Mental Health STRATEGIES

LONDON BOROUGH OF RICHMOND UPON THAMES

NHS Richmond

Mental Health Joint Commissioning Strategy for Adults of Working Age 2010 – 2015

Published March 2010

CONTENTS

1. INTRODUCTION

This document sets out the joint mental health commissioning strategy for adults of working age in Richmond upon Thames, for the financial years 2010 to 2015. It describes:

- The vision and strategy, including the case for change deriving from the national and local context for mental health services,
- An overview of the proposed changes
- The commissioning intentions
- The financial framework
- Arrangements for the implementation of the strategy.

Additional information is given in appendices, including a summary of local needs and current services, and details of the process of stakeholder engagement. Appendix Six is a 'jargon buster' which explains terms or abbreviations which may be unfamiliar.

From the outset this strategy aims to:

- Enable commissioners, from both the NHS and the Local Authority, to work together with a clear and shared understanding of our aims and intentions
- Help providers to identify opportunities to work with us to achieve those aims
- Enable our local community to understand and to contribute to the work we are planning.

2. VISION AND STRATEGY

2.1 Context – national and local drivers of change

National Context

In 1999, publication of the National Service Framework (NSF) for mental health signalled the start of a decade of great change in mental health services for adults of working age. Across the country, we have seen the implementation of a range of new specialist teams, reductions in some older patterns of services, and unprecedented levels of new investment. The main changes over the decade have been:

- Creation of crisis resolution teams, enabling some people with acute mental health problems to stay at home, instead of being admitted to hospital

- Creation of assertive outreach teams, supporting people with some of the most complex mental health and social problems
- Early intervention in psychosis services, working to reduce the risk of young people developing serious and long-term problems
- Improving access to psychological therapies, with its major increase in resources available to treat common mental health problems (such as anxiety and depression) in the community
- An increasing emphasis on supporting people with mental health problems into mainstream community life, be that employment, education or social activities
- A gradual reduction in inpatient beds, and "building-based" day services.

As the implementation period for the National Service Framework has come to an end, there is now a shift in national policy from the 'building blocks' of services (the new teams and service structures) towards a greater emphasis on how services work with individuals and families, the outcomes they achieve, and the wider impact of many other aspects of national and local policy on mental health.

This shift has been summarised in a document published in December 2009 by the Department of Health: "New Horizons: a shared vision for mental health." This describes itself as "a comprehensive programme of action for improving the mental well-being of the population and the services that care for people with poor mental health by 2020." It aims to influence organisations across national and local government, voluntary and statutory agencies, as well as local communities and individuals to work towards "a society that values mental well-being as much as physical health." It also outlines the benefits of reducing the burden of mental illness and "unlocking the benefits of well-being in terms of physical health, educational attainment, employment and reduced crime." Both NHS Richmond and the London Borough of Richmond upon Thames, as the bodies responsible for commissioning mental health services locally, fully support this vision.

At a local level 'New Horizons' does not bring either specific new targets or new resources. Our task is therefore to interpret this vision within our overall approach to planning mental health services in Richmond, emphasising the key themes of:

- Prevention of mental illness and promotion of mental health
- Early intervention
- Tackling stigma
- Strengthening transitions
- Personalisation
- Innovation

In all our commissioning, the issue of personalised care or personalisation will be especially important, initially in social care, but perhaps also in aspects of health care in due course. The London Borough of Richmond upon Thames has taken a national lead in piloting the implementation of self-directed support (SDS – which is one way in which personalisation can be achieved), offering a personal budget to those who are eligible for publicly funded support, following completion by the service user of a supported self assessment. This budget is provided in order to meet the outcomes defined in the individual's support plan, and can be taken as cash by the service user (a direct payment) or held by the borough to commission services on the individual's behalf. In other words, rather than a commissioner deciding what people need, individuals themselves decide.

The introduction of this system – which will become the default system for social care - will therefore mean significant changes for how social care and joint services with health are designed, developed, delivered and evaluated.

Whilst responding to the national context, our proposals must also consider the impact of the financial climate, remain affordable, and achieve good value for money throughout all services. Current levels of spending on services will not be sustainable in the context of a recession.

Regional context

A programme of "whole system" change in South West London is under way, across all aspects of healthcare. This work intends to improve health and reduce inequalities in all five South West London boroughs (Kingston, Merton, Richmond, Sutton, Wandsworth) (six if Croydon is included, as it is for some service issues). Central to this vision is improving the quality and integration of care outside hospital through 'polysystems'. These polysystems coordinate services and pathways of care on 'a hub and spoke' basis in a given geographical locality, encompassing general practice, outpatients, community health, diagnostics, pharmacy and long term condition management. The same approach will shape mental health care in the future. In particular there will be opportunities to co-locate mental health and social care services with general healthcare services as part of polysystems (as already happens in some places), and to integrate mental health and physical health care around individual needs.

Local Context in Richmond

In preparing this strategy, we have considered a wide range of local information and evidence, including:

- Estimates of the levels of mental health need in our local community
- The range of services we currently have, how they work together, and how this compares with other similar places
- Work already underway to address local and national policy issues
- The resources we currently invest, and what we expect to have available
- The experiences and aspirations of a wide range of people working in and receiving services locally.

A summary of our estimates of the levels of mental need in Richmond is given in Appendix One. In outline, we estimate there may be around 20,000 people in Richmond with a common mental health problem, such as anxiety or depression; there may be around 725 people with schizophrenia, and around 1,250 people with a bipolar mental disorder.

A full list of current mental health services in Richmond is given in Appendix Two.

In preparing this strategy we arranged a series of meetings with people working in and receiving services locally as well as those who care for them. We also made briefing materials available via our websites, inviting written submissions – we received over 50 submissions in this way. Details of the engagement process are given in the various appendices.

2.2 Summary of the Case for Change

Taking this national, regional and local context together, the main reasons services need to change are therefore:

- Whilst we have implemented the new NSF services in Richmond, we have done less than other places to change the older patterns of service as a result. We have more inpatient beds, NHS rehabilitation beds, and larger Community Mental Health Team (CMHT) caseloads than evidence suggests we need in the future. The role of rehabilitation services should more clearly focus on actively promoting independence and the regaining of skills than is possible within relatively institutional service models.
- In addition, the introduction of new types of community teams (early intervention, crisis and home treatment, assertive outreach) has led to the future role of the CMHTs requiring redefinition.
- Through the personalisation process, we need to give people and their carers more control over their long-term support.

- We need significantly to improve the mental health services available in primary care, both to avoid people needing more specialist help, and to support people leaving more specialist services.
- We need to make local joined-up primary and social care systems work - including employment, recreation and further education support, which have preventative benefits. These systems offer the best use of resources for everyone.
- We want to stimulate and support the role of local and smaller voluntary sector providers.
- We have to live within our means, and to manage the improvements we want within the resources available. This means reducing our investment in some services.

3. OVERVIEW OF PROPOSALS

There are many strengths in Richmond's mental health services, including the commitment and skills of staff across all agencies, and innovations such as the development of recovery services and personality disorder services.

However, it is now clear that some services are not working as well as they should in terms of patient experience or use of resources.

For example:

- There are delays and shortfalls in access to appropriate skills and interventions at the 'front end 'of services.
- Recovery services for those with severe, complex and longstanding mental health problems are still under-developed, and have not yet achieved sufficient partnership with carers.
- Pathways for acute and rehabilitation needs depend too much on inpatient services, and are therefore too expensive.

Our overall aims are therefore that:

- Services should deliver evidence-based, preventative interventions, with speedy and flexible access for all those in Richmond who experience mental health problems.
- Services should be planned around pathways of care, with defined roles for specialist mental health expertise, from primary and community to inpatient care
- All services should focus on prevention, independence, recovery, integrated care, rights, equalities, user and carer engagement and improvements in outcomes.

In some areas of services, this will mean substantial changes to the design of services, new ways of working and shifts of resources. However, in others, such as carer support and the mental health sections of the Quality and Outcomes Framework (QOF - a voluntary annual reward and incentive programme for all GP surgeries in England) in primary care, our aims can be achieved by doing better those things that services already do.

4. COMMISSIONING INTENTIONS

This section sets out the five commissioning intentions which together form our strategy to improve mental health care for people in Richmond upon Thames within available resources.

They are:

- Improved access, prevention and treatment in primary care.
- Reconfigured pathways for people with severe, longstanding and complex needs.
- Improving accommodation options and rehabilitation.
- Reducing inpatient service use.
- Engagement and equality.

For each, the following headings are used;

- The local case for change
- The pathways we want to see
- The national drivers
- The key requirements (called strategic commissioning intentions)
- How we intend to make the changes happen

4.1 Improved access, prevention and treatment in primary care

The local case for change

When people experience mental health problems, their first request for help is usually to their GP. It therefore makes sense for primary care mental health services to have the resources and skills to deal with as wide a range of mental health problems as possible. By 'primary care mental health services' we don't just mean GPs, but also specialist staff working alongside GPs in primary care. These services are however currently very limited in Richmond, and this has led to several important local problems:

- There are larger numbers on CMHT caseloads than in similar areas, and GPs told us that they cannot get support they want. Although the Trust told us that the higher numbers reflect characteristics of local need (and possibly greater willingness to seek help amongst the borough's relatively affluent community), the result is that CMHTs are overstretched.

- The most recent service activity information before the production of this strategy (Q2, 2009/10) showed:
  - 18 days average wait for referral to CMHT
  - Richmond had the joint highest percentage in the Trust of enhanced Care Programme Approach (CPA) patients with last review recorded over one year ago (52 per cent)
  - Richmond had the joint highest percentage in the Trust of failed appointments (where people do not attend or (DNA)) at 18.4 per cent

- Local feedback from service users, carers and GPs tells us that the links between primary care and the Mental Health Trust are not working as well as they should.

- People cannot get quick enough access to talking therapies. Demand is likely to increase during an economic recession.

- Some vulnerable people do not fit eligibility criteria for services, due to the way criteria are currently defined or put into practice. Clinicians and managers have told us that some individuals who are turned away from services because they do not meet the threshold of assessed need, sometimes experience hardship, social exclusion, and a worsening of their condition or their circumstances. This is a particular concern if their problems have an impact on other members of their family who are vulnerable, for example children or frail older relatives. Other examples may include care leavers, who have a higher risk of mental health problems.

- Some people cannot get help if their mental ill health does not meet

current criteria for secondary services, which may include some with long term disability linked to their mental health problems. As another example, Richmond Borough MIND (RB MIND) stated they cannot refer homeless clients with mental health problems to CMHTs if they are not registered with a GP.

- Some individuals may be eligible for social care under Fair Access to Care Services (FACS) criteria, but may not come into contact with social services unless referred to secondary mental health care (eg a CMHT).

- A study (entitled 'All we need is someone to listen') carried out through RB MIND (with the support of the Local Authority and the PCT) found that members of Black and Minority Ethnic communities surveyed were dissatisfied with the services offered by GPs and practice staff due to concerns about communication, lack of confidence and lack of knowledge of the system, leading them to rely more on A & E. In particular, they reported a lack of opportunity to discuss issues causing mental distress.

