Mental Health Joint Commissioning Strategy 2010 - 2015

Maximising Opportunity

Our Strategy will set out our vision to deliver a world class commissioned Mental Health Service for our population.

Putting the user at the centre of decision-making and making recovery and wellbeing our focus.
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Foreword

Developing mental health services remains a high priority within the boroughs of Sutton and Merton.

Mental health conditions affect one in four of the population at some time in their life and needs and intensity of needs vary from person to person. We recognise that the individual should be at the centre of determining these needs and the expectation of outcomes.

Our strategy sets out our direction over the next five years to ensure that the commissioning of mental health services for our population best meets their needs and maximises people’s ability to manage their mental health conditions as close to home and as independently as possible.

Our strategy will look to meet the needs of older people by addressing the inequalities of access highlighted by the Healthcare Commission Report "Equality in Later Life", ensuring services are delivered on the basis of need rather than age. It will build on work already underway to deliver to the objectives of the National Dementia Strategy.

Our strategy looks to build on existing transformation set out in the National Service Framework for Mental Health (1999), where we saw the development of services that improved access and responsiveness of care including:

- Crisis Resolution / Home Treatment;
- Early Intervention Services; and
- Assertive Outreach.

We will also look to embrace new and emerging policy and guidance:

- New Horizons;
- Transforming Social Care;
- Healthcare for London;
- World Class Commissioning;
- National Dementia Strategy;
- The NHS Constitution;
- Better Healthcare Closer to Home.

All of the above look to put the service user at the centre when developing service provision, which remains focal to commissioning partners.

Services for people with mental health problems should be seen in the wider context of those affected and our strategy will put the needs of the carers as a driver of change.

Throughout the development of our strategy we have engaged with a wide cross section of people to understand at the point of delivery what the hopes and concerns were, and this forms the foundation stone for our strategy. We will commit that this level of engagement continues throughout the life of the strategy to ensure continuous feed back.

In order for us to deliver our vision, we are committed to develop and maintain multi-agency commissioning and collaboration.

Bill Gillespie  
Chief Executive  
NHS Sutton and Merton  

Paul Martin  
Chief Executive  
London Borough of Sutton  

Ged Curran  
Chief Executive  
London Borough of Merton
Clinical Foreword

For many years the provision of mental health services has not been valued to the same degree as those aimed at physical health and this strategy seeks to address access for service users across the broad range of mental health services that we commission for our population. Alongside this, national policy, such as New Horizons and Transforming Social Care, give us clear guidance which to set our strategy.

As we enter a period of real financial constraints we must closely examine our spending on local health and social care provision to ensure that we are realising the best outcomes for those using services, whilst achieving the best value for money.

The mental health pathways can at times be complex and for the user and carers can seem confusing. We look, where possible, to break down that complexity and ensure the best care is delivered at the right time and in the right place.

The last 10 years has seen significant advances in mental health care, including new types of services such as Early Intervention and Crisis Resolution, where expert teams provide timely assessment and treatment to support independence and recovery. We have also seen advances in medication, which can lead to better outcomes for users.

General Practitioners provide around 90% of mental health care and are the main referral route into specialist health and social care. We have responded to changing treatment needs, recently exemplified by the tremendous investment in Improving Access to Psychological Therapies. This provides fast and effective access to therapy helping those people affected by mild to moderate depression and anxiety.

Locally we have developed a significant change in healthcare provision through the Better Healthcare Closer to Home programme. Mental health services will form a crucial element of this approach, with the vast majority of care, through General Practice, Community Mental Health services and Psychological Therapies in Primary Care being delivered close to users’ place of residence, supporting recovery. This will also give us an opportunity to bring mental health and physical health needs together.

Some people with more intense needs will at times require specialist care provided within an inpatient facility. Through effective commissioning we will ensure that this need is seen as a method of resolving the episode of crisis and that the focus is to enable users to return to their homes, jobs and families in as short as time as possible.

Mental health remains a high priority for health and social care commissioning organisations and this strategy sets out our aims and our vision of success.

Dr Martyn Wake
Joint Chair Professional Executive Committee
Joint Medical Director
NHS Sutton and Merton
Economic Foreword

Over the next five years we will see a major review of public spending and health and social care will not be exempt.

There will potentially be significant constraints on spending on health and social care and we must see this as an opportunity to look at how services are commissioned and delivered to ensure value for money.

When working through the priorities set out in this strategy we will need to take this into account.

It will still be our main priority to commission safe and effective mental health care for our population, but we will look to further change the balance of investment, ensuring that the best outcomes are met at the right time.

We will need to work in the context of planning scenarios for health ranging from 0.75% real growth, 0% growth and, potentially, a reduction of 2.3%. We feel it is responsible to plan for all three scenarios. Social services will also be working in the context of potential reductions in spending and these too will be planned for.

Local Authorities face similar constraints with respect to future spending and these planning assumptions will need to be factored in to future decision making.

We accept that this economic downturn is not unique to the public services but affects the majority of the population. We therefore must see this as an opportunity to ensure, as stated before, that services best meet the needs of our population.

Mike Sexton
Director of Finance
NHS Sutton and Merton
1. **Introduction:**

1.1.1 The mental health care pathway should be looked on as a time of continuous care and support in which expert intervention is provided when needed to support individuals and their carers.

1.1.2 This strategy aims to provide a framework for commissioning agencies in the boroughs of Sutton and Merton to commission spending effectively in health and social care and maximise the recovery opportunities for mental health service users.

1.2 **Definition of Joint Commissioning**

1.2.1 Care for services users with mental health needs often include both health and social care provision and therefore to ensure effective outcomes for users, services are commissioned using a single approach by health and social care organisations.

1.2.2 This Strategy represents commissioning direction for NHS Sutton and Merton, the London Borough of Sutton and the London Borough of Merton.

1.3 **Scope of the Strategy**¹

1.3.1 The strategy will cover services for Working Age Adults and Adults of Older Age. This will include transition for younger people into adult services and for working age adults into older people’s services for patients or residents registered in Sutton and Merton for Health and Social Care.

1.3.2 The strategy will not set commissioning direction for Child and Adolescent Mental Health Services.

1.3.3 The strategy will not set commissioning direction for specialist services including:
- eating disorders;
- forensic services;
- services for the deaf;
- perinatal (mother and baby);
- severe learning difficulties or personality disorder;
- specialist post-traumatic stress disorder.

1.4 **Engagement**

1.4.1 Throughout the development of the strategy we have sought the views and aspirations of people currently using mental health services and those who care for people with mental health problems² and this information underpins our strategic direction.

1.5 **Acknowledging the past**

1.5.1 The strategy builds on the significant work that has been done previously to develop a local mental health strategy. We have over time redeveloped our spending to ensure quality care for our population and this strategy aims to clearly set out our direction for the next five years.

¹ Strategies for children (1.3.2) and specialist services (1.3.3) are covered by distinct and separate organisations, not by Sutton and Merton PCT and Joint Commissioning: see for instance the Sutton and Merton strategy for people with learning disabilities, “2020 Vision”.

² See section 4.5 for a summary of the views expressed.
2. Understanding the Needs of the Population

2.1 Overview

A comprehensive mental health needs assessment has been carried out which measures the current scale of mental health needs for the populations of Sutton and Merton. It also estimates the expected need over the next 5 years, which will allow us to inform our commissioning decisions through the life of this strategy.

The population of both boroughs is expected to increase, Merton by rather more than Sutton but with a larger relative increase in the population of older people in Sutton.

The total number of people suffering from mental health problems such as depression, anxiety and schizophrenia is expected to rise as the population increases. Relative to the population as a whole the incidence of these problems will remain fairly steady among people of working age, among older people the incidence will increase.

Not all those who suffer from mental health problems present themselves for treatment. One aim of national and local strategy is to improve awareness of the importance of mental wellbeing and to reduce the stigma associated with mental health problems - and so to encourage more people to seek help, and at an earlier stage in the development of their problems.

