AGENDA ITEM

REPORT TO HEALTH AND WELLBEING BOARD

16 JUNE 2015

REPORT OF DIRECTOR OF PUBLIC HEALTH

Integrated Mental Health Implementation Plan

SUMMARY

Mental illness is the single largest cause of disability in the UK with around one in every fourth person suffering from a mental health condition. Nearly half of all lifetime cases of diagnosable mental illness begin by the age of 14.

The national response to tackling mental health was the publication of two a cross government strategies in 2011 'No Health without Mental Health' and in 2014 'Closing the Gap'.

This report outlines a proposal for the board to consider the formation of a task and finish group consisting of representatives of all members of the board to review the requirements of these two documents and develop an integrated strategy to address them.

RECOMMENDATIONS

1. Convene a task and finish group that represents all commissioners, providers, service users and carers to review the actions identified within No Health Without Mental Health and Closing the Gap. This should work across the age spectrum and identify what actions are yet to be addressed locally.

2. The Stockton Health and Wellbeing Board are asked to adopt the national strategy as its overarching mental health strategy and develop an integrated implementation plan. This will incorporate all commissioning requirements as well as the actions required to achieve the six priorities within the strategy and the 25 priorities within Closing the Gap. This integrated strategy should be implemented by 2018 and be based upon the needs identified within the locality.

DETAIL

3. Mental illness is the single largest cause of disability in the UK with around one in every fourth person suffering from a mental health condition. Nearly half of all lifetime cases of diagnosable mental illness begin by the age of 14, and three-quarters of lifetime mental illness arises by mid-twenties. With an estimated cost to the economy of approximately £100 billion annually, and. annual mean costs to UK society of mental illness during childhood and adolescence is estimated to range from £11,030 to £59,130 annually per child

Within Stockton & Hartlepool, the community mental health profile (Appendix 1 – only available at CCG level as of 2014, not by local authority) highlights a range of issues in which levels of identified need, or outcomes are significantly worse than the England average. These included the prevalence of depression and anxiety and emergency admissions for self harm/ unintentional and deliberate injuries. The full mental health profile also shows significant variation for all measures between GP practises.

4. The national response to tackling mental health was the publication of a cross government strategy in 2011 for people of all ages 'No Health Without Mental Health'. This highlights six high level objectives;

   a) More people will have good mental health
   b) More people with mental health problems will recover
   c) More people with mental health problems will have good physical health
   d) More people will have a positive experience of care and support
   e) Fewer people will suffer avoidable harm
   f) Fewer people will experience stigma and discrimination

5. The government released a further publication in 2014 entitled "Closing the Gap". Whilst supporting the six objectives in No Health Without Mental Health and the mental health strategy implementation framework and suicide prevention strategy, it sets out a further 25 priorities. These 25 areas are those in which it is expected to see the earliest changes, and therefore aims to move faster and further in relation to making improvements around mental health. It provides an implementation framework that focuses upon how local partners can work to achieve long-term objectives. These objectives will require organisational change, working together to ensure that all available resources are being utilised effectively.

6. A recommendation within 'No Health Without Mental Health' was that each locality area has a dedicated mental health partnership board to oversee the implementation of the recommendations within the strategy. Due to the changes which have taken place locally in relation to the infrastructure which supports the Health and Wellbeing board, how this partnership can be developed requires review alongside the requirements of Closing the Gap.

7. Within Stockton, each of the different member organisations of the HWB already have a variety of plans & strategies in place. These include the The Stockton Children's and Young Person Mental Health and Wellbeing Action Plan and HaST CCG Mental Health Strategy.

   Each of the member organisations of the board are responsible for commissioning different parts of the prevention and treatment pathway. However, in addition to commissioned treatment services, there is also a need to ensure that there is joined up strategic approach to promoting good MH across the population, alongside the prioritisation of prevention which is specified within the Joint Health and Well Being Strategy.

8. The two national publications highlighted outline actions which require commitment from all bodies who make up the Health and Wellbeing board, thus it offers an opportunity to develop an integrated implementation plan which will reflect the life course and encompass all required actions. An

integrated plan would allow for a sharing of resources, a smarter use of intelligence, avoid duplication and assist with ensuring issues such as the transitions years were addressed.

FINANCIAL IMPLICATIONS

9. There are no direct financial implications of this update for the council. However, the development of an integrated mental health plan may influence subsequent commissioning decisions involving mental health services.

LEGAL IMPLICATIONS

10. There are no specific legal implications of this update.

RISK ASSESSMENT

11. Recommendations and commissioning decisions that arose out of the establishment of an integrated mental health implementation plan will incorporate risk assessment as part of the development.

COUNCIL PLAN IMPLICATIONS

12. Implementation of the work will have a positive impact on both the Sustainable Community Strategy and Joint Health and Wellbeing Strategy themes in influencing the mental health and wellbeing of both children and adults.

CONSULTATION

13. Consultation with partners will be undertaken as part of the development of a task and finish group. Plan for consultation on the integrated strategy and implementation plan will be developed in due course by the task and finish group as part of the strategy development process.

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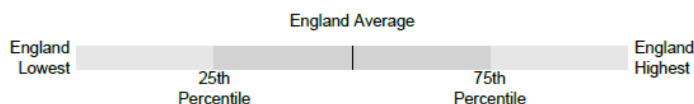
Appendix 1 Community Mental Health Profile for HaST CCG area

(full profile available at: http://www.nepho.org.uk/pdfs/cmhp/E38000075.pdf)

Summary for Hartlepool and Stockton-On-Tees

The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the black line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A dark blue circle means that this area is significantly lower than England for that indicator; a pale blue circle means that this area is significantly higher than the England average for that indicator.

