17 November 2016	ITEM: 8
Thurrock Health & Wellbeing Board	
"Implementing the Five Year Forward View for Mental Health" – Local implementation.	
Wards and communities affected: All	**Key Decision:** N/A
Report of: Jane Itangata – Senior Commissioning Manager MH & LD Commissioning, NHS Thurrock CCG	
Accountable Head of Service: Mark Tebbs, Director of Commissioning NHS Thurrock CCG	
Accountable Director: Mandy Ansell, (Acting) Interim Accountable Officer NHS Thurrock CCG	
This report is: Public	

Executive Summary

"*For far too long, people of all ages with mental health problems have been stigmatised and marginalised, all too often experiencing an NHS that treats their minds and bodies separately. Mental health services have been underfunded for decades, and too many people have received no help at all, leading to hundreds of thousands of lives put on hold or ruined, and thousands of tragic and unnecessary deaths*."[1]

Mental health problems are widespread, at times disabling, yet often hidden. People who would go to their GP with chest pains will suffer depression or anxiety in silence. One in four adults experiences at least one diagnosable mental health problem in any given year.

People can, and do, recover from mental ill health. The evidence is clear that improving outcomes for people with mental health problems supports them to achieve greater wellbeing, build resilience and independence and optimise life chances, as well as reducing premature mortality.

The purpose of this report is to inform the Health and Wellbeing Board on the local response to the recently published "Five Year Forward View for Mental Health" strategy and "Implementing the Five Year Forward View for Mental Health" guidance.

[1] *"The Five Year Forward View for Mental Health, (Department of Health, 2016)"*

1. Recommendation(s)

1.1 The Health and Wellbeing Board are asked to note the content of this report that defines Thurrock's response to the recently published recommendations of the *"Five Year Forward View for Mental Health"* strategy and subsequent *"Implementing the Five Year Forward View for Mental Health"* guidance.

1.2 That the Health and Well Being Board are aware of the progress of the work on the Mental Health Crisis Care Concordat – development of the approach to a 24/7 Mental Health Crisis Response pathway.

2. The Five Year Forward View for Mental Health

2.1 The Context

In March 2015 Simon Stevens on behalf of the NHS, commissioned an Independent Mental Health Taskforce chaired by Paul Falmer, Chief Executive of Mind which brought together health and care leaders, people who use services and experts in the field to create a Five Year Forward View for Mental Health strategy.

The independent report of the Mental Health Taskforce published in February 2016, sets out the start of a ten year journey for that transformation, signifying for the first time a strategic approach to improving mental health outcomes across the health and care system, in partnership with the health arm's length bodies.

Key to the report was communicating the views of more than 20,000 users of mental health services who unequivocally expressed that the priorities were prevention, access, integration, quality and a positive experience of care to enable them achieve their life ambitions and take their places as equal citizens in society.

The taskforce made 57 recommendations broadly targeted at:

- The six NHS arm's length bodies – to achieve the ambition of parity of esteem between mental and physical health for children, young people, adults and older people.
- Wider action – many people indicated that as well as access to good quality mental health care in the NHS, their ambition was to have a decent place to live, a job and good quality relationships in their local communities, therefore *"mental health is everyone's business!"*
- Tackling health inequalities – mental health problems disproportionately affect people living in poverty, the unemployed and those already facing discrimination and their first experience of mental health care comes when they are detained under the Mental Health Act, often with police involvement, followed by a long stay in hospital.

"The NHS needs a far more proactive and preventative approach to reduce the long term impact for people experiencing mental health problems and for their families, and to reduce costs for the NHS and emergency services".

2.2 Implementing the Five Year Forward View for Mental Health

The Five Year Forward View for Mental Health strategy has made an unarguable case for transforming mental health care. Implementing the Five Year Forward View for Mental Health provides the guidance and plan of what the system will need to focus on in further transforming mental health services and embed lasting change.

Whilst the Implementation plan is focused primarily on the role of the NHS in delivering its commitments, it is also a blueprint for mobilising partners in local government, housing, education and the voluntary sector to enable the best possible outcomes for people; this cannot be achieved by the NHS alone. Delivery of the *Five Year Forward View for Mental Health* is underpinned by significant additional funding.

