TOWER HAMLETS

Meeting of the

HEALTH SCRUTINY PANEL

Tuesday, 3 September 2013 at 6.30 p.m.

SUPPLEMENTAL AGENDA

		PAGE NUMBER	WARD(S) AFFECTED
4 .1	**Mental Health Needs Assessment and Strategy Update**	**1 - 24**	**All Wards**

If you require any further information relating to this meeting, would like to request a large print, Braille or audio version of this document, or would like to discuss access arrangements or any other special requirements, please contact:
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Committee:	Date:	Classification:	Report No.	Agenda Item No.
Health Scrutiny Panel	**03/09/2013**	Unrestricted		

Report of:	Title:
Mental Health Strategy **Originating Officer:** **Richard Fradgley**	**Mental Health Strategy** **Wards:** All

1. SUMMARY

Mental Health Strategy overview slide presentation and Draft Mental health Strategy

2. RECOMMENDATIONS

The Health Scrutiny Panel is asked to give comments, feedback.

Local Government Act, 1972 Section 100D (As amended)
List of "Background Papers" used in the preparation of this report

Brief description of "background papers"	Name and telephone number of holder and address where open to inspection.
None	**n/a**

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NHS Tower Hamlets Clinical Commissioning Group

Consultation on the draft Tower Hamlets Mental Health Strategy

Dr. Judith Littlejohns, CCG Governing Body lead for mental health, NHS Tower Hamlets CCG
Richard Fradgley, Deputy Director of Mental Health and Joint Commissioning, NHS Tower Hamlets CCG
Deborah Cohen, Service Head, Commissioning and Health, London Borough of Tower Hamlets

Our vision

Our vision is to commission integrated mental health services that are safe and effective, with friendly staff that inspire confidence in the people and families using them, and which help people to take control of their own lives and recovery

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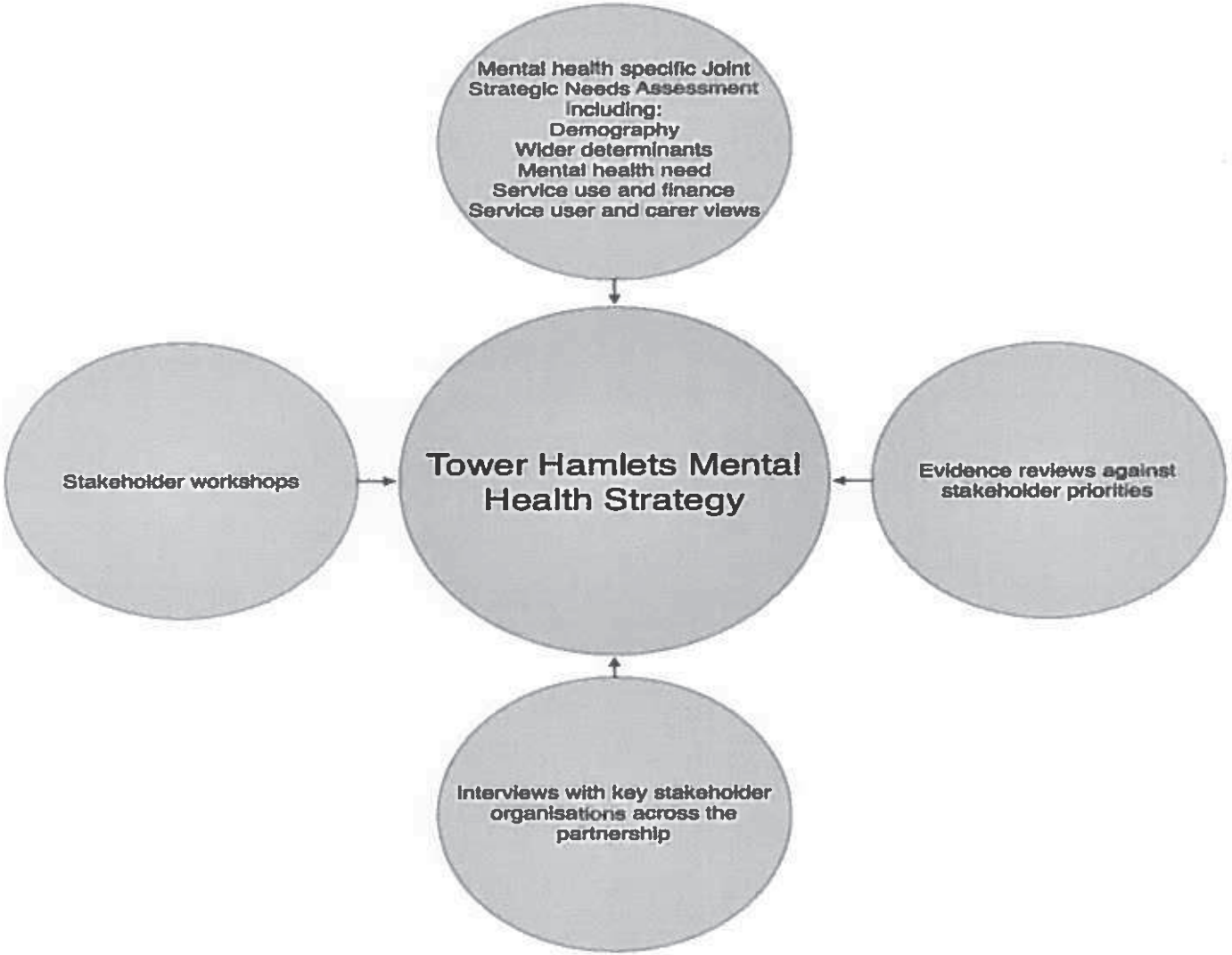
Our strategy



