



**Central
Bedfordshire**



NHS

Bedfordshire

**Joint Commissioning
Strategy for
Mental Health Services
For Adults & Older
People
In
Central Bedfordshire**

2011 – 2014

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Joint Commissioning Strategy for Adults and Older People Mental Health and Wellbeing Services in Central Bedfordshire

Executive Summary

This Joint Commissioning Strategy for Adults and Older People Mental Health and Wellbeing Services in Central Bedfordshire has been developed in partnership with NHS Bedfordshire and Central Bedfordshire Council with the aim to show what we will do to improve the mental health and well-being of our population and the quality and accessibility of services for people with poor mental health.

Our aim is to commission services which promote good mental health and focus on achieving positive outcomes for the individuals who use them. We will fully engage with the Personalisation Agenda and support individuals to identify opportunities for their own care. Choice and independence will be fundamental to our response in supporting people in their recovery.

To transform the mental health and wellbeing services in Central Bedfordshire two new service models have been developed which form the framework for all service re-design activities; the Mental Health and Wellbeing Integrated Stepped Care Model and the Recovery Model. These models will ensure that the individual is at the centre of their treatment and care planning process and will receive the least intrusive intervention first and be stepped up and down as appropriate.

The views of people with mental health needs and their careers are driving our strategy and action plans, in the context of national and local policies and information.

Our focus to improve mental health and wellbeing services across Central Bedfordshire for the next three years can be summarised as follows:

- Improving mental health through wellbeing and prevention services
- Reducing waiting times for assessment and treatment
- Developing agreed care pathways for mild, moderate and severe mental health conditions
- Maintain people's mental health post-treatment through better primary and community care services.

Whilst responding to the national and local context, we are mindful that our proposals must also consider the current financial climate, remain affordable, and achieve good value for money throughout all services. These are challenging times for both NHS Bedfordshire and Central Bedfordshire Council which we will meet in partnership to ensure that we commissioning services that address the mental health and wellbeing needs of the people we serve.

Vision Statement

Through the implementation of this Strategy, NHS Bedfordshire and Central Bedfordshire Council aim to improve the mental health and well-being for Adults and Older People in Central Bedfordshire. By working in partnership with key stakeholders, service users and carers, we aim to deliver services which meet their needs at an early stage, in an effective manner and for the majority in a community setting.

We aim to commission services which promote good mental health and focus on achieving positive outcomes for the individuals who use them. We will fully engage with the Personalisation Agenda and support individuals to identify opportunities for their own care. Choice and independence will be fundamental to our response in supporting people in their recovery.

Purpose and Scope

Attitudes and approaches to the provision of health and social care have been going through a period of radical change during the last few years. Across the country, services are moving from a system characterised by a focus on treating illness and ill health to one where there is promotion of health, wellbeing and independence; from a focus on doing things to or for people to enabling people to do things for themselves; from care provided in institutional settings to a greater focus on prevention, early intervention and support for self care in the community setting. There is also an increasing recognition, borne out by evidence from research that concepts of mental and physical health do not exist in silos but are inextricably bound together in human beings. This demands a much more integrated approach to health care than has traditionally been the case. In the commissioning of services – that is – the planning, purchasing and monitoring of care, there is a shift away from a system of commissioning for volume and price to one that focuses on quality, efficiency and value.

In mental health care, these shifts present many challenges, not least because of the range of skills which people with mental health problems may need access. Commissioning co-ordinated services for individuals whose needs cross organisational boundaries between health, social care and physical and mental health services, requires that all services work together to ensure that people don't "fall between gaps" in the system.

The aim of the strategy is to ensure that Adults and Older People with mental health problems, and their carers, have their mental wellbeing needs identified and met wherever they are in the service system or in the community, without encountering discrimination or barriers to access to timely and effective interventions. For people with functional mental health problems the clear view of the commissioning partners is that the ethos and evidence in current national policy and best practice literature does not support a differentiation in services available to those aged under and over 65. Indeed such differentiation is potentially discriminatory. Therefore a key principle of this strategy is that all mental health care to the 18+ population (apart from

dementia care), and all future service developments will need to address, explicitly, the imperative to tackle age discrimination in access to services. This will require a more integrated approach to mental and physical health and social care provision across existing age based services.

The strategy builds on national best practice and previous local work, including the achievements of the Mental Health Collaborative, the Joint Strategic Needs Assessment and the consultations and analyses of “A Healthier Bedfordshire” and around the “Section 75 Agreement”. It explicitly focuses on all the elements of the Quality, Innovation, Productivity and Prevention (QIPP) agenda. As the NHS and Local Authorities move forward in a time of financial uncertainty it is important that any new strategy is developed from a thorough needs analysis which includes these aspects. This strategy provides a rigorous platform to transform Mental Health services in Central Bedfordshire.

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Policy Framework

National Context

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

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

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

This shift has been summarised in a document published in December 2009 by the Department of Health: “**New Horizons: a shared vision for mental health.**” This describes itself as “a comprehensive programme of action for improving the mental well-being of the population and the services that care for people with poor mental health by 2020.” It aimed to influence organisations across national and local government, voluntary and statutory agencies, as well as local communities and individuals to work towards “a society that values mental well-being as much as physical health.” It also outlines the benefits of reducing the burden of mental illness and “unlocking the benefits of well-being in terms of physical health, educational attainment, employment and reduced crime.”

This message was re-enforced by the Government elected in 2010 and its new mental health strategy was published in February 2011 “**No health without mental health: a cross-government mental health outcomes strategy for people of all ages**”. It aims to improve people’s mental health

and well-being through high quality services and focuses on early intervention and prevention, recovery and challenging stigma and discrimination.

At a local level “No health without mental health: a cross-government mental health outcomes strategy for people of all ages” does not bring either specific new targets or new resources. Our task is therefore to interpret this vision within our overall approach to planning mental health services in Central Bedfordshire, emphasising the key objectives of:

- More people will have good mental health
- More people with mental health problems will recover
- More people with mental health problems will have good physical health
- More people will have a positive experience of care and support
- Fewer people will suffer avoidable harm
- Fewer people will experience stigma and discrimination

National Dementia Strategy

In 2007 it was estimated that there were over 700,000 people living with dementia in the UK (570,000 in England) and that this figure is likely to double over the next 30 years. (Dementia UK: The full report, London: Alzheimer Society) The average cost of caring for a person with dementia was estimated as £25,500 per year. 36% of these costs fall on informal carers, 41% on accommodation, 19% on social care and 8% on NHS. Two thirds of people with dementia live in their own homes with many being supported by informal carers.

The Department of Health (DH) announced that dementia would be a national priority in 2007 and “**Living Well with Dementia – A National Dementia Strategy**” was published by the Department of Health in February 2009. The DH acknowledged that dementia was the biggest challenge it had ever faced, largely due to the complexities of joining up health and social care departments and resources.

The vision in the national strategy is that services and society should transform their approach and attitudes to enable people with dementia and their carers to live well with dementia, no matter what the stage of their condition or where they are in the health and social care system. This is in contrast to the current situation where in many services people with dementia are simply ‘managed’.

In order to achieve this vision 17 objectives were identified specifying improvements in 3 key areas. Objectives 1 to 12 are grouped under 3 main headings to support a defined pathway for commissioning services:

- raising awareness and understanding,
- early diagnosis and support
- living well with dementia.

The remaining 5 objectives are cross cutting objectives which enable change to be implemented and include workforce development, commissioning, performance monitoring and evaluation and research. In addition there is a commitment to ensuring both national and regional support for the implementation of the strategy. A further objective to reduce the use of anti-psychotic medication was added following Professor Banerjee's review into the use of antipsychotic drugs for people with dementia which reported in November 2009.