- People with autistic spectrum conditions or young adults with Attention Deficit Hyperactivity Disorder (ADHD) find it difficult to access specialist assessments. An increasing number of referrals are being made to specialist services outside South West London for diagnosing and monitoring of adults with ADHD. This service should be available locally, and we will explore the potential role of the CMHT or the primary care service in providing this.

- Eating disorders pathways require improvement, including primary care psychological therapy interventions.

- Mental health service users and carers said that help from GPs for physical illness was uneven. People with mental health problems who misuse alcohol find it difficult to get co-ordinated help, and GPs also told us that people sometimes 'fall between two stools'.

- The Joint Strategic Needs Assessment for Richmond states that although there is no statistically significant difference between local alcohol related mortality rates and the England average, alcohol consumption and its potential impact on health and well-being is of serious concern and reducing it is a key priority for NHS Richmond and the London Borough of Richmond upon Thames

The pathways we want to see

Primary care will continue to be the principal setting for identifying and treating mental health problems. Most people prefer to be treated by their family doctor, avoiding the stigma attached to specialist mental health

services. A high proportion of GP consultations have a mental health element.

For everyone

- Better signposting and speedy advice which avoids the mental health label, links people up with voluntary organisations if they want it, and offers help and advice with a range of health and general day to day difficulties. Earlier intervention here can reduce service use later.

- More talking therapies (and similar evidence based interventions according to NICE guidelines) in primary care, on a stepped care model to stop problems getting worse (consistent with Healthcare for London approaches).

- Health promotion advice to support healthy lifestyles and reduce risk factors, such as through horticultural or healthy walks projects, adapted as appropriate to the needs of black and minority ethnic (BME) communities.
- Improved identification and treatment of mental health problems (particularly depression) experienced by pregnant women, new mothers, and people with long term conditions such as stroke, heart problems, diabetes or respiratory diseases.

- When people present to their GP or hospital with health problems for which there is no physical cause, we want them to have access to psychologically based approaches which will help them alleviate the symptoms.

For people with a mental illness

- People whose mental illness has stabilised should have primary care as their first port of call, but with agreed prompt access to specialist services when they need it. GPs can manage the care of people whose mental illness is stable, as long as they receive support.

- We want to see improvements in the physical health of people with severe mental illness. People should therefore have their physical health regularly monitored, with assistance to lead healthy lifestyles, and prompt treatment of physical problems. GPs have a key role here.

- Focus on gaining and retaining employment, volunteering and education and training to prevent loss of community networks and sliding further into long-term sickness and unemployment.

- Assessment and support for use of personal budgets through self-directed support (SDS) should be available for those who are eligible.

For people who misuse alcohol

- We want to see people who engage in harmful, hazardous or dependent drinking get assistance with their mental health problems and their physical health care. This should include advice on healthy lifestyles, peer support, and treatment interventions.

- Where people who misuse alcohol are receiving treatment from one of the community mental health teams, that team should coordinate their care. If they are admitted to hospital, their plan on discharge should address their drinking. If they require planned detoxification, this should be done in a suitable setting.

- There should be support available for families and carers.

National drivers

The proposed classification of mental health problems to be used for Payment by Results (PbR) includes four clusters. They relate to common mental disorders which do not include symptoms of psychosis, and can be summarised as:

- Low severity: definite but minor problems of depressed mood or anxiety with no disruption to wider functioning
- Low severity with greater need: definite but minor problems of depressed mood or anxiety, previous treatment, and with minor problems but unlikely to cause serious disruption to wider functioning
- Moderate severity: moderate problems of mood and wider functioning
- Severe: severe depression or anxiety with increasing complexity, may experience disruption to wider functioning with an increasing likelihood of risk through self harm or suicidal thoughts

In addition, some severe and enduring non-psychotic mental health problems will be suitable for treatment in primary care, in some cases with additional specialist input from time to time. They include severe depression over a number of years, some personality disorders, and substance misuse. They may include serious disruption to role functioning, high disability and risks of self harm.

The integration of physical and mental health and community well being, and primary prevention are key themes in the government's proposed framework for public mental health as part of the 'New Horizons' strategy.

National and local guidance require the PCT and Local Authority to do as much as they can to make local joined-up primary and social care systems work - including employment, recreation and further education support, which have preventative benefits. These systems offer the best use of resources for everyone.

Debt is a risk factor for mental illness, so people who lose their income during a recession will need access to services.

The national policy guidance on services for people with personality disorder services and the London strategy propose the development of 'tier one' for personality disorder
primary care services in primary care to ensure responsive community networks, identification and early referral to appropriate sources of help.

People with a common mental disorder are twice as likely to have a dependency on alcohol as those without, and people with a severe and enduring mental illness are at least three times more likely to be alcohol dependent compared to the general population. Alcohol use is linked to suicide, hospital admissions, and domestic violence.

Our strategic commissioning intentions

Our ambition is to develop a fully responsive, open access primary care mental health service, including stepped care for depression and anxiety, mental health interventions for people with long term conditions, and referral/signposting to both more or less specialist services. This will mean appointing additional staff to work alongside GPs.

We want to see systems in place to manage more people in primary care, i.e. some of the 1,200 on the Mental Health Trust's caseload. That will allow us to use resources most effectively, so the Trust concentrates on those with the most serious illness, providing access to specialist mental health skills when needed, including urgent access at times of crisis.

Where people with a functional mental illness (i.e. not an organic cause) require ongoing specialist treatment, under the requirements of the Care Programme Approach (CPA) they will be allocated to a care coordinator (from primary or secondary care services, as appropriate), who will arrange evidence-based treatments (such as those in NICE guidelines more appropriate to specialist services).

We will agree and monitor standards with local GPs on health checks for people with severe and longstanding mental illness and long term conditions, and health promotion advice for people with first onset psychosis.

We will coordinate our mental health commissioning with the emerging local polysystems which coordinate services and pathways of care on 'a hub and spoke' basis in a given geographical locality. These will encompass general

practice, outpatients, community health, diagnostics, pharmacy and long term condition management, and aim to improve the quality and integration of care outside hospital, reducing the need for hospital visits.

We will ensure that, as they develop, primary care mental health services offer focussed support to people with long term conditions such as stroke, respiratory disease, heart disease and diabetes.

Support and services for carers should be available in primary care, including health checks.

We will promote and support training and development initiatives across primary and secondary care to ensure more people can have both mental and alcohol problems addressed within a single service (for example, within a polysystem).

We will promote expert patient and mental health first aid approaches, as well as support for carers.

We will promote developments in infrastructure and communications technologies to facilitate sharing of appropriate information between primary and secondary services

How we intend to make this happen

This part of our strategy will require increased investment in primary mental health care services, as well as better use of the primary and social care resources already spent in this sector.

We will work with stakeholders to design care pathways which combine flexible access for all with speedy assessment by mental health professionals.

We recognise that these commissioning intentions signal a major change for both primary care mental health services and (in the next section) existing CMHTs.

We will continue an established process of dialogue with GPs and Practice based Commissioners about the best way to design and introduce the new model.

We will integrate primary mental health care access systems with the local authority's access, advice and information services (which are planned to expand). For example, internet based access to shared information and systems could be developed.

We will specify appropriate alcohol services for people with mental health

problems in our contracts.

MODEL FOR IMPROVED INTEGRATED OPEN ACCESS PRIMARY SERVICE

A new model is needed to replace the current system, whereby referrals are made to a CMHT for assessment against their eligibility criteria. The current system ties up CMHT resources, and leaves people who do not meet CMHT criteria without support, or with only their GP to turn to.

The best model for Richmond will depend on local dialogue, and will need to dovetail with the polysystems which are currently being developed.

This section describes our proposed alternative model which sees mental health as one part of the remit of a primary care team for long term conditions. This team can take into account the mental wellbeing of people with long term conditions (LTC), provide ready access to a GP for the physical health problems of people with mental illness, and undertake health promotion and preventative work for everyone on their books. It can also help reduce referrals for physical health interventions for medically unexplained symptoms. This model has been in operation in South Tyneside for over 2 years, with promising signs, but we will need to include clear evaluation plans in our local implementation process in Richmond.

The LTC team provides care supervision and facilitates access for all the social care needs of people with long term conditions, including people with a stable long term mental illness. These needs are accommodation, social support networks, carer support, financial security and day time occupation – traditionally provided through separate mental health services for people with mental health problems.

Under the LTC model, users are not directed to separate services set up for mental health service users, but – with support - towards inclusion and participation in mainstream services. As they are based within primary care, teams for people with long term conditions can access a range of interventions aimed at health promotions and prevention, and can improve communication with GPs.

This approach makes better use of resources because:

- It does not require mental health specialists to undertake practical support tasks
- It offers more to the substantial number of people with a stable mental illness who are already managed in primary care without the involvement of CMHTs.
- It providers earlier interventions
- As a delivery system it has the potential to integrate well with personalisation, whether through access, advice and information, or

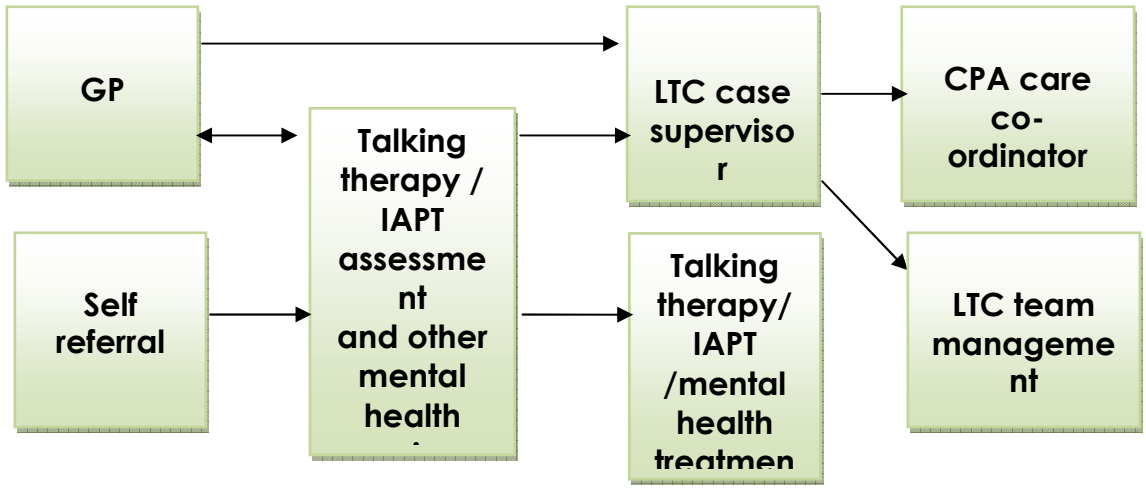
through assessment for those eligible for self-directed support (provided social work staff are members of the teams)

The service works alongside specialist mental health services with a clear remit:

- Talking therapies on the model used in the national Improving Access to Psychological Therapies (IAPT) initiative
- Care coordinators for people with severe and longstanding mental health needs, who will be on Enhanced or New CPA due to their complex needs.

