

## **Public Audit Committee**

### **Overview of Mental Health Services**

#### **Submission from NHS Greater Glasgow and Clyde**

##### **1. BACKGROUND TO GG&C: OVERVIEW OF MENTAL HEALTH PROVISION**

Greater Glasgow and Clyde has a population of 1.2m, a little below 25% of Scotland's population. Some 80% of Scotland's population classified as in the 2 most deprived deprivation categories live in the GG&C Board area - so the overwhelming majority of Scotland's most deprived population is disproportionately located in the GG&C Board area. Mental Health service use by the most deprived populations tends to be double that of the least deprived populations.

The Greater Glasgow and Clyde Health Board area is coterminous with the local authorities of Glasgow City, Renfrewshire, East Renfrewshire, East Dunbartonshire, West Dunbartonshire and Inverclyde and a proportion of South Lanarkshire.

Community Mental Health Services for adults, older people and children are managed within the 11 Community Health Partnerships. The Greater Glasgow and Clyde Adult Mental Health Partnership manages pan CHP inpatient Services (on 11 sites) and specialist services for city or Board wide populations. Additionally the MH Partnership is responsible for providing the strategic framework and performance assurance for the totality of Adult mental health services. In the case of children and elderly services these functions are provided by a lead CHCP/CHP's providing these functions on behalf of a group of CHP's.

Six of the 11 Partnerships are joint health and social care Community Health and Care Partnerships whilst the remaining 5 partnerships are NHS only Community Health Partnerships.

NHS Spend on adult mental health in Greater Glasgow and Clyde is summarised in the table below

SUMMARY ADULT MENTAL HEALTH GG&C ( based on reworking of Scottish Benchmarking submission )	Net	% total
	Costs	
	£'000	
general community services	66328	40%
specialist community services	6686	4%
<b>Sub Total Community Services</b>	<b>73014</b>	<b>44%</b>
acute and IPCU beds	22788	13%
rehab and recovery beds	19904	12%
specialist and tertiary beds	16603	11%
inpatient infrastructure	25842	16%
<b>Sub Total Inpatient Services</b>	<b>85137</b>	<b>53%</b>
<b>Sub Total AHP Services</b>	<b>5314</b>	<b>3%</b>
<b>Total all services</b>	<b>163465</b>	<b>100%</b>

Total NHS expenditure on older peoples mental health in GG&C is approximately c£34m:

- £10.5m community mental health services
- £22.5m inpatient services

The Greater Glasgow Mental Health Services have moved from a 90%+:10% split of inpatient to community spend to a near even split of spending between inpatient and community services, and have a relatively well developed and comprehensive range of community mental health services including 24/7 access to community crisis supports. This has seen the service move from hospital dominated services supported by a modest level of outpatient supports, to community services underpinned by access to brief periods of inpatient admission when required

Having developed the core components of comprehensive services the issues for Greater Glasgow are less about service deficits per se and more about the effective functioning of the services and the development and implementation of wider frameworks for Health Improvement

The Clyde services have historically been at an earlier stage of development and until recently were more dominated by inpatient services (c75% of spend) with less developed community services and very limited options for access to supports outside of 9-5 weekdays. Following the absorption of the Clyde geography into the new GG&C Health Board the Clyde Modernising Mental Health Strategy has seen the implementation of substantial service redesign and rebalancing of services. This sees investment c£12m in developing community care supports through redirection of funding previously spent on inpatient and continuing care services into a more balanced service mix, with access to extended day crisis responses and extension of primary care supports. At this stage about 70% of the rebalancing has now been implemented.

## **2. SPECIFIC QUESTIONS FROM THE PUBLIC AUDIT COMMITTEE**

### **Accessibility of mental health services**

#### **a) What targets have you set for accessibility to services (including waiting times) and the quality of services in your area?**

In the absence of national targets few local targets are applied. The main local targets apply to urgent, emergency and routine access to community mental health teams and crisis teams. The stage of service developments in Clyde are less developed than in Greater Glasgow and the position described below applies primarily to Greater Glasgow

CMHT (Nursing, OT and Social Work) –  
Emergency referral - Same day or 24 hour response,  
Urgent – 5-6 working days,  
Routine - 4 to 6 weeks.

Crisis Team –  
Emergencies seen in 1 to 4 hours.  
Urgent - within 24 hours.

Additionally the model of primary care supports has deliberately built in rapid access to a range of service responses including direct access, self referral, guided self help etc.

Medical and psychology staff aim to see new referrals within 9 weeks albeit these targets are not currently met in all areas of GG&C NHS Board.

#### **b) What action are you taking to address services with long waiting times?**

Actions taken include:

- Expanding psychotherapy resources
- Recruitment/expansion of psychology resources
- Development of evening clinics
- Review of DNA rates
- Changing catchment populations to equalise workloads
- Primary care supports include self referral/direct access to enable rapid access to guided self help and low cost supports
- Proactive management of staff absences
- Re-introduction of early screening assessment system

#### **c) What are the current issues affecting vulnerable groups in your area - children and adolescents; minority ethnic groups; prisoners and ex-offenders; older people with dementia or Alzheimer's disease?**

- Ethnic minority groups - access to good quality translated materials, shortage of ethnic minority MH staff

- Asylum seekers- continue to have separate and limited access to primary care - also when asylum is refused - problems with access to services and benefits
- Limited service supports for people with speech impairments

**d) Are current levels of service for vulnerable groups adequate and what improvements, if any, are being planned?**

- Anti-stigma training, ensuring access to interpreters and delivering culturally sensitive practices by accessing appropriate training opportunities such as E-learning EQIA
- The PCMHT has been involved in a project to increase involvement with the local Chinese community.
- Our links with Criminal Justice Team enables us to provide services to prisoners and ex- offenders
- outreach to community representatives from BME communities
- general expansion of early intervention and community based services in Clyde area
- targeted work on deprivation and gender and age within Primary Care Mental Health Services
- development of both community and inpatient specialist provision for Perinatal services and eating disorders

**Delivery of mental health services**

**e) What is your performance against the four national health targets for mental health?**

1. Suicide prevention : reduction in suicide rates
  - previously achieving significant reductions in suicide rates but since 2005 figures rising again
2. Suicide prevention 50% of front line staff trained by Dec 2010
  - currently 23% trained and projecting significant improvement in this position and aiming to achieve target by December 2010
3. Prescribing of anti depressants: annual rate of increase reduces to nil by 2010 and thereafter reduces by 10%
  - there are a number of technical complexities re the definition of this target but it is clear that we have not reduced the annual rate of increase to nil, but at the same time the local rate of increase, at 0.43% is not that far off that for Scotland generally at 0.46% (2007/08 period )
  - the local level has seen a modest reduction from a start position of 0.81% growth down to 0.46% annual growth
4. Reduction of psychiatric readmissions by 10%

- Dec 2009 target level of 1057 readmissions has already been achieved with actual readmission levels averaging 1039 readmissions as at June 2009.
5. Dementia: improve early diagnosis and management of patients with dementia evidenced by increased no.s on dementia registers
- this target is being met

More detailed analysis of the position for each of the targets is described in the text below. It is noteworthy that the only target wholly related to the actions of mental health service delivery is the target for readmissions on which local progress is good. The other targets reflect areas requiring interventions across the wider NHS or broader social determinants of health with the activity of local mental health services being that of leadership and influence.

## **H5 – Suicide Prevention**

Reduce the suicide rate between 2002 and 2013 by 20%, supported by 50% of key frontline staff in mental health and substance misuse services, primary care, and accident and emergency being educated and trained in using suicide assessment tools/suicide prevention training programmes by 2010.

### **Commentary**

While a downward trend was experienced in the first 4 years of this Target (19.08 to 16.8), from 2005 onwards the trend has been increasing. There are numerous factors at a local and macro economic level that can and do contribute to this. In the light of this, and with the absence of the 2008 data, it is not possible to be confident of achieving the 20% target by 2012.

