Working together for Mental Health in Cambridgeshire and Peterborough

A framework for the next five years

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Emma de Zoete	Cambridgeshire County Council and Peterborough City Council Public Health
Martin Stefan	Cambridgeshire and Peterborough NHS Foundation Trust
Emma Tiffin	Cambridgeshire and Peterborough Clinical Commissioning Group
Marek Zamborsky	Cambridgeshire and Peterborough Clinical Commissioning Group

for the Cambridgeshire and Peterborough Sustainability and Transformation Programme

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This document has been written as part of our Sustainability and Transformation Programme. It sets out the key priorities and next steps for our health and care system to achieve the aspirations of the Five Year Forward View for Mental Health, alongside our local Sustainability and Transformation Programme plans, and work to implement the Care Act.

Although it has been produced by a small group, we have drawn on work which has been carried out by many people and organisations over the past few years, including a large number of discussions with service users, carers and representatives of partner organisations, as well as existing mental health strategies.

Executive Summary: Headlines

There are three clear themes from strategy work to date:

- **Sustainability:** prevention, early intervention, and attention to the broader determinants of health (such as housing and jobs) are crucial for our system to be sustainable.
- **Integration** between physical and mental health care is not as good as it needs to be. Outcomes for people with physical and mental health problems are poor and there are cost-effective things we could be doing to improve this.
- **Capacity and Demand:** services for people with mental health problems are really stretched, and there are problems at the interfaces (for example between primary and secondary care; health, social care and other organisations; services for children and adults).

The Five Year Forward View for Mental Health, the Care Act 2014 and our local Sustainability and Transformation Plan set out clearly what needs to change. In delivering these changes our approach will focus on three areas:

- **Prevention:** promoting mental health and preventing mental illness.
- **Community based care:** developing an integrated approach to community based person centred care, focused on intervening early.
- **Specialist care:** timely acute, crisis and inpatient care when it's needed**.** Paying particular attention to admission and discharge processes, the management of interfaces between services and social services support.

The changes set out in the Five Year Forward View for Mental Health are being resourced through an anticipated £1bn additional national investment for mental health by 2020/21. We expect to receive a proportion of this investment locally. We estimate that our share of this **additional investment should equate to approximately £12.8m by 2020/21** (based on the funding formula in use in June 2016) but it is important to note that our high level costing work suggests that this level of additional investment is unlikely to be sufficient by itself to achieve full implementation of the Five Year Forward View or all of the priorities set out in this strategy. The national priorities for 2015/16 investment, IAPT, CAMH community eating disorder services, and early intervention in psychosis, have already received additional investment. We have also invested Vanguard funding in a community based first response service for mental health (see Box 3 for detail). Whilst we know there will continue to be national priorities for this investment, we also have local priorities which are key to ensuring that we create and maintain sustainable and effective mental health services in

Cambridgeshire and Peterborough. There is work underway in the vast majority of these priority areas but often not at the scale needed.

Our vision for mental health is:

'That health and care services for people living with long term conditions, mental health problems or advancing age are sustainable, designed with the people and communities who use them around their needs and support them to be resilient, independent and enabled.'

Key Priorities for 2016/17 and 2017/18

The key priorities for investment and focused work in 2016/17 and 2017/18 are set out below. The table combines nationally set priorities, as set out in the Five Year Forward View for Mental Health, and local priorities.

Table 1: Key priorities for investment and focused work 2016/17 and 2017/18

Pathway	2016/ 17	2017/ 18	Local focus	National aims**
Centrally led Task Force priorities*				
Perinatal mental health	X		Improved access through specialist service provision and community provision in line with NICE stepped provision. 2016/17 further work to baseline current service provision, allocate investment and commission new services. Taken forward through perinatal mental health network group as part of STP work on Children and Maternity.	By 2020/21, increase access to specialist perinatal mental health support in all areas in England, in the community or in-patient mother and baby units, allowing at least an additional 30,000 women each year to receive evidence based treatment.
Crisis care	X		Plans in place for core/core 24 liaison psychiatry service standards (by 2020/21) in all acute trusts. Further implementation of our community based first response model to the whole CCG, subject to success of pilot and funding. Continued implementation of crisis concordat action plan.	By 2020/21, all acute hospitals will have all-age mental health liaison teams in place and at least 50% of those will meet the 'Core 24' service standard as minimum.
CAMH emergency, urgent, routine	X		Continued work on the development and implementation of the ithrive model. New children's mental health service model commissioned, including primary mental health support , counselling in localities, and crisis/liaison services in acute trusts. Developing a co-commissioning approach with NHS England.	By 2020/21 at least 70,000 additional children and young people each year will receive evidence-based treatment. Local transformation plans refreshed by Oct 2016, and annually.
Integrated mental and physical healthcare pathways	X	X	Focused prevention and screening initiatives amongst those with serious mental illness (SMI). Smoke free mental health facilities by 2018. Access to psychological therapies (including IAPT) for Long Term Conditions (LTCs) and Medically Unexplained Symptoms (MUS), psychosis, bipolar affective disorder, depression and personality disorder. Supporting self-care for those with LTCs to have mental health support embedded within it.	By 2020/21 25% of people with common mental health disorders will access services each year. Majority of services integrated with physical healthcare with 3,000 new mental health therapists co-located in primary care.

Primary Care				
Health trainer access for those with SMI	X	X	Improved access to health trainers for those with SMI. Initially investment made in 2016/17. Further work to align with other initiatives supporting self-care for LTCs.	By 2020/21 A reduction in premature mortality of people living with severe mental illness (SMI). 280,000 more people having full annual physical health check. Physical care interventions to cover 30% of population with SMI on the GP register in 2017/18, moving to 60% in 2018/19.
Social prescribing Medication management Peer experts/mentor and community health resilience building/navigators	X	X	Learn from pilot and scale up enhanced primary mental health care. This will provide additional mental health resource/capacity within primary care for managing those with mental health problems of moderate to high severity and disability but who are stable, and have risk levels that can be managed in a primary care based service, with support from recovery coaches for those stepping down from secondary care. We will also integrate and/or develop interface with newly expanded neighbourhood teams, who will support those with deteriorating SMI. Further work to link existing community health/navigators within these models, and supported self-care.	
Wider determinants				
Housing support Employment support Debt/benefit advice	X	X	Further work to scope potential for delivering improved services on housing, debt and employment services, and interface with enhanced primary care, supported self-care and neighbourhood teams.	A doubling in access to individual placement and support (IPS), enabling people with severe mental illness to find and retain employment.
Support for carers		X	Further work on supporting carers including well defined support pathways for carers.	
Primary Prevention				
Suicide prevention	X	X	Continued implementation of multi-agency suicide prevention strategy and findings of suicide audit (2016/17).	By 2020/21 the number of people taking their own lives will be reduced by 10% nationally compared to 2016/17 levels.
Anti stigma campaign work		X	Initial campaign work focused on young people, and suicide for 2016/17. Build further joint cross system campaigns for 2017/18.	
Staff wellbeing programmes (non-NHS & NHS)	X	X	Programmes commissioned, or underway. Further work and investment to scale these up, with mental health as part of wider staff wellbeing programmes.	Continued implementation of health initiatives for NHS staff.
Improved resilience for children and young people Mental health skills/knowledge of professionals and parents.	X	X	Further development of the 'thrive' element of the ithrive model. 2016/17 focus on redesign and commissioned model. Non-recurrent funding for 2016/17 focused on development areas.	

Key: *Adapted from p.36 'The five year forward view for mental health'. See Annex A for a full copy of the five year table.
**Taken from 'Implementing the five year forward view for mental health'. NHS July 2016.

Next Steps

Table 2 shows what this means for our local system, and Table 3 illustrates much of the work already underway to take forward these priorities. The purpose of this strategy is to describe our collective system wide priorities on mental health so we can track progress

against these. Overall progress in implementing this combined strategy will be reported through the STP. The principles of collaboration and logistics outlined in this document will underpin this work.

1. Where are we now?

1.1. Local Mental Health strategies

A number of documents about our local mental health strategy have been published, but they are not as joined up as they need to be.

We do not seek to duplicate or repeat in detail these previously published and agreed strategies. Links to them are at the end of this document. The purpose of this document is to place them in an overarching framework, and to describe how we will work together to implement our shared vision for Mental Health.

Across all the strategy work that our system has carried out in recent years, three common themes stand out:

- **Prevention:** early intervention and attention to the broader determinants of health (such as housing and jobs) are crucial for our system to be sustainable.
- **Integration:** between physical and mental health care is not as good as it needs to be. Outcomes for people with physical and mental health problems are poor and there are cost-effective things we could be doing to improve this.
- **Capacity and Demand:** services for people with mental health problems are really stretched, and there are problems at the interfaces (for example between primary and secondary care; health and social care; services for children and adults).

1.2. What people have told us about mental health services in our communities

Throughout our engagement with service users, carers, clinicians, commissioners and other partner organisations, a number of inequalities and gaps in the provision of mental health care have been identified, and a number of consistent themes have emerged, particularly around access and crisis.

In general, people have told us they are concerned about:

- A lack of linkage and coordination between services with the need to improve communication and better sharing of information.
- Variable access to different types of services (in general and during crisis).
- A lack of open access services.
- A gap between GP care and access to specialist services.
- Fear of a “cliff edge” when service users are discharged from specialist mental health services.
- Evidence of poor access to services, particularly when a crisis may be developing, creating an escalation of need.
- The need to join-up services which support individuals, such as benefits and housing advice, with overall provision.
- Recognition of the vital role of peer and carer support.

These service issues and views reflect how the entire health system delivers mental health services alongside its partners. It is clear that we cannot look at one part of the system without considering the whole. To radically improve access to mental health services, people have said that we need to remove the barriers between GPs and hospitals and physical and mental health, and that we need to think of healthcare alongside support for the wider factors which influence mental health including employment, housing, benefits and support for families and carers.