2.2.1 Priorities for Implementing the Five Year Forward View for Mental Health

- A 7 Day NHS – right care, right time, right quality to include Crisis Care by 2020/21
- Integrating mental and physical health
- Promoting good mental health and preventing poor mental health and helping people lead better lives as equal citizens

2.2.2 Key Common principles

- Co-production with people with lived experience of services, their families and carers;
- Working in partnership with local public, private and voluntary sector organisations, recognising the contributions of each to improving mental health and wellbeing;
- Identifying needs and intervening at the earliest appropriate opportunity to reduce the likelihood of escalation and distress and support recovery;
- Designing and delivering person-centred care, underpinned by evidence, which supports people to lead fuller, happier lives; and,
- Underpinning the commitments through outcome-focused, intelligent and data-driven commissioning.

3. Mental health problems in the population

3.1 The nature and level of need

- Half of all mental health problems have been established by the age of 14, rising to 75 per cent by age 24. (1 in 10 children aged 5-16 years have a diagnosable mental health disorder).

- 1 in 5 mothers suffers from depression, anxiety or in some cases psychosis during pregnancy or in the first year after childbirth. Suicide is the second leading cause of maternal death, after cardiovascular disease.
- Physical and mental health are closely linked – people with severe and prolonged mental illness are at risk of dying on average 15 to 20 years earlier than other people – one of the greatest health inequalities in England.
- In addition, people with long term physical illnesses suffer more complications if they also develop mental health problems, increasing the cost of care by an average of 45 per cent.
- Common mental health problems are over twice as high among people who are homeless compared with the general population, and psychosis is up to 15 times as high.
- For people being supported by secondary mental health services, there is a 65 per cent employment gap compared with the general population.
- People with mental health problems are also often overrepresented in high-turnover, low-pay and often part-time or temporary work
- One in five older people living in the community and 40 per cent of older people living in care homes are affected by depression.
- People of all ages who have experienced traumatic events, poor housing or homelessness, or who have multiple needs such as a learning disability or autism are also at higher risk.
- People in marginalised groups are at greater risk, including black, Asian and minority ethnic (BAME) people, lesbian, gay, bisexual and transgender people, disabled people, and people who have had contact with the criminal justice system, among others.
- As many as nine out of ten people in prison have a mental health, drug or alcohol problem.
- Suicide is rising, after many years of decline.

3.2 **Current experiences of Mental Health Care**

- Three quarters of people with mental health problems receive no support at all. Among those who are helped, too few have access to the full range of interventions recommended by National Institute for Health and Care Excellence (NICE), including properly prescribed medication and psychological therapy.
- Nine out of ten adults with mental health problems are supported in primary care. Whilst there is significant expansion in access to psychological services since the introduction of the national IAPT programme (Improving Access to Psychological Therapies) there is still considerable variation in services with waiting times varying from 6 to 124 days.
- One-quarter of people using secondary mental health services do not know who is responsible for coordinating their care, and the same number have not agreed what care they would receive with a clinician. Almost one-fifth of people with care coordinated through the Care Programme Approach (for people with more severe or complex needs) have not had a formal meeting to review their care in the previous 12 months.

- In its recent review of crisis care, the Care Quality Commission found that only 14% of adults surveyed felt they were provided with the right response when in crisis, and that only around half of community teams were able to offer an adequate 24/7 crisis service.
- Only a minority of hospital Accident & Emergency (A&E) departments has 24/7 cover from a liaison mental health service, even though the peak hours for mental health crisis presentations to A&E are between 11pm and 7am. Too often, people in mental health crisis are still accessing mental health care via contact with the police.
- Admissions to inpatient care have remained stable for the past three years for adults but the severity of need and the number of people being detained under the Mental Health Act continues to increase, suggesting opportunities to intervene earlier are being missed. Men of African and Caribbean heritage are up to 6.6 times more likely to be admitted as inpatients or detained under the Mental Health Act, indicating a systemic failure to provide effective crisis care for these groups.
- Pressure on beds has been exacerbated by a lack of early intervention and crisis care, and the resulting shortage leads to people being transferred long distances outside of their area.
- Mental health accounts for 23% of NHS activity but NHS spending on secondary mental health services is equivalent to just half of this. Years of low prioritisation have led to Clinical Commissioning Groups (CCGs) underinvesting in mental health services relative to physical health services.
- Given chronic underinvestment in mental health care across the NHS in recent years, efficiencies made through achieving better value for money should be re-invested to meet the significant unmet mental health needs of people of all ages, and to improve their experiences and outcomes.

