NHS
South West
Clinical Senate

The South West Clinical Senate met on 19th November 2015, Taunton Rugby Football Club.

The question:

As seen through the experience of service users and their family/carers is the current provision of mental health services and their configuration appropriate?

How and where should services best be accessed for early help, ongoing support and in crises and what changes would the senate therefore recommend?

The Advice

A number of themes emerged during the initial presentations that served to focus the discussions and recommendations throughout the day:

- There is a distinction between improving mental health and improving mental illness services. The former needs broad consideration of the determinants of mental well-being including, but not exclusively, strengthened support for the acquisition of good parenting skills and strong early years' experience; communities' contribution to the interplay of housing, workplace, social and community integration and personal support networks. With the proviso that society risks 'pathologising distress', we determined that the prime focus of this Clinical Senate would be to develop recommendations to improve mental illness services. We have deliberately not focused on specific areas of mental health provision such as CAMHS or Maternal & Perinatal care where work is being led by the Mental Health Clinical Network.
- The distinction between physical and mental illness is clinically somewhat arbitrary. The presentational mix of physical and mental symptomatology in relation to the same set of antecedents can be variable and interchangeable in individuals or over time. It follows that rigid separation of service provision into two non-intersecting camps is inevitably likely to be unhelpful.
- The historic creation of independent community mental health Trusts was predicated *inter alia* on the belief that their formation would strengthen mental health advocacy; protect budget flows into mental health services; and support parity of esteem. However, there has been a fall in the proportion of NHS spend on mental illness services over time and continuing concern over lack of parity of esteem. Although there was absolutely no appetite in the Senate for reconfiguration, some argued that the demarcation caused by the existence of separate Trusts had not served the development of integrated services. All agreed minimising the visibility of organisational interfaces to patients to support clear care pathways and smooth transitions between services was crucial.
- Feedback from service users highlights the fundamental need to facilitate rather than create blocks to service access: and to assure the quality of interaction within

those services. Whilst there was appreciation that measurement of outcomes was difficult, those outcomes most relevant to users and their carers should be adopted. User involvement is implicit in every area of service commissioning.

- The centrality of appropriate case information availability and sharing was emphasised. Currently patient record systems are not sufficiently interoperable. Dubious interpretation of confidentiality / information governance protocols was felt to have unnecessarily impeded communication with carers and this undermined support for people in need of this.

The South West Clinical Senate makes the following recommendations:

1. Commissioners in the South West should investigate options for non face-to-face contact patient services in mental health that include broad peer support, signposting and supervised access to on-line therapies. Many clients might prefer to access services remotely and it may help ease of disclosure and loss of stigmatisation. Evidence suggests many acute problems can be resolved without further need to access services via 'traditional' face-to-face portals.

2. Educational opportunities for those providing non-statutory support including nursery and school teachers, Personal Health and Social Education (PHSE) leaders and Special Educational Needs Coordinator (SENCO) staff should be in place. Between mental health and physical health staff there should be sufficient crossover of training to allow awareness of holistic health needs, but there was acknowledgement that often there are specific skills required in each of the disciplines so flexibility is required. Particular initiatives that target those specific disease areas causing high morbidity and early mortality in patients with mental illness are welcomed e.g. smoking cessation and cardiovascular risk minimisation.

3. The move towards primary care consolidation is supported by the Senate. This 'primary care at scale', where GPs and primary care teams cover a minimum registered population of 30,000 patients, gives the opportunity for dedicated secondment of mental health staff (e.g. counselling, CBT, other therapists and CPNs) to those practice groupings. Provision of services, including IAPT, alongside 'physical' health services supports parity of esteem and removal of any stigmatisation. The size has sufficient critical mass to function efficiently but is not so large as to weaken relationships on which good coordination and teamwork depends. Mental health providers should consider how best to integrate to form strong multidisciplinary primary care teams. This fits with the concept of the multispecialty community provider. Access portals into services should be modernised and better coordinated. Adoption of newer technologies at access points, incorporating 'intelligent clinical triage' should enable streaming of patients to the most appropriate source of help, be that a statutory, non-statutory or third

sector organisation. To that end, any Directory of Services (DoS) needs to be complete and kept up to date. It should indicate the availability of services to match peak demand over the full week. Partnership working is impeded when this is not in place.

4. For urgent out-of-hours access, national 111 protocols are considered to be underdeveloped and should be strengthened. Urgent Care Centres and Emergency Departments should incorporate and enable access to mental illness services, linking with 'clinical hubs' offering a single point of access which may or may not be collocated in those departments. Realistically, there is a trade-off between 24-hour access and better in-hours availability that needs public and user engagement to address. There will be a need for collaboration over a broader geographical footprint for services to be available over extended hours so that clinical resource is optimally utilised.

5. There should be thorough and realistic workforce planning when developing services. This should reflect future likely demand and skill mix. Additionally, there should be proper consideration by Health Education South West and other training providers of the opportunity for career progression and comparative pay scales between posts in physical and mental health services.

6. Mental health crises should attract the same adequacy of NHS response as would be available for physical illness – a timely response can help further deterioration or crisis development. Wherever possible patients should be swiftly moved back into familiar services and teams post crisis. Bed availability should ensure out of area transfers (i.e. OATs, defined as beyond the normal boundaries of the relevant mental health provider) only occur for clinical reasons; with OATs, outcomes are poorer, support networks are severed and length of stay is protracted. Particular care over transitions of care is required. Hand overs should be carefully monitored and assessed.

7. The Strategic Clinical Network for Mental Health should benchmark length of stay of acute psychiatric inpatients and develop a quality outcomes framework, including peer review of data. The Senate requests that the Clinical Network develops a set of metrics that adequately reflects service quality as perceived by service users, their families and carers.

8. Given the importance of patient records, information in mental health services should be just as easily available (and just as protected) as information about physical illnesses. There should be no assumption that mental health records are more inaccessible as this may impair appropriate delivery of care and itself represents a failure of parity of esteem. Commissioners should ensure appropriate

record sharing policies are identified between their service providers. A process should be in place to identify one nominated carer or family member with whom it has been agreed information can be shared.

9. The proportion of NHS spend on mental illness and health services is disproportionately small considering service requirements and has fallen progressively over recent years. With due regard for value for financial considerations, Commissioners should seek to redress this issue in line with the recommendations of the Five Year Forward View: this in itself can be expected to have some cost-saving benefits to other publically-funded agencies (substance misuse and addiction, social care, the criminal justice system, Emergency Department demand *etc*.). Rather than embark on structural organisational change commissioners should consider alliance contracts or similar mechanisms for encouraging integrated provision between agencies.