosis or schizophrenia
    - family intervention to all families of people with psychosis or schizophrenia who live with or are in close contact with the service user

This can be started either during the acute phase or later, including in inpatient settings.

Promoting recovery and possible future care

- GPs and other primary healthcare professionals should monitor the physical health of people with psychosis or schizophrenia when responsibility for monitoring is transferred from secondary care, and then at least annually. The health check should be comprehensive,

focusing on physical health problems that are common in people with psychosis and schizophrenia. Include all the checks recommended in "Before starting antipsychotic medication" section of this guidance and refer to relevant NICE guidance on monitoring for cardiovascular disease, diabetes, obesity and respiratory disease. A copy of the results should be sent to the care coordinator and psychiatrist, and put in the secondary care notes.

- Identify people with psychosis or schizophrenia who have high blood pressure, have abnormal lipid levels, are obese or at risk of obesity, have diabetes or are at risk of diabetes (as indicated by abnormal blood glucose levels), or are physically inactive, at the earliest opportunity following relevant NICE guidance (CG 67, 38, 43, 127, 25, 44).
- Offer supported employment programmes to people with psychosis or schizophrenia who wish to find or return to work. Consider other occupational or educational activities, including pre-vocational training, for people who are unable to work or unsuccessful in finding employment.

NICE Quality Standard QS53: Anxiety disorders, Feb 2014
http://publications.nice.org.uk/anxiety-disorders-qs53

Many anxiety disorders go unrecognised or undiagnosed. Most of those that are diagnosed are treated in primary care. However, recognition of anxiety disorders in primary care is poor and only a small minority of people experiencing anxiety disorders ever receive treatment. When anxiety disorders coexist with depression, the depressive episode may be recognised without detecting the underlying and more persistent anxiety disorder. For people who use services for anxiety disorders, treatment is often limited to the prescription of drugs. This may be partly because evidence-based psychological services are not universally available.

The quality standard for anxiety disorders specifies that services should be commissioned from and coordinated across all relevant agencies encompassing the whole anxiety disorders care pathway. A person-centred, integrated approach to providing services is fundamental to delivering high-quality care to people with anxiety disorders in primary and secondary care.

List of quality statements
Statement 1: People with a suspected anxiety disorder receive an assessment that identifies whether they have a specific anxiety disorder, the severity of symptoms and associated functional impairment.
Statement 2: People with an anxiety disorder are offered evidence-based psychological interventions.
Statement 3: People with an anxiety disorder are not prescribed benzodiazepines or antipsychotics unless specifically indicated.
Statement 4: People receiving treatment for an anxiety disorder have their response to treatment recorded at each treatment session.

NICE public health guidance PH48: Smoking cessation in secondary care: acute, maternity and mental health services, Nov 2013
http://www.nice.org.uk/nicemedia/live/14306/65863/65863.pdf

Stopping smoking at any time has considerable health benefits for people who smoke, and for those around them. For people using secondary care services, there are additional advantages, including shorter hospital stays, lower drug doses, fewer complications, higher survival rates, better wound healing, decreased infections, and fewer re-admissions after surgery.

Secondary care providers have a duty of care to protect the health of, and promote healthy behaviour among, people who use, or work in, their services. This duty of care includes providing them with effective support to stop smoking or to abstain from smoking while using or working in secondary care services.

This guidance aims to support smoking cessation, temporary abstinence from smoking and Smoke free policies in all secondary care settings. It recommends:

- Strong leadership and management to ensure secondary care premises (including grounds, vehicles and other settings involved in delivery of secondary care services) remain smoke free – to help to promote non-smoking as the norm for people using these services.
- All hospitals have an on-site stop smoking service.
- Identifying people who smoke at the first opportunity, advising them to stop, providing pharmacotherapy to support abstinence, offering and arranging intensive behavioural support, and following up with them at the next opportunity.
- Providing intensive behavioural support and pharmacotherapy as an integral component of secondary care, to help people abstain from smoking, at least while using secondary care services.
- Ensuring continuity of care by integrating stop smoking support in secondary care with support provided by community-based and primary care services.
- Ensuring staff are trained to support people to stop smoking while using secondary care services.
- Supporting all staff to stop smoking or to abstain while at work.
- Ensuring there are no designated smoking areas, no exceptions for particular groups, and no staff-supervised or staff-facilitated smoking breaks for people using secondary care services.

NICE Clinical Guideline CG 120: Psychosis with coexisting substance misuse, 2011
http://www.nice.org.uk/nicemedia/live/13414/53731/53731.pdf

Key priorities for implementation
Working with adults and young people with psychosis and coexisting substance misuse
- When working with adults and young people with known or suspected psychosis and coexisting substance misuse, take time to engage the person from the start, and build a respectful, trusting, non-judgemental relationship in an atmosphere of hope and optimism. Be direct in your communications, use a flexible and motivational approach, and take into account that:
  - stigma and discrimination are associated with both psychosis and substance misuse
  - some people will try to conceal either one or both of their conditions
  - many people with psychosis and coexisting substance misuse fear being detained or imprisoned, being given psychiatric medication forcibly or having their children taken into care, and some fear that they may be 'mad'.

Recognition of psychosis with coexisting substance misuse in adults and young people
- Healthcare professionals in all settings, including primary care, secondary care mental health services, child and adolescent mental health services (CAMHS) and accident and emergency departments, and those in prisons and criminal justice mental health liaison schemes, should routinely ask adults and young people with known or suspected psychosis about their use of alcohol and/or prescribed and non-prescribed (including illicit) drugs. If the person has used substances ask them about all of the following:
  - the particular substance(s) used

- the quantity, frequency and pattern of use
- route of administration
- duration of current level of use.

In addition, conduct an assessment of dependency (see 'Drug misuse: opioid detoxification' [NICE clinical guideline 52] and 'Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence' [NICE clinical guideline 115]) and also seek corroborative evidence from families, carers or significant others1, where this is possible and permission is given.

Secondary care mental health services

- Healthcare professionals working within secondary care mental health services should ensure they are competent in the recognition, treatment and care of adults and young people with psychosis and coexisting substance misuse.
- Do not exclude adults and young people with psychosis and coexisting substance misuse from age-appropriate mental healthcare because of their substance misuse.
- Do not exclude adults and young people with psychosis and coexisting substance misuse from age-appropriate substance misuse services because of a diagnosis of psychosis.
- Consider seeking specialist advice and initiating joint working arrangements with specialist substance misuse services for adults and young people with psychosis being treated by community mental health teams, and known to be:
  - severely dependent on alcohol or
  - dependent on both alcohol and benzodiazepines or
  - dependent on opioids and/or cocaine or crack cocaine.

Adult community mental health services or CAMHS should continue to provide care coordination and treatment for the psychosis within joint working arrangements.

Substance misuse services

- Healthcare professionals in substance misuse services should be competent to:
  - recognise the signs and symptoms of psychosis
  - undertake a mental health needs and risk assessment sufficient to know how and when to refer to secondary care mental health services.

Inpatient mental health services

- All inpatient mental health services should ensure that they have policies and procedures for promoting a therapeutic environment free from drugs and alcohol that have been developed together with service users and their families, carers or significant others. These should include: search procedures, visiting arrangements, planning and reviewing leave, drug and alcohol testing, disposal of legal and illicit substances, and other security measures. Soon after admission, provide all service users, and their families, carers or significant others, with information about the policies and procedures.

Specific issues for young people with psychosis and coexisting substance misuse

- Those providing and commissioning services should ensure that:
  - age-appropriate mental health services are available for young people with psychosis and coexisting substance misuse and
  - transition arrangements to adult mental health services are in place where appropriate.

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Hidden Harm, Advisory Council on the Misuse of Drugs (AMCD) , June 2011
https://www.gov.uk/government/publications/amcd-inquiry-hidden-harm-report-on-children-of-drug-users

A dual diagnosis in one or both parents or caregivers has significant impacts on children living with them- the "hidden harms" of substance misuse. In June 2011, the Advisory Council on the Misuse of Drugs (AMCD) published an enquiry "Hidden Harm", which sets out 48 recommendations and 6 key messages.

The six key messages were:
1. We estimate there are between 250,000 and 350,000 children of problem drug users in the UK – about one for every problem drug user.
2. Parental problem drug use can and does cause serious harm to children at every age from conception to adulthood.
3. Reducing the harm to children from parental problem drug use should become a main objective of policy and practice.
4. Effective treatment of the parent can have major benefits for the child.
5. By working together, services can take many practical steps to protect and improve the health and well-being of affected children.
6. The number of affected children is only likely to decrease when the number of problem drug users decreases.

What works to improve mental wellbeing in older people (NICE 2008)
- Occupational therapy involvement in the design and development of locally relevant training schemes for those working with older people
- Advice and support to older people and carers
- Regular sessions based on occupational therapy principles to aid daily routine activities
- Advice and information on health, personal care, safety and other issues
- Commissioning tailored exercise programmes
- Developing, organising and promoting walking schemes

Follow the link for further information on the guidance
http://pathways.nice.org.uk/pathways/mental-wellbeing-and-older-people

NICE Clinical Guideline CG 123: Common mental health disorders: Identification and pathways to care, 2011
http://www.nice.org.uk/guidance/CG123

This guideline offers advice on the identification and the care of adults who have common mental health disorders with a particular focus on primary care.

The priorities for implementation are:
1. Improving access to services: Services need to be integrated for delivery, with clear explicit criteria for entry to the services, focused on entry and not on exclusion criteria. There should be multiple ways to entry to the services including self-referral, multiple points of access with links to wider health care system. People with common mental health problem should be provided with information about services and available treatments according to their knowledge and understanding of mental health disorders appropriate to the communities. Local care pathways should promote access to the services by wider communities including socially excluded groups such as black and minority ethnic groups, older people, those in prison or in contact with the criminal justice system and ex-service personnel.

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2. Stepped care: Use of stepped-care model to organise the provision of services and to help people with common mental health disorders, their families, carers and healthcare professionals, is the most effective way of interventions.
3. Identification and assessment: It is important to identify early possible depression particularly in people with a past history, and assessment should be done by competent staff and provide appropriate treatment and referral accordingly.
4. Treatment and referral for treatment
5. Developing local care pathways: Collaborative local care pathway needs to be developed for people with common mental health problems. Local care pathway should promote implementation of the key principles of good care. It should be negotiable, workable, accessible and acceptable by wider communities who are in need of the services. It should be outcome focused.

NICE Quality Standard QS8: Depression in adults, 2011

http://www.nice.org.uk/guidance/QS8

This quality standard covers the assessment and clinical management of persistent subthreshold depressive symptoms, or mild, moderate or severe depression in adults (including people with a chronic physical health problem).

NICE Quality Standard QS14: Service user Experience in adult mental health, 2011

http://guidance.nice.org.uk/QS14

This quality standard outlines the level of service that people using the NHS mental health services should expect to receive. It covers improving the experience of people using adult NHS mental health services. It does not cover mental health service users using NHS services for physical health problems, or the experiences of families or carers of people using NHS services specifically.

National Dementia Strategy, "Living Well with Dementia", 2009

https://www.gov.uk/government/publications/living-well-with-dementia-a-national-dementia-strategy

The National Dementia Strategy, 'Living Well with Dementia' (2009) provides a 5 year plan toward the development of dementia care services that are fit for the 21st Century. The aim of the Strategy is to ensure that significant improvements are made to dementia services across three key areas: improved awareness, earlier diagnosis and intervention, and a higher quality of care. The Strategy identifies 17 key objectives which, when implemented, largely at a local level, should result in significant improvements in the quality of services provided to people with dementia and should promote a greater understanding of the causes and consequences of dementia.

NICE Quality Standard for supporting people to live well with dementia (QS30), April 2013

http://publications.nice.org.uk/quality-standard-for-supporting-people-to-live-well-with-dementia-qs30

This quality standard covers supporting people to live well with dementia. It applies to all social care settings and services working with and caring for people with dementia. It should be read alongside the NICE dementia quality standard (QS1) (below), which covers care provided by health and social care staff in direct contact with people with dementia in hospital, community, home-based, group care, residential or specialist care settings.

NICE Dementia Quality Standard (QS1), June 2010

http://publications.nice.org.uk/dementia-quality-standard-qs1

This quality standard covers care provided by health and social care staff in direct contact with people with dementia in hospital, community, home-based, group care, residential or specialist

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care settings. It should be read alongside the NICE supporting people to live well with dementia quality standard (QS30), which applies to all social care settings and services working with and caring for people with dementia.

Guidance for commissioners of older people's mental health services, Joint Commissioning Panel for Mental Health, 2013
http://www.helplines.org/uploads/1/1/2/5/11258169/jcpmh-olderpeople-guide.pdf

The Joint Commissioning Panel for Mental Health (JCP-MH) (www.jcpmh.info) is a new collaboration co-chaired by the Royal College of General Practitioners and the Royal College of Psychiatrists, which brings together leading organisations and individuals with an interest in commissioning for mental health and learning disabilities.

The guidance provides key recommendations to commissioners:
Older people's mental health services in particular benefit from an integrated approach with social care services. Most patients in older age mental health services have complex social needs. Commissioners should ensure service providers across agencies work together if they are to meet people's needs and aspirations effectively. A whole system approach that draws together the expertise of health and social care agencies and those in the voluntary sector will deliver a comprehensive, balanced range of services, which places as much emphasis on services that promote independence as on care services.

Older people's mental health services need to work closely with primary care and community services. Models that include primary care 'in-reach' or joint working with community physical health care services, provide more co-ordinated care and should be the norm.

Services must be commissioned on the basis of need and not age alone. Older people's mental health services should not be subsumed into a broader 'adult mental health' or 'ageless service'. The needs of older people with functional mental illness (for example depression) and/or organic disease such as dementia and their associated physical and social issues are often distinct from younger people.

Older people's mental health services must address the needs of people with functional illnesses such as depression and psychosis as well as dementia. The majority of the mental illness experienced by older people is not dementia and there is significant crossover between dementia and functional illnesses such as depression and psychosis.

Older people often have a combination of mental and physical health problems. Commissioners and service providers need to seek and exploit opportunities for joint working and service delivery that can address both physical and mental health needs. Older people with long-term health conditions make up the greater proportion of this care group. Having more than one long-term condition greatly increases the risk of depression. Planning and delivering an integrated service to manage service delivery to this group through joint working protocols will be the best and most cost-effective way to manage care.

Older people's mental health services must be multidisciplinary. Medical doctors are important because of the complex physical and treatment issues common in older people, but given the complex needs of this group, integrated input from nurses, psychologists, physiotherapists, occupational therapists and speech and language therapists is necessary.

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Older people with mental health needs should have access to community crisis or home treatment services. With extended hours of working and intensive crisis management, home treatment workers help to reduce the need for admission, facilitate early discharge and reduce transfer to residential care.

Older people with mental health needs respond well to psychological input. Evidence shows that response rates amongst older people are as good as those of younger adults. The spectrum of psychological service provision at all tiers needs to reflect this.

Older people should have dedicated liaison services in acute hospitals. Over 60% of older people in acute hospital wards have a serious mental disorder which is often unrecognised and delays rehabilitation and discharge. Commissioners must ensure appropriate specialist liaison services are in place with relevant discharge care plans and support from secondary care mental health teams.

Merton's Joint Commissioning Strategy 2010-2015 is built around the outcome objectives of the National Dementia Strategy, 'Living Well with Dementia' (2009). In particular Merton is focussing on raising awareness and understanding of dementia, and ensuring early diagnosis and support. A newly commissioned 'Dementia Hub' delivered with the Alzheimer's Society will implement these objectives. Service outcomes will include enhanced quality of life for people with care and support, ensuring people have a positive experience of this care and support, and delaying or reducing the need for council funded social care.

The Triangle of Care- Carers Included: A Guide to Best Practice in Mental Health Care in England, Second Edition, 2013.
http://static.carers.org/files/the-triangle-of-care-carers-included-final-6748.pdf

The Triangle of Care is a therapeutic alliance between service user, staff member and carer that promotes safety, supports recovery and sustains wellbeing.

The key elements to achieving a Triangle of Care
The essence of this guide is to clearly identify the six key elements (standards) required to achieve better collaboration and partnership with carers in the service user and carer's journey through mental health services. For each element we suggest good practice examples and resources that may be helpful. The six key standards state that:
1) Carers and the essential role they play are identified at first contact or as soon as possible thereafter.
2) Staff are 'carer aware' and trained in carer engagement strategies.
3) Policy and practice protocols re: confidentiality and sharing information are in place.
4) Defined post(s) responsible for carers are in place.
5) A carer introduction to the service and staff is available, with a relevant range of information across the care pathway.
6) A range of carer support services is available.

In addition to the above, there also needs to be regular assessing and auditing to ensure these six key standards of carer engagement exist and remain in place. A self-assessment audit tool for carer engagement is included in the report.

What are the gaps in Merton?

1. **Equity issue: Under-representation of Asians and over-representation of black minority ethnic groups**
   Analysis of the data clearly indicates which groups are the most vulnerable in Merton and which groups needs to be therefore targeted more effectively. Black ethnicities are over-represented (in-patients) and Asians significantly under-represented (both in-patients and Community Mental Health Services-CMHS) in our mental health services. In the case of Asian communities this under-representation suggests inequity in access and cultural taboos and stigma associated with mental illness. In Black ethnicities the over-representation could be due to the underlying risks of mental illness in different ethnicities, but it is possible that a number of patients are being diagnosed later and with more severe symptoms, who could have otherwise been managed in the community. More targeted work is required with these communities and there is a need to develop services that are more accessible to BME groups- especially Asians.

2. **Services that address the dual diagnosis of substance misuse and mental ill-health and hidden harms**
   Psychoactive substances are the most common cause for community mental health referrals and the second most common cause for in-patient admissions in working age adults in Merton. The overwhelming majority of these were for alcohol related problems. The issue of dual diagnosis is a significant one for Merton - with so many admissions and referrals due to psychoactive substances, increased focus is required on prevention and early detection in addition to treatment. The 'hidden harms' aspects of this are likely to be considerable, i.e. the impact on children living with parent(s) with dual diagnosis. There could be potential safe-guarding risks, crime-related issues and a wider reputational risk to both London Borough of Merton and the NHS. The hidden harms aspect is not just about dual diagnosis but extends to parents with mental illnesses (and not substance misuse) as well.

3. **Personality disorders (PD)**
   Around 8-9% of all in-patient cases and patients in CMHS are seen because of personality disorders. Anecdotal evidence suggests that there are significant numbers of undiagnosed cases of PD in the community, and there needs to be more and better access to psychological treatment (DBT/MBT) for cases of PD and dual diagnosis with PD. Considerable preparatory work is required to get PD cases ready for such therapies.

4. **Primary care variation by practice, variable quality outcomes and under-diagnosis**
   Findings suggest that in primary care there is considerable variation by practice, variable quality of outcomes and under-diagnosis. The 2012-13 QOF data for both depression and dementia suggest that at primary care level, there is under-diagnosis of both in Merton, and that there is considerable variation between GP practices especially when comparing the GPs in East Merton (where the data indicates even more under-diagnosis) with those in West Merton.

   While the latest HSCIC data on further assessment of depression severity is reported for 2011-12 and is for Sutton and Merton PCT, it suggests that we have the lowest percentage of patients undergoing further assessment of depression in SW London, lower than some statistical neighbours and lower than England. 2012-13 QOF data suggests considerable variation by GP practices in Merton, and that in East Merton especially for MH 17 - The

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percentage of patients on lithium therapy with a record of serum creatinine and TSH in the preceding 9 months, and MH 18 - The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range within the preceding 4 months- there are more practices which have low percentages compared to GP practices elsewhere in Merton.

NHS Dementia Prevalence Calculator indicates that the current detection rate of dementia in Merton is 47% (CQUIN data Q3 2013-14) which is better than many of our geographical and statistical neighbours but still means that there are estimated to be 1,057 undiagnosed dementia cases in Merton in 2014-15. There is an on-going refresh of the Merton dementia strategy to deal effectively with this.

5. **Primary Care management of the physical health of Merton residents with schizophrenia**
   Findings suggest that more work is required to ensure the physical health of Merton residents with schizophrenia is better managed at primary care level. While emergency hospital admissions for schizophrenia in Merton are among the lowest in London and lower than all our SW London and statistical neighbours, the 2014 NEPHO SMI profile for Merton indicates that Merton has a significantly higher than average percentage of mental health service users who were inpatients in a psychiatric hospital and that Merton has a significantly higher than average (England) percentage of mental health service users who were inpatients in a psychiatric hospital. Local data indicates that admissions and referrals for schizophrenia are also increasing. This could be reflecting an increase in the prevalence of psychosis in Merton. HSCIC data indicates that in Merton the follow-up of non-attendance at annual review among patients with psychoses is among the lowest in SW London (especially considering that Kingston and Richmond PCTs achieved 100%), lower than Ealing and Harrow PCTs among statistical neighbours, and lower than England. For 2012-13 QOF indicators MH 16 (The percentage of patients aged from 25 to 64 with schizophrenia, bipolar affective disorder and other psychoses whose notes record that a cervical screening test has been performed in the preceding 5 years) and MH19 (The percentage of patients aged 40 years and over with schizophrenia, bipolar affective disorder and other psychoses who have a record of total cholesterol: HDL ratio in the preceding 15 months) the GP practices in Merton do not perform very well and there is considerable variation between practices and by East-West Merton.

