Report to:	**SINGLE COMMISSIONING BOARD**
Date:	14 November 2017
Officer of Single Commissioning Board	Gill Gibson, Director of Quality and Safeguarding
Subject:	**TRANSFORMING MENTAL HEALTH SERVICES: MEETING POPULATION NEEDS AND DELIVERING NATIONAL REQUIREMENTS – BUSINESS CASE NO.2 OF 3**

Report Summary:

The Five Year Forward View for Mental Health sets ambitious plans to improve parity of esteem for people with mental health needs, ensuring the same access to healthcare as physical health needs. The Clinical Commissioning Group is currently investing 9.7% of its total allocation on mental health services/support. The national average is around 11%, which would equate to an additional £5m.

In July 2017 the Single Commissioning Board agreed an integrated commissioning strategy to meet the national and Greater Manchester expectations regarding mental health by aligning four additional mental health funding streams, with existing mental health investment, to transform mental health provision in Tameside and Glossop. The funding streams are:

1. Clinical Commissioning Group Mental Health Investment Standard;
2. Greater Manchester Mental Health Transformation funding;
3. Adult Social Care Transformation funding; and
4. Care Together Transformation funding for Mental Health.

The proposal was also supported at Locality Executive Group on 21 June 2017 and the focus for the Care Together Transformation Funding agreed at the Integrated Care Foundation Trust Joint Management Team on 15 June 2017.

This paper is the second of three business case regarding mental health services in 2017/8. The first, agreed on 1 March 2017, committed investment in adult Attention Deficit Hyperactivity Disorder services and increased capacity of RAID (mental health practitioners working in A&E). This second business case focuses on increasing capacity to meet demand and standards for three more priorities:-

- People with common mental health disorders (Improving Access to Psychological Therapies);
- People with a First Episode of Psychosis;
- Children and their families where the child has a neurodevelopmental need, including Attention Deficit Hyperactivity Disorder and autism, and those who have behaviour that challenges.

The third business case will cover mental health crisis care when the model has been agreed and signed off by the A&E Delivery Board, Neighbourhood Complex Needs and Peer Support and Recovery. It is expected that an additional £1m will be required to deliver these priorities. There is an expectation that there will be savings in other parts of the health system,

such as a reduction in mental health admissions to secondary care and MH inpatient admissions.

Recommendations:

It is recommended that the Single Commissioning Board approves the commitment of funding through the Clinical Commissioning Group Mental Health Investment Standard in line with this business case as follows:-

2017/18	2018/19	2019/20	
£132,377	**£626,665**	**£610,665**	recurrently

Financial Implications:

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

Budget Allocation (if Investment Decision)	£132,377 in 2017-18 rising to £610,665 recurrently in 2019-20
CCG or TMBC Budget Allocation	CCG/TMBC (Improved BCF non recurrent funding)
Integrated Commissioning Fund Section – S75, Aligned, In-Collaboration	S75
Decision Body – SCB, Executive Cabinet, CCG Governing Body	SCB
Value For Money Implications – e.g. Savings Deliverable, Expenditure Avoidance, Benchmark Comparisons	This investment is to comply with Five Year Forward View for Mental Health and is based on economic evidence for which we are being held to account on achievement of mental health standards.

Additional Comments

It is recognised that investment in mental health is a key priority for Tameside and Glossop as this impacts on so many other elements of health and social care. Evidence shows that intervention in mental health at an early stage results in significant benefits and financial efficiencies and particularly in relation to secondary care costs.

Finance Group supports the recommendations in this paper subject to the following caveats and comments:

- The paper suggests the Clinical Commissioning Group is under-investing in mental health relative to its peers. Although we recognise additional investment is urgently required in mental health it is important to acknowledge this calculation is extremely subjective as different Clinical Commissioning Groups include different services and costs as part of their mental health expenditure.
- The costs quoted in this paper have not yet been signed-off by providers but there is an overall financial envelope for mental health which is reported and managed by Greater Manchester as part of the mental health assurance process. All costs must be maintained within this financial envelope for the delivery of commissioned outcomes and any funding shortfall managed across other MH services as necessary.