### **Wider factors:**

- Increased suicides rates are widely associated with deprivation levels and the GG&C Board area has circa 80% of the Scottish population of people in the most deprived deprivation categories and only 20% of the Scottish population
- Suicide rates for the most deprived areas of Scotland are double those of the Scottish Average
- Excess mortality beyond deprivation based projected levels, for a range of health conditions, has been longstanding in both Greater Glasgow and the West of Scotland
- Suicide levels are linked to macro economic and political factors ( intergenerational poverty and exclusion, educational attainment and future prospects, urban regeneration) far beyond those directly influenced by mental health provision per se and require influencing a range of broader activity

## Local action

- Active partnership with local authorities, CHCP's, and community planning partners to address risk factors associated with suicide and preventive action
- Examples of above include neighbourhood renewal work, employability programmes, green space initiatives, a strong focus on recovery approaches for people with mental health problems, active anti stigma partnership programme
- The GG&C Suicide Prevention partnership is commissioning action research/learning on prevention of suicide in multiple deprivation areas
- Specific training and development work with addictions services given the prominence of substance misuse as a factor in suicide.

**Current position : train 50% of front line staff in using suicide assessment tools by 2010**

Trajectory		Actual
2008	20%	10%
2009	35%	23% as at June 09
2010	50%	

- Current position is that 23% training coverage has been achieved and there is some risk that the 50% target may not be fully achieved by December 2010
- This target is particularly challenging in the context of GG&C given the scale and complexity of the GG&C area, coordination of overall work is a challenge, with approximately 10,000 front line staff to be trained across multiple organisational entities and management systems and multiple professional groups
- In response to local concerns about lack of national guidance on accreditation of prior competence for certain professional groups, plus limitations in the content and delivery options for programmes relative to the needs of some of these groups we have now developed pragmatic local responses as follows:
  - Agreed approach to prior competencies issues in conjunction with Health Scotland and Stirling University
  - A GG&C Training Action plan is now in place with Director level designated leads within each of the local NHS organisational units responsible for implementing local organisational training action plans
  - Enhanced training capacity has been developed and contracts for commissioned contracted in training have also been implemented which should see a significant increase in training uptake in 2009

### **T3 – Prescribing of Anti-Depressants**

Reduce the annual rate of increase of defined daily dose per capita of antidepressants to zero, by 2009/10, and put in place the required support framework to achieve a 10% reduction in future years.

#### **Commentary**

Although rates continue to increase, there are significant variations amongst CH(C)Ps and more so amongst GP practices. Latest projections could suggest that rates are levelling although this is unclear. It remains difficult to take actions that can have an immediate and attributable impact on rates and the strategy is to focus on appropriate prescribing in the longer term. Through the work being undertaken under the auspices of the MH Collaborative, an Action Plan has been prepared which details work based on best knowledge and practice and also addresses the need for national reporting requirements.

#### **Detailed information**

There are genuine unknowns concerning future antidepressant prescribing levels and we have taken an approach that minimises patient risk by concentrating on assuring appropriate use of antidepressant medication. This has been widely acknowledged in Scotland (and between the Board and the Scottish Government Delivering for MH team). Our strategic approach has been shared with the Government team.

NHS GG&C provides a stepped care model through its investment in Primary Care Mental Health Teams. The role, function and outputs from PCMHTs is being reviewed during 2009/10 and from this we will better monitor their impact.

The rate of increase baseline is noted at 0.81% at beginning of 2006. Using first quarter figures, GG&C had a ddd of 6,945.73 per 1,000 patients for Q1 of 2006 – 2007 against the Scottish figure of 6,198.04. This can be translated into a percentage of people within the population as being on antidepressants as 7.63% and 6.81%.

For the same period for 2007 – 2008, the GG&C figures were 7,358.93 (8.09%) and for Scotland 6,590.92 (7.24%). The increase in the rate for Scotland was thus 0.43% and for GG&C, 0.46%. Further work will be required to analyse trends before drawing conclusions too early. The figure does suggest a decrease in the rate from baseline.

The importance of translating ddd into 'people' (albeit making several assumptions) allows us to consider practice based or CHCP/CHP targets. This will inform our approach outlined within our strategy.

Aside from individual GP prescribing habits, it is known that poverty has the greatest impact on ADM levels. The GG&C demographic would therefore indicate much higher levels relative to Scottish averages.

We are aware of very high levels of variation in GP prescribing practice and we are working to ensure an effective system is in place to manage variance through our CH(C) Ps.

PRISM data and ISD based information is actual data collected retrospectively. It does not include benzodiazepine prescribing (this may be relevant) and it does include amitriptyline – which may be a confounder (up to 2%).

### Summary of Progress

Although rates continue to increase, there are significant variations amongst CH(C)Ps and more so amongst GP practices. Latest projections suggest that rates are levelling although this is unclear. It remains difficult to take actions that can have an immediate and attributable impact on rates and the strategy is to focus on appropriate prescribing in the longer term. Through the work being undertaken under the auspices of the MH Collaborative, an Action Plan has been prepared which details work based on best knowledge and practice and also addresses the need for national reporting requirements.

### T3.KPM1: Prescribing of anti-depressants

Year Ending	DDD's	
Jun-06	35.5	
Sep-06	35.8	
Dec-06	36.4	
Mar-07	36.9	
Jun-07	37.4	
Sep-07	38.3	
Dec-07	38.8	
Mar-08	39.2	
Jun-08	39.6	
Jun-09	39.6	
Sep-09	39.6	
Dec-09	39.6	See note 2
Mar-10	39.6	
Jun-10	39.6	
Sep-10	39.6	
Dec-10	39.6	
Mar-11	39.6	

### Notes:

1. Number of anti-depressant DDDs per capita (aged 15 and over). Based on GRO mid-year population estimates for 2006.
2. Number of anti-depressant DDDs per capita in year ending March 2010 is to be less than or equal to the number of anti-depressant DDDs per capita in year ending December 2009.
3. June 2009 to March 2011 data have been taken from the 2008-09 LDP trajectories.



## **T4 – Reduction of Psychiatric Readmissions**

Reduce the number of readmissions (within one year) for those that have had a hospital admission of over 7 days by 10%, by end December 2009.

### **Current Position**

We are already at or close to achieving this target having made early gains. Clyde services are operating at higher levels of readmission to Glasgow services which is probably a function of less developed community services in that area. However recent years have seen a shift in the Clyde balance of care away from inpatient beds towards development of community services which appears to be working as reflected in reducing readmission rates in Clyde whilst those in Glasgow appear to have stabilised/plateaued albeit at a lower level

### **Detailed Information**

Early indications are that the introduction of Crisis Services is having the desired effect on re-admission rates. Currently we are reviewing the routes of admission, to ensure that alternatives to admission are being properly considered. We are also developing our information to Consultant team and patient and ward level. There are some indications that there are patients who could be placed in better levels of support in the community, particularly supported accommodation, which would prevent admission and readmission. We are also examining in some detail short term admissions in regard to addiction and personality disorder. This work is at an early stage.

We have recently aligned Crisis Services with junior medical staff after hours to improve and reduce inappropriate admissions. A report on this is being prepared and this has proved to be a positive initiative.

In addition to all of the above, through the work being undertaken under the auspices of the MH Collaborative, an Action Plan has been prepared which details a range of improvement measures being implemented to assist in the reduction of the level of psychiatric readmissions.

### **SPARRA MD (Mental disorder)**

SPARRA data has been distributed to all Heads of MH and is being used within service redesign groups and among local teams to inform and direct clinical activity as part of a suite of performance reports aimed at reducing the level of inappropriate readmissions.

#### T4.KPM1: Reduction of psychiatric readmissions

Projected	Target	Actual		Projected	Target	Actual
Mar 2006	1167	1148		Mar 2008	1108	1010
June 2006	1160	1135		June 2008	1101	1026
Sept 2006	1152	1124		Sept 2008	1094	1031
Dec 2006	1145	1112		Dec 2008	1087	1054
Mar 2007	1138	1125		Mar 2009	1080	1053
June 2007	1131	1117		June 2009	1072	1065
Sept 2007	1123	1102		Sept 2009	1065	
Dec 2007	1116	1045		Dec 2009	1057	

#### T9 – Dementia

Each NHS Board will achieve agreed improvements in the early diagnosis and management of patients with a dementia by March 2011.

##### Current Position

Year ending	Target No Registrations	of Actual No Registrations
Mar-07	6,601	
Mar-08	7,100	
Aug 08 (note 1)		6,705
Mar-10	7,990	
Mar-11	8,779	

##### **Notes:**

1. Excludes patients in registered Nursing Homes, estimated at approx 1,100

##### **Commentary**

Significant progress has been made towards achievement of the Target, particularly since agreement has now been secured with GMS Nursing Homes to set up a Dementia Register.

A range of improvement measures are currently being implemented (via the MH Collaborative Action Plan) which are aimed at increasing the number of Dementia registrations.

