South Essex Joint Mental Health Strategy
Consultation Document

Developed in Partnership

Essex County Council
South Essex PCTs' Cluster
Southend-on-Sea Borough Council
Thurrock Council
Southend CCG
Thurrock CCG
Basildon and Brentwood CCG
Castle Point and Rochford CCG

November
2012

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Executive Summary

Our Vision for Mental Health Care in South Essex

This Strategy sets out the approach to the commissioning of Mental Health services in South Essex for the five year period April 2013 to March 2018. It has been developed through dialogue with a wide cross section of stakeholders. This strategy will describe how we plan to change the shape of mental health services over the next 3 to 5 years. The implementation of the strategy will be delivered through a number of working groups tasked with fine scoping and piloting service change.

It has been produced by partners responsible for ensuring that adult and older people mental health services are commissioned appropriately and efficiently for the people of South Essex. The key partners are Essex County Council, South Essex PCT's Cluster representing Clinical Commissioning Groups, Southend-on-Sea Borough Council and Thurrock Council.

Key Messages

- This strategy shows how we plan to improve outcomes across the full range of mental health care.
- We aim to:
- Improve the confidence and capability of GP's and practice staff to recognise, assess, support and refer people with mental health problems,
- Improve the gateway into services so people are directed to the right support at the right time,
- Improve primary care and preventative mental health services so more people are supported without the need to be in secondary care,
- Focus secondary care on providing intensive, specialist support which improves recovery, personalisation and choice, so fewer people need residential care.
- Improve crisis responses so that fewer people need inpatient care.
- Focus on developing the usage of alternative providers and self-management where it is safe and appropriate to do so.
- Focus on meeting the needs of higher risk groups who may have specialist needs.
- The strategy provides a timeline for working with partners to implement the new strategy over the next 3 – 5 years. This will involve a process of refining models, piloting, reviewing and implementing the changes.
- The strategy shows how we will commission the delivery of the strategy through co-ordinated health and social care commissioning arrangements.

Our vision is that the services we commission will support the following health and social care outcomes for people in south Essex:

- People will have good mental health
- People with mental health problems will recover
- People with mental health problems will have good physical health and people with physical health problems will have good mental health
- People with mental health problems will have the best possible quality of life

Scope

The scope of the strategy is adult and older people with functional mental health problems. These include common mental health problems such as anxiety and depression, and serious mental health problems such as schizophrenia and bi-polar disorder.

Mental Health problems do not exist in isolation. Therefore the strategy has been cross referenced against other interconnected strategic documents. Namely;

- Public health and wellbeing strategies (under consultation)
- Dementia strategy
- Drug and alcohol strategy
- CAMHS strategy (under development)
- Learning Disabilities (under development)

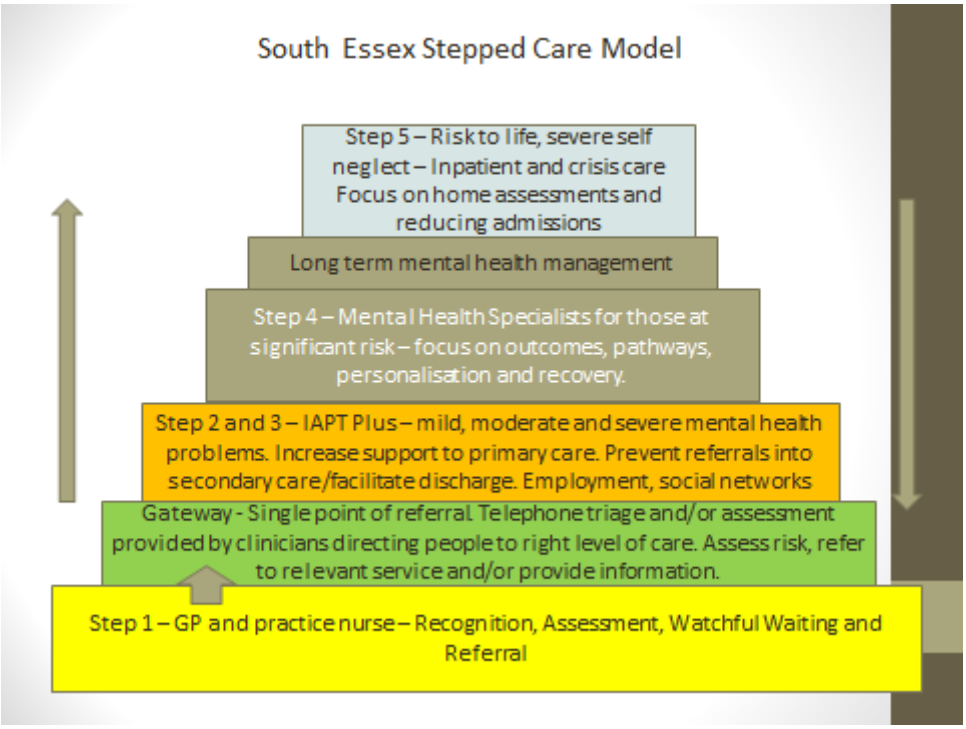
Implementation

The strategy provides a direction of travel for the system redesign. The Mental Health Commissioning Board will be responsible for overseeing the delivery of the strategy. They will be supported by 3 multi-stakeholder working groups tasked with refining models, piloting, reviewing and implementing the changes.

Models of care

The NICE commissioning guidance identifies the benefits of using a stepped care approach to commission services for people with common mental health problems. The core principle of stepped care is that people are matched to an intervention that is appropriate to their level of need and preference.

The stepped care model is a useful way to present the different tiers of mental health service for people with the full range of mental health needs, although it does not necessarily reflect the clinical pathways into services. People with a Serious Mental Illness (SMI), such as schizophrenia, require integrated health and social care treatment which can cross the different tiers of service and can involve having a GP, consultant psychiatrist and social care support.



Steps 1 – GP and practice nurses

A quarter of all GP appointments are mental health related. 90% of mental health needs are managed in primary care.

The common mental health needs seen within primary care are affected by lifestyle and environmental factors; the JSNA identified a strong correlation between mental health and deprivation, factors such as the recession are likely to increase levels of mental health need over the course of the strategy. The JSNA indicates that the overall prevalence of serious mental illness will not change significantly over the course of the strategy. However, there has been a rise in the number of people accessing specialist services over the last 3 years. This may continue over the course of the strategy. In step 1, the GP's role for people with common mental health problems is to identify, assess, provide psycho-education support, active monitoring and refer for further assessment and interventions. Step 1 includes supported self-management of psychological and emotional wellbeing. A number of patients presenting in primary care will prefer to find healing through non-traditional and social care routes.

Primary care also plays a critical role for more serious mental health problems such as schizophrenia Most people with schizophrenia have their mental health condition managed within secondary care. Therefore, the NICE guidance focuses on early intervention for first episodes –, supporting people with established diagnosis and managing physical health needs.

Through engagement we found that service users and carers wanted GP's and practice nurses to have more training and support in understanding and working with mental health and wellbeing.

This strategy proposes that step 1 (GP and practice nurse) care should be based on the following design principles:

- Good knowledge of mental health problems
- Good understanding of how and when to refer to mental health services, or alternatives.
- Good relationships with mental health services
- Clear boundaries of responsibility between primary and secondary care

Therefore we are seeking to implement the following improvements in step 1:

- Improve confidence of GP's and practice staff.
- Improve quality and consistency of referrals to services.
- Improve effectiveness of watchful waiting and supported self-management.
- Reduce health inequalities experienced by people with mental health problems.
- Improve mental health of people with long term physical conditions

The first working group will focus on Step 1 and the gateway. This working group will develop and deliver a training programme for primary care to improve their confidence and the reliability of referrals, develop and implement a plan to reduce physical health inequalities and pilot improving the psychological support to people with long term physical health conditions.

The aim of this work stream is to deliver the outcomes 'people have good mental health' and 'people with mental health problems have good physical health and people with physical health problems have good mental health'.

Gateway to services

There are currently a number of different access routes into mental health services depending on the needs of the patient. For many people, the first point of call is their GP. In 2011/12, GP's made over 16,000 referrals to IAPT (step 2 and 3). In the same period, they also made over 5,000 referrals into secondary care mental health services (step 4). Nearly 400 people accessed crisis services (step 5) through A&E with a further 1,500 crisis assessments being undertaken within the assessment unit.

The consultation events highlighted the need to improve the ease of access to services, especially through increasing the opening hours for specialist care and improved crisis responses. People wanted holistic service provision with a single point of access.

The role of the gateway will be to make a balanced judgement based on what would deliver the best, and the most sustained outcome for the person. The gateway must be able to get people the help they need with the minimum of delay.

The strategy proposes that the gateway should be based upon the following core design principles:

- Clinically responsible – it is critical that there are no gaps in clinical responsibility for the patient
- Safe – the service must be able to assess and manage risk
- Efficient – the service must be efficient at processing referrals without delay
- Multi-disciplinary – able to direct people to a range of options to meet needs safely
- Comprehensive – be able to refer people to all levels of care (steps 2 to 5)
- Capacity – must be resourced appropriately to manage the peaks and troughs of demand, especially out of hours
- Capability – must be delivered by clinicians with the right skills to do the job

Therefore the strategy is aiming to:

- Improve response times for all steps of care
- Improve service user satisfaction 'did it get you to the right care?'
- Improve safety and reduce avoidable incidents
- Reduce self-discharge and did not attend rates.
- Increased usage of alternative providers and self-management where it is safe and appropriate to do so.

The successful delivery of the strategy will mean that similar numbers of people are accessing mental health services but they will be accessing them through a single gateway. We expect the new gateway will be more effective than the current multiple entry points.

This aspect of the strategy will also be delivered by the first working group. In year 1, the group will undertake full cost benefit analysis of different 'models of gateway'; develop the service specification for new gateway and pilot new model in one CCG area. In year 2, we will review, evaluate and roll out new gateway across South Essex.

The aim of this work stream is to deliver the outcomes 'people with mental health problems recover' and 'people with mental health problems achieve the best possible quality of life'.

Step 2 and 3 – IAPT Plus

In 2011/12, Therapy4you (IAPT) received over 16,000 referrals and delivered over 52,000 therapy sessions.

The current IAPT service delivers one to one therapy, group therapy, computerised cognitive behavioural therapy and biblio-therapy. The current IAPT service is focussed on mild, moderate and severe non-psychotic conditions such as anxiety and depression. In most cases, the first assessment appointment occurs within the GP practice. Referrals to IAPT are made when the GP or practice nurse feels that their skills alone are not sufficient to help the patient.

There are also a number of patients within secondary care who have mild and moderate non-psychotic conditions. Some of these patients present significant risk and require secondary care. Others may be able to achieve the same or better outcomes if they were managed in primary care with the assurance that they can gain rapid access back to secondary care if their condition deteriorates. Likewise, there are cohorts of people with stable, well managed serious mental health problems who may also benefit from a more inclusive, primary care focussed service.

Our vision for the future is that the primary care team will be designed around the following principles:

- Evidence based – delivering NICE guidelines
- Patient-centred – delivering personalised care
- Based on need – sufficient capacity to meet different need in the least restrictive way
- Age inclusive – care should not be compartmentalised because of age
- Capable – knowledge and skills to provide services
- Integrated – seamless interface with secondary care
- Accessible – patients should be treated promptly
- Outcome focussed – systematic and measuring outcomes for patients
- Recovery focussed – help patients to help themselves
- Community linked – linked with a range of voluntary and community services, particularly to support people with long term mental health conditions and people with long term physical health conditions
- Preventative – prevent escalation for people at risk of developing more serious problems

Therefore the strategy is aiming to increase the support to primary care:

- Reduce waiting times for IAPT
- Improve recovery and outcome measures
- Increase the number of patients seen and supported in primary care
- Improve links and support for people to maintain employment, social networks and housing
- Deliver greater GP and service user satisfaction of primary care

The successful delivery of the strategy will mean that more people will receive treatment from 'IAPT plus' and fewer people will be referred into secondary care. We intend to increase the overall expenditure within primary care mental health services.

