WANDSWORTH BOROUGH COUNCIL

Contact: Martin Newton
Tel: 020 8871 6488
e-mail: mnewton@wandsworth.gov.uk

AS PROVIDED FOR UNDER SECTION 100B(4)(b) OF THE LOCAL GOVERNMENT ACT 1972, THE CHAIRMAN IS OF THE OPINION THAT THIS ITEM SHOULD BE CONSIDERED AT THE MEETING AS A MATTER OF URGENCY BY REASON OF SPECIAL CIRCUMSTANCES. THESE CIRCUMSTANCES ARE SET OUT AT THE TOP OF THE REPORT]

SUPPLEMENTARY AGENDA NO.1 FOR THE MEETING OF THE SOUTH WEST LONDON JOINT MENTAL HEALTH OVERVIEW AND SCRUTINY COMMITTEE - INPATIENT MENTAL HEALTH SERVICES SUB-COMMITTEE TO BE HELD AT THE TOWN HALL (ROOM 145), WANDSWORTH, SW18 2PU ON WEDNESDAY, 17TH DECEMBER, 2014 AT 7.00 P.M.

5. **Clinical Commissioning Groups' Information (Paper 7)**

To consider summary information from the CCGs on the community services plans for each borough. (Attached)

This is a CCG discussion paper/draft document which does not identify models or the financing.

The Town Hall
Wandsworth
SW18 2PU

PAUL MARTIN
Chief Executive and
Director of Administration

11th December 2014

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7

Adult Community Mental Health Services

A Discussion Paper 1st December 2014

Introduction

The following paper has been composed to update the JHOSC of current and future direction of mental health services. It begins by informing the JHOSC of recent changes that have occurred in mental health strategy and makes clear the drivers for future direction. The paper was written by the South West London Sector Lead Commissioner for mental health and outlines the path that Kingston CCG and Borough are taking. The individual Borough variations and specific pathways are outlined by each borough in the second section of the paper.

Section 1

1. Community Mental Health Services

Mental health services have gone through a radical transformation over the past 30 years – perhaps more so than any other part of the health system. The model of acute and long term care based on large institutions has been replaced by one in which most care is being provided in community settings by multi-disciplinary mental health teams. These teams support most people in their own homes but have access to specialist hospital unity for acute admissions and smaller residential units for those requiring longer-term care (these smaller residential units are primarily provided now by the third sector).

In 1999 the National Service Framework (NSF) for Mental Health (DH, 1999) was published which prescribed three new service models which had been delivered in England in a limited number of localities. The NSF mandated the development of these services across England. The key services comprised:

- Assertive outreach teams – enhanced case management aimed at providing intensive support for complex need who are difficult to engage in mainstream services
- Crisis Resolution and Home Treatment Teams – time limited intensive support for people in the community in order to prevent admission and facilitate early discharge
- Early Intervention – intensive care co-ordination for younger people (14 – 35) experiencing a first episode in psychosis.

The implementation of these services led to a surplus capacity of inpatient beds meaning providers were able to close beds whilst developing their community services. More recently policy has been more supportive of local innovation.

1.2 Financial modelling for service transformation

A study published in 2004 found that the costs of community-based mental health care were broadly equivalent to institutional care: "interestingly, the evidence from cost effectiveness studies of de-institutionalisation and the provision of community mental health teams is that the quality of care is closely related to the expenditure upon services, and overall community-based models of care are largely equivalent in cost to the services they replace" (Thornicroft and Tansella, 2004). A number of studies have found that rebalancing care from institution's to the community does not generate cost savings (Knapp et al, 2011).

1.3 The management of people experiencing mental health Crisis

Although not strictly part of the developing picture of community care outside of hospitals Kingston has signed its commitment to deliver the national criteria and pan London commissioning guidance. The Crisis Concordat sets out a shared statement signed by senior representatives from all organisations involved which covers what needs to happen when people in mental health crisis need help and anticipating and preventing mental health crisis wherever possible making sure effective emergency response systems operate in localities when a crisis does occur. The concordat consists of:

- Access to support before crisis
- Urgent and emergency access to crisis care
- The right quality of treatment and care when in crisis
- Recovery and staying well, and preventing future crisis

No person experiencing a mental health crisis will be turned away from services.

