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The Norfolk and Waveney Health and Care Partnership

Mental Health Update

Great Yarmouth and Waveney HOSC

7th February 2020

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Adult Mental Health Update

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Norfolk and Waveney Adult Mental Health Strategy

March 2019




Adult Mental Health

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- In March 2019, the Norfolk and Waveney's STP published its Adult Mental Health Strategy.
- Six commitments were outlined each has a working group with representatives from stakeholders including the voluntary sector, people with lived experience and their carers:

1. To increase our focus on prevention and wellbeing
2. To make the routes into and through mental health services more clear and easy to understand for everyone
3. To support the management of mental health issues in primary care settings (such as within your GP practice)
4. To provide appropriate support for those people who are in crisis
5. To ensure effective in-patient care for those that need it most (that being beds in hospitals are other care facilities)
6. To ensure the whole system is focused on working in an integrated way to care for patients .

Adult Programme Structure

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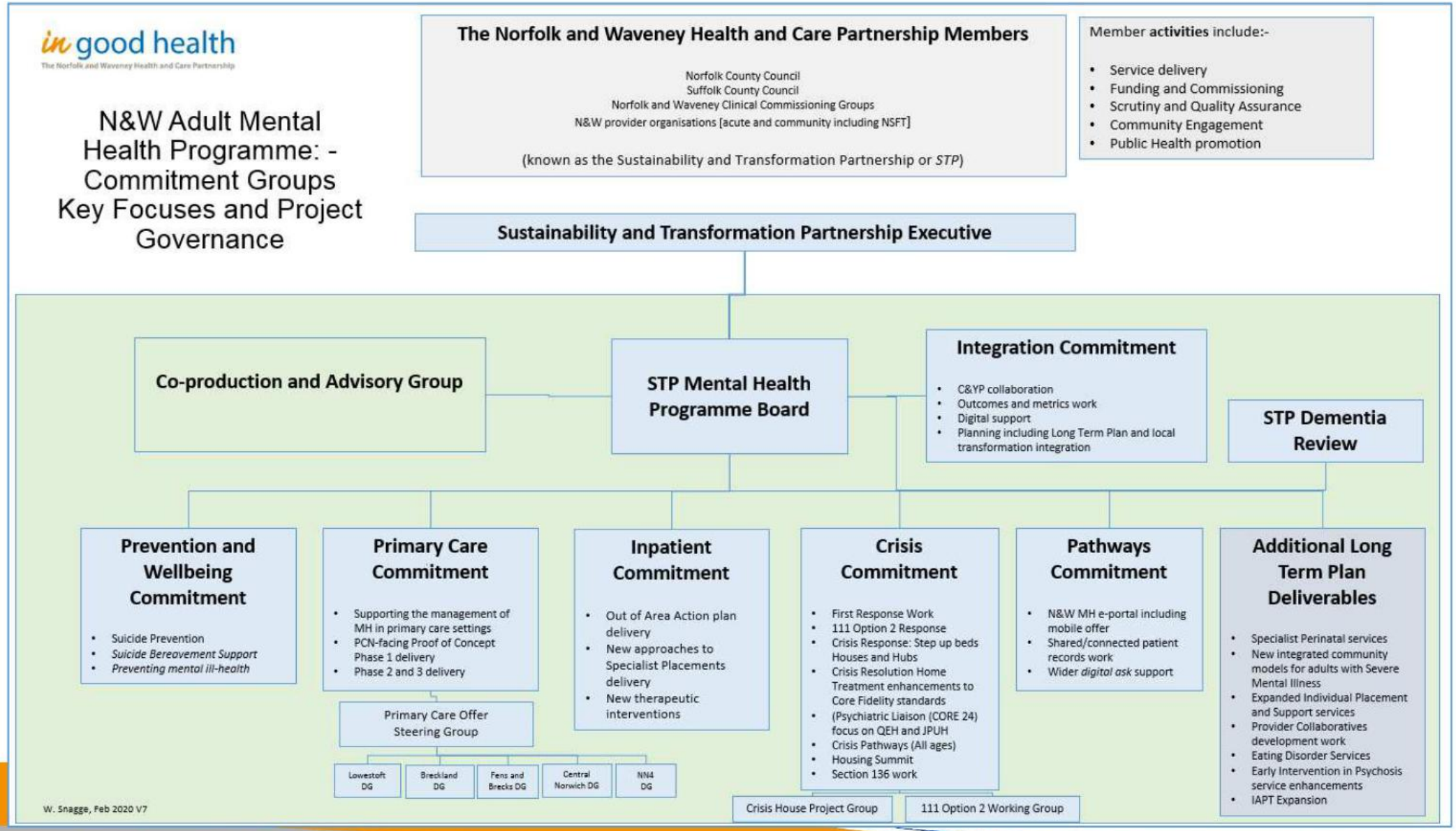