Referral is via a GP or an IAPT assessment. Like any system, it depends on good quality information at the referral stage. Based on this information, the GP can refer to talking therapies or the long term conditions team, who in turn can refer to a CPA co-ordinator for those who need to be on Enhanced CPA, or else retain the co-ordination within the LTC responsibility through a case supervisor.

Diagram 1: Long Term Conditions care pathway



4.2 Reconfigured pathways for people with severe, longstanding and complex needs

The local case for change

The introduction of new types of community teams (early intervention, crisis, assertive outreach) has led to the CMHTs' future role requiring redefinition locally. Whereas CMHTs began by being responsible for all community needs, there are now separate teams for people in crisis, for those with the most complex needs who are unwilling to engage with services, for eating disorders, personality disorders and first onset psychosis. There is a specialised primary care psychological therapy service. Taken with the range of statutory and voluntary recovery focused services for people with long term needs, and potentially overlapping drug and alcohol services, this is a very complex service to navigate.

The introduction of personalisation and self directed support will require new staffing arrangements, creating new opportunities for service users and new roles for staff.

We have heard from the engagement meetings that some specialist teams have waiting times, leaving people managed by CMHTs when they need a more specialised kind of support.

There was clear feedback from service users and carers that there are gaps in the services available to people with severe, longstanding and complex needs.

Richmond spends a lower proportion of its mental health expenditure on non-statutory services than neighbouring boroughs or than the England average. This is a proxy measure for investment, diversity and choice in recovery services.

Carers have told us they want to see improvements in the level of communication they receive from statutory agencies, and they want services to be more responsive.

Statistics show that Richmond performs less well than the rest of London in providing support to carers (of all types) after an assessment.

The pathways we want to see

People with a severe and enduring mental illness can live full lives, managing the effect of their disability, valued by family and friends and contributing to society like other citizens. People's choices and aspirations will differ but the task of services is to support them.

We want those people with a functional mental illness referred from primary care to receive ongoing specialist treatment, under the requirements of the Care Programme Approach (CPA) and to be allocated to a care coordinator (as set out in the previous section)

Ongoing treatment will be provided according to individual need by the:

- early intervention team (for first onset psychosis)
- personality disorder service,
- assertive outreach team (where service users do not wish to engage with services),
- specialist care coordinator for people on enhanced CPA (for coordination of a recovery plan, including treatment of a dual diagnosis)
- Specialist eating disorder service

These services will include management and monitoring of specialist medication, and may include specific rehabilitation programmes. Appropriate opportunities should be taken to explore opportunities to incorporate, within the work of the CMHTs or primary care service, support of people with autistic spectrum conditions or ADHD. They will ensure access to inpatient services when needed. They currently exist and should continue.

All care coordinators in secondary services will liaise with primary healthcare in order to ensure health promotion advice and activity is available to each individual, and that there are plans to address physical health problems.

The basics of housing, income, social networks, meaningful activity, good physical health, employment, volunteering, training, respect and dignity can be provided by a range of organisations with the right aims and ethos. (As explained above, this approach is often called recovery).

People should be supported to make links with community services and activities in mainstream community settings such as businesses, volunteering opportunities and colleges.

We will encourage services to provide access near where people live, including those relatively deprived parts of the borough - for example, through community organisations promoting mental wellbeing activities in those areas, supported by primary care or service users' budgets.

Carers should be full partners in the care of those they care for, with their

concerns heard, their role valued, and defined involvement in a care plan. This partnership must be discussed and agreed with the service user. Carers should have access to information, benefits, and (based on an assessment of their own needs) access to short breaks, training courses, family problem solving help, health checks, and emotional support.

Service users should have the opportunity to benefit from peer support networks as part of their individual recovery plan. South West London and St George's Mental Health Trust (the Mental Health Trust) is developing an approach based on peer support networks which is designed to meet these aims. Under this approach, trained peer support workers (who in many cases will have personal experience of recovery) will play a leading role in the support of people with severe and longstanding mental health problems. We support this option being available to those who want it.

National drivers

The New Horizons consultation document (subsequently endorsed in the final strategy) drew together the future expectations for people with long term mental illness. This group must have a care plan through the CPA process including appropriate risk assessment and risk management. Commissioners must promote social inclusion including employment and training opportunities and physical healthcare, as summarised previously in this strategy.

The needs of particular risk groups should be addressed, including those with dual diagnosis of substance misuse and mental illness. Those with severe personality disorders, offenders, and Black and Minority Ethnic (BME) groups who find it difficult to engage with mental health services.

People with severe and enduring mental illness are especially likely to be unemployed and therefore have little money to live on. Only 13 per cent are in work, according to research quoted in New Horizons.

There is not yet convincing evidence that the assertive outreach model has reduced inpatient stays for the client group who do not wish to engage with services.

The Putting People First Concordat ('a shared vision and commitment to the transformation of adult social care') called for a personalised adult social care system for all users of social care, irrespective of illness and disability.

The national carers' strategy calls for improvement in support for, and partnership with, carers.

Our strategic commissioning intentions

We will

- Develop personalisation and self directed support, to give people choice and control over how support is provided and the way in which identified outcomes are met. We want to see this lead to re-profiling of services based on investment where users find it to be most effective.

- Invest in and support user-led services within the framework of personalisation.

- Improve our performance on the things we do already for carers i.e. the identification of carers, assessing their needs, and offering or arranging appropriate support. In addition to this, we need to consider varying the range of support for example to include expert patients courses for carers

or psycho-educational training.

(Community services for people with young onset dementia (ie under 65) will be commissioned through our older people's strategy, because of the requirement for clinical expertise in dementia care.)

How we intend to make this happen

We expect resources to be released from current CMHTs and, subject to the overall savings requirements, we expect to commission services which will use them more effectively elsewhere in the system, including primary care.

We recognise that this requires a significant change management programme, and re-profiling of how existing resources are used (both health and social care). Whilst some services supporting recovery may increase, all must continue to demonstrate value for money and improved outcomes.

In particular, the system of personalisation and self-directed support which is introduced for mental health services will be critical to the success of our strategy and the achievement of our aims, as described in the section on personalisation below.

For those people who are on CPA we will develop local pathways in line with NICE guidance. In other words, the reformed role of the CMHT will be to provide the specialist interventions set out in NICE guidance, and to coordinate the care of people with complex and long term needs who are not more suitably managed through other specialist services.

We will maintain qualified social workers in integrated community mental health services in order to meet the local authority's core statutory duties (e.g. in terms of the Mental Health Act, Community Care Act and Safeguarding, where requirements have been growing) but reconfigure and realign resources used for the assessment, management and support of those entitled to receive public funded support through personal budgets.

We will support and evaluate further pilots of peer support models of care (e.g. building on the successful work of the Service User Network (SUN) for people with personality disorders.)

We will consider contracts with small providers that take into account a number of different interventions and services, so that new services could be implemented quickly and flexibly

We will define the outcomes required for carer support and services, including identification of carers, assessment of their needs, information, practical help and benefits obtained, and therapy or problem-solving interventions delivered.

Approach to personalisation

Although there was widespread support for the principle of personalised services, feedback from service users and their organisations in the

development of this strategy clearly indicated:

- Confusion about the current position on self directed support (following the initial pilot)
- Concerns that the self directed support system would benefit only a few people
- Dissatisfaction with the complexity of the administration of the scheme.

A working scheme within social care is essential to meet the aims of this strategy, in order to:

- Make it easier for service users to purchase culturally appropriate services.
- Give choice in vocational and employment and other daytime activities - (which were a key concern of service users and other stakeholders, as an underserved area currently).
- Allow individuals who wish to choose the support staff they are confident they can work with (which they could do if they were employing them) - a key concern of some users and carers consulted.
- Enable people to arrange more local social care and support, near where they live, rather than having to travel across Richmond.

An over-riding requirement is for a fair way of measuring improvements and reviewing plans and budgets for self-directed support, based on therapeutic goals for recovery. If this is not done, the system will silt up and resources will be locked into the plans of a small number of users – the exact opposite of what is required.

The other main challenges that a new, fully operational system has to meet are:

- Development of a way of assessing individual needs - and re-assessing progress - based on recovery principles.
- Modernisation of care coordinators' roles in order to manage and administer SDS, and support service users.
- Ensuring staff are well-trained, knowledgeable and enthusiastic about their role.
- Design of a way that service users could collectively pool their personal budgets to commission a new service they all wanted, but which their own 'purchasing power' could not create (e.g. because it requires rental of a space for an activity).
- Development of a market of high quality services, with appropriate safeguards.
- Management of change for existing providers who have to adapt their services.
- Expansion to personal health budgets when these become available.

We will therefore develop a programme to engage service users and carers and their organisations, potential providers, practitioners and referrers in order to consult on and develop new arrangements.

4.3 Improving accommodation options and rehabilitation

The local case for change

Our model at present is too tilted towards the most structured and high-staffed end of inpatient residential rehabilitation services, with too little provision of community options for complex needs and a limited range of step-on, less supervised accommodation.

The London Borough of Richmond upon Thames and NHS Richmond jointly commissioned a review in collaboration with South West London and St George's Mental Health Trust in order to plan for the future housing needs of people with mental health problems in the Borough for the period 2009 to 2012. The draft report of the review found (with reference to support for people with high needs):

- There is a particular deficit in accommodation or support which can help people with higher level and more complex needs and those with a dual diagnosis which includes substance misuse.
- There is some difficulty in gaining access to inpatient rehabilitation services, partly because of the difficulty in moving people from these services into supported housing or other placements.

The review also identified the need for floating support not tied to particular tenancies, and for support for people in the private rented sector.

Local feedback from the engagement process also indicated needs for support for people in placements to maintain their quality of life, needs for some services for people who could not live independently, and needs for access to general housing stock.

The pathways we want to see

Every person whose life is affected by mental illness should be offered support to regain their health, wellbeing and autonomy. This is important for everyone, but especially for people who experience lifelong disability due to mental illness, including the small number whose vulnerability or risk requires them to be detained under a section of the Mental Health Act.

People with serious mental illness need support and assistance to live independently, and management of any risk or vulnerability during their recovery. Those with the greatest need may require programmes delivered by skilled psychologists, occupational therapists and support workers, professionally supervised, including management of their medication. Sometimes rehabilitation will be a slow process, taking between three and five years.

A full spectrum of services should be available to respond to the full spectrum of needs, and to promote recovery.

This care should be delivered in specialist placements and coordinated by key workers with access to specialist skills in rehabilitation. A small number of people may need continuing care in such environments.
For the most part, however, the aim will be for people to live in supported accommodation in the community with support to rebuild their lives, including jobs, friends, social networks and a settled place to live.

