Shropshire, Telford & Wrekin STP: Mental Health Strategy review.

My contribution to the STP MH review.

David Sandbach
19th February 2019

Foreword

The STP Board for Shropshire Telford & Wrekin has commissioned Professor Steve Trenchard to help develop a Mental Health Strategic plan for the Shropshire area.

I sincerely hope the MH Strategic Plan will be written on the basis of defined clinical and social outcomes to be achieved by the STP Board over a two to five year period.

To make sure MH issues come out of the acute sector shadow the public need a plan which is backed up by robust quantitative objectives and a decent outcome matrix. The public must be able to measure the STP Board and MH service provider success or failure in their efforts to improve MH services in Shropshire.

I think a strategic plan which reduces public demand for MH services would be really well appreciated by the citizens of Shropshire.

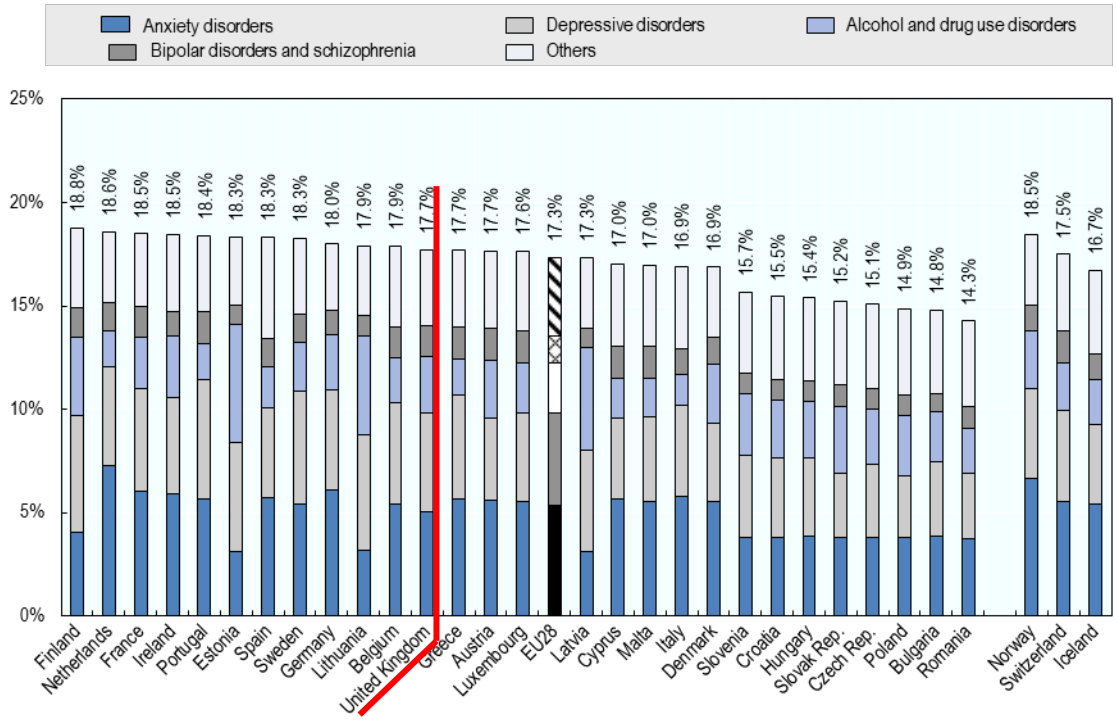
Box 1.1. **Defining mental health and mental illness**

The widely used definition established by the WHO emphasises the positive dimension that "mental health is a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (WHO, 2001). The terms mental health and mental well-being in this chapter draw on this WHO definition of positive mental health.

Mental illness is the loss of mental health due to a mental disorder. Mental disorders are defined as those reaching the clinical threshold of a diagnosis according to psychiatric classification systems including disorders such as depression, anxiety, bipolar disorder and schizophrenia. In this chapter, mental illnesses will generally comprise all those included in Chapter 5 of the International Classification of Diseases (ICD-10) on mental and behavioural disorders with the exception of dementia (which is considered, along with Alzheimer's disease, the main form of dementia, as a neurological disorder). The broad terms "mental ill-health", "mental illness" and "mental health problems" are used interchangeably and refer to mental disorders but also include psychological distress, i.e. symptoms or conditions that do not reach the clinical threshold of a diagnosis within the classification systems but which can account for significant suffering and hardship, and can be enduring and disabling.

Some head line data:

In the European Union more than 1 in 6 people had a mental health condition in 2016. This amounts to 86 million people.[1] [2]



Shropshire population 498,951[3] **@ 17.7% = 88,314 GP registered patients have a MH condition at any one time.**

EU Classification	% prevalence	Est. number of local people affected
Anxiety disorder	5	24,950
Depressive Disorder	5	24,950
Alcohol & Drug Disorder	3	14,970
Bipolar disorders and schizophrenia	1	4,990
Others	4	19,960

[1] https://ec.europa.eu/health/sites/health/files/state/docs/2018_healthatglance_rep_en.pdf

[2] http://dx.doi.org/10.1787/888933833920

[3] SCCG **311,224** + T&W CCG **187,727** registered patients

The total cost of mental ill-health, across the EU countries, is estimated at **4.1%** of GDP.[4]

- **1.3%** of GDP reflects direct spending on health care,
- **1.2%** of GDP is spent on social security programmes
- **1.6%** of GDP represents indirect costs to the labour market due to lower employment and productivity.

