Mental Health actions from the OHSEL JHOSC meetings April & May 2016

DRAFT

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Purpose: At the last meeting of the south east London Joint Health Overview and Scrutiny Committee in May 2016, the committee requested a number of updates on mental health:

The April committee requested a written explanation of how the Sustainability & Transformation Plans and the OHSEL programme are taking steps to address the following reports and recommendations:

a) Future in Mind
b) Mental Health Task Force
c) Royal College of Psychiatrists Adult Acute Inpatient Care, Feb 2016, chaired by Lord Crisp

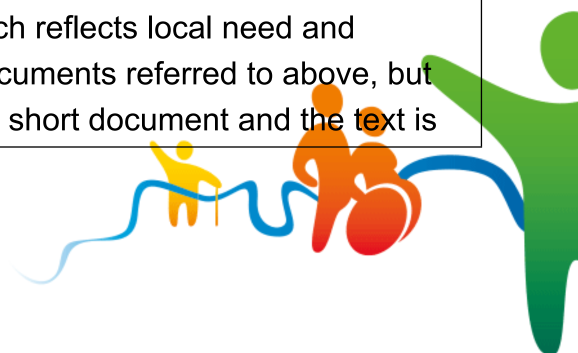
The April committee also requested more detail on specialised mental health spend, as a proportion of the £800 million spent on South East London specialised NHS care. The committee requested a breakdown of how much is spent on all mental health providers, including SLaM and Oxleas mental health NHS Foundation Trusts.

The May committee requested :

a) Request for details of how much each borough (CCG) spends on mental health placements
b) Details for spends on specialist mental health and what is the breakdown in terms of 'in area' / 'out of area'

Extract from the SEL STP on Mental Health

The STP submission on mental health was overseen by a joint group of commissioners, providers and clinicians. The idea was to agree a direction which reflects local need and national policy. It was informed by, and took account of, the documents referred to above, but was guided by an understanding of local need. The STP was a short document and the text is



reproduced below:

We are looking at further opportunities for working at scale to improve mental health, including at the interaction between mental and physical health. There are specific areas where we know that we could do better in serving those with mental health disorders:

- All of our boroughs have higher than average levels of mental health need as indicated by the PRAMH formula;
- Those with serious mental illness (SMI) have reduced life expectancy of 13 years, usually due to higher risk of physical conditions;
- Analysis of the drivers of mental health need such as deprivation, population mobility, and ethnicity indicates that SEL has some of the highest levels of risk factors in the country. People from black and minority ethnic communities are more likely to be diagnosed with a serious mental illness and are over-represented in crisis services and the criminal justice system;
- Prevention, screening and early detection in those who are experiencing inequalities or putting their health at risk will be key to helping people to sustain good health and wellbeing.

We have identified a specific priority of integrating physical and mental health so that we consistently tackle the disparity in life expectancy of people with severe and enduring mental health problems and address the mental health and wellbeing of people with physical health problems and long term conditions and medically unexplained symptoms. The table below summarises our plans against our key priority areas:

Community based care	• Integrated mental and physical health in CBC by aligning services, developing multi-professional working, supporting people with housing and meaningful occupation including employment and increase training of teams within LCNs • Building mental health into our approach for capitated budgets and risk sharing • Incorporating mental health into our population health management approach • Increase early access in primary care • Tackling wider determinants of health in children and their families • Improved services for people with dementia
Improving quality and reducing variation across both physical and mental health	• Embed an integrated mind/body approach to support both the physical and mental health of patients and service users • Deliver quality improvement methodologies across the provider landscape • Improving timely access to specialist mental health support in the community • Increase diagnosis rates for people with mental health conditions • Develop access to crisis care for children and adults • Explore how we can achieve the four hour target for mental health and ceasing OATs • Ensure sufficient and appropriate capacity is available to meet future demand
Improving	In addition to the collaborative productivity work across all SEL providers we are:

productivity through provider collaboration	• Establishing a pan-London procurement approach for mental health providers, and a shared approach to procurement of legal support across south London • Implementing A joint approach across providers in south London to managing the budget for forensic provision and which could potentially be extended to specialised commissioning of mental health services for children and young people • Collaborative approaches to estates planning to support new models of care and more integrated working
Optimising specialised services across south east and south London	• We are trialling a new way to manage budgets for specialised services through our collaboration between the three south London mental health trusts to take on the specialised commissioning budget for adult secure services. We will assess how this approach could be extended to other areas.
Standardised care across pathways	• Ensure a standardised approach to Making Every Contact Count • Encourage open and positive discussion about mental health and wellbeing across settings. • Promote excellence in relation to mental health across all services and conditions • Increase early identification, including the use of screening, and early intervention for mental health needs • *Making Every Contact Count*. We will have a standardised approach to MECC to ensure earlier identification and intervention. Health aspects will be addressed in each contact, e.g. drug and alcohol use, anxiety, mood and psychotic symptoms, wellbeing, exercise, diet, cardiovascular risk factors, with clear onward pathways for issues identified. • *Increase early identification and early intervention* for mental health needs, including through making mental health screening routine across all settings of care to promote appropriate care and timely referral where necessary.

The June submission is being refreshed with a submission on 21 October and a similarly constituted group will oversee the mental health section. We shall add our approach to the recently released 2017-19 planning guidance which includes the following "must dos".

Deliver in full the implementation plan for the Mental Health Five Year Forward View for all ages, including:

- Additional psychological therapies so that at least 19% of people with anxiety and depression access treatment, with the majority of the increase from the baseline of 15% to be integrated with physical healthcare;
- More high-quality mental health services for children and young people, so that at least 32% of children with a diagnosable condition are able to access evidence-based services by April 2019, including all areas being part of Children and Young People Improving Access to Psychological Therapies (CYP IAPT) by 2018;

- Expand capacity so that more than 53% of people experiencing a first episode of psychosis begin treatment with a NICE-recommended package of care within two weeks of referral.
- Increase access to individual placement support for people with severe mental illness in secondary care services by 25% by April 2019 against 2017/18 baseline;
- Commission community eating disorder teams so that 95% of children and young people receive treatment within four weeks of referral for routine cases; and one week for urgent cases; and
- Reduce suicide rates by 10% against the 2016/17 baseline.
- Ensure delivery of the mental health access and quality standards including 24/7 access to community crisis resolution teams and home treatment teams and mental health liaison services in acute hospitals.
- Increase baseline spend on mental health to deliver the Mental Health Investment Standard.
- Maintain a dementia diagnosis rate of at least two thirds of estimated local prevalence, and have due regard to the forthcoming NHS implementation guidance on dementia focusing on post-diagnostic care and support.
- Eliminate out of area placements for non-specialist acute care by 2020/21
- Increase access to evidence-based specialist perinatal mental health care, in line with the requirement to meet 100% of need by 2020/21, and ensure that care is in line with NICE recommendations.

https://www.england.nhs.uk/wp-content/uploads/2016/09/NHS-operational-planning-guidance-201617-201819.pdf

It is our aim that a local position is reached, which meets the above directives in the most effective and efficient way possible to deliver the best possible care, with a high standard of citizen-experience and quality. Our aim is very much to work far more preventatively with our population and support and empower self-management and recovery.

There is good evidence to show that providing good and early mental health care, leads to improved outcomes and reduced spend in the health and social care system downstream and over time.

I attach the information requested on specialist mental health placements. The table shows the specialist mental health placements by CCG, and which provider the client went to. Given that we are talking about specialist services, the information here has to be interpreted with caution: it only reflects a small part of the total mental health service received by each borough.
There is a workstream within the STP which is considering the possibility of a more joined up approach to non-acute OATs and placements across the piece also, as there are pockets of good practice that already exist. This is envisaged to bring to bear, a better position with regard to OATs and use of

placements in their entirety.

I hope this is helpful.

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