1.3. Main JSNA messages

- With a growing population, Cambridgeshire and Peterborough has growing numbers of people with mental illness. In 2016, it was estimated that over 88,000 adults (aged 18-64 years) in Cambridgeshire and Peterborough have a common mental health disorder – by 2021 this figure will be 95,200, and by 2026 it will be 97,500.
- Suicide rates have been consistently higher than England rates in Peterborough (although this was not always statistically significant) until a drop was seen in 2012/14, making Peterborough’s rates statistically similar to the England average.
- Hospital admissions rates for self-harm in those aged under 25 years are above the national average in both Cambridgeshire and Peterborough, with Peterborough the highest in the East of England.
- Patterns of service use suggest that acute ‘crisis’ services are being used more for mental health in Cambridgeshire, and particularly in Peterborough, when we compare with other areas. This is not explained by differences in population need.

- People with two or more long term conditions are seven times more likely to have depression.[1] Overall this means that locally there are an estimated 18,000 adults with two or more long term conditions with mental ill health and/or limitation, and a further 10,500 people aged 65 and over in these groups.

Further detail and references on key local data is provided at Annex C.

[1] The King's Fund. (2012) Long-term conditions and mental health: The cost of co-morbidities.

2. Where do we want to be in five years' time?

2.1. Our Vision for Mental Health

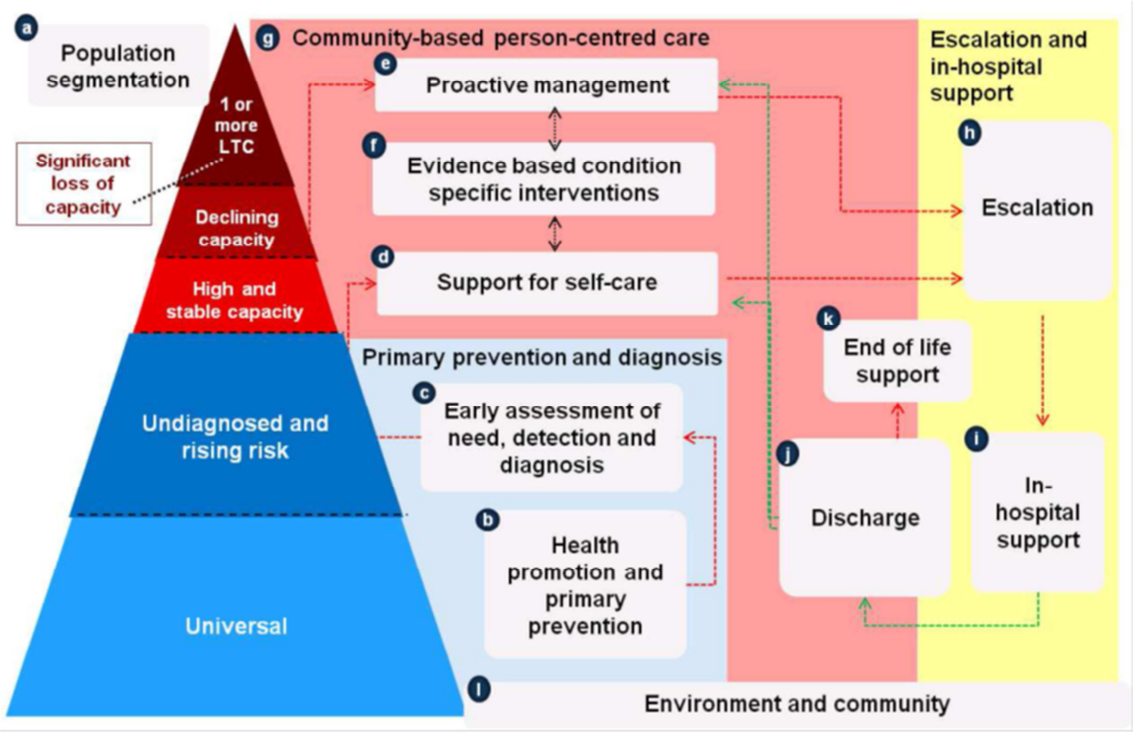
Our vision is that health and care services for people living with long term conditions, mental health problems or advancing age are sustainable, designed with the people and communities who use them around their needs and support them to be resilient, independent and enabled.

It is important to know that this vision has not been developed in isolation. We understand that many people live with multiple conditions, and it is often the psychological and social elements, including housing, employment, support from family and friends, and confidence to self-manage, as well as mental and physical illness, which determine what and how much support someone needs.

2.2. The Main Building Blocks

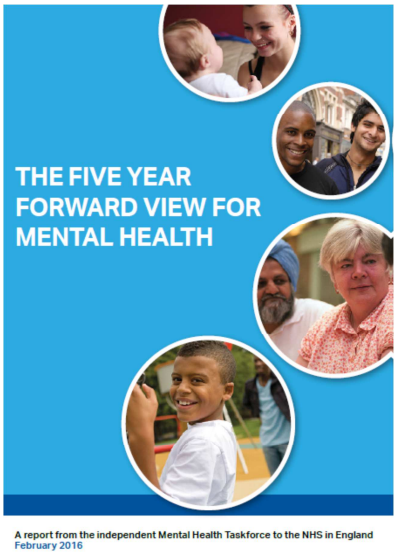
The main building blocks for our strategy include:

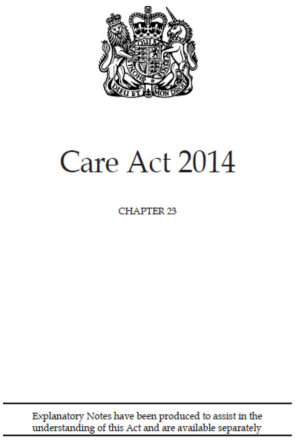
I. The Model of Care Developed by the Sustainability Transformation Programme



We have developed a model of care which places people at the centre of an integrated, community-focused approach; recognising the importance of the wider environment, prevention and early intervention; and that people frequently live with mental health problems alongside other long term conditions. The diagram above summarises how integrated health care neighbourhood teams can provide proactive care stratified by different levels of need, as determined by their medical and psychosocial conditions. This brings together work on healthy ageing, long-term conditions management and mental health.

II. The Five Year Forward View for Mental Health and the 2014 Care Act





Our objectives map closely on to those set out in the Five Year Forward View for Mental Health[2] - Prevention, Wellbeing, Delaying Needs, Good Quality Care, Information and Advice, Innovation and Research, Data, Commissioning - Market Shaping, Payments and Incentives, Leadership and Workforce. NHS England have published their implementation plan for the Five Year Forward View[3] and in Table 2 we describe what this means for our local health system.

Table 2: Local Implications of the Five Year Forward View for Mental Health

National commitment	Potential local implications
Physical care interventions to cover 30% of population with severe mental illness SMI on the GP register in 2017/18, moving to 60% in 2018/19.	2,100 people with SMI (30%) would have physical care interventions by 2017/18, moving to 4,200 (60%) in 2018/19
By 2020/21 25% of people with common mental health disorders will access services each year.	29,300 people with common mental health disorders would access services a year by 2020/21.
By 2020/21, increase access to specialist perinatal mental health support in all areas in England.	1,250 women would receive additional support for mental health problems during pregnancy and/or the postnatal period by 2020/21, with approximately 420 (or 4%) of this group having severe and complex needs.
At least 35% of CYP with a diagnosable mental health condition receive treatment from an NHS-funded community MH services by 2020/21.	6,755 (35%) children and young people with a diagnosable mental health condition would be receiving treatment from an NHS funded community mental health service a year by 2020/21.
By 2020/21 the number of people taking their own lives will be reduced by 10% nationally compared to 2016/17 levels.	There would be 6 fewer suicides a year (from 2015 levels) by 2020/21.

Please see Annex D for details of how these estimates have been calculated.

[2] https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

[3] https://www.england.nhs.uk/wp-content/uploads/2016/07/fyfv-mh.pdf

The Care Act 2014 is the most significant change to adult social care in over 60 years. It modernises care and support so that the system is built around people's needs and what they want to achieve in their lives. It will give:

- Individuals and carers more control over their care and support.
- Clarification of what individuals and carers can expect from the care system.

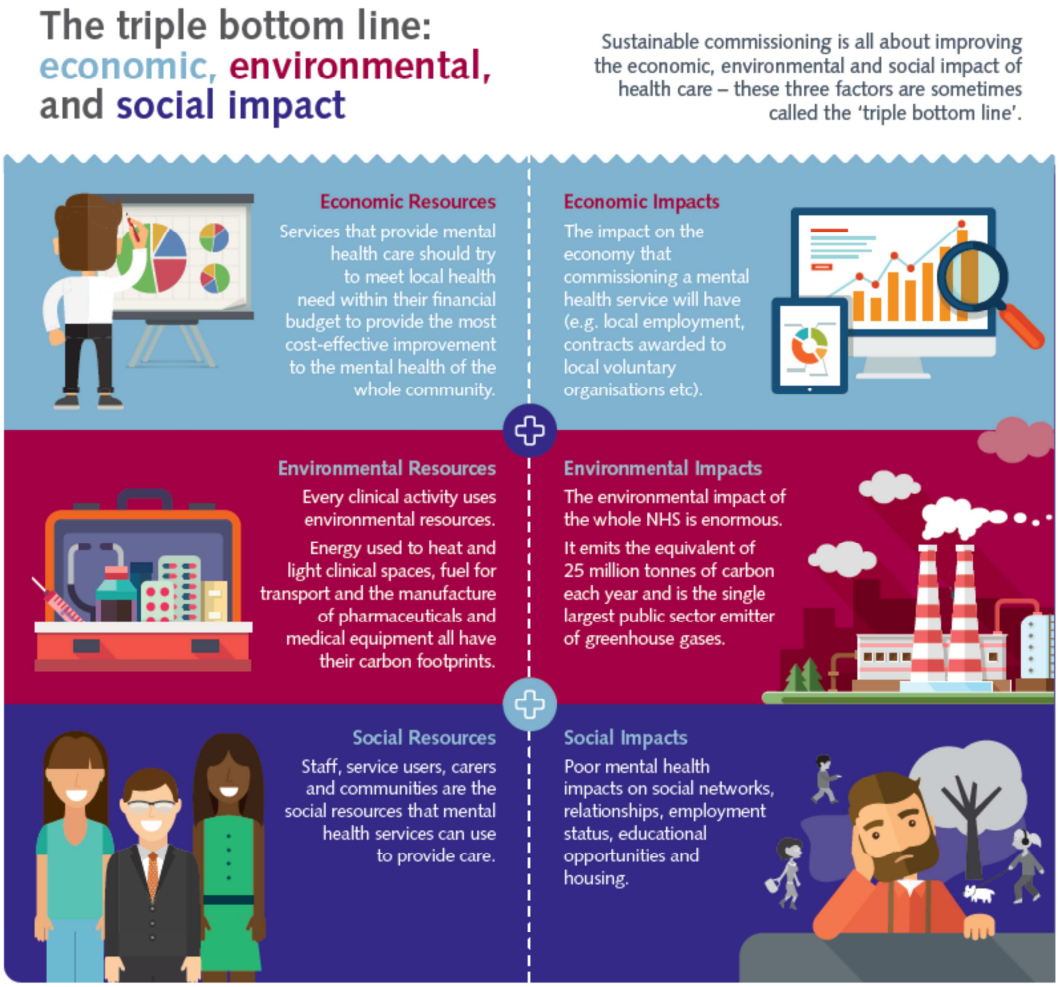
The introduction of the Care Act and its concept of 'Wellbeing' impacts upon how mental health social care services are delivered, because of the duties it places on the council to put more emphasis on responding to the needs of carers, placing more control in the hands of the individual over their care and providing better access to information.

