Hillingdon Clinical Commissioning Group

Promoting mental wellbeing and enabling recovery from mental health problems for adults of all ages in Hillingdon:

A joint strategy for mental health And wellbeing 2013 – 2015

Summary Consultation Document

Consultation:

How can I have a say?

Promoting mental wellbeing and enabling recovery from mental health problems for adults of all ages in Hillingdon: a joint strategy for mental health and wellbeing, 2013 – 2015 is a strategy produced by the Hillingdon Clinical Commissioning Group and the London Borough of Hillingdon. We are consulting on the strategy and welcome your views.

The strategy is available from http://www.hillingdonccg.nhs.uk

Or copies can be obtained by writing to

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We welcome comments on this document. Please send your comments to:

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A glossary of terms used in this document has been included at the end of the document for your reference.

Promoting mental wellbeing and enabling recovery from mental health problems for adults of all ages in Hillingdon:

A joint strategy for mental health and wellbeing 2013 – 2015

Introduction

This strategy has been developed by Hillingdon Clinical Commissioning Group (Hillingdon CCG) and the London Borough of Hillingdon (LBH) working with people with mental health needs, carers and other agencies in Hillingdon. It is intended as a statement of vision for how mental health services should develop in the future, rather than a detailed plan of how this should be done. It is our intention that this more detailed work will be under-taken after we have consulted. We will consult further on specific changes as necessary.

The strategy covers the following people with mental health conditions:

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

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

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

- people who are at risk of developing mental health problems

Where are we now?

We have been modernising mental health services in Hillingdon as part of the implementation since 1999 when the National Services Framework for Mental Health was published by the government. The strategy agreed in 2008 delivered some significant improvements including:

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

We are, however, aware that there is more work to do in these areas and a need for some significant changes to services. The new strategy describes our vision and values and priorities for improvement 2013-15.

Our Vision & Values

We think that the vision agreed in 2008 remains relevant and appropriate to the population we serve. The new strategy will simply help us to move closer to achieving it.

Our Vision:

The Hillingdon vision for mental health and well-being in is that people living in Hillingdon will benefit from opportunities for positive mental well being, which includes involvement with community, friends and family; meaningful

Our Values:

In Hillingdon People with mental ill health should be able to:

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

About Hillingdon

The London Borough of Hillingdon is a vibrant outer London borough with a character all of its own. It is home to around 273,900 people, representing a vast range of cultures and nationalities. The population in Hillingdon is set to grow over the next 10 years. Estimates suggest that the population aged 16-64 years is growing by 1% per annum. The population aged 65 years and over is likely to grow

by 7% between 2012 and 2017. As it grows, our borough's population will become more ethnically diverse.

What we know

According to national statistics about 1 in 6 adults living in private households have a common mental health problem, such as depression, anxiety or phobias. Around 4.4% of people are likely to have some form of personality disorder. Severe mental disorders, such as schizophrenia and bipolar disorder, are much less prevalent at around 0.6%, with no significant variation between men and women.

Social Exclusion

People with mental health problems experience a greater degree of social exclusion than the general population. Many people experience their first episode of mental ill health in their late teens or early twenties, with serious consequences for education and employment prospects. People with mental health problems are nearly 3 times more likely to be in debt than the general population.

Using the government's Index of Multiple Deprivation out of 354 local authority areas, Hillingdon is ranked 157 on the basis of extent and intensity of deprivation (1 being the most deprived). Hillingdon is ranked 24 out of the 33 London boroughs. However, it is constituted of demographic zones ranging from very deprived to very affluent. The level of deprivation and social status of people within a particular population has a significant impact on its mental health status and therefore its need for mental health services. Mental health need in Hillingdon is estimated to be 18% lower than England as a whole.

