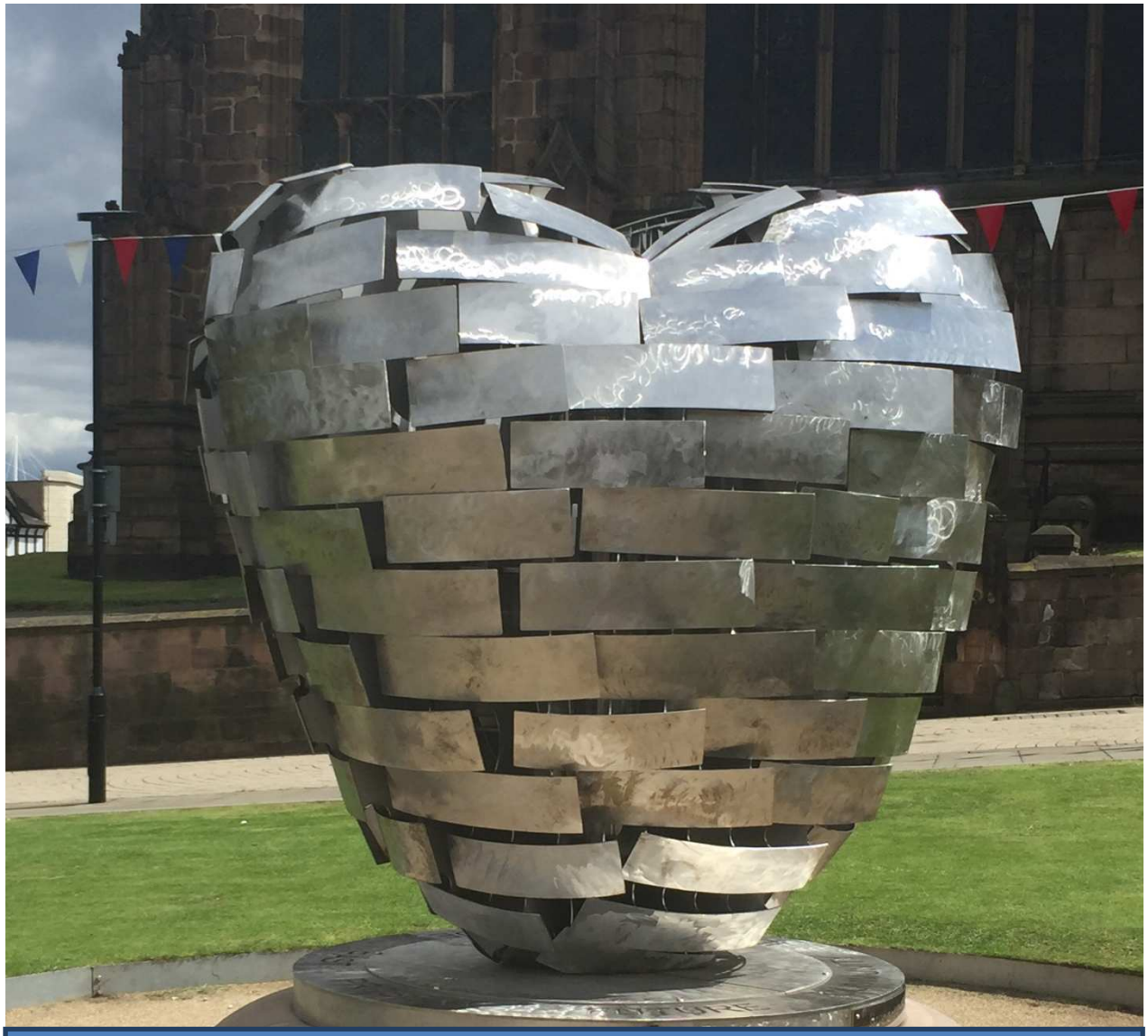


'putting mental health at the heart of all services in Rotherham'

Interim Rotherham Mental Health Strategy 2016-18

Rotherham Metropolitan Borough Council

Foreword

This overarching Interim Mental Health Commissioning Strategy for Rotherham is intended to provide a baseline position from which the Council can build its commissioning intentions. The strategy will encourage a shift of investment towards prevention and early intervention over the next 18 months. This approach will also have a strong focus on recovery based approaches for people who require more intensive residential based care and align closely to the strategic priorities of the Rotherham CCG. The interim strategy supports the Health and Wellbeing Strategy and it should be considered with other strategies which can have a positive impact on mental health, such as: the Emotional Wellbeing & Mental Health Strategy for Children & Young People 2014-19; Rotherham Carers Strategy (2016) (draft); the Rotherham Autism Strategy 2016 (draft); the Rotherham CCG Commissioning Plan, 2016-20; the Rotherham Corporate Plan 2016-17; RDaSH Transformation Plan, 2016.

At a time of increasing pressures on funding it is important that we focus our resources on those who need the most support, whilst continuing to enable those with lower needs to improve or maintain their mental health, wellbeing and independence. We will continue to recognise the contribution that positive emotional health can have on *all* aspects of health and wellbeing.

Mental health disorders do not just affect individuals but also their families, friends and colleagues. Sickness absence due to mental health problems costs the UK economy £8.4 billion a year and also results in £15.1 billion in reduced productivity. Mental ill health is the largest single cause of disability in the UK, representing up to 23% of the total impact of ill health. The total cost of mental health in England is estimated to be around £105 billion and it has been estimates that cost of health services to treat mental illness could double over the next 20 years.

The Art work has been provided by service users accessing MIND and Wellgate Court

Key Facts

Mental health conditions account for 23% of the burden of disease in England *(compared to 16% for cancer and 16% for heart disease) but comprise just 13% of NHS spending*

Over half of those with mental health problems experience symptoms before the age of 14 and 75% by age 18

1 in 10 children between the ages of 5-16 has a mental health problem (*5640 in Rotherham*)

People with severe mental illnesses die on average 20 years earlier than the general population

Carers of people with long-term illness and disability are at greater risk of poor health than the general population, and are particularly likely to develop depression

People with mental health problems often:
have fewer qualifications

- find it harder to obtain and stay in work
- have lower incomes
- are more likely to develop chronic diseases such as cardiovascular and respiratory diseases
- are more likely to be homeless or live in unsecured housing
- have poor health due to risk taking behaviours, eg

Suicide is the leading cause of death among young people aged 20-34 in the UK.
Those at highest risk are men aged between 45 and 59
Between 2010 -14 there were 96 suicides in Rotherham,76 were males.74 were aged 20-59(62 males,12 females)

Contents

The Art work has been provided by service users accessing MIND and Wellgate Court

The Vision for Mental Health in Rotherham

'putting mental health at the heart of all services in Rotherham'

Plan on a page

The Vision for Mental Health in Rotherham

'putting mental health at the heart of all services in Rotherham'

Needs of the Population

- *Adults with mixed anxiety and depression (9%), 10,187*
- *Adults with general anxiety(4.4%), 8,852*
- *Adults with depression (2.3%) 4627*
- *Adults with Psychosis (0.4%) 805*

The Five Year Forward View for Mental Health (2016)

Three key themes in the strategy:

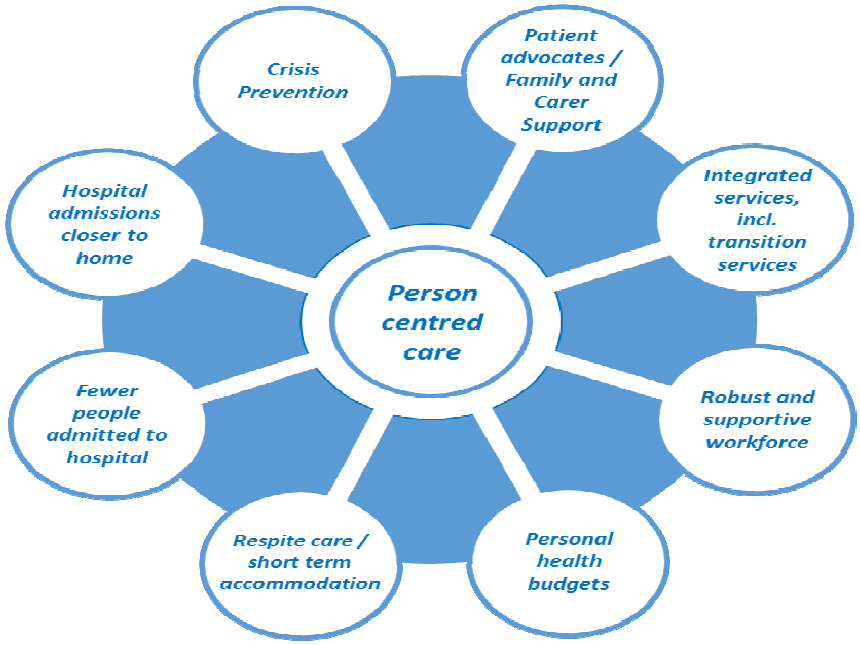
- High quality 7-day services for people in crisis
- Integration of physical and mental health care
- Prevention

Rotherham Together Partnership Plan 2016/7

- Bringing people together
- Opportunity and equality
- Welcoming places

Rotherham CCG Vision :

"Your Life, Your Health; Working with the people of Rotherham to sustain and improve health services, to improve health and to reduce health inequalities"



Outcomes

- Ensure all care is based on needs, with services users at the centre
- Learn from and embed best practice in the provision of mental health services
- Promote emotional health and wellbeing for all , thereby reducing the stigma of mental ill health
- Promote recovery and ensure all placements are least restrictive possible
- Fewer avoidable hospital admissions and reduce the use of residential care placements, including out of area placements
- Address the health inequalities in mental health, such as the mortality rates for those with severe and enduring mental health and the increased prevalence and use of restrictive practice amongst certain social groups
- Promote community assets and social inclusion
- Improve the user experience of social care
- Ensure that transition does not result in service users falling out of treatment, due to a lack of service provision.
- Support families and carers in their support of users
- Improved and appropriate sharing of information, and joint assessments between agencies

The Strategic Priorities

1: Individuals, families and communities are supported to maintain positive mental health and health

2. Effective, needs led, evidence based mental health services are in place, which are cost effective, person centred, safe and integrated across primary and secondary care and health and social care

3. Care and support services are delivered in the least restrictive setting, with a focus upon recovery and social inclusion

1. Introduction

1.1 Mental health affects us all, even though we sometimes find it hard to talk about. National statistics suggest that at any one time, at least one person in six is experiencing a mental health condition, and over a lifetime one in four will experience poor mental health. Depression and anxiety affect about half of the adult population at some time in their lives.

1.2 This Strategy contains an Implementation plan, which will be monitored and reviewed, to ensure that positive actions are undertaken to improve the mental health services in Rotherham.

2. Mental Health prevalence in Rotherham

The population of Rotherham in 2014 is estimated at 260,100, with approx. 90% being white British. The largest BME communities being Pakistani/Kashmiri and Slovak/Czech Roma

The age profile is:

- 21.7% of the population were aged 0-18 (56,400)
- 53.7% of the population were aged 18-59 (139,600)
- 24.6% of the population were aged 60+ (64,100)

The age profile for Rotherham is slightly older than the national average, with a lower proportion aged 16-44 and a higher proportion aged 45-74

2.1 Children and Young people

- 1 in 10 young people will experience a mental health problem.
- Over half of mental health problems in adult life (excluding dementia) start by age 14 and 75% by age 18.
- One in Four (26%) young people in the UK experience suicidal thoughts, though this can lead to actual physical harm, most commonly by cutting; 87% of young people who self-harm do not seek treatment from an acute hospital
- Among teenagers, rates of depression and anxiety have increased by 70% in the past 25 years, particularly since the mid 1980's.
- A recent study of young people of Asian origin in the UK found that the suicide rate of 16-24 year old women was three times that of 16-24 year old women of white British origin
- Rates of psychiatric disorder are up to four times greater in children with chronic physical illness than in children who are physically well.

2.2 Adults

- 1 in 4 people will experience a mental health problem in any given year
- 9 out of 10 people with mental health problems experience stigma and discrimination.

- In England women are almost twice as likely to be diagnosed with anxiety disorder, compared to men
- In 2013 6,233 suicides were recorded in the UK for people aged 15+; of these 78% were males
- 30% of people with a long term condition(LTC)- eg diabetes, CHC,COPD have a mental health problem and 46% with a mental health problem also had a LTC
- 40 % of Older people living in care homes are affected by depression
- 9 out of 10 Adults with mental health problems are supported in primary care
- Just 43% of people with mental health problems are in employment

2.3 Rotherham specific Mental Health data

2.3.1 Given the absence of a Joint Strategic Needs Assessment for Mental Health, to determine the actual prevalence of mental health, in Rotherham, national studies have been applied. However this cannot reflect the impact of a range of factors that affect prevalence in Rotherham, including deprivation; employment; housing; culture, race etc.

2.3.2 **The UK Wellbeing survey of 2013,** which found that nearly 1 in 5 people in the UK aged 16+ showed symptoms of anxiety and depression, *this equates to approx. 42,000 people in Rotherham.*

2.3.3 **The Adult Psychiatric Morbidity Survey** (2007), in England, found that 16.2% of adults met the diagnostic criteria for at least one common mental health problem in the week prior to being surveyed. From this figure, more than half of the adults presented mixed anxiety and depression (9%), 4.4% met the criteria for general anxiety, and 2.3% met the criteria for depression. The overall prevalence of psychotic disorder was 0.4%

This equates in Rotherham, to:

- *Adults with mixed anxiety and depression (9%), 10,187*
- *Adults with general anxiety(4.4%), 8,852*
- *Adults with depression (2.3%) 4627*
- *Adults with Psychosis (0.4%) 805*