For these reasons the overall need for help and treatment is expected to increase and the types of treatment being demanded are expected to change. Identifying and meeting the challenges presented by this is a goal of the strategy.

2.2 Population Changes

The basis for these projections is the Office of National Statistics mid-2008 estimates. Greater London Authority projections used by some planners produce slightly different results, partly because they take proposed housing development into account.

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3 See Appendix 1 – "Sutton and Merton mental health core needs assessment” for the full study quoted from and summarised in this section. The study was commissioned from Mental Health Strategies Ltd for this strategy.
2.2.1 Sutton currently has a population of 189,000 which is expected to rise to 195,000 by the year 2015 (3.4% population rise).

Merton has a population of 205,000 which is expected to rise to 215,000 by the year 2015 (4.7% population rise).

2.2.2 Merton will see a larger relative increase in people of working age (+3.8%) than Sutton (+2.6%).

2.2.3 Though Sutton has a lower percentage population increase overall, it will see a larger relative increase in older people (+4.5%) than Merton (+3.3%). Both boroughs today have a lower proportion of older people than the English average.

2.3 Mental Health Needs

This table shows the estimated prevalence of a range of mental health disorders now and in five years’ time.

### Working Age Adults

<table>
<thead>
<tr>
<th>Disorder</th>
<th>2010 M</th>
<th>2010 S</th>
<th>2015 M</th>
<th>2015 S</th>
<th>Both M</th>
<th>Both S</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression or mixed depression and anxiety</td>
<td>13,463</td>
<td>11,623</td>
<td>13,994</td>
<td>11,954</td>
<td>25,086</td>
<td>25,948</td>
</tr>
<tr>
<td>Anorexia nervosa*</td>
<td>6</td>
<td>4</td>
<td>6</td>
<td>5</td>
<td>10</td>
<td>11</td>
</tr>
<tr>
<td>Bulimia nervosa* - Min</td>
<td>143</td>
<td>102</td>
<td>147</td>
<td>105</td>
<td>245</td>
<td>252</td>
</tr>
<tr>
<td>Bulimia nervosa* - Max</td>
<td>285</td>
<td>203</td>
<td>294</td>
<td>210</td>
<td>488</td>
<td>504</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>830</td>
<td>714</td>
<td>863</td>
<td>735</td>
<td>1,544</td>
<td>1,598</td>
</tr>
<tr>
<td>Post and antenatal depression - Min</td>
<td>35</td>
<td>27</td>
<td>37</td>
<td>27</td>
<td>62</td>
<td>64</td>
</tr>
<tr>
<td>Post and antenatal depression - Max</td>
<td>209</td>
<td>160</td>
<td>222</td>
<td>163</td>
<td>369</td>
<td>385</td>
</tr>
<tr>
<td>Postnatal psychosis - Min</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Postnatal psychosis - Max</td>
<td>7</td>
<td>5</td>
<td>7</td>
<td>5</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>Bipolar (I) disorder</td>
<td>1,384</td>
<td>1,190</td>
<td>1,439</td>
<td>1,225</td>
<td>2,573</td>
<td>2,663</td>
</tr>
<tr>
<td>Antisocial Personality Disorder - Min</td>
<td>697</td>
<td>590</td>
<td>726</td>
<td>610</td>
<td>1,287</td>
<td>1,336</td>
</tr>
<tr>
<td>Antisocial Personality Disorder - Max</td>
<td>1,044</td>
<td>887</td>
<td>1,086</td>
<td>915</td>
<td>1,931</td>
<td>2,001</td>
</tr>
<tr>
<td>Borderline Personality Disorder</td>
<td>969</td>
<td>833</td>
<td>1,007</td>
<td>857</td>
<td>1,801</td>
<td>1,854</td>
</tr>
</tbody>
</table>

### Older People

<table>
<thead>
<tr>
<th>Disorder</th>
<th>2010 M</th>
<th>2010 S</th>
<th>2015 M</th>
<th>2015 S</th>
<th>Both M</th>
<th>Both S</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression - Min</td>
<td>691</td>
<td>763</td>
<td>732</td>
<td>837</td>
<td>1,454</td>
<td>1,569</td>
</tr>
<tr>
<td>Depression - Max</td>
<td>1,000</td>
<td>1,104</td>
<td>1,060</td>
<td>1,212</td>
<td>2,104</td>
<td>2,272</td>
</tr>
<tr>
<td>Anxiety</td>
<td>1,286</td>
<td>1,420</td>
<td>1,363</td>
<td>1,559</td>
<td>2,706</td>
<td>2,922</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>95</td>
<td>115</td>
<td>101</td>
<td>115</td>
<td>211</td>
<td>216</td>
</tr>
<tr>
<td>Bipolar (I) disorder</td>
<td>238</td>
<td>289</td>
<td>252</td>
<td>289</td>
<td>527</td>
<td>541</td>
</tr>
<tr>
<td>Dementia</td>
<td>1,829</td>
<td>1,967</td>
<td>1,892</td>
<td>2,102</td>
<td>3,796</td>
<td>3,994</td>
</tr>
</tbody>
</table>

2.3.1 Not everybody with mental health problems presents for treatment and so the figures represent the level of combined need both met and unmet, rather than the numbers actually being treated.
2.3.2 The evidence shows that all conditions associated with mental health problems will see an increase over the next five years.

2.4 Mental Health Need Indicators

The Mental Health Needs Index 2000 (MINI 2K) estimates the likelihood of inpatient admission for psychiatric services based on several social factors. It takes into account the historical demand for these services. The standard score for England is 100, with lower scores indicating a lower than standard need.

The Local Index of Needs (LIN) estimates a general mental health need based on a large number of socio-demographic factors. It does not take historical service usage into account. The mean score for England is 0, with a negative score indicating a lower than average mental health need.

<table>
<thead>
<tr>
<th>MINI 2K</th>
<th>LIN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Merton</td>
<td>72</td>
</tr>
<tr>
<td>Sutton</td>
<td>83</td>
</tr>
<tr>
<td>Croydon</td>
<td>76</td>
</tr>
<tr>
<td>Kingston</td>
<td>62</td>
</tr>
<tr>
<td>Richmond</td>
<td>57</td>
</tr>
<tr>
<td>Wandsworth</td>
<td>144</td>
</tr>
</tbody>
</table>

2.4.1 LIN data suggest that Merton has the 10th lowest mental health need in London, but it is still higher than the English average. Sutton has the 4th lowest need in London and is below the English average. MINI 2K data suggest that both boroughs have a lower need for inpatient services than the English standard.

2.5 Ethnicity

The boroughs of Sutton and Merton are ethnically less diverse than the average measured for London:

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4 Source for section 2.4: "SW London Mental Health Needs Analysis".
5 As the MINI 2K and LIN indices are based on different assumptions they cannot be compared one to the other.
6 Simpson’s Ethnic Diversity Score is an index where, in this case, 0 represents the lowest and 10 the highest possible population diversity.
The ethnic populations of Merton and Sutton:

<table>
<thead>
<tr>
<th>% Population is</th>
<th>Merton</th>
<th>Sutton</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>74.57</td>
<td>85.2</td>
</tr>
<tr>
<td>Mixed</td>
<td>3.12</td>
<td>2.07</td>
</tr>
<tr>
<td>Asian or Asian British</td>
<td>11.08</td>
<td>4.18</td>
</tr>
<tr>
<td>Black or Black British</td>
<td>7.78</td>
<td>2.56</td>
</tr>
<tr>
<td>Chinese or other</td>
<td>5.04</td>
<td>1.44</td>
</tr>
</tbody>
</table>

2.5.1 According to local surveys, ethnic and cultural groups are often over-broadly and inconsistently defined. These groups may be poorly understood, and anyway change over time.