Black & Minority Ethnic (BME) Groups

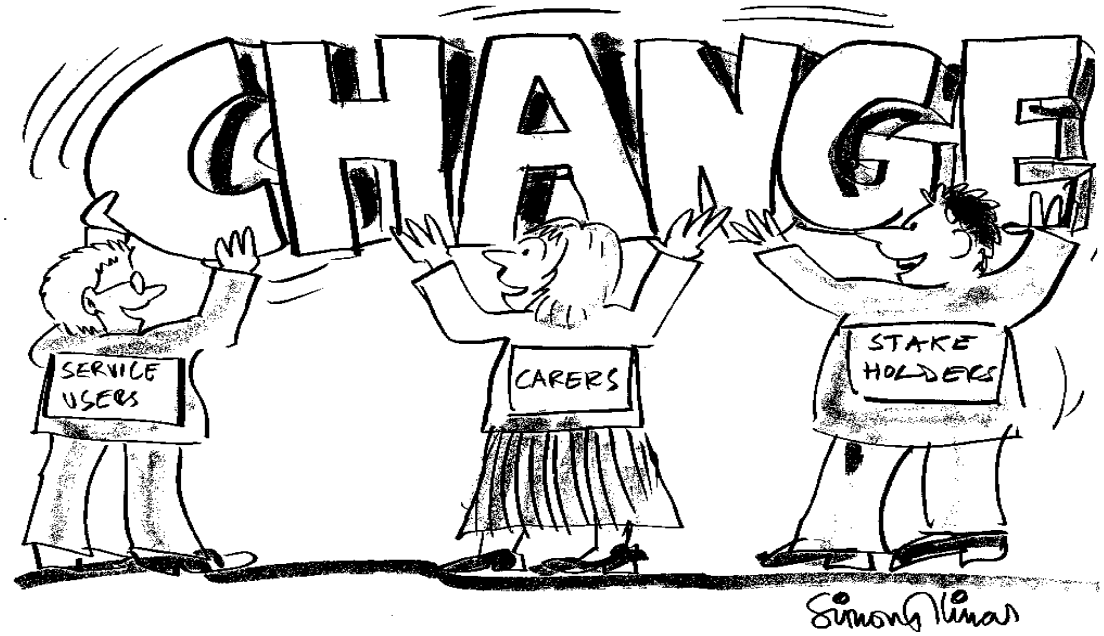
In 2008, significant differences and inequalities in service experience and outcome for some minority groups was identified. This is still the case in 2012. National evidence suggests that these differences can affect most areas of people's experience of health and social care services, including general practice and in-patient services as well as assessment and referral processes. Suicide rates are also identified as being high for people from particular minority ethnic groups. We plan to address these inequalities as a matter of priority during the timeframe of the strategy.

Current Support and services

Services for people with serious mental illness and common mental health problems such as depression and anxiety are provided by Central and North West London Mental Health Foundation Trust (CNWL). The Trust provides both inpatient and community based services. Housing and packages of support to enable people who are the most seriously ill to live in their own homes in the community

are provided by LBH. A small number of people with mental health problems are also supported in residential care or in nursing homes. Other more specialist services include those for people in the criminal justice system, personality disorders, eating disorders, a mother & baby unit, and services for mentally disordered offenders. Both Hillingdon CCG and LBH commission a range of services from voluntary organisations.

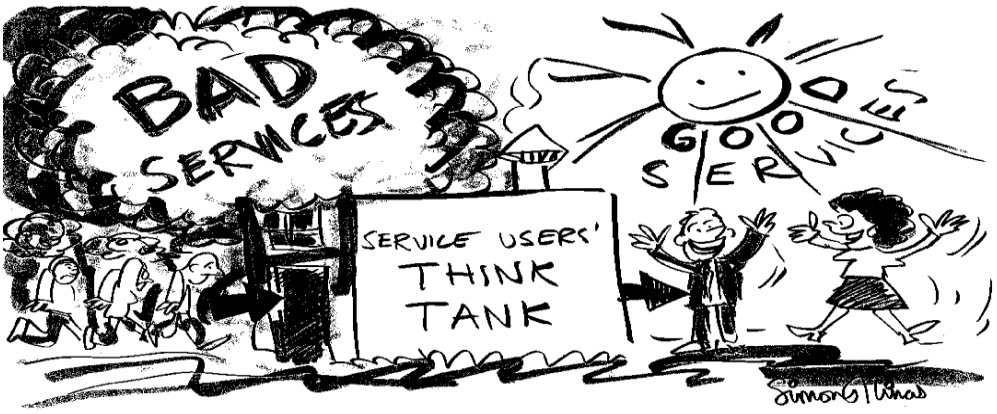
What people would like to change



Whilst local services are valued by people who use them, there is a consensus from users, carers, partners and stakeholders about what we need to change. This includes:

- Services need to be designed to promote mental wellbeing as well as to address mental ill health
- Better access is needed to services - particularly for hard to reach groups and offered in ways that are culturally appropriate
- Primary care and community-based services need to be developed as a key component of the mental health care system
- Increased inclusion and integration, helping people rebuild their lives, and engaging the wider community in supporting people's recovery is essential
- There should be a greater focus on outcomes and recovery across all mental health services
- Carers should be seen as partners in care and supported more effectively in their role

- Partnership working with the voluntary sector should be strengthened to help achieve this vision
- Access to services should be improved, including ensuring that specialist treatments and interventions are available
- Better use should be made of resources



What needs to be done?

Services will need to work seamlessly across agencies and we will develop our partnerships between health services, voluntary and independent organizations and with our local authority partners to ensure that people receive responsive and co-ordinated services. We will develop strategic partnerships to secure high quality services for adults with mental health problems. A wide range of providers will be encouraged to engage in order to provide choice and appropriate services.

There will be a focus on commissioning to evidence-based models and practice, ensuring that services demonstrate outcomes for users of the service, as outlined in the strategy. We will seek to commission services which actively and creatively reflect the diverse needs of our local communities ensuring value for money and best use of available resources.

The refreshed strategy aims to continue to help services to move towards the goals laid out in the 2008 strategy. We have developed action plans that will assist with attaining the goals not achieved and continue to improve services that have already progressed. (See appendices.)

We aim to prioritise:

- Implementing innovative approaches to the improvement of mental wellbeing
- Promoting approaches to care that are empowering and de-stigmatising and address inequalities
- Enabling primary care to increase their role in providing mental health care by developing primary care based mental health services

- Improving access: providing the best care at the time it is needed
- Improving client experience, recovery and outcomes
- Providing care in community settings as far as possible, making appropriate use of inpatient services
- Promoting independence by increasing the supply of supported housing and providing personalised packages of support
- Promoting independence by improving access to community support and activities
- Ensuring that people's mental and physical health care needs are addressed in a co-ordinated way
- Recognising the contribution of carers and improving support to enable them to continue in their caring role
- Improving the assessment, treatment and support provided for people with dementia; in particular, improving the rate of diagnosis and providing support and treatment earlier in the course of the disease
- Ensuring the involvement of service users and carers
- Improving the use of resources

These priorities will enable us to continue to address the following key themes, identified in 2008 and also underpinning this strategy:

Key Theme 1

Promotion of mental wellbeing (including recovery)

We aim to: -

- promote good mental wellbeing for all and reduce levels of distress
- ensure services and interventions promote overall mental wellbeing
- provide faster access to therapies
- focus upon 'the recovery model' to be adopted by all services
- implement the enablement agenda with appropriate support and services being in place

We will know we have made a difference if:

- More people are recovering and living independently and/or with support in their own homes
- More people are well and able to stay in their own homes and feel they contribute to and are part of their local community
- More people are able to retain or gain employment or access training opportunities
- There is a reduction in the use of acute and rehabilitation beds and fewer people are placed in out-of borough services

Key Theme 2

Improve access to services for all those who need them

We aim to: -

- Offer mental health care and support in more appropriate settings with options in the choices of care available locally
- Have easy access to up to date and accurate information about what help is available
- Simplify access to care in a crisis
- Support people to access the most appropriate support for their individual needs and goals
- Ensure that there is timely access to the most effective specialist interventions and treatments
- Provide diagnose and treatment as early as possible in the course of an individual's illness

We will know we have made a difference if:

- Access to mental health and support services is easier for everyone, including for groups that are hard to reach
- Early diagnosis and intervention is available wherever possible
- Anyone in need of a mental health service, or their carer is able to find out what services are available and how to access them quickly and efficiently
- Services are targeted to those with most need
- People with common mental health problems are able to access the most appropriate treatment and support to recover quickly
- Mental health care and support is available in more appropriate community settings i.e. out of hospital
- Staff in a wide range of agencies are able to understand and meet the basic mental health needs of their service users – and/or know what mental health services are available and how they can be accessed
- For those with the most serious problems, inpatient treatment should be available when needed, with streamlined access to the right person, particularly in a crisis

Key Theme 3

Develop primary care and community-based services as a key component of the mental health care system and shift care from secondary to primary care settings wherever possible

We aim to:-

- Configure local services to reduce the numbers of people needing to use services out of area
- Provide better joined up locally based services
- Provide more mental health care in GP surgeries and other community settings by shifting resources from specialist mental health services
- Reduce the use of hospital based outpatients
- Reduce overall admissions to hospital by creating alternatives and preventing crises by providing effective assessment and treatment

We will know we have made a difference if: -

- More treatment is provided locally; the number of out of borough placements is reduced
- More people are supported and treated by GPs and primary care practitioners (with support from specialist mental health services) and there are fewer people on the caseload of specialist mental health services

Key Theme 4

Tackle social exclusion and reduce inequalities

We aim to:

- Provide services for people with mental health needs which are integrated into other services irrespectively of age, gender, sexual orientation, disability, religion, ethnicity and culture.
- Support service users to find employment, training or other development opportunities
- Review the employment practices of LBH and local health services to extend opportunities for service users
- Ensure services are able to work effectively with all of Hillingdon's diverse communities
- Improve access for people from minority ethnic communities to appropriate services
- Establish flexible services offering levels of support appropriate to service users' needs at the time

- Improve the availability of suitable housing and support people to continue to live confidently in their own homes

- Implement the recovery model and focus on outcomes for service users and carers

We will know we have made a difference if:

- More people are accessing training and opportunities to gain work experience
- More people are in employment
- People with mental health needs are supported to find employment with major employers within Hillingdon
- There is an increase in the amount of support offered within a community setting as compared with that provided in hospital
- Services for people with mental health needs are better integrated with other community services e.g. colleges, leisure centres, community centres
- A wider range of housing support options is available to help people remain in their own homes
- More people are taking part in education and leisure activities that they want to do in the community

Key Theme 5

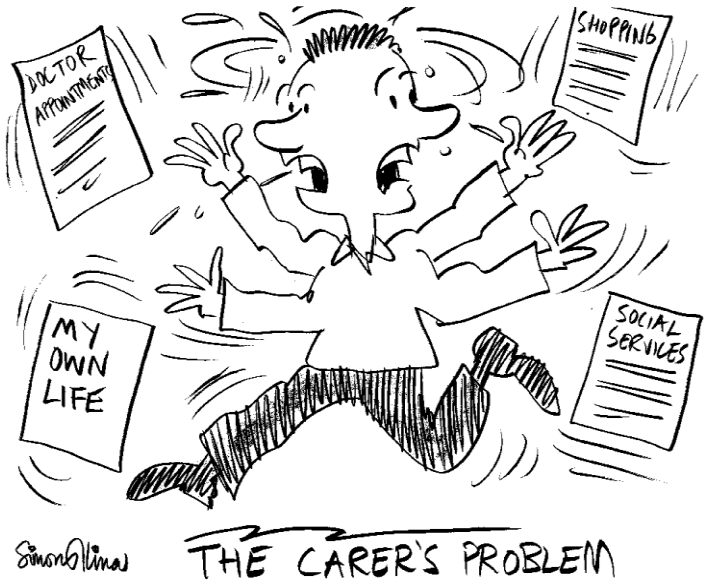
Put users and carers at the heart of services with more control over how services are used