3.3 **Local perspective**

We are aware the position nationally is reflected quite closely locally and in Thurrock partners have over the last 2 years been working very closely together to achieve our vision:

"The Health and care experience of the people of Thurrock will be improved as a result of our working effectively together."

3.3.1 **Thurrock Mental Health Priorities**

- Improving urgent and emergency care
- An integrated social care, mental and physical health approach – care closer to home
- Promoting good mental health and preventing poor mental health– helping people lead better lives as equal citizens

3.3.2 **Our Transformation context**

To enable us deliver on our priorities as well as implement the "*Five Year Forward View for Mental Health",* we are collaboratively engaged in key transformation

programmes with clearly defined strategies for transforming mental health services namely:

- For Thurrock in Thurrock
- Living Well in Thurrock
- The Primary Care Strategy
- Better Care Fund
- The Health and Wellbeing Strategy

3.4 **Our Mental Health response to "Implementing the Five Year Forward View**

3.4.1 **The Thurrock Mental Health JSNA and Mental Health Strategy**

The CCG, Local Authority and Public Health commissioners are working together on developing a Mental Health JSNA product that will inform the Thurrock Implementation Plan of the Essex, Southend and Thurrock Mental Health Strategy and this will be aligned to the Health and Wellbeing Strategy. To ensure an informed plan is developed we will also involve and engage:

- users of services, their families and carers
- providers both statutory and voluntary

It is anticipated that the JSNA will be complete by December 2016 and this will provide a starting point to help us measure the impact of our transformation programmes, whilst the strategy implementation plan that will be in place by the end of March 2017 will define and guide the direction of travel to enable us achieve the best outcomes for our residents and deliver our vision.

3.4.2 **IAPT and Recovery College (primary care and community)**

3.4.2.1 **Treating common mental disorders**

The prevalence of people with depression and anxiety 2015/16 is estimated at 20,614 and current evidence suggests that 3093 would benefit from NICE approved psychological therapies per year via the Improving Access to Psychological Therapies (IAPT) national programme. IAPT services should be integral to community-wide efforts to develop person and family-centred services, which promote emotional and psychological well-being. Those people suffering from common mental health disorders often have concerns relating to employment, housing, debt or relationship difficulties, regardless of other issues.

We have recently commissioned a new service that combines an IAPT pathway with a Recovery College, first time this has been done nationally as Recovery Colleges have tended to grow organically in secondary care. The service has been delivered by South Staffordshire and Shropshire Healthcare NHS Foundation Trust (Inclusion Thurrock) since 1st April 2016 and works in partnership with a number of our voluntary sector organisations including being in a subcontract arrangement with Thurrock Mind.

To access the service people are assessed for not just their mental health needs but also their social inclusion, housing, employment, benefits and social care needs are

taken into consideration to ensure holistic packages of care is defined with individuals.

3.4.2.2 **Building and promoting resilience**

The Recovery College will facilitate an educational approach that focuses on developing people's strengths, and enabling them to understand their own challenges and how they can best manage these in order to pursue their aspirations. It facilitates the learning of skills that promote recovery and underpin greater confidence and the self-belief that comes with recognising one's abilities and potential.

Recovery is a personal journey of discovery.[2] It involves making sense of, and finding meaning in, what has happened; becoming an expert in your own self-care; building a new sense of self and purpose in life; discovering one's own resourcefulness and possibilities and using these, and the resources available to pursue personal aspirations and goals. We felt that there are significant synergies between IAPT and the Recovery College and the two services would promote therapeutic and educational approaches to support people with recovery and build resilience.

