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Adult Mental Health System Transformation

Health and Wellbeing Overview and Scrutiny Committee

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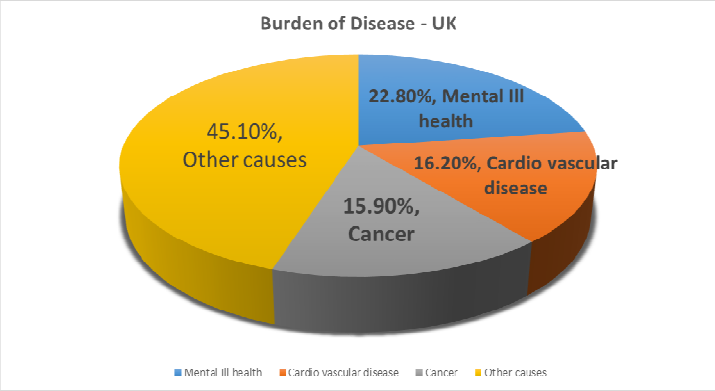
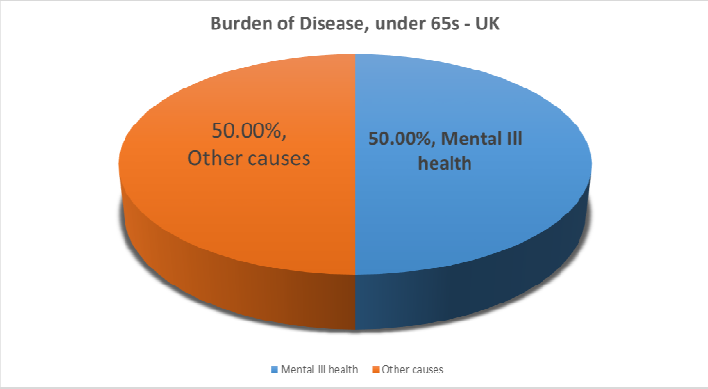
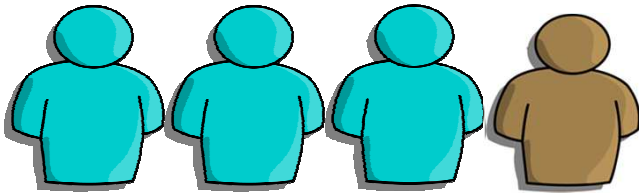
24 January 2019

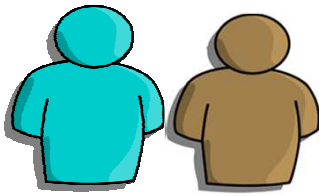
Epidemiological Overview of Mental Health