Some of the main features of the Care Act include:

- A change to the way people are assessed – so that decisions about the help they receive will consider their wellbeing, what is important to them and their family, and help to plan for the future.
- New rights for carers and people who pay for their own care (called 'self-funders') to ask for an assessment of their needs and the council's help to access services and support to meet their eligible needs.
- Provision of information and advice to everyone who requires it, not just people using services.

One implication for Mental Health services is a need to realign social work resources away from working solely with secondary care to work across the pathway between secondary and primary care services. This would strengthen the early intervention and prevention capacity of the whole mental health system in line with emphasis on wellbeing

III. A commitment to sustainable commissioning



Our approach to commissioning must be sustainable: not just economically, but also environmentally and socially.[4]

What is sustainable commissioning?
Sustainable commissioning is about 'future-proofing' mental health care. This simply means ensuring better outcomes for patients both now and in the future, despite increasing resource constraints.

[4] Source: JCPMH: Guidance for commissioners of financially, environmentally, and socially sustainable mental health services. Available at: http://www.jcpmh.info/resource/guidance-for-commissioners-of-financially-environmentally-and-socially-sustainable-mental-health-services/

Four Basic Principles for sustainable commissioning decision making.
These four principles are well known, but too rarely employed as a framework for decision-making among commissioners:

- **Prioritise prevention** – preventing poor mental health can reduce mental health need and therefore ultimately reduce the burden on health services (prevention involves tackling the social and environmental determinants alongside the biological determinants of health).

- **Empower individuals and communities** – this involves improving awareness of mental health problems, promoting opportunities for self-management and independent living, and ensuring patients and service users are at the centre of decision making. It also requires supporting community projects that improve social networks, build new skills, support employment and ensure appropriate housing.

- **Improve value** – this involves delivering interventions that provide the maximum patient benefit for the least cost by getting the right intervention at the right time, to the right person, while minimising waste.

- **Consider carbon** – this requires working with providers to reduce the carbon impacts of interventions and models of care.

2.3. Our main priorities

Our main priorities, progress to date and next steps are summarised, and mapped against national priorities, in Table 3 below. The Executive Summary to this document provides a shortened version of this table highlighting the key priorities (Table 1).

Our proposed approach focuses on three areas:

- **Prevention:** promoting mental health and preventing mental illness.
- **Community based care:** developing an integrated approach to community based person centred care, focused on intervening early.
- **Specialist care:** timely acute, crisis and inpatient care when it's needed**.** Paying particular attention to admission and discharge processes, the management of interfaces between services, and social services support.

These headings draw together the themes of prevention, integration and capacity and demand alongside many of the other priorities identified both locally by our own service users and partners, and also nationally within the five Year Forward View for Mental Health. Importantly, they also build on and link in with each other, to provide a cohesive person-centred sustainable model of health and care.

This document does not currently encompass Learning Disabilities or Dual Diagnosis. Work on dementia is being developed separately through a dementia strategy, and once available will be incorporated here.

Table 3: Mental Health Five Year Forward View – *local requirements split by local priority areas*

Local and national aims: **A: Promoting Mental Health and Preventing Mental Illness**	**Progress to date**	**Next steps**
- *Focus on groups at risk of mental illness such as vulnerable children, as well as support for carers.* - *Access to employment, housing and debt support.* - *Tackling stigma through campaigns and mental health champions in communities.* - *Incentives for NHS employers relating to NHS staff health and wellbeing. Measures of staff awareness and confidence in dealing with mental health in staff surveys.* - *Parenting programmes as part of prevention work, particularly for vulnerable groups.* - *Improved resilience for children and young people, alongside mental health skills and knowledge of professionals and parents.* - *Implementation of a whole school approach to mental health and wellbeing.* - *Individuals and their families are enabled to achieve and sustain their wellbeing through links to strong and resilient communities.* - *Vulnerable people with mental health needs and their carers find the support and care system easy to navigate.* *(Suicide prevention see section C)*	- Some focus on at risk groups including vulnerable children. - Access available through commissioned voluntary sector services to employment support, housing and debt advice for some. - Anti-stigma campaigns such as 'stress less', 'one you' and mental health awareness week supported by public health. - School champions (teacher and young people) being piloted. - NHS staff wellbeing programmes, including mental health being developed in large NHS providers. - Parenting programmes considered as part of the mental health service redesign for Children and Young People. - Training for professionals and schools provided, alongside planning for whole school approach. - Development of training packages for employers and setting out standards for workplace health, and support for those with mental illness wanting to remain and/or return to work. - Pilot project on building mentally resilient communities and evaluation with MIND. - Improving the mental health awareness for a broad range of professionals.	- Further work to ensure prevention work is targeting at risk groups. - Further work with voluntary sector to scope potential for delivering improved services on housing, debt and employment services, and the interface with enhanced primary mental health care services, and neighbourhood teams. - Build further joint cross system campaigns for 2017/18. Further development of NHS wellbeing programmes for employees. - Further development of parenting programmes as element of the ithrive model. - Alignment of voluntary sector commissioning. - Further development of 'thrive' element of ithrive model focusing on school support, mental health knowledge and life skills, building resilience, staff and parents, and those most vulnerable to mental health problems. - Continued focus on reducing social isolation, and building community resilience. - Further work on supporting carers including robust assessments and 'what if' plans, as well as defined support pathways for carers.

B Developing community-based person centred care focused on intervening early	Progress to date	Next steps
- *By 2020/21 at least 60% of those experiencing a first episode of psychosis access to NICE approved care package within 2 weeks of referral.* - *Out of area placement for inpatient care eliminated by 2020/21.* - *Reduce Mental Health Act detention through earlier intervention and targeted work to reduce over-representation of BAME and other disadvantaged groups* - *Prevent avoidable admissions support recovery and 'step down' for SMI and significant risk/safety issues, least restrictive and close to home. Tackle inequalities in detentions and length of stays.* - *Expansion of 'navigator' roles.* - *Learning from SI's.* - *Social care practice is focused on supporting people to gain and retain their independence.* - *An effective re-ablement service is available in mental health.*	- Further investment in Early Intervention Psychosis (EIP) services in line with national guidance. EIP pathway development in place. - Enhanced Primary Care Pilot in place – looking at "step down/step up" management. - Development of a primary care wellbeing pathway integrating IAPT, the enhanced primary care pilot and recovery coach service (CQUIN). - Fully scoping activity data for Personality Disorder (PD) Pathway (CQUIN). - CCG have commissioned 'recovery coaches' to support patients post discharge. Local authority have piloted a mental health 'navigator' model based on an existing 'navigator' project. - Recovery College East provided collaborative educational opportunities for CPFT service users and staff. - Development of 'what if' plans for carers.	- Establish NICE compliant pathway (Year 3). - Learn from pilot and scale up enhanced primary mental health care. This will support GPs in identifying psychological needs and primary care led interventions, with support from recovery coaches for those stepping down from secondary care. Integrate and/or develop interface with newly expanded neighbourhood teams, who will support those with deteriorating SMI. Further work to link existing community health/navigators/Peer Support. Workers/Recovery College within these models, and supported self-care. - Consider how enhanced primary mental health care can support those not registered with GPs. - Further modify PD pathway as required (including strengthening involvement and support for friends/families). - Alignment of voluntary sector commissioning. - Improved recognition of depression in patients with LTC's, and in old age. - Re-focus social work practice so service users have more engagement with their communities as part of their care plans. - Develop a set of standards for the way in which voluntary sector services enable service users to engage with support existing in their community and build this role into the requirements of all relevant contracts. - Implement and evaluate the re-ablement pilot project in Huntingdon. - Maximise direct payments through staff training and making them more user friendly. - Implementation through strands of work from the Peterborough City Council 'People and Communities' Strategy'.