##### **Detailed information**

Meeting this target is dependent on GPs identifying people with dementia and the incentive of QOF through DEM1. There is a risk that GPs do not view this as a priority. This risk will be repeated for DEM2. To address this, protected learning events on dementia are being promoted across GG&C and supporting literature is being developed along with a local directory of services. We will link those known

to specialist services with the GP Registers and make improvements in the usage of Patient Information Management Systems within specialist services.

Glasgow City has a medical practice (GMS) contracted for some 2,600 residents in nursing homes. This population has a high prevalence of dementia and a conservative estimate of 60% of the population would indicate 1,560 residents having dementia.

While GMS do not have the incentive of QOF to have a register of people with dementia, agreement has recently been reached with them for the establishment of such a register. We are in the process of finalising proposals here, with the main issue being how figures will be gathered nationally, given that GMS is not eligible for QOF payments.

Associated with this Target is a risk around the capacity of specialist services to manage the possible increase in referrals and previous unmet need. This will also have an effect on partner agencies, including social work and the voluntary sector.

The HEAT Target focuses on early stages of dementia, and there is a need to ensure that new resources are brought to this, rather than taking services from people with more severe dementia.

Within GG&C an Older People's Mental Health strategy is being developed. Further work is needed to address the contribution of Acute Health Services and Medicine for the Elderly and their contribution towards diagnosing and supporting people with dementia.

In addition to all of the above, through the work being undertaken under the auspices of the MH Collaborative, a detailed Action Plan has been prepared for addressing the HEAT Target.

Each CH(C)P has nominated a lead to carry forward the HEAT target, and a GG&C HEAT Target working group has commenced. A series of process mapping events have commenced to look at how each CH(C)P can improve the patient experience, become more efficient in delivering care and provide appropriate post diagnosis support.

A launch of 3 carer's booklets took place on 8th June and the booklets are currently being circulated throughout health, social work, and the voluntary private sectors. Further publications are planned for hospital staff, people with dementia and BME groups. 8 focus groups have taken place with the involvement of users, carers and a wide variety of staff. Key points from the information will populate medium and long term goals of the Dementia Workplan.

Over 95% of GP practices within GGC have registers of people with dementia and those with <50% expected levels are being offered assistance to increase their numbers.

## T9.KPM1: Dementia

Year ending	No of Registrations
Mar-07	6,601
Mar-08	7,100
Mar-10	7,990
Mar-11	8,779

### Notes:

1. The Board level targets have been revised to take account of the age-gender structure of the population.
2. Number of people with a diagnosis of a dementia on the QOF dementia register.

### f) How helpful do you think these four targets are?

In principle it is reasonable to attempt to focus activity on priority areas by the use of quantitative targets. However as has been set out in the detailed information provided above many of the targets are technically limited or flawed, and in some cases measure outcomes which are not directly within the gift of mental health services or Boards to deliver. Given the limitations of the targets themselves there needs to be a more qualitative interpretation of local progress beyond the numbers.

Perhaps until more fit for purpose numerical targets are developed the focus should necessarily be on action plans around the related areas rather than the crude numerical targets themselves.

**G).The suicide rate in Scotland is almost double the rate in England and Wales. What is the situation in your board area and what measures do you think will be effective in reducing the rate?**

### Wider factors:

- Increased suicides rates are widely associated with deprivation levels and the GG&C Board area has circa 80% of the Scottish population of people in the most deprived deprivation categories and only 20% of the Scottish population
- Suicide rates for the most deprived areas of Scotland are double those of the Scottish Average
- Excess mortality beyond deprivation based projected levels, for a range of health conditions, has been longstanding in both Greater Glasgow and the West of Scotland
- Suicide levels are linked to macro economic and political factors ( intergenerational poverty and exclusion, educational attainment and future prospects, urban regeneration) far beyond those directly influenced by mental health provision per se and require influencing a range of broader activity

## Local position

While a downward trend was experienced in the first 4 years of this Target (19.08 to 16.8), from 2005 onwards the trend has been increasing. There are numerous factors at a local and macro economic level that can and do contribute to this.

## Local action

- Active partnership with local authorities, CHCP's, and community planning partners to address risk factors associated with suicide and preventive action
- Examples of above include neighbourhood renewal work, employability programmes, green space initiatives, a strong focus on recovery approaches for people with mental health problems, active anti stigma partnership programme
- The GG&C Suicide Prevention partnership is commissioning action research/learning on prevention of suicide in multiple deprivation areas
- Specific training and development work with addictions services given the prominence of substance misuse as a factor in suicide.

## Detailed response

The detailed statistical picture for trends in suicides has been set out in a recent report produced by Choose Life in conjunction with the Scottish Public Health Observatory. Key data at Board level is presented below:

### “NHS Boards

- Between 1999-2003 and 2004-08, the suicide crude rate per 100,000 decreased in 13 of the 14 NHS Boards [this includes Greater Glasgow and Clyde, where the crude rates and age standardised rates fell – see below].
- During 2004-08 suicide rates were significantly higher in Greater Glasgow & Clyde NHS Board when compared to rates across Scotland generally.
- For males, suicide rates were significantly higher in Greater Glasgow & Clyde and Highland NHS Boards, and significantly lower in Lothian and Forth Valley NHS Boards, than in Scotland as a whole over this period.
- For females, suicides were significantly higher in Greater Glasgow & Clyde NHS Board and significantly lower in Forth Valley and Grampian NHS Boards, than in Scotland as a whole.”

For Greater Glasgow and Clyde, European Age-Standardised Rate of Suicide is as follows, for the most recent 2 cycles of 3 years (these are 3 year rolling averages):

**1999-2003**  
19.1

**2004-2008**  
18.4

As the national reports make clear, one of the major features of suicide rates is the link to deprivation, with risk increasing with each decile of deprivation. Suicide rates in the most deprived areas of Scotland were almost double the Scottish average. We thus see dramatically different rates for different communities within GG&C, ranging from some of the lowest to some of the highest rates of suicide in Scotland, for both men and women.

With the clear evidence of the relationship between deprivation and suicide rates, a significant proportion of the response to suicide risk in vulnerable communities needs to be seen at the macro-economic and political level, including tackling intergenerational poverty and exclusion, educational attainment and future prospects, urban regeneration. The National Confidential Inquiry into Suicide and Homicide's most recent Scottish report (2008) also highlights the strong contribution that substance misuse problems plays in sustaining Scotland's high suicide rates, so joint efforts with the addictions sphere are also essential.

As our response on SOAs and mental health makes clear, NHS Greater Glasgow and Clyde is working in active partnership with local authorities, with CH(C)Ps and with many local community planning partners in seeking to address many of the associated risk factors for suicide, as well as on more direct preventative action.

Examples include neighbourhood renewal work, employability programmes, green space initiatives, financial inclusion measures, a strong focus on recovery approaches for people with mental health problems and an overt focus on equalities dimensions (e.g. programmes of work on mental health of asylum seekers, people with sensory impairment, gender based violence programmes). Our Anti-Stigma Partnership programme ([www.phru.net/mhin](http://www.phru.net/mhin) for programme brochure) is an ambitious multi-component programme drawing in over 50 partner agencies and aimed at reducing the stigma associated with mental ill health.

Each local authority area has an active Choose Life programme in place and the Health Board and other partners provide on-going input to enable these programmes to progress. There remains a continued major emphasis on training, including a significant body of work to address the HEAT target requirements for training of 50% of front-line staff, but also training of wider partners in the community. There is also a lot of activity in the sphere of addictions and suicide prevention, including a process to commission new action research in this area, plus active training of addictions staff in suicide prevention techniques.

Most recently, we are establishing the Glasgow Suicide Prevention Partnership in conjunction with NHS Health Scotland and the CHCPs in North and East Glasgow. This initiative will give an explicit focus on action learning approaches to preventing suicide in areas of multiple deprivation. Learning emerging from this work will be shared and debated widely, with a view to influencing mainstream practice of multiple agencies. As a range of local partners, we also have a strong belief that we must build closer dialogue and partnerships with disadvantaged communities themselves, and identify community resources, resilience and innovations that have the potential to add to the suicide prevention effort. There are good examples already in place which the new Prevention Partnership will seek to build on.

With recognition of the current adverse economic climate, and elevated levels of unemployment, debt, home repossessions and allied consequences, we know from international evidence that there may be a knock on effect of upward pressure on suicide rates. We are therefore determined to ensure that suicide prevention efforts remain a priority, building on the activities of Choose Life programmes and other community planning partners, and most importantly connecting with the wider mental health improvement activities as set out in partnership plans (see responses on SOA for further details).