NHS

The NHS Long Term Plan

NHS

The NHS Long Term Plan – a summary

Find out more: www.longtermplan.nhs.uk | **Join the conversation:** #NHSLongTermPlan

Health and care leaders have come together to develop a Long Term Plan to make the NHS fit for the future, and to get the most value for patients out of every pound of taxpayers' investment.

Our plan has been drawn up by those who know the NHS best, including frontline health and care staff, patient groups and other experts. And they have benefited from hearing a wide range of views, whether through the 200 events that have taken place, and or the 2,500 submissions we received from individuals and groups representing the opinions and interests of 3.5 million people.

This summary sets out the key things you can expect to see and hear about over the next few months and years, as local NHS organisations work with their partners to turn the ambitions in the plan into improvements in services in every part of England.

What the NHS Long Term Plan will deliver for patients

These are just some of the ways that we want to improve care for patients over the next ten years:

Making sure everyone gets the best start in life	• reducing stillbirths and mother and child deaths during birth by 50% • ensuring most women can benefit from continuity of carer through and beyond their pregnancy, targeted towards those who will benefit most • providing extra support for expectant mothers at risk of premature birth • expanding support for perinatal mental health conditions • taking further action on childhood obesity • increasing funding for children and young people's mental health • bringing down waiting times for autism assessments • providing the right care for children with a learning disability • delivering the best treatments available for children with cancer, including CAR-T and proton beam therapy.
Delivering world-class care for major health problems	• preventing 100,000 heart attacks, strokes and dementia cases • providing education and exercise programmes to tens of thousands more patients with heart problems, preventing up to 14,000 premature deaths • saving 55,000 more lives a year by diagnosing more cancers early • investing in spotting and treating lung conditions early to prevent 80,000 stays in hospital • spending at least £2.3bn more a year on mental health care • helping 380,000 more people get therapy for depression and anxiety by 2023/24 • delivering community-based physical and mental care for 370,000 people with severe mental illness a year by 2023/24.
Supporting people to age well	• increasing funding for primary and community care by at least £4.5bn • bringing together different professionals to coordinate care better • helping more people to live independently at home for longer • developing more rapid community response teams to prevent unnecessary hospital spells, and speed up discharges home. • upgrading NHS staff support to people living in care homes. • improving the recognition of carers and support they receive • making further progress on care for people with dementia • giving more people more say about the care they receive and where they receive it, particularly towards the end of their lives.

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Our Vision for Future Adult Mental Health Services in Norfolk and Waveney

- Our ambition is that more people have access to effective support for their mental health in Primary Care settings and the communities in which they live.
- We will reshape our community mental health support services so that a team of multi-disciplinary professionals, with wide experience and expertise, is available and accessible at a local level - in or close to GP practices that represent the NHS front door for the vast majority of our population.
- This will ensure that people who need mental health help and support, can access it quickly, and before their condition becomes more challenging to live with.
- By 2023/24 the expectation is that the majority of mental health care and treatment is delivered at community levels, within integrated health and care systems, with quick and easy access to specialist provision where needed.

