HEALTH SCRUTINY PANEL

AGENDA ITEM 4

11 March 2014

DRAFT FINAL REPORT –

MENTAL HEALTH SERVICES CAPACITY

PURPOSE OF THE REPORT

1. To present the findings of the Health Scrutiny Panel, following their review of Mental Health Services Capacity.

AIM OF THE SCRUTINY INVESTIGATION

2. There has been an historical move away from institutionalised care, reducing the stay of patients and preventing people from becoming patients in the first place and a move towards keeping people well within the community. The review will consider if service reconfiguration in Mental Health Services has delivered better patient outcomes and efficiency savings, and whether this policy remains the best way forward for the challenges faced by Mental Health Services today.

TERMS OF REFERENCE OF THE SCRUTINY INVESTIGATION

3. The terms of reference for the Scrutiny investigation were as outlined below:

   (a) To establish what Mental Health Services are provided in Middlesbrough
   (b) To consider how money has been invested into community services and if there are sufficient community mental health facilities within Middlesbrough.
   (c) To consider whether or not reduced bed capacity has led to more pressures being placed on community based services.
   (d) To look at capacity and the effect of out of area placements.
   (e) To consider if this service reconfiguration has led to improved patient outcomes and a better quality service.
   (f) To consider if there are any areas of improvement that could be implemented in order to ensure the best services for people in Middlesbrough.

METHODS OF INVESTIGATION

4. Members of the Panel met formally between 7 November 2013 and 11 March 2014 to discuss/receive evidence relating to this investigation and a detailed record of the topics discussed at those meetings are available from the Council's website.

5. A brief summary of the methods of investigation are outlined below:

   (a) Detailed officer presentations supplemented by verbal evidence.

   (b) Meeting and detailed discussions with

   - Tees Esk and Wear Valley NHS Foundation Trust
   - North of England Commissioning Support Unit
   - South Tees Clinical Commissioning Group
   - Middlesbrough and Stockton MIND
   - Social Care officers from Middlesbrough Council's Wellbeing Care and Learning Department.

   (c) Desk Top research by the Scrutiny Support Officer

6. The report has been compiled on the basis of their evidence and other background information listed at the end of the report.

MEMBERSHIP OF THE PANEL

7. The membership of the Panel was as detailed below:

   Councillors E Dryden (Chair), Councillor L Junier, (Vice-Chair), Councillors Biswas, Cole, Davison, Kahn, McPartland, H Pearson OBE and P Purvis.

BACKGROUND INFORMATION

The National Picture

1. In September 2013 the Mental Health Foundation brought out a report which looked at the future of Mental Health Services, entitled Starting Today. Around that time there was much national attention which was focussing on the pressure mental health services were facing now and in the future.

2. The document outlined how evidence indicated that the health and economic burden related to poor mental health in the UK is significant and greater than cardiovascular diseases and cancer, yet the emphasis on mental wellbeing is often limited. Added to that the document argued that the impact of the economic downturn on people's mental health could not be underestimated and its effects would be felt for a long time.

Because of financial pressures it is possible that health and social services will never receive the same amounts of funding that the UK has seen in the past two decades and so the report suggests that what is needed is a fresh way of developing and delivering services.

3. Over the years policy makers have become more aware of the implications of untreated mental illness and that perceptions are changing about mental ill-health as somehow being self-inflicted are beginning to change.

4. The Mental Health Foundation's inquiry considered the future of mental health services in the UK over the next 20-30 years. It is estimated that there will be nearly 8 million more adults in the UK by 2020. If prevalence rates for mental disorders stay the same (i.e. around 1 in 4 people) that would equate to an additional 2 million more adults with mental health problems than today. It therefore follows that mental health services would need adequate funding to ensure appropriate levels of staff and the right number of skills staff.

5. Some of the key messages of the enquiry were are as follows

   Personalisation – that co-production in terms of service development and service delivery should in principle be the default for all patients receiving mental health services in the future, regardless of diagnosis. Early training of staff, including continuing professional development should include the need to provide patients with a personalised service. This would involve recruiting a workforce for the future that has a truly participative and listening approach to patient care as well as skills to help people who may lack capacity to make decisions. It should be about providing patients with a personalised service, ensuring engagement of service users, families and carers in the commissioning process.

   Self-Management – Mental health services need to build service users' capacity to self-manage their conditions. Be it through prescribed medication, self-help, improving diet and exercise etc.

   Mental health in primary care – GPs need to become leaders in mental health care, learning as much about mental health as they do about physical health.

   Crisis care and community support – people want local support, both in crisis and with their day to day living. There are good examples of services in the UK, albeit patchy and often under pressure from both demand and financial constraints. If mental health services in the future are to meet people's needs then local commissioners need to learn from these models and discuss with mental health service users and their carers how they can be implemented more widely.

   Collaborative working and integrated care – it is people and relationships, rather than structural arrangements which secure good integrated care. There is a need to ensure opportunities that the current and future healthcare workforce should be better informed about the indivisibility of physical and mental health and the value of collaborative working and the skills that colleagues in other disciplines can bring to patient care. There are a number of structural arrangements that can help to establish effective integrated care. Including the ability to pool budgets, sharing protocols and partnership agreements, co-locating services and multidisciplinary teams.

6. People's early lives have a big part to play on their future mental health and there are children growing up today in damaging environments. It is essential that mental health services, both today and in the future, are geared up to intervene early when problems are identified and to break any generational cycle of poor mental health and mental illness. It is recognised that investment in early years support is likely to repay its costs many times over by reducing use of health and other public services and improving the health, educational and social outcomes for children as they grow into adulthood.

7. Older people must also have a voice in future mental health services, there are increasing numbers of people across the UK who are likely to experience dementia in the future. Mental health services need to recognise the prevalence of disorders among older people and provide a comprehensive response to need.