Our strategic commissioning intentions

- Strengthen the role of CMHTs and vocational and community support services in supporting people with long-term rehabilitation needs.
- Review the current inpatient rehabilitation service to ensure that resources are used most effectively.
- Transfer at least some of our residential commissioning to high support hostels, rather than NHS inpatient beds. This may mean that NHS inpatient services will have to serve a number of boroughs, rather than each borough having its own provision – however, this is already at least partly the case at present, since inpatient rehabilitation services are shared by Kingston and Richmond in the same locations.
- Implement the recommendations of the accommodation review for more floating support as well as more places for those with complex needs.

How we will make this happen in practice.

In terms of the resources for accommodation and rehabilitation, we expect that in the medium term there may be savings in buildings costs and in the longer term possible savings from re-profiling of the workforce.

We will update the rehabilitation and accommodation strategy to extend to 2015, including finance, pathways, outcome measures and nominations to general social housing stock.

We will review the outcome of consultation on South Bank House in Kingston (which currently provides inpatient rehabilitation services for some Richmond residents) and we will review information about the needs of all people in inpatient and high support accommodation.

We will draw up specifications for inpatient services, high support services and reconfigured floating support services.

4.4 Reducing inpatient service use

The local case for change

Compared to other similar areas, Richmond uses more acute inpatient beds than would be expected.

Stakeholders have told us that a relatively large number of bed days are used by people with long stays on an acute ward (which is an unsatisfactory model of care) usually awaiting suitable services on discharge (mainly accommodation).

Feedback from carers has emphasised the importance of high quality inpatient care, and pointed out shortfalls in current services. Problems pointed out in May 2009 included the need for information for carers, better support for carers and involvement in care planning and discharge.

The survey of users of acute inpatient services published by the Care Quality Commission in 2009 covered the whole of South West London and St George's Mental Health Trust. This showed that in 29 of 36 indicators, the Trust performed in the bottom 20% nationally. As well as very poor ratings on cleanliness and food, patients reported poor experience in terms of being listened to and treated with respect.

Those service users who contributed to the development of this strategy supported the idea of a crisis house.

The pathways we want to see

Most people find admission to hospital distressing and confusing. People who experience an acute crisis in their mental health should receive care from a crisis and home treatment team, whenever it is possible and safe for them to do so. If admission to hospital is necessary they should receive follow up care immediately after discharge.

In this way admissions can be kept to the minimum. We will consider whether help lines, crisis houses, and respite beds should complement the work of home treatment teams. In some cases, services of this nature would need to cover more than one borough.

However, there should always be access to inpatient care when needed. This includes access to intensive care beds, which generally will serve more than one PCT.

There should be suitable therapeutic activities taking place on inpatient wards. These can be arranged in partnership with local organisations.

Forums to listen to service users and carers views should be developed.

National drivers

'New Horizons' states that:

- Community alternatives to inpatient care can be delivered safely and effectively
- Where crisis resolution and home treatment has been fully implemented, service efficiency can be delivered without loss of quality
- Good quality acute inpatient services are essential and achievable, in line with the recent 'Acute Care Declaration', which has been produced and endorsed by a number of national bodies.

Quality should meet national standards for the ward environment, workforce, treatment, user and carer involvement, leadership, and safety.

National guidance confirms that there should always be access to inpatient care when needed. Crisis beds (as alternatives to admission) were also included in the National Service Framework, and provision nationally has increased over the past ten years.

Our strategic commissioning intentions

We will work with other boroughs' commissioners across South West London, and with South West London and St George's Mental Health Trust, to agree a new plan for the overall organisation of acute inpatient mental health services. This will provide a better foundation for sustainable high quality inpatient care, providing more specialised and better resourced acute care on fewer sites to meet the needs of South West London.

We expect to reduce our inpatient bed numbers to match the average in similar areas (by about 8 beds).

We expect to increase investment in crisis and home treatment services.

We are determined to secure improvements to the quality of care that local people receive. We will work to develop and monitor a structure of performance measures and incentives in our contract with South West London and St George's Mental Health Trust, including an element of

financial incentives for the Trust (known as Commissioning for Quality and Innovation, or CQUINs), so that good and improving practice is clearly rewarded.

How we will make this happen in practice

We expect that reduction of inpatient requirements will release resources both for required savings in overall mental health expenditure, and for enhancement of community services to reduce admissions or support earlier discharge.

We will undertake further analysis to confirm this with the Mental Health Trust, including a comparison of beds commissioned against the number actually used for our residents.

Working with commissioners from neighbouring boroughs we will review the possibility of a 'crisis house' as a smaller and less intensive alternative for some brief inpatient admissions.

4.5 Engagement and equality

Stakeholders highlighted these two key areas about the way we do commissioning in Richmond. They relate to principles and to the delivery of services rather than to significant resource changes or new departures. However, they are central to the vision of NHS Richmond and the London Borough of Richmond upon Thames and they are therefore the subject of a specific section in this strategy.

The local case for change

The feedback from stakeholders was that the current position is not satisfactory, even though there are current obligations on services and commissioners to do these things anyway.

Engagement

NHS Richmond updated its patient and public involvement strategy at the end of 2009 with the introduction of its Engagement Strategy. It is committed to ensuring that patient and public involvement is integrated at every stage of the commissioning cycle to support the planning, delivery and monitoring of services to meet the health needs of all local communities. The Strategy includes an annual work plan, a commitment to reporting back on engagement activities and improving engagement with specific groups such as carers, and marginalised communities.

The London Borough of Richmond upon Thames updated its strategy on consultation and participation in 2007. It confirmed that it gives high priority to involving the public in decision-making though public consultation, public participation and public empowerment and in doing so wishes to involve the public as far as practical in running their borough and delivering their services. The strategy includes an annual programme, proactive consultation of minorities, use of up to date technologies, feeding back the results and acting on them as far as possible.

NHS Richmond and the London Borough of Richmond upon Thames together recognise that we need to re-work our approach to engagement of service users and carers, and to ways we involve the non-statutory sector in planning improvements. We are working with service users, carers and providers to do this and agreed to pilot new ways of engagement during the development of this strategy. (Details are provided in Appendix Four). We have also agreed a set of principles to underpin future engagement activity.

NHS Richmond and the London Borough of Richmond upon Thames are committed to building on this feedback. They are undertaking an equalities impact assessment as part of the process of developing strategies.

Equalities

Stakeholders made it clear that they expected all strands of diversity and equality to be addressed by mental health services, including gender, disability, age, ethnicity, race, religion and sexual orientation.

However particular concerns were raised about Black and Minority Ethnic and about Lesbian, Gay Bisexual and Trans communities, so these are addressed in this section.

Richmond has a low level of ethnic diversity compared to the rest of London. Paradoxically, this can mean that BME communities remain isolated, with their needs little understood, and with services having less opportunity to adapt to diversity (because staff see fewer service users from these communities). Local stakeholders have told us that because the Black and Minority Ethnic communities are smaller in the borough then elsewhere, their networks of support are more extended – people have to travel to other areas of London to take part in culturally appropriate activities run by their own community organisations. This increases the risk of the isolation that comes with mental ill health.

A study carried out through RB MIND (with the support of the Local Authority and the PCT) found that members of BME communities surveyed were dissatisfied with the services offered by GPs and practice staff due to concerns about communication, lack of confidence and lack of knowledge of the system, leading them to rely more on A & E. In particular they reported a lack of opportunity to discuss issues causing mental distress. RB MIND have also reported that service users from BME communities are over-represented on the caseloads of assertive outreach and crisis and home treatment teams (although the small numbers make statistical significance impossible.)

Black and Minority Ethnic(BME) Community Development Officers are aiming to raise awareness of mental health in BME communities and reduce fear of the mental health services amongst service users.

They will also be helping people get in touch with appropriate mental health services which should improve well being by making sure the right service is received at the right time and place.

We hope to improve race equality in mental health services by ensuring that communities have the information they need to make informed decisions themselves and that cultural needs are considered by mental health service providers.

As regards Lesbian, Gay, Bisexual and Trans (LGBT) people, the LGBT forum told us that:

- Individuals may be reluctant to disclose their sexual identity to their GP, who may be GP to all their family

- Partners may not be recognised as carers.
- Many LGBT people are concerned that staff may refuse or limit their partner's visiting rights or not involve them in decisions about their care.

The pathways we want to see

We want mental heath services to reduce social isolation, promote community participation and increase public awareness of mental health issues by tackling stigma and discrimination. This approach will underpin equality and cohesion in our communities, and challenge prejudice.

We want to build on the positive engagement undertaken in developing this strategy to develop improved ways of engaging service users and carers throughout the commissioning cycle (i.e. identifying health needs and aspirations, agreeing priorities and strategies, service design, procurement and contracting and performance management).

The established principles followed by the NHS and local authorities are:

- Services should maintain good access, be non-discriminatory and respect confidentiality.
- Staff should have appropriate training.
- Service innovations and local dialogue should be encouraged to meet the needs of groups who may otherwise find it difficult to access services

National requirements

Engagement

The Government White Paper 'Strong and Prosperous Communities'(2006) signalled that local authorities should get people more and more involved in decision-making processes. A series of NHS reforms in the last decade has set out the requirements for the health service to involve local people.

All NHS commissioners are assessed on the way they work collaboratively with community partners to reduce inequalities, and build meaningful engagement with the public, patients and clinicians. These competencies are part of the world class commissioning initiative.

PCTs are specifically required to report annually on who they have consulted on local health services and how. The government publishes a code of practice on consultation.

Equalities

All statutory bodies have a duty to ensure their services are both accessible to and suitable for all people who have need of them. The aim when implanting this strategy is to ensure that discrimination on the grounds of race, disability, gender and age discrimination do not occur and to actively promote equality to meet legislative requirements.

According to the Department of Health briefing for health and social care staff– 'Mental Health Issues within Lesbian, Gay and Bisexual (LGB) communities' (briefing 9), research suggests that some LGB people are at higher risk of mental disorder, self harm, suicidal behaviour and substance misuse. The increased risk of mental disorder in LGB people is linked to experiences of discrimination, and LGB people commonly report being the victim of a homophobic incident. They are more likely to report both daily and lifetime discrimination than heterosexual people.

Trans people is a UK term used to cover a range of gender variant experience from part-time cross-dressers to transsexuals who undergo gender reassignment surgery. They may be heterosexual, gay, bisexual or lesbian.

Specific issues include:

- Typically, many LGB people begin to question their sexual orientation during adolescence; many report experiencing rejection from family and friends on disclosure of their sexual orientation.
- Gay and bisexual young men appear to be particularly vulnerable in comparison with heterosexual young men.
- Although the risk of suicide attempts is highest during adolescence and young adulthood, research indicates that there is a substantially increased risk of suicidal behaviours among adult gay men.
- In comparison with heterosexual women, lesbians reported less social support from family members and were less positive about how others viewed their sexual orientation.
- One study found that 34 per cent of adult trans people had attempted suicide.

Lesbians, gay men and bisexual people use mental health services more frequently than their heterosexual counterparts. Despite higher usage, LGB people report mixed experiences of services. One-third of gay men, a quarter of bisexual men and over 40 per cent of lesbians reported negative or mixed reactions from mental health professionals when they disclosed their sexual orientation. Over 20 per cent of trans people found that GPs did not want to help them, and 30 per cent experienced discrimination from professionals.

