24 January 2019	ITEM: 8
Health and Wellbeing Overview and Scrutiny Committee	
Adult Mental Health Service Transformation	
Wards and communities affected: All	**Key Decision:** Key
Report of: Ian Wake, Director of Public Health	
Accountable Officers: Mark Tebbs, Director of Commissioning NHS Thurrock Clinical Commissioning Group (CCG); Catherine Wilson, Strategic Lead Commissioning, Adults Housing and Health	
Accountable Director: Ian Wake, Director of Public Health; Roger Harris, Corporate Director, Adults, Housing and Health; Mandy Ansell, Accountable Officer, NHS Thurrock Clinical Commissioning Group	
This report is Public	

Executive Summary

Mental illness is the single largest cause of disability in the UK and a major driver of health inequalities. Whilst there are many examples of good practice amongst health and care providers, the current adult mental health treatment system in Thurrock as a whole is not fit for purpose and needs fundamental system wide reform. The recent Adult Mental Health Joint Strategic Needs Assessment and Local Government Association Peer Review identified some strong assets within our local system on which to build, including a good service provided by our main mental health provider - Essex University Mental Health Partnership Trust (EPUT), Thurrock MIND and *Inclusion* Thurrock to patients being treated, Local Area Coordination, Public Health Intelligence and Thurrock First. However both also highlighted a number of systemic failures, many of which were also echoed in the Thurrock Healthwatch report – which found that 88% of mental health service users were dissatisfied with the current service offer.

Collation of the key issues raised in the three pieces of work have been grouped into five priority areas for action to improve local mental health services – each of which is discussed in more detail in this report:

1. Address the issue of under-diagnosis of mental health problems
2. Improve access to timely treatment

3. Develop a new model for Common Mental Health Disorders
4. Develop a new *Enhanced Treatment and Recovery Model* for people with serious mental ill-health conditions
5. Integrate commissioning and develop a single common outcomes framework supported with improved commissioning intelligence.

This report sets out work to date to address problems in the local mental health and care system in Thurrock and sets out plans with NHS Thurrock CCG and NHS and third sector provider partners to transform mental health services moving forward. The report also discusses the issue of suicide prevention and how best to integrate commissioning of services between the council and NHS.

The report seeks HOSC support for the new programme of transformation, and for proposals to reform the section 75 agreement between the Council and EPUT.

Recommendation(s)

1. That Health and Wellbeing Overview and Scrutiny Committee notes the contents of this report and comments on the direction of travel in terms of adult mental health system transformation

2. That Health and Wellbeing Overview and Scrutiny Committee comments on and supports the proposals as set out in section 7.14 to 7.15 of this report to develop a new Section 75 Agreement with EPUT from 1 April 2019 based on a longer term contract, with a revised performance and budget framework

3. That Health and Wellbeing Overview and Scrutiny Committee comments on and supports and approves the proposals set out in section 10 of this report in relation to suicide prevention.

1. Introduction

1.1 Mental illness is the single largest cause of disability in the United Kingdom, contributing up to 22.8 per cent of the total burden of morbidity, compared to 15.9 per cent for cancer and 16.2 per cent for cardiovascular disease. Current figures suggest that one in four people will experience a mental health problem during their lifetime. No other set of health conditions match the combined extent of prevalence, persistence and breadth of impact of mental ill-health.

1.2 Mental illness has a huge impact on population health and is a major driver of health inequalities. There is a bi-directional relationship between poor mental health and poor physical health. People with mental health problems are at higher risk of experiencing significant physical health problems; they are more likely to develop preventable conditions such as diabetes, heart disease, bowel cancer and breast cancer, and do so at a younger age. Conversely, people with long-term physical health conditions are at greater risk of mental health problems, particularly depression and anxiety.

1.3 Mental illness further affects the way individuals manage their health and interact with services. People with mental health problems are more likely to

smoke, misuse substances and less likely to be physically active. Furthermore, they are less likely to attend medical appointments and less likely to adhere to treatment and self-care regimens.

1.4 People with serious mental ill health die on average 20 years before the general population. Conversely, rates of mental illness, particularly depression, are between two and three times more common in those with long-term conditions compared to the general population including coronary heart disease, cancer, diabetes, osteoporosis, multiple sclerosis, immunological problems and arthritis. Mental health co-morbidities in those with physical long term conditions contribute significantly to poor physical health outcomes and higher treatment costs; it is estimated that £1 in every £8 spent on treating a long-term condition is linked to a co-morbid mental illness.

1.5 The cost of mental ill-health in England has been estimated to be £105 billion of which £30 million is allocated to work related sickness. This is due to increase and double over the next 20 years. The costs to Social Care for people with mental health collates to £2 billion annually and is also likely to continue to increase if mental health services are not re-organised and managed more effectively. This will put ever more pressure on an already overstretched NHS and Social Care system. In 2018/19 Thurrock Council is forecast to spend £3.259m on care packages.

2. Background – Current Provider and Commissioning Landscape

2.1 The Adult Mental Health Service Provider landscape in Thurrock is currently complex and fragmented, and is characterised with a lack of continuity of care relationships, i.e. there is the potential for many different health and care professionals are involved in an individual's care, increasingly the likelihood that they will need to tell their story multiple times.

2.2 Common Mental Health Disorders (depression, anxiety, phobias and obsessive compulsive disorder) make up the vast majority of mental health problems amongst Thurrock residents, and are mainly dealt with in Primary Care. The current treatment offer is limited to prescription of anti-depressant medication, referral to a social prescriber (in practices were this service is operating), or referral to IAPT (Increasing Access to Psychological Therapies) which is provided by *Inclusion Thurrock* who also deliver drug and alcohol treatment services to Thurrock residents. Patients known to EPUT services have access to a telephone line 24/7 where they can contact services and seek advice. Service users who are discharged from secondary care to primary care are supported through a shared care protocol. This enables a comprehensive handover of care and rapid access back into services in the event that the patient deteriorates.

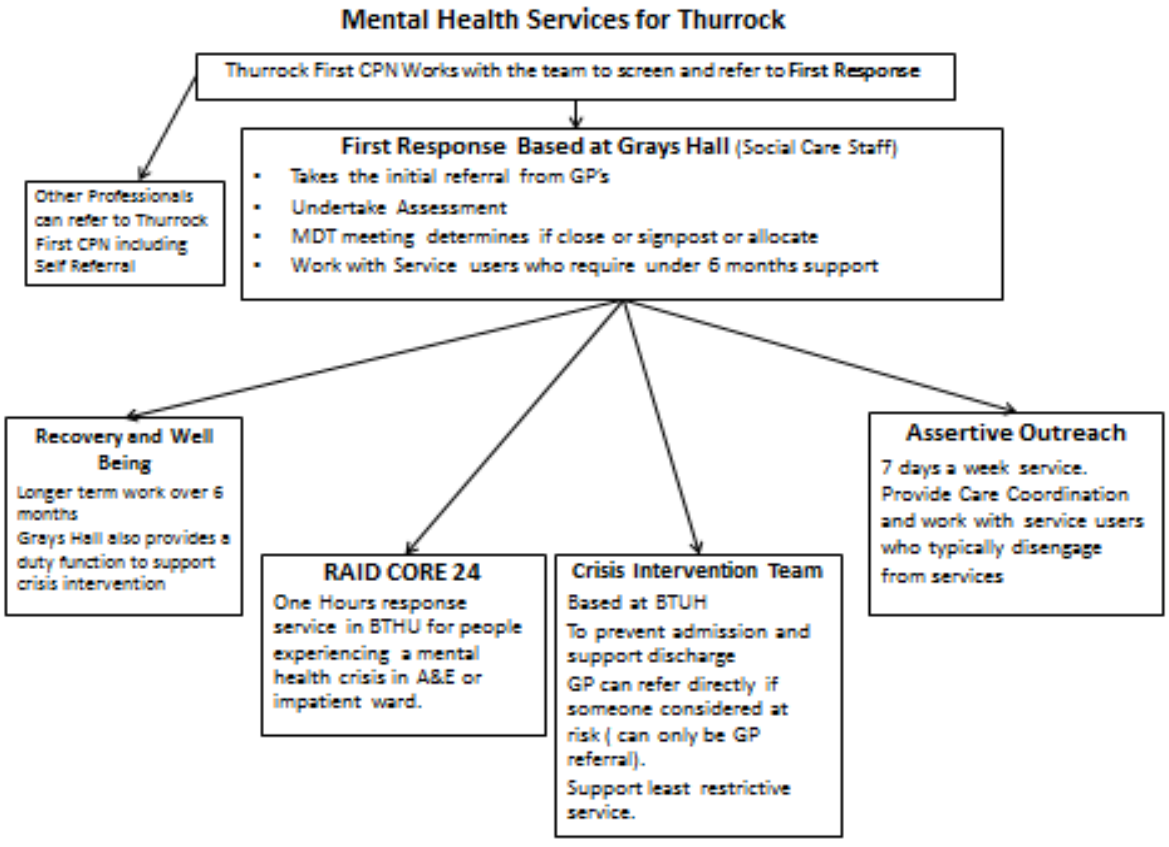
2.3 *Inclusion Thurrock* provide a *Recovery College* consisting of suites of courses which help people recovering from mental health problems self-manage their conditions. This includes programmes on mindfulness, understanding anxiety and food and mood.

2.4 A range of third sector organisations provide support to people with mental ill health. The largest provider of these services is Thurrock MIND, who provides

a range of interventions including talking therapies, supported housing, peer mentoring, positive pathways and advocacy. They are also active participants in a 'shared care protocol' which supports clients discharged from EPUT services to stay well and reduce re-admissions to secondary care. The Emotional Well Being Forum supported by Thurrock Coalition and MIND is an opportunity for those with lived experiences of services and mental health and carers to meet together for support, to gain information and to influence service developments. *The World of Work* provides support and training to enable people to become work ready through CV writing interview practice support with volunteering and support into paid employment.

2.5 More serious mental ill-health treatment services, for example for psychotic illness such as schizophrenia and bi-polar disorder, are provided by Essex Partnership University Foundation Trust (EPUT) at Grays Hall. Early Intervention in Psychosis, including Individual Placement Support (employment service) and Personality Disorders services are collaboratively delivered by EPUT and Inclusion Thurrock. This service offer can currently only be accessed through a referral from a GP. Figure 1 summarises the current treatment model.

Figure 1



2.6 Thurrock Council delegates to EPUT its statutory duty to provide adult social care assessment and care management services under the Care Act 2014 through a Section 75 Agreement. A Community Psychiatric Nurse (CPN) works within Thurrock First taking initial referrals and supporting the Thurrock First Advisors. The CPN can offer support information and advice and can also refer

directly to the First Response Team. The First Response Team works with people who require 6 months of support or less. The Team consists of social workers and community nurses together with psychiatrists and therapists offering a range of supports, including individual therapy, case management, and medication monitoring and risk management. The referral route into the team is via GP's and other professionals, not self-referral.

2.7 Within Grays Hall the Recovery and Well Being Team and the Assertive Outreach Team provide longer term support from both health and social care practitioners.

2.8 The Crisis Intervention Team is based at Basildon and Thurrock University Hospital (BTUH) and works with individuals to prevent admission and facilitate discharge. The RAID CORE 24 Team offers a one hour response to patients presenting with mental health challenges at BTUH accessing A&E or for inpatients. Street Triage based in the Police Force Control Room (FCR) supports the police and with a crisis response option to ensure appropriate application of their powers under s136.

2.9 Inpatient assessment and treatment across working age adults and older age adults is provided through the wider CCG block contract across Essex. Patients within Thurrock have access to an assessment unit, adult acute inpatient beds, older people functional beds and psychiatric intensive care beds. These beds operate across a South Essex footprint.

2.10 Thurrock has a number of services funded by the CCG and Adult Social Care to support early intervention and prevention within Mental Health and provide therapeutic self-management support.

2.11 There are a range of specialist teams which provide care for particular conditions including people with eating disorders, personality disorders, Asbergers and specialist perinatal mental health care.

2.12 The current Crisis Resolution Home Treatment (CRHT) operates 12 hours per day, 7 days per week. The team 'gate-keeps' admissions to inpatient services and facilitates early discharge. A business case is being developed to develop a 24/7 direct access mental health crisis service.

2.13 A range of universal services are accessed by service users with mental health problems. This includes social prescribing (estimated 66% of all clients have an underlying mental health issue), Local Area Coordination, Housing Operations, Healthy Lifestyles Services including NHS Health Checks operating in EPUT and MIND, drug and alcohol treatment services, and community and third sector groups.