2.5.2 Ethnic, cultural and spiritual factors have a major effect on access to and on the effectiveness of treatment. These factors include the awareness of the nature of mental health problems, the strength and effects of stigma on those seeking treatment and variations in the prevalence of mental illness between groups.

2.6 Primary Care

The Quality and Outcomes Framework (QOF) data show an estimate for numbers in primary care treatment for different disorders in 2010, compared with estimates based on National Institute for Clinical Excellence (NICE) prevalence figures.

2.6.1 The comparison suggests that numbers of people suffering from mental health conditions may not be known to primary care services.

2.6.2 Local studies\(^7\) suggest that stigma and the lack of understanding of the nature of mental health problems may account for some of this apparent unmet need.

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\(^7\) For instance the SWLStG "Black and Minority Ethnic PTiCP Report" 2009.
3. Understanding Our Current Provision:

3.1 Overview

NHS Sutton and Merton, the London Borough of Sutton and the London Borough of Merton currently spend over £75 million into working age adults and older peoples mental health services (including highly specialist services).

This covers a wide spectrum of services including:

- Primary Care
  - General Practice and Psychological Therapies in Primary Care
- Community Services
  - Community Mental Health
  - Early Intervention
  - Assertive Outreach
  - Supported Accommodation
  - Day Services
- Inpatient Services
  - Psychiatric Intensive Care
  - Acute Inpatient Wards (Working age Adult and Older People)
  - Rehabilitation

3.2 Current Financial Model

3.2.1 The diagram below shows the percentage of spending on each service area, compared to the percentage of service users who have contact with services in each area.

In both boroughs the largest expenditure is on inpatient services (including rehabilitation), while the overwhelming majority of service users are treated in primary care or through community services and community mental health teams.
3.2.2 The table below shows the spending on mental health and social services in each area of service:

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Sutton</th>
<th>Merton</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Primary Care</td>
<td>1,208</td>
<td>1,464</td>
<td>2,672</td>
</tr>
<tr>
<td>Community Services</td>
<td>12,499</td>
<td>13,343</td>
<td>25,842</td>
</tr>
<tr>
<td>Inpatients</td>
<td>21,249</td>
<td>19,021</td>
<td>40,270</td>
</tr>
<tr>
<td>Specialist Services</td>
<td>3,162</td>
<td>3,866</td>
<td>7,028</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>38,118</td>
<td>37,694</td>
<td>75,812</td>
</tr>
</tbody>
</table>

### 3.3 Use of Services

3.3.1 56% of our spending in Sutton and 51% in Merton is currently allocated to inpatient services. We have over the past three years seen a significant reduction in the demand for inpatient services with more being delivered closer to home through Community Services, where spending has remained largely unchanged.

### 3.4 Benchmark Spends on Mental Health

3.4.1 The mental health spend per capita (£) in Sutton and Merton is 170.4 compared to an English average of 182.5, a London average of 230.1 and a South West London average of 208.2. These figures are based on the Department of Health (DH) “World Class Commissioning, Finance Mapping and DH Primary Care Trust Allocations 2007/08”.

![DH Spending Benchmark 2007/08](chart)

3.4.2 This benchmark uses 2007/08 as the base year and do not include the recent adjustment to the allocation for this base year – for NHS Sutton and Merton the adjustment came to £1.8 million extra starting from 2008/09.

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8 See Appendix 2 – “Locality Financial Information”.
3.5 **Primary Care (Including Psychological Therapies in Primary Care and Prescribing)**

3.5.1 Most mental health care is provided in Primary Care (90%) through traditional GP Services and Psychological Therapies in Primary Care including:
- traditional consultation;
- care management of people with Mild to Moderate or Severe and Enduring mental health needs;
- prescribing of anti-depressants and anti-psychotic medication;
- referral to Social Services;
- referral to specialised secondary care provision.

3.6 **Community Services (Including Supported Accommodation and Day Services)**

3.6.1 Community Services include a wide range of facilities including:
- day services – resource centres and day centres;
- “drop-in” facilities;
- Early Intervention services;
- Community Mental Health Teams;
- Assertive Outreach teams.

3.6.2 The last two years in both boroughs have seen a significant change in the provision of community services with the advent of new services such as Early Intervention, Crisis Resolution / Home Treatment and Assertive Outreach teams.

3.6.3 Community Mental Health Teams caseloads are proportionally higher than those of similar teams in other regions. This has however declined over the past year (2009/10).

3.6.4 The provision of day services currently varies in both boroughs from two Resource Centres in Sutton to local community services in Merton

3.7 **Inpatient Services**

3.7.1 Inpatient facilities for nearly all users are provided at either the Sutton Hospital site or at Springfield University Hospital in Tooting (SW17).

3.7.2 The last two years have seen a reduction in the use of inpatient facilities across both boroughs for both older people and working age adults.

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9 Source: "Mental Health Bed Modelling and Analysis", a study commissioned from Sustainable Solutions Consulting Ltd for this strategy.

10 Services for the three inpatient wards at Sutton Hospital are currently relocated following the detection of legionella. See also section 6.6
3.7.3 Sutton Working Age Adult Occupied Beds August 2007 – July 2009

![Graph showing Sutton Working Age Adult Occupied Beds August 2007 – July 2009](image)

3.7.4 Merton Working Age Adult Occupied Beds August 2007 – July 2009

![Graph showing Merton Working Age Adult Occupied Beds August 2007 – July 2009](image)
3.7.5 Sutton and Merton Older People Occupied Beds August 2007 – July 2009

![Gross beds-Elderly & Net beds-Elderly 103 weeks from 6 August 2007 Sutton & Merton PCT Mental Health](chart)

3.8 Inpatient Benchmarks

3.8.1 Hospital admissions (2008/09, using an age and need weighted population):
- Sutton and Merton - 3 per 1,000 population
- England average - 2.7 per 1,000.

3.8.2 Hospital bed days (2008/09, using an age and need weighted population):
- Sutton and Merton - 225 per 1,000 population
- England average - 174 per 1,000.

3.8.3 Emergency readmission rates within 28 days of discharge (2008/09)
- Sutton and Merton - 11%
- England average - 12.2%
- other SW London areas 13.4% (excluding Kingston).

3.8.4 Inpatient facilities used by residents of Sutton and Merton meet general guidance for single sex accommodation.

3.8.5 On average 40% (Sutton) and 50% (Merton) of those admitted to an inpatient facility have been detained under a section of the Mental Health Act 1983 (as amended 2007).

3.8.6 95% of service users needing inpatient services are admitted through Crisis Resolution / Home Treatment Teams.

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11 Source: “World Class Commissioning, Finance Mapping and DH Primary Care Trust Allocations 2007/08”.  
Mental Health Strategy 2015 Draft 4 v04
3.9 Length of Stay\textsuperscript{12}

3.9.1 This graph shows the length of stay for 2,120 Sutton and Merton inpatients (section 17 leave excluded). A number of patients stay for a month or less (26% stay for less than a week, 41% for between 2 and 4 weeks). There are also a number of patients staying for 3 months or more (18%).

\textsuperscript{12} Source: "Mental Health Bed Modelling and Analysis"
3.10 Location of Services

3.10.1 Most services are currently delivered close to home, with access to Primary Care (General Practice) and Community Services provided through teams across the two boroughs.

The map below shows the location of mental health services and facilities, including third sector (voluntary and independent) facilities, for the two boroughs (the squares correspond roughly to single wards, units etc).

3.10.2 Inpatient services are currently provided through facilities in Wandsworth (Springfield Hospital) and Sutton (Sutton Hospital).

3.10.3 Day Service facilities are currently available and situated throughout the two boroughs, including the Cumberland Day Centre and Cheam and Wallington Resource Centres. These are currently provided by a range of statutory and independent providers.

3.10.4 Rehabilitation facilities are provided within the boroughs, including Norfolk Lodge and Bradshaw Close in Merton and Hexagon House in Sutton.