6. **Referrals to community mental health services**
   In terms of referrals to community mental health services in Merton, 44% were from GPs & the next largest sources of referrals were internal (16%) and then Accident & Emergency services (12%). While it is encouraging that GP referrals were the highest, this could be improved further. Furthermore it appears that GPs in East Merton are making fewer referrals than West Merton GPs. There were fewer referrals from the Merton Local Authority (including Adult Social Care, Education & other departments) combined (2.6%) than Merton residents who self-referred (2.9%) . This perhaps indicates that more training and awareness raising is required for front-line staff (in all sectors including Metropolitan Police) on detecting the signs of mental ill health, local services and pathways, and how and where to refer someone to. The DH policy "No Health Without Mental Health" states that frontline workers, across the full range of services, are to be trained to understand better about mental health, the principles of recovery and be able to tackle any stigma related to mental health[182].

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[182] Department of Health published a cross-government strategy on mental health "No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages" in 2011. (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/135457/dh_124058.pdf.pdf)

7. **IAPT services**

   In terms of IAPT services, Merton has the lowest proportion of cases that moved to recovery in SW London and compared with the London average. From August 2012- August 2013, the recovery rate for Merton was 35.7% against a local target of 43% and a national target of 50%. This has been the case for some years as the NEPHO 2014 community MH profile indicates that in 2012/13 the IAPT recovery rate at 37.9% was significantly worse than England (45.9%). The percentage of referrals waiting less than 28 days for IAPT services are significantly lower than average but in contrast for waiting times greater than 90 days Merton has significantly higher than average percentages. This could mean that more referrals are waiting over 90 days than they are less than 28 days. Merton CCG is undertaking a specific project to look at the IAPT service and how it can be made more effective.

8. **Smoking and mental health**

   Smoking and mental health have very strong and significant links. SWLStG MH NHS Trust has had a CQUIN on smoking since 2010-11 and this ends in March 2014. Data provided by the Trust suggests that an effective smoking cessation service had been established although it was unclear from the data what the disaggregated figures for Merton were. This service is meant to be mainstreamed into SWLStG MHT but there is a risk to the service till it is assured that this has indeed happened.

9. **Gaps expressed by service users in consultations**

   Although the consultations in the qualitative study identified a variety of both positive and negative experiences of mental health services in Merton, the views expressed by service users and carers were for the most part critical. Service users' main concerns in this study were around continuing attitudes to mental illness, experience of care, and cuts in services. Their most prominently expressed issues with Merton's mental health provision were the loss of drop-in/day centres, perceived powerlessness in influencing their care and services that where dominated by a medical approach to treatment.

10. **Gaps expressed by carers in consultations**

    The most important issues for carers were their poor involvement in decisions about the care, properly informed sessions, providing support in the areas of training in managing specific situations. There is no up-to-date carer's strategy for Merton and this needs to be addressed. The triangle of care model must be sustained.

11. **Cultural competence of services**

    BME service users and carers reported particular challenges in different areas, exposing the importance of developing cultural competence within the mainstream services along with targeted provision specifically tailored to their unique needs. The data stated earlier, which shows that black ethnicities were over-represented and Asians significantly under-represented, back this expressed need. Furthermore this is specifically emphasized in the DH policy, "No Health without Mental Health"[183] and the implementation framework[184] which state that services should actively promote equality and must be accessible, acceptable, and culturally appropriate to all the communities. Public Bodies must meet their obligations under the Equality Act 2010.

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[183] Department of Health published a cross-government strategy on mental health "No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages" in 2011.
(https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/135457/dh_124058.pdf.pdf)
[184] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/156084/No-Health-Without-Mental-Health-Implementation-Framework-Report-accessible-version.pdf.pdf

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Service providers offered insights into the main strategies they employed to deliver more user-responsive services. These were:

e. Adopting a more open and candid approach with users informed by the policy recommendations of the Francis report.
f. Established feedback and stepped complaints procedures
g. Developing different ways of working, and
h. Fostering partnership working.

Staff training and education underpinned all four approaches.

Health and social care recommendations

The recommendations stem from the gaps identified in the previous section. The recommendations are directed towards all commissioners, health planners, service providers, the voluntary sector and other relevant professionals and organisations. All decisions on mental health and social care should be underpinned by the principles that follow.

Overarching principles

Life-course, "stepped-down" approach to mental health
Services should be based around individuals to promote recovery and enable independence. A life-course, "stepped-down" approach should be adopted to mental health that takes into account the economic benefits of protecting and promoting mental health and well-being. Such approaches should encompass early intervention, prevention, recovery, well-being and reducing mortality, and should consider care pathways from childhood through older adulthood, providing age and culturally appropriate, evidence-based prevention and care at the earliest stage possible, with a view of acting early and effectively, so that care at subsequent stages can be stepped down.

Prevention, early detection, rehabilitation
Services should span across the whole spectrum, from prevention, early detection, intervention and treatment through to rehabilitation. Since the majority of mental illnesses have childhood antecedents, childhood interventions which protect health and well-being and promote resilience to adversity should be implemented.

Care pathway development
Clear and unambiguous care pathways must be developed that cover all facets of mental health support and services in Merton, extending back to the community to ensure that prevention is included and that all front-line workers are aware of how Merton residents can be referred to these services.

"Whole family" approach
Since parental mental health has a direct influence on child mental health, strategies to promote parental mental health and effectively treat parental mental illness are important[185]. The treatment of parent(s) with mental ill health needs to address the needs of dependent children as well, enabling parent(s) to fulfil their role(s) as primary carer(s). This requires a "whole family" approach to treating mental illness.

Whole systems approach
A whole system approach should be adopted, that draws together the expertise of health and social care agencies and those in the voluntary sector to deliver a comprehensive, balanced range of services, placing as much emphasis on services that promote independence as it does on care services, as well as the physical health of those with mental health conditions.

Mental health inequalities
In designing mental health services, care should be paid to addressing any health inequalities in service provision and the access to these services. An effective public health strategy requires

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[185] No health without public mental health: The case for action, Royal College of Psychiatrists, 2010;
http://www.rcpsych.ac.uk/pdf/Position%20Statement%204%20website.pdf

both universal interventions, applied to the entire population, and interventions focussed at those people who are less likely to benefit from universal approaches and are at higher risk[186].

Service user and carer involvement
People with mental health problems, their families and carers, should continue to be involved in all aspects of service design and delivery.

Re-aligning services and budgets to deliver a stream-lined, integrated care pathway
Opportunities for joint working and service delivery that can address both physical and mental health needs must be sought and exploited. This includes re-aligning budgets where feasible, so that the appropriate services and interventions can be commissioned jointly by multiple partners in the most cost-effective way.

Quality and safety standards of commissioned services
Services must meet national quality and safety standards laid down by bodies such as NICE & CQC. The report of the current CQC inspection of SWLStG MHT will help to determine the quality and safety of our mental health services.

Recommendations

1. *Promoting Mental Health and Wellbeing*

1.1. **Promoting public mental health**
There is growing emphasis to promote mental wellbeing of the whole population, as well as an on-going commitment to reducing health inequalities in health (there are separate recommendations on health inequalities included in recommendation 4).

    a.   It is recommended that steps are taken to promote positive mental health and wellbeing and prevent mental ill-health, taking a life-course approach.

    b.   This encompasses taking a whole community approach to recovery, addressing factors that influence mental wellbeing for everyone, whether or not they have a diagnosis; and creating environments and cultures that support wellbeing from schools and colleges, to work places and on the streets.

1.2. **Smoking cessation and healthy lifestyles**
    a.   As of 31st March 2014, the CQUIN on smoking cessation services for SWLStG MHT will cease to exist. It must be ensured that the Trust embeds this service in line with NICE public health guidance PH48 and that an on-site stop smoking services continues to be provided.
    b.   Smoking cessation support to Merton residents with mental ill-health must also be provided by community-based and primary care service and mental health should be mainstreamed within general smoking prevention and cessation programmes in the borough.

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[186] No health without public mental health: The case for action, Royal College of Psychiatrists, 2010
http://www.rcpsych.ac.uk/pdf/Position%20Statement%204%20website.pdf

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c. It is recommended that all patients on GP Practice's SMI register who smoke should be routinely referred to LiveWell for smoking cessation advice.

d. It must be ensured that people with diagnosed mental illnesses, especially psychosis or schizophrenia and those taking antipsychotics are offered a combined healthy eating and physical activity programme by their mental healthcare provider[187].

e. The percentage of adults participating in recommended levels of physical activity is lower in Merton than the London and England averages and this percentage must be increased as the link between physical activity and mental health and wellbeing is well established.

1.3. **Promoting mental wellbeing early in life**

a. The most important opportunities for prevention of mental illness and promotion of mental health wellbeing lie in childhood, many of them in the context of the family. *The most important modifiable risk factor for mental health problems in childhood, and thus in adult life in general, is parenting*[188].

b. The key way to reduce risk in very early childhood is to promote healthy parenting focusing on the quality of parent-infant/child relationships, parenting styles including behaviour management, and infant and child nutrition (including breast-feeding and healthy eating). Parental mental illness and parental lifestyle behaviours such as smoking, and drug and alcohol misuse are important risk factors for childhood mental health problems[189].

c. Schools offer another important opportunity for promotion and prevention. School, school ethos, bullying and teacher wellbeing all have an influence on children's current and future mental health[190]. Mental health promotion programmes that can modify these factors, and also mitigate mental health problems initiated from within the family, must be provided in schools in Merton.

1.4. **Enabling more people with mental ill-health to remain in or move into work**

People with mental ill health frequently experience high levels of unemployment. Conversely people who are not in employment are more susceptible to mental ill health. For people with mental ill health who are unable to attend mainstream education, training or work, London Borough of Merton should ensure that commissioned services are effective in providing alternative educational or occupational activities according to their individual needs and capacity to engage with such activities, with an ultimate goal of returning to mainstream education, training or employment.

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[187] NICE Clinical Guideline CG 178: Psychosis and schizophrenia in adults: treatment and management, Feb 2014 http://www.nice.org.uk/nicemedia/live/14382/66534/66534.pdf
[188] http://www.fph.org.uk/parenting
[189] Göpfert M, Webster J, Seema MV, (eds). Parental psychiatric disorder: distressed parents and their families. Cambridge, CUP 2004
[190] Weare K. Promoting mental, emotional, and social health: a whole school approach. Psychology Press, 2000

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1.5. **Providing good quality housing**

a. There is an extensive body of academic, policy-related and community based literature that describes the powerful nature of housing as a social determinant of population health. The relationship that exists between poor housing (or a lack of housing) and poor mental and physical health is well-documented[191][192]. The spectrum of accommodation in Merton, from high to low dependency and independent accommodation for people with mental health need should be reviewed, in order to establish the current needs, to enable forward planning for the future provision of housing and support options for people with mental health needs.

b. LBM should consider how Merton can benefit from the Department of Health recently allocating up to £43 million from the Care and Support Specialised Housing (CASSH) Fund[193] to support the construction of a small number of housing projects for people with mental health problems or learning disabilities. These projects will be designed in close conjunction with mental health and learning disability policy experts and representatives of relevant charities. Their ambition is to receive bids from potential developers by 2015 and seeing some homes available by 2017.

1.6. **Workplace wellbeing**

a. All employers in Merton (including in LBM and MCCG) should be sensitive to the potential mental health issues underlying sickness absence. They should ensure adequate occupational health provision, and through employee assistance programmes, employees are supported to prevent the build-up of unmanageable stress, and healthy workplaces are actively promoted. Evidence states that workplace screening for depression and anxiety disorders is cost-effective, with the benefits gained through the reduction in levels of absenteeism, and improved productivity through reduction in presenteeism.

b. Public Health Merton is currently developing a Merton workforce strategy based on absence research that is looking at the reasons behind the sickness absence rates in the London Borough of Merton (Council). Work related stress comes up in the findings as an important reason. It is recommended that the findings of this report are taken into account while considering measures to create a healthy workplace.

2. *Parental and child mental health*

The following generic recommendations are sourced from national policy documents[194] [195] and it is suggested that the Merton Local Safeguarding Children's Board (LSCB) partners should assure themselves and the LSCB that these are embedded in local practice.

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[191] Jacobs DE, Wilson J, Dixon SL, Smith J, Evens A. *The Relationship of Housing and Population Health: A 30-Year Retrospective Analysis Environmental Health Perspectives*. 2009;117(4):597–604

[192] Canadian Institute for Health Information. *Improving the Health of Canadians: Mental Health and Homelessness*. Ottawa: Canadian Institute for Health Information; 2007.

[193] Closing the gap: priorities for essential change in mental health, February 2014; Department of Health. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281250/Closing_the_gap_V2_-_17_Feb_2014.pdf

[194] What about the children? Joint working between adult and children's services when parents or carers have mental ill health and/or drug and alcohol problems; Ofsted March 2013, Ref no. 130066.

[195] Cleaver H, Unell I and Aldgate J; Children's Needs- Parenting Capacity, Child Abuse: Parental mental illness, learning disability, substance misuse, and domestic violence; 2nd Edition, TSO (The Stationery Office); Norwich, 2011.

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2.1 **The Local Safeguarding Children's Board (LSCB) should assure that**:
Structures are in place for joint training and joint supervision to ensure that all children's and adult services practitioners working with families affected by mental health difficulties and/or drug and alcohol problems have a thorough understanding of the impact of these difficulties on children and the opportunity to reflect together on their joint responsibilities in tackling concerns.

2.2 **Adult mental health services should:**
a. increase awareness of the role of adult mental health professionals in safeguarding the children of adult service users

b. orient early identification and assessment to ensure children and young people living with parental mental illness, learning disability, substance misuse and domestic violence, are not left in dangerous and abusive situations. Early identification depends on ensuring children and young people have opportunities to discuss their experiences with a trusted adult.

c. review recording systems to ensure that information about children is set out clearly and in sufficient detail to establish children's needs and risks, to identify young carers and to assess whether there is a need for early support

d. collate data and report to the LSCB on the numbers of children affected by adult mental health difficulties

e. ensure that managers are aware of all cases in which adults with mental health difficulties have children, or where there are children in the household, and that all these cases have appropriate and recorded oversight.

2.3 **Commissioners of adult mental health services should:**
a. ensure that the role of adult mental health services in safeguarding and protecting children is set out comprehensively and explicitly in all relevant tender documents and in contracts

b. have systems in place to monitor the extent to which adult mental health services meet their responsibilities to safeguard and protect children

c. Ensure stable funding for voluntary and community based programmes is required to provide the necessary long-term support to ensure children living with families with complex needs are safe

2.4 **Adult mental health services and drug and alcohol services should**:
a. ensure that practitioners consistently challenge decisions by children's social care to take no further action if in their judgement action is warranted, using escalation processes where necessary

b. review recording systems to ensure that children and young people who are undertaking inappropriate caring responsibilities for parents or siblings are identified, and that their needs are explicitly considered and referred for support when necessary

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c. ensure that adult assessments consider the need for early support for parents, carers and children and that action is taken to put this in place.

2.5 **Local authorities (Adult and Child Social Services), mental health services and drug and alcohol services should:**
Ensure that staff liaise with each other and agree a joint plan of action when parents or carers do not attend appointments with adult services.

2.6 **Local authorities (Adult and Child Social Services) and mental health services should**:
a. improve the quality of assessments of the impact of mental health difficulties on children, ensuring that children's social workers and adult mental health practitioners work together to assess and agree effective action plans

b. review arrangements for discharging patients from hospitals to ensure that discharge meetings involve children's social workers where appropriate; that the needs of the children are considered and that discharge plans set out clearly when/if parents or carers will be ready to resume the care of their children.

3. *Tackling Dementia in Merton*

3.1. **Supporting the Dementia Hub**
With the launch of the Dementia Hub in Merton[196] it must be ensured that relevant services are aware of this centre and how patients with dementia can be referred to it. This is particularly applicable to GP practices as GPs have a pivotal role to play in the early detection and referral of residents of Merton with dementia.

3.2. **Dementia awareness and training**
Dementia awareness and training sessions with relevant services, especially in primary care must be organised in a rolling programme that is repeated at regular intervals.

3.3. **Dementia strategy refresh**
The current five year dementia strategy (for Sutton and Merton) which is due to end in 2015, must be refreshed to reflect the current organisational changes in health and social care, and the dementia strategy implementation plan must be updated.

3.4. **Preventing dementia**
Awareness must be raised of evidence-based measures to prevent dementia (the six pillars of a brain-healthy lifestyle: regular exercise, healthy diet, mental stimulation, quality sleep, stress management and an active social life[197]) to relevant services, professionals and lay public in Merton. Community-based projects or pilots to prevent dementia and promote dementia awareness should be considered.

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[196] http://www.alzheimers.org.uk/site/custom_scripts/branch.php?branch=true&branchCode=13596&areaBC=EALO
[197] http://www.helpguide.org/elder/alzheimers_prevention_slowing_down_treatment.htm

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4. *Improving services for people with a dual diagnosis of substance misuse and mental ill-health*

4.1. **Early identification of dual diagnosis and prevention work**

Developing &/or strengthening services should be considered, to ensure that dual diagnosis of substance misuse and mental ill health is identified early and that there are clear eligibility criteria, referral and care pathways, and robust outcome measures for dual diagnosis

4.2. **Joint service provision and pathways for dual diagnosis**

   a. Joint commissioning of mental health and drug or alcohol services needs to become the norm in the areas of general health, mental health, substance misuse (including alcohol), social care, education, community safety, crime (including domestic violence) and safeguarding in both children and adults, linking promotion and prevention much more closely with treatment and care for substance use and mental health.

   b. To ensure 4.2a above, all contracts with providers need to stipulate effective joint working and clear pathways, to meet the needs of people with co-existing mental health needs and substance misuse problems.

4.3. **"Hidden harms" of substance misuse**

LBM is planning a needs assessment on Hidden Harm in Merton. It is recommended that appropriate services are jointly developed; to tackle hidden harm and support this needs assessment, considering its recommendations in the development of this work. A dual diagnosis in one or both parents or caregivers has significant impacts on children living with them. The hidden harms aspect is not just about dual diagnosis but extends to parents with mental illnesses (and not substance misuse) as well.

4.4. **Personality disorders (PD)- with and without dual diagnosis**

Around 8-9% of all in-patient cases and patients in CMHS are seen because of personality disorders. Anecdotal evidence suggests that there are significant numbers of undiagnosed cases of PD in the community, and there needs to be more and better access to psychological treatment (DBT/MBT) for cases of PD and dual diagnosis with PD. Considerable preparatory work is required to get PD cases ready for such therapies.

5. *Addressing Health inequalities and inequity*

5.1. **Black and Minority Ethnic groups**

The findings from this report indicate that black communities are over-represented in in-patient services (but not in CMHS) and Asians are significantly under-represented in both in-patient and community mental health services. A range of early intervention and support services should be considered that are culturally sensitive to Merton's BME groups that promote mental health wellbeing and reduce stigma. The services should be targeted and outcome specific.

5.2. **Local care pathways**

It should be ensured that local care pathways promote access to the services by wider communities including socially excluded groups such as black and minority ethnic groups, older people, those in prison or in contact with the criminal justice system and ex-service personnel.

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5.3. **Services for older people**

    a. It has been estimated that at any given time in a typical 500-bed district general hospital, 220 beds are occupied by older people with mental health problems: 102 with dementia and 96 with depression[198]. Services and pathways should be developed to address the specific needs of older adults in Merton and these services should be appropriate for this age group, helping to reduce the demand on acute beds by increasing care for the frail and elderly in community settings, providing a holistic assessment in the community, and ensuring that both mental and physical health are addressed..

    b. Rather than the current generic system in Merton, a specialist liaison psychiatry service for older people based in acute hospitals could be developed. Mental health liaison services can help increase productivity in acute hospitals by improving older people's clinical outcomes while reducing length of stay and re-admission rates[199].

    c. Development in this area should be linked with the on-going integration work in Merton under the Better Care Fund.

6. *Improving engagement with and support for service users and carers*

6.1. **Education and Training of front-line staff**

It must be ensured that frontline workers, across the full range of services, are trained to understand better about mental health, the principles of recovery and are able to tackle any stigma related to mental health. Furthermore training must be provided on the services that exist in Merton, the care pathways and how to refer a person to the appropriate mental health services.

6.2. **Education and Training of healthcare professionals in primary care**

Healthcare professionals in primary care including GPs need training and education in order to better recognise mental ill health, engage and support patients on this, and accord parity of esteem to mental ill health. Consultations with service users revealed that primary care professionals were perceived by some to have an inadequate understanding of mental illness, and service users reporting a negative experience on the whole.

6.3. **Carer needs**

Consultations with carers revealed that pro-active information-sharing and guidance, their involvement in decisions about the care provided, properly informed sessions and providing support/training in managing specific conditions were the most important issues for them. Feedback from the carers indicated that these arrangements and provisions were not as good as they needed to be. It needs to be ensured that these provisions are improved for carers. There is no up-to-date carer's strategy for Merton and this needs to be addressed. The triangle of care model must be sustained.