The current government has re-iterated its commitment to the needs of people living with dementia and their carers and in 2010 identified the implementation of the National Dementia Strategy as one of its priorities. This was reflected in a number of announcements and initiatives with the four priorities for dementia being:

- Good quality early diagnosis and intervention for all
- Improved quality of care in general hospitals.
- Living well with dementia in care homes.
- Reduced use of antipsychotic medication.

More generally the improvement of community personal support services is integral to and underpins each of the four priorities as it supports early intervention, prevents premature admission to care homes and impacts on inappropriate admission to hospital and length of stay.

At the same time the government stated its commitment to ensuring there is a greater focus on accelerating the pace of improvement in dementia care through local delivery of quality outcomes and local accountability for achieving them. A key element of the outcomes-focused approach is ensuring greater transparency and provision of information to individuals. Nine statements have been proposed which capture what people with dementia have said they aspire to in terms of their health and social care systems.

By 2014, all people living with dementia in England should be able to say:

- I understand, so I make good decisions and provide for future decision making
- I get the treatment and support which are best for my dementia , and my life
- Those around me and looking after me are well supported
- I am treated with dignity and respect
- I know what I can do to help myself and who else can help me
- I can enjoy life
- I feel part of a community and I'm inspired to give something back
- I am confident my end of life wishes will be respected. I can expect a good death.

Both NHS Bedfordshire and Central Bedfordshire Council fully support both the vision described in “No health without mental health” and in the National Dementia Strategy.

Personalised Care

In all our commissioning, the issue of personalised care or personalisation is especially important, both in social care and health care.

A personal budget is offered to those who are eligible for publicly funded support, following completion by the service user of a supported self assessment. This budget is provided in order to meet the outcomes defined in the individual’s support/care plan, and can be taken as cash by the service user (a direct payment) or held by the Council/NHS Trust to commission services on the individual’s behalf. In other words, rather than a commissioner deciding what people need, individuals themselves decide.

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

Personalisation for mental health services will be a key action in Central Bedfordshire with the aims to:

- Make sure people with mental health problems can take as much control as possible over their support arrangements, to pursue their recovery and social inclusion on their own terms
- Commit to developing a more equal and creative relationship between people using services and practitioners
- Close any gaps of understanding and procedure between local authorities and provider NHS Trusts to make sure self-directed social support can benefit people with mental health problems
- Have relationship-based rather than process-driven ways of working, changing your own personal practice as a community mental health worker or manager
- Deal effectively with the specific challenges of risk management, fluctuating conditions and public stigma to make sure people with mental health problems benefit equally from more choice and control
- Adapt job roles, the organisation of teams and the allocation of resources over time to make sure services can meet people’s needs and aspirations in more personalised ways.

The personal health budget is currently being piloted in England involving around half of the primary care trusts. The programme and its evaluation will explore who will benefit from personal health budgets, and how the NHS can make them work. The pilot programme is currently in its second year and will run until 2012.

Local context

The strategy builds on a wide range of local information and evidence, including:

Organisational change:

Following the creation of the Central Bedfordshire unitary authority, the opportunity must be taken to further develop joint working for people with mental health needs in services that were previously in separate organisations, such as social care, housing and leisure.

QIPP (Quality, Innovation, Productivity and Prevention)

These are testing times for public services. NHS commissioners, local authorities and providers of health and social care services have all agreed that they will only be able to transform health and care services if they work together so they can give local people seamless, integrated care pathways based on their needs rather than hindered by historic care boundaries. This is the QIPP challenge –quality, innovation, productivity and prevention – and the reform of the local health system. A number of work streams have been identified and one of them is looking at the modernisation of Mental Health services.

The overall aim of this work stream is to deliver mental health services that are primary care facing, while also delivering good quality measurable outcomes for service users. This will be achieved by transforming mental health services in the community and ensuring that these services are recovery focussed.

A number of projects have been identified which will over the next four years bring about the changes to local services. These include shifting resources from expensive hospital based secondary care mental health services to community based services, strengthening Primary Care services, transforming the Dementia Care and Common/Severe mental health pathways. These projects are reflected in the Implementation Plan.

A Healthier Bedfordshire – working with you for life, Dec 2009

NHS Bedfordshire and the unitary authorities carried out a range of consultation events and activities during the development of the strategic plan for people with mental health problems and this is what people have told us:

- People would prefer to have their mental health managed in primary care. They saw admission to inpatient units as not the most therapeutic and wanted contact with specialist mental health services only as a last resort.
- There was a strong sense of the need for robust crisis response services, particularly out of hours, with alternatives to admission being a high priority for many.
- Many people felt that housing and supported accommodation were a particular need.

- Service users should be given greater choice.
- Services should be improved for black and ethnic communities.
- Improvements should be made to mental health promotion.

Actions developed based on what people told us were identified as strategic priorities in **A Healthier Bedfordshire – 2 year Strategic Plan 2010/2011**. These priorities are reflected in the Mental Health Strategy Implementation Plan.

Central Bedfordshire Joint Strategic Needs Assessment 2010

The Joint Strategic Needs Assessment identified the following priorities which has informed development of this strategy:

- Developing a joint Social Care and Health Prevention Strategy to promote support models which work to minimise the need for acute hospital admission, residential and nursing home admission and also maximise the opportunities for people to remain in their own homes. These models include: provision of telecare and telehealth equipment packages, community aids and adaptations and use of third sector services such as Village Care Schemes.
- Developing clear pathways for information and advice on services of all vulnerable people and carers
- Ensuring implementation of local response to the National Dementia Strategy which addresses the needs of people with dementia aged under 65 years
- Ensuring that people can live well with dementia through early diagnosis and joint assessment; improved community-based support including carers and workforce education.
- Continue to work with the provider of specialist mental health services, South Essex Partnership NHS Trust (SEPT) as it improves quality and develops mental health services

Central Bedfordshire Mental Health Delivery Partnership:

Central Bedfordshire's Healthier Communities and Older People Partnership has developed a **Strategic Framework for 2010-2013**. This Partnership provides a structure for the eight Delivery Partnerships, and it brings together representatives from organisations, including NHS Bedfordshire and Housing representatives, from across the area to deliver the 7 health and well-being outcomes.

The Mental Health Delivery Partnership Board is one of the 8 Delivery Partnership Boards identified in the Healthier Communities and Older People Partnership Strategic Framework. Its main aims are to ensure:

- A wide range of high quality mental health services to enable people with mental health problems to reach their full potential

- More service users and carers within the community can take a lead role, exercising choice and control, in determining their own care needs and increase their integration within the commissioning of services.
- A greater focus on mental health at primary care level with increased opportunities for talking therapies.
- The commissioning of recovery focussed care pathways

The Key Priorities are reflected in the Mental Health Strategy Action Plan 2011-2014.

Supporting People

The Supporting People Programme provides housing related support services to help vulnerable people live independently. It is a key contributor to promoting and sustaining the independence of vulnerable people through the range of services it funds. This includes supported accommodation, community alarms, the housing improvement agency and floating support services. Supporting People also plays an important role in preventing premature entry to residential care and reducing the impact of health related problems connected to poor housing conditions.

This strategy complements the Central Bedfordshire Sustainable Community Strategy, NHS Bedfordshire's A Healthier Bedfordshire Strategy and the Central Bedfordshire Healthier Communities Strategy.

Within the vision of delivering sustainable growth, it is important that everyone within Central Bedfordshire is afforded the best opportunity to develop and that existing inequalities in health and economic status are reduced. The Central Bedfordshire Healthier Communities Strategy sets out how we will support people to have healthier lifestyles.

Public/Patient Voice Involvement

In addition to the consultations which helped to develop the "A Healthier Bedfordshire" document, a number of other consultation events took place which assisted in the formulation of this strategy.