2.14 Commissioning of the current mental health system is also fragmented. NHS Thurrock CCG lead commissioning Inclusion Thurrock to provide IAPT services, the secondary healthcare treatment services provided by EPUT on behalf of the Mid and South Essex CCG Joint Committee and commission some third sector provision. Similarly Thurrock Council Adult Social Care also commission EPUT through the section 75 arrangement for social care staff, and commission a range of third sector and community social care support. The Council's Public Health Team commission drug and alcohol and healthy

lifestyles service provision. NHS England commission Primary Care services. Basildon and Brentwood CCG lead commissioning of A&E services on behalf of the Mid and South Essex Joint Committee. NHS England, via specialist commissioning, commission low and medium secure services. West Essex CCG commission children's mental health and emotional wellbeing services.

2.15 Some work has already commenced to integrate commissioned care pathways. This includes improved collaboration between *Inclusion Thurrock* and NELFT; *Inclusion Thurrock* and EPUT; and within *Inclusion Thurrock* for clients receiving both IAPT services and Drug and Alcohol Treatment (dual diagnosis).

3. Background – Transformation of Mental Health Services work to date

3.1 Thurrock Council, Thurrock CCG and local NHS healthcare provider organisations and the third sector have embarked on a major programme of health and social care transformation over the past three years. This has included the *Stronger Together* programme of community development using a strengths and asset based approach, new models of integrated primary, community and social care set out in *Better Care Together Thurrock,* proposals to build for new Integrated Medical Centres, and a new Integrated Care Alliance and MOU which seeks to integrate commissioning and delivery of a single health and care system around a new outcomes framework.

3.2 Thurrock CCG has developed an STP wide service mental health transformation group. The group has initially focussed upon delivering the core mental health targets identified within the Mental Health Five Year Forward View (MHFYFV). This has overseen the significant additional local funding into Perinatal Services, Early Intervention in Psychosis Service, and Psychiatric Liaison in BTUH and Employment services.

3.3 The CCG GP clinical lead has established a clinical forum with consultants from EPUT, Inclusion and other partners to improve relationships and co-ordination of care. The group has significantly improved engagement and created an environment within Thurrock which promotes innovation and trust.

3.4 However, historically the issue of mental health and mental health treatment services has not featured as strongly as perhaps it could within wider system transformation plans. As a result, three major pieces of work have been undertaken in 2018 considering the issue of adult mental health transformation in Thurrock:

- An Adult Mental Health Joint Strategic Needs Assessment was undertaken by Public Health and agreed at the March 2018 Joint Health and Wellbeing Board.

- A Local Government Peer Review was undertaken in June 2018 which considered eight issues: current thresholds to access treatment; the extent to which services were person centred and outcome focussed; market capacity and development needs; the extent to which the current service offer was holistic; prevention and early intervention; partnership working; the section 75 arrangements between the council and EPUT, and; the suitability of current commissioning arrangements.

- Healthwatch Thurrock undertook research with residents who were users of local mental health treatment services to better understand patient experience of existing local services. It concluded that 88% of respondents felt unsupported in their mental health issue and made a series of recommendations for system wide transformation.

3.5 A report by the Director of Public Health which aimed to triangulate learning from the JSNA, LGA Peer Review and Healthwatch Research and propose strategic action on transforming the local adult mental health treatment system was agreed at the September 2018 Thurrock Joint Health and Wellbeing Board. The report set out five priority areas for action to improve local mental health services which are discussed in more detail in sections 5 to 8 and made a series of recommendations. These are included in the action plan in section 10.

1. Address the issue of under-diagnosis of mental health problems
2. Improve access to timely treatment
3. Develop a new model for Common Mental Health Disorders
4. Develop a new *Enhanced Treatment Model* for people with serious mental ill-health conditions
5. Integrate commissioning and develop a single common outcomes framework supported with improved commissioning intelligence.

4. Address the issue of under-diagnosis of mental health problems

4.1 As with many other long-term conditions in Thurrock, there are a significant cohort of the population living with Common Mental Health Disorders who remain undiagnosed and are therefore not receiving support treatment. The latest modelled estimates from Public Health England (2016) found there are likely to be as many as 21,317 residents who have depression in Thurrock, of which 8,628 remain undiagnosed. The size of this cohort is a significant public health issue in itself and also will likely be compounding poorer health outcomes in patients with other co-morbid long term conditions.

4.2 The Mental Health JSNA shows an approximate four-fold variation in GP Practice Depression QOF register completeness ranging from 24% through to fully complete. A number of programmes are already being implemented to *find the missing thousands* of residents with undiagnosed depression. These include:

- Including the PHQ-9 depression screening tool as part of the Thurrock NHS Health Check Programme
- Commissioning ICS to interrogate SystmOne in GP practices to identify patients' medical records that have entries that may suggest depression (for example prescription of an SSRI) but who are not on depression QOF registers
- Piloting proactive template prompts in SystmOne that highlight the need for a GP to undertake a PHQ-2/9 depression screen with patients being reviewed/newly diagnosed with physical long term conditions (starting with diabetes with a view to rolling out across all LTCs if successful).

- Piloting embedding electronic IAPT referral into SystmOne in response to a positive screen on a PHQ-9.

4.3 There are further opportunities to embed depression screening across the health and care system locally, particularly by front line professionals such as community nursing and social care staff working with older people (who are at significantly greater risk of having undiagnosed depression), other community workers for example Local Area Coordinators and Social Prescribers, and moving forward the new *Wellbeing Teams* about to be piloted in Tilbury and Chadwell. Future mental health transformation plans need to consider these and other opportunities for embedding depression screening into the role of the wider workforce, and for widening access to symptom checkers for the general population. For example, there may be further opportunities to embed depression screening tools into existing E-Consult/Web-GP and NHS Choices software.

5. Improve timely access to treatment

5.1 Difficulty in accessing current local mental health treatment services is a recurrent theme running through the JSNA, LGA Peer Review and 'User Voice' work undertaken by Healthwatch This is true of both services to treat Common Mental Health Disorders and more serious mental ill-health.

5.2 The DH has a national ambition to have 25% of patients estimated to have depression or anxiety treated by an IAPT service by 2020/21. Thurrock is on track to deliver against this target. However, the Thurrock average hides significant variation between practices. The figure in Thurrock varies from 8% to 46% across different GP practice populations. Further work is required to understand and address variation in access to IAPT services. Furthermore, we need to understand why only 50% of people recover following treatment and to understand how to provide more responsive care.

5.3 Accessing secondary mental health treatment services is equally problematic and is highlighted in both the LGA Peer Review and User Voice work. Historically, EPUT only accepted new referrals from a GP surgery. This caused an immediate problem to residents in need of urgent mental health support who are unable to access a GP appointment quickly, leaving them without access to timely assessment and treatment and risking further deterioration in their mental health. The LGA Peer Review commented that "*GP referral is building unnecessary delays into the system."* However, recent improvements to the care pathway now mean that referrals can be made directly from Thurrock First into EPUT.

5.4 A lack of direct open access 24/7 crisis care is repeatedly referenced in the user voice and LGA peer review as an issue, and is likely to be a key contributory factor to avoidable demand on A&E, currently the only part of the system offering direct access to services for residents in mental health crisis. A RAID (Rapid Access, Interface and Discharge) team is operating at Basildon Hospital.

5.5 Thurrock CCG is leading the work to develop an open access 24/7 community crisis service in EPUT. The model will enable people to access specialist crisis

care via 111. EPUT will provide both the triage and the specialist teams to assess and treatment teams. The ambition is that the funding will be approved to enable the service to begin mobilisation in the new financial year and be operational for the winter 2019.

6. A new treatment model for Common Mental Health Disorders

6.1 Common Mental Health Disorders (CMHDs) include depression, generalised anxiety disorder (GAD), panic disorder, phobias, social anxiety disorder, obsessive-compulsive disorder (OCD) and post-traumatic stress disorder (PTSD). CMHDs account for the vast majority of mental health problems in the population and moreover, the vast majority these cohorts of patients will be treated in Primary and Community Care. The most prevalent CMHD in Thurrock is *Mixed Anxiety and Depressive Disorder*, affecting just under 12% of residents aged 16-74.

6.2 There is an unacceptable level of variation in the clinical management of CMHD between different GP surgeries with many surgeries failing to review newly diagnosed residents with depression in a timely manner. The CCG's Primary Care Development Team in conjunction with Healthcare Public Health staff need to address this variation and improve performance on this indicator through the ongoing work of continuous quality improvement based around the GP Profile Card and GP Practice visits.

6.3 The current treatment offer for CMHDs is too narrow. Currently patients typically are offered anti-depressant medication and/or referral to talking therapies provided by IAPT. However CMHD risk is strongly associated with socio-economic and psycho-social factors. As such, CMHDs are not evenly distributed amongst the population and are dependent at least in part by the environment in which the individual lives. CMHDs are more likely to persist in people in lower socioeconomic groups such as people who are on low incomes, long-term sick or unemployed. The Marmot report*, Fair Society, healthy lives*[i] showed that, among other factors, poor housing and unemployment increase the likelihood that people will experience mental health disorders and affect the course of any subsequent recovery. Feelings of loneliness are worse and social network size is smaller among mental health service users than in the general population.[ii,iii] Conversely, there is a wide body of evidence that demonstrates the highly mentally health protective effect of having strong positive social connections and being employed.

6.4 There is a strong and growing evidence base demonstrating exercise to be an effective intervention for treatment of mild to moderate depression a valuable complementary therapy to the traditional treatments for severe depression. Physical activity has been shown to be as effective as anti-depressant medication and psychotherapy in reducing both depression and anxiety with the greatest gain observed in those who already have clinical symptoms. [iv] However at present, very few patients with CMHD are referred by GPs into Public Health commissioned physical activity programmes and action needs to occur to ensure exercise on prescription becomes a common treatment offer to local residents who have been diagnosed with depression or anxiety. Further

work is required to understand this issue and increase referral rates from GP surgeries into this treatment option.

6.5 There is an unequivocal link between CMHDs and long term physical health conditions. 30% of people with a long-term physical health problem also had a mental health problem and 46% of people with a mental health problem also had a long-term physical health problem. Co-morbid mental health problems have a number of serious implications for people with long-term conditions, including poorer clinical outcomes, lower quality of life and reduced ability to manage physical symptoms effectively and this translates to considerable excess treatment costs to the NHS.

6.6 There is an urgent need to expedite recommendations set out in the *Tilbury and Chadwell New Model of Care Case for Change,* to integrate treatment on mental ill-health with that of physical long term conditions in a single one stop shop.

6.7 Significant opportunity also exists to design a new model of care for treatment of CMHD that broadens the offer to encompass a 'strengths based' approach to mental health, having a different 'strengths based' conversation with residents suffering from CMHDs, connecting them with community assets to increase social capital and helping them to address wider determinants of health where appropriate, particularly employment.

6.8 In the medium term, the new Integrated Medical Centres provide an opportunity to create new models of care that integrate mental health treatment provision with physical long term condition services, and those that address wider determinants of health such as employment support and wider 'community wellbeing' approaches through flexible space for third sector groups and Local Area Coordination.

7. Developing a new 'Enhanced Treatment and Recovery' Model for Serious Mental Ill-Health

7.1 Serious Mental Ill-health (SMI) is defined by this report as psychiatric conditions too complex to be treated in Primary Care or by IAPT. It encompasses a wide spectrum on conditions that would include very severe non-psychotic disorders, personality disorders through to patients with severe and enduring psychotic illness including schizophrenia, schizotypal and delusional disorders and Bipolar Affective Disorders.

7.2 Current clinical interpretation of thresholds for access to treatment across the mental health systems is resulting in inadequate service provision for patients in the lower end of the enhanced treatment spectrum. The LGA Peer Review team termed these residents *The Missing Middle*; a cohort of patients too mentally unwell to receive an appropriate treatment offer in Primary Care or IAPT but not unwell enough to meet EPUT thresholds for access to services.

7.3 Anecdotal evidence on the characteristics of The Missing Middle suggests that they often return to Primary Care, Thurrock Healthwatch and Local Area Coordinators looking to access services from parts of the system that are not best skilled or equipped to provide it. Local GPs and Healthwatch report that

many people within the Missing Middle have personality disorders, and often have chaotic lifestyles with multiple issues including housing and drug/alcohol problems. A multi-agency project group has been established to focus on improving outcomes for those with personality disorders. The group is working on:

- Understanding the profile of those with personality disorders, including where in the system they present.
- Designing an evidence-based assessment and treatment pathway which will comprise of a partnership approach.
- Developing a training package to relevant professionals to improve confidence with identifying and treating these individuals.

7.4 Like CMHDs the current offer is too clinical and not sufficiently person centred or holistic. There is clear evidence the wider determinants of health including housing, employment and social isolation can have a major influence on relapse and recovery rates of SMI, yet at present these are commissioned and provided by other parts of the health and local government system largely in isolation of secondary clinical services. Furthermore, the current service offer is seen as too reactive, waiting for patients to hit mental health crisis before services are available and with insufficient focus on early identification and intervention to prevent patients with SMI entering crisis.

