NHS
Morecambe Bay
Clinical Commissioning Group

AGENDA ITEM NO: 7.0.

Meeting Title/Date:	Governing Body - 18 July 2017		
Report Title:	Update on Mental Health Developments in the Bay		
Paper Prepared By:	Dr Jim Hacking/ Anthony Gardner	**Date of Paper:**	June 2017
Executive Sponsor:	Anthony Gardner	**Responsible Manager:**	Anthony Gardner
Committees where Paper Previously Presented:	Better Care Together Programme Board MBCCG Executive Committee		
Background Paper(s):			
Summary of Report:	Paper describes national focus on developing integration between physical and mental health services and our local application of this model in different care settings.		
Recommendation(s):	The Governing Body is asked to:- a) Note and support current Mental Health developments. b) Discuss and provide feedback on the draft vision (noting further development work will take place including with the Workshop in September).		

		Please Select Y/N
Identified Risks:	Progress dependent on securing commitment from primary care, UHMB and mental health services to develop an agreed model.	Y
Impact Assessment: (Including Health, Equality, Diversity and Human Rights)		
Strategic Objective(s) Supported by this Paper:		**Please Select (X)**
To Improve the health of our population and reduce inequalities in health		X
To reduce premature deaths from a range of long term conditions		
To develop care closer to home		X
To commission safe, sustainable and high quality Hospital Health Care		X
To commission safe, sustainable and high quality Mental Health Care		X
To improve capacity and capability of primary care services to respond to the changing health needs of our population		X

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Update on Mental Health Developments in the Bay

1. Introduction

This paper provides an update on mental health developments in the Bay aimed at improving mental health services for our populations. It shows a summary of some of the needs and challenges we face together with current work programme and future direction. Local developments are of course being framed within the national context for mental health. An NHS taskforce was commissioned to create a vision for mental health transformation which culminated in the Five Year Forward View (FYFV) on Mental health, a national report and development plan describing both challenges and aspirations to improve the way that NHS and wider services provide care for, and tackle issues, for people living with mental health illness or related conditions. Irrespective of your age, income or background, the likelihood is that you or someone close to you has experienced mental illness. Nationally 1 in 4 of us will have a common diagnosable mental disorder in any given year and in our local system of Morecambe Bay we know we have need in some areas of mental health, e.g. depression, psychoses and dementia that is higher than the national prevalence rate.

In the last few years, public awareness of mental health and mental illness has grown significantly. We talk about mental health more openly. We understand mental illness better, and we have started to remove some of the stigma that has long surrounded it. These positive steps mean that as a system we need to recognise how we can integrate Mental Health into all of our service provision, how we ensure mental health services are not isolated from physical care services, and create a new set of behaviours and language whereby mental health is seen as everybody's business and embedded in all of our system transformation plans.

Embedding aspirations from the FYFV into our local plans is an opportunity to drive real and sustained improvement in access and delivery of mental health services and help us deliver mental health services that are available 24/7, are dedicated to helping people live well, and be focussed on managing their own mental health in their homes and communities.

Cumbria and Lancashire health care systems have both faced challenges in the past with regard to mental health and service delivery. Within the Bay we are seeking to balance the legacy of work from the two areas as we move towards accountable care arrangements within the wider Lancashire and South Cumbria STP.

Key facts

Like Many areas, the Bay faces some significant challenges:

- In all of our localities people 18+ registered with depression on GP Registers is above the overall prevalence rate in England
- If you are under 75 years and with a serious mental health illness your mortality rate is getting worse and worse than the national rate
- Hospital admissions for self-harm, alcohol related issues and some depressive illnesses are significantly higher than England rates

- The number of people living with dementia in our Bay system is growing with up to a 60% increase in our Cumbrian residents and up to 50% increase in Lancashire
- We see an increasing trend locally of people attending hospital emergency departments and admitted to a general ward
- Currently we are experiencing a high number of 12 hour breaches on the treatment target of 4 hours in ED from complexity of accessing mental health care or services.

Our local spend

Within Morecambe Bay the CCG spend on mental health services including CPFT and LCFT, Bradford and NTW, and MH care Packages is £54.3 million. This does not include indirect spend e.g. prescribing costs. In addition to the identifiable 'CCG-commissioned' spend we must recognise the amount of funding (not yet quantifiable) brought into the system from community and third sector providers who form an essential part of our system response to MH need.