**g) There has been a fourfold increase in the prescribing of anti-depressants since 1993-94. What is the prescribing policy in your board area and how is it monitored?**

### **Prescribing Policy**

NHS GG&C issue formulary guidance which includes reference to evidence based best practice. This recommends 'first line' drugs of choice – fluoxetine and citalopram (these are generic formulations and inexpensive). It is expected that GPs refer to the appropriate NICE guidance and SIGN guidelines for depression and anxiety.

These recommend a period of 'watchful waiting' and consideration of self help or brief therapies for less severe presentations of these problems. They suggest that for moderate or severe depression, antidepressant medication (ADM) should be considered.

Antidepressants don't work for everyone – perhaps around 60% of people for whom they are appropriate will benefit. The only way to tell if they work is to try them. GPs may need to try several drugs to find one that works and is tolerated by the patient. Where GPs encounter treatment resistant depressions or recurrent or long term conditions, they have the option of consulting with mental health services – ordinarily through referral to the local Community Mental Health Team (CMHT). Practices can also seek advice from local Prescribing Advisers.

The greatest volume of antidepressant medication (ADM) relates to General Practice. Current spending on ADM for GG&C in primary care is approximately £10m. Over the last year or so, this is a decrease of over £1m. This is attributable to more efficient use in cost and formulary terms rather than a reduction in patients receiving antidepressants.

Through mental health services, 'specialist antidepressant prescribing' - is only around £150k.

### **How monitored.**

Within GG&C, we are able to access the (national) database of prescribing – PRISMS – to identify usage of antidepressants. This is available at a Board, CH(C)P and GP practice level. The challenging issue is significantly influencing these levels – this is discussed below.

As the Audit Committee have noted, it is not patient specific data but aggregated prescriptions counted as 'defined daily doses' (ddd).

When interpreting these data, it is important to note what is known (and what is not) about the fourfold increase, how the figures are constructed, confounding factors, and the locus and context of prescribing decisions.

The Committee speculated that the increase may be in relation to numbers of people using antidepressants or increased dosages or both. This could be the case, but it could also be neither. The measure used – defined daily doses (ddd) – are based on WHO figures for 'typical' doses of individual drugs. The problem is the assumption about what is typical – and the assumption that ddds equal people. Older drugs were perceived to be less safe and GPs tended to prescribe them at low doses – in some cases what is termed 'sub-therapeutic doses'. GPs also tended not to prescribe them for long enough and the drugs themselves could be used at less than the ddd.

What this means is that the ddd rates were possibly several times lower than they should have been – despite the concerns noted. Newer drugs may be prescribed for longer time periods, have a higher ddd and may be prescribed in multiple ddds. In practice, one patient taking a drug may have started on an old drug equivalent to half a ddd, switched to a new drug at 1 ddd but to get better effect now be getting 3 ddds - and they may continue taking this until six months or more after they are better or indeed long term – and all of this may be appropriate.

There is a view that better GP awareness of dosage and length of treatment, combined with a switch from older to newer drugs could account for the increase in ddds whilst the number of people being treated has stayed the same. The best research we have available does not suggest that the level of depression is increasing, that more patients are seeking help or that GPs are detecting more depression.

ADM is also used for conditions other than depression – in addition to other common mental health problems like anxiety; they are used for sleep problems and management of pain for example.

There requires to be more research in this area. There is no evidence that GPs are over-prescribing – not least because there is no consensus on what an 'appropriate level' should be. If anything, the evidence has suggested GPs tend to under-prescribe – and we know that this is the case in South Asian populations for example.

The existence of the HEAT Target, incentives in the GP contract to detect more depression, campaigns to reduce stigma and promote help-seeking, raised awareness for GPs, and the use of antidepressants for more disorders, is if anything likely to further increase usage.

The greatest concern is variation and there has been research on this. It is important to note that the greatest single factor that predicts variation in ADM prescribing is deprivation. Multiple disadvantages compound this. It is therefore



unsurprising that absolute levels of prescribing are higher in GG&C because of our demographic profile.

**h) What work are you doing locally looking at prescribing patterns to determine whether antidepressants are being prescribed appropriately and what other treatments are available to people with depression, such as psychological therapies, increased social support etc?**

**Work being done locally-**

Through funding from the Mental Health Collaborative, GG&C have appointed a dedicated prescribing adviser to examine trends in prescribing at (selected) GP practice level. This work aims to increase our understanding of patterns of ADM usage and to test that prescribing is appropriate. The learning will be utilised to provide further guidance for GP practices.

Our early findings suggest that around one in ten adults in deprived areas are receiving ADM – and the recorded severity of their disorder suggests this is appropriate. However, many patients appear to be receiving ADM for long periods with less evidence of this being reviewed in terms of both appropriateness and effect.

It is estimated that 80% of ADM usage relates to longer term use. The sheer volume of individuals concerned precludes the systematic review of every patient. We will consider exploring methods for opportunistic review, but a systematic exercise is only likely to be possible if this were agreed as a funded contractual addition to the GMS contract.

The GMS contract has also introduced a new quality measure for GPs to review patients diagnosed with depression within 5 – 12 weeks. This measure is not explicitly focused on ADM, but as antidepressants usually do not show an effect for three or four weeks, this promotes GPs to review their prescribing decisions for new patients.

Again using Collaborative funding, we are developing dialogue and further guidance for GPs in the context of this quality measure and are planning sessions with GP practices to discuss ways of supporting appropriate prescribing. All of this work is included within our Mental Health Collaborative Action Plan.

**Other therapies**

In terms of 'other treatments available', it is important not to assume that these are an alternative to medication. For mild or transient presentations, antidepressants are not appropriate but other therapies – such as self help or brief therapy may help. Of course mild presentations can deteriorate and what appears transient may persist. However, where medication is indicated as appropriate, it is rarely the case that therapy offers a direct alternative. Commonly both medication and therapy in combination are appropriate and effective.

We do not have the evidence that having therapy available reduces prescribing. Indeed the findings from recent Scottish research do not support this assumption.

Anecdotally, GPs will report that if therapy was available more quickly, this may affect their prescribing decisions – however, this needs to be more robustly evidenced.

When a patient is depressed and referred for therapy, even a short wait for assessment and subsequent commencement of treatment means that they will not experience a benefit for many weeks and possibly months. As noted above, antidepressant effectiveness can be expected in three to five weeks.

In Greater Glasgow & most parts of Clyde, all GP practices have a Primary Care MH Team (PCMHT) available to them. Each Team comprises a range of therapists and offers information, self help materials and brief (around 6 – 8 weeks) individual therapy. Some offer large group therapies/classes. They can provide brief social support or signpost patients to local services for this.

This is a significant investment for the Board – around £5m per annum. This level of provision remains unmatched in Scotland. Although the waiting time for each Team and the different therapies available vary, responses are around 4 – 6 weeks. Some Teams are providing responses quicker than that. Although the figures vary, around half of these patients are already receiving antidepressant medication and this appears to be appropriate. We should stress that this is early data and requires to be scrutinised further.

As a part of this service development, GG&C have made available written and visual resources in libraries, including quality web based resources that offer instant access and are easy to use.

It is also important to note that these PCMHT services are not the ‘psychology waiting times’ documented in the Audit Scotland report. The waiting times in the report refer to ‘secondary care’ – in other words community mental health services for serious, severe or enduring mental illness. Patients waiting on these services have needs beyond the PCMHT. If they are using ADM, this is likely to be appropriate and will continue to be appropriate during therapy. Such patients are – in a manner of speaking – a different population to the one where (it is assumed) a more rapid or alternative response to ADM is possible.

Even with this level of provision, ADM use in GG&C remains high.

Again as a part of our Collaborative Action Plan, we are reviewing the PCMHT services to ensure Board-wide consistency in terms of services available and response times.

Finally, it is important to note the scale of the problem. Common but significant mental health problems are estimated to be present in a fifth of the population – that is several hundred thousand people in GG&C. If findings suggest that up to one in ten adults are receiving antidepressants, that would be over 100,000 people. Our PCMHTs can provide a service – at our most optimistic – for 30,000 people.

