Suicide Prevention: A North East overview

Julie Daneshyar Health and Wellbeing team    PHE NE
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The National policy context
“Preventing Suicide in England” cross government strategy (2012, 2015 and 2017)

- Reduce the risk of suicide in key high-risk groups
- Tailor approaches to improve mental health in specific groups
- Reduce access to the means of suicide
- Support research, data collection and monitoring
- Provide better information and support to those bereaved or affected by suicide.
- Support the media in delivering sensitive approaches to suicide and suicidal behaviour
- Support research, data collection and monitoring
- Increased focus upon custody/mental health settings and preventing self harm
Suicide Prevention:

Interim report Jan 2017

• Implementation: a clear programme monitoring national strategy at a local level
• Services to support vulnerable people

• Consensus statement on sharing information with families
• Data- timely and consistent to enable swift responses
• Media- Review of adherence to media guidelines. Focus upon the internet.
“The Department of Health, PHE and NHS England should support all local areas to have multi-agency suicide prevention plans in place by 2017, contributing to a 10 per cent reduction in suicide nationally. These plans should set out targeted actions in line with the National Suicide Prevention Strategy and new evidence around suicide, and include a strong focus on primary care, alcohol and drug misuse. Each plan should demonstrate how areas will implement evidence-based preventative interventions that target high-risk locations and support high-risk groups (including young people who self-harm) within their population, drawing on localised real time data. Updates should be provided in the Department of Health’s annual report on suicide.”

6,122 deaths/ year (saving 500/600 lives per year)
Suicide data
Suicide

- There were 4,820 suicides in 2015; figures show a steady increase over recent years.
- Men are three times more likely than women to take their own lives.
- Whilst female rates have stayed relatively constant, the male suicide rate is at its highest since 2001. The rise is most marked amongst middle aged men.
- The highest suicide rate in the UK in recent years was among men aged 45 to 59,
Suicide: by age & geography

Suicide rates per 100,000 2012-14/age

Suicide rate (persons) 2013-15 by LA

Suicide rate (persons) 2013-15 by region

Source: PHE Public Health Outcomes Framework
At risk groups

- young and middle-aged men
- people in the care of mental health services, including inpatients;
- people with a history of self-harm;
- people in contact with the criminal justice system;
- specific occupational groups, such as doctors, nurses, farmers and agricultural workers.

**North East** recent local audits have indicated a greater prevalence amongst adult males between the ages of 25 -65
Risk factors

- drug and alcohol misuse
- history of trauma or abuse
- unemployment
- social isolation
- poverty
- poor social conditions
- imprisonment
- violence
- family breakdown

- North East local audits indicate common associated risk factors of unemployment, debt, relationship breakdown, substance misuse, recent contact with primary care, recent contact with mental health services, history of previous attempts and self harm
The role of Public Health
Public Mental Health in the 5yfvmh

What is PMH?

• “Public mental health is concerned with promoting mental wellbeing, preventing future mental health problems and with the recovery from mental health problems” this is inclusive of prevention, early intervention to addressing the wider determinants that assist recovery

Better mental health for all, A public health approach to mental health improvement FPH, MH Foundation 2016

Role of public health

• Strategic leadership:
• Lead suicide prevention plan
• Lead Prevention Concordat
• Data, intelligence and analysis – lead improvements in the local JSNA
• Promote the physical health and wellbeing of people in the MH system e.g. Health Check, Obesity, smoke free MHT
• Address inequalities and stigma
• Educate and raise awareness
• Work with employers
• Drug/alcohol and mental health pathways
Suicide Prevention
Suicide Prevention Planning Guidance

Local Suicide Prevention Planning guidance PHE 2016

- develop a suicide prevention action plan
- monitor data, trends and hot spots
- engage with local media
- work with transport to map hot spots
- local priorities to improve mental health

Support after suicide-a guide to providing local services PHE 2017

- helps commissioners understand why and how they can deliver support after suicide in their local areas.
Suicide Prevention activity in the North East
North East Suicide Prevention activity

- 2016 - National survey of Suicide prevention plans, all Local Authorities in the North East confirmed they have a plan

- 2016 - North East Suicide Prevention master class – sharing examples of practice / resulting improvement activity. Issues raised e.g. data definitions, role of the Coroner, engagement of GPs, prisons, drug and alcohol services.