2. The Bay Mental Health Workstream

We have now established a Morecambe Bay Mental Health workstream under Better Care Together, as a key driver towards transformation of mental health services. This workstream aims to provide:

- Clear strategic direction for the Bay (linked to STP and Cumbria/Lancashire work)
- Determination and delivery of priorities and transformation within FYFV
- Space in which to review performance and hot issues
- A positive culture of integration and joint working across organisations, within the developing ACS and wider
- Continuity of care as we establish our local system and embed as a new CCG
- Put Patients, families and carers at the front of design and change

We have not as yet agreed a final model to for mental health services in Morecambe Bay but have determined principles and priorities and have prepared a draft clinical model on which we are currently engaging partners in – as set out below. It is too early in our evolution and model to address and include public/patient engagement however where able the workstream uses current connectivity into the wider community and third sector systems.

The workstream has met 3 times and is evolving with strong representation from the clinical body across Lancashire and Cumbria; CPFT, LCFT, UHMBT, Primary care, management leads in CCG and provider trusts, Local authority colleagues and as we evolve we wish to widen membership. At present we have not managed to secure representation from Local authority colleagues in Lancashire; but this is an action underway to resolve. Terms of Reference are attached in appendix 2.

3. Strategic direction

Our strategic direction is that we provide the best mental health services within our system, that meet the needs of our population and enables people to live healthy and happy lives in

Morecambe Bay. Our approach to mental health transformation echoes that of the national agenda where we see people living with mental health as no different to people living with a long term illness or requiring physical care interventions; we strive to provide parity of esteem in our services and commissioning approach and we wish to see everybody flourish to their optimum ability.

We have the challenge of working with the legacy of two existing Mental Health strategies for Lancashire and Cumbria. Now that we are part of the Lancashire and South Cumbria STP, we are seeing a clear direction emerging, in line with the national 5YFV Strategy; however, we are keen to ensure that this work continues to support the strategic direction for North Cumbria STP so that we do not undermine sustainability of County-wide services and work with both CPFT and Cumbria County Council Given that both STPs are basing their work on the Mental Health 5YFV and partners are active in both STP work programmes, this risk is being actively managed.

Morecambe Bay is defining and clarifying our strategic approach for the Bay within these wider contexts and particularly supporting delivery of STP priorities. Under the MH programme the STP has 12 national priorities from the FYFV (appendix 1) and a localised delivery plan that is evolving from the Bay MH workstream will capture the local delivery plan for this and other local priorities.

To support clarity of the local strategic approach, we have a draft vision from our clinical lead, Dr Jim Hacking, (appendix 3) and this is being discussed in the STP and Bay Partnerships. This vision focuses on the triple integration: health and social care; hospital and out of hospital care; physical and mental health care. It also focuses on:

- Building on our system approach in BCT
- Providing a focus on wellbeing, prevention, self-care etc
- Creating support in primary and community settings through ICCs
- Collaborating across pathways and organisational boundaries to enable a holistic plan of care to embed mental health interventions
- Specialist care that is able to provide advice and guidance to clinical decisions

The interface between local authority, health, community and life style services is key to providing a bespoke offer to people living with mental health issues and to build a strong foundation earlier with an individual to deliver flexible and high quality services at all touch points.

5. September workshop

The Bay MH workstream are developing a system wide workshop in September to further engage and develop our local strategic vision and delivery plan and to share best practice and identify steps forward with reference to integration.

Chris Naylor, a senior fellow in Health policy at the King's Fund is opening the workshop as our keynote speaker and sharing some of the national learning from Vanguards and new models of care to date. We are creating opportunity for our local system clinicians and managers to come together and start to co-create delivery of our shared vision and share more widely our

ambitions. Indeed, colleagues from across the system are helping to identify and design workshop sessions.

6. Key priority issues

As set out above, our key local priorities will be set as part of the development work in the September workshop and in line with the emerging Vision and STP work. However, we already know we have some key issues to address:

A) IAPT & MH Crisis and Liaison: The FYFV gives us a set of priorities that we will be delivering across our STP and clearly monitored by NHS England and the NHS improvement team, as set out in Appendix 1. Within the Lancashire and South Cumbria STP plans are two distinct transformation projects that attracted funding for local development and implementation. The first is IAPT, which aim to increase access to talking therapies and to extend the model to people living with physical LTC and a MH comorbidity. This also aims to up-skill the IAPT workforce re LTC and share best practice as we work in integrated teams to address MH issues and improve holistic care of individuals. On top of the LTC IAPT funding is another source of income from DWP to implement employment advisors into IAPT services and improve opportunities to individuals.

