REPORT OF: THE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE (HOSC):

Adult and Older Adult Mental Health in Oxfordshire:

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INTRODUCTION AND OVERVIEW

1. At its meeting on 12 September 2024, the Oxfordshire Joint Health and Overview Scrutiny Committee (HOSC) received a report providing an update on adult & older adult mental health in Oxfordshire.

2. The Committee felt it crucial to receive an update on both the general patterns of adult and older mental health in Oxfordshire, as well as around the development and delivery of mental health services for adults as well as older adults. The Committee also sought to assess the degree to which system partners were working collaboratively to deliver and improve adult mental health services.

3. This item was scrutinised by HOSC given that it has a constitutional remit over all aspects of health as a whole; and this includes the mental health and emotional wellbeing of adults, as well as the availability and effectiveness of services to diagnose as well as to treat ill mental health amongst adults. Prevention is another key area that would also encompass mental health, and is a key commitment within the Oxfordshire Health and Wellbeing Strategy. When commissioning this report on Adult/Older Adult Mental Health, some of the insights that the Committee sought to receive were as follows:

    - The degree to which there is an Adult and Older Adult Mental Health service for Oxfordshire, and how this operates.

    - Current trends and patterns of Adult and Older Adult Mental Health amongst Oxfordshire residents; including any data relating to this.

    - The nature of commissioning for such services, and any examples of such Adult and Older Adult Mental Health Services being commissioned.

    - The degree to which there is overall effective partnership working within the Oxfordshire system for the purposes of Adult/Older Adult Mental Health.

    - The extent to which there is an adequacy of resource, including funding and workforce, for adult/older adult mental health services.

    - The support being provided to tackle suicide.

- Whether there are any high-risk groups that have been identified, and the kind of support that such vulnerable groups can expect to receive.

- Whether any Mental Health Needs Assessments have been conducted.

SUMMARY

4. The Committee would like to express thanks to Dan Leveson (BOB ICB Place Director for Oxfordshire), Chris Wright (Assistant Director Partnership Development, Oxfordshire), Lola Martos (Head of Older Adult Services at Oxford Health NHS Foundation Trust), Manny Jhawar-Gill (Commissioning Manager, Improve Enable, Adult Social Services, OCC), Pippa Corner (Deputy Director Commissioning, Adult Social Services, OCC), Nicola Leavesley (CEO of Response and current Chair of the Oxfordshire Mental Health Partnership, OMHP), Catherine Sage (Head of Service for Mental Health Urgent Care, Social Care, and Adult Eating Disorder Service, Oxford Health), Jared Fellows (Health Improvement Practitioner, Public Health, OCC), Karen Fuller (Director of Adult Social Care, OCC), and Ansaf Azhar (Director of Public Health, OCC) for attending the meeting and answering questions from the Committee in relation to this item.

5. The Committee first inquired about the adult eating disorder service, specifically the contract between the BOB ICB and other providers covering community eating disorders. They asked about the extent to which these services were dealt with separately or as part of overall mental health, and the level of specialist provision available. The BOB ICB Place Director for Oxfordshire explained that specialist adult eating disorders services were commissioned on a larger scale through specialist commissioning, with Oxford Health as the lead commissioner. He clarified that the community services were delivered locally and were part of the system they worked on together. The Head of Service for Mental Health Urgent Care added that the regional services primarily included inpatient services and some intensive treatment services to avoid admission or support post-discharge. She mentioned that Oxfordshire had one inpatient service at Cotswold House in the Warneford Hospital and that the community adult eating disorder service covered the entire county.

6. The Committee then asked about the engagement of older adults, specifically those over 65, in the design and commissioning of older adult mental health services. The Head of Older Adult Services emphasised the importance of engaging service users and carers through active groups and working closely with the voluntary sector. She acknowledged the difficulties faced by older adults to have their voices heard, and this concern was always at the forefront of the service's efforts. The BOB ICB Place Director for Oxfordshire added that Oxford Health had a long history of person-centred, goals-based care, and that patient feedback was integral to service design. The Assistant Director of Partnership Development at Oxford Health highlighted their strategic initiative to increase patient involvement in care, surpassing their 80% target with 88% of service users reporting participation. This approach aimed to enhance

patients' experiences and inform service delivery and commissioning decisions. Additionally, they planned to consolidate services for older adults and eating disorders under a single contract to offer a broader range of interventions. Patient surveys and external reviews were conducted to understand current service perceptions and identify gaps and challenges.