The second working group will focus on delivering these changes. In year 1, we will undertake cost-benefit analysis of different models of IAPT plus/secondary care and develop pilot specifications. The new model and pathways will be piloted in one CCG area. In year 2, we will look to roll out the new model across South Essex. In addition, we will also look at the alternatives to primary & secondary care services that can be delivered through voluntary and community services.

The aim of this work stream is to deliver the outcomes 'people with mental health problems recover' and 'people with mental health problems achieve the best possible quality of life'.

Step 4 – Secondary care community services

In 2011/12, there were nearly 8,000 people with functional mental health problems in secondary care services. On average each person received 12.5 face to face contacts with secondary care services per year.. The role of step 4 services is to provide specialist care for people who have complex needs and are at significant risk. This includes the management of people who have been treated or are still under treatment through the Mental Health Act (1983).

There are currently a number of different services which provide this care. These include:

- Outpatient services
- Community mental health teams
- Early intervention in psychosis teams
- Assertive outreach teams
- Day care
- Therapies and psychology
- Voluntary sector
- Independent sector

SEPT, with support of commissioners, has looked at the opportunities to redesign elements of their services to improve patient care & experience. Their consultation and engagement showed there was the opportunity for secondary care to provide more intensive support for people earlier on in their condition. They also felt that there were people in secondary care that could be supported in primary care with the right services around them. Changing the balance of care delivered between primary and secondary care is a key strategic aim because it will enable people to get the help they require when they need it. The design principles for secondary care will therefore be:

- Clear, evidence based and efficient pathways
- Managing care in the least restrictive environment, reducing the need for residential and inpatient care.
- Rapid access back to specialist care when needed
- Regular multi-disciplinary reviews
- Focus on improving holistic patient outcomes, including social inclusion, housing and employment.
- Ensure statutory social care responsibilities for assessment and care management are effectively integrated into the care programme approach
- Focus on recovery and co-production
- Able to deliver choice and personalisation
- Targeted on the people who need it most
- Delivering integrated health and social care services

Therefore the strategy is aiming to:

- Intervene earlier
- Improved patient outcomes
- Embed personalisation and promote recovery
- Increased use of personal budgets, where appropriate
- Reduce reliance on residential care
- Encourage innovative approaches
- Greater use of alternative provider options
- Reduced use of mental health act procedures

The successful delivery of the strategy will mean that fewer people will be managed in secondary care for shorter periods of time. As the transition progresses we intend to shift resources from secondary care to primary care. The phasing of the implementation is described in Steps 2 and 3 (above). It is important that the primary care and secondary care models are developed together to ensure that we achieve the right balance between the two tiers of care (see above).

The aim of this work stream is to deliver the outcomes ‘people with mental health problems recover’ and ‘people with mental health problems achieve the best possible quality of life’.

Step 5 – Crisis and inpatient care

There are currently over 240 beds used within the crisis pathway in south Essex. These include psychiatric intensive care beds, assessment beds, adults and older people inpatient beds There is also a crisis resolution home treatment team who manage access to the inpatient wards via the assessment unit. The majority of these beds are used for people with functional rather than organic mental health problems such as dementia.

Benchmarking shows that different mental health systems operate with different bed bases and different models of community crisis interventions. There is little consensus on the optimum balance of beds to community services. There is little evidence that high bed numbers increase safety. As a system, through clinical dialogue, there is a consensus that there are better ways to deliver crisis care. Clearly inpatient services are expensive and it is critical that they are used effectively to help more people to recover.

The consultation events highlighted the need for easy, prompt access to crisis services.

Therefore the vision is to commission the most responsive crisis care delivered in the least restrictive environment. The design principles for crisis care will be:

- Safety – making sure that services are safe and evidence based
- Accessibility - making sure that everyone knows how to access crisis services and that access is quick
- Capacity – that there is the right balance of inpatient and community resources to meet the need
- Integrated – good pathways from crisis services to prevent relapse and support Reablement
- Capability – the right skills within teams
  Develop alternatives to inpatient services – develop alternatives to admission which help people to recover quickly and safely

Therefore the aims are that the system will increase its focus on:

- Avoid unnecessary admissions – crisis teams with capacity and confidence to stop unnecessary admissions
- Reduce need for mental health act assessments
- Reduced length of stay – having clear care plans to help people to recover from the crisis and get home as quickly as possible
- Reduced need for A&E attendance – some people will need to attend A&E to rule out any physical health problems. However, for other people, attending A&E is often distressing Reduced delayed discharges – making sure that the system wide discharge planning allows people to go home as soon as they are ready
- Increased home assessments – when people are in crisis they often want to be assessed in their own homes

We anticipate that there will be similar numbers of crisis episodes in 5 years' time. We intend to reduce spending on inpatient care but increase spend on crisis care in the community. We expect that more crisis episodes will be managed in the community by the crisis intervention home treatment team and fewer will be managed in inpatient settings. We will develop alternatives to admissions where

there is a strong clinical and financial rationale to do so. The current NHS contract has a plan to improve crisis responses and reduce the bed base. The timeline is to complete the consultation by February 2013 and begin full roll out shortly afterwards. The third working group will be responsible for overseeing this work stream and developing alternatives to admissions. The aim of this work stream is to deliver the outcomes 'people with mental health problems recover'.

Commissioning arrangements

To deliver this strategy we need stable, effective and co-ordinated commissioning arrangements.

This will be achieved through integrated commissioning between the 4 Clinical Commissioning Groups (CCGs) and the three local authorities (Essex, Southend-on-Sea and Thurrock).

We will maximise our impact by commissioning services through jointly agreed strategies and joined up delivery plans. This will be underpinned by strong leadership through the South Essex Mental Health Joint Commissioning Board (SEMHJCB) which will be accountable to the three Health and Well-Being Boards; individual Health and Local Authority Executive Boards and Clinical Commissioning Groups.

Consultation questions:

The consultation questions are:

1. **Do you support the focus on improving the skills and confidence of primary care practitioners such as GP's and practice nurses?**
2. **Do you support the development of one gateway into mental health services?**
3. **Do you support the need for an expanded primary care mental health team (IAPT plus)?**
4. **Do you support the need to deliver care in the least restrictive way, reducing the need for hospital beds and residential care?**

5. **Do you support a crisis service designed to offer quick response, prevent admissions and support Reablement?**
6. **Do you have any alternative suggestions or views to improve the strategy?**

Chapter 2: The Case for Change

Key Messages

- The aim of this section is to describe the engagement process and to summarise the key findings from the dialogue.
- The strategy has been developed over 12 months through dialogue with a wide cross section of stakeholders.
- The dialogue has engaged with stakeholders through 4 key work streams; an independent service user report, a series of locality workshops, a multi-agency working group looking at outcomes and a series of clinical workshops.
- At the same time SEPT has also been reviewing its outpatient services and looking for opportunities to ensure that people get the right support at the earliest opportunity.
- Local people who experience mental ill health, or who care for people with mental ill health, said they wanted different responses focusing on recovery, personalisation, ease of access, consistency and a focus on their individual needs.
- GP said they wanted services that were more responsive, especially if people are in crisis.
- The case and opportunity for change is compelling and there is a growing consensus on the opportunity to improve care for people by doing things differently.

Aims of this section

The aim of this section is to describe the engagement process and to summarise the key findings from the dialogue. Extensive dialogue has taken place over the last 12 months with a wide range of stakeholders. The dialogue has created a growing consensus on the opportunity to redesign mental health services to improve the quality of care for the people of south Essex.

Engagement process

The dialogue has had 4 key work streams:

- Independent service user report - Making Involvement Matter in Essex (MIME) was commissioned to undertake an independent review of mental health services. They produced a report ‘The Big Conversation’.
- Locality engagement workshops - A number of workshops and focus groups have been held across South Essex with service users, carers, professionals and other stakeholders to understand how current services are experienced, and how they can be improved.

- Multi-agency working group developing the outcomes framework - Working group to develop an 'outcome based accountability' model for delivering the Strategy
- Clinical workshops - There were 4 GP clinical workshops held to review the different steps of care and to review evidence base and best practice. These were followed up with a several clinical workshops with SEPT.

Summary of the dialogue

The key messages emerging from the dialogue are:

- The desire for **recovery** focused services was common amongst service users, carers and also professionals. People want to reach a point where they can take control to manage their condition and become as socially included and independent as possible. People wanted the opportunity to take control through options such as **personal budgets.**
- Stakeholders wanted better access to services in **crisis**, they wanted to be able to gain entry back into services once they have been discharged, and reducing the need for people to go to hospital or receive treatment in a specialist mental health service.
- Employment, support and carer's **involvement**, are all crucial, it is families and carers who know their loved one best. Once informed and prepared, they can help the service user remain in their environment. Having daily activity and employment help. These aspects ensure a growing sense of self-worth.
- **Integration** and partnership between service providers is important as combined knowledge and expertise is central to achieving a holistic view and approach to helping people receive the service they deserve.
- People wanted **single access**, one-stop-shops, with as few visits to Centers as possible - helping the individual feel listened to and seen as whole person.
- Ease of **access** to services, increased opening hours to make specialist services more available, not confined by walls and time, with choice and accessibility.
- Stakeholders wanted to ensure that services were safe and managed risk. They wanted us to ensure that the strategy improved **safety** by providing rapid access to specialist care when they need it most.
- **Continuity** of professional presence - seeing different people each visit has been a real concern for service users, having to repeat one's story and to develop yet another trusting relationship only slows down recovery.
- Well trained, knowledgeable and **informed staff** that ensure effective responses, assessment and care.
- Multipoint access to **information** can aid the quick location of important advice and
- assistance.
- Reduced use of **hospitalisation**, with community alternatives for pre- and post-hospital. Many people commented that they did not like being in hospital. Also it is clearly a very expensive option.

- People reflected to us that some people do not seem to fit any service but really need support. They wanted services that treated the **person as a whole** and not just an illness.
- The **GPs** we spoke to want to build on the skills they have to support patients with complex mental health needs as they do with any long term condition. They consider they would benefit from additional support to manage the many differing levels and complexities of long term mental illness.
- People want to know that they can move in and out of services without having to go back on a waiting list so that they can be secure in the knowledge that should they suffer an episode of particularly poor mental health that they will be able to access help instantly to **prevent deterioration** and that those around them will recognise this and be able to offer support. This will also help to break the culture of dependency on services.
- This would mean that for a number of people currently known to secondary mental health services their needs could be met through their GP with **community** support but this has implications for the way services are currently constructed.
- We want to be able to provide services in the most **person centred** and least restrictive way for individuals with easy access and clear ways of exiting services to ensure that dependencies on services are not created.
- The feedback highlighted the mental health needs of different groups and the need for the strategy to reflect the diversity of the community. In particular, some stakeholders felt that the mental health services for people who have suffered **sexual abuse** could be improved**.**
- People who use services do not necessary want professional input all the time and valued the support they were able to share as peers. They find some of the facilitated **peer support** as important in recovering from mental illness and found a value in themselves helping others going through the same situation.

The following organisations were consulted and have contributed to the development of this strategy:

Advance housing
Basildon Mind
Brentwood Mind

Basildon and Thurrock University Hospital
Cambridge and Peterborough NHS Trust
Essex & Southend LINKs
Estuary Housing
Family Mosaic
Granta Housing
Hertfordshire NHS Trust
MCCH
Making Involvement Matter in Essex
North East London Foundation NHS Trust
North Essex Partnership NHS Foundation Trust
Rochford Association Voluntary Services
Rethink
Richmond Fellowship
Southend Association Voluntary Services
South Essex Partnership University NHS Foundation Trust
South Essex Rape & Incest Crisis Centre
Strategic Health Authority
Southend Carers Forum
Southend Mind
Southend University Hospital NHS Foundation Trust
Thurrock Links
Thurrock Coalition
Thurrock MH forum
Thurrock Mind
TRUST
Trust Links

Chapter 3: Local Health and Social Care Needs Assessment

Key Messages

- Mental ill health constitutes a heavy burden in terms of suffering, disability and mortality contributing substantially to both health and social care costs.