2016/17 regional activity includes:

- Local authority leads network
- Criminal justice workshop events
- Network Rail/ British transport police workshop
- Media management and local protocols
- Facilitated data analysis to assist local targeting
- Mental resilience and football project using football as a means to target men
- Connect 5 mental wellbeing
Suicide Prevention activity - local

1. 12 plans, all Local authorities had conducted audits and have some form of multi agency planning group.

2. 2 multi agency sub-regional planning groups

Tees Valley suicide prevention strategy – collaboration of 4 Local Authority areas. Joint commissioning e.g. Tees Valley training hub, Cruse postvention support service, exploring real time data surveillance and confidential inquiry

Offender health and community forensic services
Suicide Prevention activity - local

- County Durham & Darlington - real time data surveillance, If U Care Share postvention support, Custody diversion, targeted information campaigns.
- Sunderland - “Sunderland stands together” information campaign, bridge signage
- Newcastle and Gateshead – collaboration on suicide audits, hot spot identification and bridge signage
- Northumberland- “Silent Voices” YP campaign work with Network Rail, Perinatal
- North Tyneside – information campaign targeting men accessing sport and leisure services & via Pubwatch.
- South Tyneside – hot spot signage, building resilient communities
- Healthy Cities, integrated wellness, loneliness and isolation
More information:

julie.daneshyar@phe.gov.uk
South Tyneside

Lifecycle Primary Care Mental Health Service

Dr James Gordon, Clinical Director, NHS South Tyneside CCG
The **Lifecycle** Service

- Why did we need to change?

- Collaboration and Co-commissioning

- Achievements and challenges
Why did we need to change?

- IAPT not achieving access and recovery standards
- Multiple providers, not all data collected
- Specialist CAMHS services overwhelmed
- Lack of comprehensive “Tier 2” services for children
- Unacceptably long waits for all
- Disengaged and frustrated referrers
Collaboration and Co-commissioning

- Model developed in partnership with statutory partners, local people and national experts
- Single service for young people, families, and older adults incl. CYP and Adult IAPT
- Single point of access for all CAMHS services
- ‘Normalising’ young people’s mental and emotional healthcare
Collaboration and Co-commissioning

- Meeting the needs of 16-25 year olds, transition and young adults.
- Access targets for adults AND young people.
- Multi-agency procurement evaluation panel including experts by experience (CCG, Youth Parliament Rep, Clinical, NECs, LA, Clinical Quality, Finance)
Achievements

- Family level interventions, inc 14-19 yr specialists
- Support to universal services inc LAC/Schools/Acute sector
- Trained and accredited workforce – 99% (CYP) IAPT
- Wide range of therapeutic approaches
- Open access and Self referral 34% YP, >80% adults
- SPA, reduced refs into specialist CAMHS
- Reduced waiting times
- Excellent engagement with referrers, robust data management
- Shift towards early intervention for all ages
Challenges

• How do we increase capacity in a sustainable way to achieve 25% access?
• Unpicking funding from other contracts
• Uncovering unmet need in children and young people
• Funding pressures from social care and local authority commissioned services.
• Maintaining choice and flexibility whilst keeping waiting times down
• Achieving joint working in CAMHS, Thrive etc.
Thank You
Resilience Building in Cumbria Schools

2nd February, 2017

Anne Sheppard - Strategic Manager Emotional Wellbeing and Mental Health Services – Children and Young People

Lindsey Ormesher - Resilience and Wellbeing/5-19 Healthy Child Programme Officer
Cumbria Picture

- Estimated 103,500 0-19 yr olds across Cumbria
- Estimated 10,000 to 11,000 children in Cumbria aged between 5 - 19 years likely to have an emotional or mental health difficulty.
- Approximately 1800 children and young people in contact with specialist mental health services at any one time
- 272 LA maintained, 48 Academies and 17 independent/free plus 5 FE Colleges
- Only five urban areas have a population of over 20,000 people
- Barrow-in-Furness - highest level of overall deprivation, ranking 29th out of 326 district local authorities.
- Hidden pockets of deprivation in some of the county’s most rural and remote communities
Our Whole System Vision