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Engagement

Engagement to help shape strategy:

Stakeholder workshops (Autumn 2012 and Spring 2013):

- Children and young people
- Adults of working age
- Older people

Interviews with key organisational stakeholders

GP survey

Pre-consultation engagement

- July CCG Governing Body
- July Mental Health Partnership Board
- July CCG Childrens Programme Board
- July Children & Families Partnership Board
- July GP Network Leads Meeting
- July Health and Well-Being Board workshop
- August CCG/LBTH/ELFT Exec Meeting
- August Mayors Awayday

Children and young people

Issues

- Population growth and diversity – significant rise in population of children and young people; 55% of under 19's are of Bangladeshi origin
- Mental health awareness in schools and other settings
- Proactive support for children and young people at risk of developing mental health problems
- Mental health support for looked after children and other vulnerable children
- Families where the parent has a mental illness
- Waiting times and responsiveness

Commitments

- Review child and adolescent pathways across the system
- Clear offer for schools (inc. specialist services, school nursing etc.) and other settings
- Improved offer for families where the parent has a mental illness
- Perinatal mental health & parenting
- Coherent commissioning/contracting

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Adults of working age

Issues

- Population growth, diversity and churn
- Very high levels of mental health need
- System largely working effectively at present
- Second highest number of people in touch with secondary care in London, third highest emergency admissions for psychosis
- Highest prescribers of anti-psychotics by some margin
- Physical health outcomes for people with SMI are poor
- Social outcomes including employment uneven
- Pressures on services due to demand and efficiency requirements
- Service users want more recovery focussed services

Commitments

- Maintain community
- Further developments to primary/secondary care interface, primary care liaison psychiatry
- Crisis pathway – consortium evaluation of HTT and crisis house development, police and LAS
- Review of rehabilitation and resettlement pathways
- Review of talking therapies across sytem
- Primary care depression service
- Recovery culture and orientation across the system
  Evidence based approach to supporting people with SMI with physical health, RAID
- Accommodation
- In-patient services across east London

Older people

Issues

- Dementia services working well, but need to maintain focus
- Quality and capacity to support people with dementia in care homes
- Tackling loneliness
- Talking therapies for older adults
- Redesign of older adults beds
- Building mental health into integrated care teams

Commitments

- Older adults beds review
- Review older adults community mental health team
- Build significantly greater capacity into integrator function in new integrated care teams
- Review of care homes and continuing care for people with dementia.

Cross-cutting themes

Issues

- Experienced stigma and discrimination
- Capitalising on the strengths of the third sector
- User led services/peer support
- Parity in mental and physical health, mental health of people with long term conditions
- Patchy information for service users
- Self directed support – social work contribution to multi-disciplinary teams
- Access to services by protected characteristic
- Finance - pressures on services due to demand and efficiency requirements

Commitments

- Time to change pledge
- Care package development for Payment by Results, social work contribution, focus on third sector delivery and peer support in context of future procurement and PBR
- Mental health is everybody's business – integration into CCG and public health programmes
- Better information - single web portal for mental health info
- Using contractual levers and procurement to drive quality, productivity and efficiency.