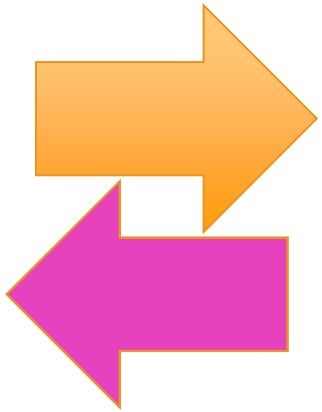




Lifetime



Preventable in childhood



Bi-directional relationship

LIFESTYLE™

Physical Health

NHS

Self Care

Health Service Usage

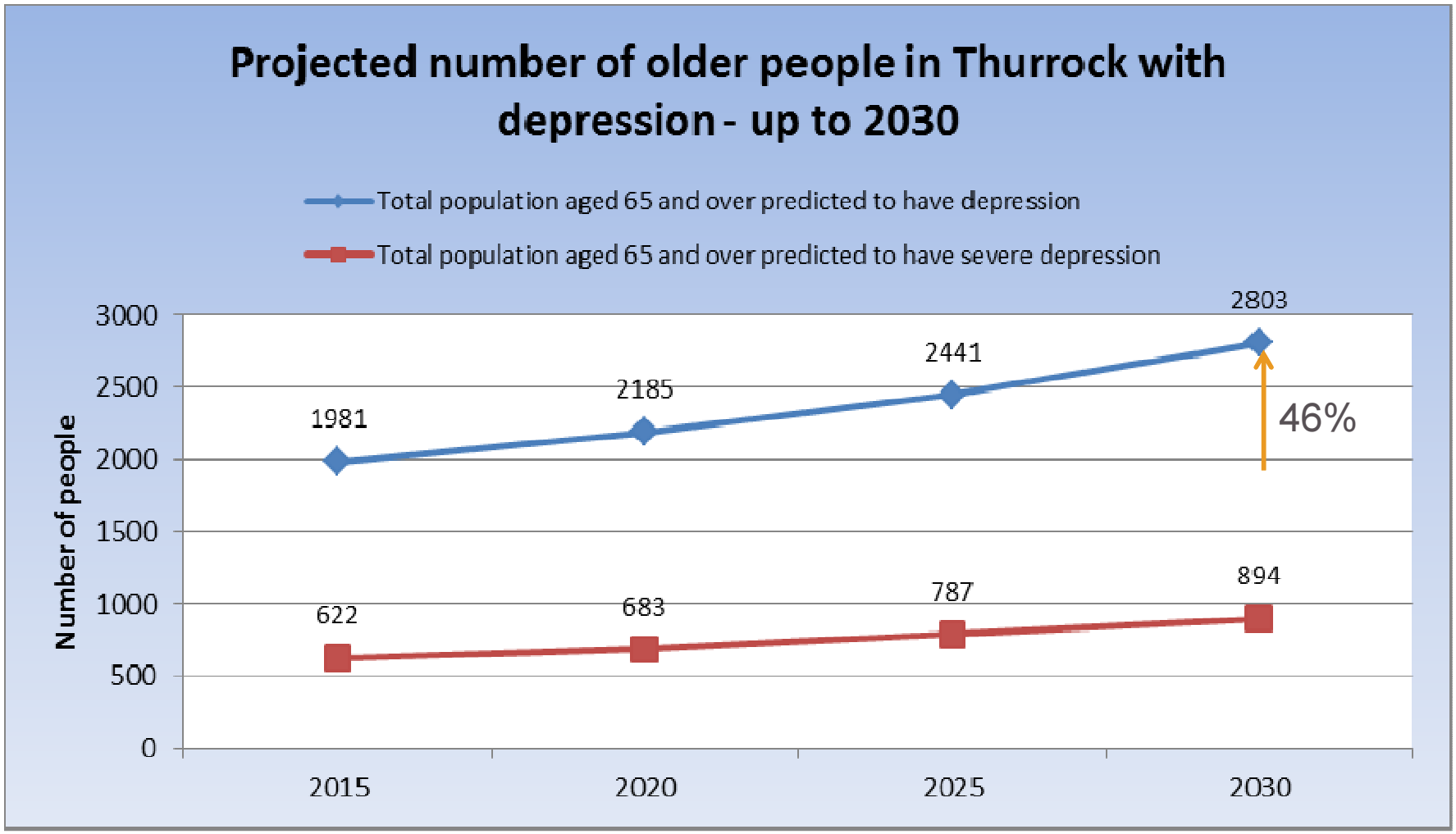
£1 in 8 – LTC condition spend **£28M Thurrock**

£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?

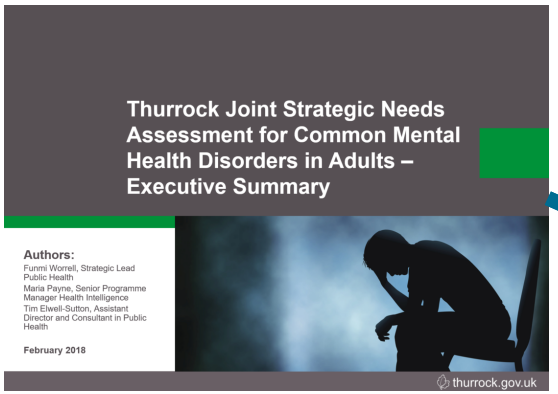
Thresholds

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 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