- Mental Ill Health presents a growing problem and at the moment 1 in 6 people will experience mental health problems at any one time in their lives, in south Essex that is almost 17% of the adult population (77,471 adults).
- Mental illness prevalence will remain fairly stable as the projected rise is 2.7% by 2020 however the use of specialist mental health services has increased by 4% over the last 3 years this may continue over the course of the strategy.
- Depression prevalence has shown a significant increase over the last 3 years.
- Many of the risk factors for mental illness are linked to deprivation; 6.8% of Basildon, Southend-on-Sea, and Thurrock residents live in seriously deprived small areas, defined as those in the 20% most deprived nationally
- Southend-on-Sea has the highest rate of mental health related Incapacity Benefit claimants in south Essex, with Basildon and Thurrock also above the national average – an indicator of mental ill health need
- Local high risk groups include Black and Minority Ethnic (BME) populations, survivors of sexual abuse, Deaf community, prisoners, Gypsies and Travellers
- There is a strong relationship between physical health and mental health. People with long term physical health conditions often have poor mental health and people with mental health problems often have poor physical health.
- Good housing is central to positive mental health
- Real work represents the most effective treatment for mental illness.

Aims of this section

This Chapter brings together a range of data on factors which can give rise to poor mental health, including estimates of mental illness drawn from national data and an assessment of what this means for South Essex, and commentary on contributory risk factors and high risk groups as well as summarising the mental health chapter of the Essex Joint Strategic Needs Assessment.

It also highlights that the prevalence of serious mental health in south Essex is not going to change that significantly rising by 2.7% (PANSI)[1] over the next 5 years but indicates that resources will need to be managed differently to ensure that those with complex needs are supported in the most appropriate recovery focused services, in an individualised approach, in the least restrictive ways and at the earliest point possible.

The Joint Strategic Needs Assessment (JSNA) for Essex includes a comprehensive chapter reviewing the mental health and wellbeing of the Essex population. The chapter is called “JSNA Mental Health Chapter – Towards better health and

[1] www.pansi.org.uk – Based on the report Adult psychiatric morbidity in England, 2007: Results of a household survey, published by the Health and Social Care Information Centre in 2009.

wellbeing"[2]. The JSNA tells us that measuring mental health need in a population is complex and is best understood with reference to a variety of socio-economic factors such as poverty, employment and other measures of deprivation such as benefits claimants and the generic indices of deprivation. The JSNA uses the prevalence of mental health conditions data to estimate the number of people living in Essex who have common mental health disorders, personality disorders and have a psychotic disorder.

The JSNA concludes that there is a close correlation between the numbers of those claiming incapacity benefits as a result of mental health needs and the demand for mental health services across the whole population.

Mental Health Demographics

The data shown in figures 1 and 2 gives an overview of the demographics in South Essex including both health and social care information. There is a need to support people in the Community but also a proportion of people with higher needs who require support in residential and nursing care. People using specialist mental health services are only a small percentage of the total number of people experiencing mental health difficulties however, they will have the most complex needs and are likely to be eligible for some type of social care support.

Figure: 1 Mental Health Profile of South Essex

NHS South West Essex PCT	NHS South East Essex PCT
• South West Essex has a population of 405,115 (2009) • The ethnic composition is 93%	• South East Essex PCT has a population of 336,551 (2009) • The ethnic composition is 95%

[2]Find a copy on the Essex Partnership Portal: www.essexpartnershipportal.org

white, 1% mixed race, 3% Asian, 2% black and 1% Chinese • The three most deprived wards are Tilbury St Chads, Tilbury Riverside and Thurrock Park, and Vange There were 4,560 claimants of incapacity benefits due to mental health conditions in 2010 • There were 319 inpatients formally detained and 777 informally detained in hospital in 2010/11 • There were 1474 hospital admissions for mental health illness in 2010/11 • There were 1,707 on CPA in 2010/11	white, 1% mixed race, 2% Asian, 1% black and 1% Chinese • The three most deprived wards are Kursaal, Victoria and Milton • There were 4,220 claimants of incapacity benefits due to mental health conditions in 2010 • There were 336 inpatients formally detained and 653 informally detained in hospital 2010/11 • There were 1207 hospital admissions for mental health illness in 2010/11 • There were 1,356 on CPA in 2010/11

Mental Health Minimum Dataset 2010-11. Health and Social Care Information Centre

Figure 2 Social Care Profile for South Essex

	Essex CC	Southend-on-Sea BC	Thurrock BC
Community Support	In 2010/11 1608 people were supported to live in	In 2010/11 796 people were supported to live in	In 2010/11 569 people were supported to live in

	the community	the community	the community
Residential Care	In 2010/11 Essex supported 82 people to live in residential care	In 2010/11 116 people supported to live in residential care	In 2010/11 Thurrock supported 26 people to live in residential care
Nursing Care	In 2010/11 Essex had 26 people in nursing care		In 2010/11 Thurrock had 1 person in nursing care
Employment	There were 139 people known to the MH Trust in employment as at March 2011	There were 44 people known to the MH Trust in employment as at March 2011	There were 85 people known to the MH Trust in employment as at March 2011
Advocacy	72 people received forensic advocacy support in 2010/11		
Day Services	In 2010/11 57 people were supported with day services	In 2010/11 98 people were supported with day services	In 2010/11 21 people were supported with day services
Personal Budgets/ Direct Payments	In 2010/11 73 people were supported by a personal budget/direct payment which enabled them to choose their own support	In 2010/11 38 people were supported by a personal budget/direct payment which enabled them to choose their own support	In 2010/11 15 people were supported by a personal budget/direct payment which enabled them to choose their own support

In the future personal budgets and services that promote early intervention and prevention are expected to increase in line with the Personalisation agenda.

Estimates of Common Mental Health Disorder (CMD) and Psychosis Prevalence in South Essex

The main source of data about mental illness in adults and older people is the Adult Psychiatric Morbidity Survey 2007 published by the NHS Information Centre in 2009, which provides information on both treated and untreated psychiatric disorders in the population. The two main groups of psychiatric disorders are termed ‘Common Mental Disorders’ (CMD) and ‘psychoses’. The definitions of these terms are included in the Essex JSNA.

The table 3 below show the prevalence of mental health in south Essex

Source: PANSI – Adult Psychiatric Morbidity Survey (NHS IC, 2007)

Evidence of Service Usage

There is some clear evidence about mental health service use from **The NHS Information Centre for Health and Social Care** published in 2010 covering five years with the most recent information being for 2009/10. This shows that over

	Common Mental Disorder	Personality Disorders	Psychosis
Essex (Basildon, Brentwood, Castle Point and Rochford)	40,135	1,984	997
Southend-on-Sea	15,800	784	393
Thurrock	16,175	801	402
Totals	72,110	3,569	1,792

those five years the use of inpatient facilities has risen due to an increase in people being compulsorily detained. These figures suggest that NHS mental hospitals are increasingly used to care for and contain people who pose a risk to themselves or others.

- The latest figures show that the number of people spending time in an NHS mental health hospital increased for the first time in five years in 2009/10 to 107,765.
- Over 1.25 million people used NHS specialist mental health services, the highest number since this data collection was started. This represented a rate of access of approximately 2,700 per 100,000 population.
- Overall this was a 4.0 per cent rise from 2008/09 and numbers rose for men and for women in all adult age categories and all ethnic groups.
- While the number of people using specialist mental health inpatient services has been rising, until this year the number of these people who spent time in hospital was steadily falling. This year, however, the number of people who received inpatient care rose by 5.1 per cent to 107,765, the first increase since 2003/04-2004/05 and they represented 8.5 per cent of the total number using services.
- The rise in the number of people spending time in hospital was due to a 30.1 per cent rise in the number of people being compulsorily detained in hospital under the Mental Health Act, from 32,649 in 2008/9 to 42,479 in 2009/10. The number of voluntary patients has been falling for the last four years and fell by 6.6 per cent between 2008/09 and 2009/10.
- The number of women detained under the MHA who came into hospital via prison or the courts rose by more than 85 per cent since 2008/09 to 830 and women were a larger proportion of the people detained in hospital via the criminal

justice system in 2009/10 than in previous years (22.0 per cent in 2009/10 compared with 16.6 per cent in 2008/09). The number of men in this category rose by 48.1 per cent since the previous year from 1,982 to 2,935.

- The proportion of inpatients who were detained during the year rose across all ethnic groups, but this was particularly noticeable for the Black group, of whom 66.3 per cent were detained in 2009/10 (compared with 53.8 per cent in 2008/09).

This information has supported the thinking within the strategy about developing a new model of service that can support more people outside the hospital environment. Part of the work with the implementation strategy will be to monitor the local impact of more personalised community based responses and whether this reduces the need for inpatient beds.

According to Essex Trends, (2011) those who seek treatment for mental health problems are generally seen by their GP and just under half will be diagnosed as having a mental illness. Those with more serious problems - almost a quarter - will be referred to a specialist service and around 6% will become inpatients in psychiatric hospitals. Although only a small number of patients' progress beyond primary care, addressing the problems of mental illness takes a lot of local resources. Around one in four GP consultations concern mental health problems. Table 4 below shows the numbers and prevalence of those registered as having Serious Mental Illness (SMI) and those with Depression in GP surgeries as collected through the Quality Outcomes Framework (QOF)[3]. The JSNA shows that the prevalence for those with serious mental illness such as the Psychoses and Personality Disorders is not going to change significantly over the next 5 years however depression a Common Mental Disorder, is increasing at quite a considerable rate indicating it will be important to increase resource in primary care to meet this demand and also to ensure people receive support at the earliest possible point

Figure 4 Prevalence of mental health in south Essex (QOF)

Year	NHS SW				NHS SE			
	SMI		Depression		SMI		Depression	
	No.	Prev.	No.	Prev.	No.	Prev.	No.	Prev.

[3] The national Quality and Outcomes Framework (QOF) was introduced as part of the new General Medical Services (GMS) contract on 1 April 2004. www.nhsemployers.org/PayAndContracts/GeneralMedicalServicesContract/QOF/Pages/QualityOutcomesFramework.aspx

2009	2,575	0.6%	15,169	3.6%	2,419	0.7%	16,726	4.6%
2010	2,772	0.7%	17,874	4.2%	2,602	0.7%	18,125	5%
2011	2,913	0.7%	23,136	7%	2,675	0.7%	20,954	7.2%

Impact of Health Behaviours and physical health on mental health

There is a powerful relationship between physical health and mental health (Royal College of Psychiatrists, 2008).

Life expectancy of people with serious mental illnesses such as schizophrenia and bipolar disorder is between 10 to 25 years lower than the general population. This is predominantly due to cardiovascular disease and many of the risk factors are preventable. Overall mortality is increased by 50% in people with depression. Increased mortality occurs for a wide range of conditions, including cardiovascular disease, cancer, respiratory disease, metabolic disease, nervous system diseases and accidental death. People with physical illness are more likely to be depressed, but studies have shown that depression itself predicts the later development of coronary heart disease, stroke, colorectal cancer and back pain (JSNA, 2010).

People with mental health problems have higher rates of health risk behaviour, including smoking, alcohol and drug misuse, high risk sexual behaviour, lack of exercise, unhealthy eating and obesity. Smoking rates are much higher among people with mental illness than among the general population. Over 70% of mental health in-patients smoke. Around 44% of people with common mental disorders are smokers and more than 70% of people with schizophrenia smoke. Alcohol consumption can be a cause of mental illness, or a resulting factor. Evidence suggests an association between increased alcohol consumption and mental illness. Alcohol is responsible for much psychiatric co-morbidity, with chronic heavy drinkers likely to suffer from depression, anxiety, and/or more serious cognitive impairment and psychosis. 65% of adult suicides are associated with excessive drinking.