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13 See Appendix 4 – "S+M Locality" for a larger-scale map of the boroughs and services.
4. Understanding the Views of our Population:

4.1 Understanding the views of those using services is crucial when developing strategic direction and these views to will underpin this strategy.

4.2 While developing the strategy we have engaged with wide range of people, in particular service users and those who care for them.

4.3 When seeking the views of users and carers we used a variety of engagement methods to ensure that we gained a comprehensive understanding of views and aspirations. We used:

- workshops;
- focus groups;
- 1:1 Interviews;
- existing national and local surveys and reports;
- surveys and reviews of local services.

4.4 The people consulted came from across the care pathway, from Primary Care through to Community Services and Inpatient facilities.

4.5 This section sets out some of the themes and views that emerged. We will look to the full set of the views of service users and carers to inform our strategy.

Consultation and engagement has given us an understanding of how our services are currently perceived and where the strengths and weaknesses are.

Continuous consultation will help to turn the general aspirations of national strategy into practical, relevant and realistic objectives for the populations of Sutton and Merton.

Many of the comments below reflect the opinions sometimes of one, sometimes of a few people. These are not intended as a representative survey or analysis of service provision, rather as a summary of the views that service users and carers expressed.

<table>
<thead>
<tr>
<th>Theme</th>
<th>Summary of Service Users’ and Carers’ Views</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carers</td>
<td>• Well-supported carers are crucial to the recovery of those in treatment and recovery.</td>
</tr>
<tr>
<td></td>
<td>• Overall, carers’ satisfaction with inpatient services was lower in Sutton than in Merton.</td>
</tr>
<tr>
<td></td>
<td>• There were significant concerns about patient safety on wards, especially in Sutton.</td>
</tr>
<tr>
<td></td>
<td>• Carers for inpatients were most likely to be satisfied when they felt involved and they could see that the person they cared for was receiving proper attention, consideration and care from staff.</td>
</tr>
<tr>
<td></td>
<td>• There are big variations in both boroughs in satisfaction with community services.</td>
</tr>
<tr>
<td></td>
<td>• Most carers had not had a formal assessment or review of their own needs in last 12 months (a statutory right); many did not have their own care plan.</td>
</tr>
<tr>
<td></td>
<td>• Only about half of carers had an out-of-hours support number.</td>
</tr>
<tr>
<td></td>
<td>• There was a lack of information about the cared-for person’s condition, treatment and recovery.</td>
</tr>
</tbody>
</table>
Several factors make the carer’s role difficult, including:

- isolation and stigma;
- lack of perceived support from services and from family and friends;
- practical limitations on time, money, knowledge, and the carers’ own health problems;
- interpersonal and relationship difficulties;
- mental health caring being seen as a ‘hard’ job.

The great majority stated caring had a negative impact on their overall well-being: stress, anxiety and depression were mentioned most frequently.

There are several things that would help with caring, including:

- The cared-for person being better supported by services;
- better information for the carer, especially at the early stages;
- more practical support (e.g. with finance, transport etc) and more respite;
- more time.

### Community Services

Inpatients felt that they were prematurely discharged without proper advice, direction or support, as did their carers.

Community mental health services are seen as under-funded. There is lack of resource both in inpatient wards and community mental health services which seriously affects monitoring and follow-up, increasing the possibility of relapses and crises.

To maximise value for money PCTs should invest in community mental health services.

Ongoing support is required from GPs and CMHTs once users are referred to the voluntary sector. People are left to fend for themselves once direct care has ceased.

Other professionals (e.g. police, welfare and benefits staff) who come into contact with users, need urgent training in mental health issues as there is a lack of understanding which in itself is perceived as a barrier to recovery.

Simplification and streamlining of services is required with multi-agency commissioning and collaboration. Having too many different services causes confusion and unnecessary duplication.

A complete and sustained care pathway is needed e.g. safe houses enabling early intervention and crisis management, complementing the role of drop-ins for long-term care in the community upon inpatients being discharged.

Generally the degree of cohesion and co-ordination between community services is seen as poor.

Just under half of people who called a crisis line said they got the help they wanted.

Key workers providing health, welfare and general support on a one-to-one level seen as vital for recovery.

Support workers are seen as working to a reactive model and need to take a more active/early intervention approach.

### Dignity and

Inpatients feel dignity and respect is the very least they can
| Respect | • Privacy is not always respected.  
• Staff have a low opinion of inpatients and are condescending.  
• When inpatients are sectioned, a lot of mistreatment happens.  
• Older people with mental health problems are often neglected and people with dementia are not effectively supported.  
• Inpatients are prevented from doing some activities without explanation, which is highly distressing.  
• Personal effects are confiscated without reason, leaving users feeling confused and resentful. |
| Equalities | • Ethnic minorities were less likely to say they understood their care plan or had been fully involved in deciding what was in it.  
• Asians were more likely to report they had an unmet need in finding work.  
• Black people were less likely to receive talking therapies.  
• Older people were less likely to have copies of their care plan, or to have had a recent care plan review.  
• Older people were less likely to have information about local support groups.  
• The needs of disabled people are not always understood and responded to.  
• There are numerous barriers to seeking help including  
  o stigma particularly in some black and minority ethnic groups, and its effects (in the community, at work);  
  o language, cultural and religious barriers;  
  o lack of understanding of mental health symptoms and issues;  
  o suspicion of the authorities (and of the terminology they use).  
• Community and religious organisations could and should be more active in raising awareness, reducing stigma and encouraging people to seek help.  
• Local and national media are potentially effective education tools and could be used more extensively.  
• Services and staff should be better attuned to the cultures they are dealing with.  
• A more detailed study of the communities in the area is needed, especially as they are continually changing and are more fragmented and diverse than may be currently understood. |
| Faith & Cultural Sensitivity | • Users felt that more access to areas of worship and spiritual guidance is needed.  
• Inpatients did not know whether or not there is a prayer room at Springfield.  
• Chaplains should have more involvement with inpatients and need to offer multi-faith services.  
• Religion and spiritual experience can play an important part in inpatient treatment and too little attention is paid to it. This is especially true where the causes of illness are perceived as spiritual rather than psychological.  
• There is a lack of understanding of minority cultures in hospitals and in the community that has negative effects in |
several ways: it can result in members of minorities being referred to inappropriate services.

- The culture of some minority groups is not understood e.g. when people are perceived as being loud and aggressive for what is normal behaviour culturally.
- Problems with language and communication mean that users can be misunderstood. This is particularly frustrating for some black and minority ethnic users who cannot explain what they are going through in order to attain the best support in a timely way.
- Lack of cultural sensitivity is seen as a barrier to user involvement.

<table>
<thead>
<tr>
<th>Innovation</th>
</tr>
</thead>
<tbody>
<tr>
<td>• More home and crisis support is needed. Counselling and crisis lines need immediate attention.</td>
</tr>
<tr>
<td>• Creative thinking when commissioning future services. More choice wanted, with service delivery through a range of providers as opposed to a monopoly provider.</td>
</tr>
<tr>
<td>• Combining some services, for instance having Community Mental Health Teams work closely with the “Imagine” service.</td>
</tr>
<tr>
<td>• More projects to enable people to develop skills and be involved in working for or running enterprises.</td>
</tr>
<tr>
<td>• Sustained funding to maintain projects including user-led projects like music therapy.</td>
</tr>
<tr>
<td>• More befriending and mentoring schemes, increased peer support provision with necessary support for voluntary workers.</td>
</tr>
<tr>
<td>• Better twilight services, as with most drop in centres closing at 5pm there was a lack of activities or places to go for people with mental health problems.</td>
</tr>
<tr>
<td>• We were urged to rethink social inclusion – mental health users crave acceptance. Users felt that they were trapped in a “mental health ghetto” where all friends and contacts are in the mental health system.</td>
</tr>
<tr>
<td>• A community liaison worker who would be in continual touch with service users and help them deal with benefits and housing problems as well as health issues, and an independent inspectorate to make sure problems, both medical and social, are dealt with, were requested.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Inpatients</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Therapies, peer support on the ward, and one-to-one sessions with staff all contribute to recovery and they should be made more accessible.</td>
</tr>
<tr>
<td>• The staff-patient ratio is too low and staff are tied up with admin, resulting in low visibility on wards. There is lack of one-to-one support leading to a wholesale approach. With limited personalisation, there is increased room for error with medication and treatment plans.</td>
</tr>
<tr>
<td>• Staff would benefit from training to enable them to provide more holistic healthcare as standard, including support for physical health needs.</td>
</tr>
</tbody>
</table>
| • There were concerns relating to agency staff capabilities and attitudes. Also trained and experienced permanent staff tend to move on, leaving health care assistants who have only
basic training to do the work.
- Access to green spaces and fresh air is important.
- The upkeep of premises needs to be addressed, as is cleanliness and hygiene in communal areas, bedrooms etc.
- Food quality is poor and the diet is not very healthy, with little understanding shown for the dietary needs of vegetarians and members of minority cultures. Mealtimes should be monitored to ensure people are eating properly.
- Safety was highlighted as key area of concern, with low staff presence leaving patients feeling vulnerable. Only half of male and a quarter of female inpatients felt safe most or all of the time.
- Regular breakfast and supper meetings would improve collaboration between service users and staff.