The UKs GDP is £2.11 trillion [5] 1% of £1 trillion is £10 billion.

1. Total costs

The aggregate cost of mental ill health in the WMCA in 2014/15 is estimated at £12.6 billion, equivalent to a cost of around £3,100 per head of population. The breakdown is as follows:

	£ billion	% of total
Care costs	3.59	28.0
Employment costs	3.94	31.5
Human costs	5.07	40.5

Table 1: **Cost of mental ill health to the WMCA**

Source: MENTAL HEALTH IN THE WEST MIDLANDS COMBINED AUTHORITY[6]

Cont

[4] https://ec.europa.eu/health/sites/health/files/state/docs/2018_healthatglance_rep_en.pdf
[5] https://www.statista.com/statistics/281744/gdp-of-the-united-kingdom-uk-since-2000/

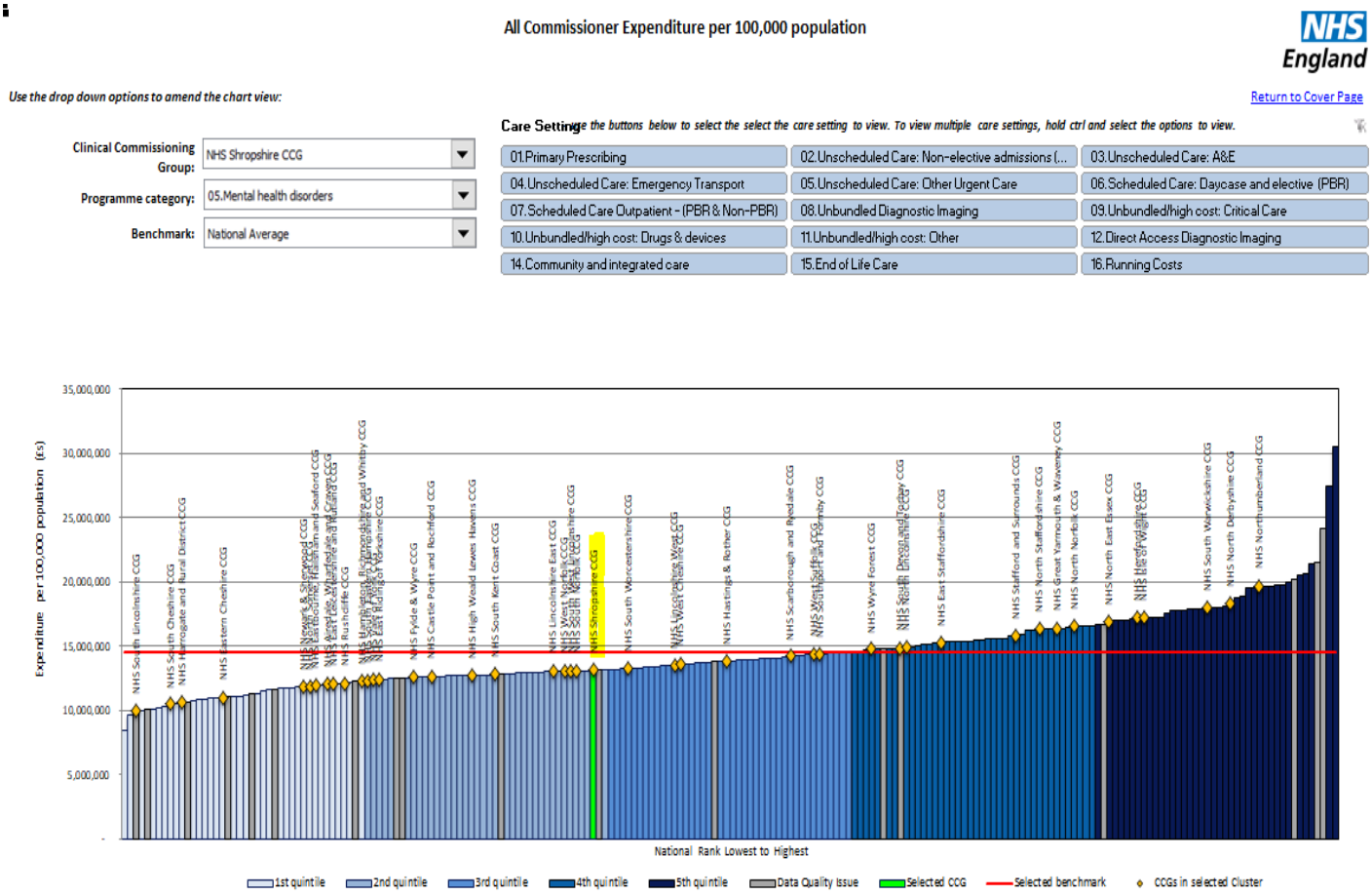
[6] https://www.birmingham.ac.uk/Documents/college-social-sciences/social-policy/HSMC/news-events/2017/mental-health-in-the-west-midlands-combined-authority.pdf