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Prevention and Wellbeing

- Public Health role
- Strong linkages with NCC
- Less strong with SCC
- Suicide reduction
- Suicide Bereavement Support

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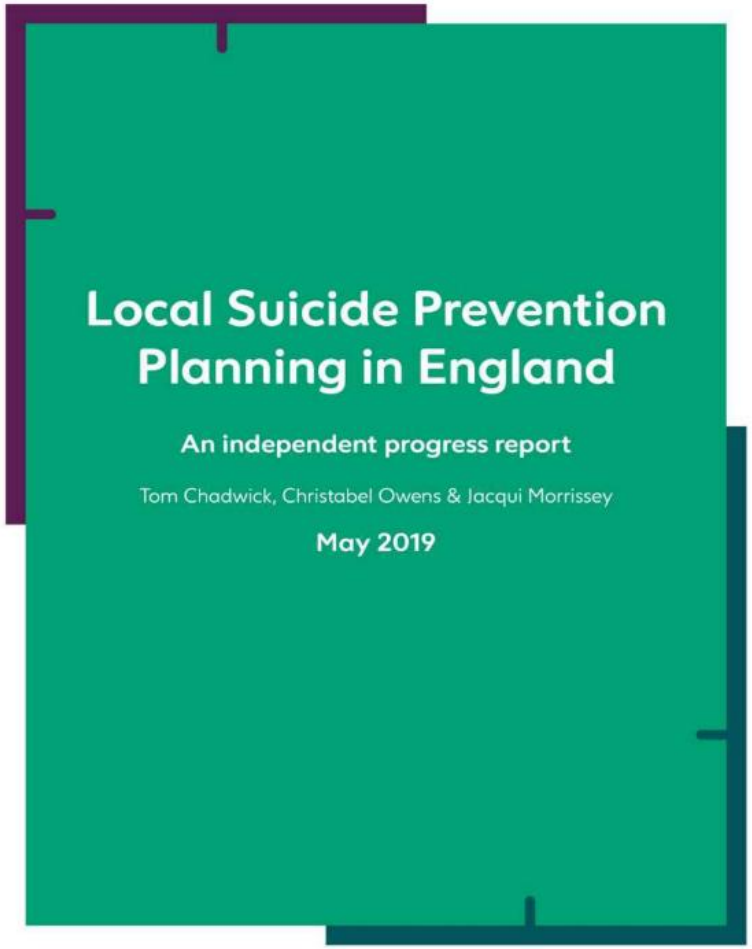

SAMARITANS

Working in partnership

UNIVERSITY OF EXETER

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Prevention and Wellbeing – Suicide Prevention.

- Suicide prevention – Norfolk Public Health Audit May 2019
  - Average of 80 suicides a year, mainly men (76%) and mainly in 46-55 age group.
  - Home is commonest place followed by woodland. Suicide by hanging is the commonest method (54%)
  - Nearly a quarter had seen their GP in the week before death
  - Poor mental health and deprivation and poverty are all strong influences
  - Norfolk and Waveney STP was successful is obtaining additional national funding to support suicide prevention schemes in…..
  - The STP commitment is to reduce suicide rates in Norfolk and Waveney by 10% in 2020/21. We have agreed to adopt a zero suicide strategy

Achievements so far

The Norfolk Suicide Prevention 'I am (really not) okay' strategy and action plan (2016-2021) were launched in January 2017. The Norfolk Strategy adopted the national target with a view to reducing the suicide rate further in later years.

Primary Care Networks

- Long Term Plan 2019
- In response to
  - Ageing population
  - Increasing complexity of care required
  - Challenges of recruitment into primary care
- Groupings of practices of around 30-50,000 patients
  - General Practitioners
  - Allied Health Workers – mental health, pharmacists, social care etc
- Working collectively to deliver comprehensive good patient care