	• Regular monitoring information is to be provided to demonstrate the delivery of outcomes and qualitative and quantitative benefits arising from the investment.
Legal Implications: **(Authorised by the Borough Solicitor)**	Regular monitoring to ensure the allocated monies remain in line with the business case set out in this report should protect against successful challenge. If compliance is compromised a further report to the Single Commissioning Board will be required to ensure there is sufficient governance for the decision to remain lawful. Members of the Board should ensure they have read, understood and agree with the Equalities Impact Assessment which supports the business case, and that they are satisfied the proposals will provide the desired outcomes for the mental health agenda within the allocated budget.
How do proposals align with Health & Wellbeing Strategy?	The proposal aligns with Living Well and Aging Well in the Health and Well-being Strategy.
How do proposals align with Locality Plan?	The proposal aligns with the ambition to embed mental health within all our developments.
How do proposals align with the Commissioning Strategy?	The proposal aligns to our Commissioning Strategy
Recommendations / views of the Health and Care Advisory Group:	The Health and Care Advisory Group recommends that the business case is supported.
Public and Patient Implications:	Healthwatch is engaged in the development and the proposals are in line with Healthwatch findings from service users. Healthwatch are establishing focus groups to confirm and challenge the detailed proposals.
Quality Implications:	The proposals will improve access, capacity and quality of mental health provision in Tameside and Glossop.
How do the proposals help to reduce health inequalities?	People with mental health needs often experience poor physical health and vice versa. The proposal of integrating mental health into the neighbourhood and across the hospital will reduce these inequalities.
What are the Equality and Diversity implications?	The proposal will not adversely affect protected characteristic group(s) within the Equality Act. See **Appendix 2** for Equality Impact Assessment. The service will be available to Adults with a mental health need regardless of ethnicity, gender, sexual orientation, religious belief, disability, gender reassignment, pregnancy/maternity, marriage/ civil partnership.
What are the safeguarding implications?	None.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	None.

Risk Management:	The paper clearly sets out the risks associated with the options included. These will be managed through the existing Clinical Commissioning Group 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

1. SUMMARY

1.1 The Five Year Forward View for mental health makes 58 recommendations for the NHS and system partners. The priorities include:

- Genuine Parity of Esteem between Physical and Mental Health;
- Prevention;
- Improved Waiting Times & New Commissioning Approaches to Transform Services;
- Integration of Physical and Mental Health Care;
- High Quality 7-day Services for People in Crisis;
- Provision Close to Home for those with Acute Intensive Needs, particularly Young People;
- Focus on Targeting Inequalities.

1.2 The Must Do's for 2017/19 are as follows:

- **IAPT**
  - Waiting times
  - Access – ratchet-up for up to 25%
  - Integrated (Long-term conditions / employment)
  - Recovery
- **Severe Mental Health Illness**
  - Early intervention in psychosis waiting times and NICE treatment compliant up to 53%
  - SMI IAPT
  - Individual placement and support prep
  - Physical health care – smoking / obesity
- **Dementia United**
  - Diagnosis
  - Post-diagnostic support
  - Carers
- **Armed Forces**
- **CAMHS**
  - Waiting times
  - Community Eating Disorders
  - Crisis care support & acute mental health liaison
  - Tier 4 collaborative
  - Early intervention and prevention – iThrive+
  - Perinatal – Specialist and early help
  - Transforming care
- **Crisis care**
  - A&E Psychiatric liaison – core 24 / RAID
  - All-age acute care pathway redesign (including CRHTs and Primary care MH)
  - Crisis care triage / support
  - Custody / liaison and diversion
- **Suicide prevention**
- **Secure care pathways**