- Significantly lower than England average
- Not significantly different from England average
- Significantly higher than England average
- Significance not calculated



Domain	Indicator	Period	Local value	Eng. value	Eng. lowest	Eng. highest
Levels of mental health and illness	1 Depression: QOF prevalence (18+)	2012/13	7.0	5.8	2.9	11.5
	2 Depression: QOF incidence (18+)	2012/13	1.2	1.0	0.5	1.9
	3 Depression and anxiety prevalence (GP survey)	2012/13	14.8	12.0	8.1	19.5
	4 Mental health problem: QOF prevalence (all ages)	2012/13	0.78	0.84	0.48	1.46
	5 % reporting a long-term mental health problem	2012/13	5.1	4.5	2.5	8.2
Treatment	6 Patients with a diagnosis recorded	2013/14 Q1	10.1	17.8	1.1	63.2
	7 Patients assigned to a mental health cluster	2013/14 Q1	94.8	69.0	1.9	94.8
	8 Patients with a comprehensive care plan	2012/13	89.4	87.3	79.9	95.0
	9 Patients with severity of depression assessed	2012/13	93.0	90.6	77.4	97.8
	10 Antidepressant prescribing (ADQs/STAR-PU)	2012/13	7.6	6.0	2.7	9.0
	11 People with a mental illness in residential or nursing care per 100,000 population	2012/13	45.8	32.7	0.0	124.3
	12 Service users in hospital: % mental health service users who were inpatients in a psychiatric hospital	2013/14 Q3	1.9	2.4	0.7	12.3
	13 Detentions under the Mental Health Act per 100,000 population	2013/14 Q1	7.2	15.5	0.0	44.5
	14 Attendances at A&E for a psychiatric disorder per 100,000 population	2012/13	299.3	243.5	3.0	925.5
	15 Number of bed days per 100,000 population.	2013/14 Q1	4150	4686	685	11073
	16 People in contact with mental health services per 100,000 population	2013/14 Q1	2116	2176	116	5442
	17 Carers of mental health clients receiving of assessments	2012/13	85.5	68.5	0.0	343.4
	18 Spend (£s) on mental health in specialist services: rate per 100,000 population	2012/13	26135	26756	14296	49755
	19 % secondary care funding spent on mental health	2011/12	10.9	12.1	7.1	19.1
Outcomes	20 People on Care Programme Approach per 100,000 population	2013/14 Q1	711	531	17	1895
	21 % CPA adults in settled accommodation	2013/14 Q1	26.2	61.0	5.0	94.6
	22 % CPA adults in employment	2013/14 Q1	4.8	7.0	0.0	22.7
	23 Emergency admissions for self harm per 100,000 population	2012/13	348.0	191.0	49.8	595.6
	24 Suicide rate	2010 - 12	9.5	8.5	4.8	19.6
	25 Hospital admissions for unintentional and deliberate injuries, ages 0-24 per 10,000 population	2012/13	165.1	116.0	68.6	201.7
	26 Rate of recovery for IAPT treatment	2012/13	48.6	45.9	22.6	80.3

Indicator Notes

1 % adults (18+) with a record of unresolved depression recorded since 2006 (2012/13) 2 % adults (18+) with a new diagnosis of depression recorded in 2012/13 3 % respondents to the GP survey who reported moderate or extreme anxiety or depression, 2012/13 4 % adults with a serious mental illness (schizophrenia, bipolar disorder or other psychoses, or on lithium therapy), 2012/13 5 % people in people the GP practice survey reporting a long-term mental health problem, 2012/13 6 % patients in contact with mental health services with a diagnosis recorded, Q1 2013/14 7 % patients in contact with mental health services assigned to a cluster, Q1 2013/14 8 % patients with a serious mental illness who have a comprehensive care plan recorded, 2012/13 9 % new depression cases with a severity assessment at outset of treatment), 2012/13 10 Average dailly doses of antidepressants prescribed per patient (STAR-PU), 2012/13 11 Mental health clients aged 18-64 receiving community, residential or nursing home care in 2012/13 per 100,000 population 12 Standardised admissions of all people in contact with specialist mental health services/ 100,000 population 2012/13 13 Detentions under the mental health act\100,000 population, Q1 2013/14 14 Attendances at A&E for a psychiatric disorder, 2012/13 15 In-year bed days for mental health\1,000 population, 2012/13 16 17 People in contact with specialist mental health services\100,000 population, 2013/14 Q1 17 Carers of mental health clients aged 18-64 who were assessed during 2012/13 per 100,000 population 18 Spend on all publicly funded mental health services for adults aged 16-64, rate per 100,000 adults, 2010/11 19 Spend for specialist mental health services as a % of all secondary care services, 2011/12 20 People on CPA per 100,000 population 2013/14 Q1 21 % people with mental illness on CPA, aged 18-69, in settled accommodation, 2013/14 Q1 22 % people with mental illness on CPA, aged 18-69, in employment, 2013/14 Q1 23 Directly standardised rate for emergency hospital admissions for self harm, 2012/13 24 to Directly standardised mortality rate for suicide and undetermined injury, 2010-2012 25 Admissions for unintentional or deliberate injuries in <24s, 2012/13 26 % people completing IAPT who have moved to recovery, 2012/13

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