Agenda Item No: 5a

REVISED JOINT STRATEGIC NEEDS ASSESSMENT (JSNA): AUTISM, PERSONALITY DISORDERS AND DUAL DIAGNOSIS

To: Health and Wellbeing Board

Date: 2nd October2014

From: Emma de Zoete – Consultant in Public Health

1.0 PURPOSE

1.1 This report is to explain the changes made to the JSNA on Autism, PersonalityDisorders and Dual Diagnosis (attached as Appendix 1), and to respond to related questions raised, followingthe Health and Wellbeing Board (HWB) meeting in June.

2.0 BACKGROUND

2.1 The HWBdiscussed the draft JSNA at the June meeting and requested furtherwork to the document as well as additional work on information from the MentalHealth Trust that was not available at the time of the JSNA. The board also raisedspecific questions about the demographic data used and personality disordertreatment. Reassurance was provided to the board following the meeting in Juneabout the population estimates used within the report. A request was made for ashort report on the progress of the work reflecting the Autism standards and strategyand this is provided in a separate paper(see agenda item 6).

2.2 The board requested that work on the recommendations of the JSNA should not be delayed, due to the changes required to the JSNA.

3.0 FURTHER WORK TO THE JSNA

3.1 The following changes have been made to the JSNA in response to the issuesraised by the board. These are largely focused on pages 33 to 43 of the document.

a) The source of prevalence estimates, and the methodology behind these has been provided. The prevalence tables have been reworked to make the data they provide clearer.
b) The section of Autism Spectrum Condition has been expanded to include an explanation of the conditions with the spectrum (in the introduction and the prevalence section), the basis for the prevalence estimates and the limitations of the data available.
c) The clear link between physical and mental health has been highlighted in the introductory section.

4.0 ANALYSIS OF THE MENTAL HEALTH NATIONAL MINIMUM DATASET

4.1 An analysis of CPFT service activity from the Mental Health Minimum Dataset (MHMD) was not possible for this JSNA as the data was not available in time, or complete enough, to be including within the JSNA. It is now a specific requirement of the contract which CPFT have with the CCG to provide the MHMD in a timely and accessible format to commissioners. The public health team committed to undertake an analysis of the available data to provide additional service information for this JSNA.

4.2 As agreed with CPFT we are now receiving an anonymised version of the mental health national minimum dataset at the same time as the data is returned monthly to the Health and Social Care Information Centre (HSCIC). This is a mandatory requirement from April 2014 for all mental health trusts, and this data forms the basis of the introduction of payment by results.

4.3 We were also provided with data for 2013/14 but found that the data quality was poor, and therefore have focused on data for April 2014 onwards which is more complete. We have undertaken an initial analysis of the data for April and May 2014, and have received the data for June and July which we are now working on.

4.4 As part of this process we have found there to be a number of issues which means that we have had to delay the additional section of the JSNA based on the analysis of the national minimum dataset. We had hoped to bring this to the board for this meeting. There are a number of reasons for the delay.

a) The national minimum dataset is a new dataset designed to support the introduction of payment by results. It is taking us some time to understand the dataset, and the payment by results system.

b) It is clear from our initial analysis that there are still considerable issues with data quality. We are working closely with CPFT to see which of these can be easily resolved, and which need to be addressed in the longer term in the data collection process. This is not unusual, particularly given that this is a new dataset.

c) Only once we have resolved the data quality issues, it should be possible to undertake further analysis and to interpret the data accurately. In some cases it is clear that we will need to discuss what the data may be showing with clinicians within the trust to understand if there are explanations for apparent findings. For example, as this is a new dataset we might find that all the cases in one team are being coded, possibly not entirely accurately, into one cluster (there are 21 cluster groups).

d) The dataset is primarily an activity dataset, rather than a clinical one. There are some elements of the data, such as diagnosis, which remain largely incomplete and therefore analysis of these is limited. In particular this means that although the output from the analysis of the data will be useful and informative it is unlikely to provide specific information by condition. Our final report will therefore be much broader than the three conditions focused on in the JSNA.

4.5 Overall, we therefore want to ensure that the final report, which will cover the vast proportion of CPFT activity for adults and older people for the first six months of 2014-15, is as accurate as possible in terms of the data presented and its interpretation. To do this we need to take longer over the analysis and therefore proposed to bring the draft report to the HWBB in January 2015.

5.0 PERSONALITY DISORDER PATHWAY

5.1 The board requested more detail of the care pathway for personality disorder tounderstand better any decision to exclude an individual from the secondary carepathway.

5.2 Any decision not to take an individualonto the pathway would be based on individual circumstances. The type of factorsthat would be considered would include whether the individual meets the thresholdfor the secondary care service or would be more appropriately treated by otherservices, such as 'Improving Access to Psychological Therapies' (IAPT). Theindividual also needs to be willing to receive treatmentand support, and in cases where they are not the GP would be written to and itmade clear that if the situation were to change they should re-refer the patient.

5.3 CPFT and the CCG are currently considering options for increased access to the Personality Disorder pathway, working with MIND, Healthwatch and other representative groups.

6.0 PROGRESS ON OTHER JSNA RECOMMENDATIONS

6.1 Following a Mental Health Roundtable on 1st July chaired by Sir Graham Bright it was agreed that there should be cross agency work to deliver a local mental health crisis declaration for Cambridgeshire and Peterborough. The first meeting on the mental health concordat declaration group, which is chaired by ACC Mark Hopkins and Dr Emma Tiffin from the CCG, took place on 27th August.

6.2 The multiagency Dual Diagnosis Strategic Steering Group has finalised the Dual Diagnosis Strategy and launched this across the County by holding four local events with key stakeholders and presenting a service user case study. At this forum feedback was provided for inclusion in the Draft Dual Diagnosis Protocol which will specify how organisations will work together operationally and is hoped to be finalised in the next few months. The group has also developed a training programme which will be rolled out to key stakeholders and front line workers over the coming year.

6.3 As requested there is a separate paper on Autism standards and strategy.

7.0 RECOMMENDATION/DECISION REQUIRED

7.1 The Health and Wellbeing Board is asked to approve the revised JSNA, and to note the change to the supplementary report on the Mental Health National Minimum dataset.