7.5 Some progress is being made to broaden the current treatment offer. *Inclusion* Thurrock is increasing its staffing resource to provide Individual Placement Support (IPS) to patients being treated by the Early Intervention in Psychosis team. This new service will aim to facilitate clients back into employment. IPS will also soon become fully operational within EPUT's Community Mental Health Teams. A review of care coordination by EPUT is underway to ensure a more holistic approach to care is delivered within EIP and CMHT teams.

7.6 People with serious mental health problems face one of the greatest health inequality gaps in England. The life expectancy for people with SMI is 15-20 years lower than the general population. 40% of people with SMI still smoke. National guidance was released in February 2018 to improve the physical healthcare of people with SMI in primary care. The guidance sets out that good quality physical health care is based on the completion of the physical health assessments, follow up referrals and ongoing personalised care planning. There have been parallel work to improve the physical health of individuals in secondary care. This has focussed on improving cardio-metabolic assessments.

7.7 Despite these improvements a radically new model of Enhanced Treatment and Recovery is required that:

- Enhances specialist mental health support within primary care to improve timely access to care.
- Reduces fragmentation in current care pathways within EPUT and provides a stronger continuity of care relationship.

- Reduces fragmentation between Primary and Secondary care including access to Psychiatric Nursing as part of Primary Care mixed skill workforce teams.
- Seeks to reduce un-necessary inpatient stays and re-admissions through focusing on prevention and early intervention activity.
- Embeds physical health assessment, health improvement and lifestyle modification into secondary care pathways.
- Provides an integrated treatment offer for patients with dual diagnosis including the ability to have SMI and drug and alcohol misuse issues treated in parallel.
- Better leverages the skill set of specialist social care field work staff in addressing the wider determinants of health.
- Encompasses a 'strengths-based' community asset focus that promotes per support and increases service users social connectivity in the context of their families and wider communities.
- Shifts the current balance of treatment from one of reactive intervention in crisis to one of proactive crisis and relapse prevention.

7.8 Delivering a new model of care that encompasses the above requires a whole system change across the whole mid and South Essex STP. It is not going to be possible to change one part of the system in isolation. Addressing the 'missing middle' will require a whole system change. It will require co-ordinated changes in prevention, social care, primary care, secondary care and crisis care across the whole STP footprint. To this end, partners across the STP have embarked upon an exercise to develop a 'costed' strategy. Partners are aiming to work rapidly to articulate a clear case for change, high level care model, workforce plan, estates plan, and digital plan and associated finances. The aim will be to produce a radically different model of care which is deliverable within our current workforce and financial constraints. In effect, the STP plan will 'unpick' the block contract to facilitate, enable and empower our Thurrock locality working.

7.9 ***Open Dialogue*** is a Finish holistic, strengths based approach to treating people with psychosis that is currently being piloted in the UK. Unlike traditional medical models treatment, it conceptualises psychosis as a problem occurring between individuals and in relationships rather than a problem that occurs in the brains of patients with SMI. It rejects traditional medical model paradigms of expert assessment and diagnosis plus pharmacological interventions and hospitalisation treatment with a community based approach that seeks to repair the relationships in the lives of patients and help them generate their own solutions.

7.10 The *Open Dialogue* approach is humanistic and non-hierarchical. Patients are treated in their own homes (where possible) within 24 hours of reporting mental health crisis and therapy occurs between up to three therapists, the patient with psychosis and their family working together in the same session. The purpose of therapy sessions is to generate dialogue between therapists, patients and their families, and all parties reflect openly about their feelings towards one another and discuss ideas about the situation. The primary purpose of therapy is dialogue and "meaning making" and as a product of this dialogue solutions

begin to emerge and relationships begin to be repaired. Medication is kept to an absolute minimum and used for the shortest period of time possible, and only to help patients get over the worst symptoms. Sedatives to help patients sleep are favoured over neuroleptic medication which is seen as preventing "meaning making". Hospitalisation of patients is also avoided in all circumstances possible, with community nurses staying overnight in patients' own homes when they are very seriously unwell. Treatment is continued in terms of 'open dialogue' until medication is ceased.

7.11 Outcomes for patients using the *Open Dialogue* approach have been highly positive in Finland. Two thirds of patients with psychosis never used anti-psychotic medication and of the third that did, 50% ceased using during treatment meaning only one in six patients with psychosis continued on long term anti-psychotic medication. In patient bed use has almost completely ceased. More impressively, the approach claims that 85% of patients with First Episode Psychosis (FEP) recover within six months meaning that schizophrenia prevalence has dropped in Western Lapland from one of the highest in the world to one of the lowest. (This compares to the gold standard target for NICE recommended Early Intervention in Psychosis interventions in the UK of 50% recovery. Furthermore, background unemployment rates of FEP patients who recover using Open Dialogue are lower than in the general population in Finland, suggesting the treatment produces productive individuals who integrate well back into general society.

7.12 Following a workshop led by Public Health and NELFT (who are piloting the Open Dialogue approach in localities outside Thurrock), EPUT, Thurrock Council and NHS Thurrock CCG committed to participation in a national Randomised Control Trial that is assessing the impact of the *Open Dialogue* approach in the UK. A multi-professional team of EPUT clinical and Thurrock Council Adult Social Care staff will be trained to in delivering *Open Dialogue* during 2019, and will aim to implement the approach in Thurrock in late 2019 / early 2020. The approach has the potential to radically improve both timely access and outcomes for patients in mental health crisis, provide a continuity of care relationship throughout a patient's treatment journey, reduce demand on secondary mental health care in-patient beds and deliver significantly more holistic and family centred approach to treating serious mental ill-health. It has the potential to address many of the key criteria set out in section 7.9 in terms of a new and improved treatment offer for patients in mental health crisis. The approach also integrates well with the wider asset/strengths based transformation programme as set out in section 3.1.

7.13 **Section 75 Agreement.** The Section 75 Agreement between Thurrock Council and EPUT allows the Local Authority to delegate its statutory duties under the Care Act 2014 to deliver social work and social care services. The current model is embedded in an existing medical model of GP referral (or referral by other professionals via Thurrock First) and the threshold for access to services is very high and not fully compliant with the principles of the Care Act. For a number of years we have tried to address this but this has not progressed as fast as we would like. The performance framework within the Section 75 Agreement is not outcome focused and as stated above a considerable amount of joint work between EPUT and the three local authorities is taking place to

address this. We are clear that the current Section 75 Agreement is now not fit for purpose however what we have learnt from the development of the Southend, Essex and Thurrock Mental Health Strategy, the outcomes for the Thurrock Health and Well-being Strategy, the recommendations of the Mental Health Joint Strategic Needs Assessment and the Peer Review is that a partnership approach is required to develop a new model for the provision of mental health services.

7.14 The Council will therefore work in partnership with EPUT and the CCG to ensure that Section 75 approach is aligned with our CCG colleagues. The council will develop a new Section 75 Agreement with EPUT from the 1st April 2019 with a revised performance and budget framework. The Section 75 Agreement will also focus on the social work role and the work around social work for better mental health to ensure a more robust approach to Care Act delivery. We propose offering EPUT a longer term agreement, in line with CCG commissioning intentions. The first year of the new agreement will enable all partners to engage with the work to develop a costed strategy that will then be reflected in the four year longer contract. Within the first year, we will seek to agree the following:

- A new Performance and Outcomes Framework
- Enhanced data sharing between EPUT and commissioners to support the Performance and Outcomes Framework
- A new workforce strategy that supports social care staff
- Transparency around finance
- A new operating model

7.15 The successful completion of the work and the development of a care model which addresses Care Act compliance, the missing middle and the move towards prevention will then be the basis for the longer term contractual arrangement. It will enable CCG and council colleagues to develop a more integrated approach to this work. The revised performance framework will be key to the delivery of an outcomes approach and the transformation of mental health approaches in Thurrock. The framework will be based on extensive work currently being undertaken across the three Local Authorities in partnership with EPUT ensuring that high level strategic information is available supported by the outcomes achieved with individuals. It will be important to support the joint commissioning approach that performance can be monitored jointly with the CCG. The initial framework will be in place by 1 April 2019 and the first year of the new section 75 agreement will allow for further development alongside the new and innovative approaches for mental health transformation. If Thurrock Council is not satisfied with the rate of progress in establishing a long-term section 75 framework it reserves the right to withdraw from the agreement and end the secondment arrangement for its social care staff. A review meeting will be held before the end of September 2019 to assess whether sufficient progress has been made.

8. **Integrate Commissioning and develop a single common outcomes framework supported with improved commissioning intelligence**

8.1 Commissioning arrangements in mental health are complex and dispersed. Thurrock CCG leads mental health commissioning across the Mid and South Essex STP geography. The role focusses on three aspects; leading the EPUT contracting and performance management, commissioning urgent and emergency care and co-ordinating work across the STP.

8.2 This is based on the principle of 'do it once' where CCG's and EPUT avoid duplication of effort to maximise efficiency and reduce bureaucracy. This is particularly important in relation to services which are delivered at scale. For example, there is only one assessment unit or PICU unit for the population of South Essex. The CCG ensures that there is good financial governance and performance management. This is particularly important for quality monitoring where it is important to look at trends over a larger footprint. For example, over the contract, we monitor is there an increase in serious incidents in particular service areas.

8.3 However, it is also fair to say that there are occasions where the 'do it once' approach causes local frustrations. As local economies develop locality based integrated care models there is a need for developing local flexibilities to reflect local needs. This is felt strongly within Thurrock where our alliance work is well progressed. There is therefore a tension between local and system.

8.4 We are therefore working towards developing a three tiered governance structure which co-ordinates STP system executive leadership, a focussed EPUT transformation board and a Thurrock Mental Health Transformation Board. This will ensure that there is system oversight, EPUT delivery and local integrated delivery.

8.5 Reporting arrangements against these contracts happen at individual contract level and are inadequately focussed on outcomes, tending instead to concentrate on process inputs such as numbers of patients seen and interventions delivered. Furthermore, their focus is almost completely clinical and many fail to capture wider wellbeing metrics and those focused on the wider determinants of health such as employment and housing. Primary Care performance is not triangulated with secondary performance, reinforcing the fragmentation of care between these two settings.

8.6 There is a clear need to rationalise and integrate the current disparate and fragmented commissioning arrangements relating to the local mental health service into a single shared CCG and Local Authority function, and to agree a single systems wide performance framework focused on outcomes which underpins a transformed provider landscape and new integrated treatment models. The LGA Peer Review Team highlighted the lack of integrated commissioning and lack of evidence of a single reporting and outcomes framework as a *significant shortfall* in current arrangements and also suggested that the current section 75 agreement between the local authority and EPUT needed to be considered as part of a wider commissioning review.

8.7 Future commissioning arrangements need to broaden the current focus and be more holistic and wider than current clinical services, encompassing the key issues of social support, housing and employment highlighted in sections 6.3 to 6.11 and 7.8. A Thurrock Mental Health Partnership Board will be established to

drive the local mental health agenda. The Board will bring together CCG, local authority and public health commissioning arrangements. This Board will be the first step towards developing more formal joint commissioning arrangements. The board will provide a specific mental health focus to the work of the *Thurrock Integrated Care Alliance* including a shift from individual contract and provider process/input KPIs to single system wide outcome KPIs with agreed financial risk and reward mechanisms.

8.8 Much NHS Commissioning of secondary mental health services now occurs through the CCG Joint Committee at an STP rather than Thurrock footprint. This includes secondary care inpatient services, Crisis Resolution and Home Treatment Teams and Rapid Assessment, Interface and Discharge services in A&E. The Thurrock Mental Health Partnership Board will need to align to the STP Partnership Board so that there is co-ordination between system wide services and integrated locality working.

8.9 The Integrated Dataset work being led by Public Health through MedeAnalytics has the potential to improve commissioning intelligence moving forward, and it is expected that IAPT data will be linked to SUS, Adult Social Care and about 25% of GP Practice System One data by spring 2019.

8.10 The Mental Health Service Data Set has been specified by Public Health in their contract with Arden GEM (the DSCRO that flows SUS data into Mede Analytics. As such, secondary mental healthcare data will form part of the integrated dataset moving forward.

9. Joint Work between Mental Health Commissioning and Housing

9.1 The connection between positive mental health outcomes for individuals and settled accommodation is well documented and researched. Shelter's Report – The impact of housing problems on mental health, published in April 2017 highlights that of 3,509 interviewed for the research adults experiencing mental ill health 69% of them said that housing problems such as poor conditions, struggling to pay rent or being threatened with eviction had a negative effect on their mental health.

9.2 The LGA Peer Review also highlighted that in Thurrock there was evidence of good practice in the community concerning housing support and that the Housing and Mental Health operational group supported the resolution of operational issues.

9.3 However there is no clearly defined specific Housing and Mental Health Strategy and it is recommended through the LGA Peer Review and agreed that across Mental Health Commissioning and Housing there needs to be a joint Strategy and Policy. This is identified in the action plan and will be developed and co-produced through 2019.

