Report to:	**SINGLE COMMISSIONING BOARD**
Date:	14 March 2017
Officer of Single Commissioning Board	Clare Watson, Director of Commissioning
Subject:	**TRANSFORMING MENTAL HEALTH SERVICES: MEETING POPULATION NEEDS AND DELIVERING NATIONAL REQUIREMENTS**

Report Summary:

The pressures in mental health services are unprecedented due to an increase in demand, an increase in acuity and an increase in expectations laid out in the national Mental Health Standards. It is acknowledged that investment in mental health services is required and Clinical Commissioning Groups have had investment targets over a number of years. Previously called Parity Of Esteem and now called Mental Health Investment Target it is expected that the Clinical Commissioning Group will uplift Mental Health investment by £1m in 2017/8. To achieve this and meet the needs of the population mental health investment needs to be prioritised within the Care Together Transformation Fund, the Greater Manchester Transformation Fund as well as within the Single Commission.

This report asks for a decision regarding ongoing funding for two services that are funded until March 2016:-

1. Mental Health Crisis Provision – update on developments and proposal to maintain investment at the current level until Greater Manchester developments are known.
2. Specialist service for adults with Attention Deficit Hyperactivity Disorder – proposal to expand and extend the pilot for a further 12 months.
3. A decision on a request for a contribution to a GM Enhanced Street Triage Pilot.

This is the first report focused on two elements of service provision that require decisions regarding ongoing funding:-

It is proposed that the Single Commissioning Board receives further papers regarding the following priorities:

1. Mental Health Transformation in line with Care Together
    - Mental Health Crisis Care – meeting requirements of Core 24
    - Early Intervention and Prevention – reducing demand across the system through effective integrated neighbourhood working
    - Reducing the demand on MH beds - ensuring safe effective care in the community through a range of options
    - Dementia – improving post-diagnostic support
2. Healthy Lives
    - Improving Access To Psychological Therapies – extending provision to meet national target of 16.8% in

2017/8, rising to 25% by 2020/21 with a focus on:

- Extending support to people with long term conditions;
- Extending Intermediate Service for people who require a more intensive psychological intervention.

3. Early Intervention in Psychosis – extending provision to meet the national standards.
4. Adult Autistic Spectrum Disorders – managing demand.
5. Parent Infant Mental Health – further improvements to meet NICE guidance and national standards.

Recommendations:

The Single Commissioning Board is requested to:

1. Note the high priority of mental health nationally and in GM.
1. Note that this report supports a reduction in use of A & E, aligns to Locality priorities and contributes to the Parity of Esteem 2% growth required in 17-18
2. Recommend the commitment of the proposed investment in Mental Health Crisis Care as follows:
   - Extend £146,000 funding for Mental Health Crisis funding for a further 12 months
   - Invest £32,690 in the GM Enhanced Street Triage Pilot for 2 years.
3. Support the expansion and extension of the Adult Attention Deficit Hyperactivity Disorder Pilot to meet the needs of the population by committing £60,780 for a further year.

Financial Impact		
1) Mental Health Crisis Provision		**£**
RAID		**116,000**
Sanctuary		**30,143**
2) GM Enhanced Street Triage Pilot		**32,690**
3) ADHD Pilot		
Option 1	35,455	
Option 2 (recommended)	60,780	**60,780**
TOTAL		**239,613**

Financial Implications:

(Authorised by the statutory Section 151 Officer & Chief Finance Officer)

In 2017/18 the CCG is required to demonstrate a 1.99% increase in Mental Health spend in order to meet the Mental Health Investment Standard (previously known as Parity of Esteem). To ensure this is met, CCG budgets include some unallocated resource to be spent on mental health. If this business case is supported from a clinical and operational standpoint, the MH reserve can be released to fund this business case. This spend would be included as part of the section 75 pooled budget.

We are however conscious that there is significant change planned for mental health (in particular dementia) in neighbourhoods, the flexible community bed base and at a GM level. It is important that PRG are assured that this business case is fully aligned to these external initiatives before making any decision.