Integrated mental/physical health & access to psychological therapies - *Physical health checks for those with SMI.* - *Improved access to prevention and screening initiatives for those with mental illness.* - *All mental health inpatient facilities to be smoke free by 2018.* - *Access to psychological therapies (particularly for LTC's; psychosis, bipolar, PD and common mental health problems) Access to psychological therapies to meet 25% of need, and integrated into physical health pathways.* - *Improve offender services, including all age liaison and diversion schemes and forensic services.*	- Work underway to clarify responsibilities for annual checks with different groups of patients for GPs and CPFT. - Investment made in health trainers working within the enhanced primary care service. - Closer working between stop smoking and mental health services. - IAPT Access and recovery rates as per national targets. - IAPT already focusing on patients with LTCs.	- Clarity built into contracts, and provision monitored. Improve the proportion of SMI patients with a high quality annual health check. - Focused prevention and screening initiatives, and numbers accessing services amongst patients with SMI improved. Smoke free mental health facilities by 2018. - Improved access to health trainers for those with SMI. Initially investment made in 2016/17. Further work to align with other initiatives supporting self-care for LTCs. - Improve access to psychological therapies where this is of known benefit including for LTCs, MUS, psychosis, mood disorders including bipolar affective disorder and PD (improved). Impact analysed, financial flow adjusted between LTC and MH services. - Plans developed to implement smoke free inpatient facilities by 2018. - Supporting self-care for those with LTCs to have mental health support embedded within it. - Develop liaison psychiatry skills in primary care to reduce presentations to acute trusts and support them in moving services into the community
Perinatal, Children and Young people - *Improved access to evidence-based specialist mental health care including psychological therapies and specialist community or inpatient care* - *One in three children and young people with mental health needs to access Mental Health services by 2020*	- Perinatal mental health outcomes built into 0-19 contract for children's services (including health visiting, school nursing and children's centres). - Initial work on Children's mental health redesign to ithrive model underway. Service will: o Increase availability and accessibility of early interventions services through	- Continued work to recognise the impact of parental mental health on children and focus practice on responding to the needs of the whole family through whole family assessments and joint visits with other professionals wherever possible. - Improved perinatal access through specialist

	improved signposting, advice, guidance. o Movement of those CYP with mild needs to locality based support. o Effective early MH specific assessment to ensure access to correct interventions and support as early as possible. o Development of wellbeing lead roles to support, advise, guide professionals working with children and young people within the community. o Embedding the use of shared decision making and setting of outcomes and goals from first interaction with services (supported by a programme of training). o Reviewing model of delivery to ensure effective evidence based interventions are delivered and development of innovative workforce models with a range of people skilled to delivery these interventions.	service provision and community provision in line with NICE stepped provision. 2016/17 further work to baseline current service provision, allocate investment and commission new services. - Continued work on the development and implementation of the ithrive model. New children's mental health service model commissioned, including primary mental health support and counselling in localities. - Focused work to reduce transition issues between child and adult services. - Further development of co-located, jointly commissioned, fully integrated services for children including those with long term conditions. - By December 2016 developing a co-commissioning approach with NHS England focusing on alternatives to admission.
C Timely acute, crisis and inpatient care when it's needed	**Progress to date**	**Next steps**
- *By 2020/21 all acute hospitals to have all-age mental health liaison services in A&E and inpatient wards, and meeting core 24 service standards.* - *By 2020/21 24/7 community based mental health crisis response available. Including Crisis Resolution and Home Treatment Teams (CRHTTs) provision of intensive home treatment.* - *Equivalent model to adult model for children and young people.* - *Implement new duties to ban use of police cells as a "place of safety" for those under 18 years* - *Multi-agency suicide prevention plans in place by 2017, contributing to 10%*	- Implementation of phase 1 of UEC Vanguard for 24/7 mental health crisis in Cambridge. - Pilot of community based safe place with voluntary sector. - Mental health nurses in police control room as part of UEC Vanguard project provide early input and support to police and provide alternatives to use of Section 136. - Investment of £360k to improve psychiatric liaison services for children and young person including extending assessments to midnight and increasing capacity of Intensive Support Team - S136 Mental Health Based Places of Safety to meet national guidance.	- Plans in place for core/core 24 service standards (by 2020/21) in all acute trusts, subject to staffing limitations. Review Emergency Department Liaison Psychiatry provision, adjust as necessary. - Further implementation of our community based first response model to the whole CCG, subject to success of pilot and funding, to provide 24/7 self referral for mental health crisis with teletriage and mental health first responders available to provide urgent assessment when needed. - Develop multidisciplinary paediatric liaison services to acute trusts - Continued implementation of crisis concordat action plan (years 2-5).

reduction in suicide.	- Multi-agency suicide prevention plan and implementation group established. - Successful Stop Suicide Campaign and targeted training programme.	- Ensure there is a countywide Approved Mental Health Professional (AMHP) service with sufficient capacity and sufficient access to S12 approved medical practitioners. - Improved use and sharing of Crisis/Care Plans. - Develop pathways/processes to ensure ithrive and crisis redesign integration. - Continued implementation of suicide prevention strategy and findings of suicide audit (2016/17).

Sources: STP aide-mémoire: Mental Health and Dementia and Five Year Forward View for Mental Health. All relevant local strategies

2.3.1. Our first local priority: promoting mental health and preventing mental illness.

Preventing illness, promoting mental health and intervening early and effectively, when people become ill, are the foundations of our strategy.

The Five Year Forward View for Mental Health emphasises the importance of *promoting good mental health and preventing poor mental health – helping people lead better lives as equal citizens***,** and recognising that this his is not the remit of the NHS alone – it requires support for parents, good schools, decent housing and supportive communities. Our *Public Mental Health Strategy*[5] sets out the evidence for such an approach.

Our cross system prevention work will focus on:

- Building resilience, mental health knowledge and life skills in children and young people.
- Introducing a "whole school approach" to improving mental health and a similar approach in the early years environment.
- Supporting parents, particularly through evidence based parenting programmes.
- Engaging with communities to promote mental health and reduce stigma, including through anti-stigma campaigns.
- Mainstreaming mental health promotion within our healthy lifestyles work.
- Developing training packages for employers and setting out standards for workplace health, and support for those with mental illness wanting to remain and/or return to work.
- Improving the mental health awareness for a broad range of professionals who come into contact with those with mental illness but are not mental illness specialists.
- Work to address the factors that increase the risk of mental illness, such as improving access to employment support and debt advice.
- Work to improve the mental health of those with physical illness and the physical health of those with mental illness.
- Continued implementation of the Suicide Prevention Strategy.[6]

As described below much of the challenge with this work is ensuring that it takes place at a sufficient scale to have a significant impact.

2.3.2. Our second local priority: developing community-based, person centred care including intervening early where possible

At the heart of our vision is an integrated service, community based, which brings together physical and mental health care, alongside social care, the voluntary sector, and the many resources which exist within our communities. Considerable work is already underway, much of which is currently being tested in small geographical areas, but this needs further commitment and investment to be expanded across Cambridgeshire and Peterborough.

[5] http://www.cambridgeshireinsight.org.uk/health/healthtopics/mh
[6] http://www.cambridgeshireinsight.org.uk/health/healthtopics/mh/suicide

One key area of activity in this area focuses on **improving access to and availability of mental health services**, including:

- Significantly more children and young people accessing high quality mental health care, including timely access to inpatient beds as close to home as possible when these are needed, alongside alternatives to admission where this is appropriate.
- Specialist perinatal mental health services available locally for all women who need them.
- Access to psychological therapies to meet 25% of need, integrated into physical health pathways.
- Expansion of rapid access for people experiencing their first episode of psychosis in line with NICE-approved care.
- Multi-agency action to reduce the suicide rate by 10%.

As part of our plan to achieve these goals, we will immediately set up a Cambridgeshire and Peterborough perinatal mental health network group; and we will also consider options for developing more specialist services for perinatal mental health, including exploring the option of establishing a regional Mother and Baby Unit, alongside the development of the whole perinatal pathway. We will expand our Long Term Conditions IAPT service, and take action to allow our early intervention in psychosis teams to increase their treatment pathways from two years to three, and to expand services for the assessment of individuals with at risk mental states.

Work on children and young people will build on the 'ithrive' work described below.

Box 1: ithrive redesign for children's mental health

We are developing a new model for emotional health and wellbeing services based on the ITHRIVE framework. This will, we hope, reduce the demand we see later on in life for mental health, specialist health, and social care services. Thrive is a conceptual framework for delivering a need based model for CAMHS. Cambridgeshire and Peterborough is one of the national accelerator sites for implementing this approach. More detail on Thrive can be found at http://www.annafreud.org/service-improvement/service-improvement-resources/thrive/

The model supports self-resilience of CYP and families and supports them within their localities and in ways that meets their needs. The model supports the concept of increasing the availability and accessibility of early intervention and preventative activities and therefore ensuring that only children and young people whom would benefit from specialist mental health services need to be referred.

Key points of new model:

- Removal of tiers to a whole system approach.
- Needs based as opposed to diagnosis led.
- Outcome to be defined from beginning of interaction with services.
- Enhance preventative activities to support Thriving and build resilience.
- Increase in early intervention and provide interventions, advice, support earlier and not wait until crisis.
- Use of shared decision making to identify goals and outcomes to be achieved.
- Ensure use of evidence based or best practice interventions.
- Stop treatment if not achieving goals.
- Improvement in access.
- Access to advice and guidance from specialist services earlier through wellbeing lead.
- Improved training and knowledge of mental health across all sectors.

A second area for development focuses on providing people with community based holistic care, recognising their mental and physical health needs.

We know that we need to do more to bring together and co-ordinate services which can focus on the needs of the individual and understand them in their wider environment and work to address the factors contributing to their mental health problem. This means focusing on wider support such as housing, employment and benefits, alongside supporting family and/or carers.

We also recognise the need to expand support for people who are below the threshold for specialist services but who need more support than can be provided through GPs. Support for self-care and recovery, are central to this. Housing is a crucial part of this and there is a need tor review the sufficiency and spread across the County of specialist accommodation and access to general needs housing for those with severe and enduring mental health problems.

As part of our plan to achieve these goals, by 2017 we will have developed our Recovery Coach model to support discharge from secondary care, and our Enhanced Primary Care service for Mental Health will be developed to allow us to test out approaches to improve the effectiveness of our step up and step down pathways, and help address the "fear of a cliff edge" which causes many of our service users and carers concern when discharged from secondary Mental Health services. The Enhanced Primary Care mental health service will, along with all NHS services, support the physical care of patients with mental illness, and identify and address the psychological needs of those with long term conditions and is described in the box below. Our dementia strategy will be developed to continue to meet national targets for early diagnosis; and to improve the support (including crisis and end of life care) for people living with dementia and their carers.

Box 2: Enhanced primary care mental health services

The Model: The service will provide additional mental health resource/capacity within primary care to manage the defined patient group (see above) by supporting the GP with specialist Mental Health staff who have the knowledge, expertise and capacity to support the safe discharge/transfer of stable patients from Secondary to Primary Care and vice versa. Physical health monitoring and where appropriate physical and mental health interventions will be provided in collaboration with the wider MDT team. There will be three teams across the CCG consisting of: Band 6 nurse (mental health interventions and escalations to secondary care where needed); one Health Care Assistant for physical health interventions; and one Peer Support Worker to enable access to community resources.

Who is the service for?