1.4 London Strategic Clinical Network crisis commissioning guidance

Recent guidance (NHSE/LSCN, October 2014) has been issued pan-London to inform the commissioning of crisis services. The guidance clearly defines the services which should be available in Kingston:

1.5 Access to support before crisis

- Crisis telephone helplines – a local mental health crisis helpline should be available 24 hours a day, 7 days a week, 365 days a year with links to out of hours alternatives including NHS111
- Self-referral – people have access to all the information they need to make decisions regarding crisis management including self-referral
- Third sector organisation – Commissioners should facilitate and foster strong relationships with local authorities and the third sector
- GP support and shared learning – Training should be provided for GPs, practice nurses and other community staff regarding MH crisis assessment and management

1.6 Emergency and urgent assess to crisis care

- Emergency departments – a dedicated area for mental health assessments which reflect the needs of people experiencing a mental health crisis
- Liaison Psychiatry – all emergency departments to have access to on-site liaison psychiatry services 24 hours a day, 7 days a week, 365 days a year
- Mental Health Act Assessments - arrangements in place to ensure assessments take place promptly and reflect the needs of the individual concerned
- Section 136, police and mental health professionals – follow the London Mental Health Partnership Board section 136 protocol and adhere to the pan London S136 standards

1.7 Quality of treatment of crisis care

- Crisis housing – crisis and recovery houses are in place as a standard component of the acute crisis care pathway which are offered as an alternative to admission or when home treatment is not appropriate
- Crisis resolution/Home treatment teams – the provision of crisis and home treatment teams which are accessible 24 hours a day, 7 days a week, 365 days a year

1.8 Recovering and staying well

- Crisis care and recovery plans – all people subject to the Care Programme Approach (CPA) and people who have required crisis support in the past should have a documented crisis plan
- Integrated care – services should adopt a holistic approach to the management of people presenting in crisis. This includes consideration of socioeconomic factors such as housing, relationships, employment and benefits.

1.9 The future role of Community Mental Health Teams

The Kings fund recently published a guide for the transformation of mental health services in London (Sept 2014) in which evidence from the London Health Programme was highlighted regarding mental health service provision in the capital. They found that:

- Community mental health workers often had high caseloads that resulted in lower access to evidence-based interventions
- Poorer quality interventions were being provided, which were less likely to be evidence-based
- Mental health trusts had a high number of stable patients with long-term conditions in secondary care despite the availability of local enhanced services
- There was high accident and emergency (A&E) usage as a means of accessing mental health care, leading to revolving door and high cost
- There was low access to servicers for carers in their own right
- There was poor translation of research into service improvement

1.10 Future Community services model for Kingston

In response to the Crisis Concordat and the need for service transformation it is proposed that Kingston commission:

1.11 Primary Mental Health Care

There is an emphasis on expanding access to mental health service beyond people with severe mental illness. The development of the Improved Access to Psychological Therapies (IAPT) programme beginning in 2006 focused on common to moderate mental health need (primarily depression and anxiety) with the rapid access into time limited talking therapy (CBT normally around 12 sessions).

It is felt in Kingston that we need to greatly expand the services offered to patients within primary care and community settings. To enable us to do this we need specially trained expert GPs and supporting multi-disciplinary teams within a primary care model to support this. To achieve this aspiration 19 GPs are currently undergoing an Advanced Diploma in Primary Mental Health, with practice staff also undergoing formal mental health training – this will ensure full geographical coverage of Kingston with GPs benefiting from the support of a consultant led MDT/enhanced primary care service as the single point of access into mental health services in Kinston.

1.12 Community Mental Health Teams (CMHTs)

In Kingston, with the roll out of effective crisis services and enhanced primary mental healthcare services, we are diverting the care currently delivered to a large cohort of patients into different care pathways/settings. The traditional roll of the community mental health team needs to change in line with service changes. With primary care being able to manage tariff clusters 1 – 4, most of clusters 5 – 7 and a high proportion of clusters 11 – 12 we will see an enablement of secondary care community mental health teams to focus on high needs clusters where specialist interventions are required.

Whilst the number being managed in CMHTs will be significantly lower the quality of the interventions and productivity can be far higher.