Local CCG spend on specialist Mental Health[7] services in the STP area is:

Shropshire CCG = £**33,095,000**[8] + T&W CCG = £ **20,515,000**[9]

Total = £ 53,610,000 pa

Below are graphs which show past MH investment performance in the STP area:[10]

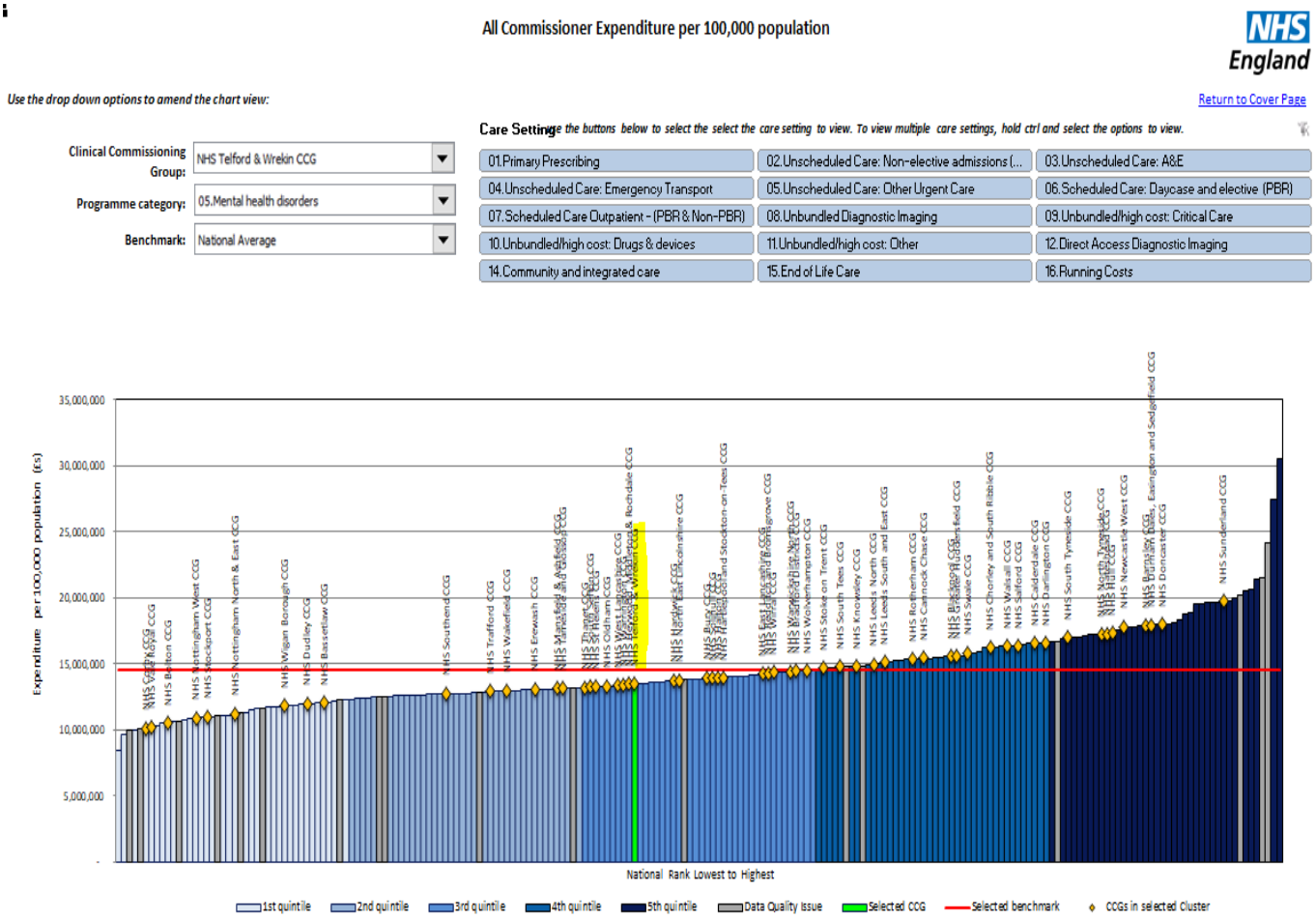


[7] Excluding private personal spending and cost of MH services provided in the primary care service by GPs.

[8] https://www.shropshireccg.nhs.uk/media/1765/shropshire-ccg-governing-body-agenda-papers-080818.pdf

[9] https://www.telfordccg.nhs.uk/who-we-are/publications/ccg-governance-board/governance-board-papers/2018/july-2018/4652-06-4-finance-report-month-2-1/file

[10] https://www.england.nhs.uk/wp-content/uploads/2015/06/13-14-ccg-prog-bug-benchmarking-tool.xlsm



NB Between January 1982 and December 1989 I was part of the Mental Health service team in Shropshire.