Mental Health Problems – The statistics

- 1 in 4 people will experience a mental health problem at some point in their life and 1 in 6 adults have a mental health problem at any one time.
- 1 in 10 children aged between 5 and 16 has a mental health problem, and many continue to have problems into adulthood.
- Half of those with lifetime mental health problems first experience symptoms by the age of 14 and three quarters before their mid-20s
- Self-harming in young people is not uncommon (10-13% of 15-16 year olds have self-harmed)
- Almost half of all adults will experience at least one episode of depression during their lifetime.
- 1 in 10 new mothers experiences postnatal depression
- 1 in 100 people have a severe mental health problem
- Some 60% of adults living in hostels have a personality disorder
- Some 90% of all prisoners are estimated to have a diagnosable mental health problem (including personality disorder) and/or substance misuse problem.

Source – No Health Without Mental Health – HM Government

The economic burden of mental health

8. Mental ill health represents up to 23% of the total burden of ill health in the UK. Estimates have suggested that the cost of treating mental health problems could double over the next 20 years. More than £2bn is spent annually on social care for people with mental health problems. Sickness absence due to mental health problems costs the UK economy £8.4 billion a year and £15.1bn in reduced productivity. [1]

9. Mental health problems add considerably to the costs of the education and criminal justice systems and homelessness services. They are also the most common reason for incapacity benefit – around 43% of the 2.6 million people on long-term health related benefits have a mental or behavioural disorder as their primary condition.

10. A Guardian article from 23 September 2013 highlighted that mental health treatment was stretching services to the limit and services were "straining at the seams" to cope with the growing number of people with mental illnesses. According to calculations by the Mental Health Foundation, mental disorders cost the economy more than £100bn a year. The article highlighted that mental health services had been under pressure over the past few weeks with no inpatient beds in the private or public sector available in the whole of England. That services were under pressure due to the ageing and growing population, high rates of disorders among all age groups, tight finances in the NHS and the number of patients who have mental and physical health problems.

11. The lack of a cure for mental illness means that the only way that mental health services will cope with the demand in 20-30 years' time is to prevent mental illnesses and reduce the number of people developing a mental disorder.

12. An article in the BBC News on 16 October 2013 suggests England's mental health service is in crisis. Dr Martin Baggaley, medical director of the South London and Maudsley NHS Trust spoke as an investigation by BBC news and Community Care magazine revealed that more than 1,500 mental health beds have closed in recent years. He said that he thinks that currently the system is inefficient and unsafe and that a lot of time is spent struggling to find beds, sending people across the country. Care Minister Norman Lam said that while there was a drive to treat more people in the community, he said beds must be available when patients needed them.

13. Figures show that 1,711 mental health beds have been closed since April 2011, representing a 9% reduction in the total number of health beds available in 2011/12. There is coupled with an increasing demand for mental health services. Partly explained by a reduction in beds, resources coming out of the health system, the squeeze on social services budgets and the general economic situation.

[1] No Health Without Mental Health -, HM Government February 2011

Service Transformation

14. Mental Health services have gone through a radical transformation over the past 30 years – perhaps more so than any other part of the health system.[2]

15. The report, by the Kings Fund, noted that the closure of the asylum system overall was a success and that no further large institutions exist. The concept of mental illness and perception of needs has also evolved. Traditionally it was thought that mental illness was a lifelong debilitating illness, however with more awareness, and a system with new models of care coordination a system has developed which incorporates the capacity to intervene early and manage the illness to enable people to achieve a fulfilling life.

16. Briefly, the transformation of mental health services stretches back years but begins in earnest from the 1980s, with 3 distinct phases

    i) A period of increasingly rapid de-institutionalisation
    ii) Development of comprehensive models of care including care co-ordination and community service systems
    iii) Diversification of service provision and delivery to meet local needs.

17. The Kings Fund document gives a background to the transformation in mental health services. It outlines drivers for change and how those changes have been implemented over the years. The document notes that there have been a number of innovations in service delivery which have supported the transformation of mental health services, including moving from a generic system to one in which specific needs were targeted. User-led and recovery-orientated community services, many of which have developed independently within the third sector, have highlighted how service users can take control of their lives and also provided commissioners with the potential for developing mental health provision beyond the core roles.

18. The changing role of professionals and cultures has also affected the transformation. Psychiatrists benefited from a move to services based in district hospitals or community settings which dissociated them from discredited institutions. Nurses were now free to innovate in community services

Finances

19. The majority of the transformations in mental health services have been accompanied by financial models that support or facilitate change. Concerns around the moral and therapeutic aspects of asylums were added to by the belief that they could not be financially sustainable. However this did lead some people to be opposed to the change suggesting the real motive for change was to save money.

20. The Kings Fund document noted that a study in 2004 found that the costs of community-based mental health care were broadly equivalent to institutional care and that whilst there is no doubt that the process of de-institutionalisation has released significant funds, a number of studies have found that rebalancing care from institutions to the community does not generate cost savings.

Lessons Learnt and Potential Issues for the future

[2] Service Transformation, Lessons from Mental Health, The Kings Fund – February 2014

21. The research within the Kings Fund report identified a number of national lessons and consequences from the transformation process. Which are as follows

    Re-institutionalisation – the danger that institutionalised professional behaviours would continue in community settings, e.g. buildings changed from large asylums to smaller acute wards but the institutionalised culture and the mind-set of staff remained, thus creating institutionalised community care.
    System Complexity – there is a plethora of complex pathways for individuals to navigate in order to access services, whilst creating a system to meet a particular set of needs, it failed to take into account other existing and potential areas of need. Resulting in an inflexible and unresponsive system. The development of a single point of access in many parts of the country has been an attempt to address these issues.
    Complexity of partnership working – there has been a lack of clarity around the professional role and governance of social workers within the teams which has caused conflict between sectors. Mental health services can only be successful if housing and social care services, in particular, are working well. Some felt that where strong partnerships had existed between social care and health care organisations, they were being eroded, partly due to budget constraints and a misunderstanding of the role of the local authority.
    Unintended Consequences – The number of hospital beds for people with mental health problems has decreased by more than 60 per cent between 1987 and 2010 compared with a 32 per cent reduction in general and acute physical care beds. However new demands on beds have arisen from groups of service users who would not previously have been cared for in long-stay asylums.