In February 2010, an event was held by Central Bedfordshire Council, Bedford Borough Council and Luton Borough Council to consult with service users, carers and stakeholders on the proposed Mental Health Section 75 Agreement which was being developed with South Essex Partnership Trust for the provision of specialist mental health services. This event was organised to ensure that the Agreement would reflect the views of those attending and meet the aims and objectives for the provision of mental health services across Bedfordshire and Luton.

Priorities for the service users and carers were:

- Information and guidance to be easily available
- Employment

- Housing

Further information sharing events were organised in May 2010 by the Local LINK network and MIND to engage with service users and carers to increase their awareness of the services available.

The quarterly Central Bedfordshire Carers Forum held in February 2011 focussed on mental health services, with attendance and advice from local voluntary organisations and South Essex Partnership NHS Trust.

Rethink – Bedfordshire Carers Support Service – held a Supported Housing Event in July 2011 which highlighted the need for provision of supported living opportunities. Many carers have concerns about the lack of housing available to people with mental illness as well as a lack of opportunities for people to live independently from their families in a safe, supported environment. People with mental illness are vulnerable in the community when not in receipt of adequate support in their rehabilitation journey and this often results in additional pressures for family carers.

Summary of the Case for Change

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

- Whilst we have implemented the new NSF services in Central Bedfordshire, we have done less than other places to change the older patterns of service as a result. We have more inpatient beds, NHS rehabilitation beds, and larger Community Mental Health Team (CMHT) caseloads than evidence suggests we need in the future. The role of rehabilitation services should more clearly focus on actively promoting independence and the regaining of skills than is possible within relatively institutional service models.
- In addition, the introduction of new types of community teams (early intervention, crisis and home treatment, assertive outreach) has led to the future role of the CMHTs requiring redefinition.
- Through the personalisation process, we need to give people and their carers more control over their long-term support.
- We significantly need to improve the mental health services available in primary care, both to avoid people needing more specialist help, and to support people leaving more specialist services.
- We need to make local joined-up primary and social care systems work - including employment, recreation and further education support, which have preventative benefits. These systems offer the best use of resources for everyone.

- We want to stimulate and support the role of local voluntary sector providers.
- We have to live within our means, and to manage the improvements we want within the resources available. This means reducing our investment in some services.

Background

The Mental Health Foundation describes good mental health as ‘not simply the absence of diagnosable mental health problems. It is characterised by a person’s ability to fulfil a number of key functions and activities, including:

- the ability to learn
- the ability to feel, express and manage a range of positive and negative emotions
- the ability to form and maintain good relationships with others
- the ability to cope with and manage change and uncertainty’

Mental Health problems are very common and affect children and young people, working age adults and older adults. Problems range from every day worries to serious long term conditions which would require a range of psychiatric and psychological support. It is important to recognise that mental health does not exist in isolation; it has been well documented that good mental health is linked to good physical health. Rates of heart disease, hypertension, diabetes, stroke and epilepsy are all higher in those with schizophrenia or bipolar disorder compared to the remaining population. Good mental health is also linked to social health and is key to increased employment opportunities, improved educational attainment, reduced offending behaviour, reduced substance misuse, reduced social exclusion and reduced health inequalities.

Mental health conditions are poorly understood by the wider community and are often associated with fear or stigma. The Stigma Shout survey found that almost nine out of ten people with mental health problems reported the negative impact of stigma and discrimination in their lives. 69% of service users said they had been treated in a negative way because of their mental health problem and 71% said stigma and discrimination had stopped them doing the things they wanted to do. Individuals can feel debilitated by their condition which also adversely affects family and social relationships.

In 2009, the Department of Health published *New Horizons: A Shared Vision for Mental Health*. This Strategy aims to develop a society where people understand that their mental well-being is as important as their physical health. It sets out the expectation that good quality, effective mental health services which promote recovery are available to everyone who needs them. Statistics cited within *New Horizons* illustrate that mental health conditions are common:

- One in six adults will have a mental health problem at any one time

- Over half of all adults with mental health problems will have begun to develop them by the age of 14
- Just over 20% of working-age women and 17% of working-age men are affected by depression or anxiety
- Approximately 5% of men and 3% of women can be assessed as having a personality disorder and over 0.4% of individuals have a psychotic disorder such as schizophrenia or bipolar affective disorders
- 10% of children have a diagnosable mental health condition
- No other health condition matches mental ill health in the combined extent of prevalence, persistence and breadth of impact
- Half of those diagnosed with a common mental health problem are limited by their condition and around one fifth are disabled by it

Following on from this, New Horizons sets out two aims:

- To improve the mental health and well-being of the population
- To improve the quality and accessibility of services for people with poor mental health

It cites the importance of delivering a life span approach to mental health services if we are to commission an effective treatment and recovery system. This approach, aligned with the Think Family Agenda, takes account of how the problems of one individual can affect the whole family and works to co-ordinate the service offered to deliver a care system with positive outcomes.

To achieve these approaches, it is vital that key stakeholders work in partnership to deliver shared and agreed goals. This Strategy is a joint agreement between Central Bedfordshire Council, NHS Bedfordshire and partner agencies and all organisations have agreed to the attached implementation plan.

Demography

About Central Bedfordshire

Central Bedfordshire covers some 716 square kilometres from Leighton Buzzard and Dunstable in the west to Sandy and Arlesey in the east. It is classified as predominantly rural with just over half of the population living in rural areas. The area is diverse with picturesque villages, hamlets and historic market towns. However, it is at the same time one of the most rapidly growing areas in England and is planning for substantial additional development as part of the Milton Keynes and South Midlands Growth Area.

In terms of deprivation, no areas are in the 20% most deprived nationally. However, if deprivation is assessed at a small area level (known as Lower Super Output Areas – LSOAs) and compared with the East of England, there are nine LSOAs which fall within the 20% most deprived regionally, these are within Dunstable, Houghton Regis, Plantation, Northfields, Flitwick East and Sandy.

Overall employment in Central Bedfordshire is high at 83.8%, compared to the regional average of 77.6%. Although economic activity rates exceed national averages, Central Bedfordshire has been impacted by the recession with a total of 4,674 people claiming Job Seekers Allowance in March 2010, a rate of 2.9%.

The picture for adults' health and wellbeing in Central Bedfordshire is good, with life expectancy steadily increasing for both men and women. In the last ten years life expectancy has risen by 2.6 years for men to 79.1 years and by 1.4 years for women to 82.4 years.

Mental Health in Central Bedfordshire

Key findings:

The number of people with a mental health condition in Central Bedfordshire is predicted to rise, primarily as a result of the changing population structure. To the period 2016, the largest absolute increase is in neurotic disorders where it is estimated that 1 in 6 adults experience some sort of neurotic disorder over their lifetime, the most prevalent type being mixed anxiety and depression. The largest relative increase is in the number of people with dementia which predominantly affects people over 65 years. A table detailing the estimated prevalence of Mental Health Conditions in Central Bedfordshire is attached in appendix1.

Of the adults of working age with a mental health problem who seek help for their condition:

- 88% will be identified, assessed and treated in primary care;
- 10% will be treated in the community by mental health services;
- 2% will require acute admission.

Mortality and Morbidity

The national suicide rate is 10 suicides per 100,000 population, giving an expected rate of 25 suicides each year. There were 10 suicides in Central Bedfordshire in 2007/08 and 11 in 2008/09.

People with mental illness are 1.5 times more likely to die prematurely than those without mental illness partly due to suicide but also due to death from respiratory and other diseases. People with mental ill-health are also more likely than others to have strokes and coronary heart diseases (CHD) before the age of 55.

Inequalities / vulnerable groups:

There are strong links between social deprivation and mental ill health, therefore service provision and treatment should be focused towards the more deprived areas within Central Bedfordshire.