The data in the graphs above look no different than it was in my day. Getting a fair share of local NHS investment for our MH service was then and I think still is, an up-hill struggle. Shropshire has never been in the top spending quintile when it comes to MH services.

"Over recent years, welcome commitments have been made to increase funding for mental health services. There are concerns, however, that this is not reaching frontline services.

Many CCGs across England are either maintaining or decreasing current spending levels and a significant number are not meeting the Mental Health Investment Standard set out by NHS England. Data from FOI (Freedom of Information) requests indicate that half of CCGs plan to decrease their spending

on mental health services this year. At the same time, various indicators show the mental health sector is under increasing pressure."[11]

Source: BMA report "Lost in transit? Funding for mental health services in England"

"In 2011, the Coalition government published a mental health strategy setting six objectives, including improvement in the outcomes, physical health and experience of care of people with mental health problems, and a reduction in avoidable harm and stigma. The strategy was widely welcomed. However, despite these initiatives, challenges with system wide implementation coupled with an increase in people using mental health services has led to inadequate provision and worsening outcomes in recent years, including a rise in the number of people taking their own lives."

Source: THE FIVE YEAR FORWARD VIEW FOR MENTAL HEALTH[12]

Working in MH services is sometimes like being a participant in the play-Waiting for Godot – "Nothing happens. Nobody comes, nobody goes. It's awful."

With any luck the final curtain is due to fall on this perception and we will all get a better MH service in future?

The burden of MH conditions falls mainly on:

a) Women.
"Women are more likely to experience common mental health conditions than men; While rates remain relatively stable in men, prevalence is increasing in women. Young women are a particularly high-risk group, with over a quarter (26%) experiencing a common mental disorder, such as anxiety or depression – almost three times more than young men."

b) Young females 14 years.[13]
"Fifth of 14-year-old girls [actually 22%] in UK 'self-harm'", reported BBC News today.

[11] https://www.bma.org.uk/-/media/files/pdfs/collective%20voice/policy%20research/public%20and%20population%20health/mental%20health/lost-in-transit-funding-for-mental-health-briefing-feb2018.pdf?la=en
[12] https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf
[13] https://www.nhs.uk/news/mental-health/nearly-quarter-14-year-old-girls-uk-self-harming-charity-reports/#what-evidence-did-the-report-look-at

c) People under the age of 24

"Half of all mental health problems have been established by the age of 14, rising to 75 per cent by age 24. One in ten children aged 5 – 16 has a diagnosable problem."

d) People and families who are not so well off.[14]

e) People who are homeless.

"Common mental health problems are over twice as high among people who are homeless compared with the general population, and psychosis is up to 15 times as high."

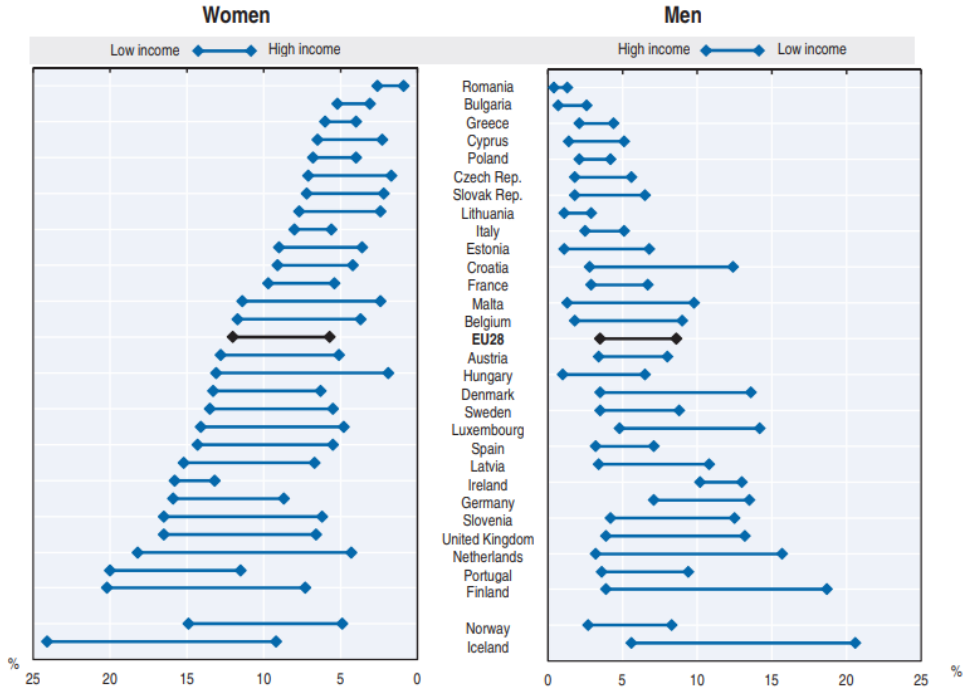
f) Veterans of our armed forces.

"Only half of veterans of the armed forces experiencing mental health problems like Post Traumatic Stress Disorder seek help from the NHS and those that do are rarely referred to the right specialist care."

g) Older people.[15]

"One in five older people living in the community and 40 per cent of older people living in care homes are affected by depression."