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[198] Anderson D, Banerjee S, Barker A, Connelly P, Junaid O, Series H, Seymour J (2009). The Need to Tackle Age Discrimination in Mental Health: A compendium of evidence. London: Faculty of Old Age Psychiatry, Royal College of Psychiatrists. Available at:
www.rcpsych.ac.uk/pdf/Royal%20College%20of%20Psychiatrists%20%20The%20Need%20to%20Tackle%20Age%20Discrimination%20in%20Mental%20Health%20Services%20-%20Oct09.pdf
[199] Naylor C, Bell A (2010); Mental Health And The Productivity Challenge, Improving quality and value for money; The King's Fund and Centre for Mental Health.

6.4. **Enabling access to services for Merton residents with mental health conditions**

Service users and carers in our consultations felt that not having the Freedom Pass severely limited their ability to get around and could contribute to a worsening of their problems. Many mental health service users are not in employment or on low incomes and they struggle with the cost of transport. It is recommended that the London Borough of Merton takes steps to enable Merton residents with mental ill-health to access services that are so vital for their wellbeing, bearing in mind that the Freedom Pass is no longer available.

7. *Primary care and IAPT services*

7.1. **Variation in quality and under-diagnosis in Primary Care**

Variations in quality and under-diagnosis need to be understood in greater depth (i.e. how much is due to differences in coding and how much is actual) and minimised in primary care, particularly in GP practices in East Merton. In the consultations in this needs assessment both service users and carers expressed the view that health services continue to give less attention to mental illnesses than to physical illnesses and primary care professionals had an inadequate understanding of mental illness. Health professionals in primary care (including GPs) need training and education in order to better recognise mental ill health, engage and support patients on this, and accord parity of esteem to mental ill health.

7.2. **Physical health of Merton residents with mental ill-health**

The physical health of Merton residents with mental health conditions needs to be monitored regularly. NICE guidance CG 178 recommends that GPs and other primary healthcare professionals should monitor the physical health of people with psychosis or schizophrenia when responsibility for monitoring is transferred from secondary care, and then at least annually. The physical health of patients with schizophrenia in particular needs to be better managed in Primary Care.

7.3. **Transfer of care from secondary to primary care**

The transition between secondary care and primary care in relation to all mental illnesses but specially schizophrenia must be well managed.

7.4. **Primary Care integration**

There must be more integration of mental health related services in primary care between health, social care, housing, employment, legal services and community services. This includes greater integration between physical and mental health, and the early identification of illness and comorbidity, reduced stigma, and social inclusion.

7.5. **Psychological therapies**

There are a number of issues around the current IAPT service that are being addressed by the Merton CCG. These include consistently low recovery rates against local and national targets, and the profile of cases being seen tending to belong to the more severe spectrum of mental disorders. Merton CCG is undertaking a specific programme of work that is reviewing the IAPT service and considering how to make it more effective.

8. *Improving rehabilitation and stepped down provision*

8.1. There is a need to undertake a more detailed piece of work to understand the current step-down provision from acute services when patients are well enough to be discharged from an acute bed but not well enough to live independently at home. This work will help to consider alternative options and to design a provision that is fit for purpose, mindful of the principle of "Right Care at the Right Place" and commissioning services closer to home and in the least restrictive environment.

8.2. Co-ordinated working with LB Merton will be required to understand the demand and capacity for step-down placements for social care needs, including housing.

9. *Areas where more research required*

While this report covers a wide expanse of issues pertinent to adult mental health in Merton, there are some areas that are not covered and need more work. These areas are learning disabilities, the interface between children and adult mental health services (especially the transition) and in general there is need for a CAMHS health needs assessment.

Appendix 1: Qualitative work: Information Sheet

Merton Mental Health Review
Information Sheet

What is the review about?
Merton Council Public Health team is currently carrying out a review of Mental Health services for adults and elderly people in the borough. The aim is to get a clearer picture of mental health needs and identify what services are lacking.

What will it involve?
We wish to get feedback from people who use mental health services, the people who care for them and the services that provide their care. We plan to do this through consultations where we will ask your views about current services. The questions will cover a range of areas such as knowledge of what services are available, problems with accessing them, and the quality of care provided. We are also interested to know what has worked well, what you value about the services, and what you would like to see improved.

How will it be carried out?
If you are happy to take part, we will discuss with you either one-to-one or as part of a small group of about six to eight people at a time and location convenient for you. The discussion will last about 30-40 minutes for individuals and about 60-90 minutes for the groups. With your permission, we will record what you say to ensure that we correctly understand it. Refreshment will be provided at the group events.

Who will see my information?
Whatever you tell us will be used only for the review. Any personal information you provide will be treated in confidence and will not be able to be used to identify you. You have the right to refuse to answer any questions you are not comfortable with and to withdraw from the discussion at any time without having to give a reason.

How will the information be used?
The information you provide, alongside other statistical information we are reviewing, will be included in a report that will describe how well current services are meeting people's needs and how they can be improved.

Where can I get further information or make a complaint about the consultation?
You can contact the following people from Merton Council Public Health and the Consultation team.

Merton Council Public Health | Consultation team

Dr. Anjan Ghosh | Dr Patrick Tobi
Interim Consultant in Public Health | Institute for health and Human Development
Public Health Team | University of East London
London Borough of Merton | Water Lane, Stratford
phone: 020 8545 4848 | phone: 020 8223 4473
email: anjan.ghosh@merton.gov.uk | email: p.tobi@uel.ac.uk

Thank you for taking part.
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Appendix 2: Qualitative work: Consent form

Merton Mental Health Review
Consent form

tick

The purpose of the consultation has been explained to me and I know where to get further information. I understand what is being proposed and why I have been approached.

I understand that any personal information I provide will remain strictly confidential and will not be able to be used to identify me. Only those directly involved in carrying out the review will have access to the information.

I understand that the answers I provide will be recorded with my consent. The reason for recording has been explained to me.

I understand that I have the right to refuse to answer any questions I am not comfortable with and to withdraw at any time without disadvantage to myself and without being obliged to give a reason.

I am a *(tick one)*:   Mental health service user   ☐

Carer of a mental health service user   ☐

Mental health service provider   ☐

Participant's name: …………………………………………………   Signature: …………………………………
          (BLOCK CAPITALS)

Interviewer's name: …………………………………………………   Signature: …………………………………
          (BLOCK CAPITALS)

Date: …………………………………………………

Appendix 3: Qualitative work: Interview schedule for service users

Focus Group Topic Guide for Service Users

Discussion theme	Probes
1. KNOWLEDGE OF SERVICES Can you briefly tell me what mental health services in Merton you know about?	*Range of provision* *Sources of knowledge*
2. ACCESS What is your experience of attending an appointment? How well does the referral process work?	*What is the average waiting time?* *Do the times/dates of appointments suit you? Is there flexibility in scheduling appointments?* *Distance to services* *Transport support (Freedom Pass)* *Physical barriers in the service setting*
3. QUALITY OF CARE How effective do you find the care you receive? How would you describe your relationship with the health professionals who provide your care?	*How confident are you in the competence of the health professionals?* *Professionalism of the staff* *Sensitivity of the service to your cultural values*
4. WIDER SUPPORT In what ways does the service involve your family and carer in your care?	*How are they supported to care for you?*
5. CONTINUITY OF CARE What is your experience of being referred between different services, for instance from primary to secondary care?	*In what ways are you involved in and kept informed during transition or referral?*
6. DECISION MAKING To what extent do you think your views and preferences are taken on board in decisions about your care?	*Sense of coercion?*
7. COMMUNICATION How understandable is the information you receive from your health professional? Are you able to contribute your views?	*How is information usually communicated to you – phone, text, email, etc?* *From whom do you get the information?* *Are there any particular words or phrases used that you find inappropriate or objectionable?* *Are you able to question, seek clarification or give feedback?*
8. STIGMA/DISCRIMINATION What do you think of current attitudes to mental illness?	*How open are you about discussing your mental illness?* *How has that changed from the past?* *Do you feel that you would be treated differently if you had a physical illness?*
9. GENERAL Finally, can I ask what aspects of mental health services overall you like and do not like and why?	*Service barriers/facilitators*

Appendix 4: Qualitative work: Interview schedule for carers

Merton Mental Health Review
Topic guide for Carers

Theme	*Questions*
1. Role	• Tell me about your role as a carer? • What type of support do you provide - role at the beginning, accessing care, planning care, involvement in meetings, role in medication, etc)?
2. Service user's relationship with the service	• Views about performance of the service and quality of care provided • Contact with service – comfortable/uncomfortable • Kind of care needed/wanted versus care received/not received • Crises and response of service(s) • Communication with service providers
3. Your own relationship with the service	• Views about performance of the service and quality of care provided • Contact with service – comfortable/uncomfortable • Kind of support needed/wanted versus support received/not received • Crises and response of service(s) • Communication with service providers
4. Your needs	• What problems do you face (e.g. stigma, lack of time/resources, changes to relationships/social networks, mental and physical health)? • Have your needs ever been assessed? • What kind of support would be helpful to you?
5. Information needs	• Understanding of information given by providers (e.g. care arrangements, discharge plans, medication and side effects) • Carers groups/services • Cultural competence
6. Improvement	• With current services, what has worked well for you and what hasn't? • What would you see as an ideal service for you?

Appendix 5: Qualitative work: Interview schedule for service providers

Merton Mental Health Review
Interview guide for service providers

Theme	*Questions*
7. Attitudes	• How do you think attitudes to mental illness have changed (a) in the wider society, and (b) among health professionals? (e.g. openness about mental illness, recognition of it as being at par with physical conditions)? • How have mental health services themselves changed in the way they deal with service users?
8. Provision	• Who are the main users of your services? • What do you think are their barriers to accessing care and how does your service minimise these barriers? • How are relationships developed with service users? • How do you involve users, their families and carers in the provision of care? • When it is needed, in what ways are you able to provide culturally competent care? • What is your view about the demand for mental health care in Merton and the capacity to meet it by (a) your organisation, and (b) Mental Health services more generally? • What links/relationships do you have with other Mental Health services, and how can these be strengthened?
9. Service assessment	• How do you evaluate your service – in terms of user experience and service performance? • What complaints process do you have in place?
10. Gaps	• Who are you currently not reaching that you would like to? • What are you not currently providing that you would like to?
11. Development	• What new services are you planning for the future? • What suggestions do you have for how services might be better commissioned?

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Appendix 6: ICD 10 Codes for mental illnesses

ICD10 code range chapter F	Broad code grouping
F01 - F09	Organic including symptomatic disorders
F10-F19	Psychoactive substances
F20-F29	Schizophrenia, schizotypal and delusional disorders
F30-F39	Mood affective disorders
F40-F49	Neurotic, anxiety and stress disorders
F50-F59	Behavioural syndromes
F60-F69	Adult personality & behavioural disorders
F70-F79	Mental retardation
F80-F89	Disorders of psychological development
F90-F98	Behavioural and emotional disorders with onset usually in childhood or adolescence
F99	Unspecified mental disorders
Source: World Health Organisation The ICD-10 Classification of Mental and Behavioural Disorders	

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Merton Mental Health Needs Assessment:

Supplementary Report

Merton Mental Health Review

Stakeholder Workshop 28.07.2014

"This is possibly the first time since I became an unpaid carer in 2009 that I felt comfortable enough to speak honestly about my experiences and overcoming my fear of health professionals."

-Quotation from a participant at the event

CONTENTS

Word Cloud* from the feedback of the workshop

*A word cloud is a pictorial depiction of a collection of words. The bigger a word, the more frequently it was mentioned.

Summary

A workshop was held on 28th July 2014, with service users, carers, voluntary sector and community organisations, and statutory organisations including key providers, commissioners and mental health professionals in Merton. Hosted by the London Borough of Merton (LBM) and NHS Merton Clinical Commissioning Group (MCCG) and facilitated by Merton Healthwatch, this event obtained views and facilitated discussion about the Merton Adult Mental Health Needs Assessment (MMHNA) findings. In addition to the recommendations from the MMHNA, feedback in this report will support the future commissioning of mental health services in the Borough.

Detailed feedback is described in this report in themes corresponding with the MMHNA themes, plus there is additional feedback. There are some broad themes that emerged from the stakeholder workshop, which are key areas that commissioners must take into account in their plans:

Parity of esteem: It is vital to regard, talk about and address mental ill-health in the same way we do about physical ill-health.

Re-entry into the community: A critical juncture in the recovery and support of people with mental ill-health is when they are discharged from acute care into the community. It is crucial that there is a supportive and stable environment available to people with a mental health condition, especially around housing and countering the loneliness, isolation and alienating effects they may experience.

Community support and easy access to care: This is of paramount importance in sustaining patients once they are discharged from hospital, as well as for people with mental ill-health seen in the community. High quality, easily accessible and culturally competent services must be available to all groups of patients that need them.

Caring for carers: Formal and informal carers are often the back-bone of out of hospital care for people with mental health conditions. It is imperative that carers are provided good quality support for their own physical and mental health needs, have access to appropriate training, and are involved in the care plans of the person(s) they care for. Carers must be supported in order to sustain out of hospital care.

Commitment to on-going dialogue and regular workshops: This stakeholder event was very well received by service users and carers, who clearly expressed that this this needs to be a regular and on-going process. Therefore the key commissioners and planners in the borough must commit to regular workshops with users and carers regarding mental health services to ensure commissioners hear live messages, and progress on commissioning and service delivery is shared.

Introduction

A review of Merton's adult mental health services is currently underway. This work is in two stages, the first being an assessment of adult mental health need (completed) and the on-going second stage, which is the development of a commissioning plan. As part of this stage, a stakeholder engagement event was organised jointly by London Borough of Merton (LBM) and NHS Merton Clinical Commissioning Group (MCCG), supported by the Merton Mental Health Review Task and Finish Group and Healthwatch Merton.

Aims and objectives of the event

- Obtain feedback from members of public, service users, carers and local providers, voluntary sector, LBM and MCCG commissioners and key decision makers in Merton about the seven themed areas in the draft Merton Mental Health Needs Assessment (MMHNA).
- Provide recommendations for commissioners in the borough to consider as they formulate their commissioning intentions.
- Facilitate a sense check about the recommendations being considered in the draft MMHNA.

Overview of the day

The event was held from 9:30am to 4:00pm on the 28th of July 2014, at the Vestry Hall in Mitcham, Merton. Around 60 people attended the event, representing most of the major stakeholder groups in Merton including service users, carers, voluntary sector organisations, Merton Voluntary Service Council (MVSC), Healthwatch Merton, faith and community organisations, SW London and St. Georges Mental Health NHS Trust, LBM and MCCG.

The full programme is included in the appendix. The morning session was chaired by the Director of Public Health who also delivered the welcome address. This was followed by an opening speech by the Chief Officer of MCCG, who stayed the entire morning session and returned in the afternoon to make the closing remarks and thank participants for their contributions- something that was appreciated by the participants and recognised as MCCG's commitment to the review. After the opening speech a presentation on the key findings and recommendations of the draft MMHNA (a copy of which was made available to all participants prior to the event) was made. This was followed by table discussions about the MMHNA findings and recommendations, identifying three top questions to ask the panel during the panel discussion that followed. The panel discussion was chaired by the manager of Healthwatch Merton and had eight panel members (see programme in appendix for composition).

The afternoon session was chaired by the manager of Healthwatch Merton and consisted of themed table discussions on the seven themes under which the MMHNA recommendation are organised. Facilitators led the workshops and took notes of these discussions. After this a feedback carousel took place where all the facilitators moved from table to table presenting the main findings for three minutes and taking further comments for another five minutes at each table.

The seven themes for the workshops were:

1. *Mental Health and Wellbeing: Promoting Positive Mental Health, Prevention and Resilience*

This workshop explored the promotion of mental wellbeing of the whole population, lifestyle factors that influence mental health and the physical health of people with mental ill-health, prevention of mental ill-health through intervening early in life, and building resilience in children, young adults and older adults in our communities.

2. *Tackling Dementia*

This workshop explored how we could better support the newly inaugurated Dementia Hub, raise awareness of dementia in professionals and in the public, as well as steps that could be taken to prevent dementia.

3. *Community Mental Health Services, substance misuse and dual diagnosis (Substance misuse and mental ill-health)*

This workshop was around community mental health services (CMHS) and dual diagnosis, which is the term used to describe a person who has both a mental health and substance misuse problem. This looked at how we could improve CMHS and better address dual diagnosis, and the impact on the children of parents with dual diagnosis.

4. *Addressing mental health inequalities and inequity (access)*

Merton has marked mental health inequalities and potential barriers to access (inequity). For example people in East Merton and from poorer sections of our communities have higher rates of hospital admissions and community mental health services referrals. Certain ethnic groups have disproportionately high or low presence in our mental health services. This workshop explored what steps we could take to reduce these inequalities and inequity.

5. *Improving engagement with service users, carers and communities*

This workshop explored how the service users, carers, communities and health professionals could all work better together and design services that serve Merton's population the best.

6. *Primary care and IAPT services*

This workshop explored how we could improve the early detection and management of mental ill-health and the physical health of those with mental health concerns in our local GP practices and in the community.

7. *Hospital Care*

This workshop explored ways to improve care of mental health patients admitted to hospital, ensuring that they are provided the right care at the right place and at the right time, closer to home and in the least restrictive environment.

After this the Chief Officer of MCCG made the closing remarks, mentioning the next steps that would be taken and thanked the audience for their contributions.

In addition to direct feedback, the venue had an IDEAS WALL- participants were encouraged to use this to jot down any ideas/ feedback/ flashes of inspiration and stick these

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on the ideas wall during the breaks. There was a comments sheet provided to each participant to capture further feedback and this also served as a form of informal evaluation of the event.

There was also an additional ten day post-event remote feedback period where participants and others who were not able to attend the event, could email their feedback to an email box specifically set-up for this purpose.

Feedback from stakeholders

A. Themed table discussions

1. *Mental Health and Wellbeing: Promoting Positive Mental Health, Prevention and Resilience*

What is working well in Merton?
- At an individual level, access to leisure facilities and being able to do what one likes doing (enabling environment and infra-structure).
- Merton has many Mental Health support groups for service users, and also for carers. Many of these groups allow people to talk about their own experiences and help people to develop [Imagine, Focus-4-1, Rethink, Positive Network (not a MH specific support group), SURGE (Sutton and Merton User Group), PROSPER].
- Employment specialists in secondary mental health teams- help MH patients in EET (Education, Employment and Training) and provide appropriate support, working independently of care coordinator in their own place of residence.
- Merton Adult Education (MAE) is viewed as a valuable resource.

What does good look like?
- Engaging different faith groups in Merton: different faith groups and places of worship have a potentially significant role to play in engaging and supporting Merton residents with MH problems. "Mental Health Wellbeing Hubs" could be created in vetted, trained and quality assured faith settings that residents could safely access. The risk is that some faith settings/ religious groups regard mental illness in an unhelpful and discriminatory manner that actually exacerbates stigma and taboos. Wandsworth has a model that could be considered.
- In order to support residents with mental ill-health to live independently and gain employment, retail banks could be engaged to provide small loans and/or support to start small business. Job centres could be engaged this way too.
- Provision of day centres that are linked with secondary mental health care and community services- to provide a base for social activities, enhancing life skills, and reducing loneliness and isolation. Similarly provision of lunch-clubs and befriending services (although remote/ telephonic befriending can be isolating).
- Providing avenues and supporting people with mental ill health to tap into/ express their creative side, for example using arts, drama. Could create a project where art work is created and loaned out for exhibition in public places, such as in Merton Council buildings including libraries. Sutton has a project like this.

- More investment in carers and supporting carers who are also in employment and young carers.
- Promoting work place wellbeing- mentors, counselling,

What should be kept?
- Crossroads
- Services users groups
- Carer support
- Sure Start centre programmes (five to thrive)
- Mental maternity nurses

What should be changed?
- Invest in a programme where the voluntary sector trains GP practices on tackling and addressing stigma and discrimination in mental health
- Invest in primary care in terms of carers and their needs
- Engage more faith groups and communities
- Create a time-bank type model for exchange of expertise and experience, and tackling loneliness and isolation.
- Improve prevention of mental illness and building resilience in schools by:
  - Addressing the MH wellbeing of teachers and children
  - Targeting early years in primary school, promoting mental resilience and ways to manage stress
  - PSHE should include mental health
  - Address low level substance misuse and impact on MH in schools
  - Promote positive lifestyles
  - Create a cadre of mental health champions (perhaps from educational psychologists)
- Broaden role of statutory services and include CAMHS

Feedback carousel (other tables)
- Effect of cannabis on mental health is not widely known
- Recovery college: very important in relation to MH wellbeing
- i-Merton: many people do not have access to internet and other ways to disseminate information need to be created
- Involve and inform parents, in partnership with teachers
- Services for post-natal depression
- Good parenting and links with health visiting
- Support for children of parents with MH problems
- Linking with anti-bullying work
- Create a network of practitioners to encourage mindfulness and mindfulness practice
- Being on benefits could reinforce and/or create a negative reality
- Promoting good nutrition in schools
- Using social media
- Problem with Free-dom pass and issues of access. Need better access to services to reduce isolation
- Many more places to hang-out for free

- Create facilities for community activities in residential areas
- Role of libraries
- Better use of Merton Centre for Independent Living
- Destigmatise services
- Promoting self-esteem in children in creating a vocabulary around mental health
- Craft classes
- Advocacy services for people with learning difficulties
- Young peoples substance misuse services and learning difficulties specialism in CAMHS being phased out
- Safe secure housing
- "How to stay well" courses in MAE
- Exercise on prescription

2. Tackling Dementia

What is working well in Merton at present?
- Merton Dementia Hub is a positive initiative especially for raising awareness about dementia - however it must be used; it is a focal point and not the only place services around dementia are available. Regular tours for health and social care professionals are ensuring that the referral process is accessible for all. However, these tours and the promotion of such need to be on-going as there are significant staff changes in these sectors and teams need to be kept up to date.
- London Borough of Merton is driving the Dementia Action Alliance forward. This will eventually impact upon mainstream provision, and make services more accessible for people with dementia.
- Dementia Hub tends to focus on early to mild dementia sufferers; severe dementia sufferers have been moved to Woodlands.
- An increasing number of third sector providers are making their specialist services more accessible to people with dementia and there are significantly more services available to people with dementia and their carers.
- Carers Support Merton- working well.
- The growing number of Dementia Champions.