| **Primary Care** | • Social contact, leisure interests, work and physical activity all help people to stay well.
• There are several barriers to getting primary mental health care:
  - stigma – admitting you have a problem; concern about having mental health issues on medical records;
  - lack of support and empathy from GPs;
  - lack of GP knowledge of available services;
  - waiting lists for treatment.
• There should be better publicity about services – in GP surgeries, and other public places
• People should be able to access services without going through a GP.
• A range of NHS treatment options should be offered, not just medication. |
| **Prioritising Resources** | • The majority of service users put rehabilitation as the first priority, prevention second and inpatient services third.
• Carers tended to put prevention as a priority before rehabilitation. |
| **Recovery** | • Inpatients were positive about their opportunities to talk over their worries and concerns with staff, their fellow patients and with people already in recovery.
• Giving people enough information, whether medical (diagnosis, side-effects of medication etc) or general (about PALS, treatment and care options etc) is a notable weakness.
• Only a very small minority of inpatients were offered copies of their care plans. In the community too, only a minority of service users are given copies of their care plans.
• Only a small minority of inpatients felt they were involved in deciding their own treatment or in their own risk assessment.
• According to a local survey, of the 5 boroughs in SWLStG, Merton is the most and Sutton the least effective in implementing recovery-based practice in the community.
• Areas of weak performance include giving people help with benefits or with finding work, and giving family members information and support.
• To increase the chances of re-integration users ideally need practical support and realistic but appealing employment opportunities. |
- Encouragement and confidence-building from support groups is imperative and the emphasis should be on recovery not medication: over-medicated people cannot return to work.

**Stigma**
- Stigma was reported as the biggest barrier by far to recovery and employment.
- Attitudes were seen as a key factor. Bad press further prejudices people’s understanding of mental health issues.
- To improve this, users stated the “Time to Change” campaign needs more projection and positive PR.
- Some service users fear meeting members of their own community (working as translators for instance) because of the stigma involved in being known to have mental health problems.

**User Involvement**
- There was a strong view that user involvement was one of the most important aspects of inpatient care.
- Inpatients in many cases felt looked down on and patronised, with staff presuming they were unable to contribute to their own care and treatment.
- Inpatients do not want to be dictated to, but listened to.
- Service users want autonomy, and empowerment to get more involved in forming care plans and deciding treatment and medication.
- As well as personal participation, users wanted to increase carer and family involvement.
- To enable high quality contemporary care, users felt that there has to be a shift in the power between healthcare professionals and inpatients, with greater emphasis on users getting involved in decision making.
- Users also wanted greater involvement opportunities within their personal care and in influencing wider mental health decision-making.
5. The Case for Change:

5.1 Overview

*New Horizons* sets out the case for major changes to the way mental health and social services for those with mental health problems are thought of and delivered. Key themes are:

- the promotion of good mental health and wellbeing throughout the community;
- an emphasis on early intervention and prevention, with the transition from adolescence to working age to older age strengthened;
- the reduction or removal of the stigma associated with mental health problems;
- personalised care, encouraging service users to make their own decisions and choices, and with the emphasis on recovery as the desired outcome where possible;
- commissioning strategies that promote innovation and the development of dynamic health service markets and ensure good value for money.

*Mental health problems are common and the costs to the individual, society and the economy are considerable. A great deal is already known about what can be done. There is therefore an increasingly powerful economic case as well as a moral imperative for taking this programme forward.*

*New Horizons p10*

In Sutton and Merton the need for mental health services will grow over the next five years as the population increases. At the same time the incidence of mental problems among the older population will increase.

It is difficult to estimate unmet demand, but it is apparent that a number of people do not look to mental health services for support or treatment for their problems, at least not in the early stages. There will be a growing emphasis in the next five years on education in mental health and wellbeing and on the reduction of stigma. As more people become aware of the nature of mental illness and more willing to seek help at the onset of problems, the demand for services will grow.

For several years a growing body of evidence and experience\(^\text{14}\) have shown that the provision of mental health services in the community, and a care model centred on the needs and choices of the individual which encourages recovery and the return to a full life, are more effective in most cases than a ‘medicalised’ service centred in hospitals and clinical facilities.

Our service users and carers have expressed concerns about the effects of weaknesses in our community services, notably about the lack of co-ordination between the various health and social service agencies and the lack of provision for continuing care and support. All of these weaknesses can reduce the potential of a successful recovery.

For these reasons the demand for primary care and community-based services in Sutton and Merton is expected to increase in the next five years, whilst better provision within the community is expected to decrease demand for inpatient care. Improving the quality, co-ordination, effectiveness and safety of community services is a major objective of the strategy.

Based on evidence gained from our analyses of need\(^\text{15}\) and current provision, and on the views of users and carers, this section sets out our main aims for the next five years.

\(^{14}\) As discussed for example in the *New Horizons Consultation Document*.

\(^{15}\) See Appendix 1 – "Sutton and Merton mental health core needs assessment".
5.2 Growth in Need

5.2.1 Our needs analysis tells us that we will see a growth in mental health disorders over the next five years including:

<table>
<thead>
<tr>
<th>Working Age Adults</th>
<th>Growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenia</td>
<td>3.5%</td>
</tr>
<tr>
<td>Depression</td>
<td>3.4%</td>
</tr>
<tr>
<td>Post Natal and Antenatal Depression</td>
<td>4.3% (max)</td>
</tr>
<tr>
<td>Bipolar Disorder</td>
<td>3.5%</td>
</tr>
<tr>
<td>Antisocial Personality Disorder</td>
<td>3.6% (max)</td>
</tr>
<tr>
<td>Borderline Personality Disorder</td>
<td>3.5%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Older People</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>8.0% (max)</td>
</tr>
<tr>
<td>Anxiety</td>
<td>8.0%</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>2.7%</td>
</tr>
<tr>
<td>Bipolar Disorder</td>
<td>2.7%</td>
</tr>
<tr>
<td>Dementia</td>
<td>5.2%</td>
</tr>
</tbody>
</table>

5.2.2 The above represents growth across both boroughs.

5.2.3 Prevalence rates vary across the boroughs and our needs analysis (see Appendix 1) details prevalence rates for each postcode.

5.2.4 The growth in the prevalence of depression and anxiety for older people is markedly higher than for working age adults.

5.3 Primary Care – Health and Wellbeing

5.3.1 Feedback from our users and evidence gained from the needs analysis suggests that spending should be targeted towards the promotion of wellbeing and good mental health.

5.3.2 As most care provided to people with mental health needs is through General Practice, care pathways will need to promote access to these services and address cultural stigmas that may affect access to services.