The Policy Context

22. The Government Document 'No Health Without Mental Health' outlines how the Government recognises that good mental health is central to people's quality of life. It outlines the Government's commitment to ensuring they and all sectors have a part to play in the challenges posed by mental ill health and how it wants to remove power away from the centre and let people take more control over their lives, with more flexibility for local people to make decisions based on local needs, empowering local organisations and practitioners to have the freedom to innovate and drive improvements in services that deliver support of the highest quality for people of all ages.

23. The document received widespread support and set out six objectives to improve the mental health and wellbeing of the nation through high quality services. It outlines the need for a parity of esteem between physical and mental health, interconnecting with housing, employment and the criminal justice system.

24. In a commitment to the strategy funding of £400m over 4 years was given to expand the improved Access to Psychological Therapies (IAPT) Programme. The government has acknowledged that spending cuts to mental health is not a wise investment and that investing in the country's mental health is investing in the future.

25. Nationally the strategy has generally been well received, especially as it recognises that mental health is not simply a 'health' issue.

THE PANEL'S FINDINGS

TERMS OF REFERENCE 1 – TO ESTABLISH WHAT MENTAL HEALTH SERVICES ARE PROVIDED IN MIDDLESBROUGH

26. To begin the review the panel had a 'setting the scene' presentation from David Brown, Director of Operations from the Tees, Esk and Wear Valley NHS Foundation Trust who explained that internationally and nationally there is a policy to reduce the use of beds to a minimum, based on the evidence that this approach provides the best outcome for a patient as well as a better experience.

27. The panel learnt that during the period 2006-2013 TEWV had returned approximately 10 million pounds worth of cash releasing efficiency savings to the Commissioners and that the cost reductions, achieved through bed closures had largely, but not entirely, contributed to this requirement. Commissioners in Tees had maintained a ring fenced budget for mental health and learning disabilities services and therefore there has been investment in children and young people's services, liaison psychiatry and Improved Access to Psychological Therapies (IAPT). Some of the services where there has been investment from the mental health and learning disability budget are not provided by TEWV, for example IAPT services are not provided through Any Qualified Provider and there are six such organisations on Teesside.

28. There had been much written in the press about access to beds and placing people far from where they lived. The Trust confirmed that there had not been any patients sent outside the TEWV area in the last 2 years, and they were very proud of that. There are 58 mental health trusts and very few are in a position to be able to report that. The Chief Executive of the Trust keeps a close eye on placements; the pressure on beds comes from people being placed from out of the area. TEWV are required to demonstrate that all potential admissions have been assessed by the Crisis Home Treatment Services to ensure the correct treatment path is found for the patient and that hospital admissions are along used when the person cannot be treated in their own home.

29. The bed reductions in Middlesbrough are shown in the following table. The wards cover the Middlesbrough, shared with Redcar and Cleveland for adults and Stockton and Redcar and Cleveland for older people.

30. Table 1

	Location	Number of beds at 31 March							Notes
		2007	2008	2009	2010	2011	2012	2013	
AMH Assessment and Treatment									Exx MOD and Detox
Ayton	St Luke's	26	26	20	18	0	0	0	Closed April Moved to Overdale
Thornton	St Luke's	29	29	23	18	0	0	0	Closed April 10 – moved to Stockdale
Overdale	Roseberry Park	0	0	0	0	18	18	18	Opened April 10
Stockdale	Roseberry Park	0	0	0	0	18	18	18	Opened April 10

AMH Beds Total		55	55	43	36	36	36	36	Exc MOD and Detox

AMH – Adult Mental Health

31. **Table 2 -**Adult bed capacity is more of an issue for the services in TEWV than Mental Health Services for Older People (MHSOP) and has a higher national profile. The use of beds is detailed in the table below.

	Location	Number of beds at 31 March							Notes
		2007	2008	2009	2010	2011	2012	2013	
MHSOP functional Assessment & Treatment									
Bath Villa	St Luke's	20	20	18	16	0	0	0	Closed April 10 – moved to Westerdale North
Westerdale – North	Roseberry Villa	0	0	0	0	16	16	16	Opened April 109
MHSOP Organic Assessment and Treatment									
Wells Villa	St Luke's	19	19	16	16	0	0	0	Closed April 10 – Moved to Westerdale South
Westerdale – South	Roseberry Park	0	0	0	0	16	16	16	Opened April 10
MHSOP Beds		39	39	34	32	32	32	32	

32. Table 3 – Adult Bed Use Middlesbrough (Last 12 months)

Total number of admissions	226
Expected number of admissions (based on 179 per 100k MINI Weighted Population)	190
Number of patients not admitted to Roseberry Park Hospital	13 (6%)
Expected number of occupied bed days (based on 20 beds per 100k MINI weighted population)	7731
Number of occupied bed days used	7808
Current patients whose length of stay exceeds 90 days	2 (24 in the previous 12 months)

33. It was explained to the panel that demand for beds in Middlesbrough is close to the expected norm which suggests that the number of beds have not been cut too far.

34. Wards are split into male and female, so there can be situations where there is full capacity for one sex but a number of empty beds for the other. However, even when this is the case there have not been any patients sent outside of the TEWV area in the last two years. There have been 13 patients who have gone to Durham and Darlington and of those at least four chose to go outside of Teesside for personal reasons.

35. Whenever a patient is admitted Middlesbrough Community Mental Health team would liaise with that ward or unit to ensure that discharge arrangements follow the policies and procedures and are effected as quickly and as safely as possible. There would also be attempts to return patients to the areas in which they live if that is safe and sensible. Similarly, patients who are accommodated on wards at Roseberry Park from outside the area have contact form their community teams to maintain adherence to our Purposeful Inpatient Admission (PIPA) standards.