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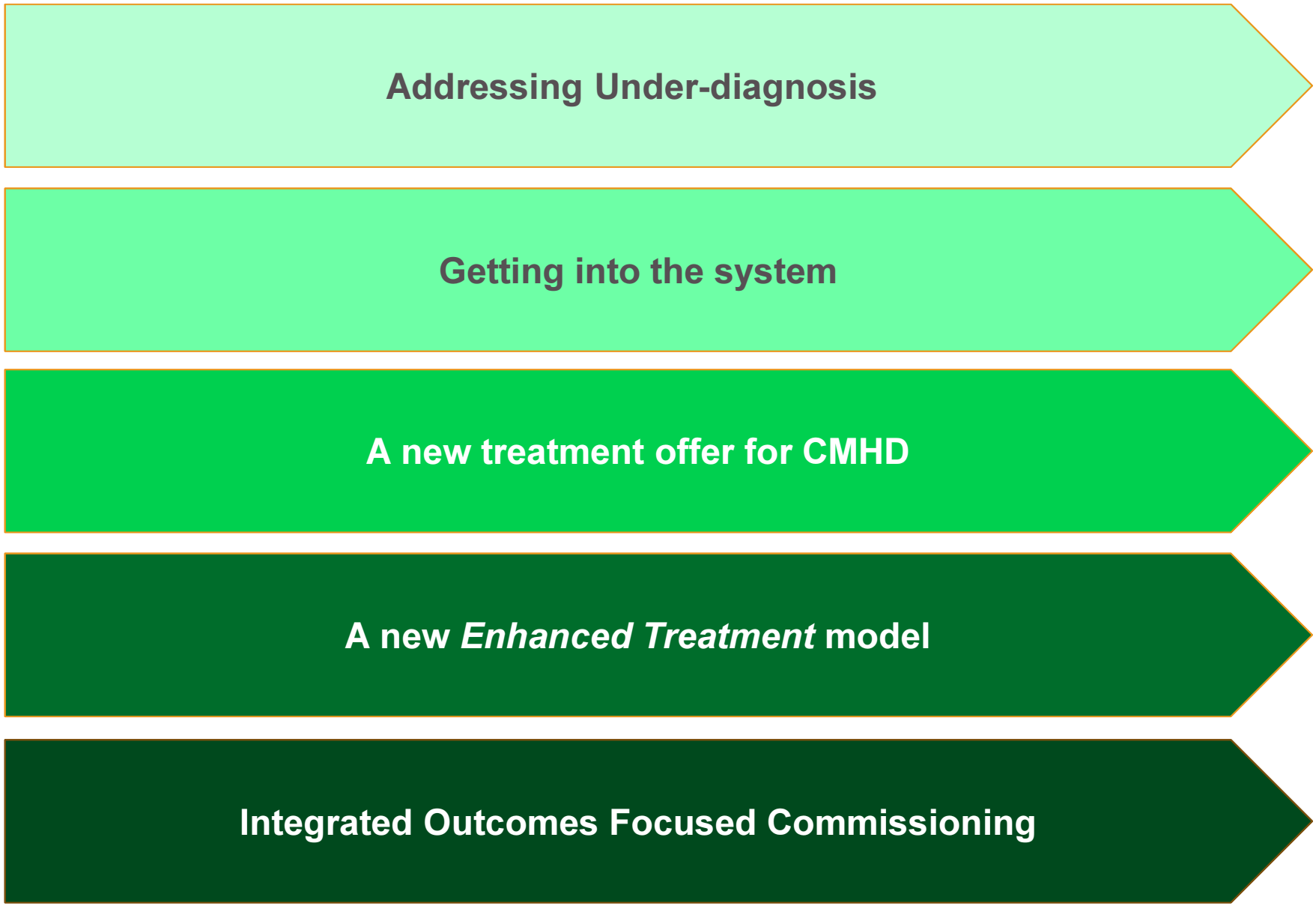
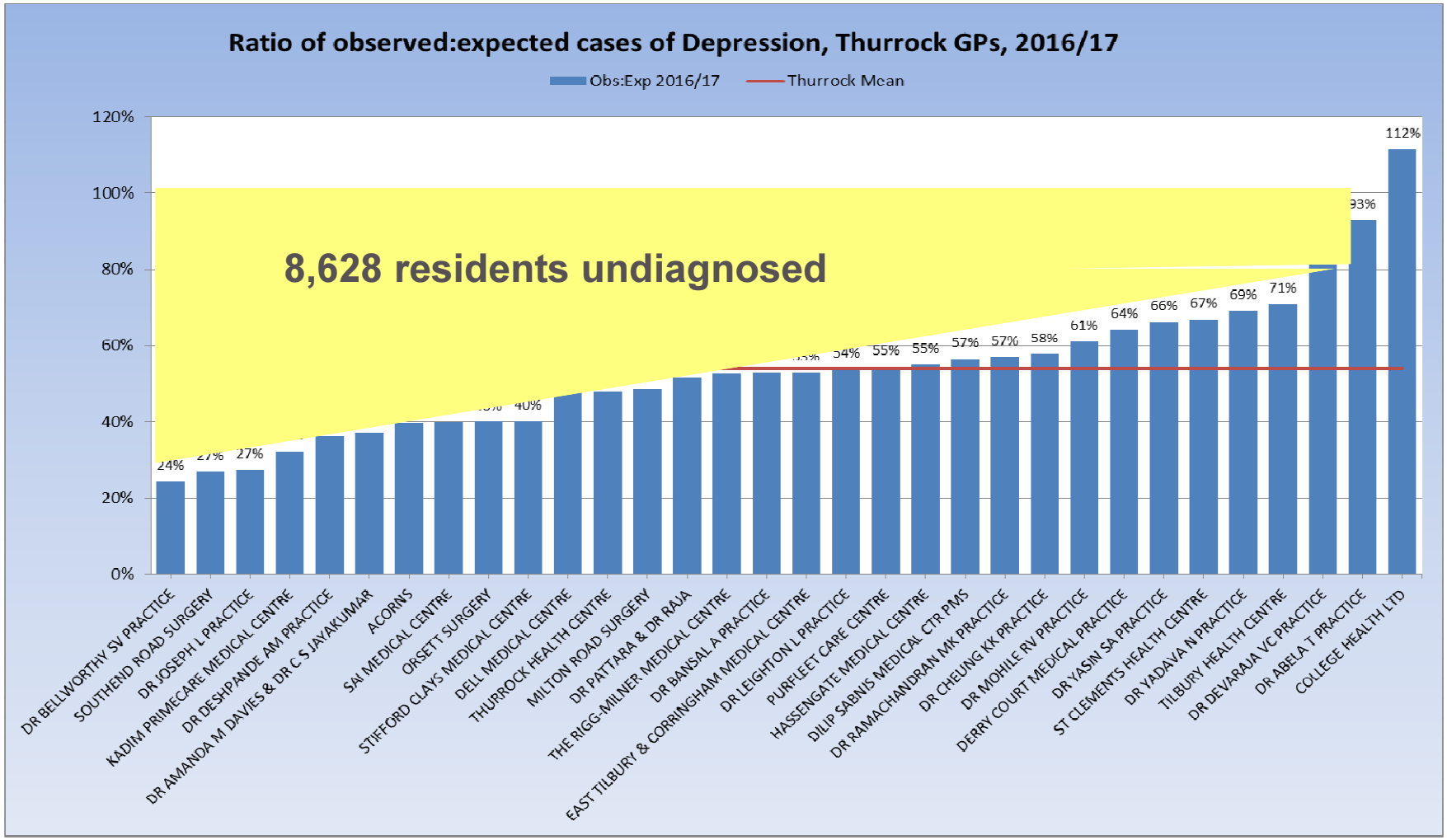
NHS Thurrock Clinical Commissioning Group