Further details regarding the relation between mental well-being and physical health can be found in Essex JSNA.

Contributory Risk Factors Affecting Mental Health

Some of the primary indicators of mental ill health are as noted above are the lack of employment and poor housing, together with social deprivation. These have a significant impact on particular high risk groups including BME communities, traveller

communities, those within the criminal justice system, those with autism and the Deaf community.

Higher Risk Groups/Communities

For some groups, the risks of developing mental illness are particularly high, for example, people from black and minority ethnic communities, migrant workers, refugees and asylum seekers, victims of abuse and violence, prisoners, and members of the armed forces. The reasons are various and may relate to trauma, language, communication and discrimination (JSNA, 2010).

Black and Minority Ethnic (BME) communities

Black and minority ethnic communities (BME) are over represented in mental health services. Their experience of urban poverty, discrimination, racism and poor employment prospects affect their mental health. The national Mental Health Strategy and its associated Equality Impact Assessment has highlighted the inequalities in mental health among some ethnic groups. The key challenge for commissioners is the duty to understand, respect and meet the needs of their BME population, including refugees and asylum seekers. Commissioners should also develop links with service providers with specialist cultural and linguistic knowledge (JSNA, 2010).

Of all adults and older people with mental health needs who receive social care support and services in Essex, 3.33% are from black and minority ethnic categories, and a further 3% are from white ethnic groups, including white Irish and other white cultural backgrounds. This equates to a total of 492 BME users and 444 white ethnic users, which is comparable to the proportions of the local adult population who are BME at 2.75% for black and minority ethnic groups and 2.96% white ethnic. 29% of the BME people who use services (141 people) are from Asian or Asian British backgrounds, 27% (135 people) are from Black or Black British backgrounds and 27% (135 people) are Mixed. Only 17% (85 people) are from Chinese or other ethnic groups (JSNA, 2010).

Economic and inward migration is increasing the ethnic mix of our population, especially in areas close to London and larger towns. In recent years the expansion of the European Union has led to significant inward migration into Essex. Migrants tend to be young adults aged 18-34 and two thirds are Polish migrants (JSNA, 2010).

Deaf Community

There is a link between mental health and deafness. While deaf people have the same range of mental illness as hearing people, the incidence of mental illness

amongst deaf people is higher. POPPI and PANSI estimate there to be 3,780 people aged 18+ with substantial hearing impairments in Essex (PANSI, 2009).

Deafness for many people is associated with social exclusion and reduced educational and employment opportunities (Department of Health, 2005).

Most deaf people seeking access to mental health care have to overcome barriers to access services that meet their needs, many of which are caused by lack of information and knowledge about deafness and its implications when assessing and treating mental illness. This has a clear implication for mental health services and it needs to be remembered that working with Deaf people takes considerably longer than with hearing individuals (Department of Health, 2005).

Many people who are born Deaf and who communicate mainly through sign language see themselves as part of a distinct community with a cultural heritage and common language, sign language being a language in its own right.

People, who are profoundly Deaf, use BSL as their first or preferred language with approximately 1,500 people in Essex across the full age range (British Deaf Association). In addition it is not just interpreting and translation services that are required but an understanding of Deaf culture, and just as for other BME groups it is about cultural empathy, knowledge and representation in the workforce, not just language skills.

Traveller community

The risk factors for travellers include social exclusion, racism and substandard site location and facilities. Gypsies and travellers have long featured in Essex. There are eleven registered sites, all of which are residential rather than transient. This affords a total of 228 pitches and capacity for 433 caravans. There are nearly 800 additional caravans on private/ unauthorised sites across the county. 35% of the total number of caravans in Essex are in Basildon. Despite socially rented caravans only amounting to 9% of the total, Basildon is home to 40% of private caravans and over 50% of caravans on unauthorised sites, the vast majority of which are classed as ‘not tolerated’ (JSNA, 2010).

People with a Learning disability

People with a learning disability are more likely to have mental illness than the general population, and it is important that they receive appropriate assessment and treatment. In many places, people with learning disabilities are unable to access mainstream mental health services, and there is often poor communication and partnership working between specialist learning disability services and mental health services. They are more vulnerable to mental health problems and psychiatric

illnesses than the general population; with an estimate that 25-40 percent of people with learning disability have additional mental health needs (Mind, 2009). It is estimated that there are 10900 people (PANSI, 2009) with learning disabilities in South Essex meaning approximately 2708 – 4335 people with learning disabilities would have additional mental health needs.

Prisoners

Prisoners typically experience poorer health than the general population, with a disproportionately higher incidence of mental health need and substance misuse compared to the general population. Up to 90% of all prisoners have a diagnosable mental health or substance misuse problem and commonly have both (Department of Health, 2002). Good mental health and substance misuse care is not only vital in its own right, but can help to reduce the likelihood of re-offending on release from prison (NHS Mid Essex, 2007).

To properly address the mental health needs of the prison population, current services need to move away from a reliance on the provision of mental health inpatient care towards the development of robust models of primary mental health services. This should be supported by other activities such as education and training (Department of Health, 2009).

Historically, mental health services and substance misuse services in prisons have not worked well together; national policy has developed separately for mental health and for substance misuse, and this has been reflected on the ground, where dual diagnosis has been used as a reason for exclusion from services rather than supporting access.

HMP Bullwood Hall in Hockley is a Category C foreign national male prison, with an operational capacity of 184 prisoners.

Survivors of sexual abuse

Research shows that both male and female victims of abuse have significantly higher rates of psychiatric problems than in the general population (PANSI, 2009). Studies demonstrate an association between child sexual abuse and a subsequent increase in rates of childhood and adult mental disorders (Spataro, J. and Mullen, P. E., 2004). In south Essex it is estimated 51,609 people aged 18-64 are survivors of sexual abuse as shown in figure 5 below.

Figure 5

	Males	**Females**	**Totals**

Essex (Basildon, Brentwood, Castle Point and Rochford)	8,575	20,160	28,735
Southend-on-Sea	3,409	7,888	11,297
Thurrock	3,465	8,112	11,577
Totals	**15,449**	**28,048**	**51,609**

Source: PANSI 2009

Drugs and Alcohol (Dual Diagnosis)

People with mental illness may also have other problems that affect their health, particularly relating to alcohol and drugs (dual diagnosis). National policy has developed separately for mental health and for substance misuse, and this has been reflected on the ground, where dual diagnosis has been used as a reason for exclusion from services rather than supporting access. Figuree 6 below denotes the prevalence of drugs and alcohol dependence in south Essex.
Figure 6

Drugs and Alcohol data South Essex

	Alcohol		**Drugs**		
	Males	**Females**	**Males**	**Females**	**Totals**
Essex (Basildon, Brentwood, Castle Point and Rochford)	10,658	4,,158	5,513	2,898	23,227
Southend-on-Sea	4,237	1,627	2,192	1,134	9,190
Thurrock	4,306	1,673	2,228	1,166	9,373
Grand total (SE)	**26,659**		**15,131**		**41,790**

Chapter 4: The Policy Context

Key Messages

The aim of this section is to describe the national context for Mental Health Services.

This section will describe the evidence base within the national policy context that supports the strategic aim of improved outcomes for people using mental health services in South Essex

Aims of this section

This section shows describes the national policy context together with the evidence base behind the proposed changes within the strategy.

The publication of **No Health without Mental Health: A cross government mental health strategy for people of all ages** in February 2011 drew together the wider principles that the Government has laid down for its health reforms, including patient-centred care and locally determined priorities and delivery. At a national level, the strategy sets out the 'high–level' objectives to improve the mental health and well-being of the population, but each local area will be expected to design services to best meet the needs of their local population.

A core theme of **No Health without Mental Health** is that it is a strategy for people 'of all ages' and there is a strong focus:

- Prevention of mental illness and promotion of mental health
- Early intervention
- Tackling stigma
- Strengthening transitions
- Personalisation
- Innovation

Resulting from this an implementation framework has been developed with three central aims:

- Firstly setting out how progress will be monitored through outcomes and how the range of outcome measures will be built on in the future.
- Secondly making a series of recommendations for local and regional organisations to take forward
- Thirdly detailing a series of national commitments to support the implementation

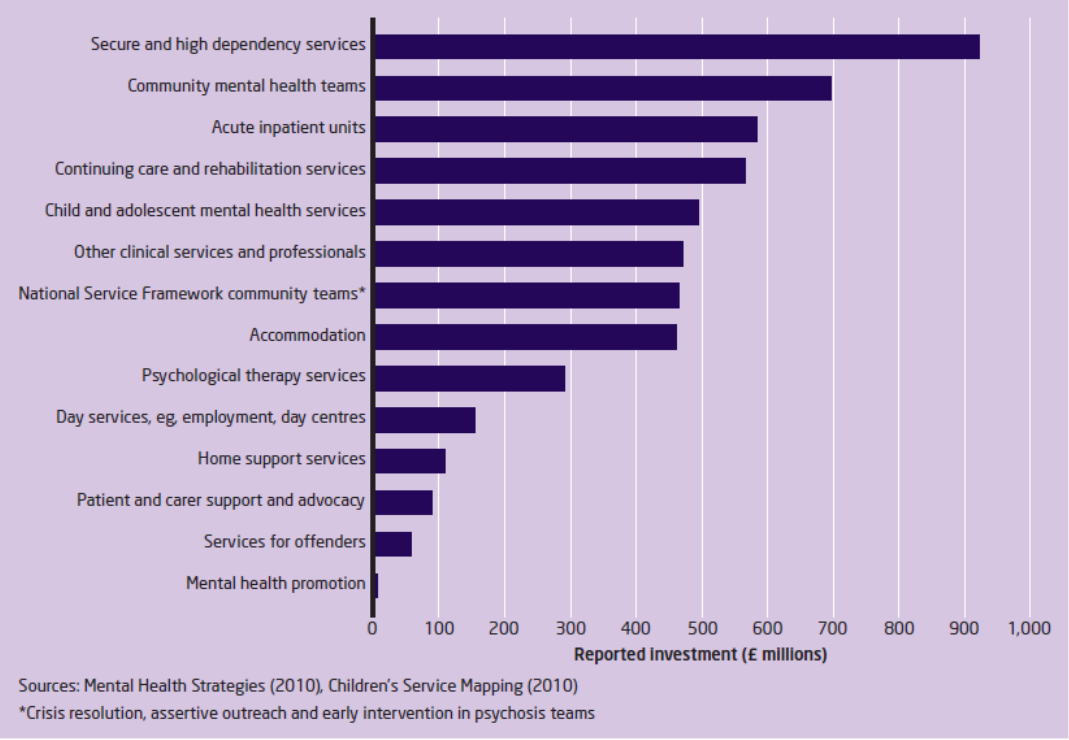
The **No Health without Mental Health: implementation framework (February 2011)** sets the vision '*to improve outcomes for mental health service users and to promote positive mental health and well-being amongst the whole population'.*

The South Essex Mental Health Strategy sets out an outcomes performance framework to improve quality and value for money for people experiencing mental ill health in South Essex. The strategy considers re-alignment, partnership working, co-production, carer support and peer support. Equality of opportunity, cultural sensitivity and empowerment are threads that run through the South Essex strategy built clearly on the national policy direction.

Another key piece of work that moved mental health services forward was the **NHS Productivity Challenge and Mental Health Services (The Kings Fund, Centre for Mental Health Report)** this has driven the requirement to deliver value for money within the efficiency agenda which is a key component of the South Essex Mental Health Strategy based on local data with national comparators. It illustrates that whilst the NHS faces a productivity gap of some £14 billion over the next 3 years needing to make productivity improvements of around 4% a year mental health service will account for 12% of the PCT commissioning budget. Mental health services need to be part of the response to the financial challenge.