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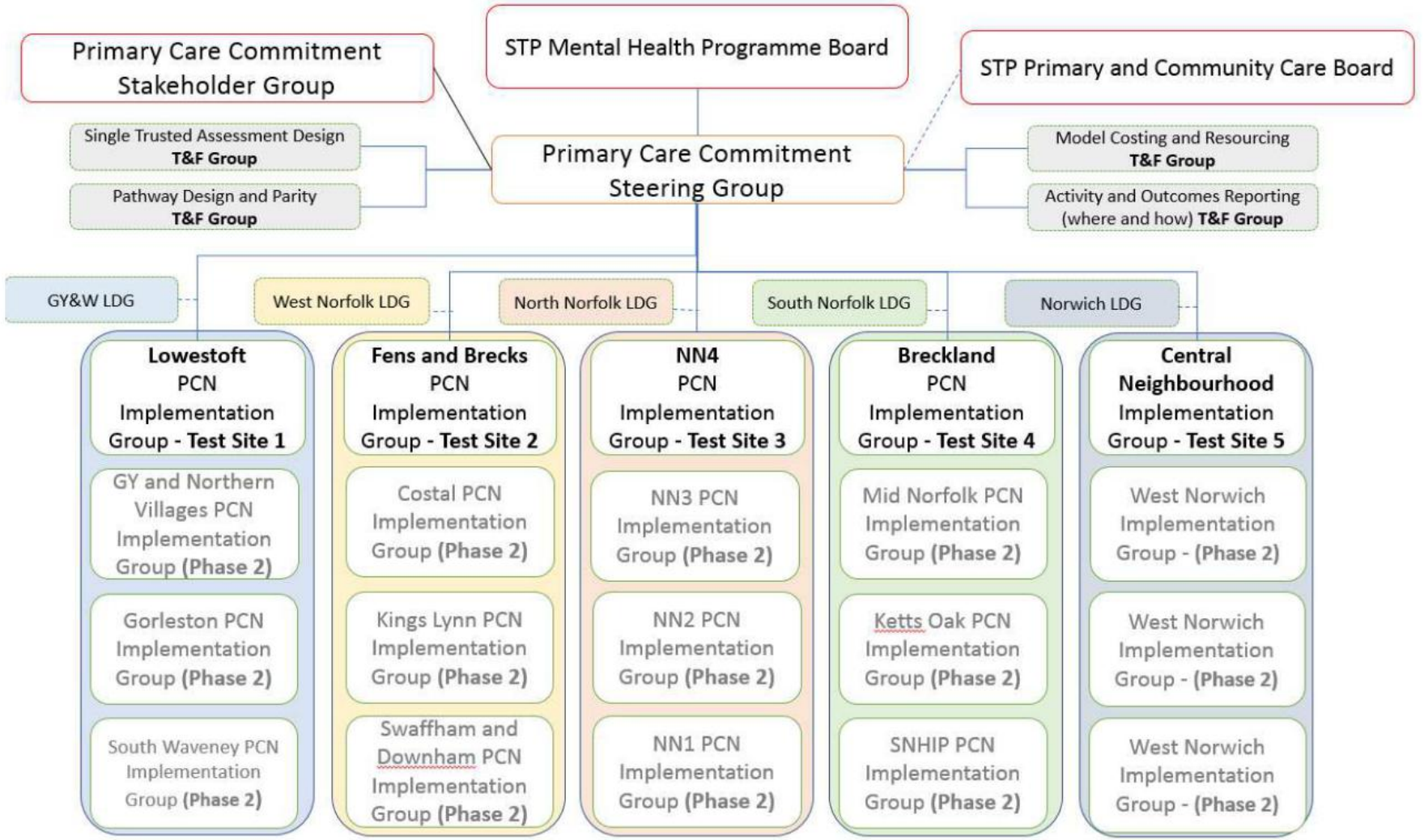
Primary Care Networks