We aim to:-

- Increase the control and range of choices people have in seeking assistance and support in meeting their mental health and wellbeing needs.
- Effectively manage risks for individuals and organisations of greater user choice
- Redesign the delivery of some areas of acute care and community services including ensuring that the contribution and needs of carers is recognised and considered when developing care plans for service users
- Increase the use of personalised support mechanisms like direct payments and personal budgets
- Ensure that carers have access to an assessment of their own needs and the information, treatment and support required to meet these assessed needs
- Ensure that all assessments are focused on the outcomes and goals for personal recovery of the individual service user and, where appropriate, ensure the full and active involvement of users and carers

We will know we have made a difference if: -

- More carers have had an assessment of their own needs and are provided with a plan to address those needs
- More carers of people with mental health problems feel supported and are able to continue in their caring role
- There are fewer crises created by breakdowns in carers'ability to continue caring
- More people with mental health problems are moving to recovery and able to live independently and/or with support in their own homes



Key Theme 6

Improved pathways and choice

We aim to:-

- Provide better joined up locally based services

- Provide more mental health care in GP surgeries and other community settings by shifting resources from specialist mental health services, or by ensuring more specialist services are delivered in community settings
- Reduce the use of hospital based services including acute beds and outpatient appointments
- Further reduce overall admissions to hospital by creating alternatives
- Improve access and utilisation of key services in line with best practice
- Ensure services are joined up with no cracks to fall down
- Ensure that there is timely access to the most effective specialist interventions and treatments

We will know we have made a difference if: -

- More treatment is provided within the Borough; the number of out of borough placements is reduced
- People have timely access to specialist assessment and treatment
- More specialist assessment and treatment is provided in community settings, such as GP surgeries rather than in hospital

Key Theme 7

Ensure high quality, effective and efficient services

We aim to:-

- Ensure that there are clearly defined care pathways that enable access to appropriate treatment and define the assessment, treatment and support that service users and their carers can expect to access for a specific illness or problem
- Measure and monitor improvements in service quality
- Make plans for the future using the best information available
- Understand what works well nationally and locally and use this information to inform us about the development of services
- Keep training, developing and monitoring the skills of people working with people with mental health needs
- Ensure the use of money and people who work in services is linked to achieving clear outcomes for service users
- Ensure that people who use services are involved in setting and monitoring quality standards and outcomes from services

We will know we have made a difference if: -

- There are clearly defined care pathways
- Services are assessed against quality standards and the outcomes are reported on
- We can demonstrate that we are making better and/or the best use of the money that we have
- Staff working in mental health services are receiving effective training to support them to do their job

- More people with mental health problems are moving to recovery more quickly
- More carers of people with mental health problems are supported to continue in their caring role

Glossary

Acute Care	The treatment of an illness for a relatively short period of time for a severe episode of illness.
Bi-polar disorder	A psychiatric condition that causes recurrent episodes of significant disturbance in a person's mood, energy, and ability to function. Also known as manic-depressive illness
Care plan	A plan of the treatment for an individual who is receiving health or social care. It will normally follow an assessment and be agreed between the person receiving care and the assessor.
Care Programme Approach (CPA)	A way of co-ordinating community health services for people with mental health problems in which one person co-ordinates all aspects of your care - including health and social care.
Carer/ carers	A person who provides support and looks after someone. In this document we only refer to informal carers (e.g. a member of the family) not paid carers.
Direct payments	A payment for people assessed as needing help from social services, who then arrange and pay for their own care and support.
Dual diagnosis	This term applies to people who have both mental heath and drug or alcohol problems.
Economically Inactive	People who are not in work, but who do not satisfy all the criteria for unemployment i.e. wanting a job, seeking a job in the last four weeks and available to start in the next two. The main groups classed as economically inactive are those looking after the family and home, students and those who are long-term sick or disabled.
Enabling/enable	To make possible or give support to help make something happen
Individual budget	A scheme that allows people needing social care and associated services to decide the nature of the services they need. A key feature is a transparent allocation of resources that gives the individual a clear cash or notional sum for them to use on their care or support package.
Intervention	An action that is intended to alter the course of an illness.
Local implementation team	A forum that brings together statutory and non-statutory representatives together with user, carer and provider groups in order improve the experience of needs assessment, planning, delivery and service performance assessment for improvement. There are four partnership boards
Outcome	The consequence of an intervention. (See above)