**i) There are currently few national outcome measures for mental health services. How are you monitoring and reviewing mental health services to ensure that your services are meeting local needs and have you included mental health issues in your single outcome agreement?**

A variety of approaches are taken reviewing intelligence from a range of sources

- To assess whether we have enough of the right mix of services we have compared and mapped local services against a template of the core components of comprehensive services,
- Periodically on a more rigorous basis we have captured and mapped the degree to which the core functions of comprehensive services, as set out in the Scottish Framework for Mental Health, are present in each local area
- Use of benchmarking, best practice and epidemiology norms
- Feedback from local user organisations
- Feedback from practitioners
- Quarterly performance monitoring digests of patterns of inpatient bed use which tend to be a good indicator of the functioning of local community services in terms of achieving community based alternatives to admission, early/timely discharge from inpatient to community settings, low readmission levels, proportion of acute episodes of care managed in community settings, % of admissions gatekept by crisis team, admission rates per 100k population
- Over time we are further developing this approach by establishing benchmarks for “best local practice” and monitoring the position of our 11 CHP areas against these benchmarks
- In primary care there is an agreed monitoring framework which seeks to capture the proportion of local activity at each tier of the stepped model of care to ensure primary care offers a range of responses rather than simply one to one therapies
- A small number of service developments have monitored health outcomes for service users using HONOS scales

In terms of the wider mental health and well being of the population these are monitored through [National Programme for Improving Mental Health and Wellbeing](#) commissioned NHS Health Scotland to undertake this work and in December 2007 a set of adult mental health indicators was finalised including indicators covering both positive mental health (mental wellbeing) as well as mental health problems. The 54 indicators agreed cover a range of ‘high level’ mental health outcomes as well as contextual indicators divided into individual, community and structural factors. That work was reported in [Scotland's Mental Health and its Context: Adults 2009](#), which provides the first systematic

assessment of mental health and associated contextual factors at a national level using the adult indicators. We are exploring the scope to populate the same indicators at a local level in conjunction with the Glasgow Centre for Population Health and to produce CHP based mental health profiles.

- In relation to the Clyde developments we are supplementing the activity based data with a review of levels of placement breakdowns for those whose care was re-provided in community settings
- The broader issue of the underdevelopment of measures of effective functioning of community services is accepted and reflects both the complexity of assessing the product of the activity of community services and the general state of development of work in these areas. The evidence base for the efficacy of care in the community has been rehearsed in some detail in GG&C work submitted to the Clyde Independent Scrutiny Panel

## **Single Outcome Agreements**

### **Summary comments**

In principle single outcome agreements reflect a move to accountability based on outcomes in relation to jointly agreed local areas of focus. Where consensual agreements exist between the NHS and local authorities this approach can reap benefits, particularly in terms of the wider social determinants of health beyond the activities of social work.

However in practice the national joins between NHS and local authority targets are inadequately developed to underpin the full potential of SOAs with insufficient fit between these targets and underdeveloped outcome measures and assurance processes.

In their most developed form outcome based agreements might potentially operate on the basis of outcome based funding for delivery of strategic local agreements in the context of national outcomes and priorities. However at this stage in their development SOA's are not underpinned by a robust enough infrastructure of joint national priorities, or money following delivery, and in practice have led to a less transparent "below the line" loss of funding to mental health, from previously ring fenced funding sources.

### **Detailed comments**

Within NHS Greater Glasgow and Clyde there are six local authorities. The Health Board works in active partnership at many levels with each of these local authorities and associated Community Planning Partnership structures. The Community Health (and Care) Partnerships are key in forging such links to local authorities and respective local planning partners, and to shaping the content of joint plans, including Single Outcome Agreements.

In order to inform the deliberations of the Public Audit Committee, we have conducted an analysis of the range of Single Outcome Agreements in place

across NHS GG&C in order to reflect on how mental health dimensions are being addressed. It is encouraging to note that mental health dimensions feature across all of the Single Outcome Agreements across Greater Glasgow and Clyde, with a number of aspects being prominent.

A number of SOAs explicitly draw out the cross connections between mental health and allied policy areas, and commonly emphasise the partnership approach that is required to address these. For example, in Glasgow City's SOA:

"The SOA details partnership work towards the national and locally-agreed outcomes, so it does not include statements about specific mental health care and treatment services delivered solely by the NHS, for instance. It does relate strongly to the underlying factors which can sustain or damage mental health. They include key issues such as: physical activity, worklessness, financial inclusion, community cohesion, volunteering. These areas are all covered in detail in the SOA, with corresponding indicators".  
(Commentary supplied by Chief Executive's Department, GCC)

Mental health is commonly featured as part of National Outcome 6 – '*We live longer and healthier lives*'. For example, this section within West Dunbartonshire's SOA highlights the 'Towards a Mentally Flourishing Scotland' policy, indicating that this programme of improving the mental health of the population will be taken forward through the work of the integrated West Dunbartonshire Mental Health Strategy Group.

A number of SOAs also feature suicide rates within this outcome area, including, West Dunbartonshire and Glasgow City. This includes direct reference to the HEAT target relating to training of front line staff in skills for assessment and prevention suicide.

Some SOAs specifically highlight improvements in the early diagnosis and management of patients with dementia by Mar 2011.

Other issues featured include analysis work of mortality rates in areas of multiple deprivation, plus linkage to problems of drug and alcohol use, as closely relating to mental health problems. There is also some feature of the impact of recession, noting its effects on stress and relationships. A wide range of cross connections are drawn in some SOAs, such as importance of promoting physical activity as a key means of promoting mental well-being along with its other benefits;

Several SOAs featured mental health issues for children, relating to National Outcome 8, Improved Life Chances for Children. For example 's SOA included:

- Reduce the number of admissions of children and young people to adult MH beds
- Develop a suicide prevention plan which will demonstrate a focus of effect on young
- men
- Ensure there is a mental health link person for every school.

## **Employability and social inclusion dimensions including focus on needs of people with mental health problems**

There is significant coverage across the SOAs of the mental health and mental ill-health dimensions of employment, employability and wider social inclusion goals, with significant target setting and clear connection to policy on tackling inequalities.

For example, this commentary provided on the West Dunbartonshire SOA approach illustrates the importance of employment:

“We have a clear target to increase and assist the number of people with a learning disability get back into paid employment. The SOA does not specifically describe the target to also increase the number of people with mental illness back into paid employment; however we have achieved our local target of getting 20 people with Learning Disability and 20 people with Mental Health problems get back into paid employment. This has been a great success and an example of good practice between WDC and the CHP as we have NHS staff working alongside local authority staff in supporting people back into employment as well as working with employers in terms of providing training and education on how employers work to support people with Mental Health problems. As a spin off to this work we also have been successful with our joint bid with (£225K) to employ three staff as employment advisors to work alongside major employers in our areas and support people who are currently in work but struggling.”

Allied examples focusing on social inclusion themes include: financial inclusion and income maximisation work, acknowledgment of the poor mental health of incapacity benefit claimants; connecting people with experience of mental health problems with the life of their community; enhancing opportunities for volunteering; promoting green space and active use of this; better neighbourhood management approaches, helping tackle problems such as road safety, litter, refuse dumping and children's play areas, all issues recognised to contribute to inequalities through generation of stress.

Mental health issues are being given focused attention and priority action at levels below that of the whole authority. One example is within South West Glasgow, Local Investment Plans (equivalent of a sub-city Community Plan), which includes mental health dimensions within its priorities.

The implementation arrangements accompanying SOA's are important. In East CHP, the SOA is supported by a linked Outcome Delivery Plan and an outcomes-focused mental health strategy which includes a range of activities across four key themes:

- We live in a community which fosters wellbeing, tackles stigma, and acts together to reduce inequalities
- People are enabled to live their lives in the most independent environment possible according to their needs and aspirations
- People are supported in their recovery and in the realisation of their potential within our communities

- People with long-term needs receive high quality comprehensive mental health care and support.

### **Further developing the mental health dimension of SOAs**

The brief analysis of SOAs presented above has demonstrated a significant amount of mental health connection within the joint planning and performance management approaches of local authorities and their community planning partners. However, there is an emerging consensus that there is a scope to take this mental health focus much further.

Most importantly, there is a growing recognition of the critical importance of mental health and well-being issues to wider social policy goals, as detailed in the UK Government commissioned Foresight Programme report, *Mental Capital and Wellbeing*<sup>1</sup>.