3.4.2.3 **Long Term Conditions**

Evidence clearly demonstrates the people with Long Term Conditions (LTCs) have comorbid underlying mental health problems. As part of this pathway we have also commissioned a psychological therapies service for people with LTCs, embedded in teams in the community. The service has also been skilling up other professionals e.g. District Nurses in screening for depression and anxiety as part of core patient care and ensuring support is provided as flexibly as possible.

3.4.2.4 **Social Care support**

Inclusion Thurrock has been delivering professional support to social care teams to enable them also screen for depression and anxiety as part of core social care assessments. We hope that this will facilitate good practice so that instead of just defaulting to additional care hours – a cost pressure to the LA, the underlying mental health problems that are normally indicated can be treated and facilitate independence and a better quality of life for the service user.

3.4.2.5 **Learning Disabilities**

Whilst people with LD can access the IAPT/RC service with support and reasonable adjustments being done further work is on-going to develop specific modules and learning materials so that people are supported in the most inclusive and effective way.

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[2] Repper, J. & Perkins, R. (2012) Recovery: A journey of discovery for individuals and services, in Phillips, P., Sandford, T, & Johnston, C. (Ed) *Working in Mental Health: Practice and policy in a changing environment*, Oxford: Routledge

3.4.3 **Mental Health Shared Care Protocol**

We are cognisant that a significant number of people are currently on secondary care caseloads but receiving no to minimal clinical input – not an effective or efficient use of specialist resource and the poor service user outcomes.
Thurrock developed and piloted a 'Mental Health Shared Care Protocol' in 2013/14 to test primary and secondary care working together to support good patient flow. The results were significant and positive and well received by all GPs and patients who were supported in the least restrictive environment with the assurance that if they required quick access back into secondary care that this would be facilitated appropriately.

Learning from the pilot has informed the review of the Protocol enhancing and mainstreaming it as a critical enabler to ensure that secondary care resources are used well, that the patient is treated by the right person, right place, right time in light of our Transformation programmes, recent national guidance and the move to outcomes based contracts for mental health.

3.4.4 **24/7 Crisis Response Care**

3.4.4.1 **Background**

In its recent review of crisis care, the Care Quality Commission found that only 14% of adults surveyed felt they were provided with the right response when in crisis, and that only around half of community teams were able to offer an adequate 24/7 crisis service. Only a minority of hospital Accident & Emergency (A&E) departments has 24/7 cover from a liaison mental health service, even though the peak hours for mental health crisis presentations to A&E are between 11pm and 7am.

Too often, people in mental health crisis are still accessing mental health care via contact with the police. There have long been concerns about the way in which health and social care services and police forces work together in response to mental health crises.

In recognition of this the Mental Health Crisis Care Concordat was launched in February 2014 and it sets out a new agreement between the police, NHS and other emergency partners in a bid to improve mental health crisis care.

Key to the implementation of the Concordat is the challenge it gives to local health, social care and criminal justice partnerships to provide strong leadership, develop and improve local responses to support people experiencing a mental health crisis. This not only serves the individual concerned better, but also helps those emergency services perform their roles better.

In response to sign up to the Crisis Care Concordat in December 2014, a Pan Essex Crisis Care Concordat multi-agency group (now Urgent Care Mental Health – UCMH) was set up to take forward the mandate of addressing the gaps in service for managing people in a mental health crisis.

The Mandate from the Government to NHS England in 2014 established specific objectives for the NHS to improve mental health crisis care. The government expects:

- NHS England to make rapid progress, working with clinical commissioning groups (CCGs) and other commissioners, to help deliver on our shared goal to have crisis services that, for an individual, are at all times accessible, responsive and high quality as other health emergency services.
- NHS England to ensure there are adequate liaison psychiatry services in Emergency Departments.
- Every community to have plans to ensure no one in crisis will be turned away, based on the principles set out in the Concordat.