Primary Care Commitment Stakeholder Group
STP Mental Health Programme Board
STP Primary and Community Care Board
Single Trusted Assessment Design T&F Group
Pathway Design and Parity T&F Group
Primary Care Commitment Steering Group
Model Costing and Resourcing T&F Group
Activity and Outcomes Reporting (where and how) T&F Group
GY&W LDG
West Norfolk LDG
North Norfolk LDG
South Norfolk LDG
Norwich LDG
Lowestoft PCN Implementation Group - Test Site 1
GY and Northern Villages PCN Implementation Group (Phase 2)
Gorleston PCN Implementation Group (Phase 2)
South Waveney PCN Implementation Group (Phase 2)
Fens and Brecks PCN Implementation Group - Test Site 2
Costal PCN Implementation Group (Phase 2)
Kings Lynn PCN Implementation Group (Phase 2)
Swaffham and Downham PCN Implementation Group (Phase 2)
NN4 PCN Implementation Group - Test Site 3
NN3 PCN Implementation Group (Phase 2)
NN2 PCN Implementation Group (Phase 2)
NN1 PCN Implementation Group (Phase 2)
Breckland PCN Implementation Group - Test Site 4
Mid Norfolk PCN Implementation Group (Phase 2)
Ketts Oak PCN Implementation Group (Phase 2)
SNHIP PCN Implementation Group (Phase 2)
Central Neighbourhood Implementation Group - Test Site 5
West Norwich Implementation Group - (Phase 2)
West Norwich Implementation Group - (Phase 2)
West Norwich Implementation Group - (Phase 2)

Criteria that will need to be met by participating PCNs

- Allowing practitioners access to SystmOne and EMIS
- Access to clinical and office space at no additional cost
- An identified mental health clinical champion in each PCN. The champion will form part of a clinical network of MH leads across the PCNs to share best practice and support service delivery
- Commitment to a data-sharing agreement and development of an agreed minimum data set for the purposes of evaluation (to be agreed)
- Engagement and availability to support reviews of the service model, and support continuous improvement and further expansion of the model into other PCN areas;

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Principles of care

- Single Trusted Assessment
- Bio-psycho-social model of care that is holistic, recovery focused
- Care closer to home in a timely manner
- Using all resources available which include wider determinants of health
  - Social prescribing
  - Debt support
  - Housing
- Improves physical health of those with serious mental illness
- Improves access to dementia support services
- Improves access to IAPT for long term conditions

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Post Title	Core Offer	Core Offer Plus
Core Functions		
Consultant Psychiatrist	x	x
GP Champion	x	x
Clinical Psychologist		x
Mental Health Pharmacist		x
Team Manager		x
Senior Clinical Practitioner		x
Mental Health Practitioner	x	x
Primary Care Dementia Practitioner		x
Primary Care Liaison and Coordination Worker		x
Social Worker		x
Trauma Informed Care Worker	x	x
Integrated Care Coordinator/Navigator		x
Peer Support Worker	x	x
Administration Manager		x
Healthcare Assistant		x
Administrator	x	x

Outcomes

- Quality Outcomes
  - Improved health and wellbeing
  - Managed in a timely way
  - Positive experience

- System Outcomes
  - Reduction in number of frequent attenders in primary care
  - Improved care for patients with an SMI
  - Reduction in A&E attendances

Crisis

- National funding
  - Improved CRHT offer across N&W – Core Fidelity
  - Core 24 services (Liaison psychiatry in district general hospitals)
    - NNUH already in place
    - 2019-20 QEH Kings Lynn
    - 2020-21 James Paget
  - Crisis House as an alternative to hospital admission
- Wellbeing Hub (Norwich)
- 111 Access to mental health practitioner

Pathways

- Identification of current directory of services
- Working with service users and others to identify how needs can be met
- Development of a Website to direct our population to information around mental health including crisis and self help
- Developing clearer pathways through services – Personality Disorder in Central Norfolk 2019/20 and throughout all Norfolk in 2020/21

Not only but also

- Perinatal mental health
- First episode psychosis
- Eating disorders
- Out of Area and Specialist Mental Health Placements
- Rough sleeping and Homelessness

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C&YP Mental Health Update

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Delivering Transformation in Children and Young People's Mental Health