Pathway or integrated care pathway	A multi-disciplinary outline of planned care designed to help a patient achieve a positive outcome during and after treatment.
Personalised	Services that are delivered to people in line with their wishes and their convenience.
Personality Disorder	Features of an individual's personality that forms a pattern of behaviour that does not help an individual adjust and function well within a social environment. A personality disorder can create problems for the individual because it causes conflict between that person and others or causes conflict within themselves.
Promoting Independence	A principle that underpins the delivery of health and social care services and stresses that care should aim to maintain and develop independence and respect people's dignity.
Provider	An agency that provides services to people – in this strategy will normally refer to an agency offering health , social care or housing services. The agency can be a public sector, voluntary or private sector organisation.
Psychosis/ Psychoses	A mental health disorder/s that produces disturbances in thinking and perception severe enough to distort an individual's perception of the world and of events within it.
Purchaser	An agency that purchases services on behalf of the population for which they are responsible. It may refer to a GP practice, a primary care trust, or a social services department.
Review	The periodic re-examination of a client's case to consider what changes to services or treatment are desirable.
Schizophrenia	A mental illness characterized by impairment in the perception or expression of reality, most commonly manifesting as auditory hallucinations, paranoid or bizarre delusions or disorganized speech and thinking in the context of significant social or occupational dysfunction.
Voluntary sector	Organisations that are independent of the Government, that work to achieve social, environmental or cultural aims, mainly reinvest any profits they make to help achieve those social, environmental or cultural aims. It includes community groups, co-operative, voluntary groups, charities and social enterprises.
Social exclusion	The government has defined social exclusion as "what can happen when people or areas suffer from a combination of linked problems such as unemployment, poor skills, low incomes, poor housing, high crime, bad health and family breakdown".
Stigma/ stigmatised	The prejudice or bigotry experienced by an individual who has a condition that society at large finds difficult to accept.
Transition	A time of significant change for a person e.g. where a person is moving from childhood (and being at school) to adulthood (and going to work or college)
Wellbeing	The state of feeling healthy and happy

Appendix 1: Hillingdon CCG and LBH joint plan for the improvement of services for adults with mental health problems 2013-15

Objective	Actions	Organisation	Year
Promote mental health and wellbeing and early intervention through the prioritisation and implementation of the evidence base for effective mental wellbeing and mental health promotion interventions	Applying the evidence base for effective mental health interventions, the Public Health department will develop and implement programmes that: • Address health inequalities • Promote positive mental wellbeing and mental health in all groups in the community by ensuring that area based groups across the borough consider and address mental health issues • Support early intervention Strategies will be developed to implement interventions already proven to be effective in the borough The mental health joint strategic needs assessment will be updated	**LBH** **LBH** **LBH**	**2013-15** **2013-15** **2013-15**
Agree and implement a suicide prevention strategy	Work with NHS Brent, NHS Ealing and NHS Harrow to agree a suicide prevention strategy building on the current draft.	**Hillingdon CCG and LBH**	**2013-15**
Support primary care to further develop their role in providing mental health services assessment, treatment and support by developing the mental health services infrastructure within primary care and enhancing arrangements for specialist mental health services support for primary care and ensuring that people whose mental health is stable are managed in primary care	Commission an enhanced community and primary care based mental health service that enables discharge from secondary care and ensures that assessment, treatment and support is provided in the least restrictive setting possible, thereby reducing specialist services activity and cost and re-investing in primary care based mental health services and other community services: • Manage people with serious mental illness whose mental health condition is stable effectively • Provide effective assessment and treatment for people with serious mental illness in the community where possible/appropriate • Provide access to psychological therapies for people with common mental health problems in primary care/the community.	**Hillingdon CCG**	**2013-15**
Improve client experience of services, recovery and outcomes and ensure that mental health need is addressed effectively and efficiently through redesign of local services and the implementation of the evidence base for effective assessment, treatment and support	Develop and implement effective integrated care pathways to ensure timely access to effective, efficient health and social care assessment, treatment and support, ensuring access to specialist (evidence based) interventions and support	**Hillingdon CCG and LBH**	**2013-15**