“An individual’s mental capital and mental wellbeing crucially affect their path through life. Moreover, they are vitally important for the healthy functioning of families, communities and society. Together, they fundamentally affect behaviour, social cohesion, social inclusion, and our prosperity.” (from report’s Executive Summary)

Areas where there is scope for further development include:

- More specific target setting around financial inclusion actions for vulnerable groups, including people with mental health problems – particularly in the current difficult financial climate;
- Further extension of approaches to employability and employment to ensure focus on people with experience of mental health and allied problems
- Wide range of measures have potential for social inclusion goals, making use of a very wide range of council services and the resources of multiple community partners – for example green space initiatives; promoting physical activity; culture, arts and creativity opportunities; equality developments and promoting community cohesion
- Neighbourhood renewal and improvement of physical environment has demonstrable impact on mental well-being – thus another area that can be effectively cross referenced to mental health in SOAs
- More generally, across many services there is scope for enhancing general understanding of services, managers, front-line staff in terms of challenging stigma and discrimination and promoting mental health and well-being
- Significant scope for activities to promote staff mental health and well-being, an issue of importance given the degree to which mental health issues feature in staff absence figures.

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<sup>1</sup> Mental Capital and Well-being Programme reports available at: [www.foresight.gov.uk/OurWork/ActiveProjects/Mental%20Capital/Welcome.asp](http://www.foresight.gov.uk/OurWork/ActiveProjects/Mental%20Capital/Welcome.asp)

The Health Board, led by its Mental Health Partnership, is active in connecting with all Local Authorities in GG&C and with the 10 CH(C)Ps in progressing an ambitious programme of mental health improvement planning and activity, based closely on the *Towards a Mentally Flourishing Scotland* policy and action plan. Examples of development areas include:

- Joint work with Glasgow City Council and the Scottish Development Centre for Mental Health to build on the ideas contained in the '*With Inclusion in Mind*' national resource for local authorities – this focuses on practical ways for councils to meet their obligations to promote social inclusion and well-being under the Mental Health Act.
- All 6 local authorities, along with Strathclyde Police and the Health Board, jointly signed the *See Me Pledge* on 25<sup>th</sup> June 2009, as a signal of the joint commitment to tackle stigma and discrimination. At this event the current programme of the Anti-Stigma Partnership was also launched, which is a multi-component programme to tackle the stigma associated with mental ill health and to promote mental well-being
- The Mental Health Partnership have created a Mental Health Improvement Network, which includes representation from agencies across the Board area, with a view to supporting and sustaining high quality evidence-informed action to improve population mental health – key features include an e-newsletter, seminar programme and a means of sharing emerging practice across agencies – further details on dedicated website – [www.phru.net/mhin](http://www.phru.net/mhin)
- The Scottish Mental Health Arts and Film Festival, which was developed in Glasgow, now has the active participation of most local authority areas (and for the 2009 programme, 9 out of 10 CH(C)Ps) taking part in terms of organising events. There will be over 100 events during this October's Festival in the Greater Glasgow and Clyde area alone.<sup>2</sup>
- New developments as part of the Glasgow City Choose Life Programme to devise effective means to prevent suicides in areas of multiple disadvantage – collaborating with NHS Health Scotland, and the CHCPs of North and East Glasgow via a new Glasgow Suicide Prevention Partnership
- The forthcoming national outcomes framework for mental health improvement will also provide further opportunities to create a formal, planned approach to mental health improvement for our populations.

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<sup>2</sup> For details of the festival see website: [www.mhfestival.com](http://www.mhfestival.com)



**j) How does partnership working in your area operate in practice and how effective is it?**

**Partnership working at a strategic and inter agency level.**

Historically good partnership working has underpinned a range of joint plans including joint strategies, joint service and financial frameworks and alignment of budgets.

Within the Clyde area there is a high level of interagency partnership in relation to adult mental health which has been important in underpinning the fundamental service redesign in these services.

The position in Greater Glasgow is now more variable at a formal agency level although it should be noted that this is perhaps more straightforward with the smaller local authority areas.

There are some concerns that the financial pressures on both NHS and local authority agencies may expose the “faultlines” further seeing a move to more extreme experiences of partnership working between those agencies with shared values and consensual approaches to aligning financial commitments for the combined “greater good”, and those agencies who primarily seek agency advantage at a time of financial constraint.

The Greater Glasgow and Clyde Mental Health Partnership has sought to support partnership working through the Mental Health Partnership Committee which includes Service Users representation, Senior Councillor membership from each Local Authority in the Health Board area and Senior Managers within the Mental Health Partnership.

**Effectiveness of Joint Working**

Evidence of the effectiveness of joint working can be found in the existence of strong shared support for the transparency and joint management of the development and implementation process of the Clyde Strategy.

This success had been reflected in a radical shift in the balance of care which has been achieved in 3 year period.

In essence, it is the underpinning shared ownership of a direction of travel which has made the activity described above work.

**k) What mechanisms do you have to deliver joined-up services with clear referral processes for people with mental health problems?**

The majority of services are delivered in teams which are jointly managed on behalf of both NHS and social work. In these teams management of the range of staff groups and team processes is integrated with NHS or local authority managers acting across both agencies.

In other teams the management processes are separate or aligned between NHS and social work.

However in general terms the teams in both these arrangements have a set of agreed operational and practice arrangements in relation to:

- Single shared assessments : agreed documentation and operational implementation
- Screening allocation and review
- Duty systems ( integrated duty systems in place in jointly managed teams)
- Care management ( integrated care management in place in jointly managed teams)
- Range of developmental and training supports to support development and implementation of agreed operational arrangements

### **Examples of Joint Processes**

- A joint duty system operates within the CMHTs with senior health and social work staff rostered to take responsibility for providing a daily duty service.
  - A care management approach is in use with both health and social work staff having responsibility for care management.
  - Screening of referrals is a joint process with health and social work staff involved in that process, and all appropriately qualified members of the team have responsibility for carrying out assessments.
  - There are clearly defined criteria for access to each of the teams (Doing Well, CMHT and Intensive Home Treatment Team) with the wider system taking responsibility for ensuring the appropriate redirection of any referral which has been inappropriately directed to the wrong service.
  - An area team structure exists within social work service in the area. Good links exist between CMHTs and Area SW teams to ensure appropriate continuity of service for the client.
  - A Joint Information Sharing Protocol exists to ensure that the appropriate service is provided to clients and issues arising are directed to the appropriate service area team.
  - The same Specialist Shared Assessment tool and documentation is used by all team members.
  - Patients / clients receive a joined up service largely within the team – patients do not find themselves passed from one team to another. This is considered to be a good indication of positive and effective joint working.
- I) How do you work with prisons to ensure that prisoners with mental health problems in your areas receive the support they need while in prison and appropriate referral to community services once they are released?**

Each of the major prisons (Barlinnie, Cornton Vale and Gateside) receive planned weekly sessional input from Consultant Forensic Psychiatrists.

Prisoners are referred by the Prison Health staff, and any concerns about the mental health status are communicated and dealt with via a consultant clinic. Cases can be managed with this input over various lengths of time either through continued liaison with the prison health team, or by referral on to the appropriate CMHT services in advance of liberation.

This process could involve the transfer of a prisoner to a health care setting, where it is felt that the primary concern is a mental health one.

**m) How do you work with educational psychology services to ensure that any issues with children's mental health are picked up in schools?**

See separate CAMHs return

### **Expenditure on mental health services**

**n) How do you decide how much will jointly spent on mental health services by the NHS boards and local authorities in your partnership?**

- To date this has been determined by periodic needs assessment work to assess unmet needs and service gaps against a framework setting out the core components of comprehensive mental health services
- This work has been supplemented by benchmarking, good practice norms, epidemiology
- Clarity of deficits and solutions has then been brokered through corporate NHS processes to negotiate resource allocation to MH within the context of available resources
- This approach has been strengthened by a combination of resource redirection and specific resource allocations

**o) Do you use pooled or aligned budgets to jointly manage mental health services in your area?**

- Aligned budgets are used extensively to underpin areas of service change and development reflected in the development of jointly agreed service and financial frameworks

**p) Are there barriers in the accountability or financial procedures that you feel prevent you from delivering better joined-up services?**

- Where local consensus is achieved we are normally able to proceed; however where local consensus is not achieved clearer and more

explicit national targets & priorities of both NHS and local authorities regarding mental health would assist

- Greater transparency of local authority spend and changes in spending audited pre and post the SOA's would assist in understanding net local authority spend and changes in spending post introduction of SOA's and removal of ring fenced funding

**q) How do you decide how much NHS resources will be transferred to councils in your partnership and how do you know that such money is being spent on mental health services rather than being diverted to other services provided by the local council, such as education or housing?**

- We now determine the level of NHS resources to be transferred to local councils by determining our joint local priorities, and a transparent and joint process of aligning the respective funding sources of both health and social care to underpin and maximise the achievement of the agreed joint priorities. The NHS resources transferred to local authorities then relate to those areas of social care and support best provided or commissioned through local authority leadership. This approach has been used to underpin our approach to the Clyde Strategy and was highly valued by all partner agencies.
- Perhaps the real issue here is the degree to which community services are developed in a given health board area and the local approach to determining priorities for development and investment and which of these services are provided by local authorities and therefore require the use of Resource Transfer arrangements. Increasingly as we move beyond the initial phases of community care the approach to service redesign and development needs to be based on joint local priorities and alignment of available budgets to underpin these priorities. In this sense MEL 55 is now outdated and too rigid.