1.3 Although further growth will be required in future years to meet the rising targets, based on an analysis of the requirements in 2017/19 the following areas require additional investment:

a. **Early Intervention in Psychosis** – Increasing team capacity to meet the national standards of 53% of people receiving NICE complaint care within 2 weeks of referral and increasing access to psychological therapy through £249,795 recurrently.
b. **Increasing Access to Psychological Therapies** – Increasing team capacity at Step 3 to reduce excessive waiting times by increasing capacity through 4 additional posts at £270,250 recurrently and support recruitment to Step 2 trainee practitioners through non-recurrent funding of £30,600. NB – we are also commissioning increased capacity at Step 1 through procuring a new provider to work in partnership with Pennine Care Foundation Trust to deliver an integrated service which will provide more access, greater choice and ensure effectiveness of NHS provision. See **Appendix 1** for details.

1.4 **Children and Young Peoples Mental Health** – increase capacity in specialist services for two groups through £90,620 recurrently and £16,000 non-recurrently to establish Positive Behavioural Support in the locality:-

- Children and young people with a neurodevelopmental condition (Attention Deficit Hyperactivity Disorder and Autistic spectrum Disorder)
- Children and young people with a learning disability and or autism and behaviour that challenges to support families at promote positive behavioural approaches at home and

school. This is in line with the Greater Manchester Transforming Care Early Intervention Project recommendations.

2. DESCRIPTION

2.1 The Five Year Forward View for Mental Health is based on economic evidence that investment in evidence based mental health services will result in savings in the rest of the system.

Current Situation

2.2 **Early Intervention in Psychosis**

- The national standard is "*More than 50% of people experiencing a first episode of psychosis will be treated with a NICE*[1] *approved care package within two weeks of referral"* in 2016/17 and 2017/18 rising to 60% by 2020.
- The team is unable to meet the demand of the increased referrals (since age range has been extended from 35y to 65y) and the need to provide a service for people who are diagnosed as being ARMS (At Risk Mental State). Referrals have risen from 95 in 2015/6 to 236 in in 2016/17.
- Team is currently struggling to meet the target of ensuring 50% of people access to NICE complaint care within 2 weeks of referral.
- There are long waiting times for Cognitive Behavioural Therapy and no family therapy within the team.
- The team is significantly small than the recommended model for a locality of our size - with 15.5 whole time equivalent compared to the national staffing model of 38 whole time equivalent.

It is proposed to extending the capacity of the Early Intervention Team to better meet the standards by investing £249,795 in 5.5 whole time equivalent additional staff.

2.3 **IAPT (Talking Therapies)**

- Although national standards of access and waiting times are being achieved at present, the secondary waits for Step 3 psychological therapy are excessive. In October 2017 239 people are waiting for more than 18 weeks for therapy, some up to 10 months.
- Recruitment of Step 2 staff has been challenging so the service will 'grow their own' through recruiting Psychological Wellbeing Practitioner trainees to permanent posts.
- The increased capacity within the service plus the addition of the new Step 1 partner (being commissioned by the Integrated Care Foundation Trust) will support the service working in a more integrated way within the neighbourhoods.

It is proposed to increase the capacity in the service by investing £270,250 in 5 WTE additional psychological therapists.

2.4 **Children and Young Peoples Mental Health**

- Integrated Neurodevelopmental Pathway – this pathway has been established between Child and Adolescent Mental Health Service, Integrated Service for Children with Additional Needs and Paediatrics and a sensory specialist is required. It is therefore proposed to fund a Band 6 Occupational Therapist
- Transforming Care Early Intervention - The Clinical Commissioning Group has been very successful in repatriating people with a Learning Disability and Mental Health needs from out of area specialist hospitals under the Transforming Care Programme. The cost for each placement is in the region of £100-200k p.a. - a significant long term cost. Our commissioner led a Greater Manchester project to ascertain what can be done better for the next generation, to prevent some of the demand by providing a comprehensive

[1] National Institute for Health and Care Excellence

approach in childhood. The findings support the need for a Positive Behavioural Support approach led by a specialist behaviour team working with young children and their families. It is proposed to invest in a Positive Behavioural Support specialist and establish a Specialist Behavioural Support Team from 0 to 25 years and to invest non-recurrent £16,000 in establishing approaches within Tameside and Glossop.