10. Suicide Prevention

10.1 In a recent speech to the Global Ministerial Mental Health Summit on World Mental Health Day, the Prime Minister announced that Thurrock M.P. Jackie Doyle-Price would become the UK's first Minister for Suicide Prevention, with a remit to reduce the current 4,500 people who take their own lives each year in

England, and overcome the stigma that prevents people from seeking help. Suicide is the biggest killer of men under the age of 45. She also announced that every local authority area should have a suicide prevention plan in place. In the Autumn Budget, the Chancellor announced an additional investment of £250 million in new mental health crisis services including money for suicide prevention activity, which can be accessed via Sustainability and Transformation Partnerships.

10.2 Many areas have signed up to a Zero Suicide ambition. Whilst the evidence base for achieving a Zero Suicide ambition is limited, the concept aims to challenge the prevailing wisdom that suicide is inevitable for some people when they hit rock bottom. The idea of 'zero suicide' provokes debate about how much more we might be able to do in the future to avoid such tragedies.

10.3 In Thurrock in 2017 there were five recorded deaths by suicide. Whilst tragic for the individuals and their family/friends, this represents 0.0031% of the population and is a very low number. However, evidence suggests that for every successful suicide there are at least 10 para-suicides (failed suicide attempts), and possibly thousands of residents with suicide ideation or in mental health crisis. **As such, effective action to prevent suicide must be set in a context of improving wider mental health services set out in sections 6 and 7, and a broader approach to improving community mental resilience in schools and workplaces, rather than direct action that focus on a very rare population outcome.**

10.4 A recent literature review of the published evidence base on suicide prevention undertaken by the Public Health Service, identified the following as being effective in reducing the risk of suicide

- School Based preventative approaches based on working with young people to identify risk factors for poor mental health and self-harm attempts
- 'Gate keeper' training of relevant health professionals including teachers and the police. There is no evidence that training of GPs specifically has any impact.
- Psycho-social assessment and on-going CBT for those presenting with a self-harm attempt.

10.5 Thurrock has agreed the following actions on suicide prevention based on guidance from Public Health England and the published evidence base. These include:

- Establishing and participation in multi-agency partnership at Mid and South Essex Level to take action on suicide prevention across all key stakeholders
- Participation in on-going suicide audit work at Essex level to improve understanding and intelligence on suicide. Because of the very small numbers involved, we propose undertaking a suicide audit across Essex based on the last ten years' data
- Development of a new Suicide Prevention Strategy at Essex level, against which new government funding can be accessed based on the findings of the Suicide Audit

- Implementation of the Mental Health Schools Based Wellbeing Service and well-being teams to boost capacity and capability in schools to prevent suicide and identify and intervene early with those young people at risk
- Implementing a training programme of suicide awareness with front line professionals at Essex level in line with the published evidence base
- Develop a local information-sharing system to ensure that information on para-suicides (and other people at very high risk of suicide) is cascaded to relevant agencies.
- Develop protocol for multi-agency action to provide support to prevent further attempts in cases of para-suicide
- Transformation of mental health crisis services as set out in section 7 of this report including improving access to 24/7 crisis care.
- Review of self-harm care pathways and improvement in line with recommendations in the published evidence base.

11. Next Steps and Action Plan

11.1 At its October 2018 meeting The Thurrock Joint Health and Wellbeing Board agreed appointment of a Strategic Lead for Public Mental Health and Mental Health Transformation, to coordinate action across all stakeholders to transform and improve the adult mental health system in Thurrock in line with actions set out in this report. The post will be accountable to a new Mental Health Transformation Board that will be a sub-group of the Health and Wellbeing Board.

11.2 The key deliverable of the post will be a Mental Health Transformation Strategy Case for Change encompassing the priority areas set out in sections 4 to 10 of this report. We would envisage this being complete towards the end of 2019.

11.3 A high level action plan, developed from the recommendations from transformation work to date, set out in this report is supplied below as an appendix.

12. Reasons for Recommendation

12.1 The current mental health and care treatment offer is failing residents and is need of urgent reform to improve outcomes, provide a more seamless and holistic care offer and strengthen prevention and early intervention approaches.

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

13.1 This report is based on work that has included a significant amount of consultation between other stakeholder organisations and residents including the Adult Mental Health Joint Strategic Needs Assessment, Local Government Association Peer Review and Healthwatch Thurrock research with service users of local mental health and care services. It is based on a report produced by The Director of Public Health that triangulated the findings of these previous pieces of work, and which was presented and agreed at the October 2018 meeting of the Thurrock Joint Health and Wellbeing Board.

14. Implications

14.1 Financial

Implications verified by: **Jo Freeman**
Management Accountant

The recommendations as set out in this report do not have any immediate direct financial implications on the council in the sense that the work programme will be funded from existing allocated resources.

Implementation of recommendations made in the new *Mental Health Case for Change* (when produced as a result of the work of the new Strategic Lead for Mental Health Transformation) in consultation with partners may identify the need for future investment across the health and care system to address the current issue of poor access and long waiting times.

14.2 Legal

Implications verified by: **Roger Harris**
Corporate Director AH&H

The Transformation of Mental Health Services in Thurrock will ensured the continued delivery of the duties outlined in the Mental Health Act 1983 (Amended 2007) and the Care Act 2014.

14.3 Diversity and Equality

Implications verified by: **Natalie Warren**
Strategic Lead Communities and Diversity

Residents with mental ill health are at significantly greater risk of experiencing health inequalities. The programme of transformation work set out in this report will help to address this issue.

15. 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):

- Thurrock Joint Strategic Needs Assessment on Adult Mental Services. Thurrock Public Health Team (2018)
- Local Government Association Peer Review (2018) into Adult Mental Health Services in Thurrock
- Thurrock Healthwatch Mental Health Consultation Report (July-August 2018)

16. Appendices

Appendix A – Mental Health Transformation Action Plan

Report Authors:

Ian Wake, Director of Public Health
Catherine Wilson, Strategic Lead Commissioning, Adults Housing and Health
Mark Tebbs, Director of Commissioning, NHS Thurrock Clinical Commissioning Group

References

[i] The Marmot report*, Fair Society, healthy lives.* London: Institute of Health Equity. 2010. http://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review/fair-society-healthy-lives-full-report-pdf.pdf

[ii] Lauder W, Sharkey S, Mummery K. A community survey of loneliness, *Journal of Advanced Nursing*. 2004;46(1): 88–94, DOI: 10.1111/j.1365-2648.2003.02968.x.

[iii] Palumbo C, Volpe U, Matanov A, Priebe S, Giacco D. Social networks of patients with psychosis: a systematic review, *BMC Research Notes*. 2015; 8: 560–560

[iv] Rethorst, C., Wipfli, B., & Landers, D. The antidepressive effects of exercise: A meta-analysis of randomized trials. *Sports Medicine*. 2009; *39*: 491– 511.

Recommendation	Key Objective	Lead	Other Key Stakeholders	Timescales
1) Improve the diagnosis of residents with undiagnosed depression and anxiety	a) Expedite roll out of the PHQ2/9 depression screening tool prompt template in SystmOne for patients that are being reviewed for physical Long Term Health Conditions	Healthcare Public Health Team	GPs, Primary Care Development Team	By June 2019
	b) Improve the uptake of NHS Health Checks Programme such that a minimum of 60% of those offered a health check receive one, as a systematic way of screening for depression through implementation of the Health Checks Strategic Plan	Thurrock Healthy Lifestyles Team Manager	GP surgeries, Pharmacies	By March 2019
	c) Embed depression screening into the practice of wider front line professionals including front line house, social care and community workers	Strategic Lead, MH Transformation	Principal Social Worker AD Housing Operations NELFT LTC Management Teams Strategic Lead Community Development	By June 2019
	d) Improve access to depression screening for the general population with the use of online screening tools linked to self-referral mechanisms	Strategic Lead, MH Transformation	Council and CCG Communications Leads	By December 2019
2) Improve Access to timely mental health treatment	a) Undertake capacity modelling to understand and implement actions to reduce IAPT waiting times to the six week minimum	CCG Mental Health Commissioning Lead	Inclusion Thurrock	By March 2019

	b) Develop and commission a new model of 24-7 direct access crisis care	CCG Mental Health Commissioning Lead	EPUT Strategic Lead, MH Transformation	*By Winter 2019
	c) Examine current and agree new system wide thresholds for treatment access for all MH clusters to ensure that *Missing Middle* are able to access timely and appropriate secondary MH services	CCG Mental Health Commissioning Lead Strategic Lead, MH Transformation Strategic Lead – ASC Commissioning	EPUT	By December 2019
3) Develop and commission a New Model of Care for Common Mental Health Disorders	a) Address the variation in referral to IAPT for CMHD amongst GP practices such that a minimum of 25% of patients estimated to have a CMHD receive treatment each year, and that age and sex variation is also reduced	Strategic Lead, MH Transformation Strategic Lead – Healthcare PH	GPs, Inclusion Thurrock	From April 2019 through rolling programme of GP surgery visits
	b) Address variation in clinical management of depression in Primary Care including inclusion of QOF indicators relating to depression review on the GP Practice Profile Card/Practice visits and future Stretched QOF iterations	Strategic Lead MH Transformation Strategic Lead – Healthcare PH	GPs	From April 2019 through rolling programme of GP surgery visits
	c) Expedite integration of IAPT Services with other LTC Physical Health Conditions to create single 'one stop shops' where all LTCs can be dealt with at the same time, as part of *Better Care Together* Transformation Programme building on the new pathway that is now in place between Inclusion Thurrock and NELFT	Strategic Lead – MH Transformation	NELFT LTC services Inclusion Thurrock CCG Mental Health Commissioning Lead	From April 2019

	d) Increase the Capacity of current Social Prescribing Service and embed within clinical teams of all GP practices, through roll out of Locality Based Mixed Skill Workforce Teams	Director of Primary Care, CCG Director of Transformation, CCG	CVS, GPs	Proposals by April 2019
	e) Design and implement a *New Model of Care for CMHDs* that encompasses programmes that support residents to address worklessness, increase physical activity and increase social capital and community connectivity, building on existing community assets	Strategic Lead MH Transformation	CCG Mental Health Commissioning Lead AD and Consultant in PH AD ASC and Community Development Community Hubs CVS	Proposals by December 2019
4) Develop and commission a New *Enhanced Treatment and Recovery* model	a) Further investigate and understand the needs of *The Missing Middle*	Strategic Lead – MH Transformation		Initial proposals by September 2019
	b) Review current referral criteria thresholds across IAPT and secondary care and agree new common standards to ensure service provision for *The Missing Middle*	Strategic Lead – MH Transformation	CCG MH Commissioning Lead Strategic Lead, ASC Commissioning Inclusion Thurrock, EPUT	Initial proposals by September 2019

	c) Reduce current fragmentation in care pathways within EPUT to improve continuity of care	Strategic Lead – MH Transformation CCG MH Commissioning Lead Strategic Lead, ASC Commissioning EPUT Operations Leads		Initial proposals by December 2019
	d) Reduce current fragmentation in care pathways between Primary and Secondary Care including basing Psychiatric Nursing Capacity within Primary Care Mixed Skill Workforce Teams	Strategic Lead – MH Transformation CCG MH Commissioning Lead Director of Primary Care, CCG Director of Transformation CCG		Initial proposals by December 2019

	e) To understand the current use of the available Bed base under the current Health Contract, particularly the increase in demand to then reduce this demand in line with increased community resources	Strategic Lead – MH Transformation CCG MH Commissioning Lead Director of Primary Care, CCG Director of Transformation CCG	EPUT	April 2019 Reduction on going through 2019 aligned to development of community resources.
	f) Embed physical health assessment, health improvement and lifestyle modification into secondary care clinical pathways to address the physical health needs of patients with SMI and improve life expectancy, integrating the current CQUIN into 'business as usual'.	Strategic Lead – MH Transformation AD and Consultant in PH	Inclusion Thurrock, Thurrock MIND, EPUT CCG Primary Care team	On-going
	g) Develop an integrated treatment offer for patients with SMI and drug and alcohol misuse problems, that treats both issues in parallel	Strategic Lead – MH Transformation AD and Consultant in PH CCG MH Commissioning Lead	Inclusion Thurrock EPUT	Pathway redesign from April 2019

	h) Leverage the professional skill set of social care staff in addressing the wider determinants of health of patients with SMI	Strategic Lead – ASC Commissioning Principal Social Worker, ASC.	EPUT	On-going through 2019 to be in place by April 2020
	i) Encompass a 'strengths-based' community asset focus that promotes peer support and increases service users' social capital within the new treatment model	Strategic Lead – MH Transformation	AD – ASC and Community Development EPUT Thurrock MIND Inclusion Thurrock (Recovery College)	Initial Proposals December 2019
	j) Integrate employment and housing support as an integral part of the new *Enhanced Treatment Model* and on-going recovery	Strategic Lead – MH Transformation	AD – Housing Operations, TBC Strategic Lead, ASC Commissioning	By March 2020
	k) Commission programmes that seek to identify and intervene at an earlier stage in the patient journey, shifting the current focus from crisis support to prevention and recovery	Strategic Lead – MH Transformation Strategic Lead – ASC Commissioning CCG MH Commissioning Lead		Initial Proposals December 2019
5) Integrate Mental Health Commissioning across council and CCG	a) Create a single shared commissioning function and strategy between TBC and NHS Thurrock CCG to undertake all commissioning across the current and future provider landscape	Director of Commissioning TCCG Strategic Lead - ASC Commissioning		Initial model by May 2019 further development ongoing through 2019

	b) Develop a single shared commissioning outcomes framework	Director of Commissioning, TCCG Strategic Lead - ASC Commissioning	Strategic Lead – MH Transformation CCG MH Commissioning Lead	Initial framework by May 2019 with ongoing development through 2019

To note – other actions relating to suicide prevention are outlined in the main body of the report.