Legal Implications: **(Authorised by the Borough Solicitor)**	It is a necessary legal requirement that the funding is spent in accordance with the agreed business case following agreement by the Single Commissioning Board. It is important going forward that such matters are considered expediently taking into account that there will always be a need to consider urgent matters or developments.
How do proposals align with Health & Wellbeing Strategy?	Improved care and outcomes, a focus on early intervention and prevention for all patients are priorities of the Health and Wellbeing Strategy.
How do proposals align with Locality Plan?	This report is consistent with the following priority transformation programmes: • Healthy Lives (early intervention and prevention); • Enabling self-care; • Urgent integrated care services.
How do proposals align with the Commissioning Strategy?	This report aligns to the Commissioning Strategy by: • Patients and communities being empowered to care for themselves and to work together to support local health and wellbeing; • Identification and support of "at risk" people; • Fewer overnight stays in hospital and more community based urgent care.
Recommendations / views of the Professional Reference Group:	PRG supported the recommendations in the report including the commitment of the following resources: Investment in Mental Health Crisis Care as follows: • Extending £146,000 funding for Mental Health Crisis funding for a further 12 months. • Invest £32,690 in the GM Enhanced Street Triage Pilot for 2 years. Expansion and extension of the Adult Attention Deficit Hyperactivity Disorder Pilot to meet the needs of the population by committing £60,780 for a further year.
Public and Patient Implications:	This report requests the extension of existing services for people with Attention Deficit Hyperactivity Disorder and mental health needs.
Quality Implications:	The report proposes to maintain and improve the quality of existing services by reducing waiting times. The Quality Impact Assessment can be found in **Appendix 3**.
How do the proposals help to reduce health inequalities?	The proposals support people with Attention Deficit Hyperactivity Disorder and mental health needs to achieve better health outcomes, as they can be vulnerable to poorer health than the general population.
What are the Equality and Diversity implications?	It is anticipated that the proposal will not have a negative effect on any of the protected characteristic group(s) within the Equality Act. EIA Screening form can be found in **Appendix 2.**

What are the safeguarding implications?	Maintaining current levels of safeguarding.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	There are no new IG implications. The provider organisations work to required Information Governance standards.
Risk Management:	The paper clearly sets out the risks associated with the options included. These will be managed through the existing CCG risk management processes.
Access to Information :	The background papers relating to this report can be inspected by contacting Pat McKelvey, Head of Mental Health and Learning Disabilities: Telephone: 07792 060411 e-mail: pat.mckelvey@nhs.net

MENTAL HEALTH CRISIS SERVICES IN TAMESIDE AND GLOSSOP

1. INTRODUCTION

1.1 A mental health transformation project is being established to explore options to transform mental health crisis services in line with local, GM and national requirements. As the recommendations from this work will not be made for some time it is proposed that, in order not to destabilise key services, non-recurrent funding is agreed for a further 12 months for the following two services:-

- Continuing the investment in our local Street Triage service as it is integral to RAID in A&E;
- Continuing the investment in The Sanctuary as per Greater Manchester developments.

1.2 It is also proposed that the Single Commissioning Board agree to funding the new Greater Manchester enhanced Street Triage Service for 2 years.

2. BACKGROUND

2.1 The Five Year Forward View for Mental Health (Feb 2016) lays out ambitious plans to transform mental health support to ensure people with mental health needs have the same access to healthcare as those with physical health needs.

"The NHS needs a far more proactive and preventative approach to reduce the long term impact for people experiencing mental health problems and for their families, and to reduce costs for the NHS and emergency services".