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

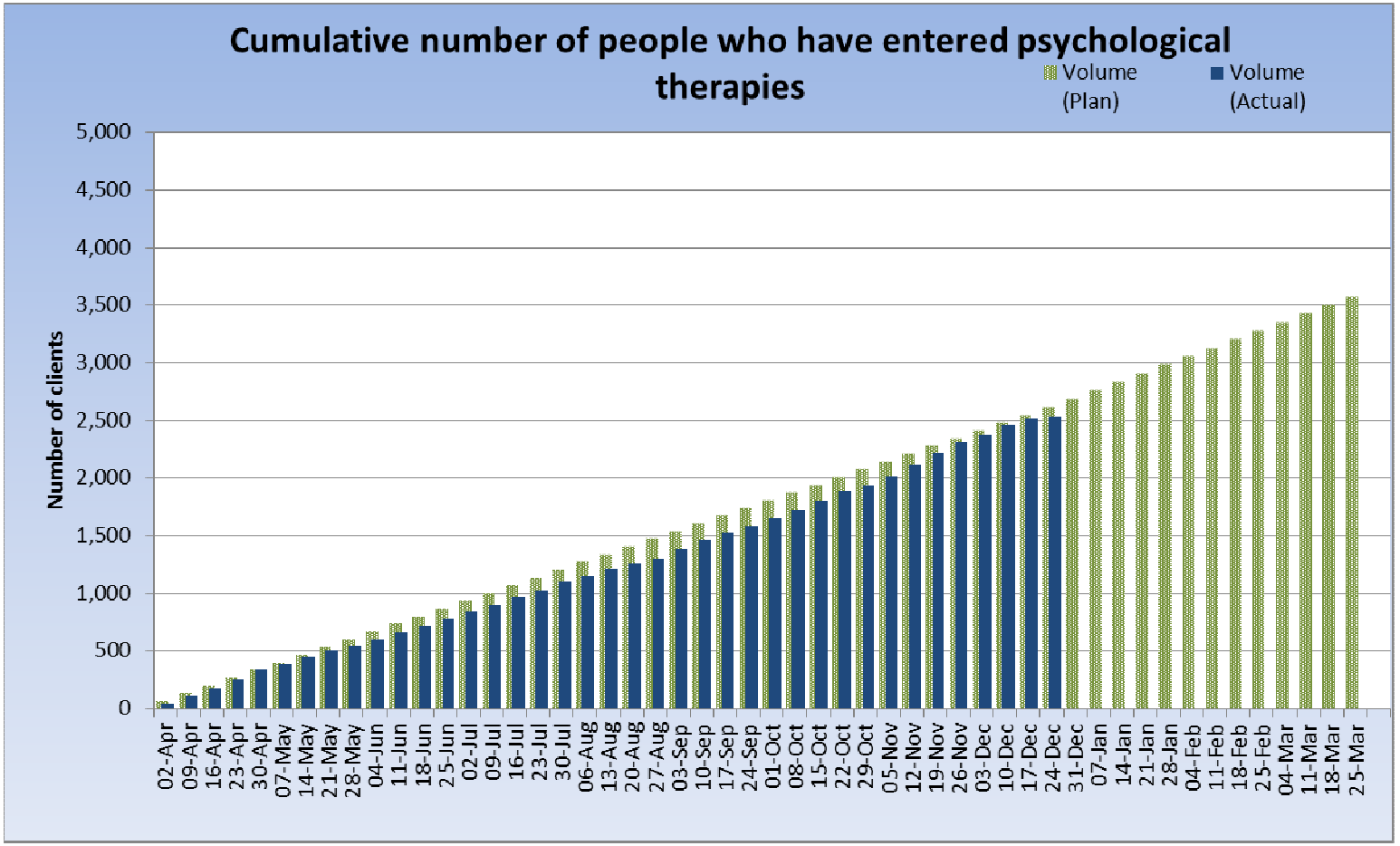
Key Questions for further Metal Health Transformation

- 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?