5.4 Community Services

5.4.1 The last two years in both boroughs has seen a significant change in the provision of community services with the advent of new services such as Early Intervention, Crisis Resolution / Home Treatment and Assertive Outreach teams.

5.4.2 For traditional Community Mental Health Teams caseloads are proportionally higher than those of similar teams in other regions. This has however declined over the past year (2009/10)

5.4.3 We will see a rise in care needed for older people with dementia and also a higher demand from older people with depression and anxiety.

5.4.4 The provision of day services currently varies in both boroughs from two Resource Centres in Sutton to local community services in Merton which can lead to potential inequity in service provision.
5.4.5 Most care is currently commissioned through a small range of providers and with the development of personalised budgets the user will be encouraged to be the commissioner of services, and the development of a wider choice of providers and services will be promoted.

5.4.6 Over 95% of patients’ mental health care is currently provided in community settings rather than inpatient facilities. This will be further supported by the Better Healthcare Closer to Home proposals to locate most community health services in local care centres, helping to reduce the stigma that can arise when mental health services are not located in familiar settings and aiming to provide physical and mental health services in the same setting.

5.5 Inpatients

5.5.1 The past three years have seen a reduction in the need for inpatient episodes with more care being delivered through community and primary care services.

5.5.2 Inpatient facilities for our population are largely provided in less than modern environments. Many comments from former inpatients indicate that this can be forbidding and can increase the sense of stigma.

5.6 Summary

5.6.1 The demand for mental health services will grow over the next five years and therefore the need for specialised care (care from community teams, in inpatients and from highly specialist services) will remain crucial to the delivery of effective health and social care.

5.6.2 We are seeing reducing demand for inpatient care with more being delivered by primary care and specialised community services.

5.6.3 Most services are provided close to user’s place of residence across both boroughs.
6. Our Priorities:

6.1 Overview

Our major priority over the next five years is to maximise the opportunities of commissioning community services with resources needed to facilitate this coming from inpatient services.

Awareness of the value of good mental health and wellbeing, and of the nature of mental health problems, will be promoted throughout the community. The stigma associated with mental health problems will be reduced.

The quality, co-ordination, effectiveness and safety of community services will be improved to ensure that they enable service users and carers to make the choices and decisions that best work for them and to achieve the outcomes they desire.

Moving from a ‘medicalised’ or clinically-based service model to a community-based model is a complex process. Research and monitoring will need to be carried out continuously to ensure that the services that are needed in the new model are available and effective, and that the different agencies and providers who will be involved work together in a coherent way.

To support this move commissioners and service providers will:
- help people to make good and informed decisions about the care they choose by providing information, advice and advocacy;
- enable people to jointly commission services by encouraging the development of social enterprises and similar agencies;
- monitor the way people use services so that they can be adapted to need and demand;
- promote the development of informal networks and peer support groups.
- develop more flexible and adaptable ways of contracting for services.

People will make decisions about the services they need and will be supported by information, advice and advocacy to take the responsibility of looking after their own health and wellbeing. Four key elements must be managed and monitored well to ensure the delivery of better health and social outcomes in this way:
- the personalisation of health and social care services;
- the value for money of services delivered;
- the safeguarding of service users, their carers and families and the community at large;
- the collection of comprehensive data, quantitative and qualitative, about the operation of health and social care services.

Commissioning will encourage the growth of a dynamic services market offering innovation, quality and choice to the community, and will monitor the effects of investment to ensure that good value for money is realised.
6.2 The Potential Change in Spending

6.2.1 In order to maximise commissioning potential it will be necessary for commissioning agencies to challenge the current distribution of spend for Mental Health as detailed in 3.2.1.

6.2.2 The figure below shows how, against a background of potential reductions in budget for both mental health and social services, spending could be re-allocated so that the proportion of spending on inpatients is reduced and the proportion of spending on community and primary care is increased.

<table>
<thead>
<tr>
<th>Health and Social Care: Share of Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sutton</td>
</tr>
<tr>
<td>6% of Total Spend</td>
</tr>
<tr>
<td>39% of Total Spend</td>
</tr>
<tr>
<td>46% of Total Spend</td>
</tr>
<tr>
<td>9% of Total Spend</td>
</tr>
<tr>
<td>Merton</td>
</tr>
<tr>
<td>6% of Total Spend</td>
</tr>
<tr>
<td>41% of Total Spend</td>
</tr>
<tr>
<td>42% of Total Spend</td>
</tr>
<tr>
<td>11% of Total Spend</td>
</tr>
</tbody>
</table>

In this scenario spending on community and primary care would be maintained and increased as part of the proposed transition from inpatient to community services.

<table>
<thead>
<tr>
<th>Potential spending in Sutton and Merton</th>
<th>Sutton £000</th>
<th>Sutton %</th>
<th>Merton £000</th>
<th>Merton %</th>
<th>Total £000</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care</td>
<td>1,846</td>
<td>6</td>
<td>2,035</td>
<td>6</td>
<td>3,881</td>
<td>6</td>
</tr>
<tr>
<td>Community Services</td>
<td>13,173</td>
<td>39</td>
<td>13,648</td>
<td>41</td>
<td>26,821</td>
<td>40</td>
</tr>
<tr>
<td>Inpatients</td>
<td>15,937</td>
<td>46</td>
<td>14,266</td>
<td>42</td>
<td>30,203</td>
<td>44</td>
</tr>
<tr>
<td>Specialist Services</td>
<td>3,162</td>
<td>9</td>
<td>3,866</td>
<td>11</td>
<td>7,028</td>
<td>10</td>
</tr>
<tr>
<td>Total</td>
<td>34,118</td>
<td>9</td>
<td>33,815</td>
<td>11</td>
<td>67,933</td>
<td>10</td>
</tr>
</tbody>
</table>

6.2.3 This will give commissioning agencies the opportunity to deliver against our outlined priorities from 2010 through to 2015.

By 2015...

6.3 Primary Care

6.3.1 We will promote education in mental health matters at all ages for the public and professionals to improve the understanding of and reduce the stigma of mental illness. Maintaining and restoring sound mental health not only for those who have suffered problems, but for the population as a whole, is a major objective of this strategy.
6.3.2 We will encourage the development of primary care services provided in familiar surroundings, for example in GP surgeries, local libraries and religious centres.

6.4 Community Care

6.4.1 We will develop care pathways which will include prevention, early intervention and good quality diagnosis. This will be supported by simple referral processes and assessments which cover all the needs of the individual in treatment and recovery.

6.4.2 We will ensure that personalised care is based on the individual’s needs and wishes and directed at recovery where possible, managed through personal care budgets.

6.4.3 We will track the changes being brought about by such policy as Transforming Social Care and work closely together as joint commissioners to ensure that implementation is supported and the effects monitored from the perspective of both mental health and social services.

6.5 Community Care and Inpatient Services

6.5.1 We will re-balance community and inpatient services so that the use of inpatient services is reduced as far as possible, complemented by growth in effective community care, support, rehabilitation and day services.

6.5.2 We will in the first year of the strategy review current commissioning of day services to evaluate effectiveness and appropriateness of the care model and its fit within future models of care.

6.6 Inpatient and Acute Services

6.6.1 Working at a regional (south-west London) level we will provide modern and therapeutic inpatient services backed by rehabilitation and supported accommodation facilities.

6.6.2 We will address the lack of dignity and privacy, and the fear and lack of security, reported in surveys and engagement groups especially by women while on inpatient wards.

6.6.3 We will in the first year of this strategy reduce the number of commissioned working age adult acute beds across Sutton and Merton (Sutton from 30 to 22 and Merton from 34 to 28). We will look to develop a revised model of care for older people, seeing inpatient admission as an infrequent treatment option, supported by an enhanced community model.

6.6.4 We will look in the first year of the strategy to revise the model of care for rehabilitation moving more towards an individual needs/placement model seeing a significant reduction in current “inpatient” rehabilitation beds.