7. The Committee raised the issue of loneliness among older adults and asked about measures being taken to address this. The BOB ICB Place Director for Oxfordshire acknowledged the challenge, citing factors like rurality and transient populations. He highlighted various initiatives, such as the Move Together programme and Integrated Neighbourhood Teams, aimed at bringing people together and fostering community engagement. The Director for Public Health also mentioned the establishment of community hubs funded by Community Capacity Grants. He highlighted the Mental Health Prevention Concordat, a quarterly partnership focusing on enablers like green spaces, voluntary sector resources, and addressing different settings such as residential care and maternity. The approach aimed to systematically bring partners together to enhance mental health services, ensuring no one was overlooked, and to build workforce confidence in providing better mental health support.

8. The Committee inquired about the outcomes-based contract, which was coming to an end in March next year. They asked about its success, future plans, and evaluation methods. The BOB ICB Place Director for Oxfordshire explained that the outcomes-based contract was a pioneering model that linked payments to outcomes, although measuring outcomes had proven challenging. He mentioned that the contract had evolved over time, with a focus on delivering better value care through integrated pathways.

9. The Committee then turned to specific issues around suicide prevention and workforce support. They asked about the influence of the 2023 National Suicide Prevention Strategy on local efforts, stakeholder input, and training for professionals. The Health Improvement Practitioner explained that the local strategy was being refreshed to align with national priorities, with a focus on high-risk groups and targeted training. He reported that local suicide statistics and risk factors in Oxfordshire were consistent with national trends, with drugs, alcohol, relationship breakdowns, and bereavement being the leading risk factors for men. The male-to-female suicide ratio in Oxfordshire was lower than the national average, with 60% male and 40% female. At the end of the previous year, Oxfordshire Mind was commissioned to deliver a suicide prevention and mental health training programme, which began in January. This programme targeted key groups identified in national strategies, such as middle-aged men, pregnant women and new mothers.

10. The Committee also asked about the transition between different mental health services and the potential risks involved. The Head of Service for Mental Health Urgent Care acknowledged the challenges but assured that mechanisms were in place to ensure smooth transitions and minimise risks. She highlighted the importance of maintaining patient history and effective communication among professionals.

KEY POINTS OF OBSERVATION & RECOMMENDATIONS

11. Below are four key points/themes of observation that the Committee has in relation to adult and older adult mental health in Oxfordshire. These four key points of observation relate to some of the themes of discussion during the meeting on 12 September, and have also been used to shape the recommendations made by the Committee. Beneath each observation point is a specific recommendation being made by the Committee.

Personalisation and coproduction of adult eating disorder services: The Committee was keen to understand the extent to which adult eating disorder services constituted a specialist form of provision that was distinct from the general mental health support services available to adults. The importance of having specialist eating disorder services is due to the complex nature of adult eating disorders. According to a study published in the Journal of Biological Psychiatry in 2015, adult eating disorders are indeed complex, and this is partly due to the fact that such disorders can be elicited by a plethora of factors including genetics, biological conditions, psychological factors[1]. Additionally, according to Mind, adult eating disorders are complicated in nature and there are various types of such disorders[2]. Therefore, the Committee urges Oxfordshire system partners to recognise this complexity, and to ensure that adult eating disorder services are as personalised as they could be so as to address this complexity. Individuals with such disorders may themselves feel confused as to why they are experiencing such symptoms, and may not always recognise the type of help and support that they need. It is crucial that eating disorder services are sufficiently resourced and that these services have a reach and capacity that is countywide. Additionally, professionals ought to be adequately trained in being able to provide as much targeted and personalised support to such patients. The process through which patients can be referred to such services should also be as smooth and efficient as possible. Patients with such disorders can often feel reluctant to seek support, and any complications in being referred or being able to access eating disorder services could increase this reluctance.

Related to the above is the importance of coproducing eating disorder services with individuals who have experienced such disorders and symptoms. It is the first-hand experience of these disorders that makes the insights and experiences of such patients valuable in the design of such services. Coproducing the service with service users could also help reassure such patients that the system is there to hear, understand, and support them.