What should good mental health services in Merton look like? How do we get there?
- Promote what to look out for in terms of the early signs of dementia; what can an individual do to help prevent/delay the onset of dementia? What can you do to keep the mind alive?
- Raise awareness of dementia right across the community; make dementia more 'ordinary'.
- Provision of practical support around the care pathway and planning for the future; how do you overcome the challenges around planning? How you get to the right mind-set to be able to plan your care?
- Co-location of services.
- Equity in access to services, so no matter where a diagnosis of dementia is given, people can access the same support across the borough at the point of diagnosis e.g.

the Dementia Adviser should be co-located with the Memory Service as this position will signpost to all organisation.

- Equitable access to services. Challenging dementias are often seen as a secondary diagnosis e.g. alcohol, drug and aids related dementias, so are not referred to the hub. Everyone with a dementia has the right to exercise choice and access the relevant information and support. CMHT to ensure all conditions are treated and supported in their own right.
- Improved Awareness Raising, particularly in BME communities. The Asian community do not have a word for dementia, and attach much stigma to this condition.
- In caring for someone with dementia, particularly if stigma is attached, it is recognised that up to 50% of carers of people with dementia will go on to develop their own psychosis, increasing the demand on the mental health service as a service user in their own right, and on social care as they become increasingly unable to remain the primary carer. The costs associated with this could be negated with a specific, strategic awareness raising campaign and targeted screening.
- More financial investment in dementia support services.
- An agreed diagnostic pathway that is visible on local health and social care websites so people understand the process and what to expect.
- Early evidence to support people with dementia need a prompt to 'remember' appointments – can be done by admin in GP practices and CMHT's. Increased attendance will increase capacity of Consultants etc.
- End of life care for people with dementia should be addressed.

What are the things that should be kept? What are the things that need to change and how?
- Enhance existing resources.
- Service users need to be aware of the services at the Hub so that they can access them.
- Ensure good partnership working across third sector organisations that provide similar services - there is currently a lack of co-ordination.
- There is a potential gap around the support available for 'Middle' level dementia sufferers.
- There is a gap around carer respite – this gap is not being addressed at the Hub.
- There is an issue around working carers, they can't leave the cared for at services and or they can't get them there – how do they access good quality carers for their loved ones?
- There is an issue around confidence levels in Care Provider Agencies – how can carers be practically supported to select good quality carers?
- The carer's voice needs to be heard; the carer's view needs to be acknowledged.
- There is an issue around travel support to get to the Hub (can existing travel schemes accommodate a Hub drop off?
- Run an on-going feedback system for carers.
- We need to understand the cultural issues surrounding dementia.
- Issue around GP's in terms of early diagnosis as well as knowledge of the dementia support services across the borough; provide dementia awareness training for GP's and create structured referral processes for GP's.
- Improve the experience of dementia for those who develop a dementia in a care home. This is now their home and they are less able to cope with another move.

By 2014 Dementia Quality Outcomes (DH) states that all people living with dementia in England should be able to say:

- I was diagnosed early
- I understand, so I make good decisions and provide for future decision making
- I get the treatment and support which are best for my dementia, and my life
- Those around me and looking after me are well supported
- I am treated with dignity and respect I know what I can do to help myself and who else can help me
- I can enjoy life
- I feel part of a community and I'm inspired to give something back
- I am confident my end of life wishes will be respected.
- I can expect a good death

3. *Community Mental Health Services, substance misuse and dual diagnosis (Substance misuse and mental ill-health)*

<u>What is working well at present?</u>
- What do we mean with regards to dual diagnosis? Does this include cannabis? Is probably should....?
- DART (Drugs and Alcohol Recovery Team) look at any king of addiction. From a commissioner's perspective, the focus is on Class A drugs. Also mental health tariff classifies it as addiction and psychosis
- Commissioning has worked well.
- In-patient service can be effective, but not geographically convenient
- HTT (Home Treatment Teams) in Merton do community alcohol detox
- Good recovery rates
  - o Opiate detox (maintenance) Merton is the highest performing borough nationally
  - o Good outcomes for cocaine
- Merton Adult Crack Service (MACS) provides good, long term care (recovery team Merton) - provides high levels of care / commitment to the service (recovering service users lead on engagement)

<u>What should good look like?</u>
- Prevention services ....
- Clear mechanism for referral
- Recognition in primary care
- GP's with a knowledge about addiction and skilled in motivational interviewing.
- Comprehensive, rapid assessment (including post release from jail)
  - o Joint assessment
  - o Single point of access
- Clear care pathway
- Good communication between services
- No gaps in the service provision
- Outreach service for people who struggle to engage with treatment
- Evidence-based effective care.
- Psychological therapy

- Effective transition between adolescent / younger adult and adult services

How do we get there?

What are the things that you most want to keep?
- DART Team (we need an effective treatment team)
- To continue with an inclusive commissioning process (we must avoid fragmentation)

What are there things that you most want to change, and how?
- More access to psychological treatment for people with dual diagnosis.
  - Particularly treatment for people with a comorbid personality disorder - preparatory work to get someone ready for DBT / MBT
  - Psychological treatment for people with comorbid anxiety and depression.
- Better joint working between agencies (including school / looked after children)
- More access to care coordination for complex people with dual diagnosis
- Early prevention services.
- Have agencies working together at a high level - particularly with regards to challenging families.
- Better strategy for prevention of addictions in children and young adults (what is the current strategy?)

Feedback carousel (other tables)
- Geography of the ward is a problem (located in Crawley)
- How do the police integrate into the service?
- Housing and benefits do not link in particularly well, and can be particularly challenging
- Are there services accessible for people with LD?
- Is there any screening for people with a LD?
- How are people enabled to hold on to a housing tenancy
- What support is given to carers of a patient with dual diagnosis?
- Self knowledge about addictions / the association between anxiety disorder and drinking
- Better access to support in the evening
- More investment in low level cannabis use - services that can respond in the evenings
- More educational about the best ways to maintenance
- Big problem with housing - people not able to maintain tenancies due to substance misuse
- Greater emphasis on carers. More could/should be done with this, to battle the stigma of addictions
- Probation services will have high numbers of patients with dual diagnosis.
- Have a better educational service in the school - more focus on early prevention.....
- How can you support children who are living with a parent with drug and alcohol problems
- This is a long term problem. We have a fragmented approach to dual diagnosis. We have to support people to begin to the stage that they are ready
- What is the evidence for residential placement - is there no other way
- More joined up services with Merton youth justice service ...

- Addressing alcohol use in society - particularly increase alcohol consumption in women.. The hidden problem associated with harmful use of alcohol
- Addiction in the home can be destructive...
- Improve the opportunity of early intervention in the faith communities .....

4. *Addressing mental health inequalities and inequity (barriers to access)*

What is Working Well in Merton?
- Once one has overcome the "access barriers" the services provided on the whole are good
- There are really good examples of Partnership working in Morden i.e. the Probationary Service work quite well with Springfield Hospital. They have Advance Case Discussions and a consultant rom Springfield Hospital who comes to tell give talks on Common Mental Heath Disorders
- In Merton the Mental Health Assessment Teams operate as a Single point of Access (SPOA) which is a best practice model and other boroughs aspire to have a SPOA
- The Voluntary Services provide invaluable services
- On the in-patient units the patients are treated equally, because there are many safeguards and systems in place to ensure equity. The staff are also from diverse backgrounds
- Early Intervention is good on the whole in Merton
- The concept of the Crisis management and Home Treatment team is good although there are issues with how the current service is run. The current service tends to concentrate on medication compliance and not holistic care, there are also concerns on whether the service is adequately resourced

What does good look like and how do we get there?
- Proportionate representation in terms of access, meaning that the service user demographics align with the borough demographics. This can be achieved through targeted outreach and educational programme to reduce stigma and increase awareness
- There will be an increased of common mental health disorders in order to reduce stigma and more education top enable the recognition of mental health issues particularly among underrepresented groups. This can be achieved through making use of religious groups i.e. churches and mosques
- There will be more people with mental health issues diverted from the Criminal Justice System by implementing scheme such as the Street Triage Scheme (adopted in Lambeth Midlands that ensures that people with mental health issues are kept out of police custody and receive the right treatment and care).The 'street triage' scheme, which sees mental health nurses and paramedics accompany police officers to incidents where it's believed people need immediate mental health support. This can be achieved by rolling out the pilot after evaluation.
- There will be better management of crisis situations through a review of the crisis and home treatment team
- There will be a discreet assessment suite for Mental health that is not A&E
- Merton GPs will be involved and interested in mental health. This can be achieved through finding out from the GPs how to better engage them

5. *Improving engagement with service users, carers and communities*

What is working well in Merton?
- Service user-led groups
- Service user engagement with MH Trust
- Various specific service areas and individual professionals
- Improvement in communication between carers and services
- Basic structure for carer involvement
- Recovery College
- IAPT

What should good MH Services look like?
- Joined up; integrated
- Effective
- Inclusive
- Transparent
- Triangle of Care embedded with more than token involvement by staff
- Carers' Strategy
- Support for carers (not just engagement/consultation)
- Young Carers-greater recognition, understanding, inclusion of their needs in service planning

How Do We Get There? **see below for notes on each area*
- COMMUNICATION
- NETWORKING, FEEDBACK AND REVIEW
- BETTER CONTINUITY AND INTEGRATION OF PRIMARY AND SECONDARY HEALTHCARE
- ADDRESS SERVICE ISSUES
- CARER STRATEGY

Most want to keep?
- Triangle of Care
- Service user engagement
- IAPT

Most want to change and how?
- Improve networking and participation:
  - *access to easy, relevant venues and timing e.g. evenings not mornings*
  - *improved capacity to travel – Freedom Pass*
  - *meaningful service user and carer representation and involvement*
- Develop inclusive Carer Strategy
- Address gaps in communication between professionals, service users and carers

* COMMUNICATION
- Structure of regular networking opportunities

- **Evening 'Surgeries' for information sharing with reps from each organisation picking up information to disseminate to their groups**
- Website information – Pros: prolific capacity; cheap. Cons: whether people can access it – need to assess/train; information overload
- Paper information – Pros: visually stimulating; good point of reference; easy to keep info. Cons: people often don't read; expensive. **Posters across Merton public spaces.**
- Newsletters?
- Grapevine - **CMHTS having information and verbalising it – importance of communicating information and sources of support;** could be a hugely helpful resource but there needs to be consistency/continuity of service
- **Trust needs to show its telephone number so it doesn't come up as a private number**
- Transparency of planning, development and outcome with clear links

*NETWORKING, FEEDBACK AND REVIEW
- Time consuming nature of involvement – needs to be more effective
- Intelligent approach - consider timing of involvement. What are the specific needs of the groups? e.g.:

Service Users
- Mornings bad because of medication
- Pick times when travel passes are valid
- What are incentives? (No tokenism)

Carers
- Consider view of what a Carer is
- Working?
- Capacity to travel? (Localise events)
- Has other family or caring responsibilities?
- May need respite care in order to attend?
- May be tired/stressed – what are incentives? (People want to see real change as a result of consultation, with quick feedback about what's happening)

- How do we make this an on-going conversation, not a one-off event? – **FEEDBACK on an ongoing basis so people feel things are taken on board e.g. YOU SAID/WE DID**
- **Planning ahead for each work stream or issue – future dates arranged/notified <u>in advance</u>**
- Longer notice of events not less than minimum of 3-4 weeks
- Widespread publicity to reach all groups

*CONTINUITY AND INTEGRATION
- Continuity of staff and high turnover – addressing this. Acknowledge can't necessarily stop the problem but want to know: what kinds of induction are there?
- Basic 'toolkit' for Agency Staff in relation to Triangle of Care and expected role/standard.
- Thought given to matching service users with appropriate worker where possible – may not be but – need to have **realistic assessments of how well the relationship is working – 3 and 6 month <u>reviews.</u>**

- IAPT Services – putting trust in them can be hard but mostly a positive experience. Recognise how they best meet needs (not as alternative to secondary services for people with severe/enduring conditions). Develop better communication pathways between CMHT and IAPT, not passing service users to IAPT to enable discharge from CMHT.

*ADDRESS SERVICE ISSUES
- Funding is OUTCOMES-focussed yet people are worried some outcomes aren't easily measurable e.g.: *time spent with someone might be effective in preventing suicide*. How to allow for outcomes involving quality time/interventions that are not as easily evidenced?
- Understanding impact of major changes that come about such as Welfare Reform, and helping people to understand them. E.g. trauma of 'fit to work' outcome of assessments, where there was no understanding or awareness shown.

*CARER STRATEGY
- Acknowledge hidden harms.
- Develop Risk Assessment procedure for carers and consider safeguarding procedure.
- Active support for carers
- Respond to new elements from Care Act and raise awareness/how will they be implemented?
- Young Carers:
  - Massive issues and overlooked
  - AYCES (Action for Young Carers Education and Support) is Big Lottery funded, not commissioned.
  - Half of Carer Support Merton's Young Carers look after someone with mental health issues
  - Young carers in families where there is drug/alcohol use are under-represented.
- For Young Carers there needs to be:
  - Central source of information
  - Educate around Mental Health. Drama – use in schools/colleges
  - Reduce stigma through campaigns
  - Time for Change initiative

Feedback carousel (other tables)
- **Work Assessments**
  - Regulation 29 and 35 at risk of suicide
  - Really need to hone down the **solutions** and **what** is good/bad
- Exploit **Time For Change** campaign
  - Social Media – make better use!
- **Hidden Harm**
  - Need to do something around Drugs/Alcohol. Talked about/not widely acted on.
- **Discharge planning –**
  - Look at the needs of the Young Carers/Children
  - How long to balance adult's needs and keeping case open because of children's needs.
  - Children's Services – don't know enough about Adult Mental Health Services

- o   Much better understanding of what's needed **strategically.**
- Hear to **Carers' Strategy**!
  - o   Create pathway for **Anonymous Feedback** (RTF is anon but needs to be more widespread/accessible).
  - o   **Transparency** – to include political transparency – attendance by Councillors.
- Joining up of organisations – **Directory of community based services** – so that Carers and Service Users know about them and Health Professionals can access the information
  - o   **Tackling Stigma** – Staff in GP Practices.
  - o   **Surgeries** – under threat? Not immune to funding changes.
  - o   Long term investment from Health and Social Care
- **LTC – discharge plan** once under care of GP – structure for support and addressing needs when under Primary Care Services.

6. *Primary care and IAPT services*

What is working well in Merton at present?
- Availability of IAPT service the combination of people and process is very good
- Option by potential service users to self-refer
- GPs are aware of the service
- Commitment from CCG to improve current services

What should good look like?
- Increase awareness of IAPT services
- Leaflets (in GP practices including messages on Jayex board, sports centre, supermarkets, libraries, churches, mother and baby clinics etc.)
- Include pregnant women
- Accurate diagnosis of the condition so correct therapy is offered
- An optional service if IAPT doesn't work
- Signposting patients after the IAPT sessions to help them build confidence and independence (use 3rd sector possibly?)
- Increased number of people returning back to work, after being signed "fit" by the GP
- Reduced number of people returning back (repeat attenders) to access the service
- Offer IAPT as standard to people with co morbid conditions (cancer, diabetes, COPD, Falls etc.)
- Compatibility between therapist and service user

How do we get there?
- Ensure service is adequately funded
- Generate more resources by collaborating with private sector
- Other services to work in collaboration with IAPT. (for example the Addictions team, employment services, criminal justice system etc. should establish linkages)

What are the things you most want to keep?
- Retain the number of sessions offered up to 16 weeks
- One to one and group therapy.

What are the things you most want to change and how?
- Change the name of the service- (it's a mouthful, what does it mean to the general public). This view was shared by 4 of the 7 tables
- Reduce waiting times to access treatment following assessment; else the purpose of accessing the service and being assessed is lost leading to reduced productivity
- Introduce a way of proactively following up on service user who has recently been discharged from the service. That was re-entry can be delayed or even avoided

How change can be initiated?
- GP should be better informed
- Encourage more people to self-refer
- Improved and increased marketing
- Make available **one** directory of all services including health, social, 3rd sector etc. that is regularly updated (like a phone book or yellow pages)
- Teaching and encouraging service user to take responsibility for their own health

7. *Hospital Care*

This discussion highlighted the need for a spectrum of hospital/supported and independent accommodation to be available for the population of Merton, dependent on their mental health needs. Thus whilst people should be treated in the least restrictive environment required to enable their recovery, they should also be able to access higher dependency care (e.g. in-patient care) when required, dependent on their needs.

At the high end of the spectrum, this entailed hospital care provided from well- designed environments that equated to the Government's commitment on Parity of Esteem e.g. single rooms with en-suite facilities. Service users felt that the main stressor in inpatient environments was the behaviour of other patients, and that the ward needed to be designed in a manner which promoted privacy and dignity, but was also able to absorb noise/disturbance in contained areas of wards, without making the whole ward disturbed.

A study at Springfield Hospital had demonstrated the importance of design, where a rebuilt ward had only experienced 2 serious incidents over the previous 2 years, whereas a refurbished ward without the same scope to build from scratch had experienced 27 incidents over the same period. There was thus support for the redesign of the Springfield Hospital site such that all wards could be rebuilt to this level of design.

The availability of community based accommodation in Merton was perceived to be a particular problem – this ranged from step-down, crisis house, rehabilitation placements, supported accommodation and access to independent accommodation. There was felt to be a shortage of this, which resulted in bottlenecks where people were left in higher dependency accommodation than what they required, or that they were sometimes placed out of borough and the community and networks that they were familiar with.

This shortage meant that it was all the more important for existing resources to be aligned to need, and thus provide a cohesive spectrum of accommodation through which people can

move through, dependent on their needs and recovery. This was not felt to exist at present, and thus there is an urgent need to review the stock/levels of accommodation, both health and social care funded, and to re-profile this against need. There may be a need for imaginative interim solutions in this e.g. use of empty office space.

There was felt to be a particular shortage of supported accommodation for people perceived as high risk e.g. offenders, dual diagnosis.

B. Additional feedback from morning session

1. There is no up to date carer's strategy in Merton
2. Not enough information in the MMHNA on people with learning disabilities or young carers
3. The report does not have enough information on supported housing
4. Crisis points are not featured in the recommendations
5. No police statistics are featured in report
6. People have to pay for services (Law Centre)
7. Awareness of IAPT/ Secondary care interface- waiting time for IAPT treatment after phone assessment
8. BME residents need investment in services, not just voluntary sector "unregulated" organisations but statutory organisations as well. Voluntary sector groups may be well meaning but are not adequately joined up with mainstream organisations
9. Primary Care and secondary MH services need to be more joined up in their support for MH patients with long term conditions
10. The physical impact of taking medicines for mental illnesses is not adequately addressed
11. All other boroughs in the SWLStG MH NHS Trust have a client development worker to bridge the gaps and provide a more joined up service. Merton is the only borough that does not have one
12. Crisis intervention: "Living Room Experience" not A&E. (Examples of best practice: Chicago, USA http://www.gjcpp.org/pdfs/2013-007-final-20130930.pdf; http://informahealthcare.com/doi/abs/10.3109/01612840.2013.835012 and Southend, UK)
13. There are also concerns about bed occupancy management and people not being admitted when needed because of non-availability of beds
14. People fall through gaps are no seen by the Home Treatment Teams (HTT) and medication being missed. HTT does not work for people who live alone
15. There is a sense of lack of continuity between community mental health teams and in-patient/ HTT. People experience lack of communication between them and CMHS "disappears"
16. Personality disorders are a priority area but are not specifically mentioned in the report-there are 5 WTE workers in S&M for Personality Disorders
17. GPs lack knowledge of mental health and there is need for more expertise in primary care

C. Feedback on ideas wall

1. Regarding the Assessment suite other than A&E, can we use some of the new health centres in Merton?
2. Why do Merton GPs appear to lack interest in mental health issues?
3. Can we make mental health information available in GP surgeries
4. Can we require GPs to "up skill" or as a first step ask them to cluster a number of practices to offer expert help
5. Can the service providers use clear and easy to understand vocabulary
6. Leaflets in public areas would be useful to enable the public to identify their problems i.e. baby clinics, libraries, playgroups, sports facilities, chemists, GP surgeries etc.
7. How can anyone self refer to IAPT if they've never heard of the service?
8. For carers to access services for people they care for they have to organise transport and or a companion which is often impossible
9. Service users need empowerment with self-management techniques with early detection of relapses when discharged from hospital
10. There needs to be more recognition of health professionals of physical side-effects of drug treatments. I feel more training in this area is needed
11. Has anyone considered the effect of taking away freedom passes from service users on their mental well being?
12. What is unpaid caring and who are these people?
13. Commission an organization to put together an A-Z resource booklet of all services within the borough e.g. Local Authority, Private and voluntary services
14. The Home Treatment Team does not work for those who live alone
15. Why was there no GP representation from Merton in the Mental Health Stakeholder engagement event?
16. Are all the "grey" areas being fully identified? e.g. Are women expected to become unpaid carers without being asked if they want to? Are possible generalisations being made about minority ethnic groups? How much of the work of "community care" is falling on unpaid carers?
17. Circle housing is not responsible for mental health issues in their tenants .There is a tendency to create "ghettos" of people with drug, alcohol or mental health problems
18. More awareness of emotional health of service users is required for those who live in isolation
19. The average gap between onset and diagnosis of bipolar affective disorder is ten years. How can this be reduced?
20. IAPT offer fantastic services
21. The Smoking cessation services has been stopped. Service users want it back as people there understood their particular problems
22. How can the communication between inpatient , HTT , CMHT be improved as it is sorely lacking and impacts on Service users experiences of the services
23. Many service users experience bereavement of friends, can we have some bereavement counselling for them?