1.13 Crisis services

- A mental health crisis telephone helpline – this is currently a commissioned service which is delivered centrally by the local mental health trust – the local feedback in Kingston from users/carers that have used the service has not been positive. We should engage our third sector partners in developing a local service in Kingston

- Self-referral – ensuring that there is a single point access into MH services which encourage self-referral into services. This should be delivered in the enhanced primary care service

- Third sector organisations – commission 'sub crisis' services from our local non statutory mental health service providers in partnership with the Royal Borough of Kingston

- Psychiatric services in Kingston Hospital – A Consultant led psychiatric service which is available 24 hours a day 7 days a week. The service will incorporate the current A&E liaison service, the older person's liaison service with knowledge, access and agreed protocols around perinatal mental health and Children's and Young people's psychiatric services. The service must be able to access an appropriate area for psychiatric areas where patients experiencing mental health crisis can be assessed in privacy and with dignity

- Psychiatric Street Triage service – this new initiative has been successfully piloted in eleven areas. There are different models. In Kingston we would recommend this as an out of hour's service to be co-located with the police at Kingston custody suite. The service offers senior nursing advice to the police on the management of people who are experiencing a mental health crisis. The service will go out with police to offer interventions and advice to ensure the person is triaged into the correct service. The pilots have shown a decrease in the use of S136 and inappropriate A&E attendance's

- Crisis Housing/beds – this facility should be in place as a standard component of the acute crisis care pathway as an alternative to admission or when home treatment is not appropriate. These are non-clinical areas less medically focused in comparison to inpatient wards. Crisis housing can be provided within the NHS or the third sector (there is no single model). Access to Crisis housing/beds should be gate-kept through the Crisis and Home Treatment team who should also provide in-reach support to the service/s

- Crisis Resolution and Home Treatment Team – The team will provide a 24/7 mobile workforce inclusive of Doctors, nurses, social workers, OTs and support workers with access to specialist clinical advice. The service will have the capacity to visit service users up to three times daily, providing a range of psychological and physical interventions including support and psycho-education for carers and families. Referrers are guaranteed an immediate telephone response and face to face assessment when needed within two hours.

  The teams will have a 100% gatekeeping role to Acute and Crisis Housing and will also be 100% involved in inpatients discharge – arranging same day follow up home visits and daily follow up until the end of the acute phase to ensure patients are well supported in their home environments and prevent relapse.

1.14 Future Mental Health Accommodation models for Kingston

Historically Kingston CCG and Local Authority have invested in traditional models of residential accommodation originally designed in the late 1990s to facilitate the closure of Long Grove psychiatric hospital. With the years moving on the original group of patients has decreased and the patients remaining have different needs in terms of physical frailty. The model Kingston is left with does not meet the needs of our new severe and enduring mental health patient group who require some form of support through a rehabilitation/re-enablement pathway. It is the intention to commission 'step down' accommodation in Kingston in a range of settings developed with a range of local providers. The range of settings will be from 24 hours staffed supported living environments to self-contained accommodation with up to 12 hours support available to residents daily (as they move towards further independence). For some patients independent accommodation is sadly not in their best interests or their wish. We need to be mindful of this and ensure that some longer term accommodation is available to meet this group's needs.

1.15 Conclusion

Kingston has an aspiration to transform community mental health services for adults who have functional mental illness and, in doing so, to respond to and implement recent policy and best practice guidance. The aim of this paper has been to begin the discussion on the service model described above and how changes to current commissioning of services may need to change.

References

2 References

Components of a modern mental health service: A pragmatic balance of community and hospital care; overview of systematic evidence (Thornicroft G, Tanselkla M, 2004)

London mental health crisis commissioning guide (NHS LSCN, October 2014)

Mental Health Crisis Care Concordat – Improving outcomes for people experiencing mental health crisis (HM Govt, February 2014)

Service Transformation – Lessons from mental health (The Kings Fund, Feb 2014)

The economic consequences of deinstitutionalisation of mental health services (Knapp et all, 2011)

The NSF for mental health (DH, 1999)

Transforming Mental Health – A plan of action for London (The Kings Fund, Sep 2014)

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Section 2 Borough Variations

2.1 WANDSWORTH POSITION ON COMMUNITY SERVICES

Wandsworth's Joint Mental Health Commissioning Plan 2013-16 explicitly seeks to deliver safe, high quality services (Priority 2) within the community, "…Our aim is to…continue to invest in & promote the development of fast, innovative community based services…". This will be accompanied by continued reduction inpatient stays and reduction in use of NHS and private sector beds.

This local Commissioning Plan and the adoption of the South West London CCG's Collaborative MH Strategy evidences the commitment to development of effective community services to ensure that residents of Wandsworth can receive services in the least restrictive environment and as close to their home as possible.