[1] What Causes Eating Disorders, and What Do They Cause? - Biological Psychiatry (biologicalpsychiatryjournal.com)
[2] Types of eating disorders - Mind

Recommendation 1: *To ensure that adult eating disorder services are personalised in a manner that takes the unique needs and experiences of each individual patient. it is recommended that this service is coproduced with adults with eating disorders as much as possible.*

Tackling loneliness amongst older adults: Loneliness is a pervasive and often overlooked issue that affects individuals across all age groups. However, it is particularly prevalent among older adults, leading to significant mental health implications. As society continues to age, understanding and addressing the causes and effects of loneliness in the elderly population becomes increasingly vital. According to recent studies, a substantial proportion of older adults report feeling lonely. Factors contributing to this sense of isolation include the loss of loved ones, retirement, reduced mobility, and the decline of social networks. For many seniors, the transition from an active, social lifestyle to one of relative isolation can be abrupt and challenging. Physical health declines can also contribute to loneliness. Chronic illnesses, mobility issues, and sensory impairments can limit an older person's ability to engage in social activities. Moreover, the stigma associated with certain health conditions may lead individuals to withdraw from social interactions.

According to a study published in the Annual Review of Clinical Psychology, depression is one of the most common mental health issues associated with loneliness in older adults. The persistent feeling of being isolated can lead to a sense of hopelessness and sadness, diminishing one's quality of life[3].

Therefore, the Committee is calling for adequate measures to be taken to tackle loneliness amongst older adults. It is also vital that efforts are made to reach out to older adults, particularly those with lived-experience of poor mental health elicited by loneliness, and to include such adults in the process of designing older adult mental health services. The Committee is pleased that system partners acknowledge the challenges around rurality and transient populations. The Move Together programme and ongoing development of Integrated Neighbourhood Teams should play a key role in bringing people together and fostering further community engagement. The Committee also calls for further collaboration with/within the Oxfordshire Mental Health Partnership to help to explore appropriate and innovative avenues to improve the coproduction and use of I statements for older adult mental health services. The Committee notes that meaningful coproduction and I statements are core to the strategy of over 200 third sector organisations working across health and care who make up National Voices https://www.nationalvoices.org.uk/about-us/our-strategy-2024-2029/

Recommendation 2: *To take adequate measures to tackle loneliness amongst older adults, and to make every effort to reach out to older adults (with lived-experience) and to include them in the designing of older adult mental health services. It is*

[3] Depression in Older Adults | Annual Reviews

recommended that there is liaison with the Oxfordshire Mental Health Partnership to explore avenues to improve coproduction and use of I statements here.

Communication, information-sharing and preventing 'bouncing': Transparency and the ethical sharing of information regarding mental health patient history and records are fundamental to providing quality care. In the realm of mental health, patient records hold sensitive and personal information that must be handled with the utmost care and confidentiality. At the same time, transparency in sharing this information among healthcare providers is essential for ensuring continuity of care, improving treatment outcomes, and fostering trust between patients and healthcare professionals.

Transparency in handling mental health records involves clear, open communication, and the ethical sharing of information. It is crucial for several reasons:

- Trust: Patients are more likely to trust healthcare providers who are transparent about their treatment processes, including how their records are managed and shared. Trust is a cornerstone of effective mental health treatment, as patients need to feel safe and secure in sharing their personal and often distressing experiences.

- Improved coordination of care: Mental health patients often receive care from multiple professionals, including potentially from psychiatrists, psychologists, social workers, or primary care physicians. The sharing of patient history and records ensures that all providers are on the same page, which is critical for coordinated care. This seamless exchange of information helps to avoid redundant tests, conflicting treatments, and potential medication interactions. The Committee is also aware of the need for improved sharing of information and coordination with health and care professionals working outside of mental health because of needs highlighted in annual reports for improving the physical health of adults with serious mental health conditions. The Committee understands that physical health problems significantly increase our risk of developing mental health problems and that people with poor mental health are more likely to have a preventable physical health condition.

- Improved treatment outcomes: If healthcare professionals have good access to comprehensive patient history, this enables them to make better-informed decisions about treatment plans. Understanding a patient's prior diagnoses, treatment responses, medication history, and other contextual factors can significantly enhance the effectiveness of current and future interventions.