Secondly there is a programme commencing now but with funding coming in 2018/19 to improve and increase MH liaison as core 24 hours a day in ED and acute care. This will target 50% of our STP ED departments and as a system we are exploring best models to deliver in both urban and rural sites across the STP.

Both projects are transformational and deliver benefit to individuals and to services; however, we have difficulty recruiting to roles in our local system, nationally there is a shortage of staff, and we are not confident that we can provide the resources in terms of recurrent funding and workforce and so are exploring with the STP how we can mitigate challenges locally.

B) ICCs: ICCs are a cornerstone of the BCT Strategy and our local system has been engaged with a Kings Fund Community of Interest Programme to develop more effective models to Integrate mental health, primary and community care services. Kendal ICC have been part of this exciting programme. , Working alongside colleagues in Carlisle ICC in North Cumbria, Kendal helped shape the thinking about possibilities to integrate care further and with the Kings Fund and clinicians from other systems, explored a new seamless model from local design and international learning. Based on this, clinicians explored the 'Inter-mountain model' which is a North American system of care and is described in detail in Jim Hackings paper at Appendix 3. This provides a potential and emerging model for MH integration within ICCs and will be tested in some of our nest steps to action. Kendal ICC is keen to continue and we will work with other interested ICCs in the Bay.

C) Inpatient Bed Modelling: Modelling our need for beds across the system has been undertaken in both Lancashire and Cumbria; and the L&SC STP has undertaken additional work to ensure a consistent approach to the inputs and outputs so that we can determine consistent conclusions from the work. To date analysis indicates that we broadly have the

right number of beds in the two STPs; but we still have potential issues in South Cumbria, particularly relating to the legacy of concerns regarding the Kentmere ward in WGH and how it is used. We will continue to work through what this means and potential options for change (if needed) and use our partnerships within the L&SC STP and with WNE STP to provide the response to consider with public and patients. However, it is important to ensure that we engage the public on the whole MH agenda not just inpatient beds and so we are exploring how best to open a new conversation with our public and create the optimum environment to start this, so that we see earlier interventions, prevention and self-care just as important as beds.

D) Dementia: Dementia remains a strong area of service improvement and we have leadership in the Bay from Sam Jebur who connects into STP wide work and to date much of the dementia national programme has been delivered locally and will be embedded further through our Bay workstream. There are many areas of connectivity for dementia patients in the Evolving ICCs, in the system flow and targeting new innovations such as Dementia care navigators is under consideration in the groups. The Dementia champion roles continue and spreading knowledge and skills to identify and support dementia across third sector, independent care providers, NHS staff etc. has been a success of the work so far.

E) Transition: Transition and improving the connection for people as they move from children's services to adult is a critical enabler and are of work we're keen to develop. The FYFV doesn't specifically set out to describe this area but locally we know we want to make this experience the best and safest it can be. We see all ages of MH a priority and aligning developments is important to us.

F) Complex packages of care: The other are of work that we see as a local priority is a time limited piece of work which is underway to transfer responsibilities for commissioning processes for MH complex care assessments and packages of care. We have a transition plan for this with North Cumbria CCG and the CSU in Midlands and Lancs so we oversee that work in the workstream to ensure accountability is maintained and the system is able to respond to the individuals, putting aside NHS structural reform that created this challenge.

7. ACS & Provider issues

Early discussions between LCFT and CPFT have taken place regarding joint working and integration; at the same time we have been able to open this dialogue to primary care colleagues and those in the local acute trust. The discussions with CPFT, Cumbria County Council and North Cumbria CCG on County-wide services in Cumbria (including MH) are under way to ensure stability and sustainability for all of our population.

8. Recommendations

The Governing Body is asked to:

a) Note and support current Mental Health developments
b) Discuss and provide feedback on the draft vision (noting further development work will take place including with the Workshop in September).

We need to get to all STPs delivering their share of…

NHS England

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

Appendix 2. Terms of Reference MH Workstream

Morecambe Bay Mental Health Oversight Group

Draft Terms of Reference

Name of Committee
Morecambe Bay Mental Health Oversight Group

Constitution
To provide an effective forum for the clinical and managerial leadership of Lancashire North CCG, Cumbria CCG, Cumbria Partnership Foundation Trust and the Lancashire Care Foundation Trust to collectively gain an oversight of Mental Health services in Morecambe Bay.