Our strategic commissioning intentions

Over the period of this strategy we will work to have user and career engagement integrated at every stage of the mental health commissioning

cycle to support the planning, delivery and review of local adult mental health services.

We seek training for staff to ensure services are provided in a culturally sensitive way, such as Race Equality and Cultural Capability training, which was developed as part of the Delivering Race Equality initiative.

We will request providers to demonstrate how their services are accessible to all sections of the community, including BME and LGBT people.

We will distinguish between the needs of different minority groups, eg the mental health needs of people of Irish origin and people classified as 'White other' are likely to be distinct from the 'White' population groups and from each other.

How we intend to make this happen

We will plan to achieve these improvements by better use of existing resources.

We will develop structures for implementation and evaluation which promote the involvement of service users and carers, their organisations, and local organisations for hard to reach groups.

Standard contracts and legal obligations on public bodies require them to promote equality. In addition we will:

- include requirements for training
- develop partnerships and joint approaches with providers to promote training and access and service innovations
- require providers to demonstrate how they will provide an appropriately trained workforces

5. FINANCIAL FRAMEWORK

5.1 London Borough of Richmond upon Thames Financial Context

The worsening financial position faced by the public sector has placed significant financial challenges on the Local Authority. These are being addressed through the Local Authority's Efficiency Challenge, a major organisational review which could generate savings of up to £10m per annum over the next three years. Elements of this review relate to commissioning, procurement and contracting and are therefore likely to have an impact on the commissioning processes for mental health services.

In addition the Local Authority will need to continue to make efficiency improvements in delivering services within the context of increasing demand for services and reduced public sector funding. Local Authorities are required to make minimum efficiency savings of 3% of which an element will need to be met from mental health services.

5.2 NHS Richmond Financial Context

In common with all public services, NHS Richmond faces significant financial pressures over the coming decade.

Analysis of national financial mapping data for 2008/09 indicates that we spend 17% more per head than the average for England on mental health services for adults of working age, after adjusting for the structure of our local population in Richmond. We also spend 10% more per head than the average for the ten places most similar to Richmond (all ten are other London boroughs).

We know that some national measures will be taken to help with the financial situation, such as expected reductions in the tariff for payments we make to acute hospitals. It is however clear that the PCT will have a responsibility to find substantial efficiency savings, and mental health services cannot be an exception to this pressure. There are however mental health services in which we are determined to invest: primary care mental health, crisis services and memory assessment. We are therefore proposing a plan which envisages a withdrawal of £3.8M (from total current mental health spend of £27.1M, of which £21.1M are spent on local services for adults of working age and older people) from service lines which are less effective or relatively over-provided, and reinvestment of £1M into our priority areas.

Appendix Three contains a summary of the main financial changes arising from both this strategy, and the strategy for mental health services for older people.

6. IMPLEMENTATION

This section explains how we intend to implement the strategy, and the issues arising.

6.1 Procuring improved services in line with this strategy

This section explains how we propose to work with current and prospective future service providers and service users and carers to ensure that services develop in ways which are consistent with this strategy.

Procurement can in principle involve negotiated change with existing service providers. It can also involve formal competitive tendering for blocks of service, or case-by-case commissioning for individual people. We will ensure our approach is consistent with local and national requirements concerning personalisation, practice-based commissioning, payment by results, and the new standard contract for mental health services.

Our overall intentions are:

- We will pursue implementation of this strategy via negotiated change, where possible
- We plan to work with service providers over the lifetime of this strategy to gradually improve the focus and usefulness of the information we receive about the performance of services.
- We expect to align PCT commissioning with practice based commissioning over the lifetime of this strategy. GPs play a vital role as part of multi-disciplinary case management and they will play an increasingly prominent role in local commissioning of healthcare services. As part of the PCT's polysystems approach to prepare all practices for greater engagement in clinical commissioning for appropriate levels of clarity on governance, budget setting information, and quality.
- NHS Richmond will use the new standard Department of Health Mental Health contract with all providers, including smaller providers. We will not place undue burdens on smaller providers, but, in return for greater levels of financial certainty, we will expect proportionate improvements in both service and information quality.
- We do however intend increasingly to develop service specifications and performance management arrangements in partnership with neighbouring PCTs and local authorities.
- We envisage close joint working with all stakeholders on those commissioning intentions which require this, most notably our

proposals to reduce the number of beds and sites from which inpatient services are provided.
- We expect to use the PbR clusters and pathways recommended by DH to classify and plan activity for the realigned health services.

6.2 Performance management

For each of the commissioning intentions and priorities set out in this strategy, we will determine relevant monitoring data, and work with service providers to ensure this is available. It is however important that we go beyond this, and that we improve the range and relevance of routinely available data. We therefore plan to work with service providers, service users and carers over the lifetime of this strategy to gradually improve the focus and usefulness of the information we receive about the performance of services. This information is currently mostly about service activity (the number of contacts or episodes) with more limited information about other dimensions of quality, and least of all on service outcomes and service user experience. We expect to develop and agree datasets which include information about:

- Service outcomes i.e. how services are measurably improving the lives of the people who use them (for example by use of validated psychometric instruments). These will be based not simply on generic instruments such as HoNOS, but on instruments agreed to be clinically relevant for each service line
- Audited adherence to evidence-based practice standards
- Service user experience, including the experiences of carers, where relevant. This will need to be based on a sound survey/interview method, and not simply on the views of representative groups, or patterns in complaints.
- Safety, including untoward incidents
- Access, including waiting times for services, retention in services, and the operation of choice. This could also include data on out of area placements
- Equity, understanding use of services by age group, gender, ethnicity, and by locality. This should include an analysis (where possible) of qualitative data on service user experience by the different groups who use services.
- Productivity, understood as the cost for each output or outcome achieved.

Delivery of data of this nature will be a requirement of future service specifications. We aim to develop these datasets consistently across all our providers, enabling local benchmarking of levels of performance.

We will work with providers in managing the development of new datasets, reviewing them regularly and jointly, and developing shared

and intelligent understandings as to what the data provided actually means (i.e. what is improving or deteriorating, possible explanations for changes where this is ambiguous.) We will also meet regularly with providers to agree approaches to quality improvement, and providers' performance against agreed targets.

We are confident that providers will share our aspirations here, and that we can work together to achieve significant improvements over the lifetime of this strategy.

6.3 Governance

This subsection describes who will take responsibility for the process of implementation, and how we will take account of changes required in future.

Responsibility for implementation of this plan will rest with the designated mental health commissioning officers of both NHS Richmond and the London Borough of Richmond upon Thames. The process will be overseen by respective Directors and Chief Officers. The mechanism for this, in the immediate future, will be the Mental Health Joint Commissioning Group (JCG) overseeing the work of a range of project groups via a Steering Group, the JCG itself reporting to the Health and Wellbeing Partnership. The mental health subgroup and service redesign groups will act as reference groups. It should however be noted that the detail of these arrangements and their memberships will be kept under review, and may change as needs require. These individuals and groups will ensure that:

- Work is taken forward to address each of the initiatives in this plan
- Progress against these initiatives is regularly reviewed
- Resources are made available where required
- Plans are revised in the light of progress, or of changes in the national or local context
- There are regular communications as required with other commissioning organisations, with service providers, and with the wider communities of people who receive services, their families and carers, about progress with this strategy.

6.4 Evaluation

We hope that our strategy has prepared us for the changes we expect to see, both locally and nationally. No strategy, however, can anticipate all the changes which will happen over a five-year period. Some of the things intended here will be overtaken by other events, or will prove more difficult to implement than we had hoped. Some will progress more quickly. New opportunities and issues will arise which we cannot currently foresee.

We will therefore continually evaluate whether this strategy is working as intended, drawing on the performance data described in 6.2 above, and on continuing processes of public engagement. The evaluation process will include:

- Routine consideration of our evolving performance management datasets, to check trends across the domains of outcomes, service user experience, access, safety, equity, and productivity
- Consideration of progress against the specific commissioning intentions set out in this strategy, any risks or problems emerging, and action required as a result
- Continuing discussion with people who provide and use services as to the impact the strategy's changes are having
- Regular summary review (at least annually) of the continuing appropriateness and relevance of the strategy's objectives
- Communication with all relevant parties as to commissioners' ongoing intentions.

This may result in changes to what is proposed here, or to new areas of action altogether.

6.5 Consultation

We recognise that this strategy proposes important changes to the pattern of mental health services available to the community of Richmond. These changes are driven by both our wish to secure the most effective range of services possible, and by the inevitable realities of the current financial climate. We believe that the proposals in this strategy represent the best means of protecting essential services, developing new services, but also living within our means.

We have engaged regularly with interested groups and individuals during the preparation of this strategy (there is a report on this engagement in Appendix Four), and we greatly welcome the many contributions received. In view of this, we do not propose further formal public consultation at this stage. We do however propose that, once the planned review of mental health inpatient sites and services has taken place there may be a need for formal public consultation on proposals emerging.

6.6 Phasing and a timeline

Implementation arrangements to ensure engagement and diversity are not shown separately as they are integral to the other commissioning intentions.

IMPROVED ACCESS, PREVENTION AND TREATMENT IN PRIMARY CARE	
Consultation with Practice Based Commissioners (PBC) on commissioning proposals for primary care mental health, including specification, partnership with LB Richmond upon Thames, pilot service, procurement and contracting	Year One

arrangements	
Consultation on poly systems for SW London	Year One
Agreement with PBC	Year Two
Specification for alcohol treatment for people with common mental disorders	Year Two
Links with personalisation agreed.	Year Two
Pilot service starts	Year Three
Evaluation of pilot service	Year Four
Full implementation	Year Five

RECONFIGURED PATHWAYS FOR PEOPLE WITH SEVERE, LONGSTANDING AND COMPLEX NEEDS	
Specification of carer outcomes	Year One
Implementation plan for mental health personalisation agreed, and first phase changes made	Year One
Agreement of community care pathways including dual diagnosis and rehabilitation	Year One
Capacity plan for specialist teams	Year Two
Implementation of phase 2 of personalisation, including market stimulation	Year Two
Innovative pilots for mental health pilots agreed	Year Two
Transitional period of shadow working – new arrangements in existing systems	Year Three
Mental health personalisation fully operational	Year Three
New secondary service operational	Year Four

IMPROVING ACCOMMODATION OPTIONS AND REHABILITATION	
Update of rehabilitation and accommodation strategy to extend to 2015 including finance, pathways, outcome measures and nominations to general social housing stock	Year One
Review of needs of people in inpatient and high support accommodation	Year One
Outcome of consultation on South Bank House in Kingston	Year One
Specification for inpatient services	Year Two
Specification for high support services	Year Two
Specification for reconfigured floating support services including reconfiguration of current supported accommodation provision	Year Two
New inpatient and high support services operational	Year Three
Reconfiguration of supported accommodation to floating support implemented.	Year Three

REDUCING INPATIENT SERVICE USE	
Contract for use of commissioned beds by Richmond the	Year One

residents at levels to reflect actual use	
Capacity plan for increase use of crisis and home treatment (including over 65 with functional illness	Year One
Interim action plan and monitoring of quality and standards	Year One
Feasibility study and research of market for crisis house	Year One
Consultation on South West London proposals	Year One
Revised service specification for inpatient care agreed with Trust and other commissioners	Year One
CQUIN related to quality of inpatient care	Year One
Implementation plan for new South West London acute	Year Two
Increase capacity and performance of community and crisis services	Year Two
Open crisis house (subject to feasibility)	Year Three
New model implemented	Year Four

APPENDIX ONE: NEEDS ASSESSMENT SUMMARY

The full Joint Strategic Needs Assessment is available on the website of NHS Richmond. This appendix summarises key facts about demography, ethnicity, epidemiology and stakeholder views.