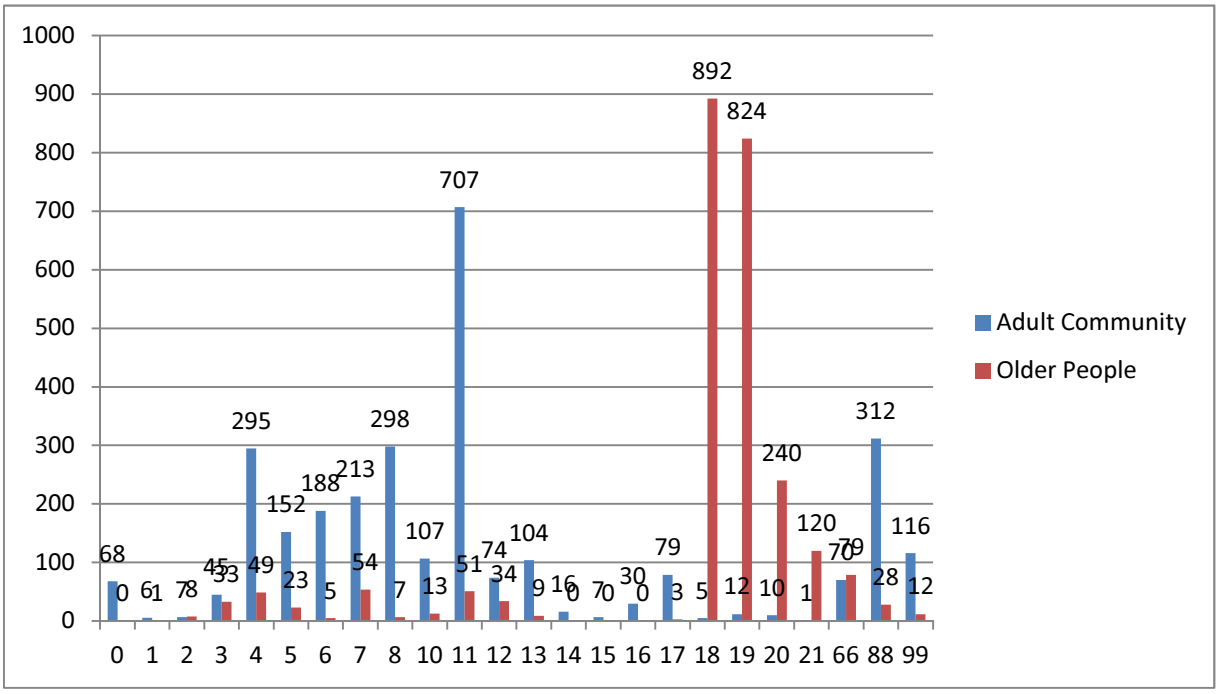
2.3.4 **Public Health England publish mental health data, based on CCG data**,(see Appendix ii)

Indicator	Period	England	Rotherham
% People estimated to have any common MH disorder (age16-74)	2014/5	15.62	15.54
% of GP patients with depression on GP register	2012/3	5.8	8.9
Anti-depressant prescribing: average daily quantities	2013/4	1.2	1.6

Dementia- recorded prevalence- all ages	2014/5	0.7	0.9
Psychotic disorder : estimated % of people aged 16+	2012	0.40	0.37
No with SMI known to GPs - % on register	2012/3	0.84	0.84
GP prescribing of drugs for psychoses and related disorders per 1,000 population	2013/4	43.8	37.0
Use of MH services by BME groups	2012/3	8.6	3.7
New cases of psychosis served by EI services, per 100,000	2013/4 Q4	24.9	24.7
Rate of people treated by EI teams, per 100,000	2013/4 Q4	39.1	60.8
% CPA adults in employment	2013/4 Q4	6.8	4.1
% CPA in settled accommodation	2013/4 Q4	59.4	74.1
Social Care MH users in residential care or receiving home care aged 18-64	2012/3	6.8	4.1

2.3.5 RDaSH data

- 829 Adults were referred into IAPT in the period May 2015 to April 2016 and 383 entered treatment.



3. Adult Mental Health services and spend

3.1 Services

3.1.1 Rotherham covers 110 square miles of urban, suburban and semi rural environments, with 70% being open countryside; the services in Rotherham need to reflect this, as transport may be an issue.

3.1.2 The CCG commission Rotherham, Doncaster and South Humberside NHS Foundation Trust (RDaSH) to deliver mental health services in Rotherham. The services are separated into primary and secondary care.

3.1.3 Primary care services include Talking Therapies/IAPT (Improving Access to Psychological Therapies); secondary care services include inpatient services and various community services, which are currently based on care clusters (see Appendix iv). For all those requiring secondary care services there is a Single Point of Access for all which provide triage and assessment.

3.1.4. However following consultation the secondary care services are being transformed, with new care pathways being developed.

3.1.5. The CCG also commission a number of Voluntary organisation to deliver Social prescribing for those with long term conditions, which may also include mental health co-morbidity; and also for mental health service users in clusters 7 and 11 (see Appendix iv), to support their discharge from secondary care mental health services.

Mental Health Social Prescribing session

3.1.6. Rotherham MBC commission services, through Public Health and also social care. The social care services commissioned include:

i. Day provision from MIND and also at Wellgate Court
ii. Supported Housing and floating support
iii. Residential care. In August 2016, there were 37 mental health placements; 11 of which are Out of Area (29.7%), however only 2 (5.4%) placements are outside South Yorkshire. The costs of Out of Area packages of care range from £500-£2500 per week and most service users stay in these placements for 1-2 years.

3.2 Spend

3.2.1 NHS England has estimated that poor mental health carries an economic and social cost of £105 billion a year in England. Analysis found that the national cost of dedicated mental health support and services across government departments in England totals £34 billion each year, excluding dementia and substance use.

3.2.2 Both the NHS and social care face significant financial challenges over the next few years. Overall spending in local government has reduced significantly over the past five years and is projected to continue to decline in real terms. The NHS Five Year Forward View sets out a "mismatch between resources and patient needs of nearly £30 billion a year by 2020/21" with an expectation that action will be required on three fronts – demand, efficiency and funding. All commissioners recognise the importance of good mental health services and will continue to focus on all three areas of managing demand, improving efficiency and providing funding where possible.

3.2.3 In 2015/6 Rotherham MBC spent £4.6m on mental health social care services and the CCG, in 2014/15 spent £33.5 million on all age mental health, with planned spend for 2015/16 is £35 million.

3.2.4 Break down of spend, Rotherham MBC:

Day Opportunities

Name of Service and Provider Organisation	Planned Expenditure	Number of places commissioned
Wellgate Court - RMBC		
MIND	£105,000 (includes 10 people on floating support)	50

Supported Living

Name of Service and Provider Organisation	Planned Expenditure	Number of places commissioned
Elliot Court (Action Housing)	£105,000	16
Beaconsfield Road & Carlisle Street (MIND)	£50,992	5
Browning Court & satellites (South Yorks Housing)	£183,120	26
Burns Court (South Yorks Housing)	£154,674	10

Crisis House

Name of Service and Provider Organisation	Planned Expenditure	Number of places commissioned
Cedar House (Rethink)	£259,099	4

Residential Care

Name of Service and Provider Organisation	Planned Expenditure	Number of places commissioned
Various Residential Care Providers in Rotherham Borough and nationally	£1.4m	50 (38 residential care, 12 nursing)

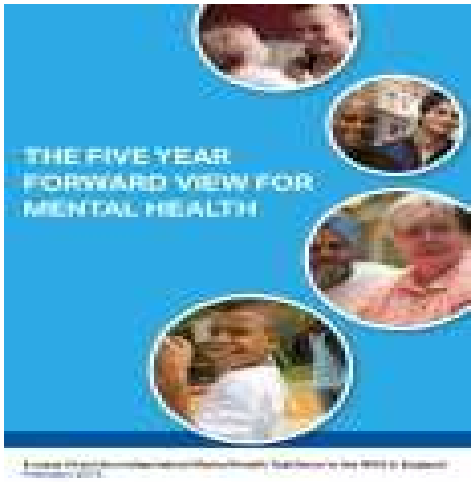
3.2.5 NHS England also commission Adult mental health services, including the following inpatient services: low, medium and high secure; mother and baby; deaf mental health. They also commission Gender Identity services.

4. National, Regional and Local Strategies

There are a number of recent National, regional and local mental health strategies that has been taken into account when preparing this document

4.1 National Strategies

4.1.1 **The Five Year Forward View for Mental Health (2016)** and the subsequent Implementation plan (July 2016) set out the transformation that will be required to mental health services; including targets to be achieved.