There are also a number of groups who are more likely to suffer from mental health problems, including:

- People who are unemployed, perceive themselves to be at risk of unemployment or are in poor quality employment
- People with drug and alcohol problems
- People who have been abused or who have been victims of domestic abuse
- Prisoners
- Lesbian, gay and bisexual people
- Veterans

Homelessness

Central Bedfordshire homelessness acceptances show that young people make up the majority of applicants. Qualitative interviews with homeless agencies revealed that rough sleepers' needs were not coherently addressed. Research suggests that both these groups have an increased risk of mental health problems. One third of young homeless people have also attempted suicide (Craig et al 1996) and the life expectancy of a rough sleeper who has been on the streets since the age of 16 years is 40.2 years (Halligan 2008). Meeting the mental health needs of these groups as well as accessing primary care services is a main priority across Bedfordshire as well as in Central Bedfordshire.

Key points

- Access to mental health services if not registered with a GP
- Support for Hostels/ temp accommodation providers when dealing with mental illness.
- Discharge processes, particularly late on a Friday.

VETERANS AND MENTAL HEALTH

In recent years there has been a greater focus on the health care available for veterans, as acknowledged by the Department of Health Gateway Reference 9222, issued in 2007, which increased their entitlement for priority treatment. This guidance was subsequently supplemented by a series of Department of Health documents, including the 2010/11 Operating Framework, which further identified the need to address veterans' poor health experiences. The term *veteran* refers to anyone who has experienced military service, or who is ex-military personnel and covers a very large and diverse range of the population.

It is impossible to be definitive about the number of veterans in Central Bedfordshire. A best estimate for the local Bedfordshire veteran population, extrapolating from the 2006 UK level data, and based on the county

population of approximately 413,000 , would be somewhere in the region of 32,000, as consistent with the above definitions.

The strategy needs to address the priority mental health and related issues of non-elderly or recent veterans through:

- ensuring sufficient capacity in evidence-based interventions commissioned for a range of disorders, including alcohol and drug misuse
- Recognition by all those referring veterans with a mental health problem that generic counselling is not effective for PTSD, but that there are effective alternative interventions.
- identification and targeting, by providers, of veterans at greatest risk of mental health problems and suicide, i.e. young male veterans with short service, territorials and reservists, through effective collection and monitoring of patient information.
- Improvement of mental health promotion and awareness

It would also be cost effective to offer support and training to veterans groups, developing them so that they can be commissioned to provide effective evidence-based interventions.

The actual or expected waiting time for veterans to access services, specifically mental health services, has been raised as a serious concern by veterans, voluntary agency staff and health professionals.

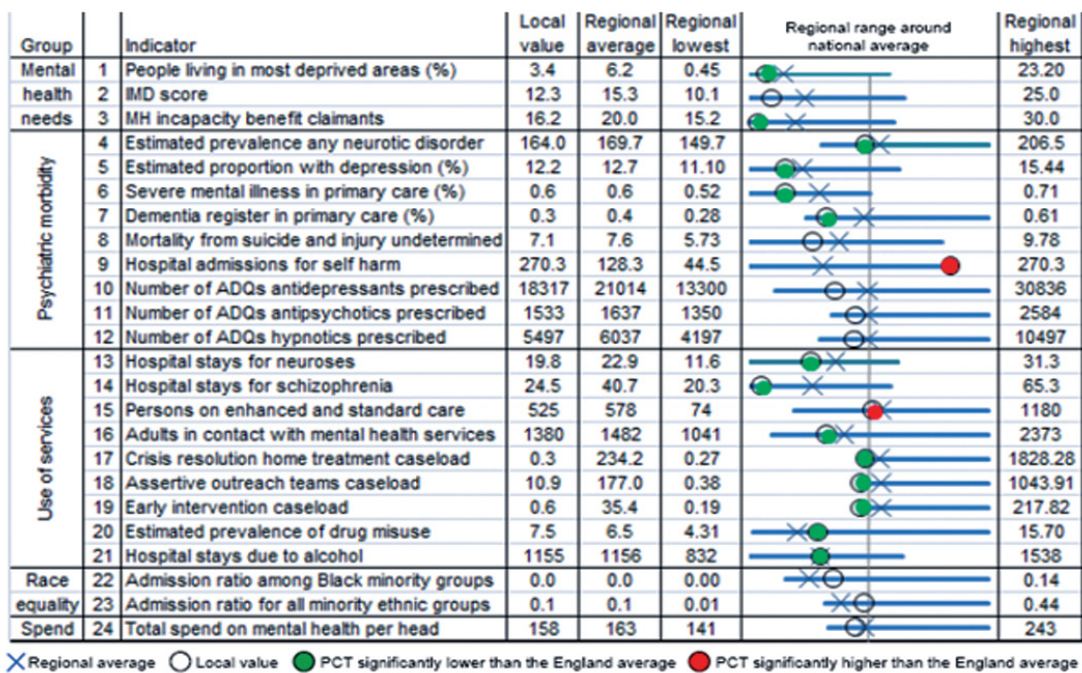
Key Points:

- Access to appropriate mental health services
- Training with professionals to recognise mental health issues related to service history
- Prioritisation of veterans for mental health treatment when related to service history.

NHS Bedfordshire has commissioned a Health Needs Assessment specifically around mental health requirements for veterans and their families which should be completed Winter 2011.

Outcomes

The most recent analysis by the eastern region public health observatory (at a Bedfordshire level only) used public health and outcome indicators where data was reliable and valid, rather than measures of service provision. This analysis showed Bedfordshire to be significantly higher than the England average for hospital admissions for self-harm (calendar years 2003 & 2004) and for persons on enhanced and standard care (2005/06)



Source: erpho

Best Practice in Mental Health

NICE guidance is available for specific mental health interventions and conditions (www.nice.org.uk)

New Horizons sets out the expectation that services to treat and care for people with mental health problems will be accessible to all who need them, based on the best available evidence and focused on recovery.

Improving the mental well-being of the population requires action on three main levels:

- Promoting mental well-being and reducing the risk factors for poor mental health
- Targeting interventions towards those who are at risk of developing mental health problems
- Promoting recovery and better outcomes for people who have mental health problems.

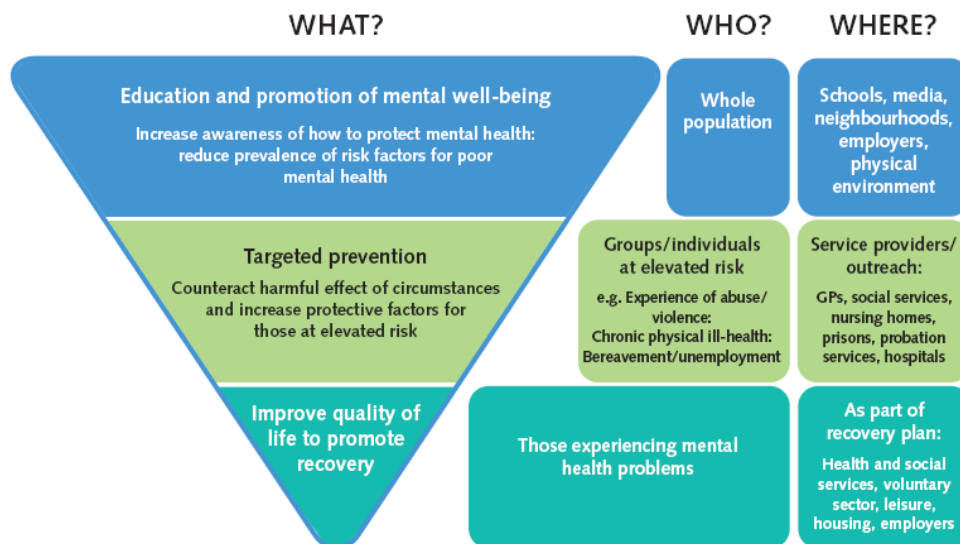


Figure 1 Approaches to improving mental well-being

Approaches known to be effective:

- Tackling stigma and discrimination which can discourage people from asking for help, make it harder for them to find or return to work and harder to form and maintain relationships
- Increasing self-care and personal responsibility for maintaining and improving mental health and well-being.
- Mental health and the workplace. Meaningful work is good for mental health and good mental health in the workplace is good for employers.
- Lifelong learning can improve skills, confidence and employment and may prevent cognitive decline

Dementia

Dementia is characterised by a collection of symptoms, including a decline in memory, reasoning and communication skills needed to carry out daily activities. It can affect adults of working age, but is most common in older people. One in six people over 80 years and one in 14 people over 65 years have a form of dementia.