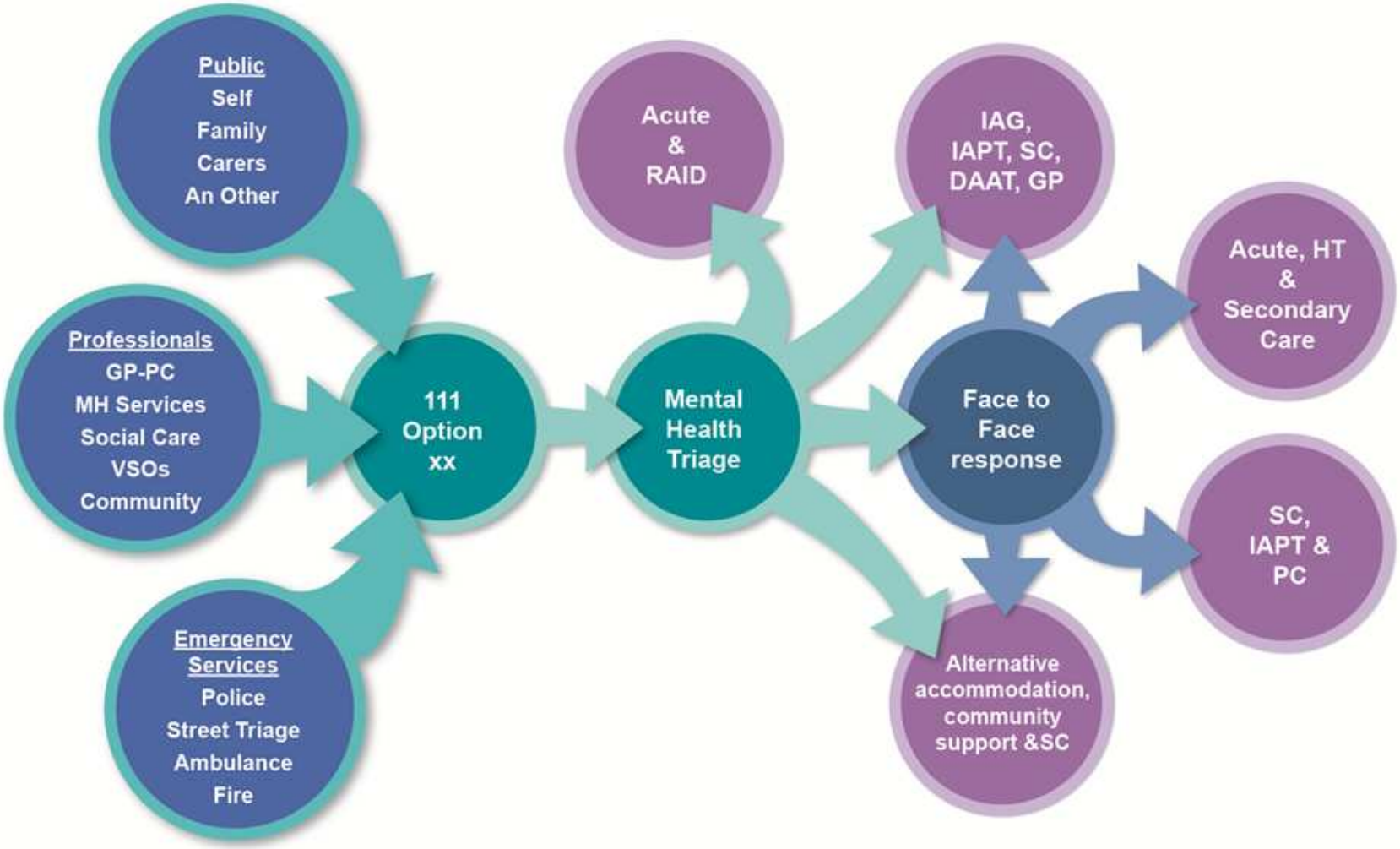
Existing Assets to build on

- Thurrock First
- Local Area Coordinators
- Community Hubs
- Primary Care Locality Mixed Skill Workforce Team
- IAPT
- Thurrock MIND
- Hospital based RAID Team
- EPUT Assessment Services