D. Remote post-event feedback

1. Crisis happens 24 hours per day 365 days per year - crisis support needs to be the same. As a carer, when I see my son relapsing outside of hours there is little help for me. I'm simply told to call police. I'm alone and distressed and get no support during the process and no follow up afterwards. A crisis plan must be part of the care plan.
2. Out of hours service should be compulsory element of training for trainee psychiatrists and practitioners.
3. Would it be possible to have a work experience programme for professionals linking them with service users/carers giving both professionals some work based practical learning and service users/carers an opportunity to influence professional development?,
4. GPs and psychiatrists need to consider the impact of long term medication on patients health and compliance and alternative treatments, when requested, should also be an option (including holistic, herbal, etc.)
5. Referrals for specialist clinical psychology should be available as an intervention
6. Patients were supposed to have the right to choose service and this should have been in place since April.
7. Communication between hospital, CMHT and carer is poor. I'm often left out of the loop and only learn of issues when things have gone wrong. As the primary carer and person with the most intimate knowledge of the situation I have a unique and valuable insight into how things are progressing, if recovery is working, if relapse is happening.
8. We (carers) need access to occupational therapy as part of a comprehensive care plan
9. Peer support from those that have the lived experience is invaluable and should be one of a menu of options made available to service users and their carers when agreeing a care and recovery plan

"I'm constantly told inadequate staffing and budget restrictions limit the service. This shouldn't be an excuse but should encourage service providers to come together to look at new ways of working and providing a service. Innovation and creativity should be encouraged and alternative providers commissioned for time-bound, targeted, specific outcomes."

10. Primary care patients with chronic biological diseases such as schizophrenia, bipolar and unipolar depression are not picked up at an early stage and do not receive consistent treatment throughout their lives.
11. For those already in treatment this has become even more relevant now that CMHTs are being encouraged to refer patients back to their GPs as soon as possible. And as with other serious illness, such as breast cancer, follow up and intervention are important. GPs may therefore be interested in specialist training to identify key markers at early diagnostic stages as well as on-going management and re-referrals.
12. One of the main points that I felt (service user) was not addressed at the workshop was increasing the contribution of primary and secondary health care professionals and carers, in the encouragement of users to self-manage their health conditions. Although in some cases, efforts are being made in this direction, it would be good if it could be rolled out across the board. This would include out-reach workers helping users identify

triggers, avoid stressful situations and , in conjunction with health professionals to act more immediately to alter medication levels or medication type to prevent the whole cycle of relapse. Carers should be involved at all stages where possible.

13. I (service user) am concerned about the lack of an intermediate environment for users who have just been discharged from hospital or who are in an intermediate situation but not ill enough to be admitted to hospital. Housing was mentioned at the workshop. This is obviously essential. There should also be a safe, understanding space for users to spend their days. The closure of drop-in/day centres is a backward step. I have often seen people with whom I have been in hospital, just walking the streets.

14. I (service user) believe that greater liaison is needed among Mental Health professionals, GP's and General Hospital staff. Physical health of users is often treated as secondary to Mental Health. In my opinion, there is a lack of acknowledgement from Mental Health professionals of the physical and mental side-effects of medications.

15. Recently my outpatient and care-in-the-community experiences have been very good. However, I understand from other people at the Workshop, that this is not the case for everyone. In many cases, users do not have family or friends to look out for them when needed. The Mental Health Teams are often not adequate and in some cases the out-reach workers are unreliable, frequently changing or cancelling appointments or not getting back to the user with information that has been requested. Often the user is not well enough to chase new appointments, and situations deteriorate until the situation reaches crisis point.

16. Appropriate housing stands out as being one of the key elements for leading a stable, healthy life. Issues range from:
   - The need for practical support upon discharge from hospital,
   - A guarantee of no discharge without an offer of appropriate accommodation and support
   - The need for short term high support accommodation as well as secure long term housing. This means no short term lettings in the private sector where tenancies can be ended at any point after the first six months, without reason

17. There is significant variation in the experiences of carers and people with mental health needs when visiting GP's. We have heard encouraging stories from people who say that their practice has improved its approach. It is sadly not a common tale. This applies across the spectrum of mental health, i.e. people with dementia as well as those with acute and long term mental health needs. It is difficult to understand why this variation exists – why are some practices/GP's supportive and knowledgeable about mental health issues and why do others fail at what are often critical and traumatic times for individuals? Some practices do not even offer the most basic information in their waiting areas, or fail to engage with voluntary organisations that are keen to offer information and/or support.

"The workshop appeared to be well received by carers, and users of services. The presence of key decision makers, such as Eleanor Brown, enhanced the sense that people might be listened to. We would support the development of a more regular forum, based on the workshop model to ensure that the implementation of the strategy has the support of local people with mental health needs, and their carers."

18. Leighton House was built not so long ago to act as a halfway house for people recovering from issues – mental health, drug abuse etc. and as supported accommodation. It has now been closed for some years and is gradually becoming more derelict. Can I suggest that Merton claw this back from the Housing Association?

19. Day care can be a life-saver for carers, and even enable them to work without worrying about their "patient". The removal of funding by the council and consequent closure of many of these is causing significant distress. Sending someone with e.g. learning difficulties to an adult education centre where they are not in a proper caring, safe environment is not the same.

20. The fact that the trust is apparently reducing the number of acute beds for five boroughs to only 126 seems very unwise, particularly as there are people being sent away early (and therefore coming back within a short time) or having to be transferred out of the area because of a lack of beds. It is suggested that extra stress on staff concerned with these patients is leading to a high turnover of staff, in itself a very expensive exercise, and not good for anyone. It is strongly urged that Merton re-think their policies in relation to relatively minor cost cutting in this area, and take into account the bigger picture. They really should look after the sector of society with mental health issues who cannot look after themselves, and often inadvertently cause extra costs due to their condition – e.g. in terms of violent or unsocial behaviour.

21. Merton does not have a client development worker for service users; all the neighbouring boroughs have a specifically employed worker for the good of their borough.

Evaluation of the day

Positive
1. Generally a helpful day, especially in the afternoon
2. Generally an engaging day
3. Feedback carousel, worked well, good use of time
4. Good venue, excellent catering
5. Glad to be a voice of the users, carers need more of that
6. Useful event in bringing people together
7. I believe there is a commitment to improve mental health services in the future whilst there is recognition that carers need support
8. Excellent organisation, facilitation and catering
9. Clear presentations, productive day
10. Please continue to include users and carers views in policy planning
11. Very relaxed atmosphere
12. Good central location apart from traffic noise
13. These days need to continue in the long term
14. A thoroughly enjoyable day, thank you
15. Good networking opportunity
16. This is possibly the first time since I became an unpaid carer in 2009 that I felt comfortable enough to speak honestly about my experiences and overcoming my fear of health professionals. The experience of unpaid cares should be incorporated in your report

Areas for Improvement

1. I would have liked to see the needs assessment earlier with more time to prepare
2. MHNA summary presentation had a lot of jargon
3. Why was the event held on Eid , this excludes practicing Muslims
4. The facilitator eight minutes feedback was good but towards the end my concentration levels were low, perhaps a short comfort break midway would have been good
5. Needs to be backed with some action, vision and strategic leadership
6. More consideration should be given to the timing of these events to ensure maximum service user involvement and access by working carers
7. Start these events with an overview of who is who e.g. LBM, Merton CCG, health watch etc.
8. Please address the needs of people with learning disabilities
9. GPs need to be part of the next workshop
10. The measure of this will be in the delivery, we need to see some early wins to build trust

**Merton Adult Mental Health Review
Stakeholder Workshop 1, 28th July 2014
Vestry Hall, Mitcham, Merton**

PROGRAMME

Registration
You will need to sign in on the registration sheet and then choose and add your name to a workshop theme from the sheets on the table. There will be a pre-set limit of how many can sign-up for each workshop and once filled you will only be able to choose from the remainder. You will be asked to sit at the table in the hall labelled with the name of your workshop on it.

Ideas wall
There will be an IDEAS WALL and each table will have post-its on it. Participants are encouraged to use these (and/or the comments sheet) to jot down any ideas/ feedback/ flashes of inspiration and stick the post-its on the ideas wall during the breaks.
_____

09:30-10:00 **Registration, tea and coffee**

10:00-10:10 **Welcome address and overview of the day by chair**
Kay Eilbert, Director of Public Health, Public Health Merton, London Borough of Merton

10:10-10:20 **Opening speech**
Eleanor Brown, Chief Officer, NHS Merton Clinical Commissioning Group (MCCG)

10:20-10:40 **Presentation: Key findings and recommendations from the Merton Adult Mental Health Needs Assessment**
Anjan Ghosh, Consultant in Public Health, Public Health Merton, London Borough of Merton

10:40-11:00 **Table discussion:**
- **What did you think about the findings and recommendations of the mental health needs assessment?**
- **Top three questions from each table for panel.**

11:00-11:20 Tea and Coffee break

11:20-12:20 **Panel Discussion**
- **Three questions from each table**
- **Other additional questions/ issues arising (if time permits)**

Panel members:
1. Dave Curtis, Healthwatch Merton (Chair)
2. Sue Batley, Carers Support Merton
3. Vanessa Anenden, Focus-4-1
4. Caroline Farrar, NHS Merton CCG
5. Laurence Mascarenhas, NHS Merton CCG
6. Rahat Ahmad-Man, London Borough of Merton
7. Anjan Ghosh, London Borough of Merton
8. Mark Clenaghan, SW London and St. George's Mental Health, NHS Trust

12:20-01:00 Lunch

01:00-01:10 **Welcome back and overview of afternoon session by chair**
Dave Curtis, Healthwatch Merton

01:10-02:10 **Themed discussions at tables**
- **For table theme, what is working well in Merton at present?**
- **What should good look like?**
- **How do we get there?**
  - **What are the things you most want to keep?**
  - **What are the things you most want to change and how?**

Table themes:
1. Mental Health and Wellbeing: Promoting Positive Mental Health, Prevention and Resilience
2. Tackling Dementia
3. Community Mental Health Services, substance misuse and dual diagnosis (Substance misuse and mental ill-health)
4. Addressing mental health inequalities and inequity (barriers to access)
5. Improving engagement with service users, carers and communities
6. Primary care and IAPT services
7. Hospital Care

02:10-02:30 Tea and Coffee break

02:30-03:30 **Feedback carousel**
Each table facilitator goes to the next table and presents for 3 minutes and takes feedback for 5 minutes, and then moves to next table till all tables are done.

03:30-03:45 **Q&A**

03:45- **Closing remarks and thanks**- Chair
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Committee: Health and Wellbeing Board

Date: 30 September 2014

Wards: All

Subject: Public Consultation - Inpatient Mental Health Services in South West London

Lead officer: Andrew Dean, Director of Nursing and Quality Standards **South West London and St George's Mental Health NHS Trust**

Recommendations:

The Health and Wellbeing Board is asked to note the proposed consultation programme and to ask any questions of the NHS representatives present.

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1.   Introduction

This consultation is about the future location for mental health inpatient facilities for people in Kingston, Merton, Sutton, Richmond and Wandsworth, and for a range of specialist mental health inpatient services serving a wider catchment area.

The consultation is being run by the NHS clinical commissioning groups for Kingston, Merton, Sutton, Richmond and Wandsworth (who commission the local services), by NHS England (who commission the specialist services) and by South West London and St George's Mental Health NHS Trust (who provide these services).

The proposals are designed to improve the experience for service users, carers and staff and to ensure that these services will in future comply with quality and legal standards for such services, that they reflect national and local commissioning intentions, and that they are flexible to respond to future changes in demand.

2.   Background

There is general agreement that, with a few exceptions, the facilities for the provision of mental health inpatient services in South West London are not appropriate for modern mental health care. Commissioners and South West London and St George's Mental Health NHS Trust agree that many buildings do not comply with current standards and involve too many compromises in the provision of high quality care.

South West London and St George's Mental Health NHS Trust has brought forward proposals to modernise the estate and to provide a pattern of services that reflect current and future commissioning priorities, as expressed by NHS England and by commissioners in South West London (including the draft five-year strategy published by South West London CCGs in May 2014).

The proposals are for an investment at two of the Trust's hospitals, Springfield University Hospital, Tooting, and Tolworth Hospital, Kingston. The capital investment required is substantial, of up to £160 million at 2014 costs. This can be resourced by disposing of surplus land no longer required by the NHS and using the proceeds to re-invest in the development of the new facilities.

The proposed consultation is about the range of services that should be provided from each of the two hospitals, and about the options for the continued future use of Queen Mary's Hospital, Roehampton, for mental health inpatient services.

Consultation is part of a wider process to deliver estates modernisation. Other elements include:
- seeking planning consent for the regeneration of Tolworth Hospital and for the detailed proposals at Springfield University Hospital (within the overall planning consent currently in place), and;
- approval of the estates modernisation Outline Business Case (OBC) by commissioners

These elements are due to complete by March 2015. A full submission for approval for estates modernisation will then be made to the Department of Health and the Treasury.

A joint Health Overview and Scrutiny Committee (HOSC) was held on the 17 July, with representatives from the five borough councils. The decision was taken to establish a sub-committee of the joint HOSC in order to scrutinise the consultation process. Discussions are still ongoing with NHS commissioners in south west London to decide the consultation start date. This will enable commissioners to decide on the preferred option in early 2015.

3.   Development of the proposals
The proposals were developed from discussions with service users, carers, commissioners and stakeholders. The earliest discussions date from 2004 and focussed on the potential regeneration of the Springfield site. This led to the granting of planning permission for the Springfield site in 2012.

Further discussions with service users, carers, commissioners and stakeholders in 2012 led to the adoption of a set of criteria which are set out in detail in the draft consultation document. These include:
- Provision of high quality care in the best possible surroundings
- Accessibility of premises to service users and carers (including transport and travel arrangements)
- Services to be located on more than one site, and fewer than four sites
- Construction phase to be completed within five years of starting building work

4.   What we are consulting on
We want our mental health inpatient services to be in the right place to support local people in south west London and people from further afield who use the Trust's specialist inpatient services.

We are consulting on:
- A two-site option with local and specialist services in new accommodation at both Springfield University Hospital and Tolworth Hospital. Local services would no longer be provided at Queen Mary's Hospital. Overall this is our preferred option because it means everyone would be cared for in the best possible surroundings.
- A three-site option with local services in new accommodation at Springfield University Hospital and in the existing wards at Queen Mary's Hospital. Specialist services would be in new accommodation at Springfield University Hospital and Tolworth Hospital. Local services would no longer be provided from Tolworth Hospital.

Under both options we are also consulting on:
- Relocating some specialist services from Springfield University Hospital to the new development at Tolworth Hospital. This will help us provide the best possible accommodation for these services using the available space at both hospitals
- The best location for a ward for older people with age-related mental health conditions. This could be in new accommodation at either Tolworth Hospital or Springfield University Hospital

5.   Impact on Merton
The proposed changes do not dramatically affect people living in Merton. People will benefit from the continued development of alternatives to hospital admission, and the development of more community and outpatient mental health services within each borough.

South West London and St George's Mental Health NHS Trust and commissioners will work with service users and carers on the best way to develop local outpatient mental health services for people in Merton. This will include the development of the community base at Mitcham with the intention of using the Nelson Local Care Centre (the current base for older people's mental health services) as one of the community clinics.

People needing inpatient care could be admitted to either Springfield University Hospital or Tolworth Hospital under the preferred option, with Springfield University Hospital the most likely for most Merton residents due its proximity. These people will benefit from the new accommodation at either Springfield or Tolworth hospitals.

If the three-site option is chosen, people in the west of Merton will have to travel to Springfield to benefit from the improved accommodation (because Tolworth Hospital will not provide local services). Those people who prefer to travel to Queen Mary's Hospital would be treated in accommodation that does not meet the latest standards. This is because the wards at Queen Mary's Hospital cannot be upgraded.

6.   Strategic considerations
The estate modernisations proposals are related to the strategic plans of the NHS in South West London, and to the future of South West London and St George's Mental Health NHS Trust.

The proposals have been developed within the context of a continuing shift in mental health care away from hospitals to settings closer to home, emphasised in the draft strategy from South West London Clinical Commissioning Groups published in May 2014, and of the national priority for mental health services to have parity of esteem with other NHS services. They are designed to meet future needs and be flexible to meet changing demands.

They address the need to comply with NHS and Care Quality Commission standards for the quality of the physical environment for mental health inpatient services including those relating to access to open space, natural light, en-suite facilities, ending of mixed-sex accommodation, privacy and dignity.

Replacing the out-dated estate will contribute to the Trust's long term financial sustainability through a reduction in estates maintenance costs and greater efficiencies in the deployment of frontline staff (this is because the new wards will have improved lines of sight for observation, and will be designed to improve patient and staff safety, reducing the number of potentially aggressive incidents – both factors which influence day to day staffing requirements).

The proposals are aligned with the Trust's Integrated Business Plan and with the financial, human resources and planning assumptions contained in the Trust's application to become an NHS Foundation Trust.

They have been designed to comply with the legal, policy and regulatory framework of:
- The National Health Service Act 2006 (including as amended by the Health and Social Care Act 2012)
- The Equality Act 2010
- 'No Health Without Mental Health' (Department of Health 2011), the national strategy for mental health
- The Darzi Review (2009), which set out the case for shifting care from inpatient to community settings, helping people to take greater control of the plans for their care, and creating a health service focussed on improved outcomes.
- The Francis Report and subsequent national guidance on quality and regulation, following the investigation at Mid Staffordshire; the Winterbourne Report, the Keogh Report and the Berwick Report Royal College of Psychiatrists guidance 'Not Just Bricks and Mortar' (1998) and 'Do the Right Thing, How to Judge a Good Ward', 2011)
- 'Closing the Gap' (Department of Health 2014), which set out 25 priorities for achieving measurable improvements in mental services, including reducing waiting times, the links between mental and physical health and providing more psychological therapies
- 'Everyone Counts: planning for patients 2014/15 to 2018/19' (NHS England, 2013), which established the principle of parity of esteem between mental health services and other health services
- Draft five-year plan, published by clinical commissioning groups in South

- West London (May 2014), which sets out the intention to develop capacity in community mental health services with a view to providing better care and reducing acute in-patient mental health admissions from 2017-18

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Committee: Health and Wellbeing Board

Date: 30 September 2014

Wards:

Subject: **Nelson and Mitcham Local Care Centre Developments**

Lead officer: Adam Doyle

Lead member: Adam Doyle

Recommendations:

A. To note the contents of the report.

| 1 | PURPOSE OF REPORT AND EXECUTIVE SUMMARY |

The purpose of this report is to provide an update to the Health and Wellbeing Board on the development of the Nelson and Mitcham Local Care Centre developments.

2 BACKGROUND

2.1. The Merton Better Healthcare Closer to Home programme has six key delivery objectives, to:

- Improve outcomes for patients;

- Provide more care locally;

- Tackle health inequalities;

- Meet changing demographics and healthcare needs;

- Modernise the estate; and

- Use resources more efficiently.

2.2. The programme aims to meet these objectives through the development of new care pathways that better meet the patients' needs by keeping them at the centre of all service redesign. In designing the new pathways the intention is that the patient will be able to access these services closer to where they live.

2.3. The development of new healthcare facilities in West and East Merton was identified as key components of the Merton Better Healthcare Closer to Home programme. The delivery of these new facilities is in response to the poor condition of the current estate and the opportunity to consolidate services into modern, purpose built healthcare buildings.

2.4. Whilst the renewal of the community estate is a key priority, these developments need to be designed in response to the overall model of care to be implemented in West and East Merton. They must act as hubs for

primary care services with the clinical services designed to meet the needs of the local population served.