Figure 1.3. **Women and men in the lowest income group are more than two times more likely to report chronic depression than those in the highest income group across the EU**



Note: High income refers to people in the top income quintile (20% of the population with the highest income), whereas low income refers to people in the bottom income quintile (20% of the population with the lowest income). Countries are listed in order of rate of reported chronic depression by women (from lowest to highest). Data for Switzerland is not available.

Source: Eurostat Database (based on EHIS 2014).

StatLink http://dx.doi.org/10.1787/888933833958

[14] http://dx.doi.org/10.1787/888933833958

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

RECOMMENDATIONS

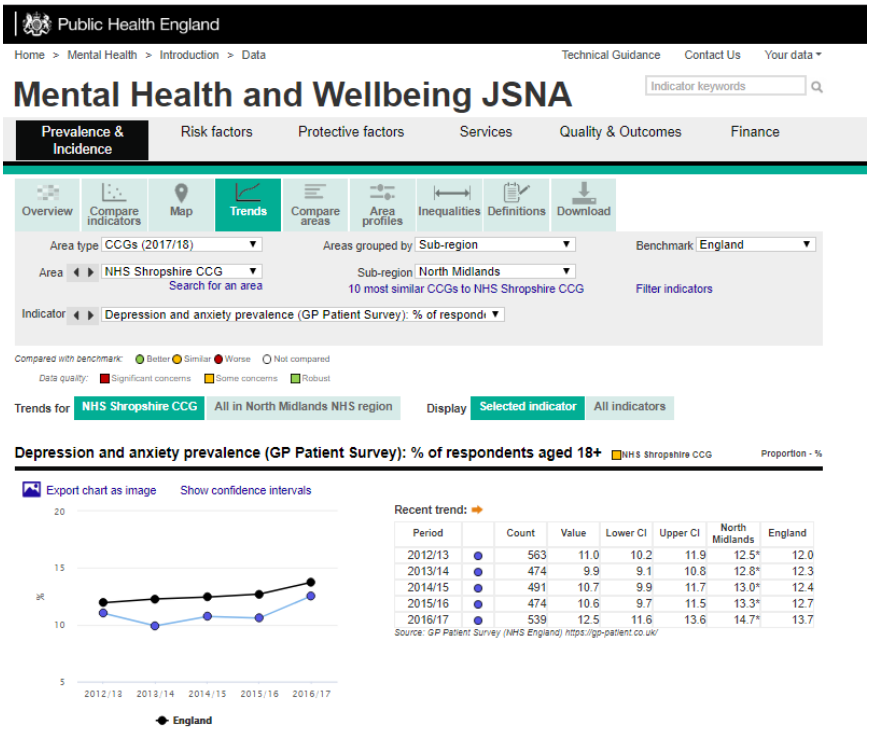
During his presentation to the Shropshire Patients Group on 12th December 2018 Prof. Trenchard invited SPG members to contribute to the development of the STP Mental Health Strategy. He asked people to identify three recommendations which should be in the STP MH Strategy document.

The following are my 3 + one or two more recommendations for inclusion in the STP MH strategy document:

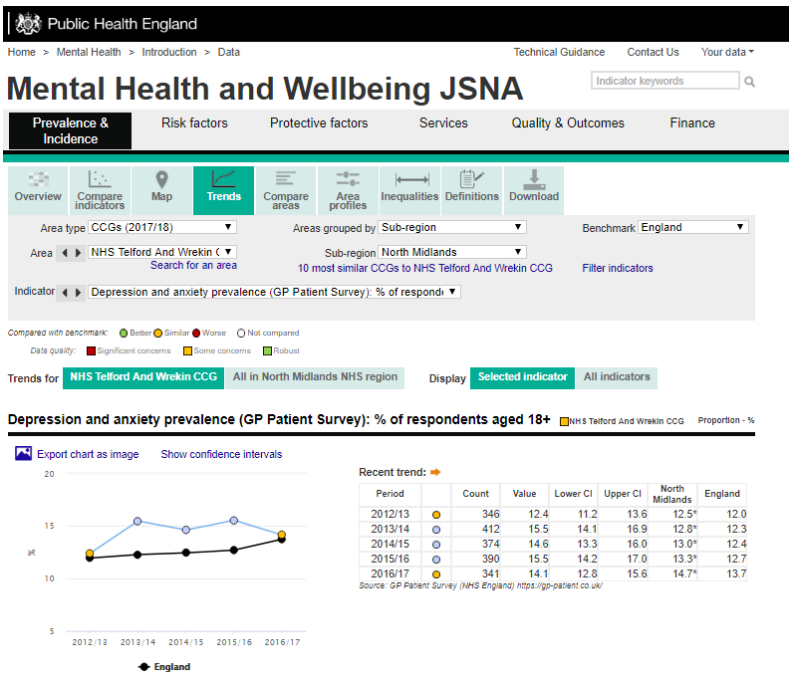
1) Information transparency.

   How can citizens know if we are getting a good deal for the £53.6 million pa we are investing in the MH service? How can citizens know where the STP membership stand in terms of investment in MH services compared to other areas?