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Proposed Next steps

Consultation:

- September 3rd – October 10th

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Barts Health NHS
NHS Trust

WELC
Care Collaborative

NHS
Tower Hamlets
Clinical Commissioning Group

Health Scrutiny Panel
3rd September 2013

John Wardell
Deputy Chief Officer, Tower Hamlets CCG

Paul Larrisey
Associate Director, Community Health Services Division
Barts Health NHS Trust

Integrated Care

- Why integrate care ?
- What will happen if we don't ?
- Who will it involve ?
- Key principles and structure in all 3 boroughs.
- What does it mean in Tower Hamlets ?

Why integrate care…?

- To enable individuals to live independently and remain socially active, tailoring care to people's individual needs and preferences
- To proactively manage people's health towards their own goals of care
- To enable high-quality care that responds to people's needs rapidly in crisis situations
- To prevent admission to hospital wherever possible by supporting care at home or in the community
- To avoid duplicated of effort in situations where a patient has many people involved in their care ensuring the most effective possible use of clinical time and resource.

We aspire to build an integrated care system in WELC across physical, mental health and social care

Empower people and their carers

- Enable people to live independently and remain socially active.
- Establish education and self-care programmes for people
- Personalise care to people's needs and preferences

Provide more responsive, coordinated and proactive care

- Proactively manage people's health and improve their outcomes
- Enable high-quality care that can respond to people's needs rapidly in crisis situations
- Provide more care in the community or at home
- Prevent avoidable admissions and minimise residential care
- Leverage tools and technology to deliver timely and better quality of care

Ensure consistency and efficiency of care

- Deliver the best possible care at minimum necessary costs
- Avoid duplication of effort in situations where people are seen by multiple health and social care providers
- Ensure most effective possible use of clinical time and resources

THIS

Sufia, 89

Lives with her husband Vishal, 91, who she looks after

Sufia usually manages reasonably well. A carer visits once a day and district nurses visit to help her with her incontinence. She became unwell with a UTI and saw her GP who gave her antibiotics

The antibiotics didn't give the expected results and Sufia's condition deteriorated. She became confused and had a fall. She then had to be admitted for a fractured hip.

While Sufia was in the hospital being treated for her hip, Vishal had nobody to look after him anymore. He was admitted into respite care

Sufia is discharged but can no longer take care of Vishal given her condition. They are both admitted into a nursing home

TO THIS

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Sufia is discharged but can no longer take care of Vishal given her condition. They are both admitted into a nursing home

What would happen in an integrated care system?

Sufia's GP places her on an integrated care plan. Her carer is in close contact with the nurses to discuss anything that might affect Sufia's health. Sufia has a number she can call if she is unwell

A nurse visits Sufia every day over the next 5 days to monitor her condition very closely to ensure it doesn't deteriorate

Social care is notified when Sufia is admitted, letting them know that Vishal now has no carer. The social care team assess Vishal to determine the optimal support for him and ensure he can remain at home

Sufia recovers from her UTI. The nurse now visits her at a lower frequency to make sure she doesn't get another infection. Social care conduct a reablement assessment to determine any ongoing needs

What will happen if we don't...?

Patients

- Reduced access to services, with longer operation and social care wait times, fewer consultant appointments and cuts to low-level care
- Less flexibility in treatment options, e.g., forced switch to cheaper drugs and treatment options

Commissioners

- Increased spending on acute services at the expense of social, mental and prevention activities, leading to a long term crisis of untreated and un-diagnosed illnesses
- Disputes with providers, leading to poorer outcomes for patients and missed opportunities to deliver the best care possible

Providers

- Facing a major financial challenge, which will lead to a need to reduce ward, bed and staff numbers
- Challenge of delivering more with less, resulting in increased wait times for patients and missed quality targets
- to deliver the best care possible

This will lead to an increase in poorly treated and undiagnosed patients who will further reinforce the financial burden in WELC

An integrated care system around three core principles will improve patient outcomes in Tower Hamlets and ensure quality care at the minimum necessary cost