The Prime Mister, David Cameron, on publication stated: "….has set out how we can work towards putting mental and physical healthcare on an equal footing and I am committed to making sure that happens."

4.1.1.1 The Strategy covers all ages and there are three key themes in the strategy:

- High quality 7-day services for people in crisis
- Integration of physical and mental health care
- Prevention

Implementing this Strategy will largely rests with Rotherham CCG however there will be a need to engage with all partners, including the Council

4.1.1.2 There is also a focus on targeting inequalities and supported by 58 recommendations for the NHS and system partners and £1bn additional NHS investment by 2020/21 to help an extra one million people of all ages.

4.1.1.3 The report found that:

- An estimated that up to three quarters of people with mental health problems receive no support at all.
- People with severe mental illness are at risk of dying 15 - 20 years earlier than other people.
- In a crisis, only 14% of adults surveyed felt they were provided with the right response.

4.1.1.4 Priority recommendations for the NHS in the strategy.
Priority 1: A 7 day NHS – right care, right time, right quality

Key recommendations for 2020/21:

- No acute hospital should be without all-age mental health liaison services in emergency departments and inpatient wards.
- A 24/7 community-based all age mental health crisis response should be available in all areas across England and services should be adequately resourced to offer intensive home treatment as an alternative to an acute inpatient admission.
- At least 10% fewer people should take their own lives through investment in local multi-agency suicide reduction plans.

4.1.1.4 Priority 2: An integrated approach to mental and physical health care

Key recommendations for 2020/21:

- 30,000 additional women each year should have access to evidence-based specialist mental health care during the perinatal period.
- There should be an increase in access to evidence-based psychological therapies to reach 25 per cent of need. There should be a focus on helping people who are living with long-term physical health conditions or who are unemployed. There must also be investment to increase access to psychological therapies for people with psychosis, bipolar disorder and personality disorder.
- 280,000 more people living with severe mental illness have their physical health needs met by increasing early detection and expanding access to evidence-based physical care assessment and intervention.

4.1.1.5 Priority 3: Promoting good mental health and preventing poor mental health

Key recommendations for 2020/21:

The best start in life:

- Implement the whole system approach described in Future in Mind, helping 70,000 more children and young people to access high quality care.

Employment:

- Up to 29,000 per year more people should be supported to find or stay in work each year through increasing access to psychological therapies for common mental health problems (described above) and doubling the reach of Individual Placement and Support (IPS).
- Ensure that qualified employment advisers are fully integrated into expanded psychological therapies services.
- Identify how the £40 million innovation fund and other investment streams should be used to support devolved areas to jointly commission more services that have been proven to improve mental health and employment outcomes

Justice:

- Establish a comprehensive health and justice pathway.
- Expand Liaison and Diversion schemes nationally.

Housing:

- Explore the case for using NHS land to make more supported housing available

- Use evidence to ensure that the right levels of protection are in place under the proposed Housing Benefit cap to Local Housing Allowance levels for people with mental health problems who require specialist supported housing.

4.1.1.5 Priority 4: 'Hard-wiring' mental health across the NHS

System transformation:

- Promote equalities and reduce health inequalities in mental health through leadership and transparency
- Integrate commissioning for prevention and quality
- Establish comprehensive access pathways and standards for mental health (across conditions, ages and settings)
- Promote a co-ordinated approach to innovation and research • Produce and deliver on a multi-disciplinary workforce plan
- Improve data and transparency, including a MH FYFV dashboard
- Reform payment and incentives to move away from unaccountable block contracts
- Update the regulatory framework
- Establish strong leadership (local, national and cross-Government) for a mentally healthy society

4.1.2 'No Health without Mental Health (2011)'

This was a Government strategy for England and paved the way for increase integration of mental health into the physical health and emphasised the that people can and do recover from mental illness

The six priorities in the strategy were:

- More people will have good mental health
- More people with mental health problems will recover
- More people with mental health problems will have good physical health
- More people will have a positive experience of care and support
- Fewer people will suffer avoidable harm
- Fewer people will experience stigma and discrimination

4.2 Regional

4.2.1 Development of Sustainability and Transformation Plans (STP)

4.2.1.1 The STP for Rotherham includes the Bassetlaw and South Yorkshire CCGs/Local Authorities and covers the period October 2016 to March 2021. The STP will outline how local services will evolve and become sustainable over the next five years – ultimately delivering the Five Year Forward View vision of better health, better patient care and improved NHS efficiency.

4.2.1.2 NHS England have suggested the following mental health services that could be effectively commissioned across a STP area, such as South Yorkshire and Bassetlaw could include:

- Liaison mental health services
- Addressing physical health needs of people with SMI
- Holistically addressing mental and physical health needs via IAPT
- Children and young people's local transformation plans (LTPs)
- Perinatal mental health
- Delivering the well pathway for dementia/ innovative care packages for dementia e.g., care home vanguard
- Co-commissioning for tertiary services inc. CYP/ Secure/ ED/ CAMHS tier 4
- Employment/ Health join up including IPS and IAPT
- Housing and Health join up
- Single point of 24/7 access to MH Crisis Care

4.3 Local Strategies

4.3.1 The Rotherham Joint Health & Wellbeing Strategy 2015-18

The joint health and wellbeing strategy sets out the priorities that the local health and wellbeing board will deliver to improve the health of people in the borough. The

strategy and its priorities have been developed based on evidence of local need described in the Joint Strategic Needs Assessment.

The six priorities are:

- Prevention and Early Intervention - Rotherham people will get help early to stay healthy and increase their independence
- Expectations and Aspirations - All Rotherham people will have high aspirations for their health and wellbeing and expect good quality services in their community, tailored to their personal circumstances
- Dependence to Independence - Rotherham people will increasingly identify their own needs and choose solutions that are best suited to their personal circumstances
- Healthy Lifestyles - People in Rotherham will be aware of Health risks and be able to take up opportunities to adopt Healthy lifestyles
- Long-term Conditions - Rotherham people will be able to manage long-term conditions so that they are able to enjoy the best quality of life
- Poverty - Reduce poverty in disadvantaged areas through policies that enable people to fully participate in everyday social activities and the creation of more opportunities to gain skills and employment.

4.3.2 Rotherham CCG Commissioning Plan 2015-19

4.3.2.1 The Vision is “Your Life, Your Health; Working with the people of Rotherham to sustain and improve health services, to improve health and to reduce health inequalities”

4.3.2.2 In relation to mental health, the overarching priority is to deliver 'parity of esteem' - ensuring that people with mental health problems are treated with the same priority and urgency as people with physical health problems

5. Priorities that this Strategy need to address by 2016-18

5.1 Address Health Inequalities

5.1.1. People with severe and prolonged mental illness are at risk of dying up to 20 years earlier than other people. Two thirds of these deaths are from avoidable physical illnesses, including heart disease and cancer, many caused by smoking. McManus et al (2010) found that 42% of total tobacco consumption in England is by those with a mental disorder. People with a long term physical health condition are two to three times more likely to experience mental health problems. It is estimated treating people with long term conditions that have co-existing mental health problems costs the NHS in the region of £8–13 billion per annum. Poor mental health problems complicate physical health conditions. This leads to more time spent in hospital, poorer clinical outcomes, lower quality of life and a need for more intensive support from health services.