Ensure that the specialist needs of service users are addressed effectively through service reconfiguration and redesign	Work with NW London commissioners and the National Commissioning Board to develop: i) Community forensic pathways ii) Community eating disorder pathways iii) Appropriate pathway from Heathrow and detention centres	**Hillingdon CCG**	**2013-15**
Provide assessment and treatment for acute physical and mental health problems in the least restrictive setting possible	Work with NW London commissioners to rationalise PICU provision Ensure effective and appropriate use of inpatient services to inform acute bed capacity and ensure onward transfer of care enables timely discharge and effective treatment and support in the community Improve the effectiveness and efficiency of rehabilitation services; this will include reviewing bed usage and determining the number required to meet need Evaluate the psychiatric liaison service in Hillingdon Hospital to reduce admissions ensuring admission only where necessary to treat a physical health care need and to ensure effective treatment of mental health problems of those admitted to hospital Ensure that arrangements are in place to provide effective support to service users in crisis	**Hillingdon CCG** **Hillingdon CCG** **Hillingdon CCG** **Hillingdon CCG and LBH**	**2013-15** **2013-15** **2012-13** **2013-14**
Ensure that the physical health care needs of people with mental health problems are addressed effectively	Ensure consistent and appropriate assessment and treatment for the physical health needs of people with mental health problems in primary care Ensure that secondary care services monitor clients' physical health care needs	**Hillingdon CCG** **Hillingdon CCG**	**2013-15** **2013-15**
Ensure effective use of resources	Continue to ensure the effective use of specialist mental health placements Maximise the benefit of current investment in order to make best use of resources (direct costs/indirect cost/capital charges) Explore the potential to improve effectiveness and efficiency through improvements to the model of: • Joint delivery • Joint commissioning	**Hillingdon CCG and LBH** **Hillingdon CCG** **Hillingdon CCG and LBH**	**2013-15** **2013-15** **2013-15**

Promote independence and empower people with mental health problems by increasing the supply of supported housing and providing personalised packages of support	Deliver an additional 55 units of supported housing accommodation for people with functional mental health problems Ensure the personalisation of existing supported housing services for people with mental health needs Ensure the personalisation of existing supported housing services for people with mental health problems	**LBH** **LBH** **LBH**	**2013-15** **2013-15** **2013-15**
Ensure that service users and carers have access to support that is as de-stigmatising and empowering as possible and addresses inequalities in mental health status	Work with key stakeholders to review all contracts with non-specialists mental health services commissioned by Hillingdon CCG and LBH in order to establish an integrated "community connections" service (may not be a single contract but contracts will be set within a framework specifying required outcomes) Work with bme and faith groups and leaders to identify and begin to address mental health inequalities	**Hillingdon CCG and LBH** **Hillingdon CCG and LBH**	**2013-15** **2013-15**
Ensure that service delivery is focussed on recovery, personalisation and outcomes for service users and carers	Implement nationally agreed performance measures (PROMS/CLOMS/ HoNOS) Explore the potential benefit of implementing a service user outcome measure e.g. Recovery Star	**Hillingdon CCG/LBH/ CNWL** **Hillingdon CCG/LBH/ CNWL**	**2013-14** **2013-14**
Improve support to carers of adults with mental health needs	Explore the need to establish a Borough wide forum for carers of people with mental health problems Establish a programme of courses run by the Recovery College so that a programme for carers in Hillingdon is provided routinely Address the psychological needs of carers by promoting awareness of the right of carers to referral to psychological therapies in their own right amongst GPs and other professionals Work with carers – individually and collectively - to find effective ways of providing support when the person they support is in crisis	**Hillingdon CCG/LBH/ CNWL** **Hillingdon CCG/LBH/ CNWL** **Hillingdon CCG/LBH/ CNWL** **Hillingdon CCG/LBH/ CNWL**	**2013-14** **2013-14** **2013-14** **2013-14**
Ensure the effective involvement of service users in service delivery and planning	Work with service users and key agencies to develop the Borough wide service user forum to ensure effective involvement of service users in service delivery and planning Establish a programme of courses run by the Recovery College so that a programme for service users in Hillingdon is provided routinely	**Hillingdon CCG/LBH/ CNWL** **Hillingdon CCG/CNWL**	**2013-15** **2013-15**