Currently Wandsworth commission a range of community services both in secondary care, including Community Mental Health Teams, an Early Intervention Service, Crisis and Home Treatment and Psychiatric Liaison services and in primary care such as the Improving Access to Psychological Therapies services (IAPT). Wandsworth CMHT's are already targeting people with more complex needs and the IAPT service works with people with milder anxiety and depression through to those with more severe non-psychotic disorders. Wandsworth's Mental Health Clinical Reference Group is exploring the most clinically effective primary care models and this is coupled with the work within SWLSTG's community transformation programme to improve primary care interfaces to allow better discharge of stable, but more complex patients.

As referenced in the Local MH Commissioning Plan, Wandsworth GP clinicians retain strong input into SWLSTG's Community Transformation work stream and the development of a clinically safe and responsive model of community services. Wandsworth CCG commissioners are not in a position to sign off the Community Transformation savings plan until there is clinical satisfaction & the certainty of a robustly developed model. However, CCG Commissioners are continuing to work with SWLSTG to better understand and shape such a local community model. It is the clear view of CCG

Commissioners that such a model will include the combination of interventions from CMHTs, Early Intervention, Crisis and Home Treatment and Liaison Psychiatry services.

Wandsworth supports increases in funding to Crisis & Home Treatment Team and see this as being a key community service which retains the vital links with acute in patient services. Helping to avoid admission, provide care and support within the home and help to support the earliest possible discharge, thus reducing length of stay. The review of Liaison Psychiatry across SW London as set up in the SWL MH Collaborative strategy is also supported.

It is further noted that recent system resilience funding within Wandsworth, which is linked to the National Crisis Concordat, has a focus on enhancing discharge support within CMHT, reducing waiting times for Early Intervention services and strengthening Crisis and Home Treatment Teams.

2.11 Primary and Community Mental Health Services in Sutton

Introduction

This paper looks to set out the commissioning direction with regards the provision of non Hospital care for those people with a mental health condition.

Background and Strategic Context

Both nationally and locally the provision of care for those people with the broad spectrum of mental illness, has undergone significant transformation in the past 25 years and in particular in recent years with the aspiration to achieve "parity of esteem" across physical and mental health.

Sutton along with its neighbouring London Borough, Merton embarked upon setting its strategic commissioning direction through its Joint Commissioning Strategy "Maximising Opportunities". This strategy was set out in 2009 and continues to 2015.

http://www.sutton.gov.uk/CHttpHandler.ashx?id=7872&p=0

The strategy sets out that although the need for specialised inpatient mental healthcare is a crucial element to achieving high quality care and recovery, the need to enhance the provision of non hospital care is as crucial. This would be through a range of stakeholders across statutory bodies, General Practice, the Voluntary Sector and the Service User and their Carers.

Sutton CCG continues to outline Mental Health as one of its top priorities with significant transformation of its commissioning around non hospital mental healthcare from 2015, which this paper explains later.