Additional investment in two Band 6 posts £90,620 plus £16,000 non-recurrently is proposed.

2.5 The business case seeks to improve mental health services in line with the Five Year Forward View for Mental Health and Transforming Care to enable more evidence based interventions that have a proven return on investment to be delivered.

Value of the Proposal

2.6 The total value of the proposal is £123,377 in 2017/18 and £626,665 in 2018/19 and £610,665 recurrently thereafter. Details for the three schemes are as follows:

Early Intervention in Psychosis					
Posts		**WTE's**	**Salary**	**2017/8**	**2018/9**
Consultant Psychiatrist		0.3		£6,399	£38,393
Medical secretary	XN04mid	0.2	£26,100	£870	£5,220
Band 7 Therapist	XN07mid	1	£45,800	£7,633	£45,800
Band 3 Support worker	XN03mid	2	£22,400	£7,467	£44,800
Care Co-Cord Band 5	XN06mid	2	£38,200	£12,733	£76,400
	Total	5.5	Total Pay	£35,102	£210,613
			Non Pay	£1,100	£6,600
			Total Direct Costs	£36,202	£217,213.00
			Overheads 15%	£5,430	£32,582
			Total Costs	**£41,632**	**£249,795**
Improving Access to Psychological Therapies					
Posts		**WTE's**	**Salary**	**2017/8**	**2018/9**
Band 7 Therapist	XN07mid	5	£45,800	£38,167	£229,000
			Total Pay	£38,167	£229,000
			Non Pay	£1,000	£6,000
			Total Direct Costs	£39,167	£235,000
			Overheads 15%	£5,875	£35,250
			Non-recurrent support to permanently recruit trainee PWP staff	£30,600	
			Total Costs	**£75,642**	**£270,250**
Children and Young People					
Posts		**WTE's**	**Salary**	**2017/8**	**2018/9**
Band 6 Therapists	XN06mid	2	£38,200	£12,733.33	£76,400
	Total	2	Total Pay	£12,733.33	£76,400
			Non Pay	£400.00	£2,400
			Total Direct Costs	£13,133.33	£78,800
			Overheads 15%	£1,970	£11,820
			Total Costs	**£15,103**	**£90,620**
			Non-recurrent PBS development		£16,000
				£15,103	**£106,620**

Notes

1. Costs are still to be agreed with Providers
2. Funding for posts will follow recruitment to new posts

3. NATIONAL, STRATEGTIC AND LOCAL CONTEXT

3.1 The Five Year Forward View for Mental Health (2016) is based on economic evidence that investment in the priorities will result in savings within the system. The Five Year Forward View for Mental Health is the basis for the Greater Manchester Mental Health Strategy and we are being held to account on our achievement of the mental health standards.

3.2 This business case supports the "Care Together Commissioning for Reform Strategy 2016-2020" commissioning priorities for improving population health and supporting positive mental health. This also supports the ambition to deliver integration of primary, community and secondary physical and mental health care, public health programmes and social care services as well as co-ordinating and commissioning services from other providers e.g. voluntary and faith sectors.

3.3 The business case supports the Single Commission's Quality, Innovation, Productivity and Prevention agenda:

Quality
- better service user and carer experience;
- better integrated health and social care approach;
- provision that meets NICE Quality Standards;
- better developed and trained workforce.

Innovation
- integration of primary and secondary care, health and social care and physical and mental health care;
- reduction in unnecessary referral and administration;
- incorporates best evidence to support a whole-system change.

Productivity
- reduced demand for acute inpatient provision;
- reduced demand for specialist mental health inpatient provision;
- increased response times;
- increased numbers of people receiving specialist assessment;
- more treatment provided in the community and home settings.

Prevention of
- inappropriate hospital admissions;
- people having to lose their independence;
- inappropriate drug prescribing;
- crises through good monitoring and early intervention in the community.