36. Information provided by the North of England Commissioning Support Unit outlined the services provided in Middlesbrough. It noted that for the common mental health problems such as depression and anxiety related conditions these are generally treated in a primary care setting and the South Tees CCG commission a range of services. For people over the age of 16 there is a primary care psychological therapy service which provides NICE accredited psychological therapies and there are 6 providers of that service. For adults who have a long term mental health problem which is currently stable there is a commissioned primary care mental health services provided by TEWV.

37. For children and young people there is a targeted mental health service which aims to provide early intervention for mental health problems to prevent escalation into specialist mental health services.

38. More complex mental health conditions are managed in secondary care by specialist mental health providers. TEWV are commissioned to provide community based services and in patient services which are as follows

Community Based Services	In Patient Services
- Specialist Community Mental Health Teams for Affective disorders (multi-disciplinary service for people with severe and complex mood related mental health problems) - Specialist Community Mental Health Teams for Psychosis (multi-disciplinary service for people with severe and complex psychotic mental health problems) - Mental Health Access service (first point of contact for referrers) - Mental Health Crisis Team (multi-disciplinary service for people with complex mental health conditions who are in crisis requiring an urgent	- Adult acute mental health wards (64 beds)for assessment and treatment of complex mental health problems at Roseberry Park Hospital - Psychiatric Intensive Care ward (10 beds) at Roseberry Park Hospital for people in an acute phase of mental illness with very high risk behaviours - Male Locked Rehabilitation (8 beds) at Roseberry Park Hospital for men who exhibit high risk behaviours relating to their mental health problems and require in patient care for a longer period of time - Female locked rehabilitation (7 beds) at Roseberry Park Hospital for women who exhibit high risk behaviours

response) - Mental Health Home Treatment service (multi-disciplinary service to support people in their own home as an alternative to hospital admission) - Intensive Home Support Service (psychologically led service for Older People in mental health crisis who exhibit complex and high risk behaviours) - Older peoples Community Mental Health Team (for assessment and treatment of older adults with complex mental health conditions) - Assertive Outreach service (to offer more intensive ongoing support for people with severe and enduring mental health problems who are vulnerable or prone to rapid relapse) - Early Intervention in Psychosis service (multi-disciplinary service aimed at people aged between 14 and 35 years who experience a first episode of psychosis, specialising in focussed family work and psycho-education alongside judicial use of antipsychotic medication) - Acute Hospital Liaison Service (specialist multi-disciplinary mental health service operating 24/7 within James Cook University Hospital to assess, treat, and help manage people with mental health conditions who present at the acute hospital, offering signposting to specialist mental health services or other provision where appropriate) - CAMHS Tier 3 mental health team (multi-disciplinary community mental health team for assessment and treatment of children and young people with complex mental health problems)	relating to their mental health problems and require in patient care for a longer period of time - Specialist mental health rehabilitation based at Parkside (Park House 14 beds) for people who require longer periods of mental health treatment, up to 18 months. - Specialist mental health rehabilitation, slower stream, based at Lustrum Vale, Stockton (20 beds), for people who require longer term in patient treatment, 18 months plus - Community eating disorders service, specialist community team providing treatment and support for people with eating disorders (primarily anorexia nervosa and bulimia nervosa).

39. In addition to the above, there are also community services commissioned from Middlesbrough MIND, which are as follows

- **Stepping Forward**, a community service aimed at people who are vulnerable, who live chaotic lives and risk presenting frequently with a range of organisations such as GPs, Police, A&E, social services they do not engage in care and treatment services. The purpose of the service is to work flexibly and assertively with individuals to attempt to introduce stability to their lives to help them engage with services.

- **Living life**, a day service for people with complex and long term mental health problems aimed at recovery through individualised work and support to access mainstream services, education and employment, and vocational opportunities.

- **Carers support service**, targeted support for people caring for individuals with mental health problems.

40. There are also contracts in place with other specialist mental health providers such as Priory Hospital Middleton St George, Cambian Hospitals at Darlington and Durham, the retreat at York and Barchester Independent Hospitals at Billingham for people whose needs require specialist input which isn't effectively provided through the other commissioned services.

TERMS OF REFERENCE 2 – TO CONSIDER HOW MONEY HAS BEEN INVESTED INTO COMMUNITY SERVICES AND IF THERE ARE SUFFICIENT COMMUNITY MENTAL HEALTH FACILITIES WITHIN MIDDLESBROUGH

41. It was confirmed that over the past 15 years, the majority of investment in mental health services had been into community services, including the specialist services already detailed in this report. The panel learnt that the services were developed prior to any reduction in bed services and allowed for the change of use of mental health beds and released resources to allow more specialist use of beds and enabled the development of Roseberry Park Hospital as a replacement for the old St Luke's Hospital. Prior to the development of community services, admitting people to hospital was the default option, now beds are just one part of the pathway and are used only when this is the least restrictive, safest and most appropriate option for people. The first response is assessment, care and treatment in peoples own homes and involving families and those closest to them as much as possible in the process.

42. The panel heard that recently there had been significant new investment in Tier 2 CAMHS, liaison psychiatry services and Primary Care psychological therapies which are aimed at earlier intervention and enabling access to effective treatment to minimise the impact of mental health conditions on their lives. Other areas of new investment such as stepping forward promote the recovery approach to help people take control of their own lives as much as possible and help them to better understand and manage their mental health condition.