‘All our children and young people can access the support they need to achieve emotional wellbeing and mental health and have the ability and confidence to ride life’s inevitable ups and downs, now and in the future’
Key Learning

• Whole school community approach – Implementation/Co-production
• Time at home – Family Resilience
• Digital Wellbeing – online emotional support

..\My Videos\Best worst mates.mp4
https://vimeo.com/185334278/42bcb87e39

• Building Capacity in the 3rd Sector to support the whole system approach
Questions / discussion
Discussion : a specific challenge
Implementing Mental Health Liaison CORE 24 Standards : Progress and Challenges

Dr Philippa Bolton, Mental Health Lead, Northern England Clinical Networks
Where are we now?
Everyone is committed to liaison. But how?

1. Sunderland
2. Durham & Darlington
3. Tees
4. Northumbria Specialist Emergency Care Hospital
5. Gateshead
6. Newcastle
7. South Tyneside
8. Cumbria
9. Northallerton

Meeting/Exceeding CORE24
Close to meeting CORE24
Further from Meeting CORE24
Challenge 1 – one size fits all?

Ratio of staff to beds, taking into account the number of sites and ED covered.
Challenge 2 - resources

- Workforce
- Integration
- Depletion of other teams
- Training
Challenge 3 - Sustainability

What are the best outcome measures to use to prove sustainability?

What support will there be nationally to develop after CORE 24 to meet local needs?

How do you get cash out of a system to make liaison self funding?

Does CORE 24 offer the best model for sustainability, given it is adult, not MHSOP focused?

What responsibility should acute trusts have for their patients with mental health problems? Should they be agreeing joint working and joint funding?

What about the lack of funding for independent evaluation and lack of skills and time within teams to get really good quality data?
There is considerable willing from providers and commissioners to support liaison and invest in it. But this needs to be matched by support from the national team to help CCG’s meet requirements and a flexibility in terms of deadlines.

The time needed to set up, recruit, train, embed and prove sustainability within a year is impossible.
Questions and discussion
How do we get to where we want to be in three years locally and nationally?
Introduction to afternoon

Catherine Haigh, North East together
Dr Angus Bell, Mental Health Lead, Northern England Clinical Networks
National perspective on implementing MH5YFV – progress, achievements, challenges

Claire Murdoch, National Mental Health Director, NHSE

2 February 2017
<table>
<thead>
<tr>
<th>We need to get to all STPs delivering their share of...</th>
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<tbody>
<tr>
<td>70,000 more <strong>children</strong> will access evidence based mental health care interventions</td>
</tr>
<tr>
<td>Intensive home treatment will be available in every part of England as an alternative to hospital. <strong>Older People</strong></td>
</tr>
<tr>
<td>No acute hospital is without all-age mental health liaison services, and at least 50% are meeting the ‘core 24’ service standard <strong>Older People</strong></td>
</tr>
<tr>
<td>At least 30,000 more women each year can access evidence-based specialist perinatal mental health care</td>
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<tr>
<td>10% reduction in suicide and all areas to have multi-agency suicide prevention plans in place by 2017 <strong>Older People</strong></td>
</tr>
<tr>
<td>Increase access to evidence-based psychological therapies to reach 25% of need, helping 600,000 more people per year <strong>Older People</strong></td>
</tr>
<tr>
<td>The number of people with SMI who can access evidence based Individual Placement and Support (IPS) will have doubled</td>
</tr>
<tr>
<td>280,000 people with SMI will have access to evidence based physical health checks and interventions <strong>Older People</strong></td>
</tr>
<tr>
<td>60% people experiencing a first episode of psychosis will access NICE concordant care within 2 weeks including <strong>children</strong></td>
</tr>
<tr>
<td>Inappropriate out of area placements (OAPs) will have been eliminated for adult acute mental health care</td>
</tr>
<tr>
<td>New models of care for tertiary MH will deliver quality care close to home reduced inpatient spend, increased community provision including for <strong>children</strong> and young people</td>
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<tr>
<td>There will be the right number of CAMHS T4 beds in the right place reducing the number of inappropriate out of area placements for <strong>children</strong> and young people</td>
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As set out in the implementation plan, investment supports these objectives and is phased over the 5yfv period.