Connectivity
Reports to:

- BCT Delivery Group
- GP Exec MBCCG
- Cumbria Partnership NHS Foundation Trust – Senior Management Team
- Lancashire Care NHS Foundation Trust - Senior Management Team

Links to Contract and Quality Meetings to understand pressures within the system.

Membership

Morecambe Bay CCG

GP Exec with Mental Health oversight	Chair
Director with Mental Health oversight	Management Lead
Mental Health Commissioner	
Deputy Director	

Commissioning Support

Commissioning support officer

Cumbria Partnership NHS Foundation Trust
Senior Manager
Senior Secondary Care Clinician
Senior Primary Care Clinician

Lancashire Care NHS Foundation Trust
Senior Manager
Senior Secondary Care Clinician
Senior Primary Care Clinician

Authority

The Group is an oversight group and does not replace the ongoing separate CCG contracting arrangements during this transitionary period.

Function of Committee

- To scope and understand the current Mental Health services across Morecambe Bay.
- To receive relevant performance information.
- To identify key priorities for service development.
- To identify key risks and concerns and communicate these to appropriate colleagues for action.
- To contribute to the ongoing STP process for Mental Health in Lancashire and South Cumbria.

Outputs of the Group

- Conduct gap analysis, mapping current Mental Health services in the context of the STP priorities to understand the services that are required.
- Identification of key performance concerns and suggestions for actions.
- Identification of key risks with appropriate escalations.
- Develop a dashboard utilising CCG data.
- Utilise learning from North Cumbria Mental Health programme to initiate the implementation of Mental Health STP in North Lancashire and South Cumbria.
- Align Lancashire and South Cumbria and West, North and East Cumbria Sustainability and Transformation Plans (STP) in relation to Mental Health provision.
- Implement the major service changes required as part of the Mental Health STP and LDP.

Quorum

A minimum of two members from either CCG, one member from CPFT and one member from LCFT.

Review date for Committee – Terms of reference

March 2018

Frequency of meetings

Six weekly

Appendix 3. Dr Jim Hackings Vision paper for Integrating MH

Better Care Together– Mental Health 2017/18

Integration across Morecambe Bay partners

SRO: Anthony Gardner, Director of Planning and Performance Officer, Morecambe Bay CCG

Author: Dr Jim Hacking, GP Exec, Morecambe Bay CCG

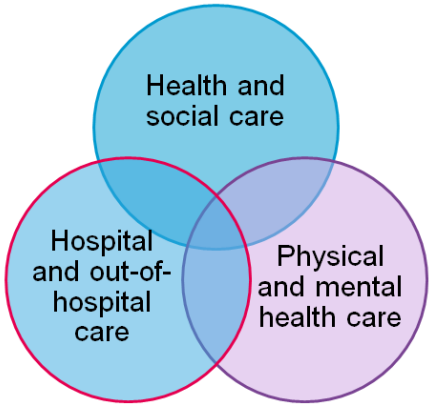
Version: 1.1

Date: 6/6/17

1. Introduction

In the 'Five Year Forward View' (FYFV) (Stephens, 2014), many of the challenges facing the NHS are outlined and it describes how our current system needs to develop and change to think differently and create transformation. It also describes the need for services to integrate around the patient which is further explained using the principle of 'Triple Integration', set out in a presentation at the King's Fund (Stephens, 2015). Triple Integration requires integration between Health and Social care, Hospital, Out-of hospital care, Physical and mental health care, and is shown in a picture below highlighting the interdependencies across the areas of care. .

Figure 1 - Triple Integration



The Triple Integration concept is not about creating a new structure or a single organisation to integrate within. It is an enabler for a range of service areas in different organisations to pull resources together and form a virtual system of support. This integrated system will focus on a defined population and make sure that the providers in that system are working effectively and optimise benefits for the defined population. The most successful systems are those who can find ways to link organisations across the continuum of care and reduce boundaries whilst maintaining a patient focus.

Key themes for integration (Naylor, et al 2016):

- No single approach to integration
- Redefining 'core business'
- Performing an educational function alongside a clinical one
- Bridging the gaps between primary and secondary care
- Redesigning the workforce e.g. through creation of new roles
- Reducing stigma

These principles have been further developed and are defined in the King's Fund report "Bringing together physical and mental health care- a new frontier for integrated care" (Naylor, et al. 2016). Recommended areas of integration include:

- Enhanced support to primary care.