Funding

43. South Tees Clinical Commissioning expects to spend £49.73m in 2013/14 on mental health and learning disability treatment services which does not include spend on mental health or learning disability continuing healthcare packages. The majority of this resource will be spent on community mental health services which are where the bulk of both specialist and non-specialist mental health treatment takes place. No funding has been removed by the CCG from bed based services although the bed configuration is markedly different than it was 15 years ago. The overall number of

hospital beds has reduced, but the range of specialities has increased and people can now expect to spend a much shorter time in hospital as a result of the range of community based services available to them. The CCG continuously monitors the capacity of services, both community and in-patient to ensure that the range and capacity of the resources available are sufficient to effectively manage demand. This was of particular importance in the current financial climate when the health service is seeing more people than ever before through the range of services available and delivery of timely and effective services is essential to maximise the opportunities for people to make a full recovery.

TERMS OF REFERENCE 3 - TO CONSIDER WHETHER OR NOT REDUCED BED CAPACITY HAS LED TO MORE PRESSURES BEING PLACED ON COMMUNITY BASED SERVICES

44. Information nationally describes a mental health service which is 'straining at the seams' to cope with the growing number of people with mental illnesses. The panel were interested to find out if there were more people, locally, using the services of MIND. In discussions with the Chief Executive from Middlesbrough and Stockton MIND the panel heard that there is a larger population, people do live more stressful lives and people have become more aware of their mental health needs. In addition to this MIND are developing more projects to help people with mental health issues and because of all of those issues, there has been an increase in the numbers of people accessing MIND for assistance. Also, people are now able to access MIND without a referral from their GP.

45. In addition to increasing numbers it was noted that there was an increasing number of people who were seeking help from MIND who had very complex needs requiring support from other organisations and not just mental health services. People are presenting with financial needs, housing issues and drug and alcohol problems. This led to discussions about the model of care and recognition that a more integrated way of working was needed at both local and national level. There was also a need for more than medication and symptom management, people's circumstances can also be improved with changes to their economic, social and/or personal situation and by considering where help could be provided by the voluntary and independent sector. It was emphasised that mental health should not be seen exclusively as a health and social care issue but that there should be a spectrum of care to meet all of a person's needs.

46. It was mentioned that implementation of recent Welfare Reforms may well have an impact on people's mental health in the future and work was on going to assess this by various agencies including the Council.

47. There are groups of people, however, who are still reluctant to come forward at all, i.e. Young people and older people. It was suggested that young people are currently getting a poor service and generally have to become very unwell before they get to MIND, and even then they still need a lot of encouragement to come forward. The ethnic population is also still a very hard to reach group and work had been undertaken to tackle the stigma attached to mental health, however the funding for the project had ceased due to the current economic climate.

48. The panel went on to hear that there is an inconsistency in the levels of referrals made by GPs. i.e some GPs make lots and others make very little or no referrals. It was

suggested that work needed to be undertaken with GPs and that better information (perhaps in the form of a portal) should be available to them to enable them to refer people to the community services that may be available to help them.

49. In evidence received from the North of England Commissioning Unit, more people are being seen by community mental health services than ever before, this had been the focus of investment for a number of years and that there were more community based mental health services available to people as a result.

50. The development of specialist community services had allowed a reconfiguration of bed based services as there were more community treatment options now available to people. Whilst there was a greater expectation for people with more complex needs to be treated in the community rather than as in-patients, there has been a significant growth in resource and investment to manage this shift. There are more people treated in the community and there has been an increased demand for mental health services generally, but the North of England Commissioning Support Unit confirmed that any increased pressure was not as a result of reduced bed capacity as there were in-patient beds available should admission to hospital be indicated.

51. This was supported by the South Tees CCG through improved in patient services and through the development of purpose built specialist mental health wards at Roseberry Park hospital and more recently the commissioning of specialist female locked rehabilitation services at Fulmar Ward which opened in 2013.

TERMS OF REFERENCE 4 – TO LOOK AT CURRENT CAPACITY LEVELS AND THE EFFECT OF OUT OF AREA PLACEMENTS

Current Provision

52. The current commissioned bed numbers available for Middlesbrough people include:
    - 64 assessment and treatment beds for adult mental health at Roseberry Park
    - 32 older peoples mental health assessment and treatment beds at Roseberry Park
    - 10 Psychiatric Intensive Care beds at Roseberry Park
    - 15 specialist locked rehabilitation beds at Roseberry Park
    - 14 rehabilitation beds at Park House
    - 20 rehabilitation beds at Lustrum Vale

53. The beds are shared either with Redcar & Cleveland and Stockton for the Roseberry park facilities or with all of Tees for the Park House and Lustrum Vale facilities. In addition to this there are currently 6 people from Middlesbrough who are receiving specialised mental health in patient services in Cambian Hospital Darlington or Cambian Hospital Durham. People are admitted after careful consideration of their individual needs and for specific therapeutic programmes of treatment and remain open to care co-ordination from the community teams in Middlesbrough. There are no other Middlesbrough patients in mental health beds commissioned by South Tees CCG out of area. This has been the direct result of commissioning a greater range of specialist beds locally.

54. To date no one had been admitted outside of the contracted beds for an acute admission due to lack of available beds. There had been incidences of emergency admissions to other parts of the country when the individual has presented in those areas but they are repatriated as soon as practically possible.

TERMS OF REFERENCE 5 – TO CONSIDER IF THIS SERVICE RECONFIGURATION HAS LED TO IMPROVED PATIENT OUTCOMES AND A BETTER QUALITY SERVICE

55. The panel, in discussions with the Operations Manager from TEWV, he recognised that there was more work to be undertaken in the evaluation of the success of current policies in terms of patient outcomes, especially in regard to community based services, although overall a much better situation had been achieve for patients over the last five years. There were fewer patients being admitted to hospital and their length of stay was generally shorter. Suicide rates in Middlesbrough are lower than the rest of the North East and the rates are not rising.

56. The Trust outlined that patients are describing a better experience. Where people are admitted to hospital it is for a shorter length of stay, they are not left sitting around, the environment at Roseberry Park is significantly better than previous provision. People have their own en-suite room, there has been changes to ward rounds from weekly to daily and patients are reviewed by a consultant.