3.4 The business case has been developed with input from Pennine Care Foundation Trust, GP Clinical leads, Healthwatch, Mind and the Integrated Care Foundation Trust Neighbourhood leads through a series of workshops and discussions.

3.5 Healthwatch ran a series of focus groups with mental health service users in the summer and they have asked developed the following key messages:-

1. *Any person receiving mental health care is to be respected as a human being, who has feelings, with everyone cared for in a personalised way.*
2. *Getting the access to services right is critical. This includes the length of waiting times to start treatment, or for follow-up appointments. Appropriate support is needed at a time of crisis. The process to accessing care is complicated, with too many barriers.*
3. *Effective communication in all areas can make the difference between a positive and negative experience.*
4. *People want to feel supported. They want to be listened to and understood. They want to receive the right care at the right time, in the right place, and with the right service. They want employers to be understanding.*

5. *The health and wellbeing of carers needs to be considered alongside the treatment provided for service users.*
6. *Peer support is very important, and is often found at community and charity support groups.*
7. *When people are struggling with their mental health, they often do not want to burden their families, and suffer alone. If families understand mental health better, people may be more likely to discuss how they are feeling with those they are close to.*
8. *When anyone is being treated for both physical and mental health conditions, they are treated separately, and the impact on each other is not always considered – treat the person as a whole.*
9. *When a person is a multi-service user, all the agencies involved need to work together, whilst respecting confidentiality.*
10. *The way a member of staff interacts with service users is remembered. For example, do they always smile, even when they are busy?*

3.6 This is what they want from mental health services:-

- *I expect caring, compassionate support, delivered by competent, understanding staff, who realise that I need to trust them if they are going to help me.*
- *I want to get the right type of help when things start to be a problem, at the right time, in the right place, and without having to wait until things get worse.*
- *I should be listened to, given time to tell my story, and feel like what I say matters.*
- *I have a voice to control the planning and delivery of my care and support.*
- *I want to feel safe in hospital.*
- *I have the information to keep me up to date about my care and to stay healthy.*
- *My family is supported which helps me to cope. I want them to understand the issues so that we can support each other.*
- *I want my situation to be treated sensitively, and I should be respected and not feel judged.*
- *I want my physical and mental health to be treated together.*
- *I want to feel that services are shaped around my needs, and not the other way around, especially if I need to see different people and services.*

4. OUTCOMES AND BENEFITS

4.1 The likely outcomes anticipated from the proposal are:

1. Reduction in waiting times for specialist mental health services, resulting in more effective intervention due to early access.
2. Increased number of people receiving NICE compliant interventions and support for their mental health.
3. Increase in positive patient reported experience.
4. Positive Behavioural Support readily available for families who have children with a learning disability and or autism who have behaviour that challenges resulting in families feeling more able to cope and a reduction in complex behaviours becoming entrenched.
5. Sensory assessment and approaches included within the neurodevelopmental pathway supporting parents, carers, schools and staff to better understand needs and plan appropriate interventions.

4.2 The outcomes detailed above will be measured and monitored as follows:

1. Ongoing achievement of the Improved Access to Psychological Therapies standards for Access, Waiting times for first treatment and Recovery.
2. Reduction in length of time with respect to Secondary Waits for Step 3 Improved Access to Psychological Therapy.
3. Increase in numbers of people with complex needs receiving psychological therapy.
4. Integration of Improved Access to Psychological Therapy services into the five neighbourhoods through having a link worker and resources aligned to neighbourhoods (where clinic space supports).
5. Achievement of the 2 week from referral to NICE compliant care for all people suspected to have a first episode of psychosis.
6. Increased number of people in EIT accessing family intervention therapy and cognitive behaviour therapy.
7. Increase in the number of families receiving early intervention from the Specialist Behaviour Support Team with a view to supporting families to care and therefore reducing the need for high cost placements.
8. Improved assessment and interventions for children with Attention Deficiency Hyperactivity Disorder and autism.