- Managing psychological aspects of Medically Unexplained Symptoms
- Physical Health Checks for people with Severe Mental Illness
- Liaison psychiatry
- Physical Health in mental health settings.

The case for seeking to support physical and mental health in a more integrated way is compelling, and is based on challenges in our system which includes the high rates of mental health conditions among people with long-term physical health problems. In addition, evidence shows there is a reduced life expectancy among people with the most severe forms of mental illness, largely attributable to poor physical health. There is also limited support for the wider psychological aspects of physical health and illness.

Thinking about integration encourages systems to further develop service delivery principles and bring Mental health developments up to speed with those in physical healthcare. Systems are encouraged to deliver 'Parity of esteem' where the aim is to make mental health services "as good as" physical health. Integration offers the opportunity to take this principle further and provide services that are fully inclusive of mental and physical health problems. This would see us moving from trying to make mental health services "as good as" physical health services to ones that are "part of" mainstream services.

Morecambe Bay's Better Care Together programme has started to create opportunities for greater integration of physical and mental health through the development of Integrated Care Communities (ICCs). These communities provide a focus on a defined population and seek to change the narrative in health and social care towards care of the whole person and their holistic needs, not defining a person by a disease or condition.

Better Care Together achieved Vanguard status as part of the New Care models programme and this offers an opportunity for our local health economy to develop new models of care and innovate where able, challenging traditional NHS or other constraints as required. These opportunities are shared nationally within many more Vanguards, each looking at different local models and finding ways to up-scale best practice and share intelligence. Naylor, et al. (2017) have described how some Vanguard sites have started to implement mental health integration but also highlights the much greater opportunities that have yet to be realised.

2. Developments within Lancashire & South Cumbria

Three strands of thinking are emerging within Lancashire & South Cumbria and this paper aims to bring this thinking into our local system from where further development can be agreed.

Firstly there is a commonality of approach across partners in Lancashire and South Cumbria to date and emerging action identifies a need for the following:

- Dedicated mental health staff within the Integrated Care Communities / Integrated Neighbourhood Teams
- Strong relationships between Mental Health Worker, GP and other Primary and Community Care colleagues
- A clear philosophy on delivery models, behaviours in our system and outcomes underpin the desired model
- Clear alignment to the Five Year Forward View for Mental Health

Secondly there are areas which require further development in terms of definitions and agreed processes:

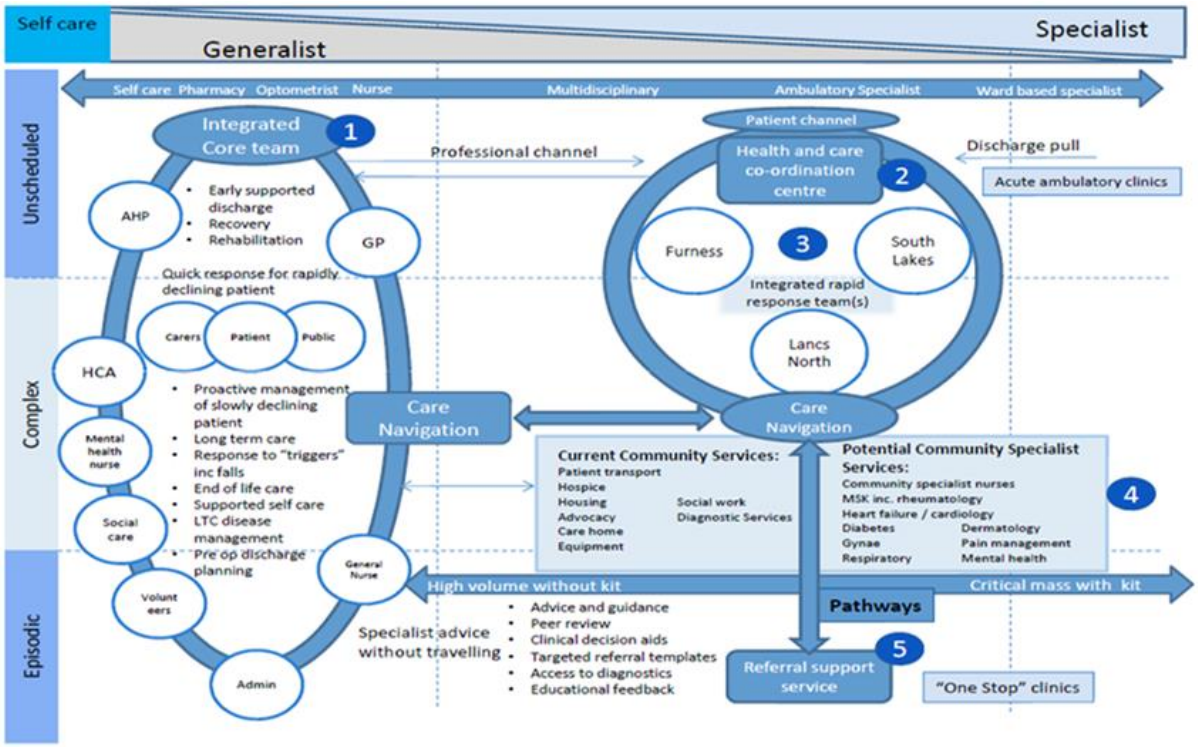
- Boundaries between levels of care; Community, Primary care, Specialist etc
- Means of navigating these boundaries
- Resource allocation and capacity, demand and activity management between specialist teams and those community resources within INT/ICC
- Formal team identity of mental health practitioners in INT/ICC
- Benchmarking of systems across Lancashire and South Cumbria