	Quality of care for residents	Better use of resources across health & social care
1	Empower patients, users and their carers ▪ Enable people to live independently and remain socially active ▪ Education and self-care programmes ▪ Personalise care to each person's needs and preferences	**Shared social care and health plans** for each individual, created from undertaking joint health and social care assessments, so **our service users only need to 'tell us once'**
2	More responsive, coordinated and proactive care ▪ Proactively manage each person's health ▪ Respond to a person's needs rapidly in crisis situations ▪ Provide more care in the community or at home ▪ Prevent avoidable admissions ▪ Use modern tools to deliver timely, high quality care	**Health & social care navigation** will provide administrative support, coordinate services and **proactively deal with people's needs across both health and social care** **Rapid response with short term reablement** will create **an alternative to unnecessary hospital and care home admissions**, respond to a crisis (including out of hours) and ensure care is set up quickly to support the service user at home
3	Ensure consistency and efficiency of care ▪ Deliver the best possible care at minimum necessary costs ▪ Avoid duplication of effort where a service user is seen by multiple health and social care professionals ▪ Ensure most effective use of professional time and resources	**Co-located Integrated Community Health Teams**, bringing social workers together with GPs, community health, nurses, mental health and other services in one place to offer a **single point of access for service users**

What will be delivered…?

WELC will provide nine key interventions for its population underpinned by five components and enablers

Nine areas of interventions

Joint health, social care, and mental health ap-proach

Self-care	Self-care, behaviour, and expectation management
Care coordi-nation	Care planning
	Health and social care navigation
	Case management
	Specialist input in the community
Ensuring people are in the most appro-priate setting of care	Discharge support for MH patients from secon-dary to primary care
	Rapid response with short term reablement
	Mental health liaison
	Discharge support from acute to community

Essential components

Information-sharing platform

Evidence-based pathways and care packages e.g.
Last years of life, diabetes, dementia, COPD, CHD, falls, alcohol, and substance misuse

Joint health and social care assessment

Creation of new roles within the workforce

- Case manager
- Hybrid health and social worker
- Health and social care coordinator
- Discharge coordinator, based in acute wards

Organisation of practices into networks

Enablers

1. Patient engagement

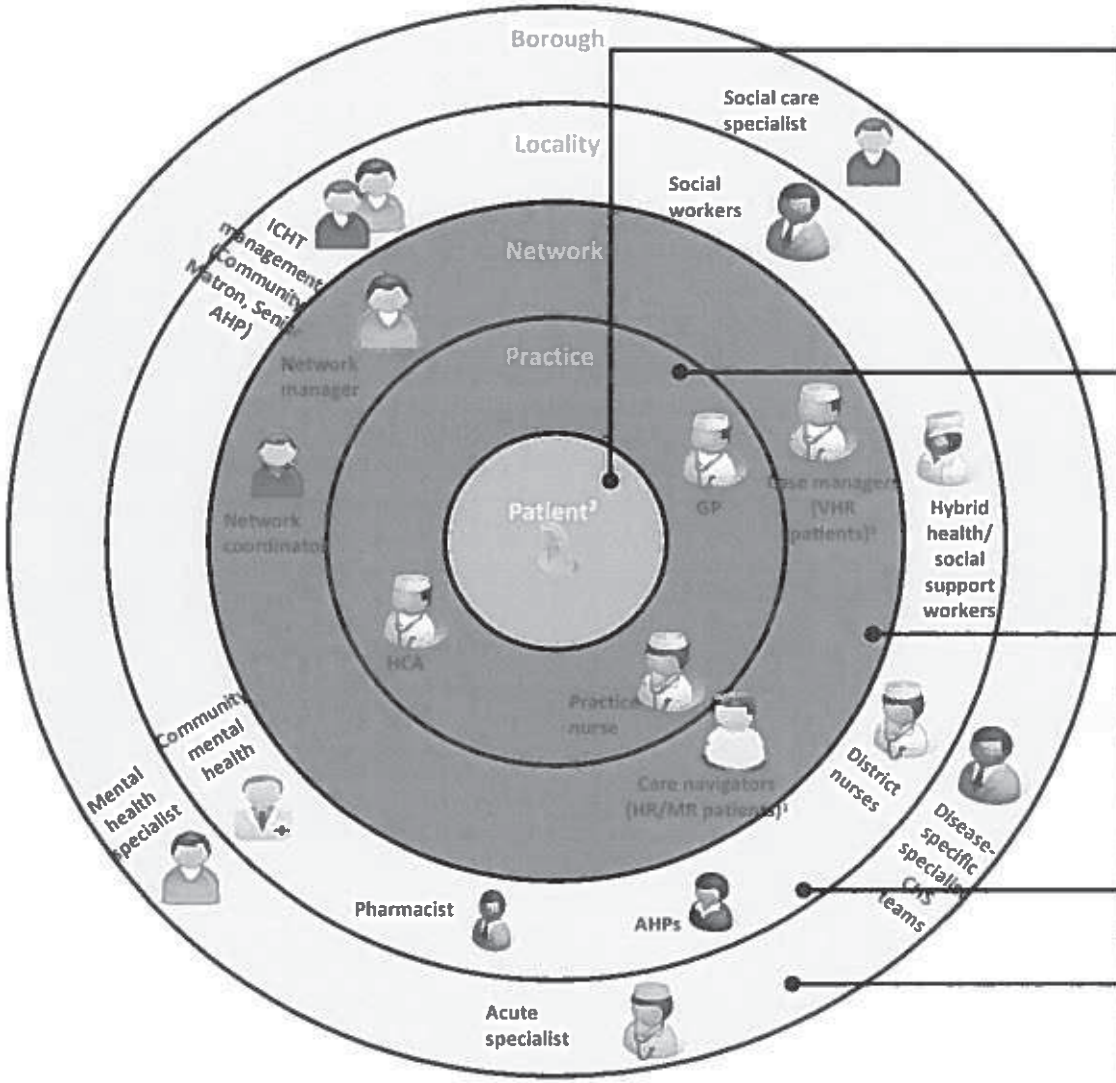
2. Joint decision making and accountability