Appendix 2: Hillingdon CCG and LBH joint plan for the improvement of services for older adults with mental health problems 2013-15

Objective	Actions	Organisation	Year
Improve the rate of dementia diagnosis in order to promote early intervention	Maximise the availability of, and access to, memory assessment services	Hillingdon CCG	**2013-15**
Promote awareness of dementia	Ensure that organisations take action to promote knowledge of dementia of the general public and the health and social care workforce Provide dementia awareness training for the public and professionals.	Hillingdon CCG and LBH Hillingdon CCG and LBH	**2013-15** **2013-15**
Provide assessment and treatment for acute physical and mental health problems in the least restrictive setting possible	Evaluate the psychiatric liaison service in Hillingdon Hospital to ensure admission only where necessary to treat a physical health care needs and to ensure effective treatment of people with mental health problems admitted to hospital Seek to improve prevention and responses to crises, giving consideration to enhancing intermediate care and rapid response services to respond effectively to the needs of people with dementia and consider establishing an intensive home treatment service Further review bed use and determine whether further bed reductions (from 25) is indicated in order to facilitate the establishment of a community based service	Hillingdon CCG Hillingdon CCG and LBH Hillingdon CCG	2012-13 2013-14 2013-14
Promote independence and empower adults with mental health problems by increasing the supply of supported housing and providing personalised packages of support	Deliver 55 units of supported housing accommodation for people with functional mental health needs, including older adults. Deliver 69 units of extra care accommodation for people with dementia In partnership with registered providers and private sector developers Personalise existing supported housing services for people with mental health need Remodel the community support services for people with functional mental health needs provided by the third sector to reflect personalisation and the prevention agenda	LBH LBH LBH LBH	2013-15 2013-15 2013-15 2013-15

Ensure that the need for specialist mental health assessment, treatment and support of service users and carers is addressed effectively and efficiently through service reconfiguration and service redesign of local services	Implement the agreed care pathways for older adults with mental health problems, ensuring that they build on and interface with the recently agreed care pathways for older adults in Hillingdon	Hillingdon CCG and LBH	2013-14 2013-14 2013-14
	Establish a single point of access to LBH services	LBH	
	Improve community based assessment, treatment and support services, including exploring the cost/benefit of establishing intensive treatment and support to prevent and manage crises in the community	Hillingdon CCG	2013-15
	Find cost effective ways of improving support to carers to enable them to continue in their caring role: • Improve carers' assessment • Improve access to respite care • Explore the need for a night sitting service	Hillingdon CCG	2013-15
	Consider commissioning a dementia resource centre to provide a setting for both health and social care commissioned services	Hillingdon CCG and LBH	2013-15
	Remodel the community services supporting people with dementia to ensure that they are contributing to the delivery of the dementia pathway	Hillingdon CCG and LBH	2013-15
	Maximise the contribution of the voluntary sector to the provision of cost effective support; this includes maximising their contribution to: • Promoting awareness of dementia • Providing training to staff working with people with dementia • Providing information and advice to people with dementia and their carers • Supporting carers • Providing day and leisure activities to people with dementia	Hillingdon CCG and LBH	2013-15
	Agree a cost effective way of providing specialist advice effectively to residential and nursing home services in order to prevent escalation of need to avoid admission to inpatient or nursing home services	Hillingdon CCG	2013-15
	Review services and develop and implement care pathways to identify need and initiate improvements to services for people with early onset dementia	Hillingdon CCG and LBH	2013-15
	Review services and develop and implement care pathways and review services to identify need and initiate improvements to services for people with a learning disability who have dementia		