Furthermore, the Committee urges that every effort is made by system partners to avoid the prospect of patients being or feeling 'bounced' between various mental health providers or services. Patients need to be

provided with the support that they require in as smooth a manner as possible. Suffering from poor ill health is challenging enough for patients, and such patients should be made to feel and understand that help is available and is accessible. The process of referrals for mental health and person-centred support for physical and mental wellbeing should also be as seamless as possible.

Recommendation 3: *To ensure that patient history is effectively communicated and shared amongst professionals/organisations providing mental health support (including those providing patients with treatment for acute or chronic physical conditions), and to avert the prospects of patients being or feeling bounced between various mental health services or across the NHS.*

Voluntary Sector Organisations and suicide prevention: Third sector or Voluntary sector organisations (VSO) play a crucial role in providing support and services to those in need of mental health support as well as in the realm of suicide prevention. These organisations are often community-led and can fill crucial gaps left by governmental and private sectors. Their contributions are vital in addressing the complex and sensitive issue of suicide, offering hope and lifelines to those that may be in despair. They often operate with limited resources but have a profound impact due to their professionalism, networks, grassroots connections and ability to mobilise volunteers. One of the most significant advantages of VSOs is their accessibility if they are signposted to effectively. These organisations often work within local communities or work with specific communities of need, making them more approachable and trusted by individuals who might be reluctant or unable to seek help from formal institutions. This proximity allows VSOs to identify and support at-risk individuals early, potentially preventing crises before they escalate.

VSOs are often skilful at providing tailored support that meets the unique needs of individuals. Unlike larger institutions, they can offer personalised assistance and maintain flexibility in their approaches. This individualised support is crucial in suicide prevention, as it acknowledges and respects the diverse experiences and needs of those seeking help.

Education and awareness campaigns are fundamental components of VSO efforts. These campaigns aim to reduce the stigma surrounding mental health issues and suicide, encouraging open dialogue and understanding. By equipping communities with knowledge about the warning signs of suicide and available resources, VSOs empower individuals to act fast and to respond to temptations for suicide.

VSOs often can also provide specific services to support those more susceptible to suicide including through counselling, peer support groups, and crisis interventions. Peer support groups create safe spaces for individuals to share their experiences and find solidarity, reducing feelings of isolation and hopelessness. Additionally, VSOs can potentially contribute to provide training for volunteers, community

members, and professionals to recognise and respond to suicide risks. This can enhance a community's overall capacity to address mental health issues, ensuring that more people are equipped to offer support and intervention when needed.

It is for the above reasons, and also from learnings through the pandemic about the value of VSOs, that the Committee is recommending that VSO stakeholder organisations working on suicide prevention should be invited to register so that all available resources across Oxfordshire are recognised and engaged. It is also recommended that the system has sufficient resource to tackle suicide, and that all partner organisations/system partners work in a collaborative manner that makes effective use of collective resource, contribution, and responsibility for tackling suicide.

Recommendation 4: *That voluntary sector stakeholder organisations who work in Oxfordshire on suicide prevention are invited to register with a VSO suicide prevention stakeholder register. It is also recommended that there is adequate resource, engagement, and a collaborative system inclusive of the VSO registered stakeholders to tackle suicide.*

Recommendation 5: *That there is collaborative system work to develop KPIs on serious mental health to maximise the impact of the existing resource available across Oxfordshire, with a view to prevention and to increase the support available to people and families in distress. It is recommended that there is engagement with the local authority and Region on KPIs relating to patients residing in long-term inpatient settings away from their families.*

Legal Implications

12. Health Scrutiny powers set out in the Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provide:
    - Power to scrutinise health bodies and authorities in the local area
    - Power to require members or officers of local health bodies to provide information and to attend health scrutiny meetings to answer questions
    - Duty of NHS to consult scrutiny on major service changes and provide feedback on consultations.

13. Under s. 22 (1) Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 'A local authority may make reports and recommendations to a responsible person on any matter it has reviewed or scrutinised'.

14. The Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provide that the committee may require a response from the responsible person to whom it has made the report or recommendation and that person must respond in writing within 28 days of the request.

Annex 1 – Scrutiny Response Pro Forma

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