Learnings from the HSJ Summit 2018 Interactive Discussion Groups

Session Theme: Mental Health

Session Leader: CF

Key Questions Posed

The Chancellor has announced £2b for Mental Health over the next five years. This simply keeps pace with the £20b announced for the NHS a whole, and holds mental health to a constant share of 11% of the NHS budget. In fact, Mental Health represents 23% of the burden of disease and our analysis in support of IPPR's report on Mental Health suggests that funding needs to increase by £4b as opposed to £2b - twice as fast as the rest of spending in in the NHS. The report also stipulates that the government should provide £500 million per annum for workforce development, and an immediate investment of £400 million for capital investment. In addition, our analysis suggest that funding is required on top of this for social care (by 2030) and public health.

Against this backdrop, we asked two questions:

1. What are the most important things that the money should be spent on?
2. What are the priorities in your area?

Outcomes and Learnings

Children's mental health services

There was a strong consensus – echoed across both groups that visited the mental health breakout table - that CAMHS is biggest priority for additional funding. Looked After Children came up as a particular group that are not currently having their needs identified or met. We can predict the typical life pathways for this group which often results in extremely poor outcomes, and the group discussed the need to change this. Another key topic was the need to get under the skin of why exactly there is such an increase in children self-harming, the reasons behind which were felt to be more complex than solely attributable to the rise of social media. Both groups agreed that more could be done in terms of whole family interventions, giving the example of the Scottish Collaborative.

Workforce

Workforce is a significant challenge in mental health – it is not felt to be an "attractive" profession. Both groups discussed this challenge as a rate-limiting factor in the context of the funding announcement: even if funding flows it does not mean that we'll be able to staff services. Turnover of staff was identified as a particular issue, especially for lower grades where there is less consistency in pay. Considering solutions, the development of new roles was discussed with particular reference to the success of introducing peer support workers. It was felt that education should be modular and competency based to develop 'shared' skills.

Partnership working

One group discussed the increase in referrals from GPs to secondary mental health services, and whether some of the funding recently announced by the Chancellor should be used to explore why that is. A GP offered the perspective that as mental health is self-reported, it can be hard to confirm diagnosis without specific expertise. There was strong agreement that partnership between secondary mental health and primary care is essential, and the example of Northampton was given as a success story in this area. As part of this discussion, there was support for the Primary Care Home.

Recognising and tackling unmet demand

Both groups reflected that it was positive to see a national focus on unmet demand, recognising that only 30% of people get the mental health care they need currently which wouldn't be acceptable in physical health e.g. cancer. It was acknowledged that mental health needs are underdiagnosed and undertreated at the moment. To deal with this, one group discussed the desire to see a focus on developing communities and formalising networks to support more people to look after each other. It was agreed that partnership working is essential to tackle unmet demand, including better working with the social sector and the need to create better links between the medical community and housing associations.

Outcome-based approach

Both groups discuss that being driven by targets is not helpful in improving services, and that it is preferable to move to an outcomes-based approach, commissioning for outcomes rather than services. There was less clarity on what outcomes might look like or the best way to measure outcomes / benefits, which needs further work.

Person-centred approach

There was a strong push that the rhetoric needs to about people's health rather than 'mental' or 'physical' health. Talking about people's lives, including the impact for them, rather than sectors or systems would change the paradigm. It was acknowledged that the service offer is fragmented and that the ideal state would be the implementation of mental health should be in every touchpoint.

Developing a person-centred approach is about culture change and organisational development as much as changing services. This has seen most success where it has been clinically led, within clinicians being given the time and space to come together to develop solutions e.g. in Northamptonshire the impact of introducing bespoke mouthguards for people receiving ECT which reduces their headaches (this was spotted by a dentist observing the treatment). The development of integrated care teams is considered to be pivotal as a delivery mechanism for person-centred care, supporting populations of 30-50,000. A good example of integrated teams in Rochdale was discussed.