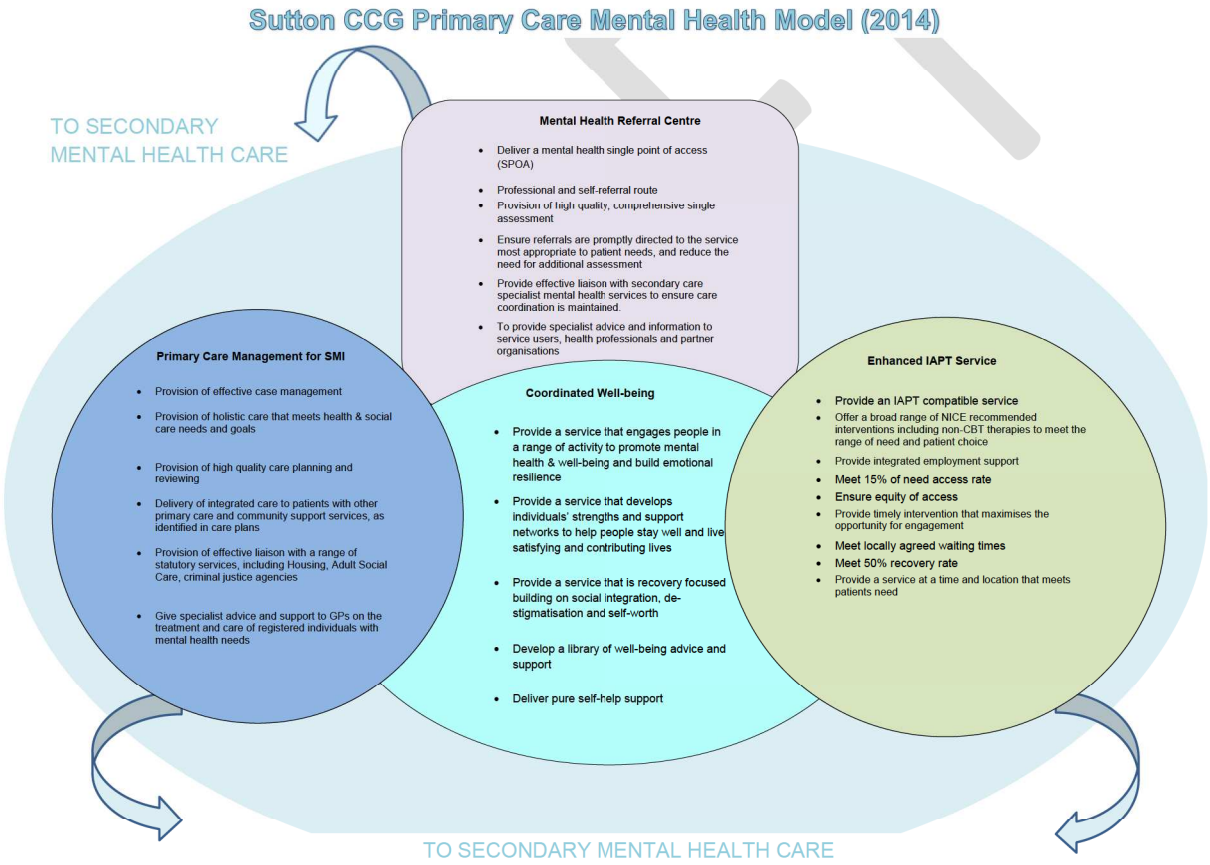
2.12 Future Commissioning

As mentioned Sutton has embarked upon a new way of commissioning elements of the non hospital provision with a procurement exercise which is currently taking place.

This model will provide a single point of access with a single approach to assessment. There will also be an enhanced IAPT (Improving Access to Psychological Therapies) service focussing on people with depression and anxiety. The model will also include a "Primary Care" service which will work with people that may have a diagnosis of a severe mental health problem such as psychosis or bi-polar disorder, but are living well with their condition with care managed closer to home.

The model will be underpinned by the concept of wellbeing with service users having access to a wide range of social and health benefits (fig1)

Fig 1



The new model of care will look to enhance the wider aspect of community care.

2.13 Specialised Non Hospital Services

Sutton benefits from a well resourced Crisis Resolution and Home Treatment service which provides a gateway to admission when needed but primarily looks to support people at home. This is

replicated for older people which has seen a reduction in the need for inpatient admission in the past 4 years.

It is the CCG's intension to continue its investment in these services.

Adrian Davey
Joint Commissioning Manger
Sutton Clinical Commissioning Group

2.2 Richmond Clinical Commissioning Group

Richmond – Community Mental Health Services: Our Vision & Approach

Richmond's mental health services are commissioned to support the national objectives in 'No Health without Mental Health'[i]. Richmond's over aching principle in commissioning services is for the appropriate interventions and services to be available to support people in maintaining their mental health including enabling support within the community. Richmond CCG works closely with the Local Authority to commission integrated health and social care services for people with mental health needs. This is supported by Richmond's integrated commissioning team who commission both health and social care services. Over the last 3 years we have invested in community and preventative services which support people to live full and meaningful lives in the community and prevent the need for inpatient care through investment in a primary mental health service. People should only be admitted to in-patient services when absolutely necessary and for as short a period as possible. Research and good practice[ii] indicate that people have better outcomes and suffer lower relapse rates if they can be treated in their own communities, surrounded by carers, families and their support networks. Our commissioning intentions for community services are to continue to work in partnership with the local authority to provide clinical and social care services to maintain mental health, prevent admission to inpatient services where possible and promote recovery and better outcomes for local people. Our community pathway is outlined in the report below.