The FYFV priorities for 2017-19 are as follows:-

Improving Access to Psychological Therapies (IAPT)

- Access – up to 25%
- Integrated (Long Term Conditions/Employment)
- Recovery
- Waiting Times

Severe Mental Illness

- Access to NICE compliant treatment up to 55%
- Waiting Times
- Early Intervention in Psychosis
- Severe Mental Illness IAPT
- Individual Placement and Support
- Physical Health Care

Dementia

- Diagnosis
- Post-diagnostic support
- Carers

CAMHS

- Eating Disorders
- Acute Care Support and Liaison
- In-patient Care
- Early Intervention and Prevention
- Transforming Care
- Perinatal – specialist and Early Help

Crisis Care

- A&E Psychiatric Liaison – Core 24
- All-age Acute Care Pathway Redesign inc. Home Treatment Teams
- Reducing Acute Out of Area Placements
- Triage/support models
- Liaison and Diversion

Suicide Prevention

Secure Care

Armed Forces

2.2 Our local work programme in 2017/8 includes the following priorities:-

1. Mental Health Transformation in line with Care Together

- Mental Health Crisis Care – meeting requirements of Core 24.
- Early Intervention and Prevention – reducing demand across the system through effective integrated neighbourhood working.
- Reducing the demand on mental health beds - ensuring safe effective care in the community through a range of options.
- Dementia – improving post-diagnostic support.

2. **Healthy Lives**
   - Improving Access To Psychological Therapies – extending provision to meet national target of 16.8% in 2017/8, rising to 25% by 2020/21 with a focus on:
     - Extending support to people with long term conditions;
     - Extending Intermediate Service for people who require a more intensive psychological intervention.
3. **Early Intervention in Psychosis – extending provision to meet the national standards**
4. **Adult Autistic Spectrum Disorders – managing demand**
5. **Parent Infant Mental Health** – further improvements to meet NICE guidance and national standards for perinatal mental health.

2.3 The Single Commissioning Board is requested to agree to receiving papers on these developments in due course.

3. PROPOSALS

Mental Health Crisis Care

3.1 The Clinical Commissioning Group commissions two providers to deliver Mental Health Crisis Care in line with the ambition to offer a 7 day NHS, ensuring that people have 24/7 access to mental health support in a crisis in both hospital and in the community. Whilst we have some provision in place our aim is to move towards Core 24 Mental Health Liaison standards within A&E and on the wards as well as to extend the current offer to increase home treatment alternatives to hospital admission and resolution to crisis in line with suicide prevention strategy. Currently two services are funded to the end of March 2017 and, as both are key to achieving the required standards, a decision on ongoing funding is required. These are Street Triage elements of RAID (Rapid Assessment, Intervention and Discharge) and The Sanctuary.

RAID

3.2 Tameside and Glossop RAID mental health service is based at the Hospital and works with people presenting with mental health crisis 24 hours a day, seven days a week. The team offers:

- Mental health assessments in A&E;
- Direct GP referral;
- Street Triage – telephone advice to Police, Ambulance and Fire Service;
- 136 Suite – mental health assessments for people detained by the police under a Section 136 of the Mental Health act;
- Self-harm follow up for all adults who attend Tameside and Glossop Integrated Care Foundation Trust with self-harm.

3.2 The Clinical Commissioning Group invested £116,000 for the last two years to fund additional nursing time to extend cover to A&E and to provide telephone Street Triage to support people accessing the most appropriate care. Although used less by the emergency services than anticipated (178 calls in 2016) these posts are critical to ensure adequate cover at peak periods.

3.3 To meet the Mental Health Liaison Core 24 standards significant expansion of the RAID service would be required and therefore it is proposed to extend the investment for 12 months until the Mental Health Transformation Project reports.

3.4 It is recommended that the Single Commissioning Board agree to an extension of the £116,000 funding for a further 12 months by which time the Transformation Project will have reported.

The Sanctuary

3.5 Provided by Self-Help Services, The Sanctuary provides a crisis support line during the day (6am – 8pm) and a place of 'safety and support' through the night (8pm – 6am) for any adult experiencing a mental health crisis. The Sanctuary has been commissioned by other Greater Manchester Clinical Commissioning Groups and decisions are still being made regarding funding for 2017/8.

3.6 It is proposed that the Single Commissioning Fund maintains a budget of £30,000 for the service in 2017/8 whilst the ongoing requirements are ascertained by the Transformation Project.