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<tr>
<td>CYP Mental Health</td>
<td>119.0</td>
<td>140.0</td>
<td>170.0</td>
<td>190.0</td>
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<td>Eating Disorders</td>
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<tr>
<td>Specialist perinatal mental health</td>
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<tr>
<td>Expansion of Psych. Therapies (IAPT access to 25%)</td>
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<td>Crisis and acute care</td>
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<td>90.0</td>
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<td>Early intervention in psychosis</td>
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<td>Physical health interventions for SMI</td>
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<td>Secure Care Pathway</td>
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<td>58.0</td>
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<td><strong>Gross Savings - MH</strong></td>
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<td>Crisis Response Home Treatment Teams</td>
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<td>-64.0</td>
<td>-135.0</td>
<td>-168.0</td>
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<td>EIP to 60%</td>
<td>-4.0</td>
<td>-8.0</td>
<td>-12.0</td>
<td>-20.0</td>
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<tr>
<td><strong>Gross Savings - Acute</strong></td>
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<tr>
<td>Reduced acute healthcare utilisation - IAPT access to 25%</td>
<td>-26.0</td>
<td>-122.0</td>
<td>-236.0</td>
<td>-364.0</td>
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<td>Reduced acute healthcare utilisation - SMI physical health</td>
<td>-27.0</td>
<td>-81.0</td>
<td>-108.0</td>
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<td>Mental health Liaison (50% of hospitals)</td>
<td>-15.0</td>
<td>-30.0</td>
<td>-84.0</td>
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<td><strong>STF Monies for Allocation (indicative)</strong></td>
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<td>Perinatal community development fund</td>
<td>5.0</td>
<td>15.0</td>
<td>40.0</td>
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<tr>
<td>Additional CCG funding to be allocated</td>
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<tr>
<td>Mental Health liaison services</td>
<td>15.0</td>
<td>30.0</td>
<td>84.0</td>
<td>120.0</td>
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<td><strong>National Programmes (indicative)</strong></td>
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<tr>
<td>Crisis care models</td>
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<td>Workforce development (HEE)</td>
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<td>22.0</td>
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<td>Workforce development (other)</td>
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<td>12.0</td>
<td>4.0</td>
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<td>Specialist in-patient / outreach</td>
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<td>11.0</td>
<td>4.0</td>
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<td>Vulnerable Groups</td>
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<td>21.0</td>
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<td>Other Programmes</td>
<td>14.5</td>
<td>5.0</td>
<td>3.0</td>
<td>1.0</td>
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<td>Mother and baby unit development</td>
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<td>10.0</td>
<td>15.0</td>
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<td>Perinatal workforce development</td>
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<td>2.5</td>
<td>2.5</td>
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<tr>
<td>Regional perinatal MH networks</td>
<td>1.5</td>
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<td>Investment in integrated services</td>
<td>20.0</td>
<td>88.0</td>
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<td>Community mental health</td>
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<td>50.0</td>
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<td>Armed Forces</td>
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<td>Secure services transition fund</td>
<td>1.0</td>
<td>5.0</td>
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<tr>
<td>Liaison &amp; diversion</td>
<td>5.0</td>
<td>12.0</td>
<td>17.0</td>
<td>27.0</td>
<td>31.0</td>
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<tr>
<td>Suicide prevention</td>
<td>5.0</td>
<td>10.0</td>
<td>10.0</td>
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<tr>
<td><strong>TOTAL</strong></td>
<td>306.7</td>
<td>450.7</td>
<td>456.7</td>
<td>519.0</td>
<td>537.0</td>
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</table>
What are the next steps?