The service will be for patients aged 17-65 years who have mental health problems of moderate to high severity and disability but who are stable, and have risk levels that can be managed in a primary care based service. This should reduce the pressure on primary care and reduce secondary care referrals, creating more capacity within the mental health system.

Next steps

The service specification and model have been agreed, with an initial proof of concept phase in the Fenland and Hunts area to better understand how the model will work in practise. Following an evaluation, the aim is to roll out the model CCG-wide from Autumn 2016.

2.3.3. Our third local priority: timely acute, crisis and inpatient care when it's needed

The Five Year Forward View for Mental Health emphasises the importance of a *seven day NHS which provides the right care at the right time and of the right quality.*

Within our local area the Crisis Care Concordat has provided a model of multi-agency collaboration to help develop and improve our crisis services. We will need to build on and develop this work. To make sure that the capacity of our acute and specialist mental health services can sustainably meet demand and achieve the best outcomes for patients, we also need to deliver effectively on our plans for prevention, early intervention and community-based care which we have described above.

We will continue to work to design integrated pathways between primary and secondary care and the voluntary sector, and to build teams that can respond quickly in a crisis and that will facilitate early discharge, with support from the right services, as soon as this is appropriate and safe. We will work to ensure that children and adolescents have timely access to crisis services that meet their needs in the community, as well as exploring new collaborative approaches to commissioning inpatient services when these are required.

We are developing and piloting a community-based mental health first response service as part of our Urgent and Emergency Care Vanguard programme, and this is described in the box below.

Box 3: Mental Health Vanguard: First Response Service

The mental health Vanguard programme aims to provide a universal, 24/7, mental health crisis care pathway, which can be accessed directly by patients and carers, alongside local NHS, social care and third sector colleagues.

The model: The new services include:

- A first response service run by Cambridgeshire and Peterborough Foundation Trust, supporting patients experiencing a mental health crisis in the community out-of-hours. The team will work alongside the existing crisis teams and will take referrals from emergency services.
- The Sanctuary, a safe place in the community, offering short-term support, run by the third sector, with referrals triaged by the First Response Service. It will provide practical and emotional support for people as an alternative to admission to statutory services. The service will run seven days a week between 6pm and 1am.
- A system-wide co-ordinator supporting calls from emergency services out-of-hours, and referring onto the new Sanctuary and First Response Service.
- Mental health practitioners in the Integrated Police Control Room providing advice to the police. This launched on 29 March and allows people in mental health crisis to be supported at the earliest opportunity, and provide police officers with advice and referral options. The team was part of the partnership response to the Crisis Care Concordat and is funded by the Cambridgeshire Police and Crime Commissioner and Peterborough City Council.
- The new model will also provide patients with the opportunity to self-refer into the services.

Phase one of the mental health Vanguard programme launched in April in Cambridge, to start to improve how we support people in mental health crisis out-of-hours. Once funding is confirmed the next stage of the programme will launch. We plan to roll out the new model of care in three phases over 2016. The phased rollout will enable us to look at mental health referrals into the emergency system and evaluate the benefits of the new service.

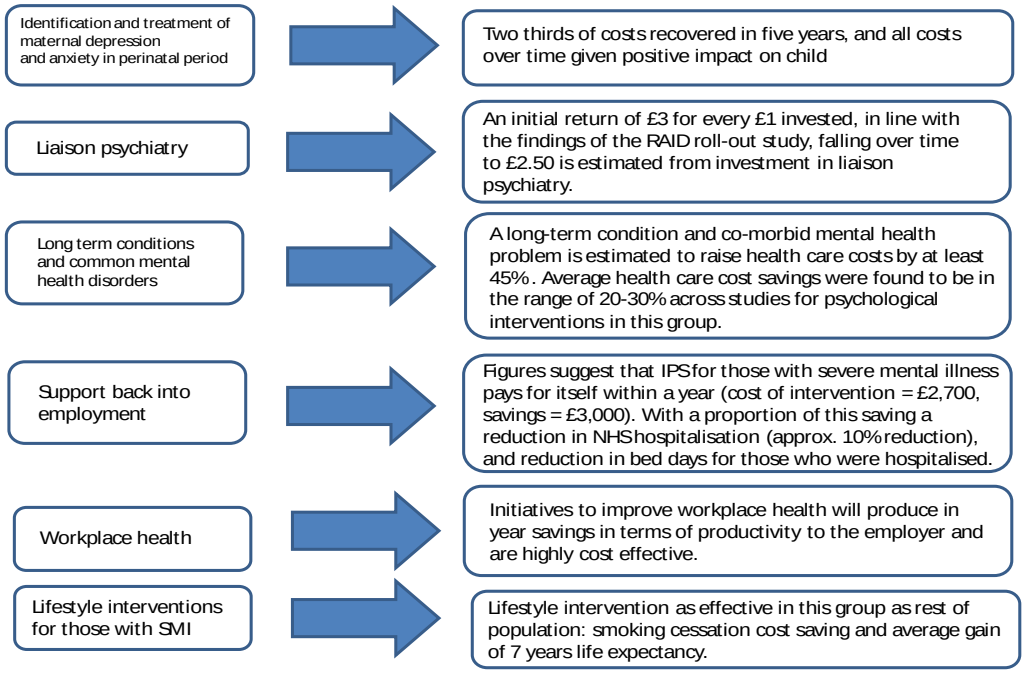
Within acute medical and surgical settings we will build on work which has already been carried out locally to develop liaison psychiatry; interventions for frequent attenders in the Emergency Department and those with medically unexplained symptoms; and building on existing and developed training to facilitate the provision of education and training opportunities for staff to adopt a holistic, integrated approach at the interface of physical and mental health.

2.4. How will we deliver our vision?

Delivering this strategy will require investment, and a detailed, costed programme plan for each element of implementation. The *Five Year Forward View for Mental Health* makes it clear that mental health services have been chronically underfunded, and estimates a requirement in England for an additional £1 billion investment by 2020/21 to help plug the gaps in the care that the NHS is currently unable to provide. We receive a proportion of this investment locally. We estimate that our share of this **additional investment will equate to £12.8m by 2020/21** (based on the funding formula in use in June 2016).

Additional investment is a fundamental requirement if we are to achieve parity of esteem between mental and physical health, but it is important to note that this strategy is not a detailed investment strategy, and there remains much work to be done to develop, cost and plan the key priorities highlighted here. It is clear from our high level costing work that the estimated additional investment of £12.8m is unlikely to be enough to achieve full implementation of the five year forward view or indeed this strategy by 2020/21. In particular this is the case as we have taken a system wide view of mental health, as we believe this is the best route to improved outcomes for patients, rather than only focusing on the Five year forward view priorities. Given the financial position of the CCG and both local authorities how we work together to maximise the value of any available investment is critical. We will be seeking to:

- Focus the additional investment to implement the Five Year Forward View for Mental Health on our key priorities.
- Maximise our opportunity to access any nationally available funding for specific mental health initiatives.
- Maximise our ‘invest to save’ opportunities, some of which are highlighted in the diagram below and at Annex D.
- Continue to ensure mental health provision is part of our core STP work on long term conditions, and primary and integrated neighbourhoods.
- Maximising our opportunities to improve quality within current services.
- Working together cross system to the principles of collaborations and logistics set out below.



As we develop our services and pathways, it is essential that we work to a set of principles to demonstrate that our proposals have been developed and implemented on the basis of consensus and collaboration, and with the best available evidence.

To achieve our goals, we will behave with transparency and openness, communicating clearly to develop collaborative consensus-based solutions, engaging widely, working as a system in the interests of the people and communities we serve.

We will work to the following principles and behaviours:

- We will put people and their families and carers at the heart of what we do, and ensure they are engaged in the design and planning of services.
- We will use evidence based solutions where possible, using data to drive and evaluate out progress. We will base our work on the best available knowledge and information.
- We will work to meet the diverse needs of the population, focusing on ensuring equity of access to care and support across our communities.
- We will focus on outcomes that are important for people and their families and carers, not on activity alone, and agree and align these with stakeholders and across agencies.
- We will seek where ever possible to embed consideration of mental health within physical health services.

2.5. Principles of Collaboration and Logistics

We will work together as partner organisations in Cambridgeshire and Peterborough to improve the system of care and support so that people are helped to help themselves live well, receive help when they need it for their mental health, and are supported in their recovery from mental health problems.

Next steps for our system cannot be delivered without collaboration across many organisations and individuals.

2.5.1. A common language

We will establish a common language that will give us the assurance we are able to work effectively and efficiently as a whole system. This will ensure that our pathways are well defined and can be navigated by any provider or user of the system, that we understand who staff working in our services are and what they do, and that we have a common framework for talking about risk.

2.5.2. Joint outcomes

We will establish a joint outcomes framework for mental health across the health and social care system.

2.5.3. Information and data sharing

Provision of the best quality and most appropriate services to children and adults in need of help and support can only be delivered if agencies have access to the correct information about service users' individual circumstances. Effective cross agency information quality and transparency is also key to ensuring an overall system that works for the population.

2.5.4. Workforce development

Greater integration means new ways of thinking, behaving and working across the whole system; and everyone working in all of our organisations will need to think differently about their role, with a clear expectation about how practice by all professionals will change to support a multi-disciplinary approach. Staff will need to develop new skills and work across traditional boundaries. Common approaches to training and development, as well as a common language across services, will be needed to achieve the full benefits of integration.

2.5.5. Property co-location

Where possible, we want staff from across the system to be co-located or able to share working space in a variety of settings. As partner organisations move towards more mobile working and reduced office space, there will need to be a better join up in relation to planning use of estates to achieve vertical or functional integration. In addition it will be important to make use of existing assets such as libraries and other community buildings to act as a point of information and advice. We will use technology to help us work more closely where we cannot be co-located and for such services as the single point of access this will be essential.