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thurrock.gov.uk

Adult Mental Health System Transformation

Health and Wellbeing Overview and Scrutiny Committee

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Director of Public Health

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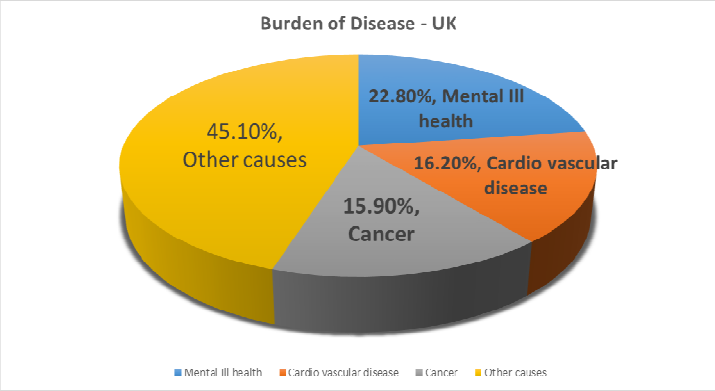
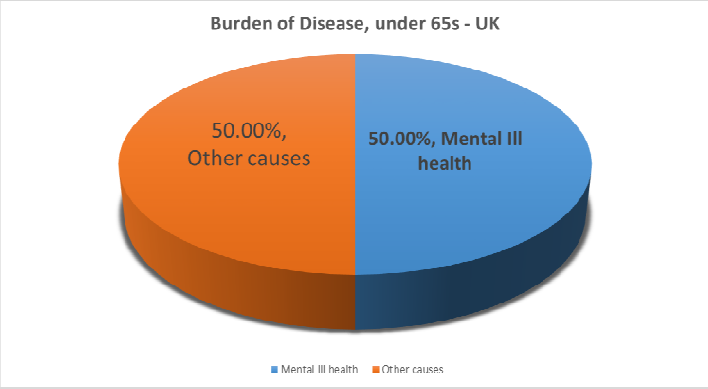
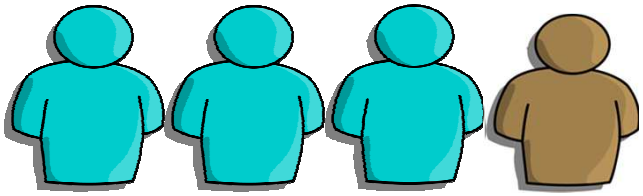
24 January 2019

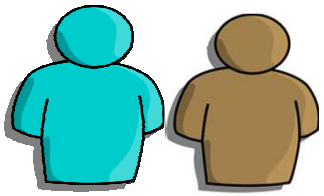
Epidemiological Overview of Mental Health



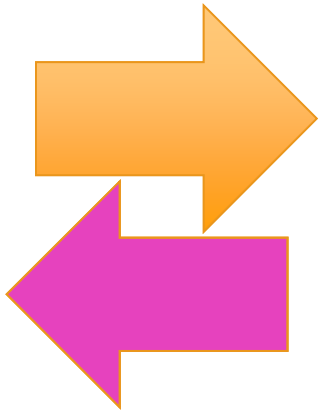




Lifetime



Preventable in childhood



Bi-directional relationship

LIFESTYLE™

Physical Health

NHS

Self Care

Health Service Usage

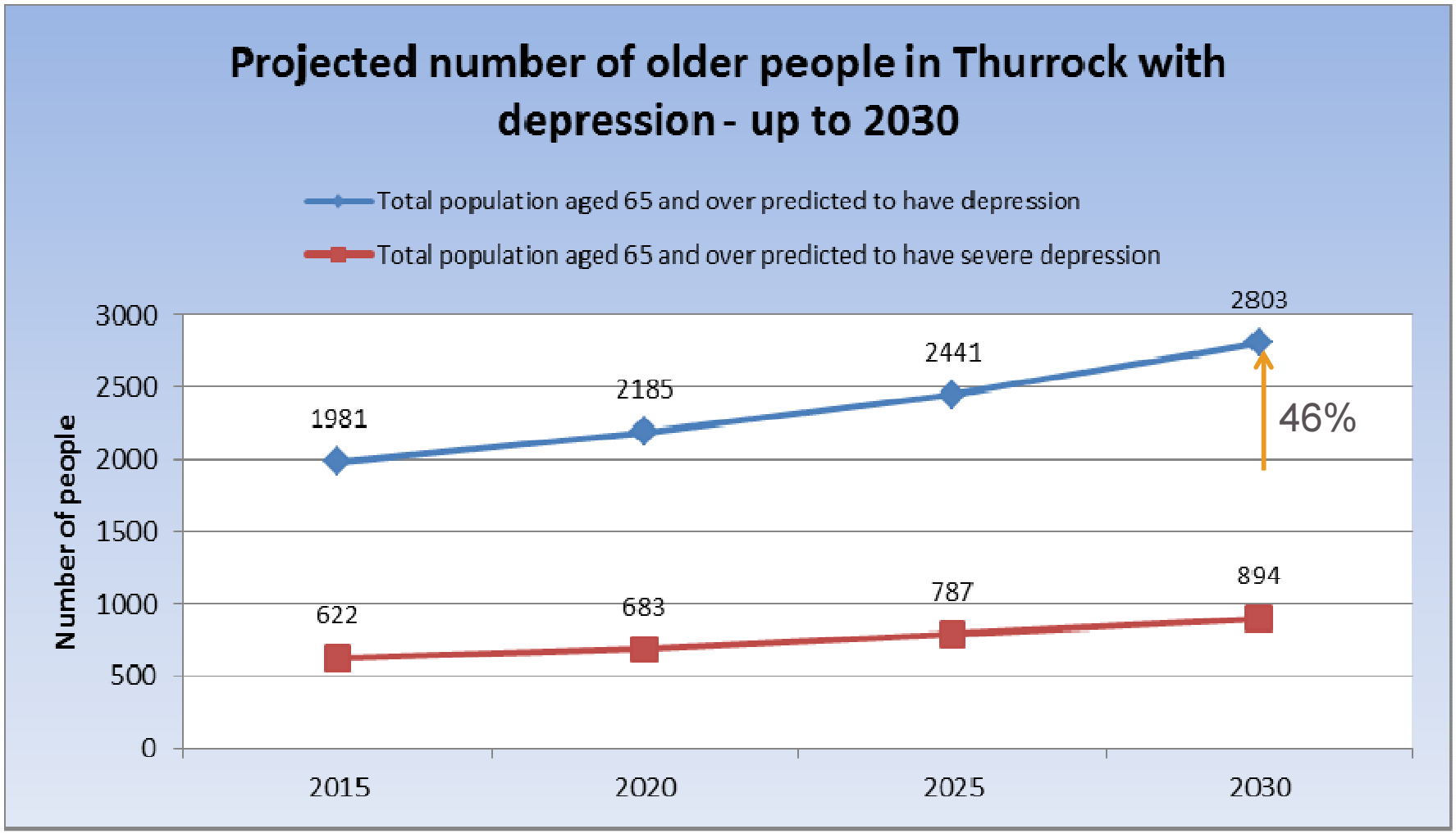
£1 in 8 – LTC condition spend **£28M Thurrock**

£circa 7M – Thurrock Council ASC

£150 Billion – doubling 20 years

A growing problem?

- 10% increase in CMHD in next 15 years



Person Centred – Outcome Focused?

Market Development

Holistic?

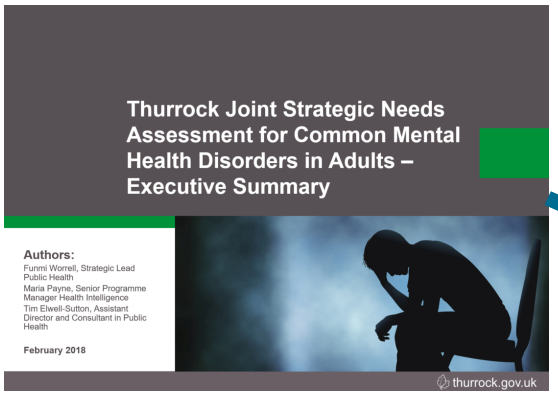
Thresholds

Preventative?

Local Government Association

Section 75?

Commissioning



Mental Health Service Transformation

healthwatch Thurrock

Published Evidence Base

Other Local Intelligence

Stakeholder Landscape

Section 75 Agreement

Secondary

70 YEARS OF THE NHS 1948 - 2018

NHS Essex Partnership University NHS Foundation Trust

thurrock.gov.uk Adult Social Care Fieldwork

Basildon and Thurrock NHS University Hospitals NHS Foundation Trust A&E

Commissioned specialist providers

Primary

GP Practices

inclusion Fulfilling Potential. Forging Success.