1. Checking and triangulating funding via planning returns
   - CCGs to confirm total **mental health funding** including **contract values** + investment in **5yfv programmes** (e.g., CYP MH) for 17/18-18/19
   - Mental health **provider CEs** asked to confirm CCG return as **accurate reflection** of investment inc. investment in others
   - CCGs and mental health providers asked to confirm that investment will deliver required transformation set out in **planning guidance**
   - Outstanding issues **resolved** with regional finance and operational colleagues and if necessary national intervention

2. Supporting STPs to improve plans for mental health
   - Reviewing the **content** and **quality** of STP plans and STP performance against **national expectations**
   - Providing targeted support to those who need **rapid support** to develop plans that will deliver 5yfv mental health transformation
   - Offering **wider support** to STPs, CCGs and providers through new **improvement ‘menu’**
   - Ongoing **monitoring and support** to STPs via performance information and intelligence nationally and regionally

Every STP area has a credible funded plan to deliver transformation to mental health services to meet the needs of its local population and deliver the local share of the 5 year forward view for mental health implementation plan meeting national commitments made for patients
## What more can we do?

### How confident are STPs at delivering?

- **Increased access** to evidence based mental health services in your local health economy for:
  - **Children and young people**
  - People with depression and anxiety (IAPT services) – particularly those with comorbid LTC
  - People experiencing a **first episode of psychosis**
  - People who need rapid access to emergency mental health care from **intensive home treatment services** or **liaison mental health services**
  - People needing specialist mental health care during the **perinatal** period
  - People with **severe mental illness** (access to **physical** health care interventions)
  - People needing **employment support** in addition to mental health care (e.g., IPS)

- **A complete elimination of out of area placements (OAPs)** for acute mental health care by 2020/21?

- **Access and waiting times standards** including access to NICE concordant care for **children and young people’s eating disorder services**, **first episode psychosis** and **IAPT services**

- **Co-commissioning** or delivering **New care models** for **tertiary mental health services** such as **tier 4 CAMHs** and **low and medium secure care** jointly with specialised commissioning colleagues

### What support would be helpful to assist in building confidence and ensuring delivery of the mental health agenda?

- STP dial in with peers and national teams
- STP data packs
- Hands on clinical or managerial support
- Support from clinical networks
- Peer support and mentoring from successful health economies?
- Consultancy-type support
- Quality improvement support

For any assistance/advice please contact england.mentalhealthpmo@nhs.net or phoebe.robinson@nhs.net
<table>
<thead>
<tr>
<th>What</th>
<th>Why at STP</th>
<th>Benefits realised</th>
<th>Evidence/ examples</th>
</tr>
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<tbody>
<tr>
<td>Liaison mental health services</td>
<td>Savings are released in acute physical care and to acute physical commissioners, where service is provided as MH specialist service</td>
<td>Improved outcomes, Reduced LOS, Reduced admissions, better care with less resources, reduced costs for MUS, reduced psychological distress following self-harm and suicide reduction</td>
<td><a href="https://www.centreformentalhealth.org.uk/Handlers/Download.ashx?IDMF=d6fa08e0-3c6a-46d4-8c07-93f1d44955e8">https://www.centreformentalhealth.org.uk/Handlers/Download.ashx?IDMF=d6fa08e0-3c6a-46d4-8c07-93f1d44955e8</a></td>
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# Examples of interventions that require collaboration at STP geography or timeline and links to information