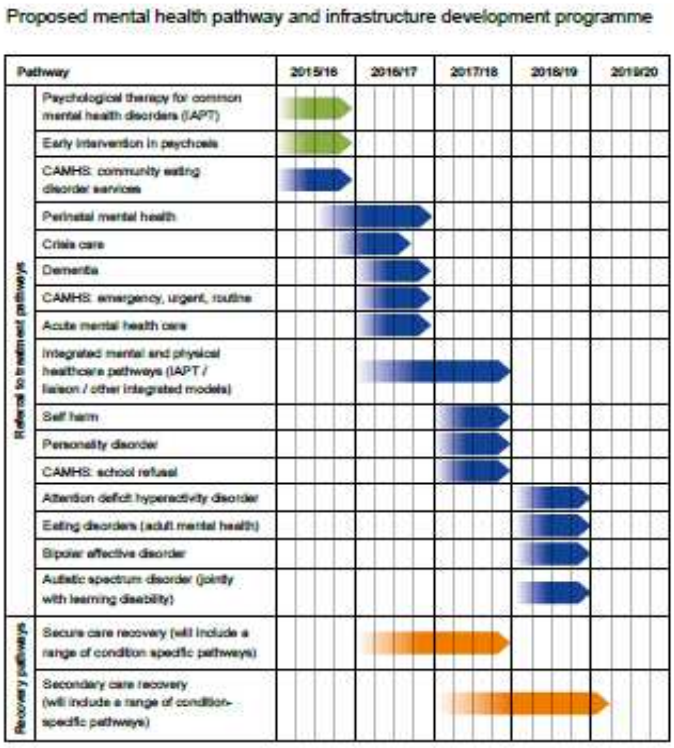
2.5.6. Joint commissioning by health and local councils working together

Service transformation is strengthened when the commissioning of services from both the statutory and voluntary and community sectors can be done jointly by the local NHS and Councils. This enables the commissioning of pathways and the delivery of coordinated services across sectors. This can be achieved through the pooling of commissioning budgets, use of the Better Care Fund pooled budget, and the encouragement of provider consortia and partnerships between the statutory and voluntary sectors. Such partnerships if properly constructed can provide greater security for third sector organisations in a difficult financial climate. The recent Vanguard First Response development was a jointly commissioned service – from a the local NHS Trust with a local voluntary sector provider. All commissioners will be looking to work more closely together, using this strategy as a roadmap , to promote

greater coordination of services and to remove duplication to the benefit of the whole health and wellbeing system.

Annex A: Task Force Priorities (p.36 The Five Year Forward View for Mental Health)

Proposed mental health pathway and infrastructure development programme



Annex B: Existing Links to Local Strategies

Cambridgeshire and Peterborough Suicide Prevention Strategy
http://cambridgeshireinsight.org.uk/health/healthtopics/mh

Public Mental Health Strategy 2015-2018
http://cambridgeshireinsight.org.uk/health/healthtopics/mh

Cambridgeshire and Peterborough Crisis Care Concordat
http://www.crisiscareconcordat.org.uk/areas/cambridgeshire/

Social Care Strategy for Adults with Mental Health Needs 2015-18
http://www.cambridgeshire.gov.uk/info/20166/working_together/577/strategies_plans_and_policies

Peterborough People and Communities Strategy
https://www.peterborough.gov.uk/council/strategies-polices-and-plans/communities-strategies/people-and-communities-strategy/

Peterborough draft health and wellbeing strategy 2016-19
https://www.peterborough.gov.uk/healthcare/public-health/health-and-wellbeing-strategy/

Cambridgeshire Health and Wellbeing Strategy 2012-17

http://www.cambridgeshire.gov.uk/info/20004/health_and_keeping_well/548/cambridgeshire_health_and_wellbeing_board

Annex C: Key local data

Mental Health – the current picture

Key points

- With a growing population Cambridgeshire and Peterborough has growing numbers of people with mental illness. In 2016 it estimated that over 88,000 adults (aged 18-64 years) in Cambridgeshire and Peterborough have a common mental health disorder – by 2021this figure will be 95,200, and by 2026 it will be 97,500.
- Suicide rates have been consistently higher than England rates in Peterborough (although this was not always statistically significant) until a drop was seen in 2012/14, making Peterborough's rates statistically similar to the England average.
- Hospital admissions rates for self-harm in those aged under 25 years are above the national average in both Cambridgeshire and Peterborough, with Peterborough the highest in the East of England.
- Patterns of service use suggest that acute 'crisis' services are being used more for mental health in Cambridgeshire and Peterborough when we compare with other areas. This is not explained by differences in population need.
- People with two or more long term conditions are seven times more likely to have depression.[7] Overall this means that locally there are an estimated 18,000 adults with two or more long term conditions with mental ill health and/or limitation, and a further 10,500 people aged 65 and over in these groups.

Prevalence levels

It is estimated that over 88,000 adults in Cambridgeshire and Peterborough aged 18-64 years have a common mental health disorder.

7% (50,417) of adults in Cambridgeshire and Peterborough were recorded by GP's as having depression in 2014/15.

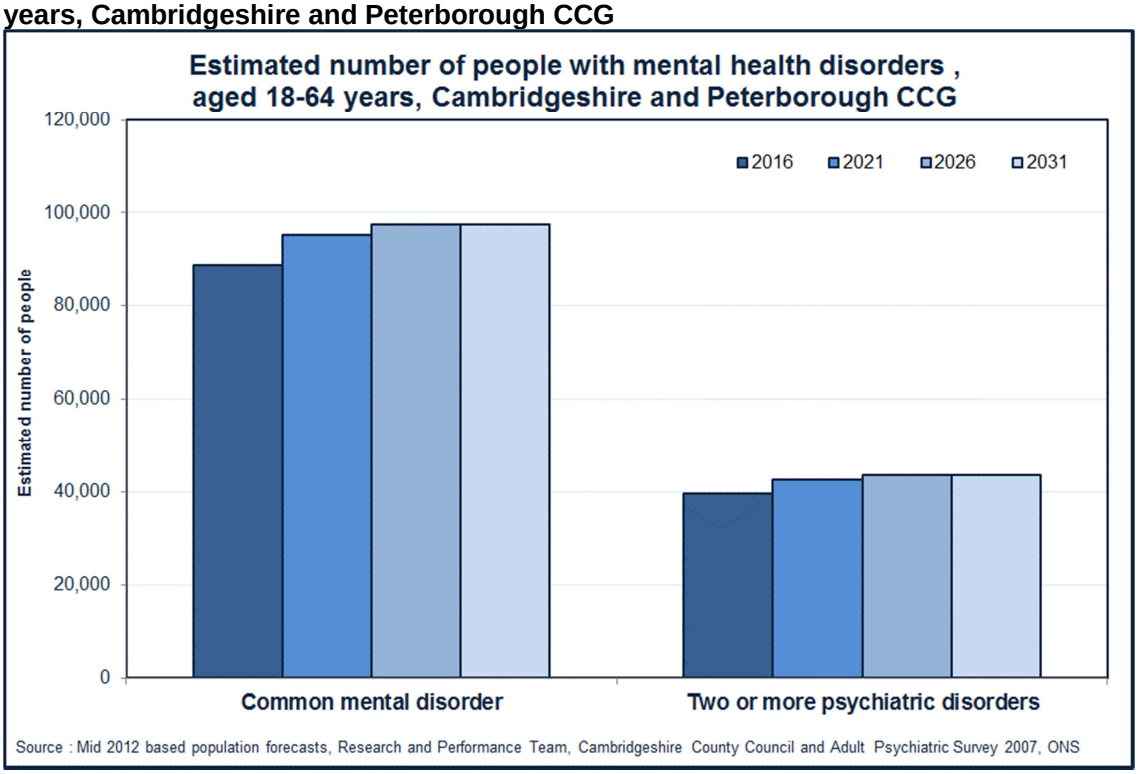
There were 775 self-harm hospital admissions in people aged 10-24 years in 2014/15 in Cambridgeshire and Peterborough. Rates are significantly worse than the England average.

7,048 patients registered in Cambridgeshire and Peterborough have a serious mental illness.

In 2016 it estimated that over 88,000 adults (aged 18-64 years) in Cambridgeshire and Peterborough have a common mental health disorder – by 2021 this figure will be 95,200, and by 2026 it will be 97,500.

[7] The King's Fund. (2012) Long-term conditions and mental health: The cost of co-morbidities.

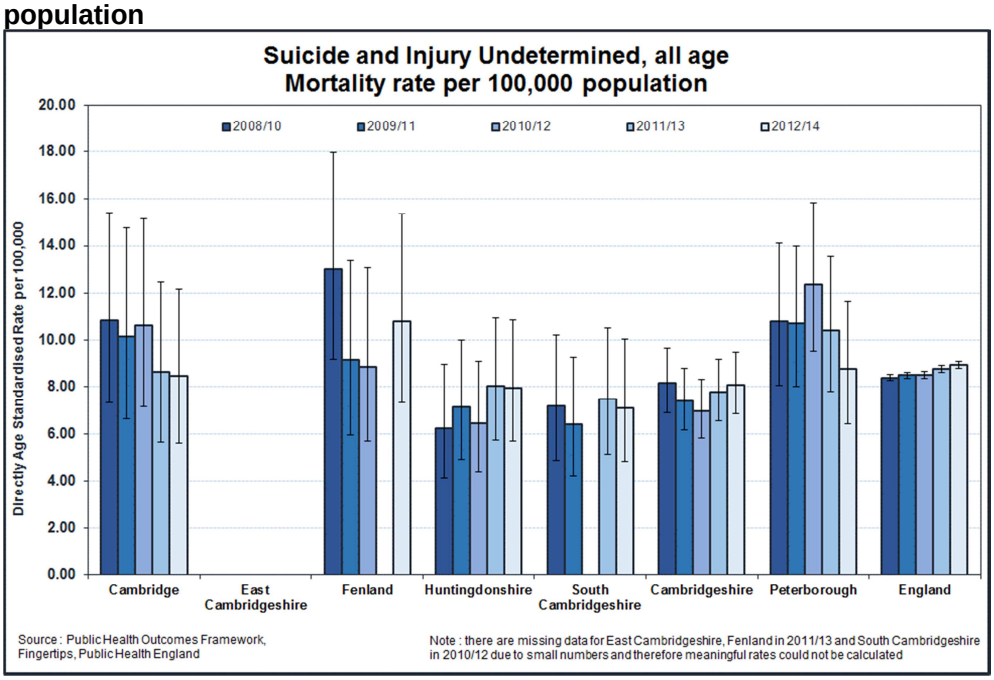
Figure 2: Estimated number of people with mental health disorders, aged 18-64 years, Cambridgeshire and Peterborough CCG



Suicide rates

Suicide rates have been consistently higher than England rates in Peterborough (although this was not always statistically significant) until a drop was seen in 2012/14. This recent improvement means that suicide rates in Peterborough are now statistically similar to the England average. Cambridgeshire rates are consistently below the England rate.