5.1.2. In addition individuals with mental health problems are twice as likely to experience a long term physical health illness or disability. NHS England information suggests the proportion receiving an annual physical health check ranges from 62% to 82% and basic risk assessments for long term conditions are not being carried out, for example less than a third of people with schizophrenia in hospital received the recommended assessment of cardiovascular risk in the previous 12 months. The side effects of medication and the impact on physical health (such as weight gain) must not be overlooked particularly for those with severe mental illness.

5.1.3 People who have experienced traumatic life events are more likely to experience mental health issues. In Rotherham there are a significant number of young adults who have been victims of Child Sexual Exploitation (CSE). The impact upon the victims mental health can include symptoms including: Post-traumatic Stress Disorder; Self harm; anxiety, depression, Personality Disorder; Eating Disorders and possibly Psychosis.

5.1.4. The proportion of black mental health patients is three times higher than the proportion of black people in the population; the proportion of Asian mental health patients is one third lower than the proportion of Asian people in the population – this may in part be due to historical under reporting of prevalence within the community. Black Caribbean patients are detained under the Mental Health Act at a rate 32% higher

than average; 25% higher for dual heritage patients and 6% lower for White British patients. (BRAP report, 2012)

5.2 Transitions

5.2.1 Children and Adolescent Mental Health services (CAMHS) work with those aged up to age 18, except for those with First Episode Psychoses, who have no transition based on age, except that interventions last up to 3 years.

5.2.2 The number of young people transitioning from CAMHS to adult mental health services, in Rotherham, who are both delivered by RDaSH is small. In the recent year the number was 6.

5.2.3 The small number may be due to the fact that CAMHS is organised differently to adult services; have different thresholds/criteria than adult mental health services, the latter being based on diagnoses/ care cluster allocation (see Appendix iv). Furthermore some young people they do not want to continue to receive mental health services.

5.2.4 A further explanation may be the limited number of emotional and well-being services that are available for children and young people. This is of concern given that over half of those with mental health problems (excluding dementia) experience symptoms before the age of 14 and three-quarter by age 18. This was highlighted in the Governments review of CAMHS which lead to the publication of 'Future in Mind' report of 2015. As a result CCGs have received additional funding on the completion of a Local Transformation Plan.

In Rotherham this funding was spent on the following:

- School based early intervention
- Workforce development
- Hard to reach groups
- Looked After Children
- Enhanced Community support
- Crisis response/liaison
- Autistic Spectrum Disorder post diagnosis Support
- Family Support Service – This will specifically work with families to help them to manage

- Increased funding for working with Children & Young People and adults affected by Child Sexual Exploitation
- Community Eating Disorder service

5.3 Personalisation – choice and control

5.3.1 Personalisation involves giving individuals choice and control over their support arrangements as their needs change and outcomes are met. To enable this to happen there needs to be improved information and advice on what care and support is available in Rotherham for individuals and their families. Personalisation includes increasing the involvement of service users in developing their care plans as well as being in receipt of personal budgets- be that social care or health personal budget

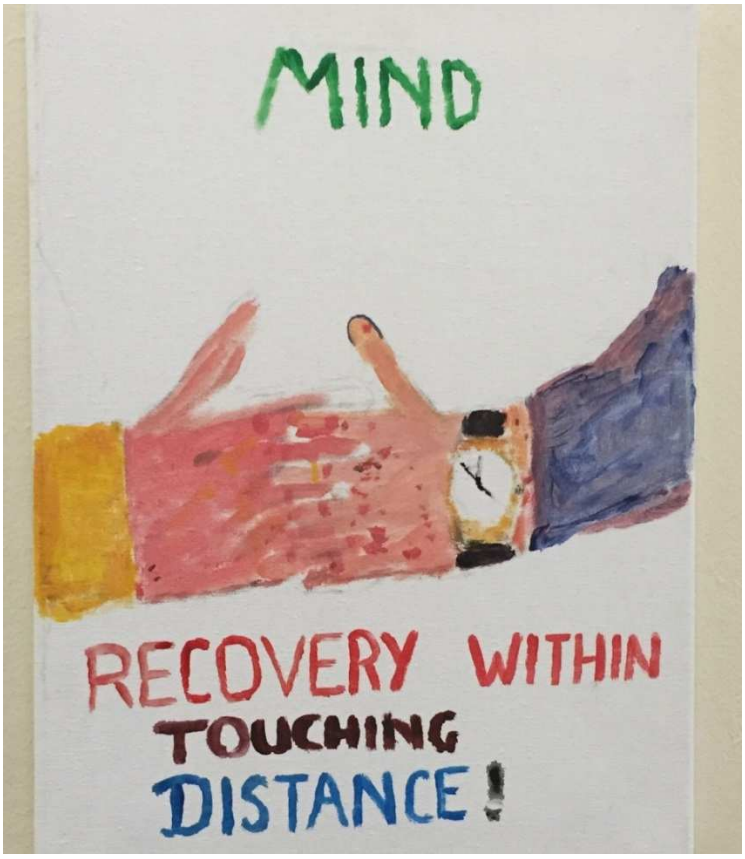
5.4 Promoting Recovery, Independence and Social Inclusion

5.4.1 Although recovery can and does mean different things to different people, but for the purposes of this strategy we are focusing on the idea that following treatment for mental ill health some people may require ongoing support to sustain wellbeing, maximise independence and become full citizens of Rotherham.

5.4.2 The priority is for services to engage people with mental health problems in treatment, therapy and activities that help them build and regain resilience, while also maintaining their place in family, community and employment; and to help them develop the skills to recognise when things are starting to go wrong as well as the expertise to manage their own treatment.

5.4.3 For this to be achievable there needs to be a comprehensive range of (NICE evidence based) treatments in Rotherham that will help people to recover from their illness and a range of supports that will help people maintain their wellbeing and avoid relapse or crisis.

5.4.4 Supporting individual's needs as they move through recovery to independence will mean different levels of support at different times. There is a need to ensure that there is a step down of intensity of service as people move from recovery to independence, together with support to access the kind of support that will help keep them well in their communities without the need for medication and/or therapy.



5.5 User and Carer Involvement

5.5.1 User and carer involvement in the commissioning of mental health services is vital due to their experience of receiving mental health services. They can contribute to commissioning through the planning, delivery and monitoring of services.

5.5.2 User and carer involvement should also be encouraged at the service delivery level to ensure that the needs of individual level users and carers are met. This can be achieved by:

- All users to be involved in the completion of the care plan and understand and agree actions and have ownership.
- Every service user receiving a care plan, which is reviewed and updated at least every 3 months
- Every carer to receive information about treatments and services to support their involvement in care planning
- Every carer to be given the opportunity to provide feed back to care coordinators about users care and treatment and raise issues of concern.