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<th>Evidence/ examples</th>
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<tbody>
<tr>
<td><strong>Children and young people’s local transformation plans (LTPs)</strong></td>
<td>Requires multi-agency buy in particularly across local authority and CCG. Requires addressing wider determinants of health in addition to improvements to clinical care (also scale needed for co-commissioning – see p5)</td>
<td>Improved early access to evidence based care, improved outcomes, long term, likely reductions to demand for adult mental health services,</td>
<td><a href="https://www.england.nhs.uk/wp-content/uploads/2015/07/local-transformation-plans-cyp-mh-guidance.pdf">https://www.england.nhs.uk/wp-content/uploads/2015/07/local-transformation-plans-cyp-mh-guidance.pdf</a></td>
</tr>
<tr>
<td><strong>Perinatal mental health</strong></td>
<td>Requires planning over a larger footprint for economies of scale, requires collaboration between mental and physical care providers over maternity providers</td>
<td>Better outcomes for mothers and children including reduced pre-term birth, infant death, improved school attainment, improved mental health, reduced costs relating to health and social outcomes of child.</td>
<td><a href="http://eprints.lse.ac.uk/59885/">http://eprints.lse.ac.uk/59885/</a> <a href="https://www.centreformentalhealth.org.uk/falling-through-the-gaps">https://www.centreformentalhealth.org.uk/falling-through-the-gaps</a> <a href="https://www.nice.org.uk/guidance/cg192">https://www.nice.org.uk/guidance/cg192</a></td>
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<th>Benefits realised</th>
<th>Evidence/examples</th>
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</table>
| **Delivering the well pathway for dementia/innovative care packages for dementia e.g., care home vanguard** | Requires co-ordination between local authority, NHS, care homes, acute providers and others. [see also Liaison MH] | Improved health outcomes, improved quality of life, reduced social isolation, shifting from fragmented to connected care, potential reduced costs in secondary care | [https://www.england.nhs.uk/mentalhealth/resources/dementia/](https://www.england.nhs.uk/mentalhealth/resources/dementia/)  
| **Co-commissioning for tertiary services inc. CYP/ Secure/ ED/ CAMHS tier 4** | Could facilitate gain/ loss share among STP partners, incentive for CCGs to make appropriate investment in non specialised services in order to reduce demand and overall costs and support sustainability. | Improved outcomes, joined up care pathways, reduced cost-shifting, lower overall costs, more investment in care closer to home, care in the lowest intensity setting, quicker discharge from inpatient settings, | [https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/03/spec-serv-collabrty-comms-guid.pdf](https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/03/spec-serv-collabrty-comms-guid.pdf) |
| **Employment/ Health join up including IPS and IAPT** | Pooled shared budgets with Job Centre+ and CCGs more feasible due to DWP admin footprints, outcome based commissioning jointly with LA/ CCG for health/work impact possible | Improved employment and health outcomes, reduced overall government spend on population, improved quality of life | [http://www.socialfinance.org.uk/impact/health-and-social-care/#sthash.j3TerH0D](http://www.socialfinance.org.uk/impact/health-and-social-care/#sthash.j3TerH0D)  
Examples of interventions that require collaboration at STP geography or timeline and links to information

<table>
<thead>
<tr>
<th>What</th>
<th>Why at STP</th>
<th>Benefits realised</th>
<th>Evidence/ examples</th>
</tr>
</thead>
</table>
| Housing and Health join up                      | • Housing is a multi-agency responsibility across NHS, social care and public health +DWP  
• suitable housing is a key determinant of MH+ can prevent crisis  
• Benefits accrue across the system | 5% reduction in bed days  
10% reduction in readmission  
4.7% reduction in bed days due to DTOCs  
50% reduction in OATs  
*Source: Housing and Health, collaboration between HACT and Common Cause Consulting* | [http://www.candi.nhs.uk/our-services/tile-house-0](http://www.candi.nhs.uk/our-services/tile-house-0)  
[https://www.mentalhealth.org.uk/sites/default/files/Mental_Health_and_Housing_report_2016_1.pdf](https://www.mentalhealth.org.uk/sites/default/files/Mental_Health_and_Housing_report_2016_1.pdf) |
| Single point of 24/7 access to MH Crisis Care    | • May require larger geography to make sustainable  
• Benefits may accrue elsewhere                                                                 | Improved service user experience,  
Increased referrer satisfaction  
Reduced calls to ambulance  
Increased productivity  
[http://www.nhsiq.nhs.uk/media/2422305/northumberlandtyne_cs_final.pdf](http://www.nhsiq.nhs.uk/media/2422305/northumberlandtyne_cs_final.pdf) |
| +local examples                                 |                                                                                                                                            |                                                                                                              |                                                                                                         |

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What more can we do to help you?
Thinking differently: new models of care and ways of working together
Tertiary Mental Health model of care pilot

Sharon Pickering, Director of Planning and Performance, Tees, Esk and Wear Valley NHS FT
New Care Model Tier 4 CYP