Figure 3: Suicide and Injury Undetermined, all age Mortality rate per 100,000 population



Self-harm in young people

Self-harm is understood as physical injury inflicted as a means to manage an extreme emotional state and is primarily a coping strategy.

In 2014/15 there were 775 admissions to hospital by young people (aged 10-24 years) as a result of self-harm – Cambridgeshire 567 admissions and Peterborough 208 admissions. Hospital admission rates for adult self-harm in 2013/14 for Peterborough (the latest data available) were highest in the East of England, at 40% above the average rate.

Figure 4: Hospital admissions as a result of self-harm (10-24 years)

Hospital admissions as a result of self-harm (10-24 years) 2014/15 — Directly standardised rate - per 100,000

Area	Count	Value	95% Lower CI	95% Upper CI
England	39,563	398.8	394.9	402.7
East of England region	3,723	354.7	343.4	366.3
Bedford	125	422.6	351.6	503.7
Cambridgeshire	567	477.6	439.0	518.6
Central Bedfordshire	161	358.9	305.4	418.9
Essex	650	261.2	241.5	282.1
Hertfordshire	628	314.8	290.6	340.5
Luton	135	317.8	266.4	376.2
Norfolk	640	431.9	399.1	466.8
Peterborough	208	611.2	530.9	700.2
Southend-on-Sea	109	362.6	297.6	437.5
Suffolk	462	375.4	341.8	411.3
Thurrock	38	128.9	91.1	177.0

For the time period 2013-15 in children and young people aged under 18 years around 56% of self-harm admissions in Cambridgeshire and almost a half of admissions in Peterborough had a diagnosis of mental health recorded, with the majority for mood [affective] disorders (mania, bipolar or depression).

Admissions are higher from the 40% most deprived areas in Cambridgeshire and Peterborough compared to the rest of the areas.

Treatment

Across Cambridgeshire and Peterborough attendances at A&E for psychiatric disorder is higher than the England average and bed days per 100,000 population are lower.

In Peterborough:

- Referral rates to Crisis Resolution Home Treatment are higher than the rest of Cambridgeshire.
- Use of police powers to take a person in mental health crisis to a place of safety (Section 136) occurred at a much higher rate in Peterborough population than in the rest of Cambridgeshire.

This is part explained by Peterborough having a high prevalence of risk factors for mental health, such as, socio-economic deprivation, children in care, violent crime, drugs misuse, homelessness, relationship breakdown, lone parent households, overcrowding and vulnerable populations, such as migrants and asylum seekers. However, the patterns of acute service use in Peterborough are unlikely to be entirely due to additional need within the population.

Peterborough also has lower levels of recorded depression (a common mental health disorder) than would be expected and the depression prevalence data does not correlate with areas of deprivation as we would expect.

Long term conditions and mental health

Compared with the general population, people with diabetes, hypertension and coronary artery disease have double the rate of mental health problems, and those with chronic obstructive pulmonary disease, cerebrovascular disease and other chronic conditions have triple the rate. People with two or more long term conditions are seven times more likely to have depression.[8]

Those with LTCs are at a higher risk of developing a mental illness; Table 12 shows the proportion of the CCG population aged 18-64 years that have multiple longstanding illnesses with and without limitation and/or mental ill health. 3.4% (1,900 people) are estimated to have two or more LTCs and mental ill health, whereas 28.4% (16,100 people) are thought to have two or more LTCs, mental ill health and limitation.

[8] The King's Fund. (2012) Long-term conditions and mental health: The cost of co-morbidities.

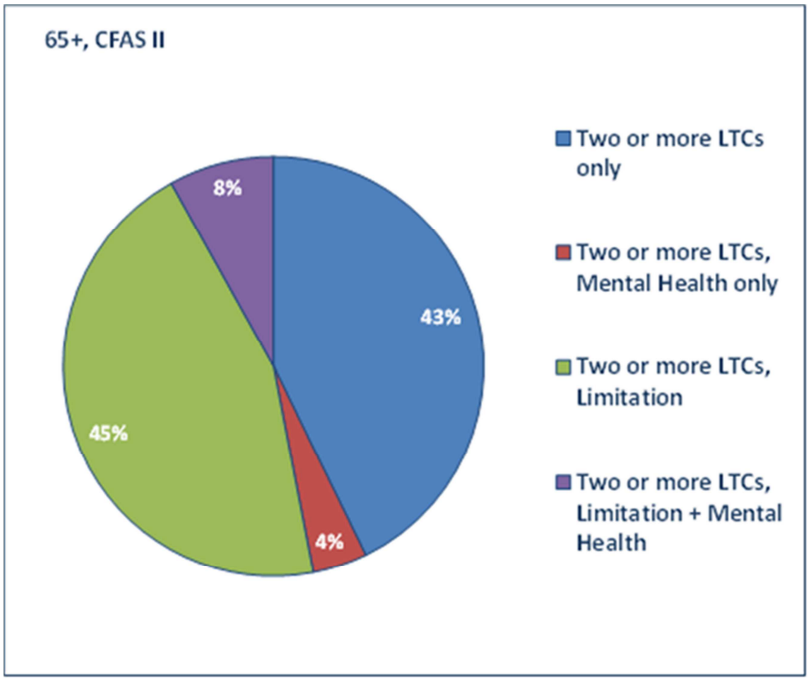
Table 3: Proportion of people aged 18-64 years with multiple (two or more) long standing illnesses with and without limitation and/or mental ill health (based on GHQ-12 score of four or more)

People aged 18-64 years with 2+ LTC	%	95% CI	Estimate of number of people in C&PCCG aged 18-64 years (2015) and range (95% CI)	
Two or more LTCs only	30.7	(26.7 - 34.9)	17,400	(15,200 - 19,800)
Two or more LTCs, mental ill health only	3.4	(2.1 - 5.3)	1,900	(1,200 - 3,000)
Two or more LTCs, limitation	37.6	(33.4 - 42.0)	21,300	(19,000 - 23,800)
Two or more LTCs, limitation + mental ill health	28.4	(24.6 - 32.5)	16,100	(1,400 - 18,400)
Total	100		56,700	

Source: Health Survey for England (2012) estimates applied to registered population. FHS Registration System (Exeter) April 2015.

Figure 5 shows data from a local study for over 65s with two or more LTCs. The data suggests that there are around 38,600 people aged 65 and over with two or more LTCs and limitation, an additional 3,600 people with mental ill health and an additional 6,900 with multiple LTCs, limitation and mental ill health (dementia, anxiety and depression). In total, it is estimated that 65,800 people aged 65 and over in C&P CCG have two or more LTCs.

Figure 5: Proportion of people aged 65 and over with multiple (two or more) LTCs with and without limitation and/or depression or anxiety (based on GMS AGECAT)



Source: MRC Cognitive Function and Ageing Study (CFAS II) (100% = people with two or more LTCs)

Overall this means that locally there are an estimated 18,000 adults with two or more long term conditions with mental ill health and/or limitation, and a further 10,500 people aged 65 and over in these groups. Prevalence of common mental health disorders is 16% in the adult population, and 10.6% in those aged 65-75 years.[9] Even at the population level of risk 3,993 people (2,880 adults and 1,113 older people) amongst this group will have common mental health disorder. Given that the risk of common mental health disorders in this group is a minimum of two of three times higher than the general population, these figures are likely to be much higher than this estimate.

[9] Psychiatric Morbidity Survey 2010.

Annex D: Potential local implications of the Five Year Forward View for Mental Health: calculations and assumptions

National commitment	Potential local implication
By 2020/21 A reduction in premature mortality of people living with severe mental illness (SMI). Physical care interventions to cover 30% of population with SMI on the GP register in 2017/18, moving to 60% in 2018/19.	Cambridge and Peterborough CCG in 2014/15 has 7,048 people with SMI (QOF data) on GP registers. Assuming levels remain the same as in 2017/18, this would mean 2,100 people with SMI (30%) will have physical care interventions, moving to 4,200 (60%) in 2018/19.
By 2020/21 25% of people with common mental health disorders will access services each year.	The Cambridgeshire and Peterborough CCG adult population (18+) is estimated to be 723,145 by 2021 (ONS population forecasts based on mid 2014). The prevalence of common mental health disorders is estimated to be 16.2% in the adult population (2007 Adult Psychiatric Morbidity Survey) or 117,150 people by 2021. 25% of this group is roughly 29,300 people with common mental health disorders.
By 2020/21, increase access to specialist perinatal mental health support in all areas in England, in the community or in-patient mother and baby units, allowing at least an additional 30,000 women each year to receive evidence based treatment.	In Cambridgeshire and Peterborough in 2014 there were 10,431 still and live births. The estimated number of women who may require additional support and/or appropriate onward referral for mental health problems during pregnancy and and/or the postnatal period is based on the NICE benchmark rate of 12% of deliveries or 120 per 1000 deliveries. This includes 4% of deliveries to women with severe and/or complex needs and 8% of women who require and take up psychological therapies. https://www.nice.org.uk/guidance/cg192 This suggests that locally annually 1,250 women will need additional support for mental health problems during pregnancy and/or the postnatal period, with approximately 420 (or 4%) of this group having severe and complex needs.
By 2020/21 at least 70,000 additional children and young people each year will receive evidence-based treatment. At least 35% of CYP with a diagnosable mental health condition receive treatment from an NHS-funded community MH services.	By 2021 it is estimated that there will be 201,000 children and Young people aged under 18 in Cambridgeshire and Peterborough. Prevalence estimates (Mental health of children and young people in Great Britain, 2004,ONS) suggest approximately 9.6% of children aged 5-16 years will have a diagnosable mental health disorder. Applying these estimates to all those under the age of 18 this suggests there would be 19,300 children and young people in Cambridgeshire and Peterborough under age of 18 by 2021 with a diagnosable mental health condition. Therefore, 6,755 (35%) of these children and young people would be receiving treatment a year by 2021*.
By 2020/21 the number of people taking their own lives will be reduced by 10% nationally compared to 2016/17 levels.'	Using 2015 as the baseline year, by 2020/21 this would mean the number of people taking their own lives will be reduced by 10% to 54 deaths from 2015 levels. **

*This is based on the 2004 psychiatric morbidity study and this is current being revised.