The Policing and Crime Bill (2016) was placed before Parliament in February of this year, tabling amendments to the Mental Health Act (1983). Main changes proposed are:

- No children or young person (under 18) should be taken to police stations as a POS under any circumstances.
- Adults can be taken to custody as a POS, only in circumstances to be specified in regulations, yet to be determined, by the Secretary of State. *It is anticipated the criteria will be exceptionally violent individuals, those who cannot be safety managed elsewhere.*
- Maximum assessment time of 72hours in a POS reduced to 24 hours – which can be extended to 36 hours if authorised by the doctor leading the assessment, or a Superintendent if a custody suite has been used as the POS.
- A requirement, *where practicable*, to consult a doctor, mental health Professional or AMHP prior to removing a person to a POS. No such requirement presently exists.

These changes are scheduled to be in place on 1st April 2017 and will also mean that police vehicles will not be used to convey patients to places of safety except in exceptional circumstances where violence is an overriding factor. Statistics released earlier this year show that Essex has the 2nd highest usage rate of custody as a place of safety (POS) nationally.

A system wide preparedness approach is therefore required to mitigate the potential impact and respond to the changes.

3.4.4.2 **Local approach to legislative changes and national guidance**

The Essex STP felt there was a need to identify a team to define an approach and take forward the development of a 24/7 mental health crisis response pathway as well as ensure the system is in a state of preparedness to respond to the proposed changes to the Mental Health Act. Thurrock CCG was asked to take on this responsibility.

A project mandate (embedded below) describing the approach the team would take was developed and ratified by the 7 Essex CCGs' AOs on 14th September, 2016. Consequently workstreams comprising representatives from the CCGs, LAs, MH

Trusts, Acute Trusts, Police and Ambulance service have been pulled together to undertake identified tasks with a view to implementing required responses by 31st March 2017.

Mental Health Crisis Care 24-7 Response

3.4.4.3 **Street Triage**

To mitigate the proposed amendments to the MHA (2003) coming into effect on 1st April 2017, the project team is reviewing the Street Triage service which has been in operation from 2014/15 with significantly positive results. Options are being explored on the best fit model that will meet the needs of people when in a crisis but also ensure that agencies are working more collaboratively to support service users frequently needing emergency services. The intention is to finalise the business case for this element of the response by 31/10/2016 so that governance can be undertaken in November in time for contracts sign off on 23/12/2016.

Progress updates from the project team are circulated to the system on a fortnightly basis.

4. Reasons for Recommendation

4.1 To ensure that the Health and Well Being Board are well informed about the developments in Mental Health service provision in Thurrock and the strategic programmes Thurrock is leading.

5. Consultation (including Overview and Scrutiny, if applicable)

5.1 N/A

6. Impact on corporate policies, priorities, performance and community impact

6.1 The failure to deliver high quality services and support to people with mental health problems especially when in a crisis would affect a significant number of Thurrock residents, it is important therefore to raise awareness of the provision available and ensure partnership working with those who use services is key to future developments

7. Implications

7.1 Financial

Implications verified by: **Jo Freeman**

Management Accountant Social Care and Commissioning

None identified at this stage. The delivery of this programme can currently be met through existing budgets. A further report will be provided to the Health and Wellbeing Board in future if financial implications are identified at a later date.

7.2 **Legal**

Implications verified by: **Christopher Pickering**

Principle Solicitor, Employment and Litigation

None identified.

7.3 **Diversity and Equality**

Implications verified by: **Rebecca Price**

Community Development and Equalities Team

A Diversity and Equality Assessment was completed as part of developing the business case for this programme. The programme is fully inclusive and extends beyond equality and diversity requirements by focussing on the wider population as well as individuals with protected characteristics.

7.4 **Other implications** (where significant) – i.e. Staff, Health, Sustainability, Crime and Disorder)

From 1st April 2017 no-one detained under s136 will be conveyed to police custody as a place of safety, unless in exceptional circumstances where violence is indicated.

8. Background papers used in preparing the report (including their location on the Council's website or identification whether any are exempt or protected by copyright):

- Mental Health Crisis Care 24/7 (Embedded within report)

9. Appendices to the report

- N/A

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