- Dates back to Planning Guidance for 2016/17
- Secondary providers to pilot managing the budget for tertiary services – Adult Secure and Tier 4 CYP
- One of 6 pilots
  - 4 Adult Secure
  - 2 Tier 4 CYP (other one is West London)
- Moved to shadow form on 1 October
- Go live 1 April 2017
- 2 year pilot initially
New Care Model Tier 4 CYP

**WHY?**

- Lack of sufficient community services
- Use of beds too high
- A lot of children in out of area placements
- Experience and evidence of impact enhanced community services can make
- Lack of local PICU beds
- Number of high cost packages
- Lack of incentives in the system to change the care pathway

**WHY WOULDN’T WE?**

- making a difference together
Our Aims

- Crisis and Intensive Homes Treatment Services available in all localities
- Improved pathway with greater alignment between inpatient and community services
- Reduced number of admissions
- Reduced Length of Stay
- Reduced overall use of beds (reduction of 50%)
- Reduction in Out of Area admissions and distance travelled
- Improved patient and carer experience
- Financial savings for reinvestment in children’s mental health
Planned Outcomes

<table>
<thead>
<tr>
<th>Locality</th>
<th>*6 Month Snapshot of 16/17 bed usage</th>
<th>Proposed bed base 2017/18</th>
<th>Proposed bed base 18/19</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No of beds</td>
<td>No of beds per 100k child pop</td>
<td>No of beds</td>
</tr>
<tr>
<td>North Yorkshire and Vale of York (A&amp;T including Eating Disorders)</td>
<td>23.9</td>
<td>15.7</td>
<td>13.9</td>
</tr>
<tr>
<td>Durham and Darlington (A&amp;T including Eating Disorders)</td>
<td>9.0</td>
<td>7.1</td>
<td>8.0</td>
</tr>
<tr>
<td>Teesside (A&amp;T including Eating Disorders)</td>
<td>9.6</td>
<td>7.7</td>
<td>8.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>42.4</strong></td>
<td><strong>10.5</strong></td>
<td><strong>29.9</strong></td>
</tr>
</tbody>
</table>

Reduction in spend on beds: £1.9 million 2017/18 and £0.6 million 2018/19
Challenges

- Working with two NHSE Regional Teams – NE&C and Y&H
- Availability of accurate data
- Legal frameworks ie ability of NHSE to delegate contract management
- Running alongside service reviews being undertaken by NHSE nationally
- Variance in service provision/utilisation across the areas we serve
Questions / discussion
Examples of voluntary, community and statutory sector joint working

Steve Nash, Chairperson and Coordinator of VOLSAG
Collective collaboration and canniness

Alisdair Cameron
Recovery...whose recovery is it anyway?

Beyond symptom reduction
• Purpose and meaning
• Agency and status
• Interest and inquisitive
• Connected and social
• Stability and security
• Trust
How not to be scared or ashamed
Cross-sector, **cross-roles**

Asset-based. Pooled knowledge. Open source, non-proprietary.

Giving people permission to be human, to be canny. *Including at work.*

- Working across sectors
- Working across organisations
- Working across professions
- Working across roles and statuses
- MH in widest sense, aiming at highest need
- Upstream, downstream, midstream, cross-currents
Nth East: out on a limb: no credit for innovation, but found our own ways of working, our own solutions. We’re canny.

Boutique and beggars
Scale  Pace  Relationships & sharing

Sharing of premises  Not kicking down and kissing up
Sharing of training  Not pretending that all that the centre wants is deliverable
Sharing of resources  Not pretending that all that the centre wants is desirable
Sharing of personnel  Not denying the political dimension
Sharing of tasks and roles  Not denying the human costs
Organisational humility  Not giving up or acquiescing in decline
Professional humility
Honesty and realism
Pooled knowledge & expertise
Questions / discussion
Refreshment break
Summary of actions and what support is there from the national team and how do we manage communications best?

Catherine Haigh, North East together
Dr Angus Bell, Mental Health Lead, Northern England Clinical Networks
Close of event

Catherine Haigh, North East together
Dr Angus Bell, Mental Health Lead, Northern England Clinical Networks