Key Findings

The prevalence of dementia will rise significantly with the ageing population and is expected to increase by 21.5% between 2010 and 2016 in Central Bedfordshire. There are estimated to be a total of 2,416 people currently living with dementia and 1,056 people develop dementia each year in Central Bedfordshire.. It is estimated that 37% of people with dementia are known to service providers.

Estimated number of prevalent and incident cases of dementia in Central Bedfordshire

Age	Prevalence (total)		Incidence (new each year)	
	Males	Females	Males	Females
65-69 yrs	86	59	58	48
70-74 yrs	136	118	96	39
75-79 yrs	173	260	94	84
80-85 yrs	224	399	83	139
85+	251	710	100	316
Total	870	1546	430	626

Nationally it is estimated that 64.5% of people with severe dementia live in private households and 36.5% live in care homes, the proportion of those living in care homes rises with age. To examine this in more detail, based on the local population, an estimate of the numbers at each level of care are shown below. The levels of care services which roughly equate to the stage of dementia, level 1 being the least intensive care eg Low level community support and level 4 the highest eg care homes. The estimated number of people (known and unknown) who require care at each level is also shown below. Unsurprisingly, people are more likely to be known to services as their care levels increase.

Estimated number of people requiring each level of care in Central Bedfordshire:

Known to services?	Level 1	Males				Females			
		Level 2	Level 3	Level 4	Level 1	Level 2	Level 3	Level 4	
Known	22	31	58	182	31	46	117	373	
Unknown	197	123	136	121	275	184	272	249	
Total	219	154	194	303	306	230	389	622	

The incidence and prevalence of dementia rises exponentially with age and affects men and women in all social and ethnic groups. On this basis the wards with the highest proportion of older people are likely to be those with higher numbers of people with dementia.

General Practitioners hold registers of the number of people with dementia within their practices. These are likely to be an underestimate of actual prevalence.

The mean survival time following diagnosis is 4-5 years but this significantly influenced by access to good quality early diagnosis.

There is evidence that early provision of support at home can decrease institutionalisation by 22% and even in complex cases, case management can reduce admission to care homes by 6%.

There is limited evidence regarding the effectiveness of strategies to prevent dementia other than strategies to prevent cardiovascular disease generally

i.e. adequate physical activity, healthy eating, avoiding obesity, controlling blood pressure and cholesterol.

Service Baseline and gaps

A series of workshops were held in November / December 2009 to map current services and gaps in provision within Central Bedfordshire against the key objectives of the national dementia strategy (see table in appendix 2). Each objective was rated red, amber and green.

The workshops included service users, carers and third sector representatives as active participants in the process. Their views informed the outputs and identification of these priorities.

Priorities for dementia

- To raise awareness and understanding of dementia. To specifically increase the public's understanding towards dementia with an emphasis on early diagnosis. Also, to reduce discrimination and to challenge the stigma of dementia.
- To provide early diagnosis and support. This will include development of specialist memory assessment clinics, improving access to information about dementia following diagnosis, the development of dementia care advisors and developing peer support networks for people with dementia and their carers.
- To ensure people can live well with dementia. This will include improved community support, implementing the Carers Strategy for people with dementia, improved care in general hospitals and improved intermediate care for people with dementia.
- To improve workforce education and joint planning.
- The overall measure of success will be to enable service users, supported by their carers, to receive care in their own communities for longer. There will be a number of ways of measuring success, including the implementation of personalisation and user / client satisfaction.

Current Provision

Both Central Bedfordshire Council and NHS Bedfordshire commission mental health services in Central Bedford. The main provider is South Essex Partnership Trust (SEPT), although mental health providers in Milton Keynes and Cambridge and the third sector also provide services in our community.

Preventative Services and Social Inclusion

Mind

Bedfordshire and Luton Mind provides mental health, wellbeing and social care services across Central Bedfordshire in partnership with other local service providers and mental health service users. Services include:

- Step 2 IAPT (Improving Access to Psychological Therapies)
- Wellbeing Centres providing supported access to a wide range of services
- Volunteering and mentoring, using the Recovery Star model
- Mind groups for service users – social inclusion, weekday, weekend and evening social clubs and drop ins
- Youth in Mind service working with young people aged 14-25 using motivational and solution-focussed mentoring
- Therapeutic groups including stress/anxiety management and mental wellbeing
- Training – anxiety management, self esteem and assertiveness, understanding anger, sleep, stress, mental health first aid, mental health awareness)
- Access to work and maintaining employment support
- Support and access to exercise and healthy living options”

Alzheimer’s Society

Alzheimer’s Society is a membership organisation which works to improve the quality of life of people affected by dementia in England, Wales and Northern Ireland. Many of their members have personal experience of dementia as carers, health professionals or people with dementia themselves and their experience helps to inform the work of the society.

Local support includes:

- Day care
- Home care
- Befriending
- “Drop in” support groups
- Outings
- Training

Primary Care Mental Health Service

Most general mental health services are provided in primary care by GPs and the Psychological Therapy services; the Primary Care Counselling service and the Improving Access to Psychological Therapies (IAPT) service known as Step by Step. Within a stepped model of care a range of both individual and group psychological therapies are offered to treat common mental health problems, alleviate psychological distress and promote mental health wellbeing. They operate close to people’s home in General Practices, Health Centres and local community centres across Central Bedfordshire and are successful in transforming peoples’ lives by offering a range of quality interventions to help people achieve their potential, realise their ambitions, cope with adversity, work productively and contribute to their community and

society. GPs are also responsible for providing physical health assessments, treatments and specialist referral where appropriate.

Employment Support Service in Primary Care

Earlier on in the year the Bedfordshire Retain/Regain Service was launched in Dunstable and Ivel Valley as a pilot scheme. This service has been commissioned from the Richmond Fellowship, a specialist provider of mental health services, to offer vocational advice and on-going support for clients experiencing stress, anxiety, depression or other common mental health conditions. The Richmond Fellowship works with clients who are at risk of losing their job or wish to return to work after a period of sickness absence or unemployment.

Enablement Service

The Enablement Service provides support for dementia care, helping people to remain in their own homes

Day Services

Older people's Day Centres are able to meet the needs of people with dementia

Assistive Technology

Telecare can be used to help people with dementia to remain in their own homes with the support of their carers

Specialist Services

South Essex Partnership Trust (SEPT) – commissioned by NHS Bedfordshire and Central Bedfordshire Council to provide specialist health and social care services to people with mental health needs who live in Bedford, Central Bedfordshire and Luton. The aim is to provide an integrated health and social care service focusing on recovery outcomes and social inclusion. Staff work to empower service users and carers to manage their mental health problems well and gain confidence and skills to live more independently.

Services are multidisciplinary, with clinical staff, social workers, nurses, psychologists, occupational therapists and support workers providing a range of support and interventions.