57. The separation of teams to enable them to become more specialist and therefore more focussed have produced a better outcome for patients. People who present at A&E with mental health problems are able to see someone from the mental health team within an hour and the impact of the liaison team has been good. It was noted that the money saved from the previous configuration had been transferred into developing new services.

58. The panel questioned if more people were presenting with mental health issues would with mean that policies had failed. In answering this, the panel heard about the number of people with mental health problems will increase in the future, due to a number of external factors, including the rise in the number of people living longer and therefore presenting with mental health issues linked to dementia, rising number of people with issues related to legal highs and alcohol consumption. Even the long term, indirect consequences of the changes in welfare reform may have an impact in the numbers in the future. This all has to be taken in to account when assessing any rise in people with mental health issues and it is difficult to separate this from the impact of any changes to service configuration.

59. When asked about what the changes in policy had meant to service users, Emma Howitt from MIND indicated that this was a difficult question to answer but suggested that the measures aimed at avoiding unnecessary admission to hospital and which focussed on facilities which were closer to people's homes and within the community was an improvement and needed to be developed further. The concern still existed around the basic principle of ensuring that people receive the right support, in the right place and at the right time in order to make a significant difference.

60. In discussing the challenges MIND faced, one of the main concerns was how to cope with the increased demand together with increasing financial constraints. It was acknowledged that not all GPs had a good understanding of the available mental health services. In a subsequent meeting Dr Waters, Chair of the CCG, responded to this issue and outlined to the panel that GPs acknowledged that the number of mental health services had developed greatly in the past few years. Previously many GPs had referred people to an individual consultant but now there is more choice, with a wide range of some 20 services available to people. Increasingly people are now self-referring and people now see a GP how will provide assistance for a self-referral. GPs

are encouraged to refer patients to the wide range of early intervention services available to prevent escalation into specialised mental health services.

61. The CCG recognised that many GPs have a general awareness of the wide range of mental health services and managed the more common mental health conditions through their experience and with training, however it was recognised that unless they had a specific interest in mental health conditions it would be difficult for all GPs to have expert knowledge of all of the services available.

62. There have been doubts expressed nationally, including by doctors' organisations about the ability of GPs to commission for specialist mental health services. Meaning that it will be important for local health and wellbeing boards to monitor and ensure that the funding for increased IAPT is used as intended.

63. The panel discussed the possibility of TEWV providing a single point of access, a website for GPs was in development which will list the various options for mental health services however it was felt that there was scope for further improvements. The availability and advertising of different categories of psychological therapies was seen as a step forward and such therapies were often regarded as better than just mediation in some circumstances. It was acknowledged, however, that for some people, they were only accessing services when their position had reached crisis point and that there was still work to be undertaken to tackle the stigma around mental health and to encourage people to seek help earlier.

Current Practices

64. Current services can be described as a stepped care model with the aim being that people are treated in the most accessible and least restrictive way to meet their needs.

Step 1 – this is for people who have a mild presentation of a common mental health problem or have an enduring mental health problem which is currently stable and can be managed by the patients GP.

Step 2 – this is for people with common mental health problems with a mild to moderate presentation who require a more specialist approach. Services at step 2 include the primary psychological therapy services who deliver all NICE accredited psychological therapy approaches, such as counselling for depression, cognitive behavioural therapy for depression and anxiety, guided self-help, bibliotherapy, trauma work, anxiety management etc. these treatments are all delivered by therapists qualified in a range of specialities. Also at step 2 are services such as the Mind day service and the stepping forward service which adopt a recovery approach to help people with common mental health problems to manage their own conditions and access appropriate services affectively.

Step 3 – this is for people with more severe and complex presentations who require treatment and support from the specialist mental health services in the community. Services at this level include the psychosis team, affective disorder team, crisis intervention team, home treatment service, early intervention in psychosis service, intensive home support service, assertive outreach service etc. risk assessment and effective risk management is paramount to ensure that people can be safely treated in the community setting.

Step 4 – this for people whose presentation is of a degree and complexity with associated risks to the degree that they require treatment in hospital as community treatment is not felt to be safe or appropriate. Access to admission to hospital is through the crisis intervention and home treatment service as they will screen people prior to admission to ensure that all community options have been explored before making the decision to admit the person to hospital. This ensures a consistent approach and that all people are offered treatment in the most appropriate environment to their needs.

65. In addition to the steps described above, there are a number of tertiary services such as specialist psychotherapy services and individual bespoke packages of care and treatment in community and hospital settings, all of which require care co-ordination and oversight from practitioners in the step 3 services.

Outcome Measures

66. The panel learnt that TEWV did not have a specific set of criteria to judge if there had been any success in this policy direction. There were of course a number of factors that could be taken in to consideration such as a reduction in the number of admissions, levels of self-harm and harm to others, suicide rates and even the quality of accommodation. However, it was noted by TEWV that patients' experiences were being improved due to improved access to Talking Therapies and Crisis and Home Treatment

67. The panel were keen to find out if there were any ways of assessing the success of the current policies. It was recognised that further work needed to be undertaken in order to assess the changes, however it was considered that in overall terms a much improved situation had been achieved in the last five years. Fewer patients had been admitted to hospital and where people were admitted this was generally for a shorter length of stay. Financially, comparisons of costs were difficult to make. The costs of the new build at Roseberry Park and the revenue costs associated with the capital investment cannot be compared to the costs incurred at St Luke's.

68. The rationale for the service configuration is for increased access and early intervention for people experiencing mental health problems and a recovery approach to maximise potential.