Greater Manchester Enhanced Street Triage

3.7 The Greater Manchester Mental Health Crisis Concordat Group proposes the establishment of an enhanced street triage service located within the GM police control room 24/7. The service will operate a structured shift pattern to meet high demand periods and provide complete coverage across Greater Manchester. The service will operate in a structured GMP environment supported by a NHS Manager and business support in order to complete the following duties:-

1) Provide real-time advice on live incidents that are mental health related allowing for enhanced critical risk management and more appropriate outcomes.
2) Where appropriate they will divert people into services without the need for police/ health attendance.
3) Have access to all-age information including CAMHS and older people (dementia/psychosis) in order to support the service.
4) Have the time to support officers considering Mental Health legislation and as a consequence it will become mandatory to use them prior to conveyance to health-based place of safety.
5) Provide better linkage into commissioned alternatives such as existing Sanctuary models, local street triage, other commissioned urgent and emergency and non-emergency health and social care services including voluntary and third sector.
6) Recognise repeat callers and be able to flag these to specialised colleagues in place based teams for necessary interventions.

3.8 The total cost of the service is £771,000 per annum. 50% will be funded by the Police and Crimes Commissioner and CCGs are asked to invest a proportional amount for 2 years.

3.5 It is proposed that the Single Commissioning Board approved the request that £32,690 is committed for 2 years.

CCG	Percentage of funding split	Estimated cost Years 1 and 2 per annum
Bolton	10	38,858
Bury	6.8	26,522
Central Manchester	7	27,293
Oldham	8.4	32,690
HMR	7.7	29,991
Salford	8.7	33,846
North Manchester	6.7	26,136
South Manchester	5.8	22,667
Stockport	10.4	40,400
T and G	8.4	32,690
Trafford	8.2	31,919
Wigan	11.1	43,098

SPECIALIST ADHD (ATTENTION DEFICIT HYPERACTIVITY DISORDER) SERVICES FOR ADULTS – FUNDING EXTENSION REQUEST

1. INTRODUCTION

1.1 This paper seeks to update the Single Commissioning Board on the pilot Adult Attention Deficit Hyperactivity Disorder service, established on the 9 September 2015 and provides options for the service going forward.

1.2 Attention Deficit Hyperactivity Disorder is a common mental health disorder that starts during childhood but frequently persists throughout adolescence and into the adult years. Common symptoms include inattention, distractibility, disorganisation, over activity, restlessness, impulsiveness and mood lability; and these may lead to considerable clinical and psychosocial impairments.

1.3 Attention Deficit Hyperactivity Disorder is often seen at a high rate in people with other significant clinical problems including substance abuse, unstable mood states, anxiety, depression, forensic cases and emerging or developed personality disorder. ADHD is often associated with specific learning difficulties and is a common problem in higher education.

1.4 Attention Deficit Hyperactivity Disordr is a clinical syndrome defined in the DSM-IV and ICD-10 (hyperkinetic disorder) by high levels of hyperactive, impulsive and inattentive behaviours beginning in early childhood, persistent over time, pervasive across situations and leading to clinically significant impairments.

1.5 Undiagnosed Attention Deficit Hyperactivity Disorder in adults may have severe consequences such as academic failure, substance abuse, criminal activity, failed relationships, troubled work relationships, and emotional difficulties such as anxiety and depression.

1.6 Impairment from Attention Deficit Hyperactivity Disorder can impact on an individual in several ways including: low self-esteem, distress from the symptoms, impaired social interactions and relationships, behavioural problems, and the development of comorbid psychiatric symptoms, syndromes and disorders.

2. PREVALENCE

2.1 Recent studies show that 15% of children with Attention Deficit Hyperactivity Disorder retain the full diagnosis by age 25, whilst for 65% enough symptoms associated with clinical impairment persist. Applying these figures to the prevalence range commonly seen in children of 4–8%, one would expect to find 0.6–1.2% of adults retaining the full diagnosis by age 25 years and a larger percentage (2–4%) with Attention Deficit Hyperactivity Disorder in partial remission. This is consistent with population surveys in adult populations that estimate prevalence of Attention Deficit Hyperactivity Disorder in adults to be between 3 and 4% (Faraone and Biederman, 2005; Kessler et al., 2006).