3. Clinical leadership and culture development

4. Information sharing and decision support

5. Aligned incentives and reimbursement models

Tower Hamlets has developed a localised vision for an integrated care system wrapped around patients, GP services and social care



Primarily care coordination | Primarily care provision

Patient

- Supported by integrated system to **self-care**

Practice

- **Accountable for care coordination** of top 20% at risk registered patients (with support from network/ICHT)
- Care coordination includes **assessment, care plans, reviews** and **navigation** (supported by **case managers** and **care navigators** from the network or ICHT)

Network

- Management, administrative and clinical **resources to support practices in care coordination for patients**
- **MDT case conferences** at network level to discuss complex patients, bringing together the full team around the patient (primary, community, secondary, social, mental health)

Locality (Integrated Community Health Team)

- Integrated **teams of physical, mental, social care providers wrapped around networks** to support ongoing patient care needs (one team to two networks)
- Duties also include **Rapid Response** and **Discharge Support** (in-reach / liaison with acute-based team)

Borough

- **Specialist/expert input** to local teams (e.g. through attendance at network-level case conferences)

Intensity of patient care coordination depends on risk of readmission

[1]Case managers (clinical/social) / care navigators (administrative) could be employed at network or locality level. These functions could be provided by aligning existing staff in Primary/CHS/Social Care, with additional recruitment if required

[2]Addressable patients: >65 years old and/or with 1+ LTC (Very High Risk 1662, High Risk 11,926, Moderate Risk 23,813)

Paul Larrisey

Associate Director, Community Health Services Division

Barts Health NHS Trust

Barts Health – Tower Hamlets Community Services Support for Integrated care

CHS currently has several core adult services working with similar or same patient groups. These include:

- **Adult Community Nursing**; – providing nursing care in the community both with a case mix of health maintenance; management of long term conditions; supporting discharge from hospital; some prevention of admission to 2nd care; managing short term episodes of care; supporting EoL care.

- **Community Virtual ward** – providing management of long term conditions for those identified as high risk (PaRR >70) of admission to hospital by actively managing and supporting self care in this group of individuals. (this group also supported by case managers)

- **CReST** – providing short term intervention to either prevent admission or support discharge home; managing short term episodes of care; i.e. IV therapy; intermediate care & rehab.

- **Specialist nurses** – range of disciplines providing advice and support to patients and other health professionals;

- **Palliative care centre** – provides advice and support to individuals and health professionals

- **Referral Hub** - Acts as a single point of access for some of our services; not but not all