   When do CCGs look at this kind of data during their public Board meetings?[16]



[16] https://fingertips.phe.org.uk/profile-group/mental-health/profile/mh-jsna/data#page/4/gid/1938132922/pat/46/par/E39000032/ati/152/are/E38000147/iid/90647/age/168/sex/4



Source MH & Wellbeing JSNA see foot note [17] below.

"In the future, the quality of mental health services and how well they are meeting the needs of the local population will be demonstrated through the provision of accurate, relevant, timely data which will be collected routinely for each person with mental health problems receiving care."[18]

As soon as possible the CCGs and STP Board should, on a regular half yearly basis report on how much or how little progress has been made on implementing the objectives in this document:[19]

[17] https://fingertips.phe.org.uk/profile-group/mental-health/profile/mh-jsna/data#page/4/gid/1938132922/pat/46/par/E39000032/ati/152/are/E38000183/iid/90647/age/168/sex/4

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

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

The members of the STP Board should make a public commitment to producing a bi-yearly report on MH services in Shropshire as a means of ensuring MH services are talked about in detail and are no longer overshadowed by other NHS service issues.

The information and data in this document "Mental Health Needs Assessment: Quick Notes" could be used as a means of testing progress and holding organisations to account.[20]

2) Services for people with Dementia should not be mixed up with services for people who have a Mental Health Condition. A separate STP strategic plan is required for this cohort of patients, almost 2/3 of who are female.[21]

	Men	Women
UK Total	360,581	677,210
EU Total	2,866,771	5,835,262

3) The overwhelming majority of people who have a Mental Health Condition are the direct clinical responsibility of their GP.

It follows that GP practices should be able to offer a service where by a practice **specialist** nurse is available to help patients who have a MH condition.

Given that there are circa 88,000 registered patients in Shropshire who have a MH condition, 50,000 with an anxiety or depressive disorder one can estimate the number of additional practice based nurses needed to adequately deal with the caseload.

[20] https://shropshire.gov.uk/committee-services/documents/g3750/Public%20reports%20pack%2005th-Jul-2018%2010.30%20Health%20and%20Wellbeing%20Board.pdf?T=10 and also https://shropshire.gov.uk/committee-services/documents/s18791/11%20MHNA%20Updated%20with%20Comments%20-%20May%202018%20v2.pdf

[21] https://eurohealth.ie/wp-content/uploads/2019/01/Women-and-dementia-in-Europe-report-2017.pdf

50,000 x 5 minutes average contact time per patient per month = 4,167 hours per month / 37 hours = 112 wte. MH practice based nurses.

Investment £ pa: 112 x £50,000 salary (including on costs) = £5,600,000 pa. Cheap at twice the price in my opinion.

Benefits:

- Improved prevention capacity available for the general population.
- Patients with a MH condition have access to local trusted help / advice and are better able to self-manage their MH condition.
- Reduction in exacerbations and crisis admissions by improved capacity to spot problems brewing up in advance.
- Reduction in direct MH caseload pressure on GPs – more time for GPs to do holistic case reviews and co-ordination tasks.
- MH service becomes more cost effective and more able to manage the never ending tsunami of demand more effectively.

4) Section 135[22] and 136.

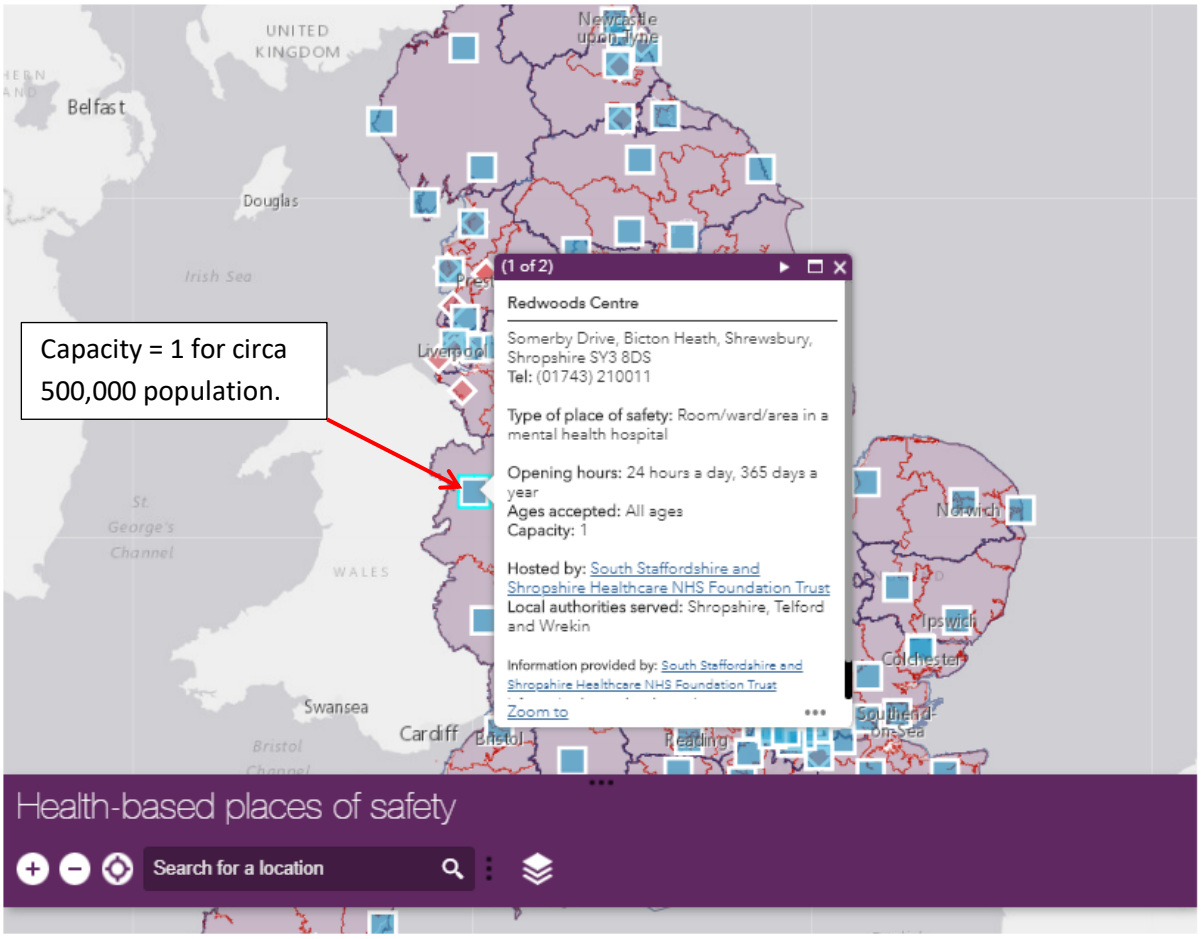
Every CCG Board meeting should have information about the use of 136 and 135 made available and logged next to the never events which are used to highlight very bad things which happen in the acute sector.