A focus in the first instance will be to identify the current resources for mental health practitioners and then map alongside resources in the INT/ICC, this will enable development of effective working relationships that will allow the definitions, processes and potential for a new model to be defined and developed.

Thirdly, the development of a new model for Morecambe Bay as part of the Better Care Together Vanguard which is described in the following section below.

3. System wide clinical model

3.1 Figure 2 Better Care Together clinical model.



The clinical model above aims to show how we want to develop towards an integrated model of health and social care across the different organisations in our system. We don't describe the model by disease or condition but we describe a flow of care that offers real transformation focussed on the individual and not the services.

Our local system must provide a fluid and flexible response to the needs of all individuals and a system that can 'breathe' without the boundaries of walls, either physically or culturally. We don't need to describe interventions and flow of care for people with MH needs separately as these are integrated into the model and service principles to deliver parity of care.

We describe the spectrum of services from self-care to Generalist/specialist services wrapping around ICCs (communities have emerged from the grouping of GP practices), to more specialist and ward based services. At each of these points in the care pathway there will be opportunity for further integration of physical and mental health care. ICCs have focussed on an approach to more effective long term conditions care, where LTCs are viewed in the widest sense to include frailty, cancer and indeed mental health.

3.2 Integration what do we mean

As we describe what we mean by integration it is important to be very clear about our understanding of this concept, what it is and what it is not.

What it is?

- Working closely together and alongside each other
- Sharing records, information and intelligence
- Ability to work across professional boundaries
- Reduction in boundaries and silo working
- Learning and developing together
- Reducing duplication & working smarter
- Sharing benefits across our system
- Monitoring impact and outcomes as a system and not as an individual organisation
- Changing expectations, behaviours and culture

What it isn't?

- Shifting work from primary to secondary care or vice versa and also not shifting work in community services from or to these providers
- Losing organisational responsibility and accountability
- Not just colocation to sit people in one building
- Community teams in MH or other delivering work currently undertaken by practice staff or hospital staff

3.3 Self-Care & Generalist

In the primary and community care setting there is considerable opportunity for integrated working between mental and physical health This has previously been tested with various projects exploring different types of link workers from Community MH Teams connecting to Primary care. Attempts to embed IAPT workers within Primary care has also been tested and a model did evolve that is currently being reviewed under the FYFV for MH and offers a model for further integration of physical and MH.

If Integration of physical and MH is to be a success it is important that this is done in a systematic way and with clear understanding of roles and opportunities to change. Colleagues need to learn together and collaborate closely when treating patients but also have access to good supervision and professional support. Challenge is important to our teams as they start to integrate, challenge to ensure that behaviours and culture change; challenge that team members understand and embrace integration, challenge to drop organisational boundaries and to place the patient at the heart of planning and action.