Demography

This section presents population data sourced from the Greater London Authority Data Management and Analysis Group. The chart and table below show the profile of current population of Richmond upon Thames. The red outline indicates what the population would look like if it matched the England average population profile.

Figure 1 - Demographic profile of Richmond upon Thames, 2009, by age and gender

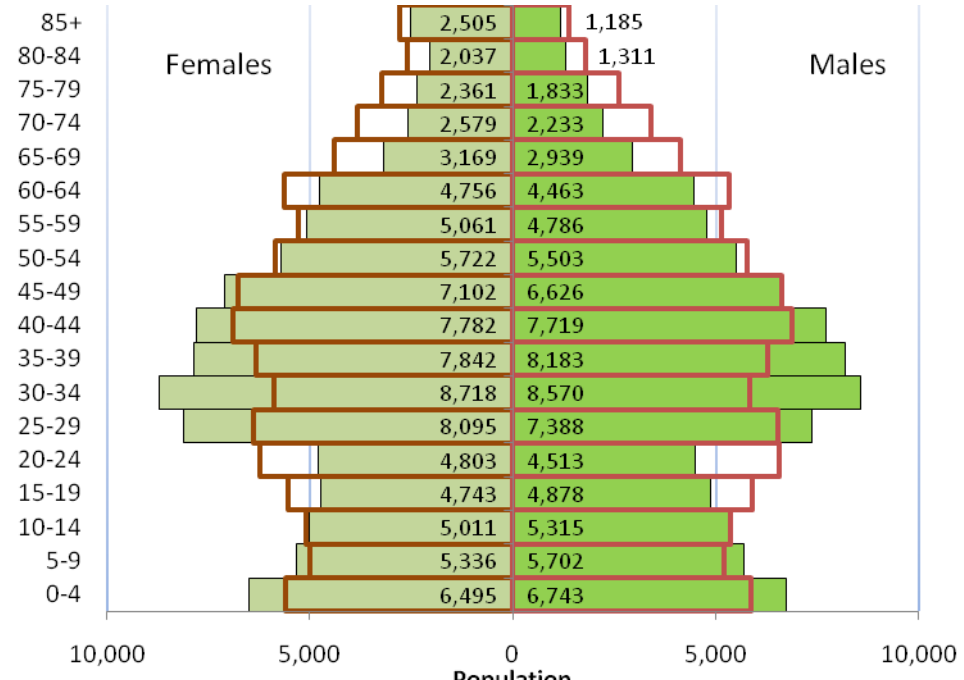


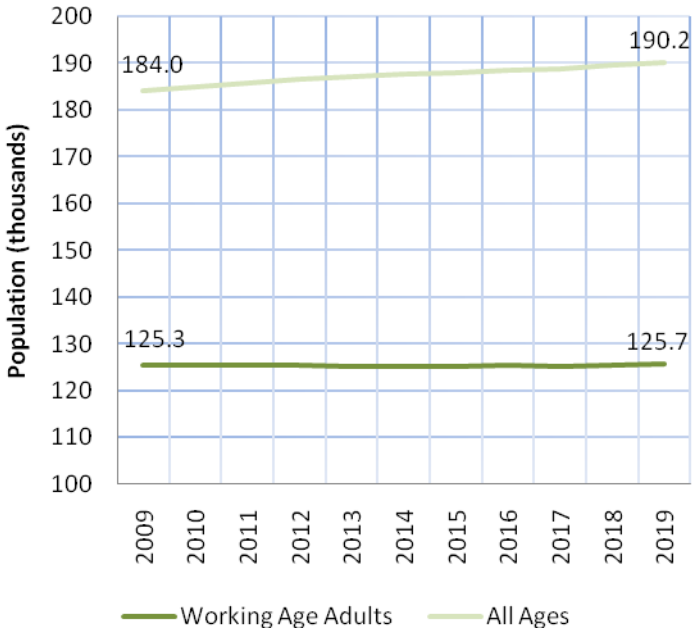
Table 1 - Summary of the population of Richmond upon Thames, 2009

Age Group	Females	Males	All Persons
Under 16s	17,773	18,759	36,531
Working Age	63,693	61,629	125,322
Older Adult	12,651	9,500	22,151
Total	94,116	89,889	184,005

Source: GLA Data Management and Analysis Group, low estimates. 2008 mid-year estimate, projection for 2009

While the overall population of Richmond upon Thames is predicted to grow slightly over the next ten years, the working age adult population is not predicted to significantly change, as illustrated below.

Figure 2 - Population projections for Richmond upon Thames, 2009 to 2019



Source: GLA Data Management and Analysis Group, low estimates. 2008 mid-year estimate, projections for 2009-2019.

Ethnicity

While demographic information on ethnicity specific to working age adults is not available, we have presented data below relating to ethnicity in Richmond upon Thames across the whole population. The tables below and opposite show the population of each ethnic group in Richmond upon Thames, and levels of diversity across London. Note that most recent GLA ethnicity data available is dated 2006 so the total population will not match the population listed on the previous page.

Table 2 - Population of Richmond upon Thames (2006) by ethnic group

Ethnic Group	Population	As %	Caseload (%)
White	161,091	89.3%	89.5%
Indian	5,084	2.8%	1.3%
Other Asian	3,384	1.9%	2.6%
Black Other	1,770	1.0%	0.7%
Chinese	1,257	0.7%	0.4%
Black African	990	0.5%	0.8%
Pakistani	770	0.4%	0.3%
Black Caribbean	649	0.4%	0.7%
Bangladeshi	615	0.3%	0.2%
Other	4,820	2.7%	3.6%
Total	180,430		

Sources: GLA Data Management and Analysis Group, low estimates. 2006 mid-year estimate. South West London and St George's Mental Health NHS Trust utilisation data (for caseload column)

The caseload column shows the relative proportion of the total caseload of all services (adult and older adult) in Richmond upon Thames broken down by ethnicity. More detail on caseloads can be found in the 'Current Caseloads' section.

Table 3 - Top and bottom ranked London Boroughs in terms of ethnic diversity

Rank (1 = most diverse)	PCT	Simpson's Ethnic Diversity Score (1-10)
1	Newham	5.84
2	Brent	4.10
3	Harrow	2.99
4	Ealing	2.90
5	Redbridge	2.87
...	...	...
29	Sutton	1.36
30	Bexley	1.27
31	Bromley	1.26
32	**Richmond upon Thames**	**1.25**
33	Havering	1.15

Source: GLA Data Management and Analysis Group, low estimates. 2006 mid-year estimate.

We can see that Richmond upon Thames has the second lowest levels of ethnic diversity out of all the London Boroughs.

Epidemiology

This section presents estimates of the number of working age adults in Richmond upon Thames with specified mental health conditions. We have also presented the expected number of adults with these conditions in 2014 and 2019. In order to produce this work, we have researched NICE guidance detailing the prevalence rates of mental health conditions. These have then been applied to the population of Richmond upon Thames as described in the previous section.

Table 4 - Estimates of the number of working age adults in Richmond upon Thames with mental health disorders

Mental Heath Disorder	Prevalence rate (Adults)	2009	2014	2019	Source
Any neurotic disorder*	166.4 per 1000	20,198	20,115	20,217	Mental Health Observatory - http://www.nepho.org.uk/mho/Needs
Depression or mixed depression and anxiety	In working age adults, 98 per 1000 (males 71/1000, females 124/1000)	11,890	11,857	11,930	Meltzer et al., 1995a and b. (see NICE CG23 p17)
Anorexia nervosa*[2]	0.19 per 1000 per year in females and 0.02 per 1000 per year in males*	5	5	5	Pawluck & Gorey, 1998 (see NICE CG9)
Bulimia nervosa	Between 5 and 10 per thousand in young women. About 90% of people diagnosed with bulimia nervosa are female.	139 - 265	138 - 263	138 - 262	Hay & Bacaltchuk, 2001 (see NICE CG9)
Schizophrenia	6 per 1000	728	725	729	Mental Health Strategies composite from King's Fund - Paying the Price (see p52)
Post and antenatal depression	10-60 per 1000 pregnancies	29 - 175	29 - 175	29 - 172	NICE guidelines (see NICE CG45 p61-62)
Postnatal psychosis	0.5-2.0 per 1000 deliveries	11 - 44	12 - 47	12 - 47	NICE guidelines (see NICE CG45 p66)
Bipolar (I) disorder	Approximately 10 per 1000	1,214	1,209	1,215	Various sources. See NICE CG38 p77-78.
Antisocial Personality Disorder	10-13 per 1000 in men, 0-2 per 1000 in women	597 - 899	591 - 892	592 - 894	Coid et al (2006), Torgersen et al (2001) (See NICE CG77)

Borderline Personality Disorder	7 per 1000	850	846	850	Coid et al (2006), Torgersen et al (2001) (See NICE CG78)

Source: Populations from GLA Data Management and Analysis Group, low estimates. 2008 mid-year estimate, projections for 2009-2019. Prevalence rates as given in 'source' column.

*Note that for 'Any neurotic disorder' we have applied the prevalence rate given by the MHO to our GLA populations for 2009, 2014 and 2019.

*[2]Note that the data for anorexia nervosa is a one year incidence rate as no prevalence rate is given in the NICE guidelines. As such, the number of people with these eating disorders in Richmond is likely to be far greater than these figures. The Kings Fund's 'Paying the Price' report .gives prevalence rates for anorexia as 3 per 1000 in young women (under 35s) and 0.3 per 1000 in young men. Using these figures the estimated number of people with anorexia in Richmond in 2009 is 80.

Stakeholder views

Stakeholders were asked their views on what made Richmond's needs distinctive from those of other areas. The said that characteristics of the local area include:

- The particular geography of the borough and in particular the way it is divided into two parts by the River Thames. Not only does this mean a distinct sense of identify for each 'half', it also means it is difficult to travel from one side of the borough to the other.

- Property prices in Richmond are high, so that land for social housing projects (including those for people with mental health problems) is expensive and difficult to obtain. It was also suggested that this may make it more likely that Richmond residents are placed in accommodation outside the borough.