69. There are a variety of outcome measures currently employed within mental health services to assess an individual's improvement. For primary care therapy services it is expected that all people who complete treatment make a clinically significant improvement and that 50% of people make a full recovery. Within specialist mental health services we are introducing a common patient rated wellbeing tool to assess the impact of mental health services and a clinician rated outcome tool consistently across all services to enable comparisons of outcomes between providers and service lines. These are currently being trialled in a number of pilots across the country. There are a large number of quality requirements within all of the commissioned mental health services which are monitored on a monthly, quarterly or annual basis with contractual mechanisms in place to ensure transparency and effective service delivery. The quality schedules cover all areas including patient safety, patient experience, clinical effectiveness and quality assurance and governance.

TERMS OF REFERENCE 6 – TO CONSIDER IF THERE ARE ANY AREAS OF IMPROVEMENT THAT COULD BE IMPLEMENTED IN ORDER TO ENSURE THE BEST SERVICES FOR PEOPLE IN MIDDLESBROUGH

70. The panel had heard from TEWV that the current system is still too paternalistic and medical a view shared by MIND. The panel wanted to consider if there were any other radical approaches which would be adopted which would yield positive results.

71. In trying to answer this question, it was noted that treating the illness is not enough, in order for someone to get better; their whole quality of life should be considered. In addition to that, resources need to be distributed effectively so that people get the service they need. I.e. A person-centred approach was required from all organisations which were required to support a person's recovery and that working alongside a medical model; other support could be provided which took into account the effects of social and economic circumstances. It was recognised that radical changes were required but that there wasn't a quick fix and that it would take significant time to change from traditional medical methods of treatment and managing symptoms to a more holistic approach.

72. As is the case nationally, in order to make further improvements to mental health and wellbeing there needed to be increased education and awareness of the nature of mental health problems and a reduction in stigma as well as improvements in early diagnosis and intervention. It was recognised that the current financial constraints within the public sector as a whole would impede any driving force around a shared vision of mental health policy.

73. The panel heard that future investments in the next 12 months will focus on increasing the capacity of the tier 2 CAMHS service to improve access and availability of appropriately skilled professionals to enable early intervention. Additionally an area of increasing concern surrounds those people who are vulnerable as a result of their chaotic lifestyles who present frequently to health, social care, police etc. but do not engage with services. The success of the stepping forward service is one example of how innovative and flexible approaches can have a positive impact on people's lives and enable them to access help. The Commissioning Support Unit will be looking to identify potential areas for development which can help this section of the population by working with partners locally and beyond.

74. Another area of increasing concern is the range of complex presentations resulting from abuse of substances an example being those drugs often termed as legal highs. There is small but increasing number of cases which have proved very challenging, work will continue with commissioned services to ensure that there are the resources available to meet these and other emerging challenges.

75. The continuing focus for future development is for increased access and early intervention for people experiencing mental health problems and a recovery approach for people with long term conditions to maximise potential and allow people to live fulfilling and rewarding lives. MIND reiterated this as their stance was that people should have the right level of support at the right time. A person centred approach was required from all organisations which supported a person's recovery and quality of life and that working alongside a medical model of mental health; other support could be provided which took into account the effects of social and economic circumstances. It was recognised that radical changes were required and that there were no quick fixes

and that it would take time to change from specific medical methods in treating and managing symptoms to a more holistic approach.

76. The panel heard that a mental health strategy group had existed and that in recent times had lost some of its focus and that perhaps consideration should be given to give that group more power in order to be able to develop a more effective strategy for the future. Financial constraints had diminished any driving force around a shared vision in terms of mental health policy. The panel then considered the roles and responsibilities of the Mental Health and Wellbeing Partnership in more detail at a subsequent meeting and found that in the past the partnership had been well established and well attended but that the focus and attendance had 'drifted' over the last 12-18 months. Previously the group had a good focus, around implementing the National Service Framework but as that had come to its natural end and had been superseded by the 'No health without mental health' government document' which was described as vague, had meant that the partnership had lacked a government direction, as the document lacked targets and had removed incentives. The panel heard that what was needed was a strong local direction and the development of a local strategy.

77. In addition to that the Partnership, which had lots of agencies signed up to it, had no dedicated administrator, no definite Chair and the panel were told that because it was such a good arena for professionals to meet that something must be done to ensure its future. Members asked about the links with the development and implementation of the Joint Strategic Needs Assessment (JSNA) but the partnership no longer had links in to that process other than through the Clinical Commissioning group and the Health and Wellbeing Board. Members thought that it was important that links with the Partnership should be reinstated and that this could provide the Partnership with a way of being able to influence the JSNA.

Integrated Teams

78. The panel learnt that there had been a review of Mental Health services undertaken by Vanessa Fryer, Lead Officer, Mental Health and Safeguarding which provided 3 options for the configuration of mental health services.

- **Option 1** - Stay the same, i.e. a Social care and Health integrated team
- **Option 2** – Ensure the team was co-located in the same building but not necessarily the same office
- **Option 3** – 'de-integration' i.e. – move Middlesbrough Council Social Care Social Workers out of integrated teams

79. The panel heard that option 3 was the preferred option and that this was not necessarily as a result of the current financial climate. The Trust has been consulted on these options, although no formal response has been received as yet.

80. In explaining the reasoning behind the preferred option 3, the panel heard that integration, from a social care perspective, had not worked. The Health's electronic system in place for recording information, PARIS, does not integrate with Middlesbrough's IAS system and as a result Middlesbrough Social Workers were spending a disproportionate part of their time inputting information on to the PARIS system to the neglect of putting information on to the IAS system. Although integrated working was seen as the best way by officers, the panel were told that, at present, the balance was incorrect. As a result risk assessments which are being completed by social workers are being inputted on to the PARIS system and not the IAS system.

81. The panel were assured that the department, that following any implementation of the preferred option, that social workers will continue to work closely with their Health colleagues and maintain a professional and effective working relationship with TEWV. That the preferred option provided a more focused service, clearer management arrangements and accountability, greater information sharing and the opportunity to maximise effectiveness in staffing.