5. EVIDENCE BASE

Early Intervention in Psychosis

5.1 In 2011, '*No Health Without Mental Health'* highlighted the effectiveness of Early Intervention in Psychosis services for people experiencing first episode psychosis. There is good evidence that these services help people to recover and to gain a good quality of life. Early Intervention in Psychosis services have demonstrated that they can significantly reduce the rate of relapse, risk of suicide and number of hospital admissions. They are cost-effective and improve employment, education and wellbeing outcomes.

Improving Access to Psychological Therapy

5.2 The Improving Access to Psychological Therapy Manual, reports that depression and anxiety disorders are extremely costly to individuals, the NHS and society.

5.3 The impact on the person, families and carers – Depression and anxiety disorders can lead to a range of adverse psychological, social and employment outcomes. These may include:

- Greater distress and poorer quality of life, including higher levels of self-reported misery and disruption to a person's social, work and leisure life.
- Poorer physical health. For example, people with a diagnosis of depression (compared with those without) have a reduced life expectancy. They are also at increased risk of developing a physical health condition, such as heart disease, stroke, lung disease, asthma or arthritis.
- Unhealthy lifestyle choices. Depression is associated with decreased physical activity and poorer adherence to dietary interventions and smoking cessation programmes.
- Poorer educational attainment and employment outcomes. There is a higher risk of educational underachievement and unemployment in people with depression and anxiety disorders. For those in employment, there is a higher risk of absenteeism, sub-standard performance and reduced earnings.
- Increased risk of relapse if treatment is not appropriate or timely.

5.4 The impact on the NHS – The Healthcare costs for those with coexisting mental health problems and long term conditions are significantly (around 50%) higher. A large proportion of this cost is accounted for by increased use of physical health services (not mental health services). For example:

- depression is associated with increased rehospitalisation rates in people with cardiovascular disease and chronic obstructive pulmonary disease, compared with the general population;
- chronic repeat attenders account for 45% of primary care consultations and 8% of all emergency department attendances; the most common cause of frequent attendance is an untreated mental health problem or medically unexplained symptoms;
- people with medically unexplained symptoms who were not offered psychological therapies as part of their care were found to have a higher number of primary care consultations, than those who were; similarly, people with chronic obstructive pulmonary disease who were not offered psychological therapies as part of their care were found to have a higher number of urgent and emergency department admissions, than those who were.

5.6 The impact on society – Together, depression and anxiety disorders are estimated to reduce England's national income (GNP) by over 4% (approximately £80 million). This reduction in economic output results from increased unemployment, absenteeism (a higher number of sick days) and reduced productivity. This is accompanied by increased welfare expenditure.

Children and Young People

5.7 Neurodevelopmental therapist - early diagnosis, intervention and self-awareness of the strengths and weaknesses of having an autistic spectrum disorder/attention deficit hyperactivity disorder is cost-effective to society as it facilitates education, career and life choices.

5.8 Behavioural support for children with a learning disability and/or autism - children with learning disabilities whose behaviour challenges need the right support early in childhood. Early intervention using methods such as Positive Behaviour Support can reduce the severity and frequency of challenging behaviour and improve quality of life. The right support provided at the right time, and delivered in partnership with families can also avoid the high costs of crisis intervention.

6. FINANCIAL CONSIDERATIONS

6.1 Mental health resources have been aligned to the priorities over the next five years, showing the growth in investment through the Mental Health Investment Standard, the Greater Manchester Mental Health Transformation Funding, the Care Together Transformation Funding and the Adult Social Care Transformation Funding, with an indication of the expected costs.

6.2 This is the second of three mental health business cases to be considered this year. Work is underway to ascertain the developments required regarding Crisis Care, Neighbourhood Complex Needs and Peer Support and Recovery.

7. PERFORMANCE MONITORING

7.1 Performance against the anticipated outcomes for this scheme will be monitored through the Pennine Care Foundation Trust monthly performance reports.

8. RECOMMENDATIONS

8.1 As set out on the front of the report.