Colleagues in Cumbria have attempted to describe how patients would be managed across an integrated service and this can be described across 3 groups-

i) Routine care from within a practice and primary care
ii) Collaborative MH integrated team in your community
iii) Specialist care across the system

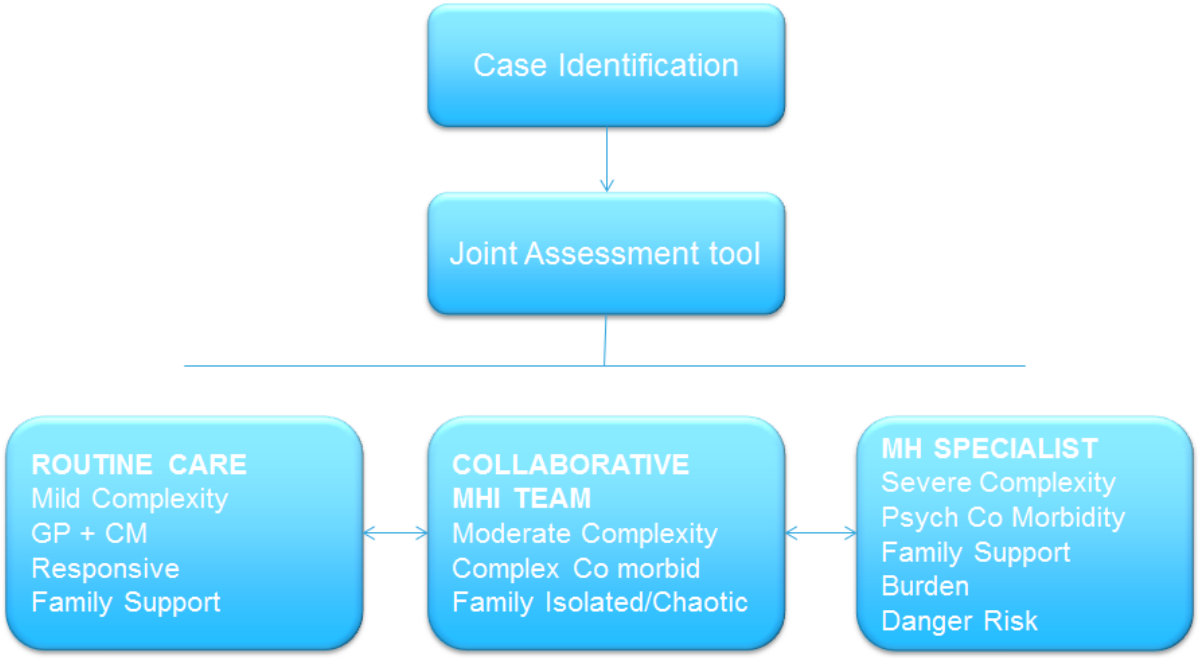
At all touchpoints there will be a culture of integration, working collaboratively, sharing expertise and skills, focussing on the needs of a patient and bringing a menu of services together from across the system providers.

A bespoke service is created based on need and should enable true integrated care and would be a key platform on which to build our service offer and commissioning plans.

This concept is based on the work of 'Intermountain Health Organisation', an American organisation who have been internationally recognised for their work. T hey have been able to integrate services across complex and huge geographic distances, facing challenges from their populations who are dispersed and yet focussing on key principles. In the UK and in our local system we can adopt the framework and ethos, learning and behaviours whilst fitting into our evolving accountable care system.

Figure 3 below demonstrates the Intermountain model of delivery.

Figure 3



This model describes how an assessment tool for physical and mental health needs would be used to identify patients as suitable for one of three types of interventions. This shows a continuum of care need and people will often not enter in a linear manner but require flexibility across and within these service areas. It also parallels the approach in ICCs to risk stratification of mild/moderate/severe patients for frailty and long term conditions.

Routine Care:
Patients with mild common mental illness would be treated by the primary care based team and may also access interventions from the IAPT service or third sector bodies. These patients would have been identified as low risk and willing to comply with a treatment plan within the surgery. The work that is currently developing in ICCs/INTs will be able to help identify earlier those people who may be vulnerable because of a physical need and we can develop joint processes to identify earlier MH needs. This is a natural development of the risk stratification approach to populations in those community settings.

Having IAPT and third sector workers embedded in primary care would facilitate a joined up integrated way of working with the current teams and also the evolving ICC/INT teams. Embedding IAPT workers in primary care and particularly co-working with patients with Long term conditions are priorities identified in the Five Year Forward View and feature in the work plan of our local MH workstream.

Collaborative:
Patients with moderate problems where there is some complexity and risk, but it is felt this could be managed within practices, would be in the collaborative care group. These patients would have moderate common mental health problems or serious mental illness with low risk and be thought likely to comply with treatment and attend appointment in practices and manage within their community and place of residence. They would be referred into services using a standardised approach and to the central referral hub but if identified as suitable for Collaborative care would be booked to see a mental health worker based in primary care.