2.21Primary Mental Health Care
In 2011 a report[iii] into local primary care approaches to mental health identified a poor service response to local need & the development of good practice exemplars elsewhere that made a reality of preventive approaches at the primary care level.

As a result, the Richmond Wellbeing Service (RWS) was procured to provide an integrated response to mental health needs in primary care. The service supports secondary care services by working with higher levels of need within primary care. It is preventative in nature in supporting people with emerging low level needs to access appropriate support and promote recovery. The service is a partnership between East London Foundation Trust and RB Mind.

The service provides support to GPs treating and managing patients within Richmond practices and consists of 2 integrated elements:

(1) A primary enhanced support and psychological therapies in line with Improving Access to Psychological Therapies (IAPT) via a single point of access; and

(2) a Primary Care Liaison service that provides support to Patients with serious and enduring mental illness who are stable delivered by a team of psychiatrists & CPNs in GP surgeries or Richmond Royal.

The service also provides a gateway to specialist mental health services at secondary care level ensuring a seamless provision of care. It works very closely with specialist mental health services as well as other community based and social care services. The service supports the aims of the National Mental Health Strategy, the Richmond Mental Health Joint Commissioning Strategy 2010-15 and the London Mental Health Models of Care Framework. Integrated IAPT & PCL services are an innovative departure and the model is being replicated elsewhere in SW London.

The benefits of more intensive investment in primary mental health care are:

- Location within primary care facilitates: greater integration of mental & physical health care support; uninterrupted service; reduction of stigma, and care close to home.
- Higher performance against national KPIs and better outcomes for patients
- High stakeholder satisfaction (Service users: 80% were happy with the waiting times and feeling that staff listen to them; GPs: 95% expressed high 'overall satisfaction with services')
- The PCL team is headed up by consultant psychiatrists who have a dual qualification in psychotherapy and are therefore uniquely placed to span psychiatric and talking therapy approaches to mental health problems. The team's existence has allowed the discharge of a cohort of patients (approx. 300) from a secondary to a primary care setting.
- The knowledge that the PCL can be quickly and easily accessed if problems arise with patients has given GPs the confidence to 'take back' some patients that would have previously remained within the CMHTs thus meeting the objectives of the Better Care Fund in relation to moving activity from secondary care into a primary care setting.
- The PCL has also allowed patients who otherwise would have been referred into secondary mental health to remain within primary health care.
- The relationship between the PCL and the IAPT service has resulted in RWS providing treatment for a cohort of patients with enduring problems who in other localities would not be treated – people whose needs are too high to be catered for within a standard IAPT service but whose needs are not high enough to be eligible for support from secondary care.

2.22 Emergency & Crisis Services

An effective approach to people experiencing mental health crisis can prevent unnecessary harm and acute hospital admission. It is therefore a crucial element in ensuring people remain within their community. Richmond has signed the Crisis Concordat which is a commitment that mandates a joined up approach to mental health crises across key agencies.

For people in mental health crisis there are several services in Richmond which can help. They are provided by SWLSG MH Trust:

- Crisis & Home Treatment Team (CHTT): support secondary mental health patients who are in crisis in the community and prevent need for hospital admission. This is a 24/7 service.
- Crisis Line: provide out-of-hours emotional support, information, advice and facilitate crisis interventions where required.
- The Liaison Psychiatric Service's in our acute providers offer an opportunity to integrate the requisite specialist mental health expertise and resource into acute hospitals to effectively manage care for this group, access appropriate support and treatment and provide better outcomes.

- Crisis planning: all secondary mental health service users have a crisis plan as part of their care package which includes what needs to happen when a crisis happens and also steps that can be taken to avoid a crisis.

Richmond has been successful along with SWLSG and the SWL Boroughs in bidding for additional national funding for crisis services. Services included within this funding include:
:

- Richmond will be involved in a pilot for a 'Street Triage' mental health scheme: SWLSTG working in partnership with Metropolitan Police and the London Ambulance Service across don boroughs to pilot a new project to ensure that people with mental health issues are kept out of police custody and receive the right treatment and care. A dedicated team of mental health nurses will accompany Police Officers and Paramedics out of hours to incidents where it is believed people are in need of immediate mental health support.
- EIS Website - providing advice, information and guidance re: psychosis and how to access support.
- Strengthen Crisis and Home Treatment Teams (CHTT) across south west London.