mind Thurrock for better mental health

Universal

thurrock.gov.uk Healthy Lifestyle Service

thurrock.gov.uk Housing Operations

thurrock.gov.uk Local Area Coordination

Thurrock CVS

Wider third sector provision

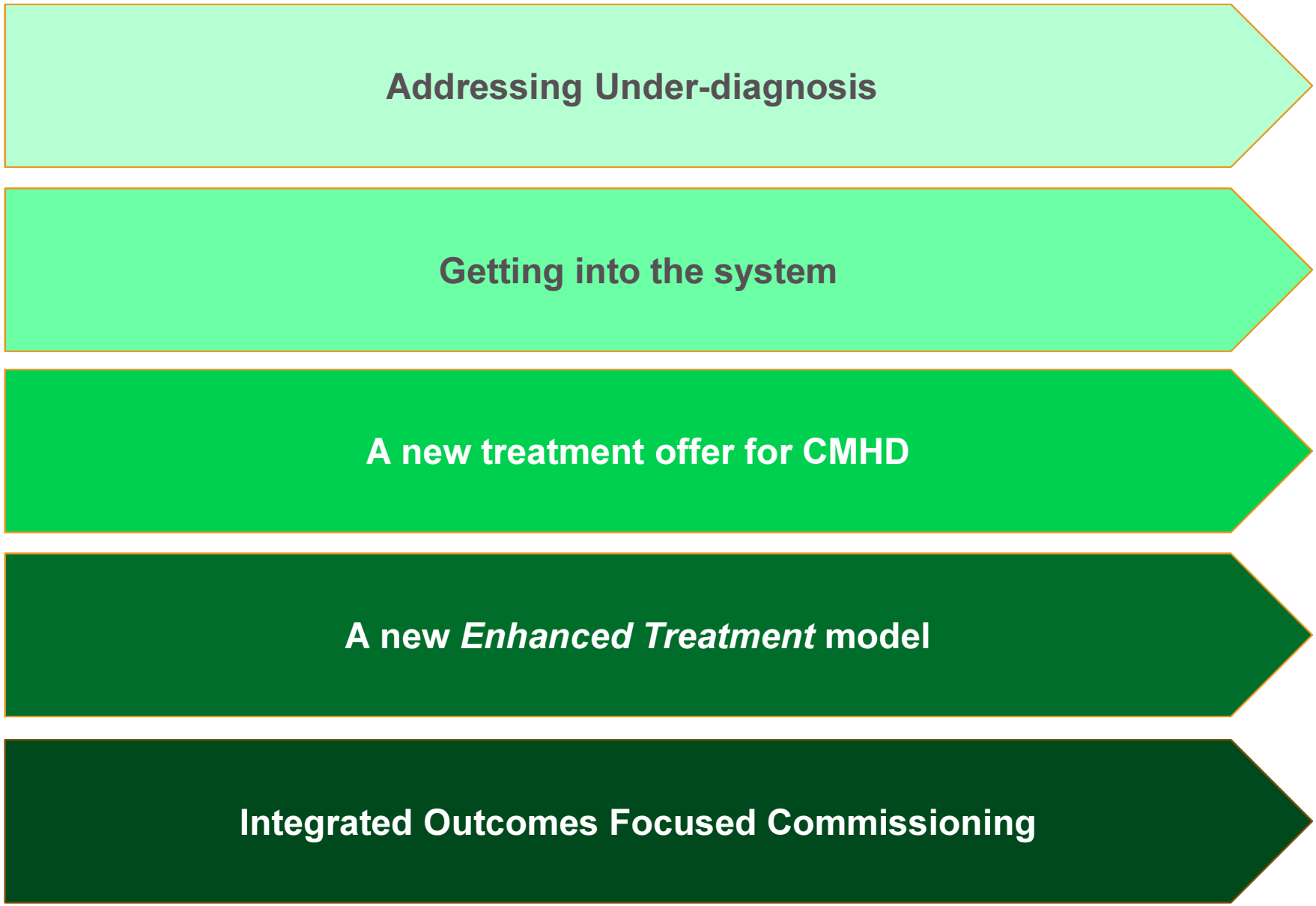
Commissioning

thurrock.gov.uk Public Health

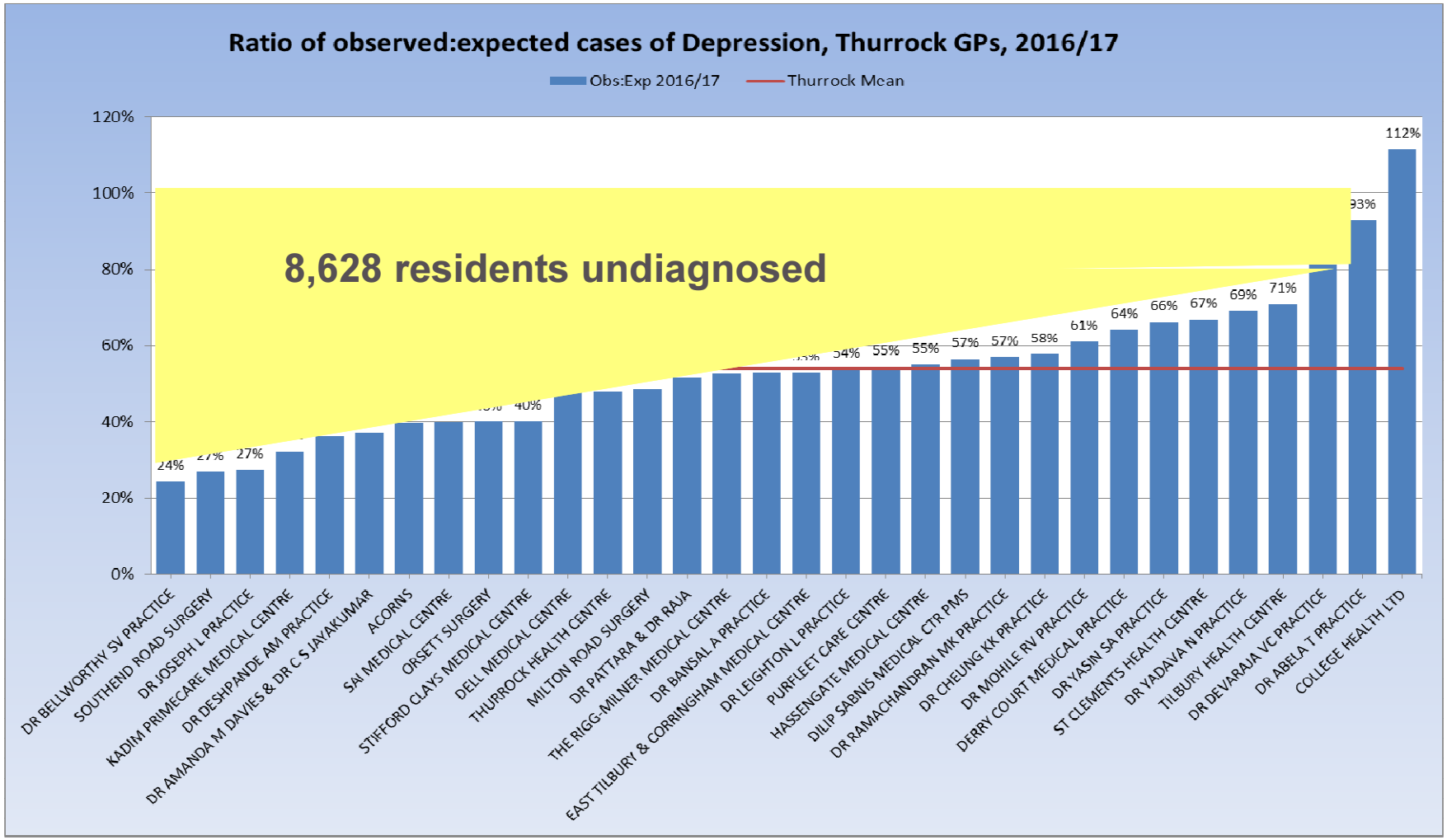
thurrock.gov.uk Adult Social Care

NHS Thurrock Clinical Commissioning Group

Five key themes



Addressing Under-diagnosis



Addressing Under-diagnosis

High Level Recommendations

- PHQ2/9 in SystmOne
- NHS Health checks at 60%
- Depression screening front line professionals
- Open access – on line symptom checkers

Key Questions for further Metal Health Transformation

- Embed best practice?
- Use of volunteers / hubs?
- Tilbury and Chadwell NMC and Wellbeing Teams?
- Commercial datasets of Google and Facebook?
- Improve uptake of NHS Healthchecks and address variation?

Existing Assets to build on

- *Better Care Together Thurrock* Long Term Conditions Working Group / Project Plan
- Tilbury and Chadwell new models of care including Wellbeing Teams and Community Led Support Teams
- HC Social Mareting Research
- LACs
- Community hubs

Getting into the system

All parts of the system

- GP Appointments
- IAPT
- MIND
- Secondary MH Care Outpatients
- Crisis Care

Impact

- “Missing Middle”
- LAC
- A&E CDU
- Anti-social behaviour

Mixed Skill Workforce in Primary Care

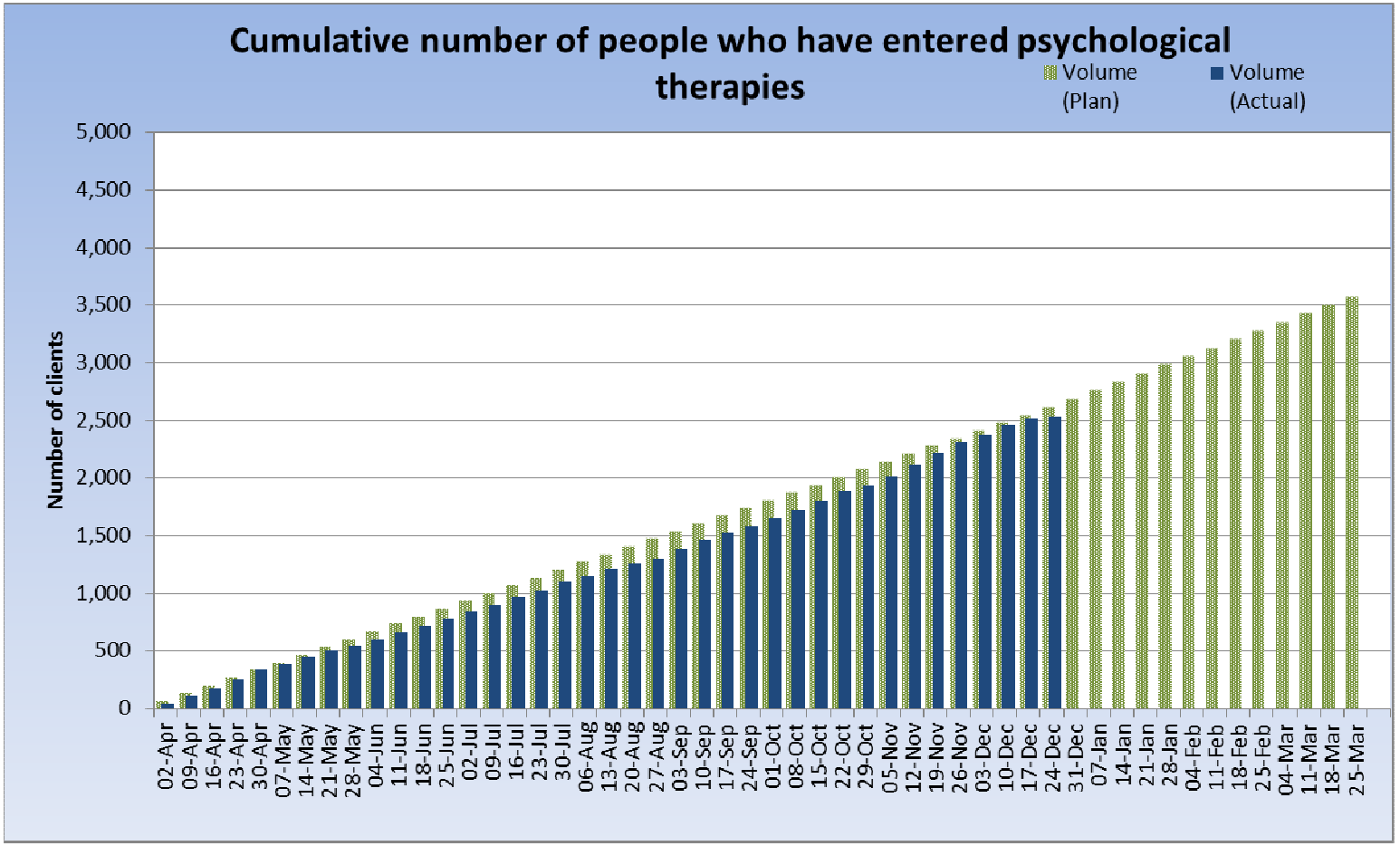
Community Psychiatric Nursing Services and IAPT closer to Primary Care

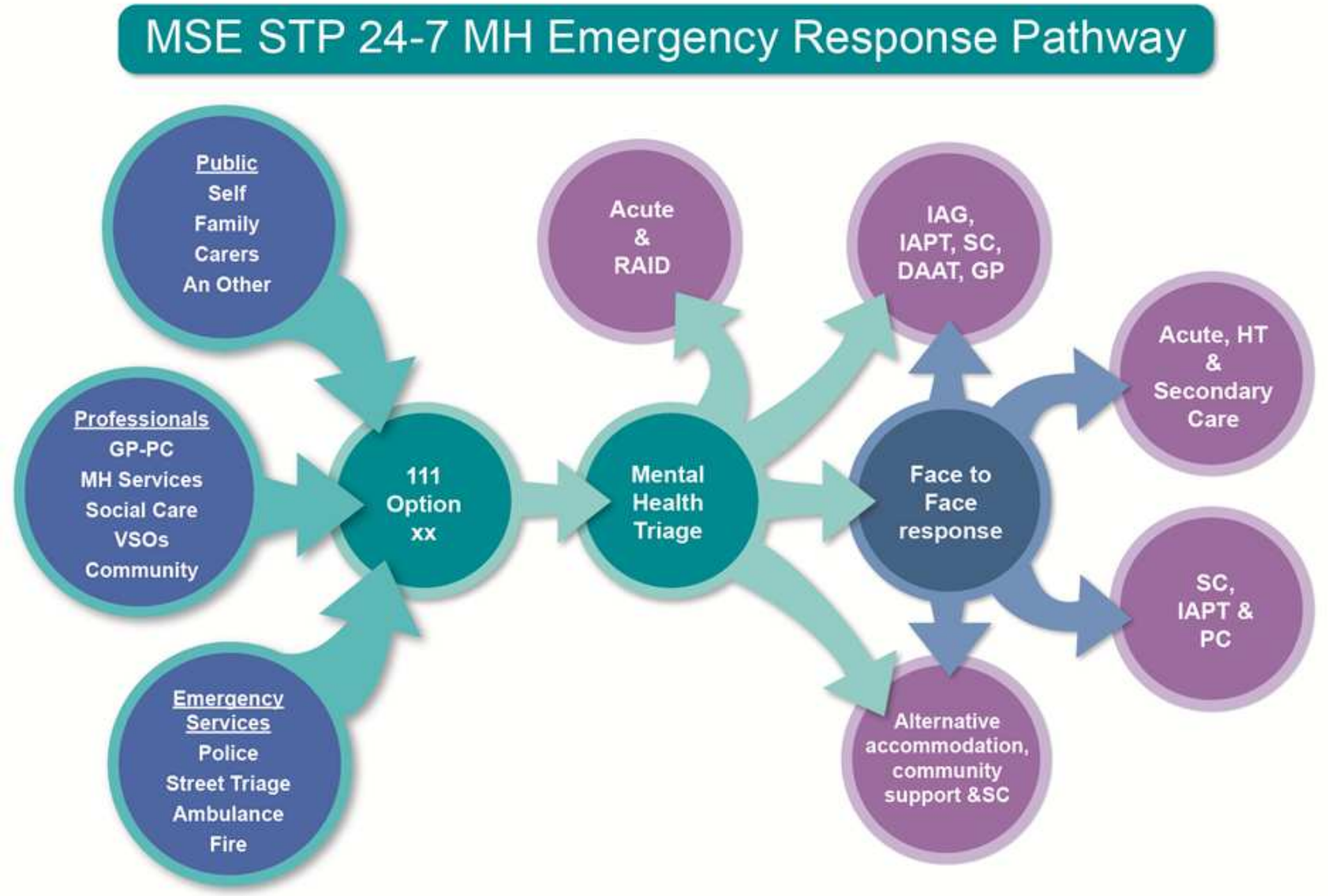
Direct referral from Thurrock First into EPUT