2.2 In adult life, the male-female ratio for Attention Deficit Hyperactivity Disorder appears to be approximately equal, which suggests that the high gender ratios favouring boys in childhood may be a result of under-identifying the problem in girls, or that girls may present with different symptoms.

2.3 In Tameside and Glossop, according to last available data there are approximately 3,349 young people living with Attention Deficit Hyperactivity Disorder and approximately 502 adults who will have retained that diagnosis by the age of 25. (https://fingertips.phe.org.uk).

3. TREATMENT

3.1 For adults with Attention Deficit Hyperactivity Disorder, drug treatment should be the first-line treatment unless the person would prefer a psychological approach. It should be continued for as long as it is clinically effective, reviewed annually. The review should include a comprehensive assessment of clinical need, benefits and side effects, taking into account the views of the person and those of a spouse, partner, parent, close friends or carers wherever possible, and how these accounts may differ.

3.2 Drug treatment for adults with Attention Deficit Hyperactivity Disorder should always form part of a comprehensive treatment programme that addresses psychological, behavioural and occupational needs. An individual treatment approach is important for adults, and healthcare professionals should regularly review (at least annually) the need to adapt patterns of use, including the effect of drug treatment on coexisting conditions and mood changes. Sources: NICE Clinical Guideline CG72[1].

4. SERVICE PROVISION

4.1 Historically the only route to Adult Attention Deficit Hyperactivity Disorder assessment was referral out of area, funded through the Effective Use of Resources Panel on a case by case basis. It was agreed to commission Pennine Care Foundation Trust to establish a pilot project and a pathway was operational by June 2016 (see **Appendix 1**). Funding was agreed on a cost per case basis but capped at £35,000, which equates to specialist assessment and follow-up of 35 people. As this number was achieved by November 2016 an additional £15,000 of non-recurrent Child and Adolescent Mental Health Services funding was committed in order to support the transition of an additional fifteen patients.

4.2 There were 55 people on the waiting list as of November 2016, indicating the demand. Attendance is good with new patients at 70% and follow-ups at 50%.

5. MEETING NEEDS IN 2017/18

5.1 It is proposed that the service is commissioned recurrently however in order to ascertain ongoing demand it is proposed to extend the pilot for a further 12 months as per one of the following options:-

Option 1 – Maintain investment at the current level
Continue to commission the service at a cost of £35,455[2] per annum as an extension to the original pilot. This gives the capacity to see thirty five people per annum but will result in a considerable waiting list.

Option 2 – Increase investment to meet predicted demand
Commission the service at full capacity to see sixty people per annum at a cost of £60,780. IT is hoped that this will be adequate to meet the demand and ensure that patients referred receive a timely service. This is the recommended option.