Specialist Secondary Community Support

Secondary MH community services support people with severe and enduring mental conditions. Teams are multi-disciplinary providing a holistic service to service users & carers in their own communities. Services are provided by specialist teams & services. Richmond's has a S.75 agreement in place with social work and care co-ordination being provided by SWLSG. : Richmond has recently remodelled its Community Mental Health teams to move from a geographical based team to one based around people's diagnosis. This will support better targeted interventions and specialist skills within teams. Secondary services in Richmond currently include:

- Mood Affect & Personality Disorder CMHT (MAP), including Personality Disorder Intensive Treatment community team
- Treatment, recovery in Psychosis (TRiP) community team.
- Early Intervention in Psychosis team (EIS) provides support & therapy for 18 -25 year olds with a first diagnosis of psychotic illness.
- Rehabilitation team support clients with high & complex needs to facilitate a recovery pathway for people with high needs who may have needed in-patient residential care to live as independently as possible within their own communities.
- Attention Deficit and Hyperactivity Disorder (ADHD) Service.

Our intention is to continue to work with our providers to ensure timely and appropriate access to secondary care services. To continue to support a recovery pathway and improve the opportunity for people to access secondary services for short interventions if needed.

Accommodation and support

Richmond has a range of specialised accommodation based services to support people with mental health needs. Effective accommodation support for people with enduring MH issues can maintain them in their community, prevent relapse and prevent hospital admission.

Service range from 24 hour support to low level visiting support. Services are able to support people with developing and maintaining their mental health and independence during their recovery. . The service providers in partnership with key stakeholders including the Trust rehabilitation team,

CMHT's voluntary sector and RSL's. Over the past year Richmond has commissioned 2 new 24 hour support services providing 14 units of accommodation, and a new medium support service for 7 people.

We will continue to work with our stakeholders and partners to review the need for accommodation based support to support a recovery pathway.

2.23 Direction of Travel for Community Services

Richmond has invested in community services and our intention is to continue to review and support our community pathway. We aim to do this by:

- Continuing to treat more people in the community if appropriate using safe, evidence based and best practice guidance
- develop a clear accessible community care pathways based around the needs of people and ensure a seamless journey through to recovery
- Continue with our successful enhanced primary care service to support GPs to care for their patients in the community at primary care level reducing the need for secondary care
- Reduce level of acute mental health demand by engaging earlier and increasing opportunity to prevent crisis admissions
- Ensure that when unavoidable crises happen services are timely & effective
- Enable seamless transitions between primary & secondary care services
- Improve the rehabilitation of people in high dependency accommodation
- Building on the positive experience of the RWS and use it as a platform for further enhancements to primary mental health care;
- Review the wider community mental health pathway to identify more integrated models of mental health care.
- Ensuring homelessness services are better supported to identify & support mental health need amongst their service users.
- Provide training for service users to build capacity & competence around joint working and co-production in commissioning and procurement activity.
- Facilitate review of the rehabilitation care pathway with stakeholders to better understand the profile of need; maximise potential for independence, and identify efficiencies.
- Explore outcome based commissioning (OBC) as a tool to develop holistic & person-centred care pathways that are seamless and ensure organisational boundaries are not a barrier to effective & safe care.

Author
Gary Nuttall – Commissioning Manager Mental Health

gary.nuttall@richmond.gov.uk

[i] No Health without Mental Health

[ii] Closing the Gap - priorities for essential change in mental health
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281250/Closing_the_gap_V2_-_17_Feb_2014.pdf

[iii] Case for Change – Richmond Primary MH Service (Sarah Rouwenhorst 2011)

2.4 NHS Merton Clinical Commissioning Group (CCG)

is working with the other South West London (SWL) CCGs as part of the Commissioning Collaborative to address priorities for mental health.

NHS mental health services are changing to deliver more care at home or closer to home. Services have moved to a model where clinicians are supporting patients, their families and carers at home or in a local clinic in their community, and the continued development of community mental health services is expected to reduce the need for hospital stays.

The Merton community mental health services portfolio currently includes Early Intervention Services (EIS) and Crisis Resolution and Home Treatment teams (CRHTT).