Getting into the system

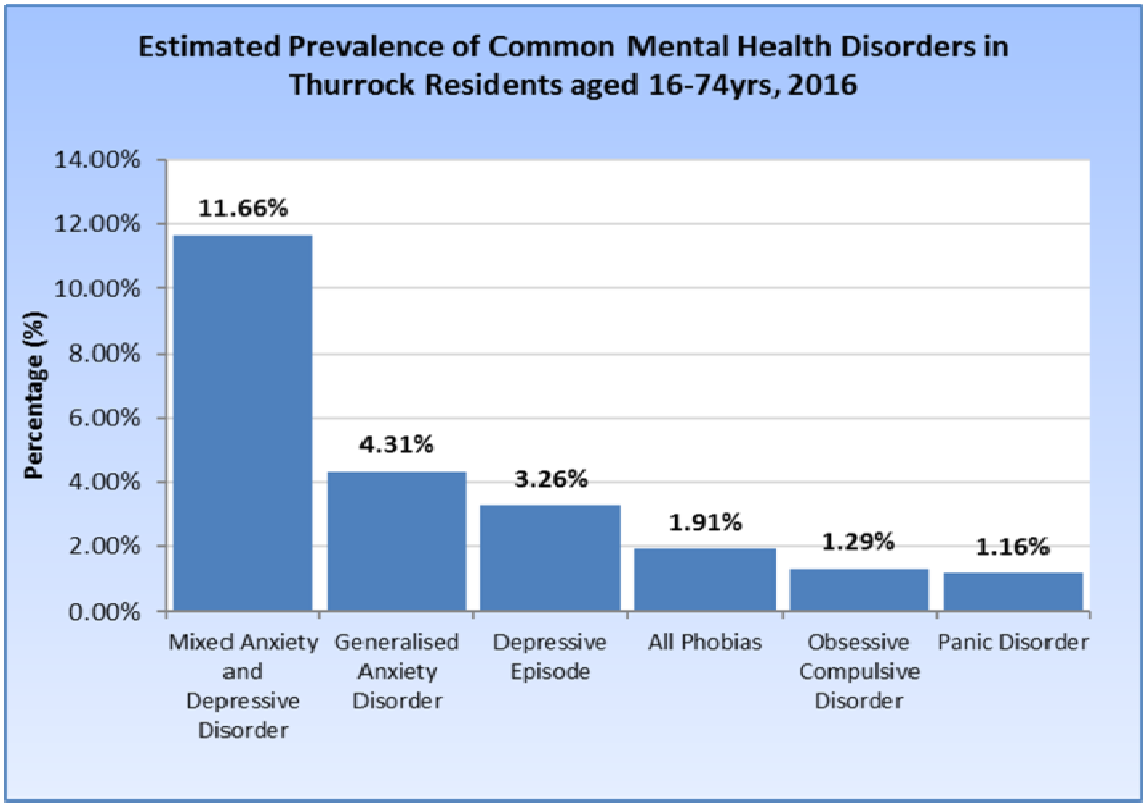
High Level Recommendations	• IAPT and MIND waiting times < 6 weeks • New model of 24/7 Community RAID – short cut GP • Agree system wide *thresholds* for 2° care
Key Questions for further Metal Health Transformation	• IAPT capacity modelling against need, demand. ROI? • What does a community crisis model look like? How funded? ROI through capacity releasing elsewhere? • Change threshold levels? Story told vs story lived? • Alternative non clinical intervention?
Existing Assets to build on	• Thurrock First • Local Area Coordinators • Community Hubs • Primary Care Locality Mixed Skill Workforce Team • IAPT • Thurrock MIND • Hospital based RAID Team • EPUT Assessment Services

Getting into the system




MSE STP 24-7 MH Emergency Response Pathway
Public
Self
Family
Carers
An Other
Professionals
GP-PC
MH Services
Social Care
VSOs
Community
Emergency Services
Police
Street Triage
Ambulance
Fire
111 Option xx
Acute & RAID
Mental Health Triage
IAG, IAPT, SC, DAAT, GP
Face to Face response
Acute, HT & Secondary Care
SC, IAPT & PC
Alternative accommodation, community support &SC

A new treatment offer for Common Mental Health Disorders

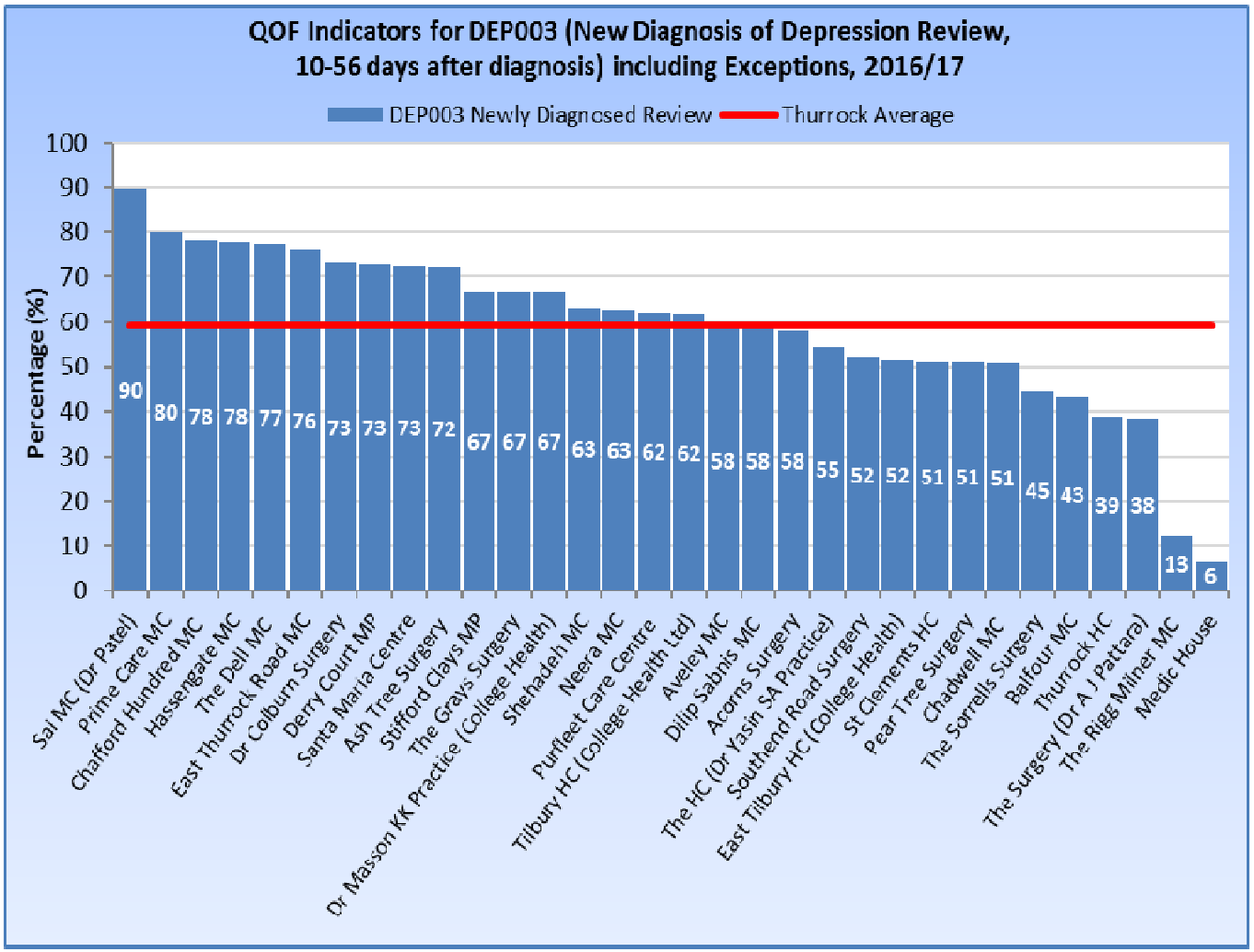


Three key issues:

- Variation in treatment access and management
- Triangulate with physical health
- Broaden the offer

A new treatment offer for Common Mental Health Disorders

Variation in clinical management



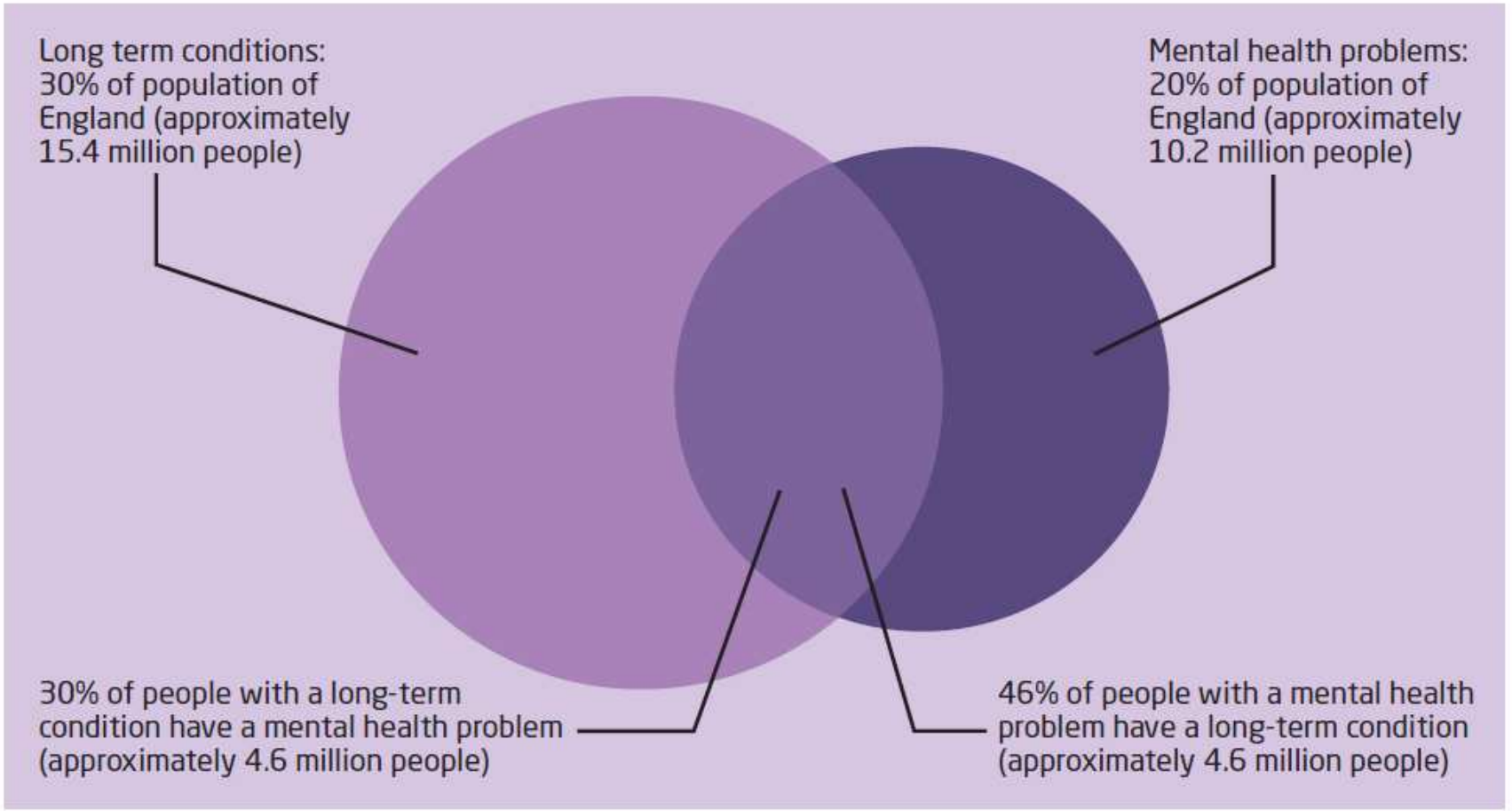
GP Profile Card and Support Visits

Improvement Contracting

New Models of Care / IMCs

A new treatment offer for Common Mental Health Disorders

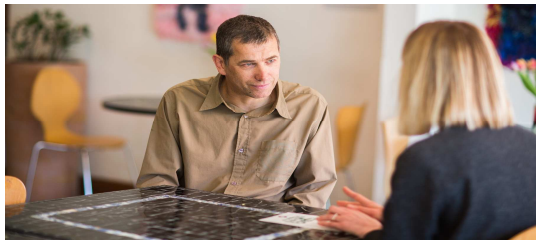
Integrate with Physical LTC Health Services



A new treatment offer for Common Mental Health Disorders

Broaden the current offer

inclusion
Fulfilling Potential. Forging Success.