5.5.3 Users and carers will be encouraged to work with Commissioners to co-produce any changes to mental health services, in Rotherham

5.6 Carer support

5.6.1 Rotherham is developing a carers strategy; the needs of those caring for those with a mental health need.

5.6.2 The strategy acknowledges:

- The value of the support provided by unpaid carers
- The whole family relationship
- That carers need to become more resilient
- That the carer role needs to become more manageable and sustainable
- That carers need to be understood and their well-being promoted

5.7 Safeguarding

5.7.1 Safeguarding of adults is based on the premise that all adults should be able to live their lives that are free from fear or harm and have their rights and choices respected. It is acknowledge that some people are more vulnerable to abuse and so need additional protection. Abuse can take many forms and includes:

- Physical
- Sexual
- Financial
- Psychological
- Discriminatory
- Neglect or acts of omission

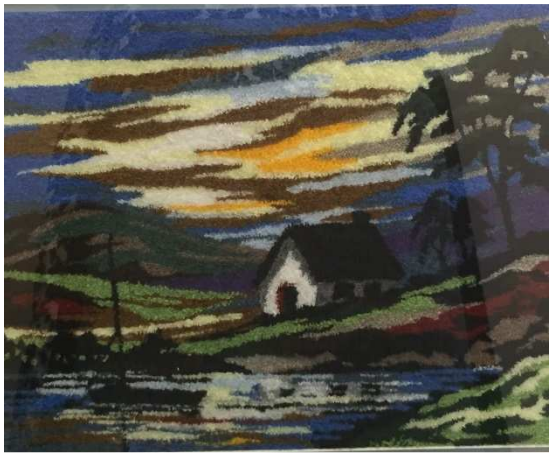
5.8 Workforce

5.8.1 The mental health workforce need to have the competencies to provide person-centred, socially inclusive and recovery-oriented services, primarily in a multi-disciplinary setting. Furthermore the focus is on early help and intervention, with the majority of care being based in primary rather than secondary care services

5.8.2. Furthermore in aiming to develop the skills and knowledge of staff who work with people with mental health problems the emphasis must be on placing the service user at the centre of the process and recognising that their perspective is of equal importance to that of the practitioner.

6. Services to promote Recovery and Social Inclusion

6.1 Housing/Accommodation



6.1.1 The Council currently work with housing and accommodation providers to support those who are at risk of losing stable housing to recovery and rehabilitation.

6.1.2 The Council will seek to review the accommodation pathway for people with mental health problems and continue discussions with providers to encourage more properties suitable for people with a mental health condition focusing on the recovery model. A major aim of recovery will be to enable people to move on from these settings to supported living or independent housing. The particular demand is for one bedroom flats/studios or self-contained provision.

6.1.3 One area of focus will be to develop services for young people, including those recovering from their first episode of psychosis, were the focus on the Early Intervention in Psychosis Service is for those experiencing their first episode of untreated psychosis; most service users will be aged under 30 years of age. The Early Intervention in Psychosis service work with service users to achieve recovery within the critical period of 3 years by focussing on all aspects of their lives, including mental wellbeing, social functioning, employment and general quality of life. Young people who are victims of CSE may also be included in the young people's recovery services/

6.2 Day Services

6.2.1 Day services play a very important role in promoting recovery and social inclusion, when those services are part of the community and are not building based. The

services can provide support, help develop new skills and increase confidence and self esteem and reduce social isolation and stigma.

produce from the Allotment group

6.2.2 In Rotherham there are currently three providers of day opportunities for those mental health issues - two of which are commissioned by the Council, one by the CCG. The Council commission MIND to run one service and also the service at Wellgate Court. Wellgate Court and MIND both provide some group work in their buildings in Rotherham town centre and Dinnington Library respectively, but the majority of users are supported to access day opportunities that are open to all residents of Rotherham. The CCG commission social prescribing for those patients leaving secondary care services and this involves developing community based services for up to 12 weeks.

6.3 Employment

6.3.1 Employment and health form a virtuous circle: suitable work can be good for your health, and good health means that you are more likely to be employed. However, nationally 43 per cent of all people with mental health problems are in employment, compared to 74 per cent of the general population and 65 per cent of people with other health conditions. For those in receipt of secondary care services the figures is small, in Rotherham only 5.2% were in employment in 2015/6.

6.3.2 The Five Year Forward View promotes employment support for people with mental health is to assist people to:

- retain employment
- gain employment

- gain skills for employment through volunteering, education, training and work experience.

6.3.2 The ambition is that by 2020/21, up to 29,000 nationally more people living with mental health problems should be supported to find or stay in work through increasing access to psychological therapies for common mental health problems and expanding access to Individual Placement and Support (IPS).

6.3.3 To increase the employment rates amongst those with a mental health need, in Rotherham will require a corporate, multi-agency approach focussing upon increase job opportunities, promotion of employability skills by all those working with service users - not just those services delivering day opportunities and needs to be included in all individual care plans.

7. How the strategies was developed

7.1 RDaSH have undertaken comprehensive consultation prior to their transformation of adult mental health services in Rotherham. In 2015/6 they consulted with 649 individuals in Rotherham, including their own staff

7.2 The RDaSH consultation (2015/6) found that stakeholders expressed a need for:

- A place based model where care is delivered closer to home
- Timely access with clear routes in
- Removal of artificial barriers such as age or narrow cluster based structures
- Reduced number of assessments
- Named contacts
- Increased close working between the NHS and the Council
- Improved transition arrangements
- A clearer process for funding application

7.3 Although there has been no formal consultation undertaken for the development of this strategy I have met with various users, carers and providers in Rotherham (see Appendix v). There is a commitment to future consultation with all stakeholders and a move to co-production, in order to agree how this Strategy will be implemented.

8. Strategy Implementation Plan

8.1 An implementation plan for this strategy is set out below:

Strategy Implementation Plan			
1: Individuals, families and communities are supported to maintain positive mental health and health inequalities are reduced			
No	**Priority**	**Action required**	**How will we know this has been achieved**
1.1	Mental health stigma will continue to be challenged to ensure that the population access early help for their mental health issues	Work with Public Health on a whole population approach to mental health	Numbers/age/gender/ethnicity accessing well-being services and Talking Therapies Numbers attending mental health first aid courses and well-being groups
1.2	Early help made for those with a common mental illness,	Ensure Talking Therapies is available and undertaking targeted interventions e.g. older adults, The whole workforce in Rotherham trained to identify mental ill health	Access and waiting time targets reached-currently 15% of the population with a common mental illness accessing services each year, rising to 25% by 2021; 75% within 6 weeks; 95% within 18 weeks and at least 50% achieving recovery
1.3	Increase the number of services which, promote positive mental health, are based in the local community	Work with local community groups and services to ensure that they are promoting positive mental health and are aware of services available	The number of services based in the local community that can evidence that they promote positive mental health and signpost onto mental health services
1.4	Reduce the incidence of suicide, especially in high risk groups	The FYFV for MH requires the development of an of a local multi-agency partnership plan by 2017	Numbers of suicide/year/age/gender
1.5	Ensure Carers receive the support required to enable them to continue to undertake their caring role	- Carers assessment to be made available, with support developed - Carers to be involved in the development of service user care plans, where appropriate	ASCOF 3C, 1D Talking Therapy services to target carers

No	Priority	Action required	How will we know this has been achieved
1.6	Ensure that mental health services are available and accessible for all members of the community; targeting of services to those who historically do not access services until they are in crisis. This includes : Older Adults; Vulnerable Adults; BAME communities; Victims of CSE; Looked After Children	Undertake regular audits/Equality Impact assessments	Audit findings of those accessing services, including crisis services
1.7	Ensure that the link between mental and physical health is understood by the whole community and that services are able to work in a holistic way	Work with primary care to develop targeting screening and intervention services for those with a serious mental illness; develop services for those with LTC that address their psychological needs	- Reduce the mortality rates for those with a serious mental illness - Increase the number receiving health screening and health promotion - Talking Therapies services to work with those with a LTC
1.8	Crisis services are available in the community to prevent the need to access	In line with the FYFV all areas have to develop a community crisis plan, building upon the Crisis care concordat	An agreed community crisis plan in place Reduction in the number of crisis admissions(both inpatient and residential care)
1.9	Effective Transition procedures in place, given that most mental illnesses have their origin in the teenage years	RMBC have set up Transition meetings and there is a mental health specific transition group led by the CCG to review the current transition policy and procedures	A joint transition Policy and Procedure for Transition in place and implemented