Specialist:
Patients with more complex needs and a significant risk or likely not to comply with appointments in practices would be assigned to the Mental Health specialist team via the standardised approach and central referral hub. This would offer an assertive proactive service from a multidisciplinary team. Links would still be made to primary care particularly for physical health checks, medication and particularly as the patient's condition improved for consideration of “step down” to collaborative care.

A similar model would also operate for older adults with CMHT workers embedded in practices linking to a central team dealing with more complex cases requiring a more proactive assertive approach.

3.4 Emergency & Urgent Care

The Emergency & Urgent Care part of the pathway offers significant opportunities for integration. FYFV and Implementing the Five Year Forward View for Mental Health (NHS England, 2016) prioritise the need for development of both Crisis and Liaison services with specialist Mental Health care in ED to the “Core 24” standard.

Implementing this in a sustainable way across Lancashire and South Cumbria in both urban and rural areas with a number of ED sites will require an integrated approach. This will require mental health workers in ED to be embedded with ED teams offering skills transfer, education, mentorship and support as well as direct patient care. It will require a flexible model across the 24 hour 7 day period that maintains access and waiting times and offers a service both to ED attenders but also to patients in the community requiring urgent mental health input who may contact services via 111, 999, GP out of hours or the police.

Our local system has been focussing on transformation in ED and as a barometer of how our system is able to react to patient need, presently we have sub-optimal responses for people with MH needs and there are many blocks across the whole system which means that patients are not receiving parity of care, not receiving a timely service and pressure is felt all along the pathway of care services.

The system has tried and tested models of MH workers in ED and with the new initiative across the STP footprint, core 24, and the introduction of a MH workstream, we have opportunity to work closer together to make change happen.

3.5 In-Patient specialist care

Patients who are the most unwell or have the greatest or most complex needs require in-patient care. Currently these patients are managed on either physical or mental health wards, often with minimal support from other specialities and not necessarily able to access the right bed or package of care. This applies both to working-age adults and older adults. If we apply principles of integration across our in-patient wards it will give us significant opportunities for improvements in care and provide opportunity to improve outcomes for people.

On adult mental health wards the physical health needs of a patient can improve significantly when care and contribution to the care plan is available from physical health care clinicians. Evidence shows that patients with Serious Mental Illness have significantly poorer physical health that the general population. In-patient stays are an important opportunity to begin to tackle some of these concerns both looking at longer term health promotion around diet, exercise and smoking cessation and also looking at more immediate complications with medications being commenced particularly antipsychotics.

We know there are many co-morbidities that are exposed when a person with mental health need is admitted, yet that previously had less of a priority to the mental health need, providing skills development, joint working, shared responsibility and a coordinated plan of care will improve outcomes and holistic care for the individuals.

Physical care adult wards often have patients with coexisting mental health problems which may include patients who have self-harmed or taken an overdose, or patients with complex symptoms often with a psychological basis. Both good access to mental health expertise and education and upskilling of ward staff regarding mental health would enable these wards to work much more effectively and benefit the patient.

Specialist Older people's wards are currently divided into either physical or mental health; both have significant challenges meeting the needs of the other discipline. Some areas have piloted wards able to treat patients with both physical and mental health problems in older age and an interim step towards this would involve much closer working ideally with co-location. The MH workstream has identified this integration of MH and physical care as a work plan priority and seek to maximise benefit from reorganising the resources we have in the system.

4. Conclusions

Better Care Together is an ongoing process of developing and improving health services for the people of Morecambe Bay. As part of the Vanguard process significant changes have already been made in the way we organise services but also in the view and opinions of clinicians and of citizens.

Along with other Vanguard sites experience of including Mental Health in the process of change has been a challenge. The Five Year Forward view encourages us to make Triple Integration a reality and include mental health in our new care models.

To do these actions and deliver the transformation we require in Morecambe Bay we must reflect the current challenges and those include:

- Financial gap across the system and a 'Capped Expenditure Process'
- Infrastructure challenges

- Workforce deficit and difficulty recruiting and retaining staff
- Skills development opportunities and training access/funds
- Geography of the Bay and impact to travel times and efficiencies

Our initial work to date has shown a tremendous amount of enthusiasm for including Mental Health in our new care model and real opportunities for both improved patient care and better use of resources.

5. References

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