3   DETAILS

3.1.   **Nelson Development**

3.2.   The construction of the Nelson Health Centre commenced in April 2013 and is now nearing completion. It is anticipated that the majority of the works will have been completed at the end of November in readiness for the final checks prior to handover to Merton Clinical Commissioning Group (MCCG) on 14th January 2015.

3.3.   Once the building has been handed over there will be a period of commissioning prior to the mobilisation of clinical services.

3.4.   The Nelson Health Centre will provide the following services:

- **Primary Care** – Cannon Hill Lane and Church Lane Medical Practices will be moving into the building and coming together to provide a full range of primary care services;

- **Diagnostics** – X-ray, ultrasound, electrocardiogram (ECG), Echocardiography and blood tests;

- **Community Services** – physiotherapy, podiatry, assessment and rehabilitation services, retinal screening and specialist nurses;

- **Acute Services** – specialist consultation (outpatients), endoscopy and minor procedures;

- **Mental Health** – community mental health and Improving Access to Psychological Therapy (IAPT); and

- **Community Pharmacy**.

3.5.   The appointment of the provider for the diagnostic and acute services has been the subject of a competitive procurement exercise which has now concluded. The preferred bidder will be agreed at the September meeting of the MCCG Governing Body. The process will then enter a two week standstill period, allowing for any challenges to be addressed, prior the award of contract.

3.6.   A full mobilisation programme will commence with all providers in October with the anticipation that the building will be fully operation by April 2015.

3.7.   **Mitcham Development**

3.8.   The project is in progress and comprises two main workstreams: the development of a new model of care within the East Merton locality and the development of a new healthcare facility within Mitcham.

3.9.   The East Merton GP Locality Group, chaired by Dr Karen Worthington as the Locality lead, is developing a new model of care to address the health needs of their local population, including the key areas of concern with regard to the health of the population of East Merton as highlighted by the Health

Needs Assessment (HNA) which was undertaken at the start of the year, led by the Director of Public Health.

3.10. East Merton has the areas within the Borough with shorter life expectancy, with most of the excess deaths attributable to cardiovascular disease and cancer. In addition, diabetes is more prevalent in East Merton than the west of the Borough, respiratory disease is common and the positivity rate for chlamydia is higher than both London and England.

3.11. The child health element of the HNA found that childhood immunisation coverage is lower than the World Health Organisation target, emergency attendance for children under 4 is higher than England levels, there has been an increase in childhood obesity, hospital admissions for alcohol specific conditions in children and young people are among the highest in London and children's dental health is declining.

3.12. A workshop involving all East Merton practices entitled "Practices working together across the East Merton Locality" was run in early July to shape further work on the model of care. The key themes to emerge from this workshop were:

- The model of care should focus on reducing health inequalities;

- The services delivered out of the Mitcham facility should complement those delivered out of the Nelson Health Centre and also complement rather than duplicate those being offered by the practices in East Merton;

- The new building should be a local base for community services to make them more locally responsive, for example District Nurses and the Diabetes service and should also offer "semi-acute services" to drive down A&E attendances;

- There is support for improved access to primary care, although there was debate as to whether this should include a walk in centre;

- Mental health and sexual health services should also be available;

- Integration with social care and the voluntary services is vital and health promotion services should also be available;

- Clinical pathways should be consultant led and there should be direct access for GPs and patients as appropriate; The model of care for East Merton should be developed with input from local clinicians who are keen to influence and shape local services and also by working closely with Public Health.

- A Proactive GP Care project is being run by Public Health focused on prevention and health promotion. It is being piloted in the Cricket Green practice and is expected to provide learnings that will inform the model of care.

3.13. A working group of clinicians, and involving a nurse and practice manager, is being set up to focus on the development of the model of care.

3.14. Work is in progress to develop the Economic Case for the Mitcham Project. This will involve selecting the preferred option out of four sites on which the new facility could be developed based on a qualitative assessment of each site and also a financial analysis of the costs involved in pursuing each option.

3.15. At the end of this process the procurement route, a LIFT scheme or a third party development, will have been determined and approved by NHS England and work can start on the development of the formal business case.

3.16. The qualitative assessment will be conducted in two parts using set of criteria that are a refinement of those used to create the short list of options during the development of the Strategic Outline Case for the Project. The first part of the assessment will be carried out by the Mitcham Project Board and the second part will be conducted at a patient and public engagement event to be run in Mitcham on 2nd October.

3.17. The results of the option appraisal will be reported to the Merton CCG Governing Body informally in October and then fully at its meeting in November.

4 ALTERNATIVE OPTIONS

4.1. Not applicable

5 CONSULTATION UNDERTAKEN OR PROPOSED

5.1. The initial public engagement on the Mitcham Project was through a stand at the Health Hub at the Mitcham Carnival in June. As a result, none members of the public indicated that they would like to be involved in further engagement events.

5.2. As part of the site assessment process a patient and public engagement event will be run on 2nd October. This is by invitation only and invitations have been issued to over 50 community and health related organisations in the Mitcham area.

5.3. During the site assessment event we will set out the aspects of the Project's development where we would welcome patient and public engagement and look for volunteers. We will also use the list of organisations invited as a contact list for soliciting future engagement. The overall aim is to involve members of the public at all stages of the project, from the design of the Mitcham healthcare facility to how the facility will operate when it opens its doors.

5.4. The mechanism by which patients and the public will be engaged in the development of the model of care has still to be determined and agreed with the East Merton Locality.

6 TIMETABLE

6.1. The high level milestones and timetable for the development of the Mitcham Project are set out in the following table.

High Level Milestones/Tasks	Target Date
Submit PID pro-forma to NHSE Capital team	30/09/2014
Run public engagement event on site assessment	02/10/2014
Prepare Economic Case	15/10/2014
Sign off PPI strategy and plan	21/11/2014
Obtain CCG sign off of Economic Case	30/11/2014
Obtain instruction to proceed from NHSE	30/11/2014
Start design development process	04/01/2015
Gain planning approval	31/08/2015
Prepare Stage 1 Business Case	15/10/2015
Obtain CCG sign off of Stage 1 Business Case	31/10/2015
Obtain approval of Stage 1 Business Case from NHSE	31/12/2015
Prepare Stage 2 Business Case	15/02/2016
Obtain CCG sign off of Stage 2 Business Case	28/02/2016
Obtain approval of Stage 2 Business Case from NHSE	31/03//2016
Financial Close	15/04/2016
Start on site	01/05/2016

7 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

7.1. There are currently four sites under consideration, two in the ownership of NHS Property Services and two owned by the London Borough of Merton.

7.2. The current work will lead to a full economic appraisal of each site and the determination of the preferred option.

8 LEGAL AND STATUTORY IMPLICATIONS

8.1. Section 242 (1B) of the NHS Act 2006, as amended by the Local Government and Public Involvement in Health Act 2007, provides that: Each relevant English Body must make arrangements as respects health services for which it is responsible, which secure that users of those services, whether directly or through representatives, are involved (whether by being consulted or provided with information or in other ways) in:

- The planning of the provision of those services;

- The development and consideration of proposals for changes in the way those services are provided;

- Decisions to be made by that body affecting the operation of those services.

8.2. The NHS Act 2012 chap. 7 PART1 s26 makes similar provision for CCGs.

9 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

9.1. An Equality Impact Assessment (EIA) was completed for the Nelson development as part of the business case process. AN EIA is in the process of being completed for the Mitcham scheme.

10 CRIME AND DISORDER IMPLICATIONS

10.1. Not applicable

11 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

11.1. An initial set of project risks has been identified and the Project Board will continue to manage the risks associated with the Project.

12 APPENDICES – THE FOLLOWING DOCUMENTS ARE TO BE PUBLISHED WITH THIS REPORT AND FORM PART OF THE REPORT

12.1. None

13 BACKGROUND PAPERS

13.1. There are no background papers.

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Committee: Health and Wellbeing Board

Date: 30th September 2014.

Wards: All.

Subject: Pharmaceutical Needs Assessment

Lead officer: Dr Kay Eilbert, Director of Public Health.

Lead member: Councillor Caroline Cooper-Marbiah. Cabinet Member for Adult Social Care and Health.

Contact officer: Barry Causer, Public Health Commissioning Manager.

Recommendations:

A. Note progress made with the development of the PNA.

B. Note the requirements of the statutory consultation period, particularly the requirement to consult with neighbouring Health and Wellbeing Boards.

C. That Public Health respond on behalf of the HWB to consultation documents from our neighbouring boroughs.

1   PURPOSE OF REPORT AND EXECUTIVE SUMMARY

The purpose of this report is to update the HWB on the progress of the Pharmaceutical Needs Assessment and set out the initial plan for the statutory 60 day consultation due to start in October 2014.

2   DETAILS

2.1.   The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 includes a requirement that the Health and Wellbeing Board publish a Pharmaceutical Needs Assessment (PNA) by 1st April 2015.

2.2.   A PNA is a tool for identifying current and future needs at a local level to explore the potential and improve quality and effectiveness of pharmaceutical services. It uses robust, up to date evidence to ensure that pharmacy services are provided in the right place and that local authorities meet the needs of the community that it serves.

2.3.   It is used by NHS England when making decisions on applications to open new pharmacies and dispensing appliance contractor premises. Such decisions are appealable and decisions made on appeal can be challenged through the courts.

2.4.   Merton's PNA will also look at the public health services commissioned by locally by Public Health and recommend areas for improvement, expansion and opportunities for the future.

2.5.   **Progress to date**

2.5.1   Following a competitive process, Merton Public Health commissioned Primary Care Commissioning (PCC) to produce the PNA. This

commissioning was undertaken jointly with Sutton Council, realising savings of around £5,000 for each borough.

2.5.2   A joint Sutton and Merton PNA steering group has been set up to provide support and direction to PCC in producing the PNAs. This steering group has representatives from Merton Council Pubic Health, Sutton Council Public Health, Merton Clinical Commissioning Group, Sutton Clinical Commissioning Group, Merton Sutton and Wandsworth Local Pharmaceutical Committee, Sutton and Merton Local Medical Council and Sutton Health watch.

2.5.3   It is anticipated that the steering group will sign off the draft Merton PNA at their October meeting, so that the formal 60 day consultation can start on 20th October 2014.

2.4   Consultation

2.4.1 The consultation on the PNA is clearly set out with regulations for the consultation to last at least 60 days and to consult with the following

- Local Pharmaceutical Committee,
- the Local Medical Committee,
- persons on the pharmaceutical lists and any dispensing doctors in the area,
- the LPS chemist in its area,
- the Local Healthwatch,
- any NHS Trust or NHS Foundation Trust,
- NHS England,
- neighbouring HWB's
- and any other patient, consumer or community group in its area who has an interest in the provision of pharmaceutical services in the area.

2.4.2 The draft PNA, consultation questions and cover letter will be available on the Council website, MCCG website and will be sent directly via e-mail and post to named individuals as required by the regulations. It will also be sent to members of the HWB.

2.4.3 Consultation documents will be sent directly to the Chair of neighbouring HWBs alongside the Officer lead for the board. Where Merton HWB is asked to comment on PNAs covering neighbouring boroughs, it is recommended that Merton public health respond behalf of the Merton HWB.

2.4.4 This formal consultation will meet the statutory requirement and will start on the 20th October 2014, ending on the 19th December 2014.

2.4.5 Once responses have been collated, the PNA will be finalised and presented to the HWB in January 2015 for sign off and publication in advance of the statutory deadline of 1st April 2015.

3   ALTERNATIVE OPTIONS

3.1. Publishing a PNA is a statutory requirement under The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013.

4   CONSULTATION UNDERTAKEN OR PROPOSED

4.1. The consultation on the PNA is clearly set out with regulations as described above.

5   TIMETABLE

5.1. The deadline for the HWB to publish a revised assessment is 1st April 2015.

6   FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

6.1. Commissioning PCC to produce the PNA has cost £32,500 from the Public Health budget.

7   LEGAL AND STATUTORY IMPLICATIONS

7.1. Publishing a PNA is a statutory requirement under The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013.

8   HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

8.1. The PNA is concerned with delivering a balanced and equitable provision of service throughout the borough. In order to address health inequalities it is important that there is access to accurate data which reflects real needs.

9   CRIME AND DISORDER IMPLICATIONS

9.1. None.

10   RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

11   APPENDICES – THE FOLLOWING DOCUMENTS ARE TO BE PUBLISHED WITH THIS REPORT AND FORM PART OF THE REPORT

- None.

12   BACKGROUND PAPERS

12.1. The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013.

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Committee: Health and Wellbeing Board

Date: 30 September 2014

Wards: All

Subject: Review of One Merton Group Terms of Reference

Lead officer: Kay Eilbert, Director of Public Health

Lead member: Councillor Caroline Cooper Marbiah

Contact officer: Clarissa Larsen

Recommendations:

To agree the revised Terms of Reference for One Merton Group.

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1. **PURPOSE OF REPORT AND EXECUTIVE SUMMARY**

   This report sets out revised Terms of Reference for One Merton Group

2. **BACKGROUND**

   The One Merton Group (OMG) has been established in its current form for two years. The current Terms of Reference were agreed in October 2013..

3. **DETAILS**

   3.1 The Terms of Reference of One Merton Group have been refined to reflect its evolving role and relationship with the Health and Wellbeing Board.

   3.2 Membership of the One Merton Group has also been revised to consider and progress strategic issues effectively.

   3.3 A set of the revised Terms of Reference are included in Appendix 1.

4. **ALTERNATIVE OPTIONS**

   4.1 None for the purpose of this report.

5. **CONSULTATION UNDERTAKEN OR PROPOSED**

   5.1 The OMG Terms of Reference have been discussed and reviewed by all members of the One Merton Group.

6. **TIMETABLE**

   None for the purpose of this report.

7. **FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS**

None for the purpose of this report.

8. **LEGAL AND STATUTORY IMPLICATIONS**

None for the purpose of this report.

9. **HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS**

The One Merton Group is focused on the vision of the Health and Wellbeing Strategy to address health inequalities.

10. **CRIME AND DISORDER IMPLICATIONS**

None for the purpose of this report.

11. **RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS**

None for the purpose of this report.

APPENDICES – THE FOLLOWING DOCUMENTS ARE TO BE PUBLISHED WITH THIS REPORT AND FORM PART OF THE REPORT

Appendix 1 – One Merton Group Terms of Reference September 2014

One Merton Group Terms of Reference

1. Purpose

1.1 The purpose of the One Merton Group (OMG) is to provide senior executive leadership and oversight of strategic issues, including integration and commissioning strategy, relating to health and wellbeing. Guiding and supporting the effective working of the Health and Wellbeing Board.

.

2. Context

2.1 Merton Clinical Commissioning Group (MCCG), the London Borough of Merton (LBM), HealthWatch and the wider voluntary and community sector recognise that by working together they can have a much greater impact to support health and wellbeing and deliver better value for money.

2.2 The Merton Health and Wellbeing Board (HWB) was formed in line with statutory requirements as a committee of Merton Council in April 2013. This succeeded the Shadow Health and Wellbeing Board which had been meeting since 2011.

The HWB is focused on improving the health and wellbeing of local people and addressing health inequalities. Its purpose is to promote joined up services and integrated care, develop a Health and Wellbeing Strategy and a Joint Strategic Needs Assessment (JSNA) which provide strategic insight and influence to local commissioning strategies and plans.

2.3 The OMG provides the HWB with a direction, expertise and scrutiny of the work programme. It reviews the HWB forward plan with a focus on promoting integration and joined up services and tackling health inequalities.

OMG also has an important role in providing strategic oversight of the Integration Programme for Merton and evaluation of the Health and Wellbeing Strategy, together with oversight of JSNA

3. Proposed Responsibilities

The One Merton Group will:

3.1 Progress and support the work of the HWB to promote joined up services and integration specifically through the Integration Programme for Merton including the Better Care Fund.

3.2 Support the oversight, monitoring and delivery of Health and Wellbeing Strategy, including assurance on performance against targets.

3.3 Review commissioning strategies and plans, and to develop new proposals, shared by the partner agencies, for new strategies

3.4 Guide the refresh of Joint Strategic Needs Assessment led by the HWB.

3.5 Provide support to the HWB on the strategic direction of future review of Health and Wellbeing Strategy.

3.6 Reviewing and contributing to the HWB forward plan.

3.7 Maintaining close links with wider groups and partners including Merton Partnership, the Children's Trust Board, Sustainable Communities the Safer Merton Partnership Board and the NHS England Commissioning Board.

3.8 Undertaking other wider work in line with any new HWB responsibilities.

4. Proposed Core Membership of One Merton Group

Core members of the OMG will attend each meeting. The agenda will, where needed be split into Part A for core members and Part B to include others in attendance.

4.1 Core members
MCCG Chief Officer
MCCG Director of Commissioning and Planning
LBM Director Community and Housing
LBM Director of Public Health
LBM Director Children, Schools and Families

4.2 In attendance
For Part B of the agenda, where appropriate, other partner representatives together with specialist officers will be in attendance.
These will include the Chief Executive of MVSC, LBM Head of Commissioning for Adults and for Children and other officers including those from environment and regeneration.

4.3 Chair
The Chair of the Board will rotate between LBM and MCCG.

Members will make every effort to attend and ensure relevant officers attend for Part B where required to present particular papers or comment on particular areas of work.

5. Operational Arrangements

5.1 The OMG will be facilitated by the organisation that holds the Chair. Members will have the opportunity to view a draft agenda and suggest items. Papers will be circulated approximately a week in advance.

5.2 The OMG carries no formal delegated authority. Members bring the responsibility, accountability and duties of their individual roles to the OMG and by agreeing to exercise those collectively, provide authority to the group. Authority to act will be on the basis of recommendations agreed by the appropriate governance bodies. Wider relationships of the OMG are reflected in Appendix 1.

5.3 To enable this transparency of working relationships, members will support the development of and share the content of each others annual plans, budgets and any other relevant documentation.

6. Quorum

Decisions taken will require a minimum of three core members to be present including at least one member of MCCG.

7. Frequency of Meetings

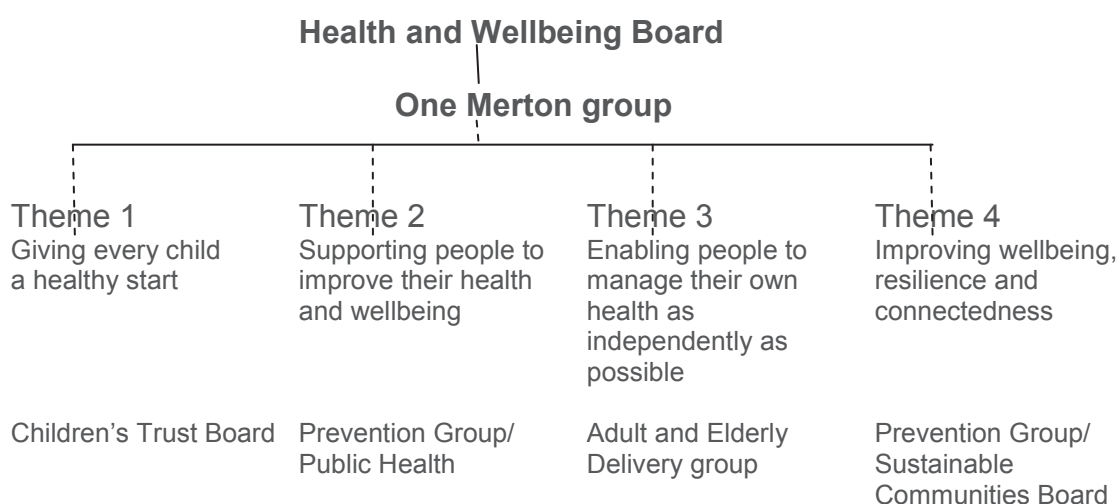Meetings will be held monthly and for up to a maximum of two hours.

8. Governance

8.1 The One Merton Group reports to the Health and Wellbeing Board and respective partners' governing bodies..

8.2 A number of groups will make reports to the HWB through the One Merton Group.

- Integration Project Board
- A Prevention group that works across Priorities 2 and 4 with the Sustainable Communities Board and Public Health
- Adult and Elderly Delivery Group for Priority 3 – a new group to deliver this priority
  For reporting on delivery of the Health and Wellbeing priority themes:
  (See Figure 1 below)

- The Children's Trust Board provides reports on Priority 1 of the Health and Wellbeing strategy but does not report to the One Merton Group.