**r) The Audit Scotland report highlighted that the total amount councils spend on mental health services is unknown. How do you know if you are meeting the needs of people with mental health problems if you do not know how much you are spending on these services?**

- Locally such issues would be explored through the Mental Health Joint Planning and Implementation Groups operating in each of the local authority areas within GG&C
- The Audit Scotland report particularly identified the difficulty in clarifying how much of local authority expenditure was using local authorities own money, as distinct from local authority expenditure funded by NHS resource transfer or other formerly "external" sources of funds ( MISG, supporting people etc). About 85-95% of all mental health service expenditure is NHS funded with about c5-15% being local authority funded – in the absence of such transparency of source and applications of funds it can be difficult to clarify the degree to which local

authorities are committing their own resources beyond resource transfer ( and the other previously ring fenced external funding sources ) which can constitute c50%+of local authority spend on mental health services

**s) Over recent years more resources have been directed into community services. What information do you have on the cost of community services and the effectiveness of these services? How are you monitoring the shift in the balance of care?**

- The table in the introductory context section provides a spending breakdown by service area and reflects spend as % of total spend and spend per head
- Staffing levels for community services based on benchmarking against Sainsbury/DoH Community services guidance and will be cross checked against services in areas of similar demography; caseloads and expected activity for given staffing level derived from same sources
- Monitoring of effectiveness of shift via comparative use of :
  - **Patterns of bed use indicating effectiveness of community services in terms of:**
    - in timely access to alternative to admission( crisis )
    - timely discharge from hospital to community services
    - readmission levels
    - benchmarked caseloads
    - levels of bed use and admission rates
    - levels of placement breakdown for those resettled into community settings
    - % of acute episodes of care managed in community rather than inpatient settings

For most of the above areas we have/are developing needs weighted local benchmarks based on “best local practice” and monitoring for each CHP/CHCP there performance against these benchmarks

Analysis to date based on within GG&C analysis comparing Clyde to Glasgow and local services to Scotland via Scottish benchmarking indicators shows better performance on most indicators for more community oriented Glasgow model of care than for more hospital oriented Clyde service model ( nb now changing ) or for other areas of Scotland with less community oriented model of care.

**Attachments:**

**1. Sample of performance front end report**

## **Child & Adolescent Mental Health Services (Camhs)**

### **Accessibility of mental health services -**

- a) What targets have you set for accessibility to services (including waiting times) and the quality of services in your area?**

Implementation of 7 Helpful Habits – Choice & Partnership Approach.

- b) What action are you taking to address services with long waiting times?**

Implementation of 7 Helpful Habits – Choice & Partnership Approach: a working group of CAMHS teams will report in September after which local actions to deliver both local and national targets can be agreed and deadlines set.

A review of referral criteria and standardisation of evidence based interventions is underway.

- c) What are the current issues affecting vulnerable groups in your area - children and adolescents; minority ethnic groups; prisoners and ex-offenders; older people with dementia or Alzheimer's disease?**

Child & Adolescent Child protection issues

Equality Issues

Parenting

Housing

Drug & Alcohol

Asylum Seekers

Minority Ethnic Groups – stigma issues & reluctance to use the service. Interpreters required then translators for any written communications. Children arrive in the UK medicated & on prescriptions for drugs not recommended here. Difficulties can be experienced in establishing therapeutic relationships if the individual's asylum status changes during the period of contact.

- d) Are current levels of service for vulnerable groups adequate and what improvements, if any, are being planned?**

The current CAMHS services available in the East CHCP for vulnerable groups are as follows:-

### **Hosted CAMHS/Teams**

Academic Teams

Adolescent Self Harm

Clinical Psychology

Eating Disorders

Forensic CAMHS (F CAMHS)

Learning Disability CAMHS (LD CAMHS)

Looked After Accommodated Mental Health Team (LAAC)

Multi Dimensional Treatment Foster Care (MTFC)

National Child Inpatient Unit

Paediatric Liaison Team

Paediatric Neuropsychology  
Clinical Psychology - Maternity & Neonatology Service  
Clinical Psychology - Department of Paediatric Psychology  
Scottish Centre for Autism  
West of Scotland Adolescent Inpatient Unit - Skye House  
Youth Alcohol & Drug Service (YADS)

Greater Glasgow locally managed CAMHS/Teams  
Child and Adolescent Community Teams  
Direct Access  
Early Intervention Psychology Services

**Clyde locally managed CAMHS/Teams**

Inverclyde CAMHS  
Renfrewshire CAMHS  
West Dunbartonshire CAMHS

**Community Child Health (CCH) - Locally managed services/Teams**

Audiology  
Child Development Centres  
Clinical Psychology  
Community Autism Team  
Community Children's Nursing Team  
Enuresis  
Home Is Where The Help Is  
Occupational Therapy (OT)  
Physiotherapy  
Special School Nursing/ School Health  
Specialist Nurse Trainers  
Speech and Language Therapy  
Visual Impairment Service

**Commissioned Services**

Notre Dame  
School Counselling Service  
Partners in Advocacy

Planned Improvements to the services that are currently provided include:-

- Accessibility for all groups will improve with reduced waiting times, albeit that is recognised that access for vulnerable groups does vary across the 7 locality CAMHS Teams in NHS GG&C.
- Work is ongoing to develop an Eating Disorders Hub to support delivery of family and home based treatment.
- Out of Hours, Crisis and Home Based Treatment service is under development.
- Adolescent Self Harm service standards are being rolled out across NHS GG&C.
- Increased use of quality outcome data from the Glasgow Outcome Measures Strategy a member of the CAMHS Outcome Research Consortium (CORC) - a national system of quality monitoring with the aim of instituting a common model of routine outcome evaluation & analysing the data derived.

- For minority Ethnic Groups:- COMPASS Asylum Seekers Child & Adolescent physiologists link to service
- For prisoners/ex-Offenders:- Forensic Child/Adolescent Mental Health Services & Youth Justice.

**e) How do you work with educational psychology services to ensure that any issues with children's mental health are picked up in schools?**

This is achieved primarily via the locality based Educational Psychologists being attached to schools in each of the CH(C)Ps, and with whom we have local multi-agency meetings.

The main procedural arrangements which support this are:

- Pre & Post assessment meetings
- Feedback meetings
- Professional meetings, and
- Additional Support for Learning meetings.

A CAMHs representative sits on each of the Autism Assessment Core Groups along with the Educational Psychologists.

**Expenditure on mental health services**

**f) How do you decide how much will jointly spent on mental health services by the NHS Boards and local authorities in your partnership?**

Aligned and pooled budgets support a transparent process via integrated children's service planning between the CH(C)Ps and the various Local Authorities.

The resource allocation method which is adopted is to agree spend based on population levels, which have been weighted for the pre-5 population and for social deprivation category.

Examples of joint Social Work & health commitments, include:

Treatment Foster Care  
Home is where the Help is  
Specialist Education Needs Nursing  
Youth Alcohol and Drugs Service  
Early Intervention Teams  
Forensic CAMHS, and  
Child Protection

**g) Do you use pooled or aligned budgets to jointly manage mental health services in your area?**

CHCPs in Glasgow City and East Renfrewshire have aligned budgets for children's services. In general, CHPs negotiate alignment with their local authority partners and there are many examples of this across NHS GGC.

Forensic Child/Adolescent Mental Health Services.



Intensive Support & Monitoring Service – multiagency intervention involving social work, youth addiction, education, forensic CAMHS, voluntary organisations and other.