2. Effective, needs led, evidence based mental health services are in place, which are cost effective, person centred, safe and integrated across primary and secondary care and health and social care			
No	**Priority**	**Action required**	**How will we know this has been achieved**
2.1	Mental health services will become increasingly person centred, with care based on user's needs. Users will be offered increased choice and control over the services they receive	Providers will ensure that their services can evidence increased involvement of users in their care - Increase the number users receiving personal budgets - Advocacy services available	Numbers receiving personal budgets Numbers accessing advocacy **ASCOF- 1C,1L**
2.2	Ensure current pathways do not require multiple assessments; that they are easy to access and are NICE compliance	Review the current pathways	User and carer feedback
2.3	Ensure that when service users need to transition between mental health services this is achieved in a seamless way	Review the transition protocols between CAMHS and adult mental health services to ensure that transition is a positive experience and that there are no gaps in provision	Monitor the number of those transitioning services and track a sample of those who did not transition to
2.4	Primary care continues to be where the majority of users receive mental health services, thereby providing integrated care	Review the current services available in primary care and determine the support primary care staff require eg training	Numbers accessing and being discharged from secondary care mental health services.
2.5	Implement effective Safeguarding practice	Ensure Safeguarding procedures are effectively implemented and monitored	Safeguarding KPIs • The number of concerns made from RDaSH to the Safeguarding Adults Unit • The number of concerns received by RDaSH from the Safeguarding Adults Unit • The number of s42 further enquiries carried out • The timeliness of s42 further enquiries must be captured • Whether outcomes have been achieved

3. Care and support services are delivered in the least restrictive setting, with a focus upon recovery and social inclusion			
No	**Priority**	**Action required**	**How will we know this has been achieved**
3.1	In line with the Five Year Forward View for mental Health develop a community crisis place	Ensure that the range of community based crisis services are available to reduce the need to access hospital based crisis services, including inpatient and residential care	An agreed community crisis plan in place Reduction in the number of crisis admissions(both inpatient and residential care)
3.2	Ensure that there are a range of recovery focussed services available to prevent hospital admissions and /or reduce the length of stay	Range of local services that deliver day provision and accommodation based support in place	Number of packages in care **ASCOF- 1B,1D,1H,1L**
3.3	Service users receive care and support in the least restrictive setting	Ensure that the community based recovery services are the least restrictive and promote social inclusion Promote access to mainstream community and day provision for those in or at risk of inpatient/residential care	Reduce the numbers in inpatient care and residential care ASCOF 1B,1C,1D,
3.4	Increase opportunities for paid employment for users with mental health issues	Promote Talking Therapies and Individual Placement and Support (IPS) to support service users into employment	ASCOF 1F
3.5	Reduce the number and length of stay for those placed in residential care, with an emphasis on those placed Out of Area and those on s117 aftercare	- Prioritise certain user groups who historically have been placed in residential care - Develop a joint funding panel (Social care & CCG) to ensure that the needs of those requiring packages of care have their health and social care needs met	Monitor the number, location, cost and length of stay for those in residential care ASCOF 2A

References

- Future in Mind (2015)
- No Health without Mental Health (2011)
- ONS Statistics on Suicide in England & Wales (2015)
- Rotherham CCG Commissioning Plan, 2015
- Rotherham Together Partnership Plan, 2016/7
- The Care Act , 2014
- The Five Year Forward View for Mental Heath, 2016
- The Mental Health Act, 1983
- The RDaSH Transformation Plan (2016)

Appendices

Appendix i

Five Year Forward View for Mental Health priorities 2015-20

Pathway		2015/16	2016/17	2017/18	2018/19	2019/20
Referral to treatment pathways	Psychological therapy for common mental health disorders (IAPT)					
	Early intervention in psychosis					
	CAMHS: community eating disorder services					
	Perinatal mental health					
	Crisis care					
	Dementia					
	CAMHS: emergency, urgent, routine					
	Acute mental health care					
	Integrated mental and physical healthcare pathways (IAPT / liaison / other integrated models)					
	Self harm					
	Personality disorder					
	CAMHS: school refusal					
	Attention deficit hyperactivity disorder					
	Eating disorders (adult mental health)					
	Bipolar affective disorder					
	Autistic spectrum disorder (jointly with learning disability)					
Recovery pathways	Secure care recovery (will include a range of condition specific pathways)					
	Secondary care recovery (will include a range of condition-specific pathways)					

Appendix ii

Glossary

Acute Care
The treatment of an illness for a relatively short period of time for a severe episode of illness.

Bi-polar disorder
A psychiatric condition that causes recurrent episodes of significant disturbance in a person's mood, energy, and ability to function. Also known as manic-depressive illness

Care plan
A plan of the treatment for an individual who is receiving health or social care. It will normally follow an assessment and be agreed between the person receiving care and the assessor.

Care Act 2014
The latest Government legislation which states what care and supports adults in England will receive from their Local Authority.

Care Programme Approach
*(CPA)*A way of co-ordinating community health services for people with mental health problems in which one person co-ordinates all aspects of your care -including health and social care.

Carer/ carers
A person who provides support and looks after someone. In this document we only refer to informal carers (e.g. a member of the family) not paid carers.

CCG
Clinical Commissioning Group

Direct payments
A payment for people assessed as needing help from social services, who then arrange and pay for their own care and support.

Dual diagnosis
This term applies to people who have both mental health and drug or alcohol problems. Or mental health and learning disabilities

Economically Inactive
People who are not in work, but who do not satisfy all the criteria for unemployment i.e. wanting a job, seeking a job in the last four weeks and available to start in the next two. The main groups classed as economically inactive are those looking after the family and home, students and those who are long-term sick or disabled.

Enabling/enable
To make possible or give support to help make something happen

Individual /Personal budget
A scheme that allows people needing social care and associated services to decide the nature of the services they need. A key feature is a transparent allocation of resources that gives the individual a clear cash or notional sum for them to use on their care or support package.

Intervention
An action that is intended to alter the course of an illness.
Partnership board
A forum that brings together statutory and non statutory representatives together with user, carer and provider groups in order improve the experience of needs assessment, planning, delivery and service performance assessment for improvement.

Outcome
The consequence of an intervention. (See above)

Pathway or integrated care pathway
A multi-disciplinary outline of planned care designed to help a patient achieve a positive outcome during and after treatment.

Personalised
Services that are delivered to people in line with their wishes and their convenience.
Personality Disorder
Features of an individual's personality that forms a pattern of behaviour that does not help an individual adjust and function well within a social environment. A personality disorder can create problems for the individual because it causes conflict between that person and others or causes conflict within themselves.

Promoting Independence
A principle that underpins the delivery of health and social care services and stresses that care should aim to maintain and develop independence and respect people's dignity.

Provider
An agency that provides services to people – in this strategy it will normally refer to an agency offering health, social care or housing services. The agency can be a public sector, voluntary or private sector organisation.

Psychosis/Psychoses
A mental health disorder/s that produces disturbances in thinking and perception severe enough to distort an individual's perception of the world and of events within it.

Purchaser
An agency that purchases services on behalf of the population for which they are responsible. It may refer to a GP practice, a primary care trust, or a social services department.