6. RECOMMENDATION

6.1 As set out on the front of the report.

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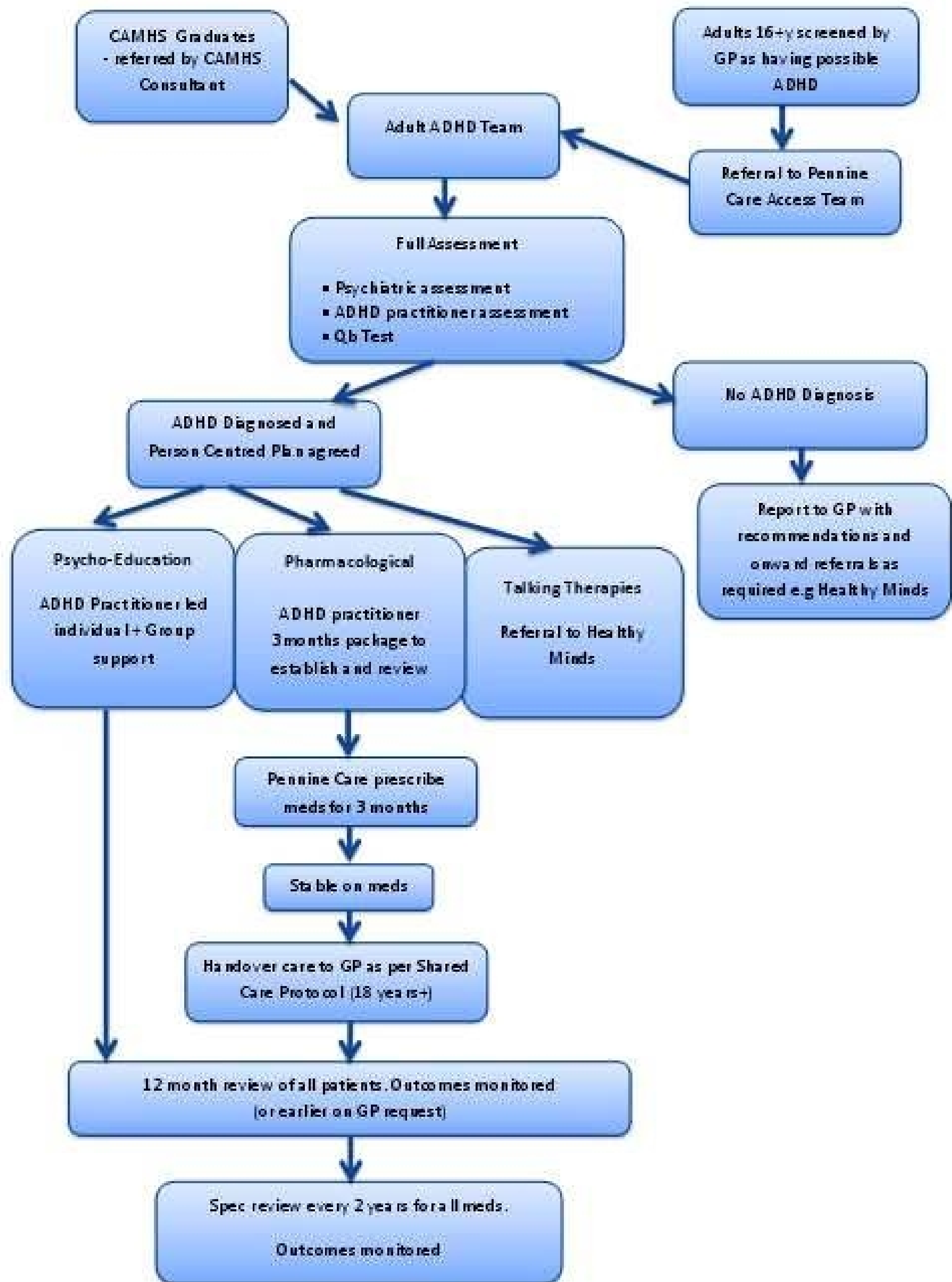
[1] https://www.nice.org.uk/guidance/cg72/chapter/1-Guidance#/treatment-of-adults-with-adhd
http://www.rcpsych.ac.uk/healthadvice/problemsdisorders/adhdinadults.aspx www.aadd.org.uk

[2] Cost per client = £1,013

APPENDIX 1

Adult ADHD Pathway in Tameside and Glossop



APPENDIX 2

Tameside & Glossop Single Commissioning Function
Equality Impact Assessment (EIA) Form
PART 1 – INITIAL SCREENING

1a.	**What is the project, proposal or service / contract change?**	1. Transforming Mental Health Services: Meeting Population Needs and Delivering National Requirements The paper focuses on two elements of service provision that require decisions regarding ongoing funding:- 1. Mental Health Crisis Care – Interim proposal to sustain investment in two services and invest in a GM Enhanced Street Triage pilot **2.** Specialist ADHD (Attention Deficit Hyperactivity Disorder) Service for Adults – funding extension proposal
1b.	**What are the main aims of the project, proposal or service / contract change?**	Maintenance of investment in existing provision while MH Transformation Project concludes.

1c. Will the project, proposal or service / contract change have either a direct or indirect impact on any groups of people with protected equality characteristics?

Where a direct or indirect impact will occur as a result of the project, proposal or service / contract change please explain why and how that group of people will be affected.