Acute and Crises Service: The inpatient service is at the Weller Wing in Bedford Hospital. People are admitted if they need inpatient assessment of their mental health needs or for treatment, care and support that will help them recover and regain their wellbeing and independence.

Acute Assessment Unit (AAU) is based at Weller Wing in Bedford Hospital and offers multi-disciplinary assessment and care to people aged between 16 and 65 who are experiencing an acute episode of mental illness.

After AAU, service users are discharged into the care of their GP, the Community Mental Health Team (CMHT), the Crisis Resolution and Home Treatment Team (CRHT) or admitted as an inpatient.

EMPOWA in Bedford provides specialist support for people with mental health problems, by offering guidance to help them seek, gain and maintain voluntary work or employment opportunities.

Crisis Resolution and Home Treatment Team (CRHT) delivers safe and effective home-based treatment to prevent admission to hospital and facilitate the resolution of crisis.

Community Mental Health Team (CMHT) is a multi-disciplinary team of doctors, clinical psychologists, psychiatric nurses, social workers and support workers. CMHTs support individuals with more complex mental health problems whose needs cannot be met in primary care settings and who require targeted clinical interventions. They work closely with primary care services to ensure seamlessness of care.

Some local voluntary organisations offer support groups and day care for patients and their carers, as well as telephone help-lines and drop in centres.

Assertive Outreach Teams (AOT) a multi-disciplinary team of doctors, clinical psychologists, psychiatric nurses, social workers, occupational therapists and support workers. They aim to support people with severe and enduring mental health problems.

The Complex Needs Service works closely with community and specialist mental health teams to improve the care delivered to service users with diagnoses of personality disorder and their families/carers. It is based at the Disability Resource Centre in Dunstable.

B:Dat, Bedfordshire Drug and Alcohol Action oversees and monitors the drug and alcohol dependency treatment services across Bedfordshire. These services comprise of care coordination (including assessment for residential rehabilitation) outreach into the community to support people with alcohol, drug, poly-drug abuse and people with a dual diagnosis of mental health problems and substance misuse. There are also inpatient beds for detoxification treatment on Weller Wing at Bedford Hospital. Currently these services are under review as pathways are being re-designed based on the Stepped Care Model.

Psychiatric Intensive Care Unit (PICU) and Low Secure Services are located in Luton. The Robin Pinto Unit is a low secure environment which provides intensive psychiatric care to individuals whose illness requires a secure and safe environment. Clients who use this service have a history of challenging behaviour or offending. There is a community element to this service which works closely with the local magistrate service.

The Prison In-Reach Team supports prisoners in Bedford prison with mental health problems.

Specialist services for people of working age include:

- Eating Disorders Service
- Electro-Convulsive Therapy (ECT)
- Direct Access Psychology Service
- Clinical Health Psychology Service
- Acquired Brain Injury Psychology Service

Carers Services

Services are available for carers of individuals with mental health conditions within Central Bedfordshire, providing essential advice and support plus training to enable them to continue their caring role.

The **Central Bedfordshire Carers Strategy** (August 2010) sets out how people caring for family and friends living in Central Bedfordshire will be supported. It sets out the needs of carers identified through national and local research and our approach to meeting those needs and aspirations.

Support for carers to continue in their caring role and enable them to enjoy a life of their own requires a whole systems approach. This has implications for public services, private employers, families as well as community and voluntary sector organisations, particularly faced with the current economic challenges.

A **GP Carers Pack** has been produced by NHS Bedfordshire in partnership with Bedford Borough Council, Central Bedfordshire Council and local voluntary organisations. This pack has been designed to provide unpaid carers with a central place to find information regarding all aspects of their caring role and is available at GP surgeries and can be downloaded from the NHS Bedfordshire and local authority websites.

Central Bedfordshire Council has a **Carers Delivery Partnership** and **Carers Forum**, which provide the opportunity, not only to talk with carers but to better understand their needs and how they wish to be supported, by helping to shape how we develop and commission services for carers.

The Financial Context

New Horizons states that the 'social and financial costs of mental health problems are immense' and that 2003 'estimates put the full cost at around £77 billion annually, mostly due to lost productivity':

- £12.5 billion for care provided by the NHS, local authorities, privately funded services and family and friends
- £23.1 billion in lost output to the economy caused by people being unable to work (paid and unpaid)
- £41.8 billion in the human costs of reduced quality of life (and loss of life) among those experiencing a mental health problem

The Central Bedfordshire Council forecast spend for mental health services 2011/12 is:

SEPT (Section 75 agreement) £2,549,940

Social Care Spend: ** £344,903

** this includes: residential care, home care, day care, respite and direct payments

NHS Bedfordshire investment across Central Beds and Bedford is;

£45,877,542 (of which £ 37,660,751) is SEPT Contract.

£ 1,686,000 contracted Primary Care Psychological Therapies.

Due to the current financial climate facing all public sector organisations, this figure is not expected to increase in the foreseeable future. It is recognised that the current block contract arrangements within the NHS are no longer sustainable and there is a greater need for clarity from both a commissioner and provider prospective with regards to what level and quality of activity is provided for an agreed income. It is deemed that Mental Health Payments by Results (PbR) will provide this clarity and understanding of service provision. The NHS Operating Framework 2011/2011 has underlined the increased requirement on the public sector to evidence value for money over the next five years and to make significant efficiency savings through the re-design and increase in effectiveness of both services and commissioning systems.

Where do we want to be

Introduction of new Service Models

To transform the mental health services in Central Bedfordshire this Strategy is based on the introduction of two service models which will form the framework for all service re-design activities; the Mental Health and Wellbeing Integrated Stepped Care Model and the Recovery Model.

Mental Health and Wellbeing Integrated Stepped Care Model

Over the last 10 years a number of mental health and wellbeing services have been introduced in line with a number of different NSF guidance's and other Government initiatives. This has resulted that services were established without an overarching Mental Health framework or clearly defined pathways for people with mental health and wellbeing problems across primary and secondary care. In daily operation the ill-defined protocols for in and out of service have led to patients being "ping-ponged" around the system and not receiving the best and most appropriate interventions on offer. The lack of an agreed framework has led to the delivery of interventions mainly in secondary settings which are expensive and resource intensive.

Part of this strategy is to introduce a Mental Health and Wellbeing Integrated Stepped Care Model (as outlined in the NICE guidelines for Depression and Anxiety) that will allow for the development of clearly defined pathways and protocols for stepping patient up/down in a number of mental health services.

The Stepped Care Model as the common framework will ensure that

- evidence-based interventions as outlined in different NICE guidelines are implemented
- patients will receive the least intrusive intervention first and be stepped up and down as appropriate
- patients will be treated earlier and closer to home in their local community
- patients will receive proactive case management within primary care setting and thus reducing the burden on the more expensive secondary care services.

The Recovery Model

'Recovery' is a process that is unique to the individual. It moves away from traditional concepts of treatment of the symptoms of an illness in which mental health practitioners are seen as the experts. One approach identifies four key components to recovery (Anderson, Oades and Caputi):

- Finding and maintaining hope – believing in oneself; having a sense of personal agency; optimistic about the future
- Re-establishment of a positive identity – finding a new identity which incorporates illness, but retains a core, positive sense of self

- Building a meaningful life – making sense of illness; finding a meaning in life, despite illness, engaged in life
- Taking responsibility and control – feeling in control of illness and in control of life

Essentially recovery means that the individual is supported to “recover” their life so that it feels worthwhile; so that they are working towards aspirations and goals that give value and meaning to their lives, although they may not “recover” fully from their illness. They find themselves living in and contributing to the community, not segregated from it in in-patient or residential care services for most of their lives. In practice this means that housing, employment, education and participation in mainstream leisure and community activities become the focus of treatment and care. People are treated in familiar settings and in a manner that is sensitive to cultural needs. Inpatient admissions become less frequent and shorter as services are established that provide acute and/ or intensive treatment in the community. To achieve recovery, the individual must be at the centre of their treatment and care planning process and have greater power in determining the supports and inputs that will assist their recovery.