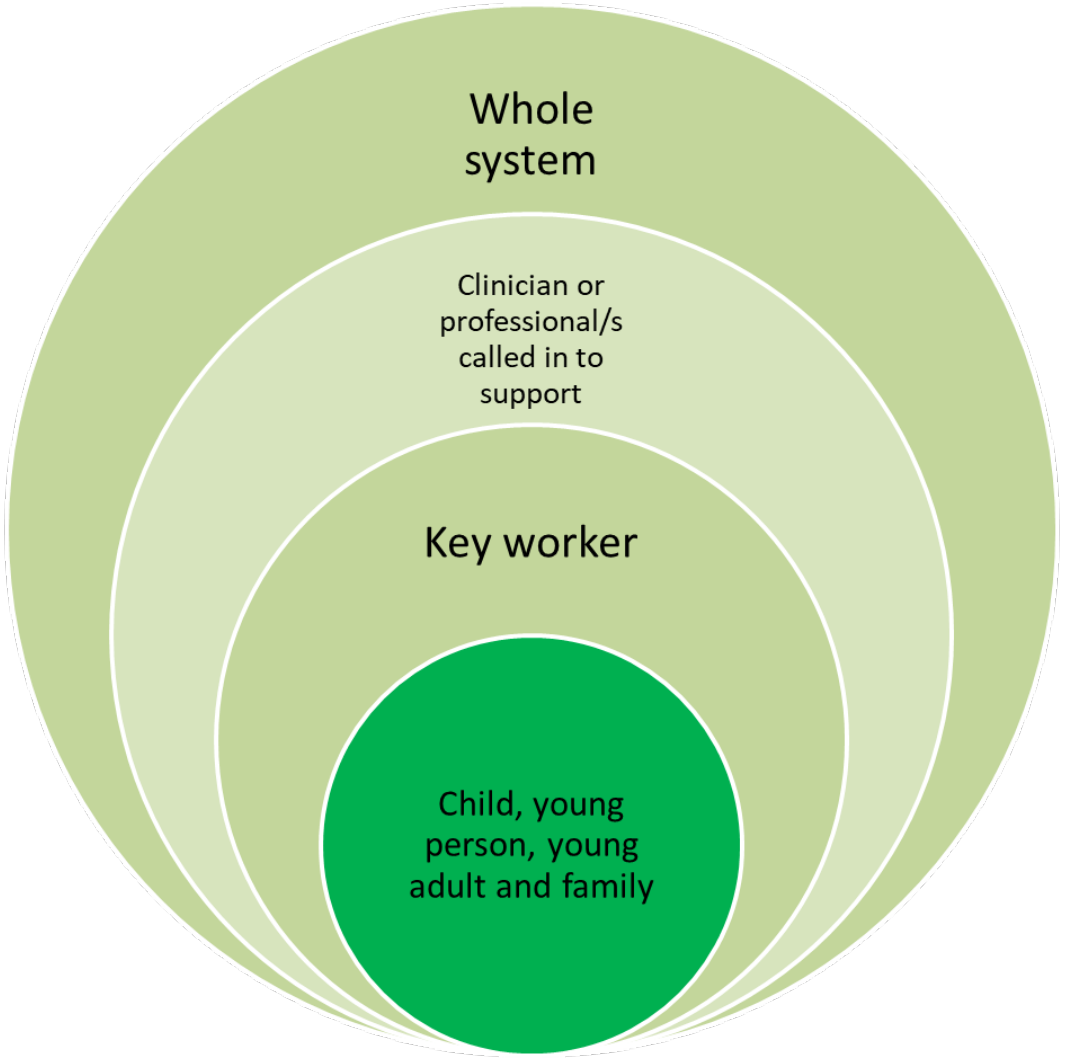
- Norfolk and Waveney's vision is that every child and young person will FLOURISH (Family, Learning, Opportunity, Understood, Resilient, Individual, Safe and Secure, Healthy).

- This is the vision of the collective system in Norfolk and Waveney for children and young people (CYP) through the CYP strategic partnership board. In every decision we undertake we will ask ourselves where the FLOURISH opportunities lie.

We want to create a system based on the THRIVE framework, a nationally recognised best practice approach cited in the Government's recent Green Paper.

- Instead of a tiered system that creates gaps and exacerbates waiting times, a THRIVE-based system focuses on the needs of individual children, young people and young adults.

- All 0—25 year olds are considered to be *'in'* the THRIVE framework. The majority will be 'Thriving'. 1 in 8 are likely to need some kind of help, with the majority having needs met through 'Getting Advice'.