Social workers & teachers work within West of Scotland Inpatient Unit & Child Inpatient Unit costs are split.

**h) Are there barriers in the accountability or financial procedures that you feel prevent you from delivering better joined-up services?**

While joint accountability of CH(C)P Directors for adult and children's MH services has helped the achievement of a level of progress towards integrating/linking children's services in localities with adult services, variations in financial and other accountabilities/drivers (between Local Authorities and the Health Department) can put a strain on the joining up of services.

**i) How do you decide how much NHS resources will be transferred to councils in your partnership and how do you know that such money is being spent on mental health services rather than being diverted to other services provided by the local council, such as education or housing?**

This is determined through the operation of a joint strategic planning process underpinned by a joint financial planning process, with involvement of all key stakeholders including Local Authority colleagues.

This drives resource allocation to jointly provided services including the reappointing of existing resources where appropriate, and the allocation of new/earmarked resources to service change/service development.

This includes resource transfer where there is transfer of responsibility for patients across agency boundaries to Local Authorities and it is appropriate to allocate NHS resource, either existing or new, to support this change.

The NHS endeavours to review the use of resources transferred to local authorities (as it is required to do under the terms of extant Resource Transfer guidance), to confirm ongoing need and value for money, but often encounters resistance to the exercise of such scrutiny and so finds it difficult to confirm exactly what the money transfer is being used for on an ongoing basis.

It is considered unlikely that Local Authorities would use resources so transferred outwith the context of overall Social Work budgets, however as explained it is difficult to clarify whether monies continue to be applied for the purpose which was originally intended at the time of transfer.

**j) The Audit Scotland report highlighted that the total amount councils spend on mental health services is unknown. How do you know if you are meeting the needs of people with mental health problems if you do not know how much you are spending on these services?**

Information on the cost of Social Work and Education services is available, as well as NHS community services – all local & hosted CAMHS Services (finance reports) measure effectiveness by CAMHS Outcome Research Consortium (CORC).

Tier 1 and 2 mental health activities are carried out by staff who are not defined as mental health service providers i.e. teachers, so it is possible to exclude or include these staff in the count.

**k) Over recent years more resources have been directed into community services. What information do you have on the cost of community services and the effectiveness of these services? How are you monitoring the shift in the balance of care?**

The CAMHS strategy in 2000–2005 invested an additional £4m in CAMHS community services and the new Adolescent In Patient Unit (IPU) and the new National Child IPU have received an additional £3m between them. So, significant sums were invested by the former Greater Glasgow Health Board and the other West of Scotland Boards. Community CAMHS expenditure across NHS GG&C compares favourably with every other Board in Scotland.

The CAMHS Outcome Research Consortium is being used to show clinical effectiveness in addition to process measures and outputs i.e. waiting times, and far more need is being met in the most vulnerable areas in NHS GG&C than before e.g. Looked After and Accommodated MH services providing support to Looked After and Accommodated Children.

We are now developing crises services for children & young people in addition to medical on call in CAMHS and developing intensive and Out of Hours nursing services to prevent admission or delayed discharge. The impact of this is increasing throughput in the In Patient Units, shortened lengths of stay and reduced emergency admissions.

Monitoring will be in the form of the 18 Week Referral to Treatment measure, which is under consideration by a working group on behalf of the Mental Health Division in the Scottish Government.

In summary, there is development of an out of hours nursing service and a move towards 'home based care', to shift NHS GG&C young people from an inpatient unit to community based care.

## **Older People's Mental Health Services (Opmhs)**

### **Accessibility of mental health services**

#### **a) What targets have you set for accessibility to services (including waiting times) and the quality of services in your area?**

The CH(C)Ps and the Disability & Rehabilitation Planning & Implementation Group (D&R PIG) have established joint performance management frameworks that include a range of national and local performance measures. A number of indicators within this framework will be influenced by the incidence of mental health problems within the older population. Examples of indicators include – delayed discharges, emergency admissions and Allied Health Professional (AHP) waiting times.

Local performance standards assume that standard referrals to Community Mental Health Teams (CMHTs) will be seen by a member of the multi-disciplinary team within 2 Wks (this is currently being delivered).

Urgent referrals to CMHTs are currently seen the same day.

Access to psychology services are measured and currently experiencing significant delays (see below).

A new HEAT Target in relation to the early diagnosis and management of patients with dementia is now in place, and as a result the GP dementia register figures have been included within the CHCP performance framework

#### **b) What action are you taking to address services with long waiting times?**

Significant delays are being experienced for patients requiring access to psychology services, primarily as a result of staff shortages arising from recruitment and retention issues.

To address this it has been agreed to manage the older peoples' psychology service across Glasgow City within our rehabilitation services framework (services for older people and adults with a disability). The development of psychology services has been agreed as the number 1 priority for investment within the older people's mental health action plan. This program is being resourced from a review of in-patient services.

The Health Board has recently initiated a review of all AHP services. This review process will include recommendations for reduced waiting times, improved efficiency and improved access arrangements.

A number of pilots are being developed within CH(C)Ps to improve Occupational Therapy services including the use of IT to facilitate remote working.

**c) What are the current issues affecting vulnerable groups in your area - children and adolescents; minority ethnic groups; prisoners and ex-offenders; older people with dementia or Alzheimer's disease?**

- 1 – Isolation: low level supports required and identified as a priority for investment.
- 2 – stigma regarding mental health
- 3 – variable levels of service across NHS GG&C. e.g. specialist dementia services for Black, Minority, Ethnic (BME) population.

**d) Are current levels of service for vulnerable groups adequate and what improvements, if any, are being planned?**

The Health Board has recently completed a review of in-patient provision including a benchmarking exercise to assess good practice. This work has led to recommendations that will see a significant reduction in in-patient capacity (both acute and long stay).

The redesign programme will result in investment across a range of community based alternatives - the development programme having been developed and agreed by the Older Peoples Mental Health Planning Group. The development priorities include:

- Further development of OPMH psychology service
- Improved OPMH liaison service to care homes and acute hospitals
- Further development of CMHTs
- An enhanced range of short breaks and day opportunities
- Enhanced care at home, care homes and supported living

The programme will also deliver savings.

**Expenditure on mental health services**

**e) How do you decide how much will jointly spent on mental health services by the NHS boards and local authorities in your partnership?**

Within Glasgow, the Disability and Rehabilitation Planning and Implementation Group (D&R PIG) oversees the development of mental health services for older people. The D & R PIG provides governance over a range of sub-groups including Older Peoples Mental Health. This group is establishing an agreed service framework and development priorities.

For a number of years the partners had established a joint financial framework for services for older people. This requires to be updated so there is financial transparency.

Older Peoples Mental Health Services devolved to CH(C)Ps are included within joint financial arrangements.

CH(C)P Directors and Heads of Service participate in the budget and service planning arrangements for both Glasgow City Council and NHS GG&C.

- f) Do you use pooled or aligned budgets to jointly manage mental health services in your area?**

Budgets for older people's mental health services are aligned.

- g) Are there barriers in the accountability or financial procedures that you feel prevent you from delivering better joined-up services?**

- h) How do you decide how much NHS resources will be transferred to councils in your partnership and how do you know that such money is being spent on mental health services rather than being diverted to other services provided by the local council, such as education or housing?**

In recent years, resources have been transferred to local authorities (primarily on the back of hospital bed closures) to fund an agreed range of community based alternatives. The investment profile reflects the agreed priorities of joint planning arrangements.

The split of resources between local authority areas is based on agreed needs indicators (usually population based indicators weighted for deprivation/need).

- i) The Audit Scotland report highlighted that the total amount councils spend on mental health services is unknown. How do you know if you are meeting the needs of people with mental health problems if you do not know how much you are spending on these services?**

There are well established joint planning groups that have agreed development programmes and performance frameworks to ensure that the appropriate service arrangements are in place across the City.

CH(C)Ps have joint performance frameworks and report on regular cycles to CH(C)P Committees on performance. This material is also used to inform formal accountability arrangements with both the NHS Board and Glasgow City Council.

CH(C)P Directors and Management Teams participate in individual performance arrangements.

- j) Over recent years more resources have been directed into community services. What information do you have on the cost of community services and the effectiveness of these services? How are you monitoring the shift in the balance of care?**

Community mental health services sit within aligned CH(C)P budgets.

Performance management arrangements are outlined above.

The CHP's are currently reassessing the balance of care for older people and proposing a further significant shift to community based services.