Review
The periodic re-examination of a client's case to consider what changes to services or treatment are desirable.

Schizophrenia
A mental illness characterized by impairment in the perception or expression of reality, most commonly manifesting as auditory hallucinations, paranoid or bizarre delusions or disorganized speech and thinking in the context of significant social or occupational dysfunction.

Third Sector
Organisations that are independent of the Government, that work to achieve social, environmental or cultural aims, mainly reinvest any profits they make to help achieve those social, environmental or cultural aims. It includes community groups, co-operative, voluntary groups, charities and social enterprises.

Social exclusion
The government has defined social exclusion as "what can happen when people or areas suffer from a combination of linked problems such as unemployment, poor skills, low incomes, poor housing, high crime, bad health and family breakdown".

Stigma/stigmatised
The prejudice or bigotry experienced by an individual who has a condition that society at large finds difficult to accept.

Transition
A time of significant change for a person e.g. where a person is moving from childhood (and being at school) to adulthood (and going to work or college)

Wellbeing The state of feeling healthy and happy

Appendix iii

Care Cluster:

1 **Common Mental Health Problems (Low Severity)**
This group has definite but minor problems of depressed mood, anxiety or other disorder but they do not present with any psychotic symptoms.

2 **Common Mental Health problems (Low Severity with Greater Need)**
This group has definite but minor problems of depressed mood, anxiety or other disorder but not with any psychotic symptoms. They may have already received care associated with cluster I and require more specific intervention or previously been successful symptoms related to their substance misuse. It is possible that this group will suffer from cognitive impairment and/or physical problems as a result of long-term substance misuse.

3 **Non-Psychotic (Moderate Severity)**
Moderate problems involving depressed mood, anxiety or other disorder (not including psychosis)

4 **Non-Psychotic (Severe)**
This group is characterised by severe depression and/or anxiety and/or other and increasing complexity of needs. They may experience disruption to function in everyday life and there is an increasing likelihood of significant risks.

5 **Non-Psychotic (Very Severe)**
This group will be severely depressed and/or anxious and/or other. They will not present with hallucinations or delusions but may have some unreasonable beliefs. They may often be at high risk for suicide and they may present safeguarding issues and have severe disruption to everyday living.

6 **Non-Psychotic Disorders of Overvalued Ideas**
Moderate to very severe disorders that are difficult to treat. This may include treatment resistant eating disorder, OCD etc. where extreme beliefs are strongly held, some personality disorders and enduring depression.

7 **Enduring Non-Psychotic Disorders (High Disability)**
This group suffers from moderate to severe disorders that are very disabling. They will have received treatment for a number of years and although they may have improvement in positive symptoms considerable disability remains that is likely to affect role functioning in many ways.

8 **Non-Psychotic Chaotic and Challenging Disorders**
This group will have a wide range of symptoms and chaotic and challenging lifestyles. They are characterised by moderate to very severe repeat deliberate self-harm and/or other impulsive behaviour and chaotic, over dependent engagement and often hostile with services.

9 **Substance Misuse**
Blank

10 **First Episode in Psychosis**
This group will be presenting to the service for the first time with mild to severe psychotic phenomena. They may also have depressed mood and/or anxiety or other behaviours. Drinking or drug-taking may be present but *will* not be the only problem.

11 **Recurrent Psychosis (Low Symptoms)**
This group has a history of psychotic symptoms that are currently controlled and causing minor problems if any at all. They are currently experiencing a period of recovery where they are capable of full or near functioning. However, there may be impairment in self-esteem and efficacy and vulnerability to life.

12 **Ongoing or Recurrent Psychosis (High Disability)**
This group have a history of psychotic symptoms with a significant disability with major impact on role functioning. They are likely to be vulnerable to abuse or exploitation.

13 **Ongoing or Recurrent Psychosis (High Symptom and Disability)**
This group will have a history of psychotic symptoms which are not controlled. They will present with moderate to severe psychotic symptoms and some anxiety or depression. They have a significant disability with major impact on role functioning.

14 **Psychotic Crisis**
They will be experiencing an acute psychotic episode with severe symptoms that cause severe disruption to role functioning. They may present as vulnerable and a risk to others or themselves.

15 **Severe Psychotic Depression**
This group will be suffering from an acute episode of moderate to severe depressive symptoms. Hallucinations and delusions will be present. It is likely that this group will present a risk of suicide and have disruption in many areas of their lives.

16 **Dual Diagnosis**
This group has enduring, moderate to severe psychotic or affective symptoms with unstable, chaotic lifestyles *and coexisting* substance misuse. They may present a risk to self and others and engage poorly with services. Role functioning is often globally impaired.

17 **Psychosis and Affective Disorder Difficult to Engage**
This group has moderate to severe psychotic symptoms with unstable, chaotic lifestyles. There may be some problems with drugs or alcohol not severe enough to warrant dual diagnosis care. This group have a history of non-concordance, are vulnerable & engage poorly with services.

18 **Cognitive Impairment (Low need)**
People who may be in the early stages of dementia (or who may have an organic brain disorder affecting their cognitive function) who have some memory problems, or other low level cognitive impairment but who are still managing to cope reasonably well. Underlying reversible physical causes have been ruled out.

19 **Cognitive Impairment (Moderate Need)**
People who have problems with their memory and or other aspects of cognitive functioning resulting in moderate problems looking after themselves and maintaining social relationships. Probable risk of self-neglect or harm to others and may be experiencing some anxiety or depression.

20 **Cognitive Impairment (High need with functional complications)**
People with dementia who are having significant problems in looking after themselves and whose behaviour may challenge their carers or services. They may have high levels of anxiety or depression, psychotic symptoms or significant problems such as aggression or agitation. They may not be aware of their problems. They are likely to be at high risk of self-neglect or harm to others, and there may be a significant risk of their care arrangements breaking down.

21 **Cognitive Impairment (High need with physical complications)**
People with cognitive impairment or dementia who are having significant problems in looking after themselves, and whose physical condition is becoming increasingly frail. They may not be aware of their problems and there may be a significant risk of their care arrangements breaking down.

Appendix iv

Feedback

- Community services are too complex
- Good services and staff at Swallownest Court
- Need to improve communication- between staff/users/carers
- Need to improve the partnership approach
- Why is there no MH Partnership Board
- Communication based on ICT excludes lots of users and carers
- Some MH users spend hours in the cafes in the town centre
- Have features on Radio Hallam/Rotherham Advertiser eg based on Carers Rights Day /MH Day
- Simplify the pathways
- Gap- carers in their 20s and 30s
- More services available localaly eg the Health Village approach
- Big staff turnover/sickness
- Increase MH issues due to changes in the benfit system
- Services change too quickly
- Lack of employment support/support for those in work
- Social prescribing is a v good idea
- Lack of a shared ICT system affects communication
- Does the Panel stop some workers referring to services
- 80-90% of the referrals from GPs have a MH component
- Services ned to be local as some people don't like coming into the Town centre and also there's the cost of travelling
- The services are mostly used by white British people
- Our services are usually used bu those aged over 30
- Why are most services provided by the NHS?
- Not all RDaSH staff refer to our services
- Users want consistent staff/key worker
- Not all users seem to have a crisis or a WRAP plan, especially younger people
- People with anxiety or depression don't get a very good service
- More peer workers are needed
- Few services promote employment


CREATIVITY
ART
If you are interested in accessing any of our services, please speak with a member of staff or volunteer.
mind
Rotherham & Barnsley