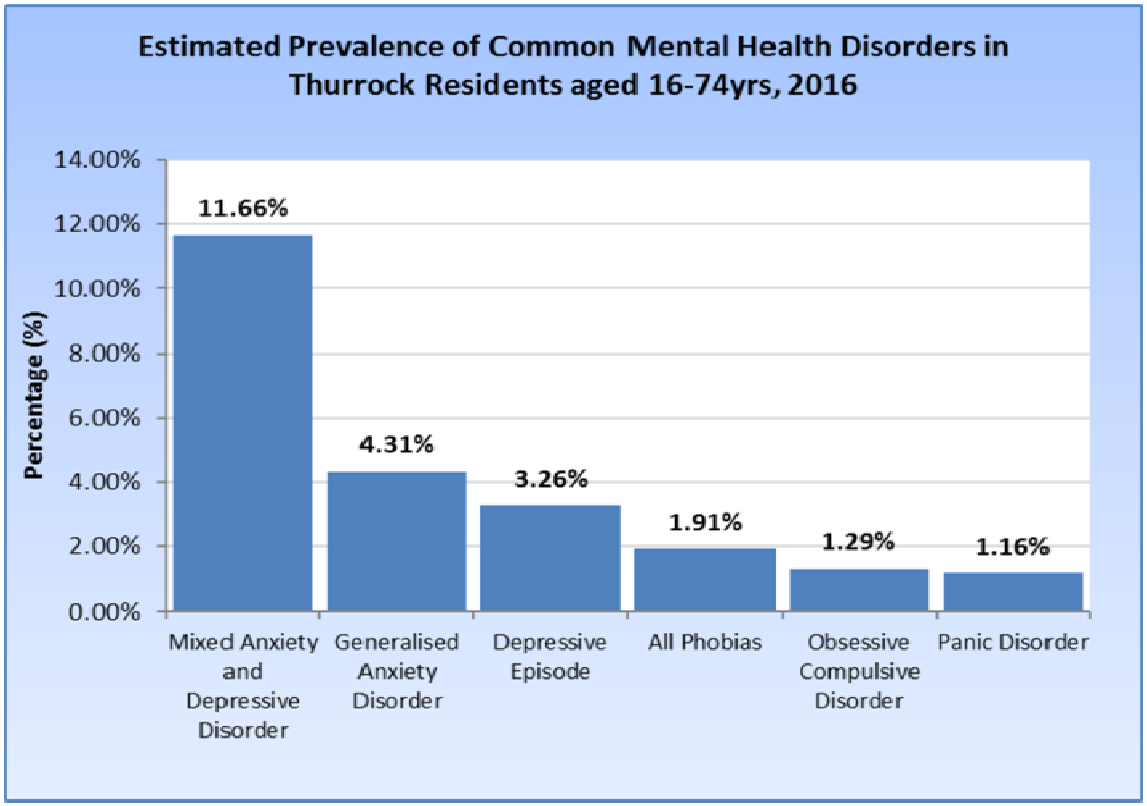
Getting into the system



MSE STP 24-7 MH Emergency Response Pathway



A new treatment offer for Common Mental Health Disorders

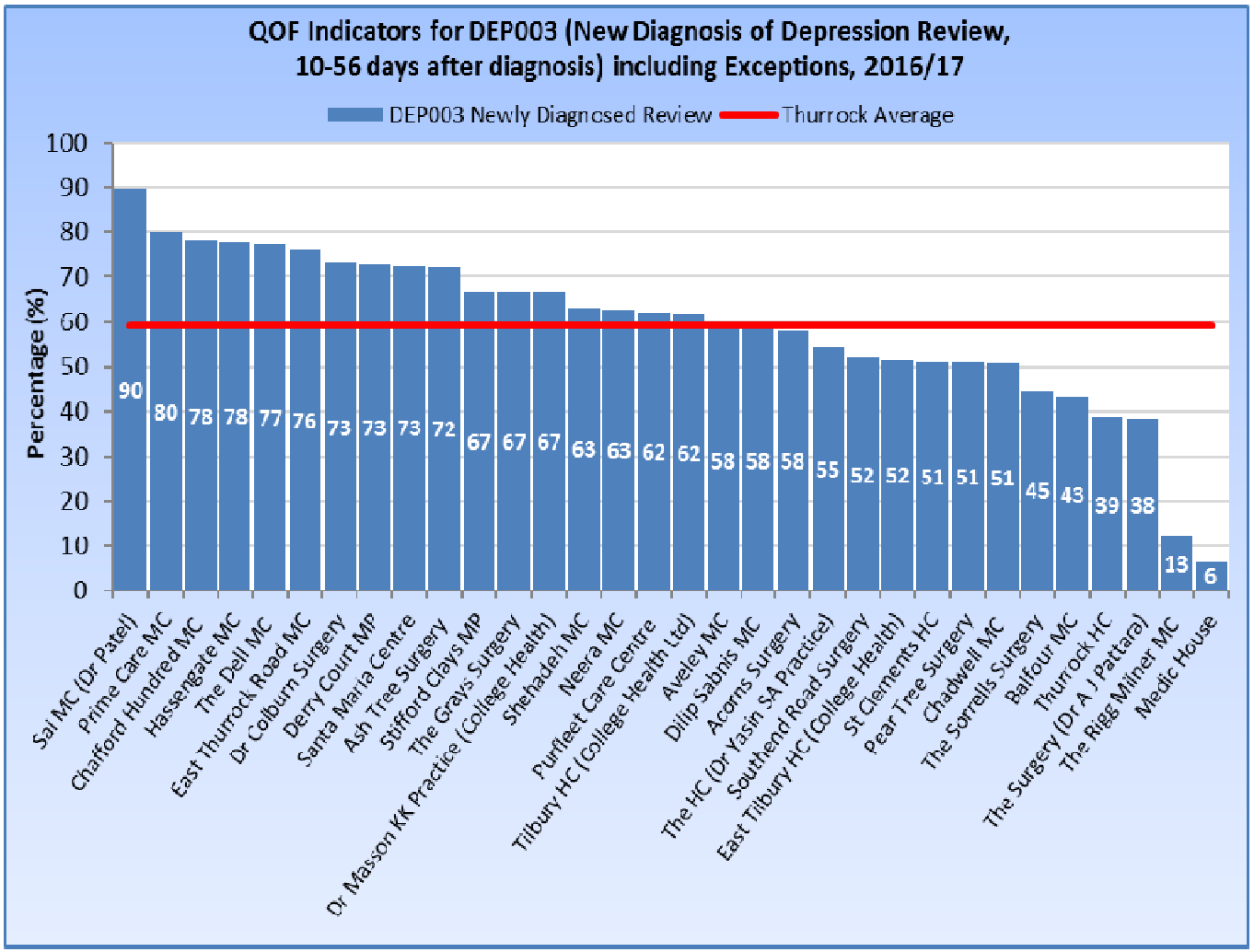


Three key issues:

- 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



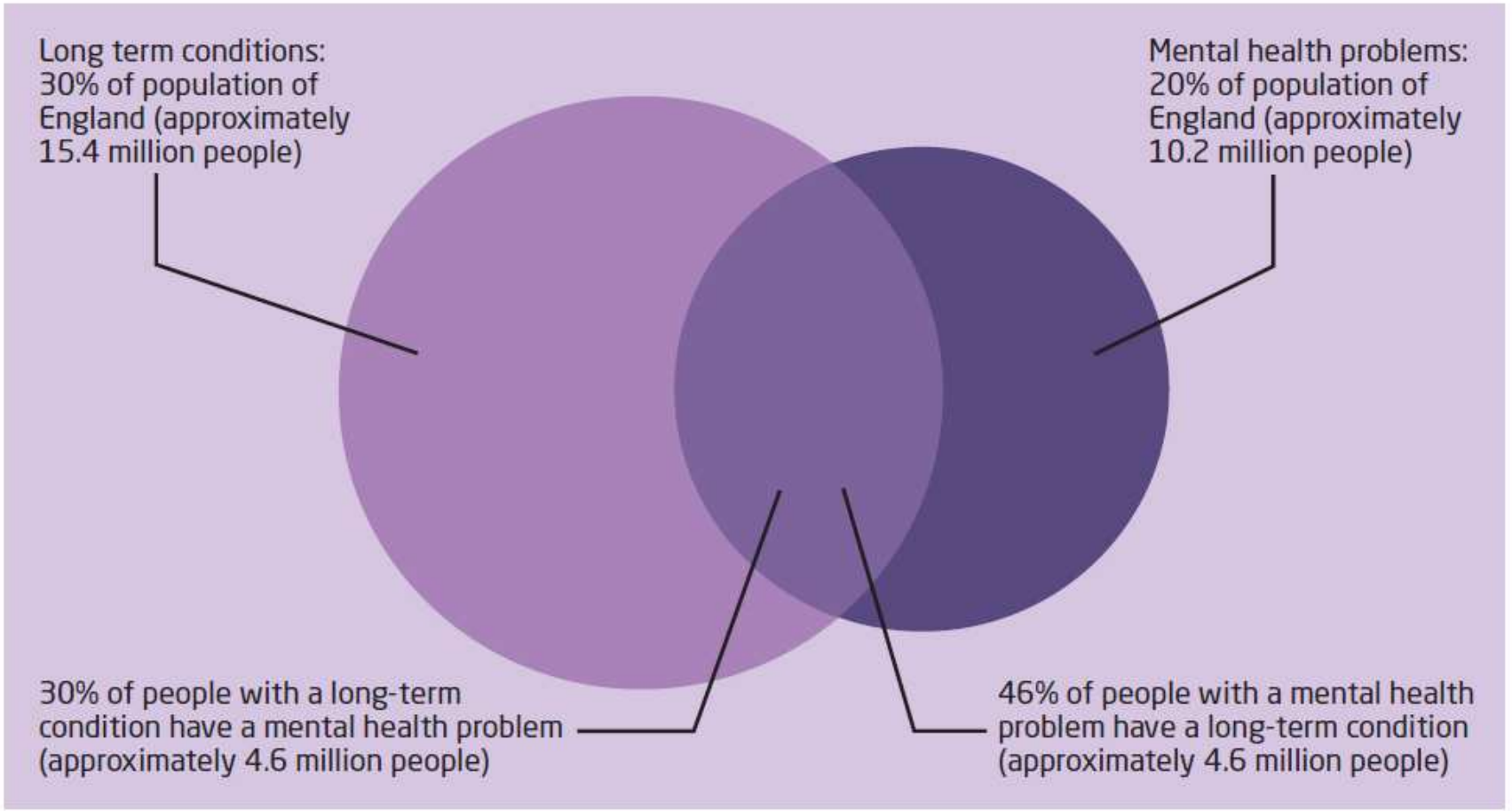
GP Profile Card and Support Visits

Improvement Contracting

New Models of Care / IMCs

A new treatment offer for Common Mental Health Disorders

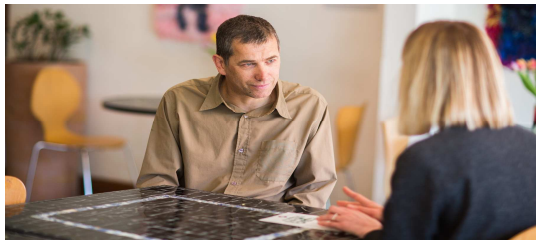
Integrate with Physical LTC Health Services