In order to facilitate recovery, services have to be much more sensitive to the needs of the individual; the individual’s uniqueness and culture has to be understood and acknowledged. This means that services have to focus to a much greater extent on the holistic needs that may arise from religious beliefs and diverse cultural norms, differences in gender and sexual orientation, age and needs arising from disability. Mental Health Commissioners are keen to ensuring recovery as a whole system response in Central Bedfordshire and are committed to work with all relevant partners to achieve this.

Commissioning Intentions

In line with the national and local policy context as well as the views of local stakeholders, Central Bedfordshire Council and NHS Bedfordshire have agreed to work towards the following goals:

Prevention and Public Mental Health

We will support the development of outcome focused preventative and creative services within Central Bedfordshire and will assist individuals with a Personal Budget to access them if their need is appropriate. Leisure Services will develop their service to provide individual condition specific exercise programmes for those who are suitable and look to provide individual support through a befriending scheme.

Central Bedfordshire Council and NHS Bedfordshire will develop their Reablement Service to ensure that individuals are supported in their own homes with the aim to regain their independence within their local community. This will be mainstreamed as an integrated response to individual’s health and social care needs.

We will identify possible mental health problems amongst those who come into contact with criminal justice system and signpost to appropriate service provision for further assessment to determine whether they should be offered an intervention. The link between substance misuse and mental health will also be addressed to ensure that individuals are given the best care possible.

Modernising Mental Health Services

The structure of Community Mental Health Teams will be reviewed and will include **all** adults that are aged from 16+. There will be a specialist organic team developed to support those people with Dementia. We aim to improve productivity, reduce duplication and achieve more integrated working within primary care.

Working with our partners we will review and improve existing specialist community services to deliver holistic pathways based on the Mental Health and Wellbeing Integrated Stepped Care approach. Each care pathway will be patient focused with clear care protocols for referral and discharge between primary and secondary care.

We will review and redesign Rehab and Continuing Care Services based on the Recovery Model to ensure that we are providing care in the right place for these people. This includes that we ensure that patients receive recovery focused rehab care in the community and continuing care patients and their carers will have increased choice regarding their living options. To achieve this more options for supported housing, extra care housing and respite will be required. We will work in collaboration with our partners to make sure there is a range of housing options, including supported housing for people with mental health issues.

The modernisation of mental health services will take account internal efficiencies and additional capacity that may be needed in primary and community services. Efficiencies include reducing the average length of stay and delayed transfers of care; improving bed occupancy and re-admission rates and aligning in-patient admissions with population needs. Benchmarking against national best practice and existing service models will continue to inform the modernisation of these services.

Dementia is one of the biggest health and social care challenge of the present day and with an increase of 21.5% between 2010 and 2016 in Central Bedfordshire it is imperative that we actively address this challenge by implementing the objectives outlined in the National Dementia Strategy and design a Dementia pathway that allows people to live at home as long as possible and receive the support they need to move through the different phases with understanding and dignity.

Development of Primary Care Services

When people experience mental health problems, their first request for help is usually to their GP. It therefore makes sense for primary care mental health

services to have the resources and skills to deal with as wide a range of mental health problems as possible. By 'primary care mental health services' we do not just mean GPs, but also specialist staff working alongside GPs in primary care. These services are however currently very limited which has led to several local problems. We aim to address them by increasing talking therapies (and similar evidence based interventions according to NICE guidelines) as per the stepped care model to stop problems getting worse, introducing the link worker role and exploring additional resources that can move from secondary care providers into primary care such as Community Development Workers and STR workers.

We aim to continue to work with fellow commissioners responsible for physical health problems to ensure that pathways are developed holistically, especially for people with long-term conditions.

As cited in New Horizons, we will support individuals with mental health conditions to retain their job or to achieve employment as appropriate. Employment will be seen as an important outcome of an individual's treatment and is an issue we will monitor locally. We aim to embed the Retain/Regain Service which is currently being piloted in the primary care setting and extend it across Central Bedfordshire.

Tackling Stigma

We will support national and local initiatives (for example World Mental Health Day) which address mental health conditions and the issues that co-exist with this, for example housing and physical well-being. To support the recovery of individuals who have a mental health condition, we will develop volunteering opportunities which will not only ensure that the recovery of the individual is addressed but that local communities begin to have an understanding of mental health, thus reducing the stigma attached to this. To improve accessibility to mental health services, commissioners need to address the stigma factor. Developing a robust partnership with the third sector in Central Bedfordshire will help us to achieve this.

Personalised Care

The Department of Health document, Putting People First, encourages a different way for individuals to access the care they need. Self Directed Support encourages individual's choice and control to buy the services needed for their own care, support and recovery. In Central Bedfordshire, there are currently 1447 individuals in receipt of self directed support, 46 of whom have a mental health condition. Our aim is to increase this number and help people through the process.

In line with this we will also shape the market to increase the range of housing options for people to help them live in their own homes for longer. This means working with suppliers and providers to develop services that respond to needs and aspirations and may result in a different mix of traditional and non-traditional care services

We aim to provide more assistive technology so that people with mental health conditions can maximise their independence. This will include joining up Telecare and Telehealth.

The Role of Housing

Understanding Housing is a key element in any strategy that aims to improve the mental health and well being for Adults and Older People in Central Bedfordshire. Housing encompasses issues around housing advice, homelessness and tenancy sustainment.

In order to achieve positive outcomes from a commissioning perspective, while engaging with the Personalisation agenda and promoting greater choice and independence, it is vital to explore the interrelationship with housing and homelessness.

Mental ill health is common among people who experience homelessness and rough sleepers: estimates range from one third up to 76%. An estimated 43% of clients in an average homelessness project in England are likely to have mental health needs, and 59% may have multiple needs. Estimated prevalence of psychotic disorders such as schizophrenia and bipolar disorder ranges from four per cent to 40%. Much higher rates of personality disorders (65%), anxiety disorders (40%), anxiety and depression (25%) and post traumatic stress disorder (25%) are found among people who experience homelessness.

There has been some success in Central Bedfordshire in preventing homelessness, but the area is still reflective of the national picture.

Decent housing makes a fundamental difference to mental and physical health and well-being and has a critical contribution to make to the value and effectiveness of the health and care systems. Poor housing combined with poor health is cited as a key reason for people moving to care homes prematurely. The strongest predictor of care home admissions is having three or more problems with 'activities of daily living' (ADL). By definition, this reflects the problems an individual may have with their home environment given poor health.

One of the great challenges will be the growth of the numbers of people with dementia and their housing needs, no matter whether they are being cared for at home, or in specialised housing. Specialised and mainstream housing and this will form a key part in any commissioning strategy.

Housing and housing related support can improve health and reduce demand for health and social care services and enable the full benefits of other services to be realised. Housing is recognised to be the central part of an effective recovery pathway. In addition, there are some compelling arguments for increased investment in housing and the reconfiguration of care pathways to include a stronger housing element. Although the economic evidence base is limited, a strong argument exists for housing to feature strongly in QIPP,

particularly when looking at out of area placements, the use of residential care and tackling delayed discharge.

It is in the area of preventable isolation, disability and disadvantage that the greatest gains are to be made in terms of better housing and better health. As we grow older, we spend more time in our homes, and they become more important to us and more likely to enhance or undermine our health and well-being. The over 65s spend over 80 per cent of their time in their homes, and this figure rises to 90 per cent for over 85 year olds. In housing terms the role of tenancy sustainment is vital in ensuring positive outcomes.