- High levels of home ownership mean that services which enable older people to manage their homes and gardens older people are particularly valued.

- Conversely Richmond's green space means the borough has ample resources for outdoor and ecological wellbeing projects.

In terms of mental health services, stakeholders mentioned that mental health problems associated with affluence, including stress, alcohol misuse, and high expectations where characteristic of local need.

Some people also claimed that because of its high level of affluence, Richmond has a higher incidence of eating disorder and personality disorders than elsewhere since these disorders to not have the same positive correlation wt deprivation that other so. These claims have not been scrutinised as part of the Joint Strategic Needs Assessment.

APPENDIX TWO: LIST OF CURRENT SERVICES

CURRENT SERVICES

People with mental health problems in Richmond have access to a wide range of services. These include, of course, many general health and social care services not specifically targeted at mental health problems. They also include services commissioned for individuals on the basis of individual need. There are also the following specialist services, provided by South West London and St George's Mental Health Trust except where stated otherwise.

Access and Crisis Services

- A crisis and home treatment service, linked to a Richmond crisis helpline
- An early intervention in psychosis service (caseload around 71) for people aged 17 to 35
- An assertive outreach team (caseload around 65)

Accommodation

- Shenehom care home (13 beds), low to medium support (Richmond Churches Housing Trust)
- There are a total of 12 accommodation based supported housing schemes in the Borough which are funded through Supporting People Grant and delivered by voluntary sector organisations. The 12 schemes, 10 of which are provided by Hestia Housing and support and two of which are provided by Threshold, contain a total of 70 bedspaces, usually in one person self contained flats, although sometimes with some shared facilities. Support is in the form of visiting support and a total of over 20,000 hours of support are contracted

Clinical Services

- Lavender ward (23 beds) acute admissions ward
- Orchids ward (19 beds, also serving Kingston) acute admissions ward

Community Mental Health Teams

- Richmond CMHT (caseload around 500)
- Twickenham CMHT (caseload around 600)

Rehabilitation

- Riverside Lodge (12 beds, also serving Kingston) a 24 hour nursed slow stream rehabilitation unit

- Rose Lodge (15 beds, also serving Kingston) a community rehabilitation unit
- South Bank House (17 beds, also serving Kingston) a community rehabilitation unit
- Kingston Lane hostel (20 beds), with 24-hour care

Psychological therapy, psychotherapy and personality disorder services

- Richmond Psychotherapies service, including personality disorder intensive treatment, and complex cases adult psychotherapy.
- Eating disorder services (community, day and inpatient)
- Primary care psychological therapies (Priory Group, and development partnerships with Imagine and RB MIND).

Services for secure/forensic needs

There are no specialist services within Richmond, although we have access to a range of Trust-wide services.

Day, Drop-in, vocational, advocacy and support services

- Richmond advocacy service, including Independent Mental Capacity Act Service (Kingston Advocacy Group)
- Vineyard project (drop-in service) (RB MIND)
- RB MIND Social Centre at Richmond Royal
- Richmond Vocational Support Services (173 clients engaged last year) – paid employment, retention and education (Imagine)
- RCVS supported volunteering project (Volunteer Centre) in conjunction with Imagine
- Recovery support team (caseload around 200) providing a wide range of community support services
- RB MIND in Mortlake
- RB MIND Eco-Therapy Project
- RB MIND BME Mental Health Community Development work
- Time Bank, which already has over 100 members, 75% with a debilitating mental illness (2,000 hours of activity) (RB MIND).
- RB MIND People's Network, through which training and support is provided to a number of local peer-run groups.

Carers' Services

Carers in Mind provides support services, including informal advocacy, support groups, education, information and respite breaks. The project also promotes carer involvement in the development of services.

Services delivered by professionals from South West London and St George's Mental Health Trust in partnership with Carers in Mind include:

- Maddison Families and Friends Support Group
- Garden House Families and Friends group
- EIS Family Group
- Family Skills Workshops at Queen Marys

APPENDIX THREE: FINANCIAL STATEMENTS

Below are summary statements of approximate financial changes arising from our mental health commissioning strategies for both adults of working age and older people.

These figures are indicative only; they do not represent agreed contractual changes or firm commitments. The purpose of their inclusion is to enable a broad understanding of the strategies' likely financial context and implications. All figures are at current pay and prices.

NHS Richmond

In outline, the current strategy envisages the following approximate movements of PCT funds:

Source of saving (£000)		**Use of savings (£000)**	
Acute inpatients	560	Contribution to PCT savings	2800
Rehab inpatients	430	Primary Care mental health	1020
Adult CMHTs/outpatients	380	Memory assessment	
Forensics*	160	Crisis services	
Older people inpatients	830	(Exact distribution of investment between service development areas to be determined)	
Older people day hospital	120		
Older people CMHTs/outreach	200		
Non-South West London*	410		
Consolidation of underspends (placements and other non-recurrent)*	730		
Total	3820	**Total**	3820

*First year savings totalling £1M should be possible from these lines. Other savings will be released gradually over the life of the strategy.

Current investment in local adult and older people's mental health services totals approximately £21.1 million per year.

London Borough of Richmond upon Thames

The following table summarises the current and planned Local Authority investment in mental health services for working age adults. This shows the broad intentions of how funding will be allocated during the period of the Commissioning Strategy. These figures are indicative only and do not represent agreed contractual changes or firm budget commitments. The Local Authority's budgets are set annually within the context of its Medium Term Financial Strategy.

Local Authority Funding for Mental Health Services - Working Age Adults	**Outturn 2008/09 £000 (Gross)**	**Budget 2009/10 £000 (Gross)**	**Budget 2010/11 £000 (Gross)**	**Provisional Budget Allocation 2012/13 £000 (Gross) (based on commissioning intentions)**
Assessment and Care Management (CMHTs)	1,439	1,334	1,356	1,140
Residential and Nursing Care	1,339	1,739	1,920	1,650
Supported Living	1,017	1,022	1,142	1,400
Recovery Services	274	300	287	290
Self Directed Support/Direct Payments	95	58	107	350
Other Services	629	395	308	300
Cashable Efficiencies/Demand-led Growth	-	-	-240	-250
TOTAL	**4,793**	**4,848**	**4,880**	**4,880**

APPENDIX FOUR: ENGAGEMENT REPORT

1. INTRODUCTION

1.1 What this report is about

This report is published alongside two strategy documents, both prepared jointly by NHS Richmond and the London Borough of Richmond upon Thames.

- Mental health joint commissioning strategy for adults of working age
- Mental health joint commissioning strategy for older people

This report explains how we have consulted and engaged local stakeholders as we have prepared these strategies, what stakeholders have said to us, and how stakeholders' views have been reflected in our strategies.

1.2 How this report is structured

After this introduction, there are four main sections:

Section 2 - briefly explains the reasons why we have developed mental health commissioning strategies, as these are also the reasons for the process of consultation and engagement.

Section 3 - describes the process of consultation and engagement – the opportunities we created for people to comment, and how much they were used.

Section 4 - summarises the concerns, opinions and aspirations which stakeholders described to us.

Section 5 - explains how those concerns, opinions and aspirations have been reflected in our mental health commissioning strategies.

2. WHY WE HAVE DEVELOPED MENTAL HEALTH COMMISSIONING STRATEGIES

There have been important changes in both national policy and the local situation in Richmond which have led us to wish to review our strategies for mental health services. The most important changes have been:

- the completion of the 10-year implementation period for the National Service Framework for mental health.
- the publication of "New Horizons", a national strategy emphasising the promotion of good mental health, early intervention, and tackling stigma.
- the publication of "Living well with dementia", a national strategy aiming to improve diagnosis, care and treatment of people with dementia.
- local and national work on personalisation of services, including personal budgets for social care services.
- the economic recession; current levels of spending are not likely to be sustainable.

In deciding how to address these issues in Richmond, it is clearly essential for us to take into account the views of local stakeholders, including people who work in them, people who make use of them, their families and friends, and the wider community. The rest of this report explains how we did this.

3. HOW WE HAVE CONSULTED AND ENGAGED LOCAL STAKEHOLDERS

Work began in September 2009; during this month we prepared some briefing materials about current services, arranged a series of meetings during the course of the autumn, and published (via the PCT website) a questionnaire seeking views about local services. In November 2009 we published an outline statement of commissioning intentions, again seeking feedback. We received 59 responses to the web-based questionnaire, and 12 feedback forms to the November circulation.

Details of the various engagement methods and their take-up are given in the table below:

Event	Client Group	Engagement Group	Participation
Web-based questionnaire (initial)	All	All	59
Meeting	Working age	Carers	12
Meeting	Working	Managers and	12

	age	Clinicians	
Meeting	Working age	Service users	9
Meeting	Working age	Carers	12
Meeting	Working age	Mental health partnership group	--
Meeting	Working age	Service users	7
Meeting	Working age	Managers and Clinicians	28
User-led engagement	Working age	Service users	24
Meeting	All	GPs – Richmond	15
Meeting	All	GPs – Twickenham	15
World Mental Health Day	All	All	--
Older People's Day	Older people	Older people and carers	-
Meeting	All	LINK Steering Group	--
Meeting	Older people	Managers and Clinicians	14
Meeting	Older people	Managers and Clinicians	12
Meeting	Older people	Carers	10
Meeting	Older people	Service redesign group	-

Some people used more than one of these opportunities. Whilst we do not have a record of individuals attending/participating, we estimate that between 100 and 150 local people engaged with these processes.

In addition, we received a small number of detailed written submissions during the course of our development of the strategies. These included submissions from staff of the following organisations:

- South West London and St George's Mental Health NHS Trust
- The London Borough of Richmond upon Thames
- Priory Healthcare
- RB MIND
- Richmond Council for Voluntary Service
- Imagine

In January 2010, we completed and published final draft version of our strategies. We then circulated the final drafts for comment, and made them available via the PCT website.

We received, in response to the final draft strategies, written submissions from the following organisations:

- South West London & St George's Mental Health NHS Trust
- Richmond Local Involvement Network (LINK)
- Richmond Council for Voluntary Service
- RB MIND
- Still Building Bridges
- a group of service users (via Richmond CVS)

We also received ten responses from individuals.

Throughout this period, we also reported progress to a range of senior level groups, including the Professional Executive Committee, the PCT Board, and the Health, Housing, and Social Care Overview and Scrutiny Committee (in each case twice).

4. WHAT STAKEHOLDERS HAVE SAID TO US

This section of the report presents both a thematic summary of stakeholders' general views and comments and analysis of specific comments on the final draft strategies. It is clearly not possible to reproduce in a summary every opinion expressed, or suggestion made; our aim here is to present an understanding of the balance of opinion on the main issues arising. We do not attribute any comment or opinion to any specific stakeholder organisation, individual or group.

We have identified fourteen main messages from the views of local stakeholders. These messages emerged consistently from every stage of the engagement process.