6.6.5 Inpatient facilities based at Sutton Hospital were temporarily transferred to Springfield Hospital, Wandsworth in September 2009.

6.6.6 The configuration and location of NHS inpatient beds is subject to the South West London Acute Services Review, which is informed by the 5 borough based mental health strategies. The service review will consider quality indicators and the patient and carer experience.

6.6.7 Healthcare for South West London is now reviewing the configuration of mental health inpatient beds across the sector, and a decision regarding the future of inpatient services at Sutton Hospital will be made and if necessary consulted on towards the end of 2010.
6.6.8 NHS Sutton and Merton will maintain the temporary arrangement until the outcome of the South West London Acute Services Review is concluded. In the interim the PCT is independently seeking a quality review of the current arrangements (as at 31 January 2010).

6.7 In All Areas

6.7.1 We will work for the reduction or removal of inequalities, including inequalities in the awareness of, access to and outcomes from the use of mental health services, across different cultural, ethnic, gender, religious, age and socio-economic groups.

This will involve engagement and research work to improve the understanding of local cultures and ethnic groups, especially of the differing effects of stigma and discrimination in different groups and of the best ways to address the particular needs of different groups.

Research will also address known inequalities, for instance the disproportionately high number of black people whose first contact with services is at the acute stage.

We will research the effects of discrimination or stigma on minorities whose position has not been studied in depth recently\(^{16}\).

6.7.2 We will promote service user and carer involvement in all areas of service provision and in the development of mental health services in future.

6.7.3 We will look to providers of services to ensure that when a services are age specific that transition between these services are seamless and continue to meet the needs of the individual.

6.7.4 We will, through the implementation of local Older People Mental Health Strategies, promote a measurable improvement in services for older people, especially as they relate to dementia and hospitalisation, to address inequalities of access and to deliver services on the basis of need rather than age.

6.7.5 We will encourage strong multi-agency collaboration and commissioning, co-ordinating the work of mental health and social services with agencies dealing with housing, transport, welfare, benefits, employment, education and other services.

This will lead to a ‘whole-system’ or ‘holistic’ approach to support and treatment and to an ability to use the entire market when commissioning mental health services.

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\(^{16}\) For instance the disabled and the LGBT (lesbian/gay/bisexual/transgender) minorities.
7. Turning the Vision into Reality:

To achieve the objectives of this strategy change will be needed both to the way services are thought of and provided and to the way the public understand and use them. This section outlines:

- the model of care underlying the changes we propose;
- the reasons for these changes;
- the benefits we hope to see as a result;
- how we will work as commissioners to implement and performance-manage these changes.

7.1 The Changing Model of Care

We are aiming for a model of care in which service users can determine their own route to recovery and the role of the professional is to support them in achieving this.

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7.1.1 The main aims of the changing care model will be to provide information, advice and care to people suffering from mental health problems at the earliest stage possible, to encourage and support their recovery to as full and active a life as possible within the community, and to provide continuous care and support to those whose condition is degenerative or irreversible.

Ideally, some mental health problems will be prevented; if problems do develop, services will intervene as soon as possible to prevent longer-term or more severe needs; if people develop severe problems, their care will be as personalised as possible. In all of this, we aim to ensure that people have a choice of services which are safe and effective for them.

7.1.2 The implications of this model can be seen across each of the three main care pathways within mental health services: common mental health problems (such as anxiety and depression); serious and enduring mental health problems (such as schizophrenia and bipolar disorders); and dementias. The table below shows the services and approaches we wish to develop and promote over the lifetime of this strategy.
<table>
<thead>
<tr>
<th>COMMON MENTAL HEALTH PROBLEMS</th>
<th>SERIOUS AND ENDURING MENTAL ILLNESS</th>
<th>DEMENTIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>PREVENTION</td>
<td>Mental health education</td>
<td>General health promotion (“What’s good for your heart is good for your head”)</td>
</tr>
<tr>
<td></td>
<td>Mental health education and stigma-reduction work</td>
<td></td>
</tr>
<tr>
<td>EARLY INTERVENTION</td>
<td>Primary care based psychological therapies and practical support</td>
<td>Early intervention in Psychosis, Crisis Intervention and Home Treatment</td>
</tr>
<tr>
<td></td>
<td>Better adolescent transitions</td>
<td>Better adolescent transitions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Peer support</td>
</tr>
<tr>
<td>PERSONALISED CARE</td>
<td>Choose and book</td>
<td>Personal care budgets</td>
</tr>
<tr>
<td></td>
<td>Support to retain or attain employment</td>
<td>Support for recovery</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Peer support</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Advocacy and financial advice</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Choose and book</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Outreach services</td>
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<td></td>
<td>Support for carers</td>
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<td></td>
<td></td>
<td>Personal care budgets</td>
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<td>Advocacy and financial advice</td>
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<td>Peer support</td>
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<td></td>
<td></td>
<td>Support for carers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dementia care advisers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>End-of-life care</td>
</tr>
</tbody>
</table>
7.1.3 A wide range of services will be provided with medical and clinical services being used as and when needed, but only forming one element of the services available to service users and carers.
7.2 The Reasons for Making these Changes

7.2.1 We are adopting this care model for four main reasons:
- it is consistent with national policy expectations;
- it is consistent with what local service users and carers have told us they want;
- it is supported by local statistical evidence;
- it is supported by research and by good practice evidence.

National Policy Expectations

7.2.2 This service direction is consistent with all key aspects of national policy, in particular New Horizons, the National Dementia Strategy, Better Healthcare Closer to Home and Transforming Adult Social Care.

Local People’s Priorities

7.2.3 As explained in more detail in section 4 above, service users and carers have told us that:
- they are keen to see a reduction in the stigma associated with mental health problems;
- they would like to see investment in community services and preventative services in preference to spending on inpatient facilities;
- community services should be better co-ordinated and the ways of accessing them less confusing;
- services need to improve their cultural sensitivity;
- carers need better support.

7.2.4 Local GPs are keen to see improvements in the mental health services available to those many of their practice population who do not require specialist secondary care.

Statistical evidence

7.2.5 As set out in Sections 2 and 3, we know that:
- local populations are growing, as are the numbers of people with mental health problems of various types;
- we will have little or no additional money - indeed we expect to have less;
- there is falling demand for inpatient services;
- we have nearly 30% more inpatient bed days than the England average despite Sutton and Merton being areas of relatively low need.

Research and good practice

7.2.7 The National Dementia Strategy was based on a comprehensive review of current research and good practice evidence, and we are confident that our approach to this care pathway is consistent with that strategy.

7.2.8 There is strong evidence for approaches to serious and enduring psychotic illnesses favouring early intervention in psychosis and for the effectiveness of Crisis Resolution/Home Treatment teams. This was first summarised in the National Service Framework for Mental Health and added to by continuing experience since then. These approaches are endorsed by the relevant National Institute for Clinical Excellence (NICE) guidelines as well17.

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17 For instance the clinical guidelines for schizophrenia, March 2009.
7.2.9 The Improving Access to Psychological Therapies programme incorporated formally evaluated pilot schemes in both Newham and Doncaster, and has clearly demonstrated benefits in health and social functioning arising from primary care based early intervention services.

7.2.10 There is good evidence of the value of mental health education programmes in schools (for example, the FRIENDS initiative in Bath). Adult programmes are less well researched but, for example, the STEPS approach in Glasgow is showing promising signs from a community-based mental health education approach. There is also good evidence that promoting community well-being (through, for example, supporting voluntary organisations or access to green spaces) can reduce the risk of common mental and physical health problems.

7.2.11 Taking these sources of evidence together, we are confident that there is a strong rationale for the model we are providing.

7.3 Intended Benefits

7.3.1 Some of the changes proposed should have relatively short time gap between our commissioning action and the intended benefit starting to being realised and it should be possible to trace a clear relationship between the two. This should, for example, be the case with improvements in crisis or memory assessment services.