82. When asked about whether this arrangement would have any impact on the pathway or whether people would find it more complicated to access the service. The panel were told that it will have no impact on the service they receive.

83. The panel were concerned about the possible communication risks associated with the de-integration, especially if people are to be located in different buildings. The social care department were aware of the risks and that they needed to be overcome. In addition to the physical location of the team, there were risks associated with qualified members of staff leaving due to the current working arrangements, which also carried with it a degree of risk. In addition, the longer there were delays implementing the findings of the review; it was thought that the more individuals could leave. If staff leave and are not replaced (there have been no deleted posts, but when someone leaves their post is not filled) then the situation could get worse, currently the situation is being manages as best as it can within the current circumstances. However there is the risk of a downward cycle, good staff remain, but workloads increase, leaving people with a larger workload which may make them stressed and more likely to leave.

84. In response to members concerns about bureaucracy, it was confirmed to Members that there would be no more additional bureaucracy and that assessments will still be done together and that multi-disciplinary attendance will continue. The panel were keen to get a guarantee of that.

CONCLUSION

85. Based on evidence given throughout the investigation the Panel concluded:

LIST OF POSSIBLE CONCLUSIONS FOR FURTHER DISCUSSION AT THE SCRUTINY PANEL MEETING

a) That the evidence presented showed that Middlesbrough had a wide range of community based services which had replaced the need for large scale institutions.

b) The panel were reassured by TEWV that capacity levels are close to predicted numbers of patients. Any pressures on services came from out of area placements and no one from Middlesbrough had been admitted to hospitals outside the trust because of the lack of available beds. The evidence presented showed that there was no increased pressure on services in Middlesbrough as a result of reduced bed capacity.

c) More work needs to be done on collecting information to assess if service configuration has improved patient outcomes.

d) GP knowledge of mental health services varies and GPs would benefit from a single point of access.

e) The Mental Health and Wellbeing Partnership had once been a successful body and the panel thought that it should continue to operate, be refocused and that it should have links with the JSNA.

f) That there were concerns about the safeguarding risks of the de-integration of the social care and health mental health teams.

RECOMMENDATIONS

86. That the Health Scrutiny Panel recommends:

DRAFT RECOMMENDATIONS BASED ON DISCUSSIONS AT PREVIOUS MEETINGS – FOR FURTHER DISCUSSION AT THE SCRUTINY PANEL MEETING

a) That a set of criteria is developed to assess if success has been achieved, this could be done by measuring the number of admissions, the number of self-harmers, suicide levels etc. Consider clinical outcome measures and patient outcome measures. Also ask people about their experiences.

b) To commit/protect small resource for secretariat of the Mental Health and Wellbeing Partnership, ensure a stable venue, commitment to re-launch it, and develop something local that is meaningful. That the partnership should be accountable, should have influence and should be able to link with the JSNA and the H&WBB.

c) That the Public Health team make use of the Mental Health and Wellbeing Partnership when producing the JSNA and use them to help shape policy

d) Any changes to services should be signed off though the Partnership

e) Commissioning intentions should also be presented to the Board for comments.

f) Following the de-integration of the mental health integrated teams that a system of referral is introduced to enables GPs to have an easily accessible, quick and efficient system where there is one point of contact.

g)

ACKNOWLEDGEMENTS

87. The Panel is grateful to all those who have presented evidence during the course of our investigation. We would like to place on record our appreciation, in particular of the willingness and co-operation we have received from the below named:

- David Brown, Director of Operations, Tees, Esk and Wear Valley NHS Foundation Trust.
- Dr Henry Waters, Chair, South Tees CCG
- John Stamp, Senior Commissioning Manager, North of England Commissioning Support Unit
- Emma Hewitt, Chief Executive, Middlesbrough and Stockton Mind.

- Colin Holt, Head of Assessment and Care Management, Department of Wellbeing Care and Learning, Middlesbrough Council
- Vanessa Fryer, Lead Officer, Mental Health and Safeguarding, Department of Wellbeing Care and Learning, Middlesbrough Council

COUNCILLOR EDDIE DRYDEN
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Date: March 2014

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BACKGROUND PAPERS

The following background papers were consulted or referred to in the preparation of this report:

(a) Minutes of the Health Scrutiny Panel meetings from 7 November 2013 until 11 March 2014
(b) Starting today, The future of mental health services, Mental Health Foundation, September 2013
(c) Service Transformation, Lessons from mental health, The Kings Fund, February 2014

Timeline of Key Events

1946	National Association for Mental Health (now MIND) is founded
1948	National Health Service Act comes in to force
1955	Chlorpromazine appears as first anti-psychotic drug
1957	Percy Commission states that mental health should be treated in the same way as physical health
1959	Mental Health Act reduces admissions to asylums through more stringent admission criteria
1962	Hospital Plan brings in smaller, community-based hospitals
1975	National Schizophrenia Fellowship (now Rethink) is founded
1983	Mental Health Act establishes the role of 'approved social worker' and imposes a duty on local social service authorities as well as health authorities to provide aftercare services
1986	First asylum closed
1990	NHS and Community Care Act introduces the purchaser/provider spilt in health services and outlines entitlement to a community care assessment for service users.
1990	Care programme approach introduced as a framework for care planning in mental health services
1998	Publication of *Modernising Mental Health Services*
1999	National service framework for mental health outlines standards of care
2000	NHS Plan underlines new community service models, funding and timetable for implementation
2001	National Institute for Mental Health in England is established to support service development
2002	National suicide prevention strategy focuses on improving inpatient environment
2006	Improved access to psychological therapies programme is established
2009	National dementia strategy for England published together with programme of service development
2009	Government strategy outline in *New horizons: towards a shared vision for mental health* prioritises equality, personalisation, stigma, and physical health of people with mental health problems
2011	Cross-government publication *No health without mental health* introduces a new focus on public health and wellbeing, and improved outcomes.

Source – Kings Fund – Service Transformation Lessons from Mental Health