Figure 1   Health and Wellbeing strategy reporting

Health and Wellbeing Board

One Merton group

Theme 1	Theme 2	Theme 3	Theme 4
Giving every child a healthy start	Supporting people to improve their health and wellbeing	Enabling people to manage their own health as independently as possible	Improving wellbeing, resilience and connectedness
Children's Trust Board	Prevention Group/ Public Health	Adult and Elderly Delivery group	Prevention Group/ Sustainable Communities Board

8.3   Task and Finish Groups
OMG will set up task and finish groups as required to progress specific pieces of work. The task and finish groups will be time limited and membership will be as nominated by the One Merton Group.
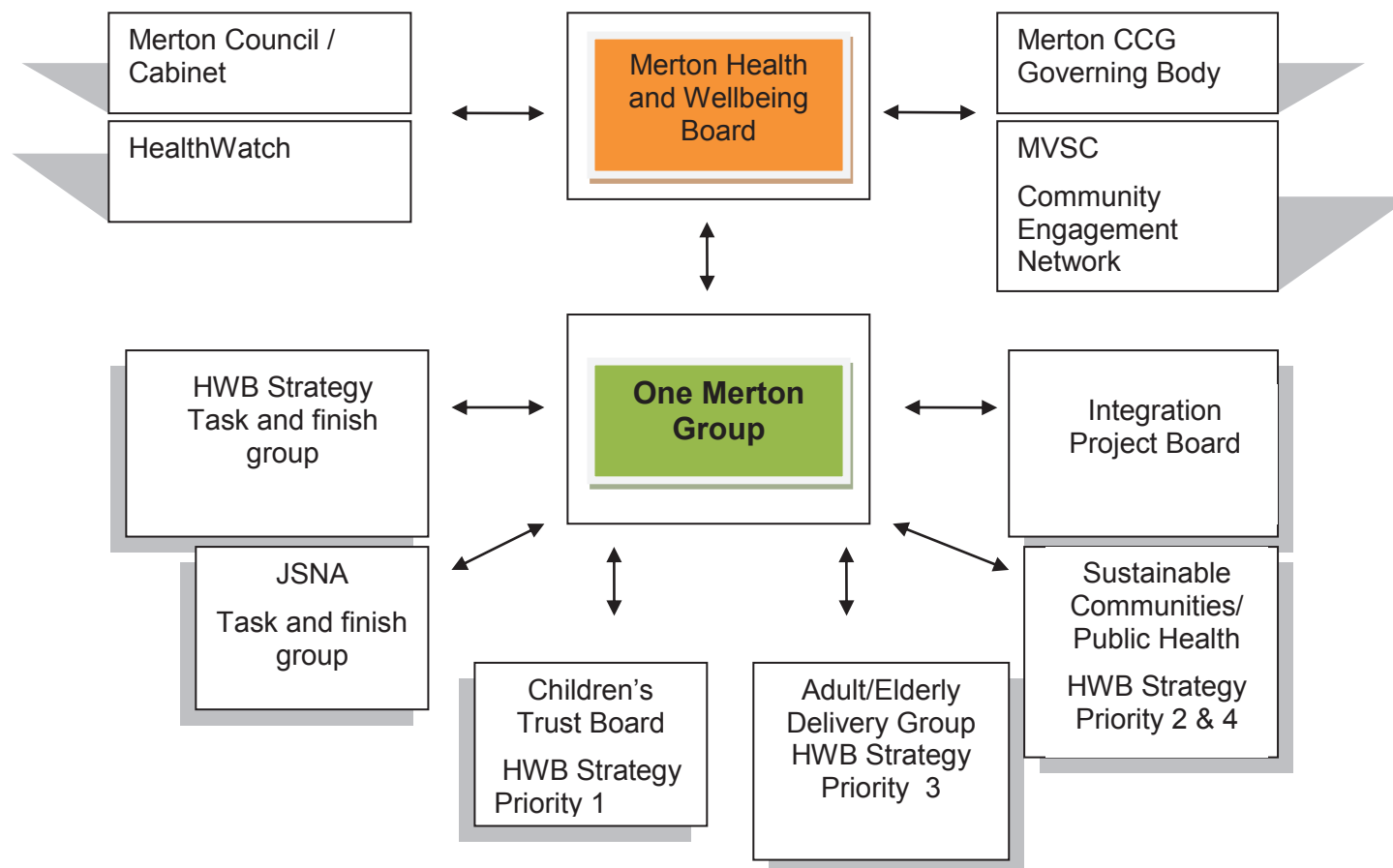
9.   Code of Conduct and Conflicts of Interests

9.1   At One Merton Group meetings or when representing the OMG, a representative of a member partner must:

- Promote equality by not discriminating unlawfully against any person;
- Treat others with respect;
- Not do anything, which compromises or is likely to compromise the impartiality of those who work for, or advise the OMG;
- Not disclose information given to them in confidence by anyone, or information they believe is of a confidential nature, without the consent of the person authorised to give it;
- Not use their position as a member of the OMG improperly to confer on or secure for themselves or any person, an advantage or disadvantage and;
- Declare any potential conflicts of interest including any of GPs as commissioners and providers.

10.   Review

The terms of reference will be reviewed in **March 2015** and thereafter annually or earlier if necessary.

September 2014

Appendix 1 One Merton Group – DRAFT Structural Links and Sub Groups

Merton Council / Cabinet	← →	Merton Health and Wellbeing Board	← →	Merton CCG Governing Body
HealthWatch				MVSC Community Engagement Network

HWB Strategy Task and finish group	← →	One Merton Group	← →	Integration Project Board
JSNA Task and finish group				Sustainable Communities/ Public Health HWB Strategy Priority 2 & 4

Children's Trust Board HWB Strategy Priority 1

Adult/Elderly Delivery Group HWB Strategy Priority 3

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Committee: Merton Health and Wellbeing Board

Date: 30 September 2014

Wards: All

Subject: Healthwatch Merton Update

Lead officer: Dave Curtis – Healthwatch Merton Manager

Lead member: Barbara Price – Healthwatch lead Trustee for MVSC

Contact officer: Dave Curtis, Healthwatch Merton Manager

Recommendations:

A   That the Board note the progress made by Healthwatch Merton.

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1.   **PURPOSE OF REPORT AND EXECUTIVE SUMMARY**

1.1   The purpose of the report is to update the Board on the progress to date and the on-going developments within the Healthwatch service for Merton.

2.   **DETAILS**

2.1   The Health and Social Care Act 2012 included a requirement on local authorities to establish a local Healthwatch in their area. This duty replaced the duty to establish a Local Involvement Network (LINk) from 1 April 2013.

2.2   As previously reported to the Board on 23 April 2013, Merton Voluntary Service Council (MVSC) was awarded the contract to deliver Healthwatch Merton in March 2013. A two-year contract was agreed with an option to extend.

2.3   Appendix 1 is Healthwatch Merton Annual Report for 2013/14 and Appendix 2 provides an update on work undertaken so far in 2014/15.

2.4   Key achievements in our first year include delivering a series of listening events; identifying the key issues for future work streams; working with Merton CCG, Public Health and other local providers to improve community engagement; and building a range of partnerships with local communities.

2.5   Since April we have began delivering on the work streams. A report on GP services will be delivered shortly; we are gathering evidence on hospital care; and we are leading on the engagement work strand of the Better Care

1

Fund project. We continue to attend a wide range of local community events.

2.6 The main tasks for the next quarter will include delivering the report on GP services, completing the work on hospital care developing a programme for delivering enter and view and putting in place a more robust governance model.

3. ALTERNATIVE OPTIONS

3.1 No alternative options are suggested.

4. CONSULTATION UNDERTAKEN OR PROPOSED

4.1 Extensive consultation took place in the autumn and winter. A series of Have your say events were supplemented by an online survey and attending a range of local groups. This information was used to help set the work strands for 2014/15.

4.2 As the contract holder Merton Council will be undertaking an evaluation of the service including a survey of local stakeholders. This will inform plans for the contract from April 2015.

5. TIMETABLE

5.1 The timetable for the key milestones is set out in Appendix 1.

6. FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

6.1 The contract for Healthwatch Merton will be £125,085 in 2014/15. Financial monitoring against this will be provided to the Council.

7. LEGAL AND STATUTORY IMPLICATIONS

7.1 Provision of an effective Healthwatch Merton is a statutory requirement under the Health and Social Care Act 2012.

8. HUMAN RIGHTS, EQUALITIES AND COMMUNIITY COHESION IMPLICATIONS

8.1 Healthwatch Merton is subject to MVSC's Equalities Policy. The contract requires Healthwatch Merton to monitor use of the service and report quarterly to the Council.

9. CRIME AND DISORDER IMPLICATIONS

9.1 None

2

10. RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

10.1 Healthwatch Merton is subject to MVSC's Health and Safety Policies.

11. APPENDICES - THE FOLLOWING DOCUMENTS ARE TO BE PUBLISHED WITH THIS REPORT AND FORM PART OF THE REPORT
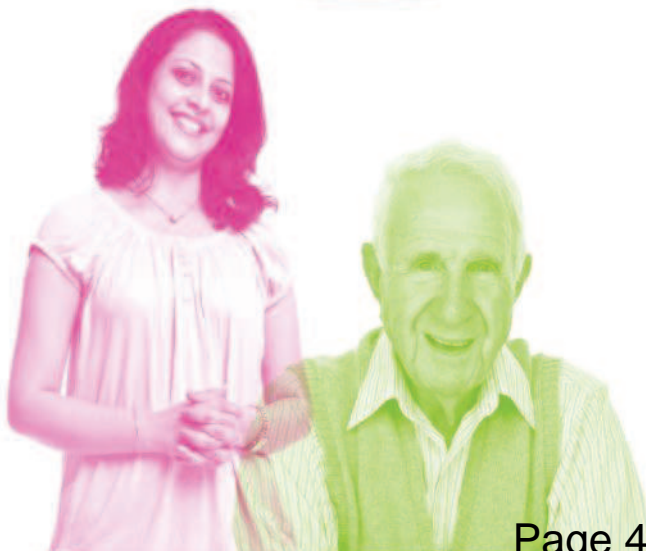- Appendix 1 –Healthwatch Merton Annual Report
- Appendix 2 – Work plan update

12 BACKGROUND PAPERS
- Health and Social Care Act 2012.

3

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healthwatch
Merton

6

Annual Report
2013 / 14

Contents

INTRODUCTION

This is the first annual report from Healthwatch Merton (HWM), the local consumer champion for health and social care in Merton.

The report outlines our workstreams for the coming year and what we've done so far.

We have been working with members of the public to gather feedback on health and social care services in the borough. With feedback we received through our survey, listening events and with internal and external influences, it has enabled us to identify our workstreams.

It's crucial that our workstreams enable us to effectively focus our time to support our function as a consumer voice. This will help us offer real value to the people of Merton.

Our workstreams will leave HWM with the capacity to respond, react and be proactive when our involvement is required in other areas.

We also received useful information that directly named services or organisations. It's essential that these named services or organisations receive this feedback for them to be able to log and address them. This information will be sent anonymised from HWM.

healthwatch Merton

Our Team

Dave Curtis
Healthwatch Merton Manager

Adele Williams
Information & Outreach Officer

Sophie Matthews
Marketing Communications Manager

HEALTHWATCH MERTON

Healthwatch Merton works to help local people get the best out of their local health and social care services. Whether it's improving them today or helping shape them for tomorrow. Healthwatch is all about voices being able to influence the delivery and design of local services. Not just people who use them, but anyone who might need to in future.

Healthwatch Merton will play a role at both national and local level and will make sure that the views of the public and people who use services are taken into account.

Merton Council awarded the Healthwatch Merton contract to MVSC because of their excellent knowledge of the borough. MVSC is based in the borough and already engaged on a daily basis with the many diverse communities in Merton. Their experience and knowledge about health and social care services working within Merton is also another strong quality.

How we work:

Every voice counts when it comes to shaping the future of health and social care, and when it comes to improving it for today. Everything that Healthwatch Merton does will bring the voice and influence of local people to the development and delivery of local services.

People need to feel that their local Healthwatch belongs to and reflects them and their local community. It needs to feel approachable, practical and dynamic and to act on behalf of local people.

We're engaging with people across Merton and we're inclusive so we can hear from all communities. If you haven't met us yet, please get in touch and join us!

We're an open organisation and want to make it easy for you to talk to us. Ask us what we're doing and we'll always tell you what's happening. You can hold us to account and we're here to help services to improve.

We will note the bad and good things we hear about services and will use your evidence to build a true picture of local services. Our representation must have an evidence base, so we will strive to check facts before taking issues forward.

3

HEALTHWATCH MERTON LAUNCH

Over 70 people representing a wide range of interests attended the official launch of Healthwatch Merton on 17th July 2013. This new local service joins a network of Healthwatch organisations across England which replace Local Involvement Networks.

Managed by Merton Voluntary Service Council (MVSC), Healthwatch Merton will ensure the views of patients and carers are heard and offers the opportunity to share concerns and opinions about improving local health and social care services. The service will also provide information and advice to the public on local health and social care services.

The successful launch was facilitated by Barbara Price, MVSC Lead Trustee for Healthwatch, and guest speakers included Dr Katherine Rake OBE, Chief Executive of Healthwatch England, Dr. Howard Freeman (Chair) and Eleanor Brown (Chief Executive)
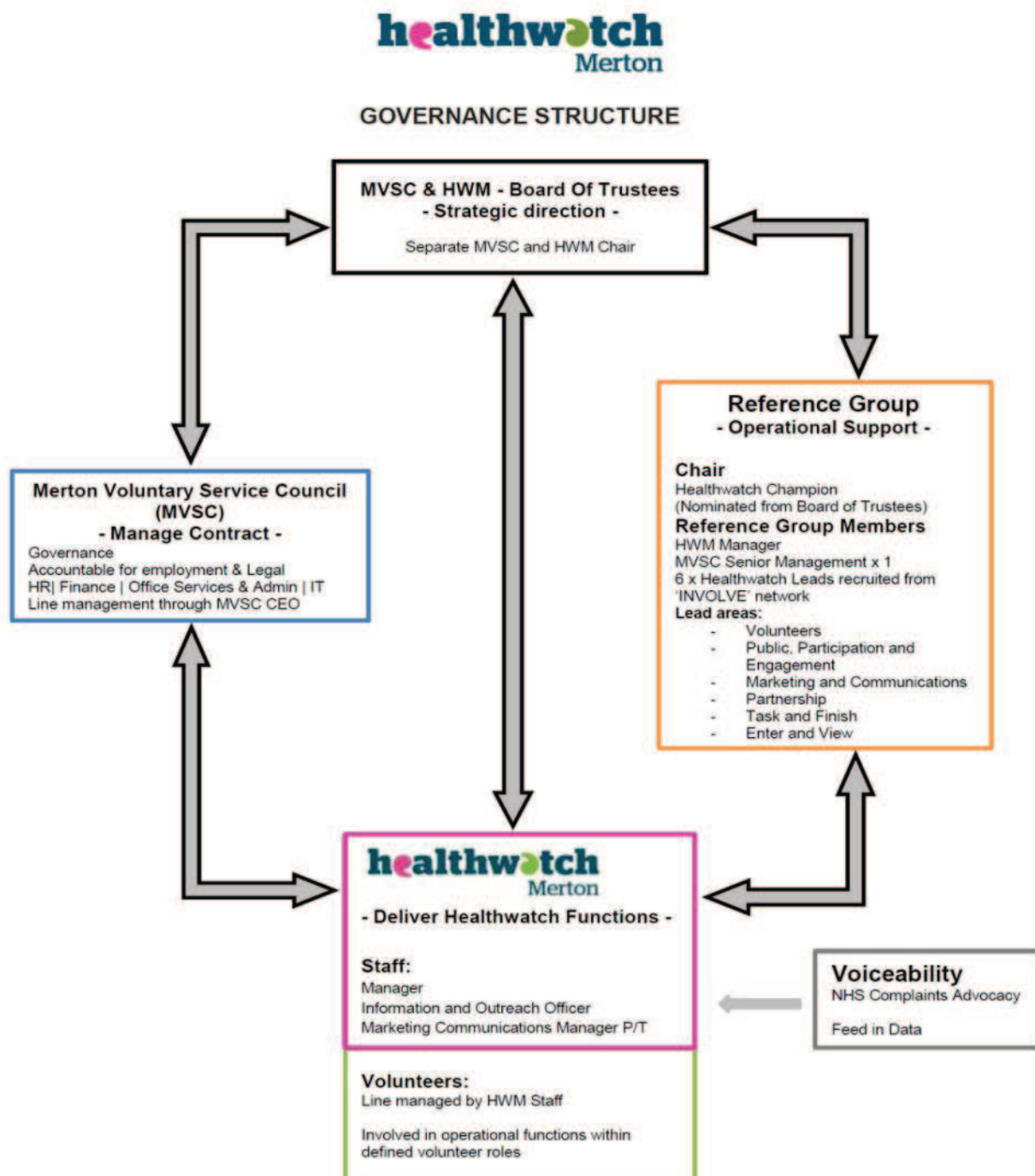
of NHS Merton Clinical Commissioning Group and Simon Williams, Director of Adult Services at the London Borough of Merton.

Chair of Merton's Health and Wellbeing Board and cabinet member for adult social care and health, Councillor Linda Kirby, said: "I'm really pleased that Healthwatch Merton has officially launched and look forward to working with them to ensure residents have a real say and can influence how their health and wellbeing can be improved."

Chair of Merton Voluntary Service Council, Lola Barrett said, "We're delighted to have been awarded the contract to deliver the Healthwatch service and pleased to continue our work with health and social care services within the borough. Partnership working in Merton is extremely successful across all sectors and we're looking forward to delivering the best possible service we can for local people."

HWM GOVERNANCE STRUCUTURE 2013/14

healthwatch Merton

GOVERNANCE STRUCTURE

MVSC & HWM - Board Of Trustees
- Strategic direction -

Separate MVSC and HWM Chair

Merton Voluntary Service Council (MVSC)
- Manage Contract -

Governance
Accountable for employment & Legal
HR | Finance | Office Services & Admin | IT
Line management through MVSC CEO

Reference Group
- Operational Support -

Chair
Healthwatch Champion
(Nominated from Board of Trustees)
Reference Group Members
HWM Manager
MVSC Senior Management x 1
6 x Healthwatch Leads recruited from
'INVOLVE' network
Lead areas:
- Volunteers
- Public, Participation and Engagement
- Marketing and Communications
- Partnership
- Task and Finish
- Enter and View

healthwatch Merton
- Deliver Healthwatch Functions -

Staff:
Manager
Information and Outreach Officer
Marketing Communications Manager P/T

Volunteers:
Line managed by HWM Staff

Involved in operational functions within
defined volunteer roles

Voiceability
NHS Complaints Advocacy

Feed in Data

*Note – From May 2014 our governance structure is being reviewed and alterations are expected based on our experience of the current structure and feedback we have received throughout the year. Revised governance will be publicised and shared widely once available.

INFLUENCE AND IMPACT

Over the last year Healthwatch Merton has worked hard to position itself to best influence changes in local services to the benefit of local people.

Healthwatch Merton has a seat on the Health and Wellbeing Board. This Board exists to serve Merton by bringing together representatives from the NHS Clinical Commissioning Group (CCG), police, schools, housing, voluntary sector, and social services as well as local councillors. This provides us with a clear route to champion the views of patients and public and influence future decision making across Health and Social Care within Merton.

We also meet regularly with a wide range of senior health and social care staff including CEOs and Executive Directors of provider organisations, the Chair and Engagement lead of the Merton CCG, senior Directors of the NHS England local area team, and senior Directors in Merton Council. We meet in a range of ways, including specific one to one meetings at our request, informal, formal and scheduled meetings.

We have built a relationship with the Merton CCG and do joint working where appropriate and also influence via attendance/ contribution to many key groups, projects and programme boards.

Notable successes:
- We provided in advance raw data to the Care Quality Commission (CQC) from feedback gathered from September 2013 – March 2014 to inform real time inspections of GP services in Merton.

- Merton Health and Social Care Services in the coming year will be developing the delivery of their services and ways they work together through its 'Integration Project' bringing about

huge local changes. Through the success of our engagement work to date Healthwatch Merton is the named engagement lead within the 'Integration Project', this means Healthwatch Merton are able to ensure the public can feed directly into shaping services through this project.

- Healthwatch Merton jointly hosted the Joint Strategic Needs Assessment (JSNA) Community Consultation event with Public Health. This was the first time Merton's Public Health team engaged face to face with local people on the JSNA. This enabled residents to directly influence the final JSNA findings.

- The Engage Merton Event held by Merton Clinical Commissioning Group (MCCG) was Chaired by the Healthwatch Merton Manager and brought local people, voluntary sector, Commissioners, Local authority leads and local councillors together to discuss and review the proposed MCCG commissioning intentions on services. The feedback and findings from the day directly influenced Merton CCG commissioning intentions for 2014/16 adding a couple of extra areas and fed into their five year strategy. The wealth of discussion also helped the MCCG to further develop their Patient Participation and Involvement Strategy.

DEVELOPED WORKSTREAMS

Locally Directed:
The people of Merton directly influenced two of our workstreams for the coming year when they highlighted GP services and Hospital Inpatient and Outpatient Care as areas of concern.

Operational:
This workstream will focus on delivering a balanced service that covers health and social care, children, young people and adults.

Top down:
HWM has identified integration as an area requiring attention in the coming year. This was set by external factors (e.g. legislative changes) that impact on local service change and development.

LOCALLY DIRECTED

It was essential for HWM to identify what local people see as important and to help us plan work for the coming year based on this.

What we did
From August 2013 we heard from people across Merton through our outreach activities. We gained a wealth of information on health and social care services used locally.

Using these findings we created a list of 'themes', and asked members of the public to select their top 5 priorities.

This survey card was sent to contacts on our database and made available at further outreach work and dedicated listening events. The survey was also available online via our website and other external sites.

We included a 'not on the list' tick option for people to add any that had not been covered by any of the options provided.

Through our survey, listening events and outreach across the borough, we heard **669** voices on health and social care services.