The following figure 7 illustrates the current allocation of resources in the mental health system nationally. This is based on reported spending on services for working age adults and data for Child and Adolescent Mental Health Services. It shows that despite the shift to community based models of care; considerable resources are still spent on in patient and secure beds. Conversely, very little is spent on preventing mental health problems or on mental health promotion. A change that is repeatedly illustrated as a high priority for improvement in mental health responses.

Figure 1 Cost of mental health services in 2009/10



Sources: Mental Health Strategies (2010), Children's Service Mapping (2010)
*Crisis resolution, assertive outreach and early intervention in psychosis teams

There are significant opportunities to reduce costs in mental health without greatly reducing the service and to improve quality without additional cost. There is also evidence that investing in a better model of mental health care can deliver savings in other budgets, by reducing service use in primary care, hospitals and elsewhere.

Promising targets for immediate attention are:

- Reducing unnecessary bed use in acute and secure psychiatric wards
- Improving workforce productivity Strengthening the interface between mental and physical healthcare, particularly for older people and people with long-term conditions
- Increasing the use of personalisation to deliver a model of service driven by supporting individuals to have more choice and control over their situation

Another report that has detailed evidence to acknowledge and support a more individual locality response, highlighted in the South Essex Mental Health Strategy is that published by **The Audit Commission, Maximising Resources in Adult Mental Health** in June 2010This refers to the scope of improving the efficiency of the acute care pathway in adult mental health, while maximising quality. The comparative data across PCT's shows variations in the use of inpatient beds, these remains after adjusting for the needs of different populations. There were twelve fold variations in bed days for psychosis, with admission rates varying fivefold. Length of stay for all admissions varied fifteen fold. This level of variation is likely to be due to a number of factors:

- Different mixes of acute and rehab facilities
- The level of service provision itself
- Different service models, clinical practice and performance

Research has demonstrated that CRHT teams can significantly reduce the use of beds. However the variation in bed days raises the question of whether the implementation of CRHT teams has been more effective in some areas than others. There was no correlation between gate keeping rates, the proportion of admissions gate kept by CRHT teams and bed days. This data is a starting point for further investigations about real services on the ground with professional and service users and this investigation and piloting of a robust model of care will be integral to the implementation plan for the South Essex Mental Health strategy.

A further report by NAO published in 2007, **Helping People through Mental Health Crisis, the Role of CRHT services,** noted there was scope to maximise impact and improve value for money by ensuring that CRHT teams were appropriately resourced and integrated within local mental health services. This thinking is followed through within the QIPP's emphasis on the need for more efficient care pathways that provide better quality care, often by providing more support, treatment and care in the community. Mental health services have good experience of doing this already. CRHT teams have led to fewer patients needing hospital care. Patients or service users prefer treatment at home, this more personalised and individual approach means that clinical and social outcomes are much better.

Further underpinning of the approach *to improve outcomes for mental health service users and to promote positive mental health and wellbeing amongst the whole population,* is the more overarching policy direction for Health and Social Care within the **Health and Social Care Reform Act 2012**, which puts clinicians at the centre of commissioning, frees up providers to innovate, empowers patients and gives a new focus to public health. This compliments and supports the No Health without Mental Health Strategy and implementation plan ensuring that an individual and localised response is firmly within the national context.

A further key area is the putting people first agenda and personalisation is at the centre of the vision to transform adult social care. It means starting with the individual responding to their preferences and needs with appropriate services rather than making everyone fit into an existing service. The aim is to give people more choice and control over their lives and the care they receive.

Chapter 5: Current Investment, Activity and Performance against Benchmarks

Key Messages

- The finance mapping shows that South Essex invests slightly more per head of adult and older people weighted population than comparable areas.
- The majority of health expenditure is spent on crisis and secondary care services.
- The majority of social care expenditure is spent on residential care.
- South Essex is similar to regional comparators on most performance measures e.g. inpatient bed days, community contacts, Crisis Resolution Home Treatment (CRHT) team contacts, caseloads, and split between inpatient and community spend.
- South Essex was an outlier with high average length of stay for all admissions Regional benchmarking data shows a wide variation in the balance of inpatient to community expenditure.
- The national patient survey results 2012 for South Essex Partnership University Foundation Trust show average performance in relation to other mental health Trusts in relation to each of the nine section scores.
- The public sector financial constraints means that the south Essex mental health system will need to make significant efficiencies over the course of the next 5 years.

Aims of this section

The aim of this section is to describe health and social care expenditure, activity and performance. We will then compare our current expenditure, activity and performance against other areas. Finally we will describe the future financial pressures.

This section will be broken down into the following sub headings:

- Financial overview
- Current health expenditure and activity
- Current social care expenditure and activity
- Regional benchmarking performance summary
- National patient survey results
- Future financial pressures

Financial overview

The finance mapping for 2010/11 for South Essex compares investment against the SHA, the ONS clusters (Office of National Statistics) which are the closest comparator area in terms of characteristics and against the England average.

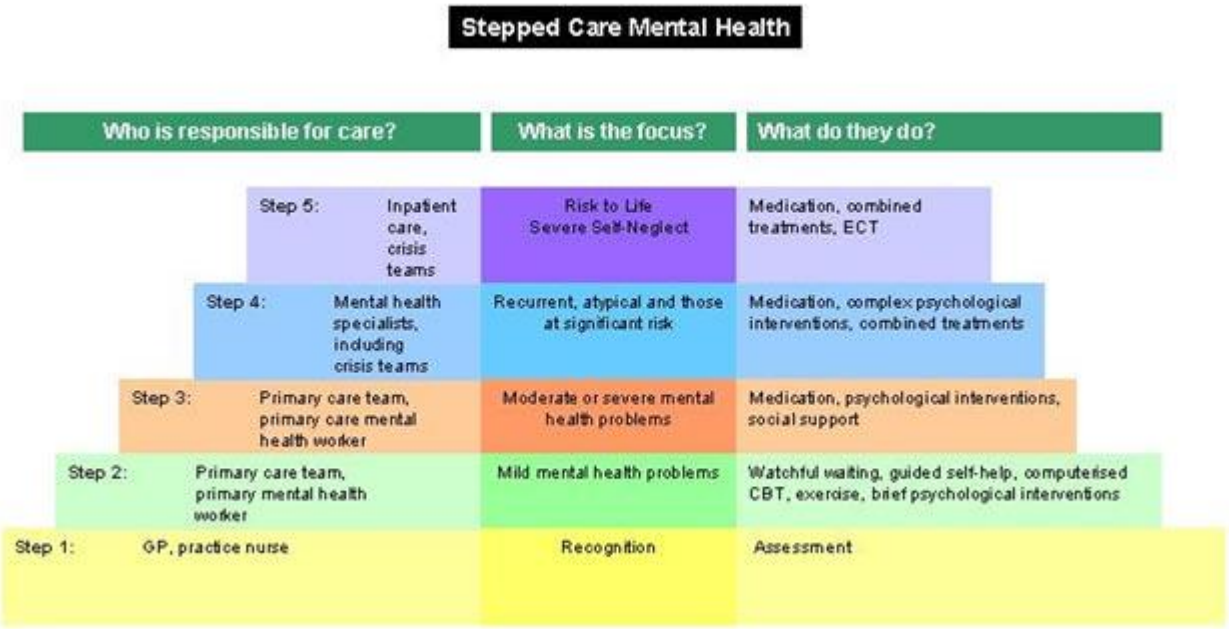
South Essex invests £209.50 per head of adult weighted population compared to an SHA average of £192.70, ONS average of £194.70 and an English average of £195.90.

For older peoples services South Essex spends £376.60 per head of weighted population compared to £342.20 per the SHA area, £330 for the ONS and £344.70 in England.

Current health expenditure and activity

The stepped care model will be used throughout this strategy to describe the mental health system – see below. The stepped care model is useful to describe the balance of spend and activity in the different areas of the mental health system.

The NICE commissioning guidance identifies the benefits of using a stepped care approach to commission services for people with common mental health problems. The core principle of stepped care is that people are matched to an intervention that is appropriate to their level of need and preference.



The table 8 below shows a summary of the 2011/12 activity and costs for the different steps of care provided by SEPT:

	Activity 2011/12	Cost 2011/12	% Activity	% Cost
Step 5	97,542 OBD and F2F** contacts	£31.4m	37%	53%
Step 4	104, 212 F2F contacts and 3650 OBD*	£21.8m	41%	36%
CAS	5343 assessments	£1.3m	2%	2%
Step 2 and 3	52,185 F2F contacts	£5.2m	20%	9%
Total	**262,932 OBD and F2F contacts**	**£59.7m**	**100%**	**100%**

*OBD means occupied bed day **F2F means Face to Face contact

The table shows that there were over 250,000 contacts, either face to face or as an inpatient or as an attendance at day care, in 2011/12.

The table shows that nearly half of the current investment is spent on the crisis pathway (step 5) and 36% is spent on specialist secondary care community services (step 4).

Stepped Care activity

Step 1

A quarter of all GP appointments are mental health related. 90% of mental health need is managed in primary care. Broadly speaking, in a group of 2000 patients, at any one time, an average GP practice will be treating:

- 352 people with common mental health problems
- 8 people with psychosis
- 120 with alcohol dependency
- 60 with drug dependency
- 352 with sub threshold common mental health problems
- 176 with personality disorder
- 125 with long term condition with a co-morbid mental illness
- 100 with medically unexplained symptoms not attributable to any other psychiatric problem.

Current Access Routes (Improved Access to Psychological Services (IAPT), Clinical Assessment Service (CAS) and Accident & Emergency (A&E) Liaison)
There are currently a number of different access routes into mental health services depending on the needs of the patient. For many people, the first point of call is their GP. In 2011/12, the GP made over 16,000 referrals to IAPT (step 2 and 3). In the same period, they also made over 5,000 referrals into secondary care mental health services (step 4). Nearly 400 people accessed crisis services (step 5) through A&E with a further 1,500 crisis assessments being undertaken within the assessment unit.

Step 2 and 3

The current IAPT service, known as Therapy4You, delivers one to one therapy, group therapy, computerised cognitive behavioural therapy and biblio-therapy. The current IAPT service is focussed on mild, moderate and severe non-psychotic conditions such as anxiety and depression. In most cases, the first assessment appointment occurs within the GP practice. Referrals to IAPT are made when the GP or practice nurse feels that their skills alone are not sufficient to help the patient.

In 2011/12, there were nearly 16,000 referrals to Therapy4You (IAPT). Over 12,000 people entered treatment and the service delivered over 50,000 patient contacts. In

June 12, they received over 1,300 referrals. The demand for IAPT is growing steadily and consistently.

There are also a number of patients within secondary care who have mild, moderate and severe non-psychotic conditions. Some of these patients present significant risk and require secondary care. Others may be able to achieve the same or better outcomes if they were managed in primary care with the assurance that they can gain rapid access back to secondary care if their condition deteriorates. Likewise, there are cohorts of people with stable, well managed serious mental health problems who may also benefit from a more inclusive, primary care focussed service.

Step 4 – Secondary care community services

Secondary care services are provided by a number of different specialist teams including:

- Community mental health teams
- Assertive outreach teams
- Early intervention in psychosis services
- Medical outpatients
- Resource therapy
- Psychological services
- Community rehabilitation
- Eating disorder services
- Personality disorder services

In 2011/12, there were nearly 8,000 people in contact with secondary care specialist mental health services. Approximately half of these were on Care Programme Approach (CPA) and half were not on CPA. Access to the secondary care services is via the clinical assessment service (CAS). In 2011/12, CAS received over 5,000 referrals. In June 12, they received over 600 referrals.

SEPT has looked at the opportunities to redesign services to improve patient care. Their consultation and engagement showed there was the opportunity for secondary care to provide more intensive support for people earlier on in their condition. They also felt that there were people in secondary care that could be supported in primary care with the right services around them. Changing the balance of care delivered between primary and secondary care is a key strategic aim because it will enable a better flow of patients.