- EIS offers early intervention to all people with a first episode or first presentation of psychosis. Referrals are accepted either from primary or secondary care clinicians who detect early onset of psychosis, mostly in younger age groups who are more likely to slip through the care net. Patients engaging with the service have demonstrated improved long term outcomes in terms of overall quality of life, social functioning and reduced length of hospital stays.
- The CRHTT delivers effective home treatment in a range of settings as an alternative to in-patient care. They work across both community services and acute in-patient services to facilitate reduced usage of in-patient beds and early discharge of patients. The team also offers 24-hour seven day week rapid response in resolving crises faced by patients, and stay involved with patients until the crises are resolved.

As with other SWL CCGs, NHS Merton CCG is planning to put in place more alternatives to hospital treatment, aiming to develop the right services in the community to:

- Reduce the number of people who need to be admitted to hospital
- Enable people who *are* admitted to hospital to be discharged home sooner with appropriate care and support.

The NHS Merton CCG Operating Plan 2014/16 commits to "improved access and outcomes within primary and community care settings with the aim of refocusing services towards prevention and early intervention, continued improvement of access into treatment for individuals who have a dual diagnosis (with a focus on mental health and substance misuse)."

NHS Merton CCG is currently in the process of re-procuring its Improving Access to Psychological Therapies (IAPT) service. The CCG has increased the budget for the new service by 25% to support service improvement and ensure the levels of activity in the contract meet the latest national targets.

The specification for the new service addresses issues identified through stakeholder engagement (which involved patients, carers, GPs and the voluntary sector), including: waiting times and the high drop-out rate between referral and treatment; the need for better marketing and engagement with the wider population to generate self-referrals, and better access including out of hours; improved links with wider wellbeing services and the voluntary sector; and the need for better access for vulnerable groups such as people with long-term conditions and older people.

Public Health Merton has supported the CCG in mapping the existing wellbeing services provided in the public and voluntary sector, with the intention of improving the link between IAPT and wellbeing, employment support and other services.

NHS Merton CCG has recently commissioned a Complex Depression and Anxiety Service (CDAS) from South West London and St George's Mental Health Trust. Starting in February 2015, this service will see and treat patients with complex depression and anxiety disorders who have previously been seen by the IAPT service. This will provide a more appropriate service to this cohort of patients, and will also improve the ability of the IAPT service to see and treat primary care mental health patients more quickly.

Funding has been agreed from the Better Care Fund (jointly managed by NHS Merton CCG and the London Borough of Merton) for three additional community nurses specifically to work with people with dementia. These nurses are expected to be in place in early 2015/16. Each will be aligned to one of the three NHS Merton CCG Localities (East Merton, West Merton and Raynes Park) to enable them to work as part of an integrated team providing holistic care. They will have a valuable role in improving the health, wellbeing and quality of life of individuals living with dementia as well as their families and carers.

These highly skilled individuals will have a number of roles across the pathway of patients with dementia and will be a valuable point of contact for people with dementia and their carers. The vision is for the nurses to care for patients in a holistic way and respond to their mental and physical health needs as well as the needs of their carers. They will have a key role in ensuring that patient care is coordinated and that people have seamless access to appropriate services and support. They will also have the expertise to support other healthcare professionals and the potential to enhance dementia skills and knowledge in a range of care settings.

NHS Merton CCG has committed to up-skilling primary care clinicians to enable them to better support people with mental health needs. For example, in November, two Dementia Education Events took place at the Merton Dementia Hub. Sessions at the events included:

- The CCG's Clinical Lead for Dementia discussing the context, priorities, progress and ongoing work regarding dementia in Merton.

- A Consultant Old Age Psychiatrist at South West London and St George's Mental Health NHS Trust, exploring the benefits of an early diagnosis from patient, family, medical, social care and societal perspectives, as well as reviewing how to make a referral to the Memory Assessment Service and progress in terms of cross-sector working.
- A Service Manager at the Alzheimer's Society outlining the range of support services offered for individuals with dementia and their carers, both at the Dementia Hub and around the borough.

The Merton Dementia Hub established earlier this year by the London Borough of Merton, in partnership with other agencies including NHS Merton CCG, is a state of the art dementia friendly facility run by the Alzheimer's Society. It offers a range of support services for people with dementia and their carers which help people to remain independent and have a good quality of life in the community. Memory clinics also take place at the Hub, at present on a monthly basis, but their frequency is due to increase.

In 2013/14 the Merton Health and Wellbeing Board commissioned London Borough of Merton Public Health to produce a Mental Health Needs Assessment. The findings and recommendations of this review, which was published in September 2014, will be used to further inform the development of the CCG's strategy for community mental health services in Merton.

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