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
5	[illegible]	This group will be experiencing severe mood disturbance and/or anxiety and/or other	[illegible]
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

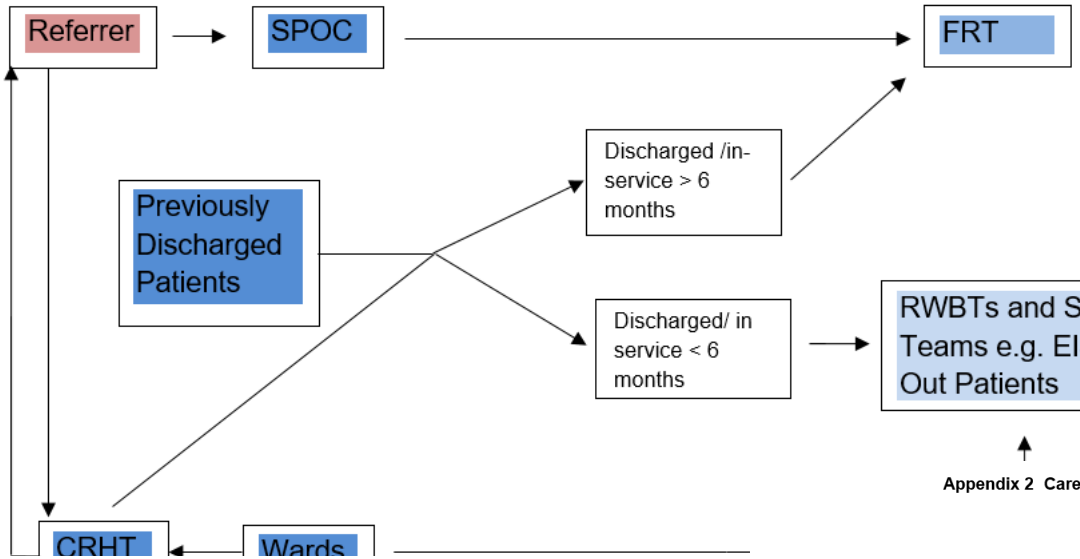
Missing Middle

- 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



ary Care

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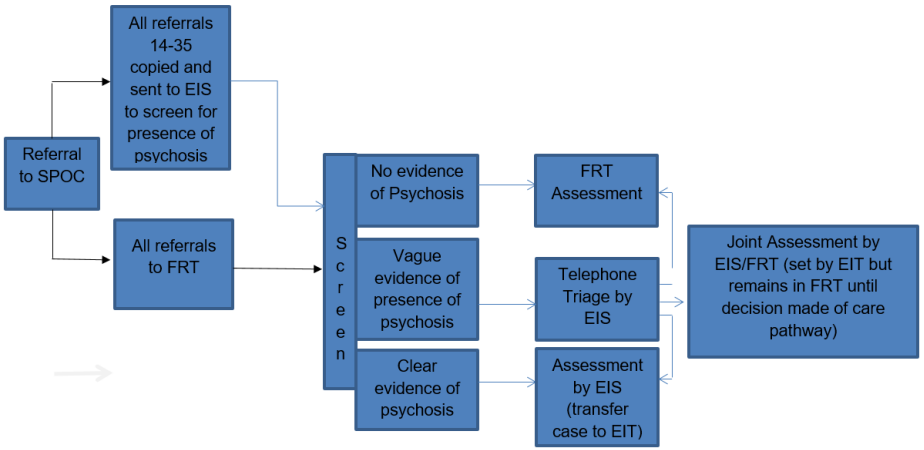
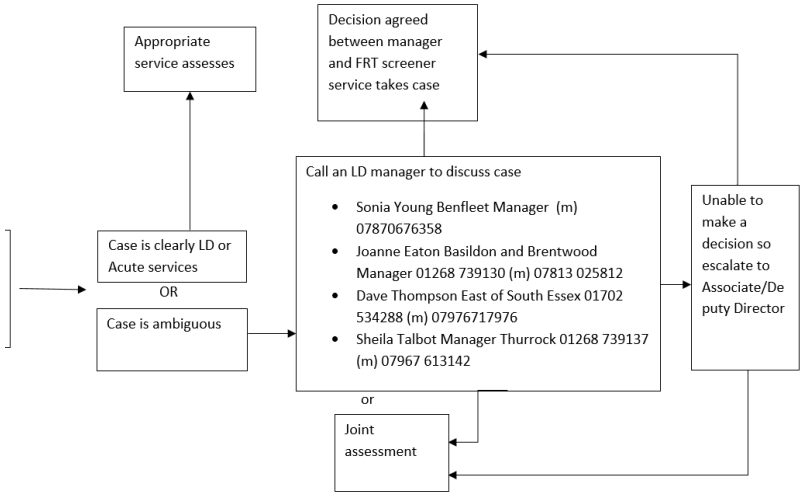
Appendix 2 Care Pathway Decision Making- Acute and LD Clinical Screening to Assessment.

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/

A new *Enhanced Treatment* model

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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