As part of the work to prepare for Payments by Results (PbR) SEPT have begun to cluster patients according to their needs. The preliminary findings show two peaks in

activity for functional mental health problems (i.e. non organic conditions). These peaks are high levels of contacts for people with mild, moderate and severe non-psychotic conditions and on-going, recurrent psychotic conditions.

The PCT also invests £2.5million in a number of voluntary sector services including:

- Day services – traditional drop in services, community bridge builder services and befriending services
- Domestic violence services
- Other counselling such as bereavement
- Service user involvement groups

Step 5 – Crisis care

The PCT commissions four acute wards (104 beds), four older people acute wards (108 beds), one Psychiatric Intensive Care Unit (PICU) (10 beds) and one assessment unit (20 beds). In addition the crisis pathway is supported by the crisis resolution home treatment team.

Benchmarking shows that different mental health systems operate with different bed bases and different models of community crisis interventions. There is little consensus on the optimum balance of beds to community services. There is little evidence that high bed numbers increase safety. As a system, through clinical dialogue, there is a consensus that there are better ways to deliver crisis care. Referrals for acute inpatient services come from consultant psychiatrists, assessment wards, crisis resolution home treatment, inter unit transfer (from secure services, courts or wards) and rehabilitation and continuing care.

Social Care expenditure and activity

All three Essex Councils commission SEPT to provide social care services. This service provides for the statutory social care assessments and reviews, and the management of individuals' care packages.

The Councils individually purchase residential and nursing care from a variety of care providers based on the individual's assessed need. All Councils are in the process of transition from purchasing directly provided care to giving individuals choice and control with an individual budget following the national personalisation agenda.

All commissioning activity is subject to best value, quality monitoring and market stimulation. Each Local Authority approaches this through either a central team or a

contracting team, which not only commissions' mental health provision, but also older people, learning disability and disability services.

Figure 9
Local authority Adult Mental Services Expenditure 2010/11 (£000s)

Service Category	Essex County Council	Southend Borough Council	Thurrock Council	Total
Assessment and Care Management	1,889	852	876	**3,617**
Residential and Nursing Care	2,742	2,658	1,376	**6,776**
Carer Services	40			**40**
Day Services	10	128	24	**162**
Home Support	820	192	608	**1,620**
Advocacy	98	170	141	**409**

Mind (excluding advocacy)			54	**54**
Total Direct Costs	**5,599**	**4,000**	**3,079**	**12,678**

Note: The values indicated above relate to expenditure that is directly attributable to adult mental health services. Additional expenditure is also included within generic adult social care

Regional Benchmarking Performance Summary

The East of England Strategic Health Authority, with PCTs and Trusts asked the Audit Commission to work with both commissioners and providers to develop a jointly agreed set of indicators for acute mental health services.

The indicators are:

- Inpatient bed days per weighted population
- Community contacts including day care per weighted population
- Crisis Resolution Home Treatment (CRHT) team and Assertive Outreach Team (AOT) contacts per weighted population
- Average length of stay for all admissions
- Caseload
- Adult acute costs per weighted population
- Split between inpatient and community spend

Inpatient bed days per weighted population - The report shows that South Essex inpatient bed days per weighted population are average compared to the other regional comparators. However, this does not include the 20 assessment beds. Other areas fulfil this function within their acute inpatient provision.
Community contacts including day care per weighted population- The community contacts including day care are slightly below regional comparators.

Crisis Resolution Home Treatment (CRHT) team - The number of CRHT contacts per weighted population is average compared to regional comparators.

Average length of stay - This shows South Essex as a regional outlier with very high average length of stays. There has been extensive discussion on the reason for this. The high number of continuing care/rehabilitation beds plus the exclusion of the assessment unit is proposed as an explanation of the high length of stay.

Caseload - The number of people on CPA per weighted population and percentage of working age adults on CPA are both similar to regional comparators.

Adult acute costs per weighted population - The adult acute inpatient cost per weighted population is just below regional average. The community costs per weighted population are significantly below regional averages.

Split between inpatient and community spend - The percentage split between inpatient and community varies enormously across the region. In South Essex the mix of community and inpatient services is within the middle range.

National Benchmarking Patient Experience Summary

The National Patient experience survey asks patients to report their experience of mental health services against nine parameters:

- Health and social care workers,
- medications,
- talking therapies,
- care co-ordinator,
- care plan,
- care review,
- crisis care
- day to day living
- overall.

The results for SEPT indicate average performance across all. The weakest areas are in having help and support to set goals and achieve goals and the strongest being treated with respect and dignity.

Future financial pressures

Each organisation undertakes an annual budget setting process. Therefore it is difficult to precisely forecast the mental health budgets over the period of the strategy.

The comprehensive spending review removed the complicated system of Grants that Local Authorities received and replaced it with a much simpler structure. This also led to a reduction in the level of grants received as well as a freeze on council tax.

Southend-on-Sea Borough Council faced cuts of 8.8% in 2011/2012, 6.1% 2012/2013 and a further 10-13% in 2013/2015. The combined effects led to a budget gap of £15.5m in 2011/2012 (with Adult and Community services facing a £6.43m reduction). 2012/2013 will see a gap of £12m, 2013/2014 £7m and 2014/2015 £9m.

Thurrock Council, in line with all other local authorities across England, is facing considerable reductions in its budget of around 15 -20% over the life of the current

Comprehensive Spending Review cycle. At the same time Adult Social Care is facing considerable demand pressures – growing numbers of older people, increased expectations from service users and younger people coming through transition who have a longer life expectancy. These are positive factors but place further pressures on over stretched budgets.

Members in Thurrock have prioritised front line services for vulnerable groups and this has meant the level of budget reductions has been lower. For 2012/13 we are forecasting a standstill budget which will mean demand pressures (estimated to be around 5% - approx. £ 2m) plus any inflationary pressures will have to be found from efficiency savings within Adult Social Care.

It should be noted that the Essex County Council Mental Health budgets are estimates only at this stage. The actual level of required budgets and efficiencies will become clearer once the annual planning round commences. However the likely impact of the above scenario on the resources available in future years is shown in the table. On top of the inflationary efficiency programme it is also assumed that providers will deliver a further, 1% efficiency in 12/13, 5% in 13/14 and 1% in 14/15. All providers will be asked to deliver this saving in 12/13.

The tables below show two scenarios. Both scenarios assume that no providers will receive an inflationary uplift. The assumption is that each organization will have to deliver efficiency savings to manage their inflationary pressures. This is a considerable undertaking for both large and small providers.

QIPP is the local projects aimed at improving Quality, Innovation, Productivity and Prevention. The plans contained within this is consultation strategy will be developed into QIPP schemes to deliver the required savings.

It should be noted that this are estimates only at this stage. The actual level of required efficiencies will become clearer once the annual planning round commences. However the likely impact of the above scenario on the resources available in future years is shown below:

In scenario one, on top of the inflationary efficiency programme it is also assumed that providers will deliver a further 1.5% efficiency. Nationally, all health providers will be asked to deliver this saving in 12/13. The total productivity challenge will therefore be approximately £6m.

Figure 10

Financial Year	**2012/13**	**2013/14**	**2014/15**		**Total**
Opening Budget	91,000	89,635	87,394		91,000
No Inflation uplift	0	0	0		0

Sub total	91,000	89,635	87,394		91,000
Efficiency @ 1.5%	-1,365	-2,241	-2,185		-5,791
Funding Envelope	**89,635**	**87,394**	**85,209**		**85,209**

In scenario two, on top of the no uplift, the 1.5% national tariff reduction, the providers will be asked to deliver a 2% saving. The total productivity challenge will be therefore be around £10m.

Figure 11

Financial Year	**2012/13**	**2013/14**	**2014/15**		**Total**
Opening Budget	91,000	87,815	84,741		91,000
Inflation Uplift @ 0%	0	0	0		0
Sub total	91,000	87,815	84,741		91,000
Efficiency @ 1.5%	-1,365	-1,317	-1,271		-3,953
QIPP @ 2%	-1,820	-1,756	-1,695		-5,271
Funding Envelope	**87,815**	**84,741**	**81,776**		**81,776**

Chapter 6: Models of care

Key Messages

- The aim of this section is to describe the shape of mental health services over the next 3 - 5 years.
- Step 1 (GP's and Practice Nurses) – The future of Step 1 services will be built on a good knowledge of mental health problems, good understanding of how and when to refer to mental health services, good relationships with mental health providers and clear boundaries of responsibility between primary and secondary care.
- Gateway – The Gateway will be the single point of access to get people to the right level of care as quickly and safely as possible. The future gateway will be delivered by clinicians with the right skills to direct people to the right level of care, ensuring that there are no gaps in clinical responsibility.
- Step 2 and 3 – More people will be seen in primary care through expanding the scope and capacity of IAPT. The successful delivery of the strategy will mean that more people will have their needs met in primary care and fewer people will be referred into secondary care. There will be more awareness of alternatives for people who prefer healing through non-traditional means.
- Step 4 – Secondary care community services will provide earlier, more intensive interventions to support people to recover. Fewer people will be seen in secondary care as primary care services are developed. Alternatives to secondary care will be developed, particularly for people eligible for personal budgets.
- Step 5 – The future crisis pathway will manage more crisis episodes without the need to admit people to inpatient settings and avoid the use of the mental health act. Alternatives to admission will be developed.

Aims of this section:

In the previous sections we have shown why mental health services need to change. This is based on feedback from service users, carers, clinicians as well as reflecting the financial pressures and shifting policy context. The aim of this section is to describe the future shape of mental health services over the next 3 - 5 years. Our aim is to describe a system overview that allows detailed service specifications and pathways to be developed. We will show how we think the system should feel and look differently.

Steps 1 – GP and practice nurses

This strategy proposes that Step 1 (GP and practice nurse) care should be based on the following design principles:

- Good knowledge of mental health problems
- Good understanding of how and when to refer to mental health services
- Good relationships with mental health services
- Clear boundaries of responsibility between primary and secondary care

Therefore we are seeking to implement the following improvements in step 1:

- Improve confidence of GP's and practice staff.
- Improve quality and consistency of referrals to services.
- Improve effectiveness of watchful waiting and supported self-management.
- Reduce health inequalities experienced by people with mental health problems.
- Improve mental health of people with long term physical conditions

The delivery of this part of the strategy will be funded through the incentive payments available through QOF and CQUIN. The delivery of the strategy is built upon good mental health knowledge in primary care.

Gateway to services

The gateway will make a balanced judgement based on what would deliver the best, sustained outcome. The gateway will get people the help they need with the minimum of delay.

The strategy proposes that the gateway should be based upon the following core design principles:

- Clinically responsible – it is critical that there are no gaps in clinical responsibility
- Safe – the service must be able to assess and manage risk
- Efficient – the service must be efficient at processing referrals without delay

- Multi-disciplinary – able to direct people to a range of options to meet needs safely
- Comprehensive – be able to direct people to all levels of care (steps 2 to 5)
- Capacity – must be resourced appropriately to manage the peaks and troughs of demand, especially out of hours
- Capability – must be delivered by clinicians with the right skills to do the job

Therefore the strategy is aiming to:

- Improve response times for all steps of care Improve service user satisfaction 'did it get you to the right care?'
- Improve safety and reduce avoidable incidents
- Reduce self-discharge and did not attend rates.
- Increased usage of alternative providers and self-management where it is safe and appropriate to do so.

The successful delivery of the strategy will mean that similar numbers of people are accessing mental health services but they will be accessing them through a single gateway. We anticipate the new gateway will be more cost effective than the current multiple entry points.