Social Prescribing

Physical Activity

Work as a health outcome

Wider third sector support and community hubs

A new treatment offer for Common Mental Health Disorders

High Level Recommendations

- Address IAPT referral variation – GP practice – Age – Sex. 25% per year
- Address clinical management variation in Primary Care.
- Single LTC Management Service
- Increase and embed social prescribing
- Design and implement a *New Model of Care* for CMHDs that encompasses:
  - Worklessness
  - Physical Activity
  - Social Capital

Key Questions for further Metal Health Transformation

- Causes of variation between GP practice populations?
- How best to support GP practices address variation. ?Stretched QOF? ?Profile Card/Practice visits?
- What does a new model of care look like?
- Additional resources?
- Integration of physical activity programmes?

Existing Assets to build on

- Primary Care Locality Mixed Skill Workforce Team
- IMCs
- Tilbury and Chadwell Long Term Conditions Working Group Programme
- Primary Care/PH Development Team
- Stretched QOF Programme and Practice Based Profile Card
- Thurrock MIND
- Existing Social Prescribing Programme
- Community Hubs
- Local Area Coordinators
- Wider third sector community assets
- Existing Employment Support Programmes
- Exercise on referral programme

A new *Enhanced Treatment* model

	Care Cluster Name	Description	Likely Primary Diagnoses
1	Common Mental Health Problems (Low Severity)	This group has definite but minor problems of depressed mood, anxiety or other disorder but they do not present with any distressing psychotic symptoms	F32 Depressive Episode, F40 Phobic Anxiety Disorders, F41 Other Anxiety Disorders, F42 Obsessive-Compulsive Disorder, F43 Stress Reaction / Adjustment Disorder, F50 Eating Disorder.
2	Common Mental Health Problems (Low Severity with Greater Need)	This group has definite but minor problems of depressed mood, anxiety or other disorder but they do not present with any distressing psychotic symptoms. They may have already received care associated with cluster 1 and require more specific intervention, or previously been successfully treated at a higher level but are re-presenting with low level symptoms	As cluster 1
3	Non-Psychotic (Moderate Severity)	Moderate problems involving depressed mood, anxiety or other disorder (not including psychosis)	As cluster 1
4	Non-Psychotic (Severe)	The group is characterised by severe mood disturbance and/or anxiety and/or other increasing complexity of needs. They may experience disruption to function in everyday life and there is an increasing likelihood of significant risks	As cluster 1 plus F44 Dissociative Disorder, F45 Somatoform Disorder, F48 Other Neurotic Disorders
		This group will be experiencing severe mood disturbance and/or anxiety and/or other	
8	and Challenging Disorders	They are characterised by moderate to very severe repeat deliberate self-harm and/or other impulsive behaviour and chaotic, over dependent engagement and often hostile with services.	F60 Personality disorder.
9	Blank Cluster		
10	First Episode Psychosis (with/without manic features)	This group will be presenting to the service for the first time with mild to severe psychotic phenomena. They may also have mood disturbance and/or anxiety or other behaviours. Drinking or drug-taking may be present but will not be the only problem	(F20-F29) Schizophrenia, schizotypal and delusional disorders, F31 Bi-polar disorder.
11	Ongoing Recurrent Psychosis (low symptoms)	This group has a history of psychotic symptoms that are currently controlled and causing minor problems if at all. They are currently experiencing a sustained period of recovery where they are capable of full or near functioning. However there may be impairment in self-esteem and efficacy and vulnerability to life	Likely to include (F20-F29) Schizophrenia, schizotypal and delusional disorders F30 Manic Episode, F31 Bipolar Affective Disorder.
12	Ongoing or Recurrent Psychosis (High Disability)	This group has a history of psychotic symptoms with a significant disability with major impact on role functioning. They are likely to be vulnerable to abuse or exploitation	(F20-F29) Schizophrenia, schizotypal and delusional disorders F30 Manic Episode, F31 Bipolar Affective Disorder.

IAPT Ceiling

Missing Middle?

A new *Enhanced Treatment* model

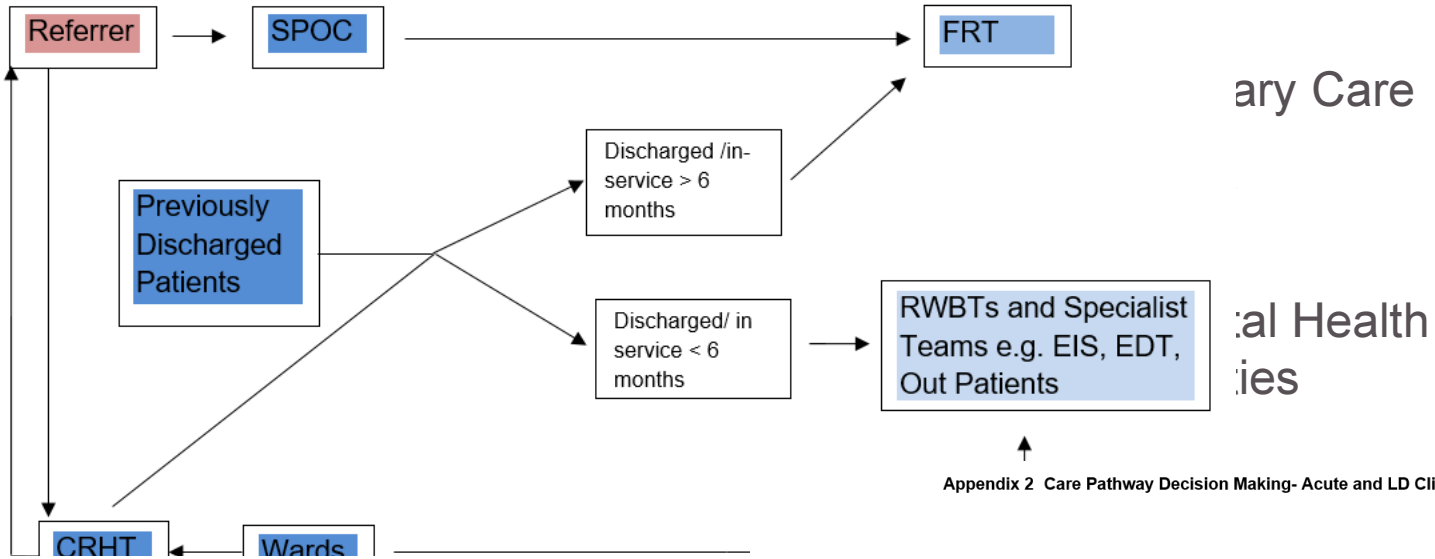
Missing Middle

- Personality Disorders
- Chaotic Lifestyles
- Multiple issues including housing problems and drug/alcohol addiction

Multiagency Group – Improving outcomes for residents with PD

- Profiling of needs
- Design of evidence based assessment/treatment pathway
- Training package to relevant professionals to improve skills and confidence

A new *Enhanced Treatment* model



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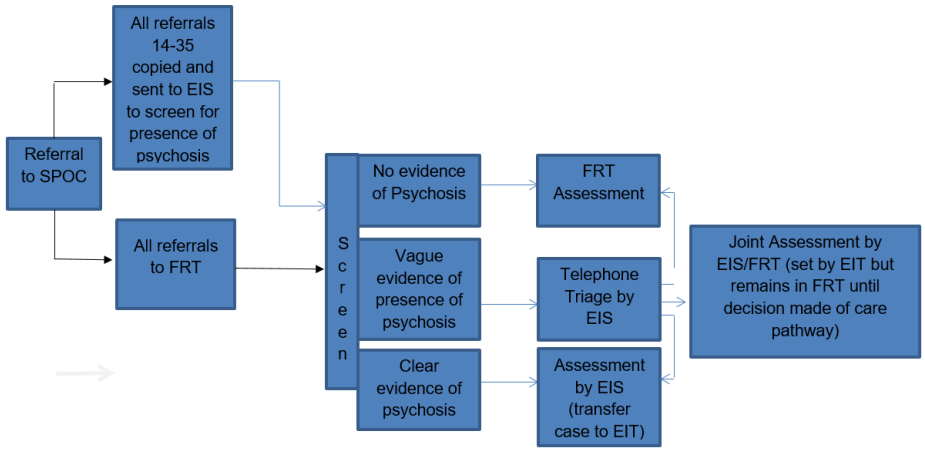
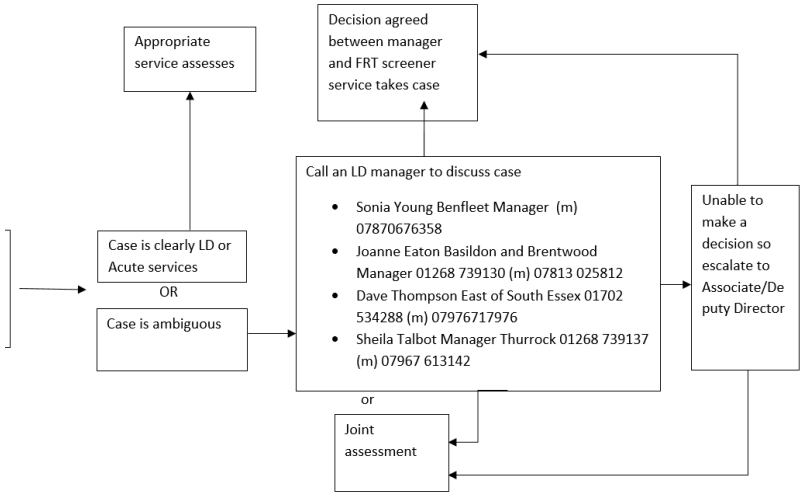
Appendix 2 Care Pathway Decision Making- Acute and LD Clinical Screening to Assessment.

Appendix 4

Interface showing relationship and pathway between the Early Intervention Service (EIS), SPOC FRT and R&WBTs





A new *Enhanced Treatment* model

Reactive → ***Holistic Preventative & Recovery***

- Shift focus to earlier intervention
- Individual Placement Support to EIP patients to facilitate clients back into employment
- Review of care coordination within EPUT to focus on more holistic offer
- Cardio-metabolic assessments offered within EPUT. NHS Health Checks at Grays Hall
- Integration of MIND and other community assets
- Recovery college

A new *Enhanced Treatment* model

Open Dialogue

- Western Lapland
- Immediate access
- Treatment in own home
- Virtually no in-patient admissions
- Conceptualisation of psychosis
- Humanistic / Non-hierachical / person centred
- Family / Social Group included rather than individual
- Very limited use of medication
- Continuity of care relationship

http://wildtruth.net/films-english/opendialogue/

Open Dialogue: Outcomes

2 Year follow up (Open Dialogue Vs Treatment As Usual):

	Treatment as Usual	Open Dialogue
No (or only mild) symptoms	50%	82%
No relapse of symptoms	7%	74%
Claiming disability benefits	57%	23%
Neuroleptic usage	100%	35%
In-patient hospital days	1000s ++	<19

- **In a subsequent 5 year follow up, 86% had returned to work or full time study**
- **90% decline in incidence of schizophrenia to 2 cases per 100,000 population**

A new *Enhanced Treatment* model

High Level Recommendations

- Missing Middle
- New treatment model
  - Reduce Primary – Secondary Care Fragmentation
  - Embeds physical health inc drug/alcohol treatment
  - Leverages social worker skill set
  - Strengths based, community asset approach
  - Integrates housing and employment
  - Moves from reactive to proactive

Key Questions

- Who are the *Missing Middle?* Services to meet needs?
- How do we improve interface between Primary and Secondary Care?
- Story lived vs Story told on thresholds?
- Restoring Social Work Skill set? Section 75?
- What is the new model?
- How to integrate Grays Hall into IMCs?
- Commissioning for prevention and early intervention?
- Relapse prevention?
- Leverage new Wellbeing Teams / CLSTs?

Assets to Build On

- User voice – co-design of services
- Mixed skill Primary Care Workforce
- Perceived quality in EPUT
- Social Prescribing
- Community Hubs
- CLSTs / Wellbeing Teams
- LACs
- Micro-enterprises
- Inclusion
- Thurrock Healthy Lifestyles Service
- MIND

Integrated Commissioning

- Single Council CCG Team
- Wider Thurrock Integrated Care Alliance
- Outcomes not process
- Include third sector
- Review section 75
- Improve commissioning intelligence
- Early intervention – risk stratification tools

Governance
- Cabinet
- CCG Board

System Oversight
- Health and Wellbeing Board
- HOSC

Thurrock Mental Health Transformation Board

Public Mental Health and Prevention

New Models of Care
- CMHD
- SMI

Commissioning and Outcomes

Service User Forum

Strategic Lead – Public Mental Health and Mental Health Transformation

Detailed Work Programme

Case for Change

Immediate Priorities

Questions

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