Protected Characteristic	**Direct Impact**	**Indirect Impact**	**Little / No Impact**	**Explanation**
Age			x	
Disability	x			ADHD is a recognised disability
Ethnicity			x	
Sex / Gender	X			Research suggests males are more likely to present with ADHD and mental health crisis
Religion or Belief			X	
Sexual Orientation			X	
Gender Reassignment			x	
Pregnancy & Maternity	X			The RAID team provide support to parents during the perinatal period

				when MH needs are more prevalent
Marriage & Civil Partnership			X	
NHS Tameside & Glossop Clinical Commissioning Group locally determined protected groups?				
Mental Health	x			The proposals relate to extending existing mental health services
Carers		x		People caring for others with ADHD and MH needs
Military Veterans	x			Research shows that there is a higher incidence of MH needs in people who have served in the forces.
Breast Feeding			x	
Are there any other groups who you feel may be impacted, directly or indirectly, by this project, proposal or service / contract change? (*e.g. vulnerable residents, isolated residents, low income households)*				
Group (*please state)*	**Direct Impact**	**Indirect Impact**	**Little / No Impact**	**Explanation**

Wherever a direct or indirect impact has been identified you should consider undertaking a full EIA or be able to adequately explain your reasoning for not doing so. Where little / no impact is anticipated, this can be explored in more detail when undertaking a full EIA.

1d.	**Does the project, proposal or service / contract change require a full EIA?**	**Yes**	**No**
			x
1e.	**What are your reasons for the decision made at 1d?**	The proposals relate to extending investment in the existing provision.	

APPENDIX 3

Quality Impact Assessment

Title of scheme: Transforming Mental Health Services: Meeting Population Needs and Delivering National Requirements

Project Lead for scheme: Pat McKelvey

Brief description of scheme:

The paper focuses on two elements of service provision that require decisions regarding ongoing funding:-

1. Mental Health Crisis Care – Interim proposal to sustain investment in two services and invest in a GM Enhanced Street Triage pilot

2. Specialist ADHD (Attention Deficit Hyperactivity Disorder) Service for Adults – funding extension proposal

What is the anticipated impact on the following areas of quality?						What is the likelihood of risk occurring?	What is the overall risk score (impact x likelihood)			
	Negligible 1	**Minor 2**	**Moderate 3**	**Major 4**	**Catastrophic 5**	**1-5**	**Low 1-5**	**Moderate 6-12**	**High 15-25**	**Comments**
Patient Safety			x			2	4			If ongoing investment is not committed there will be implications in adequate staff covering RAID 24/7
Clinical effectiveness			x			2	6			Without ongoing investment fewer people will receive a timely ADHD service
Patient experience			x			4		6		There may be some complaints received if the ADHD service is not extended
Safeguarding children or adults			x			2	5			If services are not extended there may be a risk to vulnerable adults with ADHD and those needing MH crisis

										support
Human resources/ organisational development/ staffing/ competence			x			2	2			PCFT will struggle to cover A&E 24/7 without an extension to the RAID funding
Statutory duty/ inspections	x					5	5			We will struggle to meet MH standards and NICE Guidelines without investment
Adverse publicity/ reputation		x				2	4			There may be some negativity if there is no longer a service to meet the public's expectations
Finance		x				5		10		There is research evidence supporting the CBA for investment in both schemes
Service/business interruption					x	4		10		PCFT will struggle to cover A&E 24/7 without an extension to the RAID funding
Environmental impact	x					1	1			It is not anticipated that there would be any effect on the environment.

Compliance with NHS Constitution		x				4		8		There would be some impact as removing the service would have an impact on some of the protected characteristics groups (see EIA) and there could be a question raised regarding value for money if patients have to contact consultants/GPs instead of a PDNS
Partnerships				x		4		6		A reduction in the RAID service would affect the partnership between PCFT and ICFT
Public Choice		x				3		6		
Public Access		x				5		10		

Has an equality analysis assessment been completed?	YES	If the funding for the PDNS was not put in place, there could be an negative impact on some of the protected characteristics groups
Is there evidence of appropriate public engagement / consultation?	No	Engagement with patients, carers and staff will be undertaken within the MH Transformation Project