If you have any further comments or would like to know more about Healthwatch Merton then please get in touch or visit our website www.healthwatchmerton.co.uk

0208 685 2282   info@healthwatchmerton.co.uk
Healthwatch Merton, Vestry Hall, 336 London Road, Mitcham CR4 3UD

Please tick your top 5 priorities:

Children and Young People		Mental health services	
Older people		Patient pathway – how services link together	
Maternity and post natal services		Physical or learning disability	
Services for vulnerable groups		Long term conditions	
GP services		Obesity	
A&E and Urgent care services		Cancer	
Hospital – inpatient and outpatient care		Dementia	
Health - prevention services		Diabetes	
Community based social or lifestyle projects		Physical environment and local housing	
Misuse of tobacco, alcohol and drugs		Unemployment	
Support for carers		Crime and safety	
Integration of health and social care services		It's not on the list!	

How we used the information:

We collated the feedback gathered to identify the main two areas. Though **'It's not on the list'** had most responses it was not selected as a workstream as this heading included 17 different themes within it, of which transport had the most support with 8. Therefore **GP services** and **Hospital – Inpatient and Outpatient Care** with a total of 43 and 39 respectively where the two workstream areas identified by the survey.

Listening Events
HWM held three listening events focused on providing more detailed discussion to support the workstream survey and give us a good overview generally. These events were promoted widely and we had a combined attendance of 44.

- Mitcham – December 2013
- South Wimbledon – January 2014
- Raynes Park – March 2014

These events gave us a wealth of information about how people viewed health and social care services within Merton, covering all the areas on the survey list and more.

Focusing on:

GP services
People told us what they did not like about their GP service, nothing not already known i.e. access, appointments, continuity, information, communication. The Merton Clinical Commissioning Group (MCCG) has this named as an area of improvement in their business plan.

As a result of this we will be doing research and mapping to identify improvements patients want to see across the borough and produce a report to feed into the work MCCG will be doing and to maximise potential influence and impact.

Survey responses
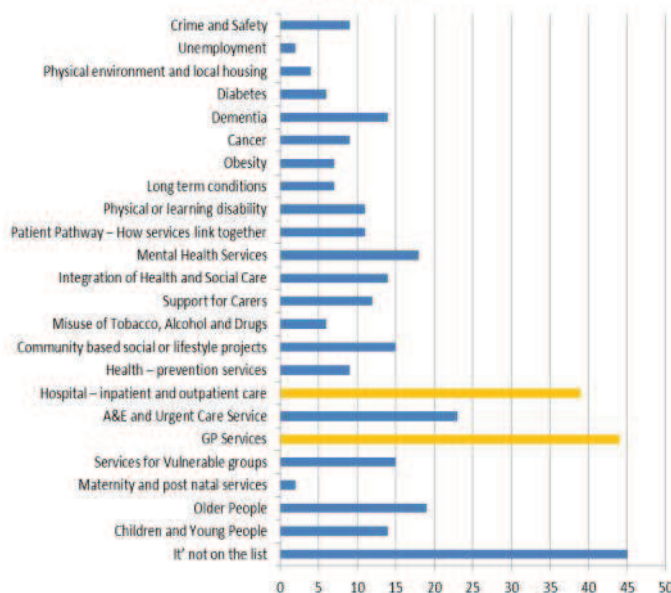
Hospital – Inpatient and Outpatient Care
Various issues were raised within the listening events around Hospitals with concerns around discharge being raised a number of times. However it was very difficult to decipher an exact area of work due to the large variety of comments.

Therefore more targeted listening events are being held to gain a clearer view of issues within Hospital inpatient and outpatient care. Once specific themes have been identified we will take a clear direction and set objectives to inform a planned piece of work.

Action:

GP services
Research and mapping to identify improvement patients want to see across the borough and produce report to feed into work MCCG are doing on this improvement area.

Hospital – Inpatient and Outpatient Care
Engagement workshops to be held to identify areas within this we should focus on. Develop work plan informed by engagement workshops. Deliver on work plan.

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OPERATIONAL

The majority of our work to date with the public, Merton Clinical Commissioning Group and the Local Council has covered mainly adult health and social care.

This has naturally been the starting point for many local Healthwatch, given they inherited areas of work to continue from the Local Involvement Networks whose remit was adult health and social care.

HWM is the consumer voice for children, young people and adults covering health and social care. Therefore we need to grow and develop our children and young people element of our work and service.

We have begun to work on some areas already, in particular working with young advisors to help services and organisations understand how to engage effectively with children and young people and involve them in influencing and developing services.

We have identified our operational workstream as children and young people. We are aiming to develop this side of HWM to ensure it can offer the same service and voice for children and young people as we are already doing for adults.

Action:

To develop and review with children and young people's groups/forums a HWM Participation and Engagement plan and then implement.

Young Advisors

TOP DOWN

We have identified integration as an area requiring our attention in the coming year. This will be an important enabler to take the local integration agenda forward acting as a significant catalyst for local change.

Integration
In Merton an Integration Project began in 2013. A partnership with MCCG, London Borough of Merton, trusts and voluntary sector, it aims to develop integrated care between social and health care.

'Integration project' will provide the opportunity to transform local services so that people are provided with better integrated care and support. Aims to improve patient and service user experience, reduce admissions to hospital, facilitate discharges, and reduce admissions to residential and nursing homes. It was previously referred to as the Integration Transformation Fund, and re-named the Better Care Fund in December 2013.

Integration plan and The Better Care Fund plan for Merton was submitted recently at the Health and Wellbeing Board and approved.

HWM has been identified in the plan to lead on several areas of public engagement.

Integration will support the aim of providing people with the right care, in the right place, at the right time and with the right outcome, including through a significant expansion of care in community settings, instead of in hospital or care homes.

> An important enabler to take the local integration agenda forward acting as a significant catalyst for local change.

The Merton Integration project is focused on two phases of individuals' care:

a proactive phase
including the identification of high risk individuals, allocation of a key worker, person-centered planning and a common care plan across organisations, development of integrated locality teams and multi-disciplinary review meetings.

a reactive phase
developing improved responses to short term crises and exacerbation of conditions, including rapidly available alternatives to hospital admission, supported hospital discharge, rehabilitation, intermediate care, reablement, and increasing the integration of these health and social care responses.

Action:

HWM form an integration monitoring group to monitor the integration project and Better Care Fund plan. Plan and Lead on identified areas of patient public engagement within the Integration Plan and Better Care Fund plan.

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OUTREACH

Healthwatch Merton launched in July 2013 with over 70 people attending our launch event. With talks from Healthwatch England and Merton Clinical Commissioning Group our local service joined a network of Healthwatch organisations across England.

Since then our Information and Outreach Officer, Adele Williams, has been working across Merton gathering people's views and experiences of health and social care services and has heard from **669** voices.

This outreach has consisted not only of visits and presentations to community groups and voluntary organisations, but also of dedicated listening events and partnership work with service providers.

This work has been undertaken with the primary aim of ensuring local people gain an opportunity to get their voices heard by decision makers.

3 Listening Events

We hosted three successful listening events across the borough. These events gave us the opportunity to have round the table discussions with local people.

I have really enjoyed this opportunity to "air my views" so to speak, thank you. Excellent event!

We gained a more detailed understanding about what improvements they would like to see and what good experiences they have to share.
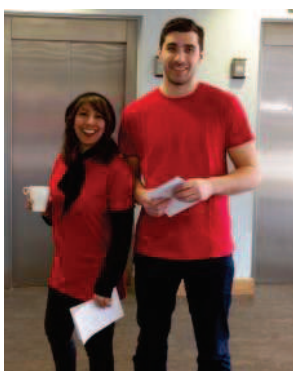
25 visits and presentations

We attended and spoke at various events across the borough. Thanks to the enthusiasm of those we spoke to and their willingness to share experiences with us, we were able to gather a wealth of information.

Community Forums
We attended forums across the borough speaking directly with members of the public about who we are, what we do and how we can help.

Merton Council Pop Up Event
We had an outreach and information stand to gather views. There are some services they couldn't do without and some which they'd like to see improve.

Support throughout life's journey
We heard from Miss Ramalingam, Consultant at Kingston Hospital and we had an information stand to raise awareness of patient engagement to medical staff and patients.

Crusoe Road Plus Residents' Association
It was great to see so many people engaged in their local neighbourhood and to hear their experiences.

Polish Family Association playgroup
During two visits we spoke to families about their experiences of maternity and GP

services and provided information in Polish on how to get involved.

Ma Kelly's Game Theatre Performance
We attended community showings to talk with attendees about what's most important to them in their health and social care.

Joint Consultative Committee with Ethnic Minority Organisations
This meeting was a great opportunity for us to talk directly to representatives from the BAEM community about how we can champion views on health and social care services.

Rowans Surgery Patient Participation Group (PPG) Meeting
We were able to talk directly to patients at the practice and listen to their opinions on how the surgery is doing and what improvements could be made.

We also attended:
- Merton Seniors Forum Health Meeting
- St Mark's Family Centre
- Crossroads Care South Thames, Annual General Meeting (AGM)
- Phipps Bridge Community Day
- Merton Mencap's Saturday club for adults with learning difficulties
- Friends in St Helier Lunch Club at St George's Church and Yenston Close

THE POWER OF PARTNERSHIPS

Working in partnership with services providers is an essential part of our role. Service providers recognise the powerful feedback patients are able to provide and how this can lead to more effective services with better outcomes.

Merton Mental Health Review (MMHR), Public Health Team
Two focus groups and several one to one interviews were held to ensure the public health team gained direct feedback from service users and carers during their review of mental health.

Engage Merton, Merton Clinical Commissioning Group (MCCG)
This event was a chance for members of the public, patients, carers and local health and social care organisations to review Merton CCG's commissioning intentions and engagement strategy for 2014/15.

Young People's Health Event, Merton Council
Merton Council's young advisors held an event to discuss (with relevant service providers) the role young people can have in decision making processes and future projects.

Joint Strategic Needs Assessment Community Consultation (JSNA), Public Health team
This consultation allowed members of the public to share opinions on current and proposed health and social care services. It provided a space where key findings from the assessment were aired and final feedback was sought.

Love Your Heart, Kingston Hospital
This community health event highlighted how to keep your heart healthy and what steps to take in managing heart conditions. Local organisations were there to provide information and support to visitors alongside free health checks.

We also worked with:
- Integrated Health Care simulation, Office for Public Management (OPM)
- Leaflet Review, Sutton and Merton Community Services (SMCS)
- Your hospitals, your services, your say, Epsom and St Helier

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COMMUNICATIONS

Use of Healthwatch trademark
Healthwatch Merton uses the Healthwatch trademark in all its statutory activities as covered by the licence agreement and has used the trademark in all the following Communication work and activities.

There are over 590 (1) voluntary, community and faith organisations currently in Merton that support the boroughs population so it was key for Healthwatch Merton to engage with these groups to ensure local people could be effectively represented.

Therefore we ensured our monthly newsletters were sent directly to them.

Healthwatch Merton has maintained a comprehensive database of contacts which forms the basis for all communications and ensures people and organisations receive the communications that are the most relevant to them.

We currently have 1,883 contacts signed up to receive our monthly Healthwatch Merton bulletin – with an average open rate of 29.51%.

Since our launch in July 2013 we have produced 8 online and printed newsletters and bulletins.

We use these to promote our events, local events, information and advice, local and national news and to ask our contacts for their feedback on health and social care services in Merton.

A variety of media has been used as appropriate and cost effective, including:

- Website
- E-bulletins
- E-Mailings
- Mailings
- Leaflets
- Fliers
- Newsletters
- Press releases
- Displays
- Social Media

We use this wide selection of media to ensure that all key audiences are reached, including those without access to electronic media.

We currently have 526 'followers' on Twitter and 10 'likes' on Facebook.

Our website receives an average of 738 page views per month, 501 Unique Page views and an average time spent viewing a page of 3:43 minutes (Report taken from Google Analytics).
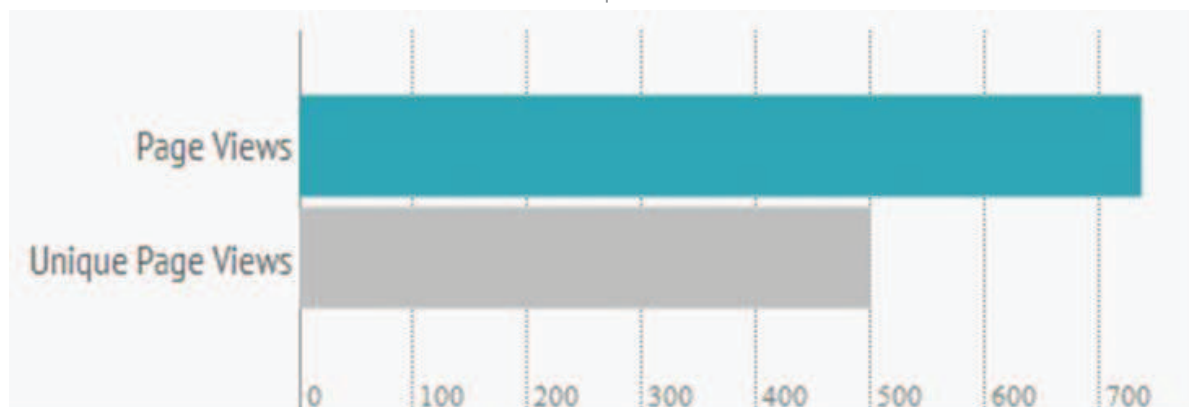
(1) According to MVSC's own database there are 594 voluntary, community and faith organisations in Merton at the time of writing up this report – state of the sector MVSC report 2014

INFORMATION AND SIGNPOSTING

Through our website and phone service we have provided information on complaints pathways for NHS healthcare, private healthcare, dental care and social care with special mention to raising a concern about a healthcare professional.

Information regarding health, social and community services has been available on our website through the following organisations:

- Merton-I
- Merton Voluntary Service Council
- Merton Council
- Merton Clinical Commissioning Group
- Merton Neighbourhood Watch
- Merton and Lambeth Citizens Advice Bureau (CAB)
- LiveWell Merton

- NHS Choices
- The NHS guide to social care
- NHS information on how to live well
- The Government's public website
- Department of Health
- Department of Social Services
- The Department for Children, Schools and Families

In addition to our office based information and signposting service we have collated a range of local and national information leaflets that are made available at our outreach activities and events.

This is part of our dedicated approach to ensuring the local community is well informed about support and services available to them.

COMPLAINTS

VoiceAbility provides the independent NHS Complaints Advocacy service in Merton. Healthwatch Merton and VoiceAbility share information to identify common trends arising from Healthwatch Merton comments received and complaints handled by VoiceAbility. VoiceAbility supports people who need help to make a complaint about NHS services they have received.

You might decide that you need support to make a complaint. VoiceAbility advocates can work with you to ensure you understand your options and help you to achieve the outcome you are seeking.

Web: www.nhscomplaintsadvocacy.org
Phone: 0300 330 5454
Email: nhscomplaints@voiceability.org

VOLUNTEERING

Healthwatch Merton recognises that it cannot work in isolation and Volunteers play an important role within Healthwatch Merton for it to fulfil its core functions and to grow and strengthen its ability to hear the voices of local people and to expand the work we do and reach out to the community.

In the last year we have mainly had people volunteer and help adhoc with events we have arranged and in the delivery of these events as support.

In 2014/15 we are looking to expand our opportunities and have already begun to seek volunteers for Outreach, Research and Policy. All opportunities are available on our website.

Enter & View:

Through the Health and Social Care Act 2012, Healthwatch Enter and View representatives have statutory powers to enter Health and Social Care premises, announced or unannounced, to observe and assess the nature and quality of services and obtain the views of the people using those services, to consider how services may be improved and how good practice can be disseminated.

Healthwatch Merton has not undertaken any statutory enter and view visits during this period, with work focussing on getting an authorised team in place. Training in May 2014 has been set for 18 local people who have volunteered to undertake the training for this role using the guidance recommended by Healthwatch England. Safeguarding (Adults and Children) training will also be undertaken alongside Disclosure and Barring Service (DBS) checks. Work to increase the pool of volunteers within this role will be undertaken over the coming year, with enter and view visits seeking to be planned across a range of services later in the coming year.

HEALTHWATCH MERTON ACCOUNTS

April – March 2014

INCOME

LBM Grants	129,445	Healthwatch Contract (Merton Council)
Other Income	3,250	Contribution towards event (Merton CCG)
TOTAL INCOME	**132,695**	

EXPENSES

Staff Costs	90,234	
Staff Expenses	1,786	Including recruitment costs
Premises Costs	9,948	Dedicated Office in Vestry Hall
Meeting Costs (room hire etc)	1,391	
Communication & Publicity Costs	857	Including website and promotion
IT Costs	5,190	Including purchase of computers
Other Costs	6,339	Including office setup costs
Expense Allocation	4,270	Contribution towards other MVSC costs
Sub-total	**120,015**	
Management Recharge	5,060	Charge for management of the contract
Total Expense	**125,075**	
Surplus (Deficit)	**7,620**	Surplus to be used to commission extra work into GP services in June 14

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WORK REPORT

Name: David Curtis

Position: Healthwatch Manager

Period Covered: July 2014 – 10th Sept 2014

Main work areas during period:

Monitoring and Reporting:
- Report as required to the Health and Wellbeing Board.
- Report as required to Board of Trustees
- Annual Report completed and shared
- GP and Hospital project reports - see workstreams update

Publicity:
Website: Still in process of developing young person's section

Ongoing – Volunteer opportunities posted - Local signposting - News stories - Events updated – website and social media kept relevant and up to date - regular tweets

Newsletters: Three electronic newsletters produced and disseminate

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Events, Meetings and Public Engagement opportunities attended and present at:

Have attended these events / forums / Meetings:
Kingston Hospital Healthwatch network; SWLSTG Foundation Trust Steering Committee Meeting; St Georges Stakeholder Steering Group; South west London Patient and Public Engagement Steering Group; BHCH programme Board; Adult Safeguarding Board; Healthwatch forum; The Merton Model Group; Mental Health services changes session;

Partnership work:
- Integration project team – health and social care (MCCG and Merton Council)
 'Joining Up Health and Social Care' public event – planned, held and delivered event on behalf of the integration project
- Mental Health Strategy workshop event (public health), HWM chaired and supported
- First South West London Local Healthwatch Forum Meeting
- Mitcham Project board
- BCF resubmission process workshop
- Prevention of admission workshop

Work Stream Updates/ current work

GP's Research Project:
- **Seven community outreach visits to organisations active within Merton**. These were selected to ensure a broad spread of demographics and to ensure the targeted inclusion of people with a range of experiences and health needs. These included a youth organisation, parent and toddler group, lunch club, charity working with carers, older people's group, an organisation run by and for people with disabilities and a user led BME mental health service users group.
- **Two GP workshops to which the general population was invited**. These

workshops allowed us to reach wider than the community groups identified above, and allowed residents not linked with any of the community groups above the opportunity to have their voice heard.

- **Questionnaire survey**. We devised a questionnaire survey which was used to gather input more widely. This was used in several ways, at various outreach events including the Mitcham Carnival and Wimbledon Carnival, posted to 258 local organisations by Healthwatch staff, Publicised through the MVSC and Healthwatch Merton web sites for completion online.

Draft GP research report has been produced and is in final stages of proofing. This will be shared with MCCG in first instance to support the *improvement of GP services, as in their business plan and will be shared more widely as required plus available on our website.

Hospital Research project:
The first phase of the work we held three workshops in the first week of July of to narrow down the areas within this work to enable us to have a focus.

Second phase we developed a survey and session plan based on the survey and held the following outreach to gather evidence for the Hospital Project. At each session an overview of Healthwatch Merton's role and the background to the Hospital Project was also given.
- 15th August – Commonside Lunch Club, New Horizon Centre, Mitcham
- 18th August – Asian Elderly Group, Merton Vision, Colliers Wood
- 21st August – St Raphaels Hospice, North Cheam
- 2nd September – Commonside Lunch Club, New Horizon Centre, Mitcham
- 2nd September – Merton Park Ward Residents Association
- 4th September – Focus-4-1, Vestry Hall, Mitcham
- 5th September – Mencap Saturday Group, Wimbledon Guild, Wimbledon
- 11th September – Merton CIL, Merton Residents and Tenants Association, Mitcham
- 17th September – Coffee Morning, Lewes Court, Mitcham
- 18th September – Kids First, Chaucer Centre, Morden

We are currently in the process of writing the report based on what we have gathered.

Children and Young people:
In process of developing HWM young advisors internally and drafting engagement and participation strategy. Will be seeking to do outreach to identify Young people areas of focus (workstreams) for 2015/16 in addition to General adult influenced worksteams.

Volunteers:
Recruiting volunteers for: Engagement and Outreach

Currently have:
x1 Website Admin Volunteer
Continuous review of the Healthwatch Merton website. The review includes reading through each page to check: spelling and grammar, information was understandable and easy to read, ensure continuity of presentation and to check all links to other webpages are active.

x1 Research and Policy Volunteer
Provides document summaries condensing long or complex documents into an easily readable, digestible format. The general public can read these to keep up to date with the Health and Social care sector, without having to read technical and confusing documents.