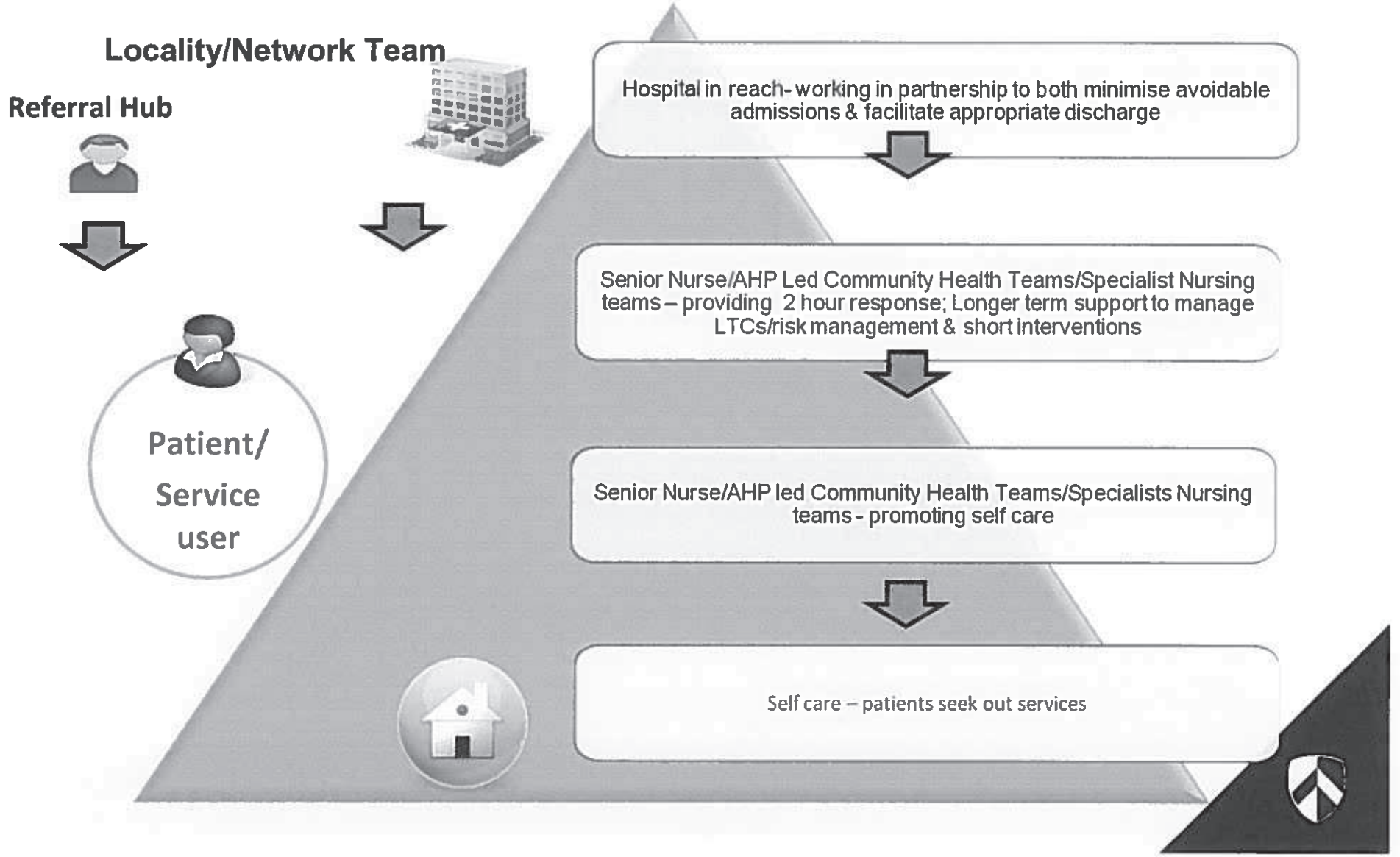
These services work as independent services and do not necessarily have established pathways between them or co-ordinated approaches to care for patients;

All interface with the same agencies to varying degrees, leading to some level duplication

Proposal for Community Health Services integrated service

- Create Senior Nurse/AHP led Locality Community Health Teams - managing a step up/down approach to care from 2 hour response for more urgent interventions through to self care
- Clinical support to/from GP and Community Geriatrician
- Create one community services hospital in-reach process
- One point of access (referral hub) for CHS Community Health Teams
- Develop IT systems that can act as single care record, provide community information dataset and share patient information along the pathway
- With commissioners and partners develop further co-ordinated care with mental health/social care partners in supporting Community Health Teams
- Specialist nursing/therapies support Community Health Teams deliver care along the step up/down continuum e.g. Respiratory care services.
- Create one Single point of access for Community Health Teams that manages referrals in and co-ordinates service responses & acts a single point of access for patient's and professionals.

CHS Locality/Network Community Health Teams will deliver care/interventions via a team of Nurses and Therapists



Benefits

- Single point of access to Community Health Teams for patient's and professionals
- Single Community Health Team co-ordinating management of patient care to reduce the number f different services a patient is cared by
- Greater focus on Multi-disciplinary working to improve patient care and experience
- More targeted focus on promoting independence and self care for patient's wherever possible
- More efficient use of clinical resources