This is a critical area where housing design and adaptation can reduce risk and promote independence. In a Department for Communities and Local Government (DCLG) publication on Health and Housing, one study found a 60 per cent reduction in the number of falls experienced by older people after minor home safety modifications were made. Other studies report more modest reductions in fall-related injuries, ranging from 6 to 33 percent.

The role of the built environment is also vital in fostering health and social well-being among adults and older people living in housing with care. Good design can be enabling for people with physical and cognitive impairment. Key factors which appear to mediate the relationship between design and quality of life in long-term care include choice and control, a sense of community, normalness, comfort and personalisation.

In order to promote continued independence, it is important to give people greater advice on housing. There is a critical need for more and better information about the range of housing choices available to older people, what might be right for each individual or family. In particular, more information is needed about the help and support that is available to older people wishing to stay in their own homes in order to ensure that those homes are safe and comfortable. There is also a need for housing advice and information to encompass wider issues around care and support, and housing-related finance, such as the potential of equity release.

There are many ways that housing, advice and homelessness can affect the mental health of adults and older people. As a consequence it can also contribute to the commissioning of services that will lead to the positive outcomes and service design required for the future.

Multi-Agency Commissioning and Collaboration

Central Bedfordshire Council and NHS Bedfordshire have co-produced this Strategy and will continue to work closely together to develop mental health service provision. We will ensure that service users, carers and third sector, statutory and private partners will continue to be consulted in a meaningful way, helping us to develop a robust partnership. Commissioners will work alongside third sector agencies to build capacity and to demystify the commissioning process.

We will map service provision against projected future need, taking in to account the rise in individuals expected to have a mental health condition over the next years. Areas of deprivation as cited within the Joint Strategic Needs Assessment (JSNA) will also be considered.

Achieving Value for Money

We aim to develop high quality outcome based service specifications which promote good mental and physical well being. These service specifications will be monitored regularly to ensure that that any failure to meet a target is addressed.

Payment by Results (PbR) will provide a transparent, rules-based system for paying for health services. It will reward efficiency, support patient choice and diversity, and encourage activity for sustainable waiting time reductions. This will, in turn, achieve value for money.

Workforce Development

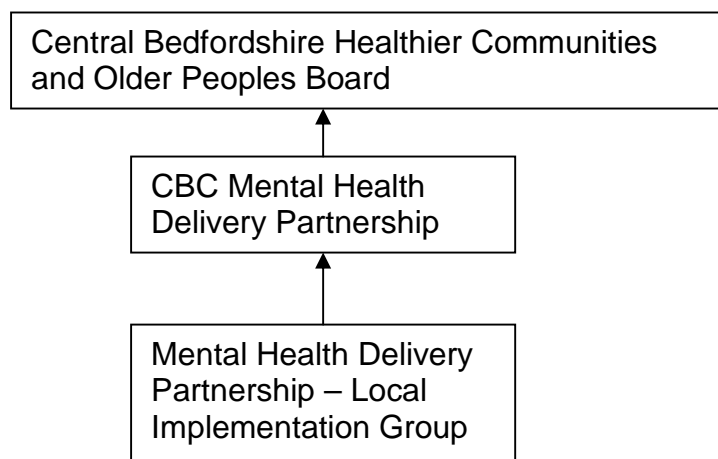
Training and workforce development is a priority within Central Bedfordshire. As we transform mental health services and redesign pathways we will ensure that the training needs of health and social care staff and GPs are being addressed and that we continuously improve the mental health skills base of primary care and community service practitioners.

Conclusion

This joint Commissioning Strategy highlights NHS Bedfordshire and Central Bedfordshire Council’s commitment to transform services for people with mental health conditions and their carers across the Central Bedfordshire. Through engaging with key stakeholders and, most importantly, the community we serve, we will improve the quality of life for people with mental health conditions and their carers by commissioning and delivering quality, person centred services which are outcome focused.

The CBC (Central Bedfordshire Council) Mental Health Delivery Partnership will agree priorities for delivering the objectives of the action plan. These will be delivered on a priority basis.

The reporting framework for this joint Commissioning Mental Health Strategy is as follows:



The Strategy will be monitored quarterly and reviewed on an annual basis by the Mental Health Delivery Partnership – Local Implementation Group. A full report will be written in 2014/15 to highlight our achievements.

DRAFT

Action Plan

DRAFT

Appendix 1

Estimated prevalence of Mental Health Conditions in Central Bedfordshire

Neurotic Disorders	2010	2016	% change
Mixed anxiety and depressive disorder	16797	17709	5.4%
Generalised anxiety disorder	8703	9238	6.1%
Depressive episode	5026	5274	4.9%
All phobias	3411	3560	4.4%
Obsessive Compulsive Disorder	2162	2233	3.3%
Panic Disorder	1358	1479	8.9%
<i>Any neurotic disorder</i>	<i>31637</i>	<i>33437</i>	<i>5.7%</i>
Personality Disorder			
Obsessive compulsive PD	1561	1680	7.6%
Avoidant	1045	1092	4.5%
Schizoid	1021	1141	11.8%
Paranoid	913	957	4.8%
Borderline	912	949	4.1%
Antisocial	673	704	4.6%
Dependent	110	119	8.2%
Schizotypal	60	65	8.3%
<i>Any personality disorder</i>	<i>5397</i>	<i>5833</i>	<i>8.1%</i>
Probable Psychotic Disorder			
Schizophrenia	321	345	7.5%
Manic depression	323	345	6.8%
Probable Psychotic Disorder	647	689	6.5%
Eating Problems			
Anorexia Nervosa	216	222	2.8%
Bulimia Nervosa	324	333	2.8%
Post Natal Depression			
Post Natal Depression	171	177	3.5%
Puerperal psychosis	17	18	5.9%
Dementia			
Dementia	3826	4648	21.5%

Source: Mental Health service in Bedfordshire Commissioning Strategy July 2007 based on national prevalence and adjusted for MINI2000 index scores for personality disorders and probable psychotic disorder.

Appendix 2

Dementia RAG Rating

Objectives	RAG rating	Key Gaps
Raise awareness of dementia and encourage people to seek help	Red/Amber	Lack of awareness, information and training regarding early identification
Good quality early diagnosis, support and treatment for people with dementia and their carers, explained in a sensitive way	Red/Amber	Lack of diagnosis and referral in primary care. Multi-agency working at referral / diagnosis stage. Awareness of service directory
Good-quality information for people with dementia and their carers	Red/Amber	Balance between different types of information
Easy access to care, support and advice after diagnosis	Red in south Green in north	Access in rural areas. Support for self-directed payments. After diagnosis no obvious next steps. Groups in south provide social support rather than peer support
Develop structured peer support and learning networks	Amber	
Improve community personal support services for people living at home	Red	Inconsistent quality of homecare. Access to support out of hours
Implement the New Deal for Carers	Red/Amber	Respite care / crisis support team
Improve the quality of care for people with dementia in general hospitals	Red	Awareness of and care of dementia on general wards
Improve intermediate care for people with dementia	Red	Specialist training for front line staff
Consider how housing support, housing-related services, technology and telecare can help support people with dementia and their carers	Red	Knowledge and availability of SMART facilities. Awareness of telecare
Improve the quality of	Red	Lack of training for staff,

care for people with dementia in care homes		poor staffing and limited provision for younger people in Mid Beds
Improve end of life care for people with dementia	Red	Discussions with families regarding their expectations at end of life
An informed and effective workforce for people with dementia	Red	No recognised quality training or accreditation
Improve assessment and regulation of health and care services and of how systems are working	Red	
Provide a clear picture of research about the causes and possible future treatments of dementia	Red	Lack of dementia champions at clinical / consultant level
Effective national and regional support for local services to help them develop and carry out the Strategy	Red	Regional lead for dementia