Step 2 and 3 – IAPT Plus

Our vision for the future is that the primary care mental health services will be designed around the following principles:

- Evidence based – delivering NICE guidelines
- Patient-centred – delivering personalised care
- Based on need – sufficient capacity to meet different need in the least restrictive way
- Age inclusive – care should not be compartmentalised because of age
- Capable – knowledge and skills to provide services
- Integrated – seamless interface with secondary care
- Accessible – patients should be treated promptly
- Outcome focussed – systematic and measuring outcomes for patients
- Recovery focussed – help patients to help themselves
- Community linked – linked with a range of voluntary and community services, particularly to support people with long term mental health conditions and people with long term physical health conditions
- Preventative – prevent escalation for people at risk of developing more serious problems

The vision is that there will be more support for primary care. Therefore the strategy is aiming to:

- Reduce waiting times for IAPT Improve recovery and outcome measures
- Increase the number of patients seen & supported in primary care
- Improve links with employment, social networks and housing
- Deliver greater GP and service user satisfaction

The successful delivery of the strategy will mean that more people will receive treatment from 'IAPT plus' and fewer people will be referred into secondary care. We intend to increase the overall expenditure within primary care mental health services.

The process of redesigning the service will enable us to focus on meeting needs efficiently and effectively in the least restrictive way.

Step 4 – Secondary care community services

The role of step 4 services is to provide specialist care for people who have complex needs and are at significant risk.

The design principles for secondary care will therefore be:

- Clear, evidence based and efficient pathways
- Managing care in the least restrictive environment
- Rapid access back to specialist care when needed
- Regular multi-disciplinary reviews
- Focus on improving patient outcomes
- Clarity regarding the statutory social care responsibilities
- Focus on recovery and co-production
- Able to deliver choice and personalisation
- Targeted on the people who need it most

Therefore the strategy is aiming to:

- Intervene earlier
- Improved patient outcomes
- Increased use of personal budgets
- Greater use of alternative provider options

The successful delivery of the strategy will mean that fewer people will need to be managed in secondary care and for shorter periods of time. We intend to decrease the overall expenditure within secondary care services as more people are successfully managed in primary care.

Step 5 – Crisis and inpatient care

The consultation events highlighted the need for easy, prompt access to crisis services.

Therefore the vision is to commission the most responsive crisis care delivered in the least restrictive environment. The design principles for crisis care will be:

- Safety – making sure that services are safe and evidence based
- Accessibility - making sure that everyone knows how to access crisis services and that access is quick
- Capacity – that there is the right balance of inpatient and community resources to meet the need
- Integrated – good pathways from crisis services to prevent relapse
- Capability – the right skills within teams
- Develop alternatives to inpatient services – develop alternatives to admission which help people to recover quickly and safely

Therefore the aims are that the system will increase its focus on:

- Avoid unnecessary admissions – crisis teams with capacity and confidence to stop unnecessary admissions
- Reduced length of stay – having clear care plans to help people to recover from the crisis and get home as quickly as possible
- Reduced need for A&E attendances– some people will need to attend A&E to rule out any physical health problems. However, for other people, attending A&E is often distressing
- Reduced delayed discharges – making sure that the discharge planning allows people to go home as soon as they are ready
- Increased home assessments – when people are in crisis they often want to be assessed in their own homes

We anticipate that there will be similar numbers of crisis episodes in 5 years' time. We expect that more crisis episodes will be managed in the community by the crisis intervention home treatment team and fewer will be managed in inpatient settings. We intend to decrease the overall expenditure within crisis care as more efficient pathways and alternatives are developed.

Chapter 7: Timeline for System Redesign

Key Messages

- The aim of this section is to describe the timetable and phasing for implementation of the strategy. This section describes how we plan to change the shape of mental health services over the next 3 - 5 years and how we will measure the changes.
- The strategy will focus on equal access for all groups and meeting the needs of those people who find it difficult to access services. We will undertake Equality Impact Assessments for each of the pilots. Consideration will be given to the needs of specialist groups e.g. dual diagnosis, travellers, survivors of sexual abuse etc.
- The timetable proposes to set up 3 working groups to deliver this strategy using the outcomes commissioning tool.
- The timetable will be developed into detailed action plans by the multi-agency working groups.
- The first working group will focus on Step 1 and the gateway. This working group has 4 elements; firstly, we will review, pilot and roll out a new gateway into services, secondly, we will fund a training programme for primary care to improve confidence and reliability of referrals, thirdly, we will develop a plan to reduce physical health inequalities and fourthly, to pilot improving the psychological support to people with long term physical health conditions.
- The second working group will focus on the balance of Step 2, 3 and 4 services. In year 1 we will pilot a new model of primary and secondary care in one CCG, review and plan to roll out the new model across South Essex in year 2 (2014/15). We will redesign voluntary sector services to support the new model by providing alternatives to mainstream services, particularly for people who are eligible for personal budgets.
- The third working group will focus on step 5. By the end of year 1 (2013/14), we will plan to fully roll out the new crisis pathway across South Essex.

Aims of this section

The aim of this section is to describe the timetable and phasing for implementation of the strategy.

The detailed implementation planning will be completed within the multi-agency working groups. Whilst this document sets an overall direction it is anticipated that each significant service change would be subject to its own consultation process.

Work stream & outcomes	**Actions to achieve quality improvements**	**2013/14** **Year 1**	**2014/15** **Year 2**	**2015/16** **Year 3**	**KPI's** (baselines and targets to be developed by working groups)	**Comm'ing** **Responsibility**
Step 1 and Gateway People have good mental health People with Mental Health Problems have good physical health and people with physical health problems have good mental health	Develop a new gateway into mental health services	Undertake full cost benefit analysis of different 'models of gateway'. Undertake full needs assessment Develop service specification for new gateway and pilot new model in one CCG.	Develop implementation plan to roll out new gateway across South Essex	Review roll out of gateway	Improve response times for accessing services, Improve service user and GP satisfaction 'did it get you to the right care?' Reduce self-discharge and did not attend rates. Improve quality and consistency of referrals to services	CCG's/CSU
	Improve confidence in primary care mental health, develop watchful waiting, supported self-management, where it is safe and appropriate	Develop alternative pathways and self-management interventions by redesigning existing VSO provision. Develop and roll out a	Monitor quality improvements against baselines & targets within primary care system dashboard. Continue the roll out of 2 year education programme for	Audit and review GP confidence against baseline	Improve confidence of GP's and practice staff. Increased usage of alternative providers & self-management Improve reliability of QOF registers for mental health	CCG's/CSU

Work stream & outcomes	**Actions to achieve quality improvements**	**2013/14** **Year 1**	**2014/15** **Year 2**	**2015/16** **Year 3**	**KPI's** (baselines and targets to be developed by working groups)	**Comm'ing** **Responsibility**
		2 year education programme for primary care on mental health problems via CQUIN Validate QOF registers against secondary care activity	primary care on mental health problems via CQUIN			
Step 1 and Gateway (Cont.) People have good mental health People with Mental Health Problems have good physical	Develop clear responsibility for management of physical health needs for people with mental health problems.	Collect local baseline data on physical health problems for people with mental health problems	Review current understanding of responsibilities for physical health care Develop plan to improve physical health care and reduce health inequalities via CQUIN	Monitor quality improvements against baselines & targets within primary care system dashboard.	% of people on SMI registers attending screening programmes Reduce number of people on SMI register who smoke Reduce number of people on SMI register who are obese % of people on SMI register aged 40 – 74yrs who have had	CCG

Work stream & outcomes	**Actions to achieve quality improvements**	**2013/14** **Year 1**	**2014/15** **Year 2**	**2015/16** **Year 3**	**KPI's** (baselines and targets to be developed by working groups)	**Comm'ing** **Responsibility**
health and people with physical health problems have good mental health					an annual health check. % of people on SMI registers who have accessed "Making Every Contact Count".	
	Physical health and long term conditions	Pilot programme of providing psychological support to people with long term conditions and frequent attenders at A&E	Review to establish system benefit and agree roll out		Improved mood of people on LTC caseload. Reduced planned and unplanned care activity	CCG
Steps 2, 3 and 4 People with mental health problems recover	Develop IAPT plus service Develop recovery focussed secondary care services ensuring	Undertake cost-benefit analysis of different models of primary care/ secondary care Undertake full needs assessment Develop pilot specifications to meet needs	Roll out new service model Review service specifications, KPI's and productivity targets for all services by April 2014 Monitor quality improvements against baselines &	Review roll out of new services	Improved recovery outcomes at each step Increase IAPT service coverage Greater service user and carer satisfaction measured through	CCG and social care

Work stream & outcomes	**Actions to achieve quality improvements**	**2013/14** **Year 1**	**2014/15** **Year 2**	**2015/16** **Year 3**	**KPI's** (baselines and targets to be developed by working groups)	**Comm'ing** **Responsibility**
People with mental health problems achieve the best possible quality of life	delivery is in the least restrictive environment	Pilot new model and pathways in one CCG Develop secondary care dashboard Redesign services commissioned from VSO's to develop alternatives to mainstream provision and support them to provide individual services as a choice for people with personal budgets Improve accommodation pathways from inpatient to independent living Provide support to people to retain and/or gain employment	targets within system dashboard		NHS patient survey and LA's service user satisfaction surveys Greater flow between primary and secondary care Reduced residential spend Increased use of personal budgets Greater use of alternative provider options Increase number of people with mental health problems in employment	

Work stream & outcomes	**Actions to achieve quality improvements**	**2013/14** **Year 1**	**2014/15** **Year 2**	**2015/16** **Year 3**	**KPI's** (baselines and targets to be developed by working groups)	**Comm'ing** **Responsibility**
Steps 5 - Crisis and inpatient care People with mental health problems recover	Redesign crisis pathway	Complete consultation on plan to improve crisis responses and reduce bed base by April 2013 and improve psychiatric liaison services Implement reconfigurations by April 2013 and on-going review to continuously improve Develop working group to investigate alternatives to admissions by April 2013 Review service specifications, KPI's and targets for all inpatient services by April 2013	Monitor quality improvements against baselines & targets within acute care system dashboard	Review crisis pathways and seek assurance that balance of inpatient to CRHT remains robust	Reduce admissions Reduced length of stay Reduced A&E assessments and admissions ? Reduced delayed discharges Increased home assessments	CCG and social care

Work stream & outcomes	**Actions to achieve quality improvements**	**2013/14** **Year 1**	**2014/15** **Year 2**	**2015/16** **Year 3**	**KPI's** (baselines and targets to be developed by working groups)	**Comm'ing** **Responsibility**

Chapter 8: Commissioning Arrangements

Key Messages

- The aim of this section is to describe the commissioning arrangements for the delivery of the strategy.
- The vision is to commission safe, effective mental health services for the citizens of Essex, Southend and Thurrock which deliver value for money.
- It is proposed that the vision will be achieved through integrated commissioning between the 4 Clinical Commissioning Groups (CCGs) and the three local authorities (Essex, Southend-on-Sea and Thurrock).
- We will maximise our impact by commissioning services through jointly agreed strategies and an outcomes frameworks.
- This will be underpinned by strong leadership through the South Essex Mental Health Joint Commissioning Board (SEMHJCB) which will be accountable to the three Health and Well-Being Boards; individual Health and Local Authority Executive Boards and Clinical Commissioning Groups.

Aims of this section

The aim of this section is to describe the commissioning arrangements for the delivery of the strategy.

Vision – An integrated commissioning approach

The vision is to commission safe, effective mental health services for the citizens of Essex, Southend and Thurrock which deliver value for money.

It is proposed that the vision will be achieved through integrated commissioning between the 4 Clinical Commissioning Groups (CCGs) and the three local authorities (Essex, Southend-on-Sea and Thurrock). We will maximise our impact by commissioning services through jointly agreed strategies and an outcomes frameworks.
Economies will also be achieved through collaboration over commissioning support functions, for example procurement.