The rationale for this proposal is the fact that in all but exceptional circumstances people who are mentally ill should be taken to a place of safety which is staffed by people with experience in MH issues. [23]

[22] **Section 135** Being taken to a place of safety from a private place. The police take you to a 'place of safety'. They can only do this if they think you have a mental illness and need care. **Section 136** is an emergency power which allows you to be taken to a place of safety from a public place, if a police officer considers that you are suffering from mental illness and in need of immediate care.

[23] https://www.cqc.org.uk/sites/default/files/20141021%20CQC_SaferPlace_2014_07_FINAL%20for%20WEB.pdf

This is a ‘place of safety’ map in our county:[24]



Progress has been made since this map was issued i.e. the Sanctuary project. However reporting the use of Section 136 and 135 numbers should be treated like the reporting of c.dif is in respect of acute health service.

5) The cost to the local economy of impaired productivity associated with MH conditions is circa £120,000,000 pa[25] this is not in anyone’s interest be they workers or employers.

[24] https://www.cqc.org.uk/help-advice/mental-health-capacity/map-health-based-places-safety

[25] My estimate based on UK GDP figures and population figure for the UK.

At SaTH MH conditions are recognized as a contributing feature of poor corporate performance:

"The committee were informed that HCA recruitment was going to be recentralised and recognised that sickness levels in the Trust are of concern. The committee acknowledged the need for mental health support to staff."[26]

A key county wide economic plank in the MH strategy must be a concerted policy targeted on reducing the frequency of MH problems suffered by the counties workers.

There are lots of cost effective initiatives available to help keep workers productive and in a state of good mental health.

The local NHS and Councils should be exemplar employers able to give a lead to all types of employers in the county in respect of cost effective techniques for keeping employees mentally well and productive.

6) Self-harm among 22% of 14 year olds looks like an epidemic to me. If there was such a frequency of self-harm among MPs and members of the House of Lords all hell would break loose.

   So why is the health system not taking this issue seriously? If we have data that a MH condition is so concentrated on a very narrow group of people it is wrong not to declare the matter an emergency at STP level and check out what the situation locally.

   The MH strategy needs to provide a mechanism which can identify MH conditions that are getting out of control or are clustering around specific communities. We do this kind of surveillance for physical health issues and transmittable diseases – so why not MH conditions?

   A good STP multiagency R&D setup would be very useful in keeping the MH landscape under surveillance and responsive to changes in needs on a community by community basis.

[26] https://www.sath.nhs.uk/wp-content/uploads/2019/02/06-Workforce-Committee-Summary.pdf

7) We know that homelessness and mental ill health are correlated. So why do we allow unused property belonging to the state to go to waste?

For example these properties which are owned by our NHS (SaTH)

These properties are former staff accommodation. They are structurally sound but need re-wired and re-plumbed, a new heating system and internal refurbishment.

If these properties and other state owned properties around the county were put to use housing folk with mental health conditions the savings to the state would be huge.

It is odd how well healed members of the establishment who are responsible for social and health care matters prefer to waste resources rather than let their less fortunate brethren in society get some use of facilities which are no longer needed by the state.

Talk about cutting your nose off to spite your face!

8) Voluntary sector.