1.	A general concern at the implications of reducing resources and service change.
2.	Significant comments as to the quality of acute inpatient services: the environment, activities, staff interaction. This is however coupled with concern to ensure bed numbers are not reduced before other service changes are in place.
3.	On balance praise for the work, expertise and professionalism of community mental health teams, but concerns that their caseloads are too heavy.
4.	Support for the retention of separate CMHTs for older people.
5.	A wish for GPs to have a clearer and more consistent role within mental health services; but a concern that their knowledge and training may need improving if this is to work.

6.	A wish to improve access to psychological therapies.
7.	On balance, support for the idea of personalisation and self-directed support, but a wish to improve how it operates in practice.
8.	Support for day services and drop-ins, with concern at recent or prospective closures of such services.
9.	A need to improve early diagnosis of dementia.
10.	A need for more supported accommodation, of various types.
11.	A wish to see significant improvements in the support available to carers, including respite and short breaks.
12.	A general wish for better involvement, care planning and support for people with serious long-term illnesses.
13.	A wish, from all sides, for better integration and "joined-up working" between the various organisations involved in mental health services in Richmond.
14.	A view that savings should be taken out of management/administration/ bureaucracy.

5. HOW STAKEHOLDER VIEWS HAVE BEEN REFLECTED IN OUR STRATEGIES

In preparing any strategy, our task is to consider the full range of information available to us. The views of stakeholders are a vital part of this as, we hope, demonstrated by this report. We must, however, also take account of national policy expectations, of research, and of the constraints of resources expected to be available.

The following table therefore explains how the main themes raised by stakeholders have been reflected in our final strategies.

	ISSUE	HOW THIS IS REFLECTED IN THE STRATEGIES
1.	A general concern at the implications of reducing resources and service change.	We are very conscious of this concern. We will continue to engage and discuss during the implementation process, which is phased over five years to avoid sudden or precipitate change.
2.	Significant comments as to the quality of acute inpatient services: the environment, activities, staff interaction. This is however coupled with concern to ensure bed numbers are not reduced before other service changes are in place.	The strategy envisages a complete review and reprovision of these services across South West London. A smaller number of more specialist units should significantly improve service quality. We will also gradually introduce clearer performance management standards and incentives into our contact with the service provider.
3.	Praise for the work, expertise and professionalism of community mental health teams, but concerns that their caseloads are too heavy.	We believe the best means of reducing the burden on CMHTs will be to divert some of their work to other services, most particularly a new primary care service. Our CMHTs will remain of similar size to services in comparable places
4.	Support for the retention of separate CMHTs for older people.	Distinct CMHTs for older people will be retained. Whether people are seen by the working age or older CMHT will depend on needs, not simply age.
5.	A wish for GPs to have a clearer and more consistent role within mental health services; but a concern that their knowledge and training may need improving if this is to work.	The development of primary care mental health services will be a gradual process, allowing time for all involved to adapt to a changing role. This should also ensure a clearer and more consistent response.
6.	A wish to improve access to psychological therapies.	The new primary care mental health service will improve access. We recognise, however, that there will remain a gap between supply and demand for the foreseeable future, within the resources available to us.
7.	On balance, support for the idea of personalisation and self-directed support, but a wish to improve how it operates in practice.	Personalisation will be relaunched, taking account of comments received during piloting, and working closely with service users and other stakeholders.

8.	Support for day services and drop-ins, with concern at recent or prospective closures of such services.	We will increase the availability and flexibility of older people's day services. "Day services" for adults of working age will be less buildings-based, as this is consistent with the preferences of most people who use mental health services.
9.	A need to improve early diagnosis of dementia.	The strategies envisage establishing a specialist memory assessment service, consistent with national guidelines.
10.	A need for more supported accommodation, of various types.	The strategies envisage an increase in the availability of floating support and high support hostels.
11.	A wish to see significant improvements in the support available to carers, including respite and short breaks.	There will be an increase in the availability and flexibility of respite services. We will work within the framework of personalisation to improve the general support available to carers.
12.	A general wish for better involvement, care planning and support for people with serious long-term illnesses.	We will review our engagement and involvement processes in the light of our experiences in preparing these strategies. The personalised approach should ensure that, within available resources, users receive the services they find most useful. Financial benefits are not in the power of local agencies in Richmond to change, but we can and will support take-up of existing entitlements.
13.	A wish, from all sides, for better integration and "joined-up working" between the various organisations involved in mental health services in Richmond.	Developing these strategies has been an important catalyst to clarifying joint working arrangements between commissioners.
14.	A view that savings should be taken out of management/administration/ bureaucracy.	All NHS organisations will be implementing reductions in management costs of at least 30% over the lifetime of these strategies.

APPENDIX FIVE: LOCAL INFORMATION SOURCES AND DOCUMENTS CONSULTED

Joint policy materials

1. Joint Strategic Needs Assessment (October 2008)

2. Notes of mental health adult stakeholder engagement review meeting (September 2009)

Local authority context

3. Mental Health Rehabilitation and Accommodation Strategy 2009 – 2012

4. London Borough of Richmond upon Thames – Consultation and Participation Strategy (2007)

5. Mental Health Self Directed Support Pilot Report (August 2009)

6. London Borough of Richmond upon Thames economic indicators September (2009)

NHS context

7. NHS Richmond Commissioning Strategy Plan (Draft - December 2009)

8. NHS Richmond Commissioning Strategy Plan (March 2009)

9. London Personality Disorder Strategy (2009)

10. NHS Richmond Engagement Strategy (2009)

11. Making Life Better Together (South West London & St George's Mental Health Trust) versions 1 and 2 and summary for service users and carers - 2009

Activity and finance

12. Activity information provided by South West London and St George's Mental Health Trust, London Borough of Richmond upon Thames and NHS Richmond (also summarised in a briefing paper by Mental Health Strategies).

13. Finance statements from South West London and St George's Mental Health Trust, London Borough Richmond upon Thames and NHS Richmond

Voluntary sector

14. RB MIND – "All we need is someone to listen" Involvement and engagement of people from Black and Minority Ethnic communities to primary care services in Richmond upon Thames (October 2009)

APPENDIX SIX: JARGON BUSTER

ADHD	Attention deficit hyperactivity disorder
A&E	Accident & Emergency
BME	Black and minority ethnic
CMHT	Community Mental Health Team (a team of mental health professionals from different professions who are based in the community. The team will work with an individual to help them recover from their mental health problems without coming into hospital).
Community services	refers to health and social care services that are provided without an individual coming into hospital. They are provided near to where people live in their local communities.
Community teams	Refers to teams of health and/or social care professionals who work in the community rather than based in a hospital.
Complex needs	refers to a range of needs, as an individual may have more than one mental health diagnosis, may also have physical health needs as well as mental health or other social needs which may contribute to person's overall complex need. A range of statutory and voluntary sector organisations may be involved in providing care.
CPA	Care programme approach
CPN	Community Psychiatric Nurse
CQUIN	Commissioning for Quality and Innovation (a reward and incentive programme for NHS Trusts)
Crisis and home treatment services	Crisis and home treatment services are teams of mental health professionals who respond quickly to people experiencing mental health crises and offer an alternative to going into hospital
Crisis house	Refers to safe overnight accommodation overnight for people with mental health problems in a crisis situation for whom home treatment is not suitable or as a short term alternative to hospital admission.
DH	Department of Health
DNA	Do not attend
Dual diagnosis	refers to individuals who have mental health problems **and** drug or alcohol problems.
EMI	Elderly mentally ill
Evidence based	refers to an approach to decision making in which the clinician uses the best evidence

	available, in consultation with the patient, to decide upon the option which suits that patient best.
FACS	Fair access to care services
Functional mental illness	Illnesses such as depression, anxiety, schizophrenia, bipolar disorders (see also organic mental illness)
HONOS	Health of the Nation Outcome Scale
IAPT	Improving access to psychological therapies
LGBT	Lesbian, gay, bisexual and trans
LTC	Long term conditions (refers to those conditions that cannot, at present, be cured, but can be controlled by medication and other therapies. They include arthritis, heart disease, stroke, Multiple Sclerosis, diabetes, asthma and respiratory diseases).
NICE	National Institute for Health and Clinical Excellence
NSF	National Service Framework
Organic mental illness	Dementias and similar diseases (see also functional mental illness)
PbR	Payment by results (paying service providers according to the volume of service provided)
PCT	Primary Care Trust
Peer support	refers to a system of support where people who have had similar experiences provide emotional or practical help to each other. A peer has "been there, done that" and can relate to others who are now in a similar situation.
Personalisation	refers to a whole new approach to social care which means that every person who receives social care support will have choice and control over the shape of that support. Personalisation will put people at the centre of assessing their own needs and personalising their own support.
PFI	Private finance initiative
Polyclinic	Polyclinics are a new way for people in London to receive healthcare. A polyclinic is set in an accessible, local and convenient location and provides a range of services which could include: ▪ GP surgeries open from 8am to 8pm every day, including weekends ▪ A walk-in service ▪ Many of the healthcare services available at hospitals, such as X-rays and blood tests,

	as well as treatment for people who have minor injuries that aren't life threatening Access to a wider range of services in one easy visit. Services include benefits support and housing advice

Polysystems	A polysystem is about a model of care that has a Polyclinic at its centre, supported by GP-led Health Centres. The central Polyclinic, often referred to as a Community Health Centre, offers additional services typically found in hospitals that could be utilised by the GP led Health Centres. The polysystem can be focused around a polyclinic based in the community or on a hospital site. Such a system ensures that patients can have quick access to services with no requirement to visit a hospital.
Primary Care	refers to the first point of contact an individual has with the health service, before being referred elsewhere. GPs and emergency departments are examples of primary care services.
QoF	Quality and Outcomes Framework (a voluntary annual reward and incentive programme for GP practices)
RCVS	Richmond Council for Voluntary Services
Rehabilitation services	Refers to services which enable people who have severe and enduring mental illness to learn and regain lost life skills as part of their recovery. The programme of assessment and activities may include personal care, domestic tasks, money management, leisure time, work activities and management and treatment of mental health problems. Levels of support vary in different rehabilitation services according to needs. The length of stay may vary although it is likely to be much longer than an acute in-patient admission.
SDS	Self directed support (a form of personalisation)
Secondary Care	refers to more specialist health services which generally do not have first contact with patients. Access to secondary care is usually by a referral from a primary care service
Severe and enduring mental health issues	refers to mental illness in terms of mood, thoughts and/or behaviour, which can have a major effect on nearly all aspects of a person's life at some stage of their illness. People with a severe and enduring mental illness often require long-term treatment and support from mental health services.
Statutory services	Refers to a service that is required to exist by law, e.g. social services and the National Health

	Service.
Stepped care model	refers to a way of providing care that treats an individual at the lowest appropriate service level, only 'stepping up' to intensive/specialist services as clinically required
SUN	Richmond's service user network

Voluntary organisation /third sector/	Refers to charities, community organisations and not-for-profit organisations. Statutory and voluntary sectors Third sector includes social enterprises and public or community benefit organisations run under a variety of different regulations. Independent sector usually means private companies but is sometimes used to cover voluntary organisations too.