Principles of operation

Our approach to integrated working will be:-

- MH Commissioning for a whole system.
- Strategic leadership and a jointly agreed outcomes framework.
- Informed by service user needs at population and locality level.
- Commissioning of service through best value principles including integrating commissioning support resources and shared information.
- Drive up performance and deliver improved mental health outcomes

- Commissioning which address the specific issues of age transition and interface between related areas of Mental Health-including LD/CAMHS/substance Misuse
- Commissioning which reduces fragmentation by age and allows for services to be delivered effectively to people with complex needs.
- Commissioning with workforce skills fit for the future-including enhanced business and market analysis skills, provider negotiating skills
- Integrated commissioning for individuals through a jointly contracted assessment service or strengthened management of commissioning for individual care.

This will be underpinned by strong leadership through the South Essex Mental Health Joint Commissioning Board (SEMHJCB) which will be accountable to the three Health and Well-Being Boards; individual Health and Local Authority Executive Boards and Clinical Commissioning Groups.

Structure

Structurally, the proposal is to formalise the governance arrangements between the South Essex Mental Health Joint Commissioning Board and the 'virtual team' which would become the Joint Commissioning Support Team i.e. the team delivering the commissioning strategy at locality level and working together to ensure consistency, joined up developments and maximise the use of commissioning resources such as procurement.

Equally the Governance arrangements between the South Essex Mental Health Joint Commissioning Board, Health and Well-being Boards require formal recognition. The effectiveness of the South Essex Mental Health Joint Commissioning Board will be critical to the success of integrated commissioning.


Health and WellBeing Board
Southend-on-Sea Health and Wellbeing Board
Thurrock Health and Wellbeing Board
Essex Health and Wellbeing Board
South Essex Mental Health Joint Commissioning Board
Southend Locality (Southend-on-Sea BC Board; South Essex PCT Board & CCG Board)
South Essex Locality (Essex CC Board; south Essex PCT Board & CCG Board
Thurrock Locality (Thurrock BC Board; South Essex PCT Board & CCG Board
Joint Commissioning Team
Jointly Commissioning Assessment and Intervention Service (Joint Contract between NHS, 3 Local Authorities and service poviders
Service delivery contracts acros primary and secondary care

Chapter 9: Glossary

The glossary below sets out a selection of key terms used in this Strategy, where it may be helpful to have a common understanding of the meaning.

Acute care	Specific care for diseases or illnesses that progress quickly, feature severe symptoms and have a brief duration.
Advocate	A paid worker or volunteer who has been trained in order to enable the person with whom they are working to say what they want and communicate their wishes, aspirations, opinions etc.
Assessed Eligible Needs	These are the needs the Councils have identified an individual as having and which the Councils have a duty to meet with provision of support and/or other services as they fall within the Councils' eligibility criteria. These needs are identified during the assessment process (see assessment and eligibility criteria)
Assertive outreach	An active form of treatment delivery; the service can be taken to the service users rather than expecting them to attend for treatment. Care and support may be offered in the service user's home or some other community setting, at times suited to the service user rather than focused on service providers' convenience.
Assessment	The collection and interpretation of data to determine and individual's need for support, undertaken with the individual, their relatives or representatives, and relevant professionals. [*See also community care assessment*]
Care Home	A home registered with Care Quality Commission (CQC) providing nursing and/or personal support, in addition to living accommodation.
Care management	The process of assessment of need, care planning and review for adults of 18 and over who are referred to Adult Social Services. Care management and CPA (see below) are integrated in mental health services.
Care Pathway	Care pathways map the support an individual can expect by specifying treatment and support for a given condition based on nationally agreed guidelines standards and protocols incorporating best practice and evidence-based guidelines. Care pathways are multi professional, cross organizational boundaries, and can act as a prompt for support.
Care Programme Approach (CPA)	This is the main way by which care is co-ordinated and delivered to individuals by secondary care services. It means that all individuals involved in the care will discuss the care with the user of the mental health services and their family/friend/carer (as appropriate) to ensure all the users' needs are met. Once the package of care is agreed by the

	user and others a Care Programme is drawn up and the individual responsible for delivering the care identified. Delivery of the Care plan is co-ordinated by the Care Co-ordinator who will also ensure there are regular reviews. There are two levels of CPA; standard and enhanced. Individuals who are receiving care from more than one individual and who have complex needs are usually on enhanced levels of care.
Carer	A person providing support who is not employed to do so by an agency or organisation. A carer is often a relative or friend supporting someone at home who is frail, ill or requiring support; the carer can be of any age.
Care package	Following an assessment, a care package is agreed to enable a patient to receive care appropriate to their needs. Where necessary this covers both NHS and social care.
Clinicians/clinical staff	Health professionals whose practice is based on direct observation and treatment of patients
Commissioning	The processes local authorities and primary care trusts (PCTs) undertake to make sure that services funded by them meet the needs of the patient.
Community Care	Care provided to support people in their day-to day living
Community Care Assessment	An assessment conducted by a local authority to determine the level of adult social care support an individual requires. Local authorities are required to conduct such assessments as described in the National Health Service and Community Care Act 1990 and the Community Care Assessment Directions 2004. [*See also Assessment*]
Community Mental Health Team (CMHT)	A team made up of a range of professions offering specialist assessment, treatment and care to people in their own homes and other community settings. The team should include nurses, psychiatrists, social workers, clinical psychologists and occupational therapists, with ready access to other therapies and expertise.
Crisis and intensive home treatment team	Services to manage/limit the crises suffered by mental health service users and support people to remain at home. They commonly operate 24 hours / seven days a week and may visit individuals daily or even more frequently providing an alternative to inpatient care.
Crisis resolution teams	Teams providing intensive support for people with severe mental illness to help them through periods of crisis and breakdown.
Critical care	An integrated service for critically ill patients when they are in the health system
Direct Payment	A cash payment made directly to a service user or carer, in lieu of services, for the purpose of purchasing goods and services to meet agreed support needs, in line with the Health and Social Care Act 2001
Domiciliary Support	Services provided to people at home to assist them in living

	independently in the community. These services include meals on wheels, community nursing, domiciliary support, equipment and adaptations.
Early intervention service	Service for people experiencing their first episode of psychosis. Research suggests that early detection and treatment will significantly increase recovery.
Early intervention service	Service for people experiencing their first episode of psychosis. Research suggests that early detection and treatment will significantly increase recovery.
Eligible needs	Those needs which fall within the Councils' eligibility criteria (see assessed eligible needs and eligibility criteria)
Eligibility criteria	When assessing an individual's support needs local authorities will take into consideration how serious a risk is to an individual's independence. Eligibility criteria provide the framework for evaluating the level of risk to an individual's independence and thus provide a structure for determining eligibility for adult social care. Councils must follow the Fair Access to Care Services (FACS) guidance (see below) when determining eligibility criteria.
Evidence based practice	An approach to health care where health professionals use the best evidence available to make clinical decisions for individual patients.
Fair Access to Care Services (FACS)	Guidance issued by the Department of Health to local authorities about eligibility criteria and which provides a framework for determining eligibility for adult social care. Fair Access to Care Services sets out the legal requirements which every Council has to follow when deciding who to give support to. The FACS eligibility criteria has four bands (Critical, Substantial, Moderate and Low) through which decisions are made about who receives support services
Functional mental health problems	A term for any mental illness in which there is no evidence of organic disturbance (dementia) even though physical performance is impaired.
IAPT	Improved Access to Psychological Therapies. (See Psychotherapy or psychological therapies)
Inpatient services	Services provided, often by the NHS, where the patients/service users are accommodated on a ward and receive treatment there from specialist health professionals.
Integrated care	NHS and local authority health responsibilities are managed together so that care trusts can offer a more efficient and better integrated service.
Local Authority	Democratically elected local bodies with the responsibility for discharging a range of functions as set out in local Government legislation.
Mental health	An individual's ability to manage and cope with the stress and challenges of life and to manage any diagnosed mental health problems as part of leading their normal everyday life.
Mental health trusts	Trusts that provide specialist mental health services in hospitals and local communities.

Non-residential services	Adult social care services that are provided outside of a care/residential home.
On-going support needs	A defined support need that continues over time (that is it is not short-term) although the intensity of care and support needed may fluctuate.
Organic illness	Illness affecting memory and other functions that is often associated with old age. Dementia, including Alzheimer's Disease, is an organic mental illness.
Outcome	The result or visible effect of an event
Outcome based accountability	Taking action to make better and more creative use of public funds to provide user services that improve quality of life and health outcomes for individuals and communities
Payment by results (PBR)	A financial system which aims to provide a transparent, rules-based system for paying NHS trusts. It will reward efficiency, support patient choice and diversity and encourage activity for sustainable waiting time reductions. Payment will be linked to activity and adjusted for the mix of types of patients and/or treatment episodes. The system will aim to ensure a fair and consistent basis for hospital funding rather than being reliant principally on historic budgets and the negotiating skills of individual managers. Instead of being commissioned through block agreements as previously, providers will be paid for the activity that they undertake.
Personal Budget	Social care funds allocated to an individual service user or carer that can be used to meet their assessed eligible needs in line with their support plans.
Personalisation	Refers to the way in which services are tailored to meet the needs and preferences of service users and carers. The overall vision is that the Government should empower service users and carers to shape their own lives and the services they receive.
Primary care	The collective term for all services which are people's first point of contact with the NHS, e.g. GPs, dentists.
Primary care mental health services	Primary care mental health services could include: • counselling services based in GP practices • psycho-educational groups • psychological therapies provided by graduate mental health workers • access to computerised psychological therapies • in-reach to primary care by community mental health teams
Psychotherapy or psychological therapies	Treatment of mental and emotional problems – such as anxiety, depression or trauma – by psychological methods. Patients talk to a therapist about their symptoms and problems with the aim of learning about themselves.
Public health	Public health is concerned with improving the health of the population rather than treating the diseases of individual patients.
Re-ablement	The use of timely and focused intensive therapy and support in a person's home to improve their choice and quality of life,

	so that people can maximize their long term independence by enabling them to remain or return to live in their own homes within the community. This approach focuses on re-abling people within their homes so they achieve their optimum stable level of independence with the lowest appropriate level of ongoing support/care.
Secondary care	The collective term for services to which a patient is referred to by a consultant. Usually this refers to NHS hospitals in the NHS offering specialised medical services and care.
Secondary Mental Health Services	These are specialist mental health services provided usually by a Mental Health Trust. Services include support and treatment in the community as well as a range of inpatient services. Individuals are referred into these services by their General Practitioners and usually have serious mental illness.
Self directed support	Support services that help give people with a disability the confidence and wellbeing to live independently, and become an active member of the community.
Service users	Patients – people who need health and social care for their mental health problems. They may be individuals who live in their own homes, are staying in care, or are being treated in hospital.
Severe, enduring and complex needs	Mental health problems which are of a sufficient severity or complexity to require specialist intervention and include the following: major mental disorder, such as schizophrenia, major depression or any mental disorder where there is significant risk to self and/or others.
Social care	The range of services that support the most vulnerable people in society to carry on in their daily lives.
Social exclusion	The process that can take place when people or areas suffer from a combination of linked problems such as unemployment, poor skills, low incomes, poor housing, high crime environments, bad health and family breakdown.
Stakeholder	A person who has an interest or stake in an undertaking or business. In the context of mental health services, all those involved in commissioning, delivering or using the service
Supporting people	Grant programme that provides local housing related support to services to help vulnerable people live independently at home.
Tertiary care	A more specialised health service that does not have a centre in every Strategic Health Authority (SHA) area. They are often provided by specialised hospitals or departments that are usually linked to medical schools or teaching hospitals. They treat patients with complex conditions who have usually been referred by other specialists.
Third sector	Non-public private organisations that are motivated by a desire to further social, environmental or cultural objectives rather than to make a profit

Vulnerable people	People who are vulnerable because of their situation, for example, homeless people or those people with disabilities and/or mental health conditions who are unable to take care of themselves, or protect themselves against harm or exploitation from others.

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