The MH strategy needs to spell out what the voluntary sector is expected to do in terms of MH service provision and under what kind of contractual conditions.

The MH strategy needs to think through how to stimulate bottom up initiatives like this:

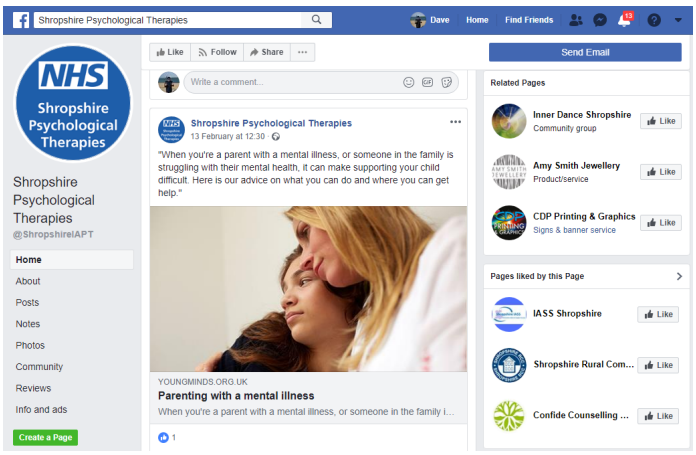
"Mental health: the students who helped themselves when help was too slow coming"[27]

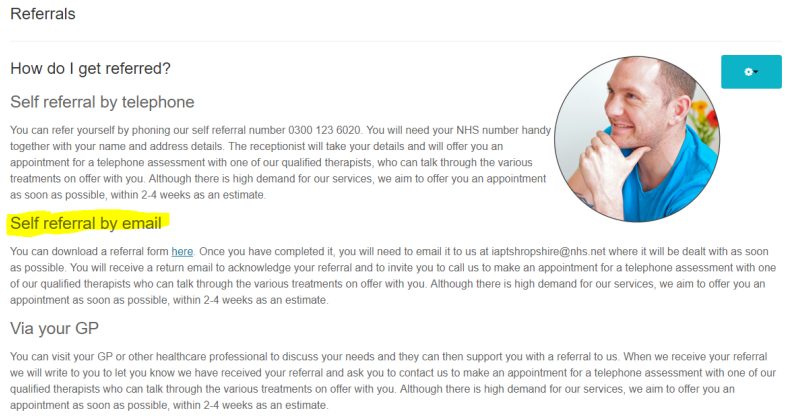
9) Digital and at a distance MH service

The MH strategy needs to spell out how digital / eHealth services are to be developed and when they are to be implemented in Shropshire. Some progress has been made e.g. [28]

[27] https://www.theguardian.com/education/2019/feb/12/mental-health-the-students-who-helped-themselves-when-help-was-too-slow-coming?CMP=Share_AndroidApp_Outlook

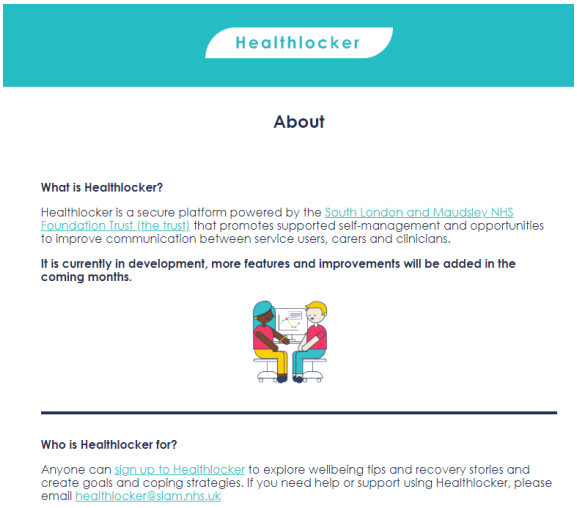
[28] http://search3.openobjects.com/kb5/shropshire/fid/service.page?id=zNmHkT5DU-0





[See self referral form here]

There are major inroads still to be made e.g. therapeutic video conferencing between clinical staff and service user's form home or from designated public buildings. Access to mobile eHealth help for people with a MH condition must be placed as a NHS IT priority service[29].



[29] https://www.healthlocker.uk/pages/about
and also https://www.youtube.com/watch?v=ns4TC_hEGKk&feature=youtu.be

10) Is MH a feminist issue given the higher burden of ill health females carry in respect of MH conditions? I am uncertain on this point but feel the question needs to be addressed in the MH strategy.

11) Should there be an independent MH champion on the STP Board – at least until MH achieves parity of financial esteem and corporate scrutiny?

The road to hell is always paved with good intentions remember these initiatives?

a) Department of Health, "**No health without mental health: a cross-government mental health outcomes strategy for people of all ages**," Stationary Office, London, 2011.
b) Department of Health, **"Closing the Gap: Priorities for essential change in mental health,"** Stationary Office, London, 2014.

Will the Five Year Forward View for MH go the same way?

12) The strategy needs to be up front about the fact local councils are strapped for cash and there needs to be some honest appraisal about what this means for the NHS and the MH service across both types of organisation.

David Sandbach.

19th February 2019.