**A three year rolling average is a more reliable measure of progress given the small numbers.

Annex E: Further information on invest to save priorities

The Priorities for Mental Health: Economic report for the NHS England mental health taskforce highlighted nine areas for investment as follows. Further detail from this report and other relevant reports is in the table below.

Prevention and early intervention

1. Identification and treatment of maternal depression and anxiety during the perinatal period, including as a preventive measure against the development of mental health problems in children.
2. Treatment of conduct disorder in children up to age 10.
3. Early intervention services for first-episode psychosis.

Physical health conditions

4. Expanded provision of liaison psychiatry services in acute hospitals, particularly in support of elderly inpatients.
5. Integrated physical and mental health care in the community for people with long-term conditions and co-morbid mental health problems.
6. Improved management of people with medically unexplained symptoms and related complex needs.

Improved services for people with severe mental illness

7. Expanded provision of evidence-based supported employment services.
8. Community-based alternatives to acute inpatient care at times of crisis.
9. Interventions to improve the physical health of people with severe mental illness.

Initiative	Evidence*
Perinatal mental health	Some 15-20% of women suffer from depression or anxiety during pregnancy or in the first year after childbirth, but about half of all these cases go undetected and untreated. This is damaging and costly, not only because of the adverse impact on the mother but also because maternal mental illness roughly doubles the risk of subsequent mental health problems in the child. According to one estimate, the long-term cost to society of a single case of perinatal depression is around £74,000, mostly because of adverse impacts on the child. The effective treatment of mothers offers the genuine prospect of primary prevention in relation to the development of mental health problems in children. The available evidence strongly supports the provision of psychological therapy as the most effective intervention, but this is currently available to only a small minority. Improving the identification of perinatal depression and anxiety (via more screening and assessment) and providing psychological therapy to all who would benefit in line with NICE waiting time standards it is estimate would lead to subsequent reductions in health service use by both mothers and children would more than cover this cost over time, with about two-thirds of costs being recovered within five years.
Liaison psychiatry	An initial return of £3 for every £1 invested, in line with the findings of the RAID roll-out study, falling over time to £2.50 is estimated from investment in liaison psychiatry. It is important that new - and indeed existing - services are targeted at those areas of activity which the evidence suggests will yield the greatest benefits. In terms of support for inpatients, this is particularly likely to mean a strong focus on elderly people. Similarly, in emergency departments, services should seek to work with those who make heavy use of A&E, keeping a register of frequent attenders combined with regular review of these patients and proactive case management. All the financial benefits of liaison support take the form of cost savings in those acute hospitals where liaison psychiatry is provided.
Early intervention psychosis	There is a strong case for in year savings. At a unit cost of £6,000 a year early intervention for psychosis has net cost savings of £2,510 per patient in **year one** and £6,728 per patient over three years. However, we have an good existing service, as Rightcare benchmarking information shows, that is already compliant to year 2 of NICE pathways.
Psychological interventions for those with Long Term Conditions	Common mental disorders (CMDs), which include depression and anxiety, are highly prevalent with long term conditions. Evidence consistently demonstrates that people with long term physical health conditions (LTCs) are two to three times more likely to experience mental health problems than the general population, with much of the evidence relating to common mental health disorders such as anxiety and depression. The additional impact of mental illness, which can exacerbate physical health problems, is estimated to raise the total health care costs by at least 45% for each person with a long-term condition and co-morbid mental health problem. Robust UK evidence establishing cost savings for psychological interventions and screening for those with long term conditions is not available. However, on the basis of studies undertaken outside of the UK it is evident that savings sufficient to cover the cost of the intervention are likely. From a large US meta-analytical study of psychological interventions for long term conditions, average

	health care cost savings were found to be in the range of 20-30% across studies.[10] Psychological interventions ranged from psycho-education treatments to those categorised as behavioural medicine interventions. Only a small proportion of studies reported that the costs of psychological treatment exceeded the cost savings. Most of the psychological interventions lead to reductions in health care costs, and these reductions were typically large enough to fully cover the costs of the psychological interventions themselves.
Parenting programmes for conduct disorder	Estimated public expenditure savings over the seven-year appraisal period amount to £3,758 per child, to be set against an intervention cost of £1,282. In other words, every £1 invested in the programme generates savings in public spending of £2.83. The breakdown of these savings is: NHS and social care £1,207 Education £2,215 Criminal justice £336 The largest savings thus accrue to the education sector, though the savings within health and social care are also almost enough to cover the full costs of the intervention on their own. Savings in the criminal justice system are small mainly because of the short time horizon of the appraisal, and over a longer period these would become the largest single item. Public sector savings over a five-year period, confined to health/social care and education, are roughly twice the cost of the intervention.
Medically Unexplained Symptoms (MUS)	The most costly 5% of patients with MUS cost the NHS around £3,500 a year, or £10,500 over three years. This compares with an intervention cost of around £1,350 per patient, again based on the PCPCS model. If the service reduces the use of health care by just 15% a year for three years, this would more than cover the full costs of intervention. Proportionate cost savings of this magnitude are well within the range suggested by the available literature.
Employment support **Individual Placement Support (IPS)**	Individual Placement and Support (for those with severe enduring mental health problems) participants are **twice as likely to gain employment compared** with traditional vocational rehabilitation alternatives. Figures suggest (from Centre for Mental Health) that **IPS pays for itself within a year** (cost of intervention = £2,700, savings = £3,000). With a proportion of this saving a reduction in NHS hospitalisation (approx. 10% reduction), and reduction in bed days for those who were hospitalised. Current CCG IPS provision supports only a small proportion of those suitable (current investment of approx. £0.5m). The commissioning for value packs show poor CCG performance in this area compared to others.
Debt advice	Debt advice – medium level evidence, debt management intervention has better outcomes and lower costs over a two-year period compared to no action. The investment in debt advice can reduce the risk of developing mental health problems, the vast majority of the savings are in reductions in lost productivity. Debt advice services are patchy across the CCG.
Suicide prevention	It is estimated that the average cost per completed suicide for those of working

[10] Chiles et al. (1999) The Impact of Psychological Interventions on Medical Cost Offset: A Meta-analytic Review. American Psychological Association.

	age only in England is £1.67m (at 2009 prices).This includes intangible costs (loss of life to the individual and the pain and suffering of relatives), as well as lost output (both waged and unwaged), police time and funerals. The model looks at the economic case over 10 years for investing in GP suicide prevention education aimed at reducing suicide among the cohort of working age adults. Based on an earlier study,GPs who go on the suicide prevention training course will have a 20% greater chance of identifying those at risk of suicidal behaviour in the year following training.[vi] The model indicates that 603, 706 or 669 suicides would be avoided over the 1, 5and 10year time horizons, respectively. The analysis of costs/savings includes expenditure on health care, police/coroner activities, funerals, productivity and intangible costs. The additional treatment and support costs for individuals who do not complete suicide are to some extent offset by a reduction in the costs to the health care system of completed suicides and serious self harm events, but the intervention has significant net costs to the health care system of up to £19m over 10 years nationally. However, if the reductions in productivity losses are also included then the intervention is cost saving by a very large margin), and remains so even if the estimated impact on productivity is reduced to just 5% of the baseline case. Overall, net savings of £1.27bn arise over 10 years if intangible costs are also included. All results are sensitive to assumptions about the future risk of suicide.
Workforce health	The evidence shows that initiatives to improve workplace health will produce in year savings in terms of productivity to the employer. Some studies suggest that there is a return on investment of approximately £9 for every £1 spent in terms of improved productivity to the employer. ➢ The potential mental health productivity savings, assuming no current action in this area, amount to nearly £5.7m across the large NHS employers in Cambridgeshire and Peterborough. ➢ The evidence and modelling is clear that investing in workforce health will generate short term productivity savings to the NHS. These are estimated, with the package modelled here to be approximately £3.9m over three years, with an investment of £335k. ➢ NHS employers should see considerable productivity savings from investing in workplace health. In particular this needs to focus on improved management and awareness of mental health and illness.
Lifestyle interventions to improve the health of those with severe mental illness (SMI)	The prevalence of smoking is particularly high among mental health service users and interventions are just as effective in this group as in the rest of the population. Smoking cessation has been shown to be perhaps the single most effective and cost-effective intervention in the whole field of public health. Estimated savings are £100.8 million, spread over a number of years, due to reduced smoking-related NHS costs. More profoundly, those successfully quitting would on average gain an increase in life expectancy of around seven years.
Community-based alternatives to acute psychiatric inpatient care for people with severe mental health illness at times of crisis	There is growing evidence that when implemented as intended Crisis home resolution teams are effective in reducing admissions and reducing length of stay in hospital without any adverse impact on clinical outcomes. They are also preferred by patients. Initiatives, such as the mental health first response Vanguard service locally anticipate an impact on reducing attendances and admissions at A&E (10% - 30% reduction in avoidances overall in year as shown in other areas), aiming for 2-3 years to break even financially.

*adapted from Health System Prevention Strategy for Cambridgeshire and Peterborough (Jan 2016), and Priorities for Mental Health: Economic report for the NHS England mental health taskforce. Centre for Mental Health (Jan 2016). Mental health promotion and mental health prevention: the economic case. LSE/PRSSU April 2011.

Additional Key References:

Health System Prevention Strategy for Cambridgeshire and Peterborough January 2016
http://cambridgeshireinsight.org.uk/health/healthcare/prevention

Peterborough Mental Health and Mental Illness of Adults of Working Age
https://www.peterborough.gov.uk/healthcare/public-health/JSNA/

Suicide Audit
http://cambridgeshireinsight.org.uk/health/healthtopics/mh

The Mental health of Children and Young People in Cambridgeshire 2013
http://cambridgeshireinsight.org.uk/joint-strategic-needs-assessment/current-jsna-reports/mental-health-children-and-young-people

Fingertips
http://fingertips.phe.org.uk/

Public Health Outcomes Framework
http://cambridgeshireinsight.org.uk/health/phof