7.3.2 Some commissioning actions may take much longer to take effect, for example those for mental health education and general health promotion work.

7.3.3 Acknowledging these differences, the following table shows the intended benefits arising from our main objectives. S indicates a shorter and L a longer timescale for the delivery of these benefits.

<table>
<thead>
<tr>
<th>Clinical and Social outcomes (measurable improvements in the lives of service users and carers)</th>
<th>Adherence to evidence-based practice</th>
<th>Service user/carer experience</th>
<th>Safety (including untoward incidents)</th>
<th>Access (including waiting, retention and choice)</th>
<th>Equity (Age, locality, ethnicity, gender, disability, sexuality)</th>
<th>Productivity (cost per unit of service)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rebalance community and inpatient services (year 1)</td>
<td>S</td>
<td>S</td>
<td>S</td>
<td>S</td>
<td>S</td>
<td>S</td>
</tr>
<tr>
<td>Education in mental health matters (years 1 to 5)</td>
<td>L</td>
<td>L</td>
<td>L</td>
<td>L</td>
<td>L</td>
<td>L</td>
</tr>
<tr>
<td>Early intervention, diagnosis and referral (years 1 to 5)</td>
<td>S</td>
<td>S</td>
<td>S</td>
<td>S</td>
<td>S</td>
<td>S</td>
</tr>
<tr>
<td>Personalised care (year 1)</td>
<td>S</td>
<td>S</td>
<td>S</td>
<td>S</td>
<td>S</td>
<td>S</td>
</tr>
<tr>
<td>Support for carers (years 1 to 5)</td>
<td>S</td>
<td>S</td>
<td>S</td>
<td>S</td>
<td>S</td>
<td>S</td>
</tr>
<tr>
<td>Multi-agency collaboration (years 1 to 5)</td>
<td>S</td>
<td>S</td>
<td>S</td>
<td>S</td>
<td>S</td>
<td>S</td>
</tr>
<tr>
<td>Better transitions between age groups (years 1 to 5)</td>
<td>S</td>
<td>S</td>
<td>S</td>
<td>S</td>
<td>S</td>
<td>S</td>
</tr>
<tr>
<td>Dementia (years 1 to 5)</td>
<td>S</td>
<td>S</td>
<td>S</td>
<td>S</td>
<td>S</td>
<td>S</td>
</tr>
<tr>
<td>Cultural awareness (years 1 to 5)</td>
<td>S</td>
<td>S</td>
<td>S</td>
<td>S</td>
<td>S</td>
<td>S</td>
</tr>
<tr>
<td>World Class Commissioning (year 1)</td>
<td>S</td>
<td>S</td>
<td>S</td>
<td>S</td>
<td>S</td>
<td>S</td>
</tr>
</tbody>
</table>
7.4 Implementation and Performance Management

Effective use of the evidence-based care pathways is the best way of improving quality and equitability. Service users and their quality of life must be at the core of service delivery. Their views plus the views of carers, the public and staff must shape care pathway outcome measures and performance frameworks must increasingly focus on these outcome measures.

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7.4.1 Delivering this programme of change will be a demanding task, requiring close co-operation with all of our various partners. This is a five-year programme, and the changes and improvements proposed will happen gradually over that time, not all in year one.

7.4.2 As part of the commissioning process:

- We are committed to improving the choice of services and providers available in Sutton and Merton. We will therefore seek opportunities for new providers to offer additional or alternative services – we will particularly welcome such opportunities to develop local and innovative services through independent providers.

- We will work closely with neighbouring boroughs on services which require change across South West London as a whole, for example the number and location of inpatient beds.

- We will also work closely with practice-based commissioners, and expect increasingly to work to concentrate our commissioning processes. This will be linked to the development of primary and community care organisations that provide a range of different services.

- We are keen to pursue early opportunities for activity- or caseload-based payment systems, and we anticipate use of associated care systems to classify and plan activity for our changing services.

- We will 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 develop and agree sets of information which will include data about all the aspects of performance and incorporating monitoring data related to the achievement of each commissioning intention.

- We will look to ensure that inpatients facilities reflect modern practice, conform to national standards (for instance in the provision of single-sex wards) and offer a therapeutic environment and care model.

- We will develop a clear process of governance and evaluation, ensuring progress is regularly reviewed, resources adjusted accordingly and plans revised where necessary.

- We will ensure that the equalities performance of all providers is effectively monitored in areas such as:
  - service user monitoring data;
  - staff training and cultural competence;
  - access to services;
  - provision of information;
• completion of Equality Impact Assessments on the services and policies provided.

This will be done using Service Level Agreements (SLAs), by the setting of performance indicators and targets, and through a continuous provider monitoring process.

• We will ensure that there is continuous engagement with and involvement of our local communities. This engagement will be important when identifying changing needs, determining the shape of future developments and measuring the effects of changes to services against the spending and activity put into them.

• We will work closely with Sutton and Merton LINks in particular both on continuous engagement and on projects relating to the development and implementation of the strategy.

• We will develop methods and standards for monitoring service providers to ensure that the services offered are effective, of good quality and realistically priced.

• To support the move to personalised budgets we will develop framework contracts, approved provider lists and processes by which providers can bid for individual contracts without the anonymity of the service user being compromised. We will ensure that service users have access to the information they need to choose services from provider lists.
Glossary:

**Assertive Outreach (AO)**
*A way of working* with people who do not for a variety of reasons effectively engage with mental health services.

**Care Pathway**
*A defined process* for the care and treatment of health problems from referral and assessment through to resolution.

**Care Quality Commission (CQC)**
The independent regulator of health and social care in England.

**Cognitive Behavioural Therapy (CBT, cCBT)**
*A ‘talking therapy’* aimed at helping people to understand and change their thoughts and behaviour. This therapy can also be provided through [computer services](#) (cCBT).

**Community Mental Health Team (CMHT)**
*A multi-disciplinary team* which aims to deal with a wide range of mental health and social needs in the community.

**Crisis Resolution / Home Treatment (CR/HT)**
*Treatment and support* after discharge and in crisis offered as close to home as is possible.

**Early Intervention (EI)**
The detection and treatment of psychosis at an early stage of the illness.

**Health and Social Care Advisory Service (HASCAS)**
The independent mental health service evidence-based development organisation.

**Improving Access to Psychological Therapies (IAPT)**
The NHS programme supporting the development of a range of psychological therapies for the treatment of depression and anxiety (including CBT and IPT).

**Interpersonal Psychotherapy (IPT)**
Psychotherapy that concentrates on problems in personal relationships and aims to improve interpersonal skills.

**Primary Care Trust (PCT)**
The NHS organisation providing or commissioning a variety of services at a local community and borough level. Many PCTs are renaming themselves to make it clearer what their function is – “Sutton and Merton PCT” is now “NHS Sutton and Merton”.

**Psychological Therapies in Primary Care (PTiPC)**
The Sutton and Merton service providing IAPT.

**South West London and St George’s Mental Health NHS Trust (SWLStG)**
The Mental Health Trust covering the boroughs of Kingston, Merton, Richmond, Sutton and Wandsworth.
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IAPT Programme
Imagine
Innovation Exchange
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Mental Health Providers Forum: Recovery Star
Merton Local Involvement Network (LINk)  
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NHS Mental Health Observatory  
Patient Advice and Liaison Service (PALS)  
Royal College of Psychiatrists Centre for Quality Improvement  
Sainsbury Centre for Mental Health  
SHIFT Programme: Tackling Stigma and Discrimination  
Sutton Local Involvement Network (LINk)  
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Work, Recovery and Inclusion  
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Commissioning IAPT for the Whole Community  
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Delivering Race Equality in Mental Health Care  
Equality in Later Life  
Equalities in Mental Health  
Mental Health and the Disability Discrimination Act  
Public Service Agreements: 15: Equalities  16: Socially Excluded Adults
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