Instead of moving a child or young person around the system, we will move the system around the child or young person. Our new model will embrace some core principles:

- **0—25 yrs:** any child, young person or young adult up to their 26th birthday will be served by this model.
- **A focus on Thriving:** investing in early prevention and aiming to return those with difficulties to a Thriving state.
- **Working as a single system**, with shared case management, performance management and assessments across providers.
- **Clear access routes** for children, young people, young adults and professionals.
- **Community Based:** serving local communities and building community capacity.
- **Relationship focused:** reducing ‘hand offs’ and reducing the amount of times children and young people need to tell their story.
- **Multi-agency multi disciplinary teams** that provide support to families, professionals, and universal settings (especially schools).
- **Goal-Focused & Episodic Interventions:** involving children, young people and young adults in setting goals and making choices.

Impact Statements	Measurable Outcomes	Determinants
Supporting children and young people to have good mental health and wellbeing	1. Improved mental health and wellbeing 2. CYPF are enabled to look after their own mental health and wellbeing 3. CYPF feel supported to recognise mental health issues and know where to go for help 4. Increased number of CYPF are appropriately supported by the right services at the right time 5. Increased knowledge and awareness within communities to support health and wellbeing	1. Sufficient, capable and informed support networks 2. Positive, supportive relationships 3. Easy access to appropriate, integrated MH help / support 4. Successful interventions 5. Equality of access for all 6. Integration between targeted, specialist and universal support across the system 7. individuals in contact with CYP recognise role in providing MHW support 8. Diverse range of access sources 9. Undiagnosed conditions
Reducing the negative effects of emotional and mental health difficulties	1. Improved functioning (social, educational) for CYP experiencing mental and emotional health difficulties 2. Reduced need for emergency, crisis and social care interventions 3. Timely access to and progress through interventions 4. Improved physical health 5. Reduced inequality gap for key developmental milestones 6. Duration of help-seeking is reduced 7. Parents/carers, CYP and professionals are aware of available help and how to access it 8. CYP are able to remain at home in safe, stable, nurturing environments	1. Access to appropriate, local targeted mental health assessments and interventions 2. Lines of referral and communication between levels of intervention 3. Effective, supportive developmental environments 4. Positive, supportive relationships 5. Adverse childhood experiences 6. Family functioning including parental mental health, conflict and substance misuse 7. Holistic health and developmental approaches 8. Identification and support around conditions such as NDD
Improving transitions into and experiences of adulthood	1. Improved engagement with universal services including school/college/university and apprenticeships 2. Improved achievement of educational milestones 3. More YP accessing training and skills development opportunities 4. YP are confident in developing their independence 5. YP report greater agency and autonomy and have sufficient understanding and skills to take a leading role in their own recovery	1. Effective, supportive, learning environments 2. Focused support for CYP with significant MH difficulties and/or significant trauma/LAC to access EET 3. Positive, supportive relationships 4. Collaborative, agreed transitions planning 5. Transitions between CYP and adult MH services 6. Access to education, training and employment opportunities 7. Additional needs 8. CYP receive support to focus on and realise their future wellbeing and choices

The Alliance Board will require all services for CYP to work together and use shared resources to achieve **shared outcomes**

All mental health staff will be working as an Alliance, with **shared IT platforms**

We will focus on **safety planning** and risk support

We will focus on measuring and achieving the **right kind of outcomes and change**.

We won't 'hand off' or refer on

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Children and Young People's Transformation Achievements

- New governing body – the Alliance Board – established.
- New service design and clinical model co-designed, and team and resource mobilised for implementation.
- New Alliance relationship between providers and commissioners established in principle, further to formal sign off.
- Implementation workstreams established, with first phase implementation planned for October 2020.
- The foundations for joined up system-wide working are in place.

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Children and Young People's Transformation Next Steps

- Bid for further three mental health support teams for submission by mid March. If successful at least one team will be focussed on Great Yarmouth and Waveney population
- Alliance agreement to be in place by end of September 2020
- Early adoption arrangements for advice service and simplified access
- Utilisation of population data and working with partners to identify locations for community bases

Community Bases

5 Local Delivery Group (CCG areas) Each of the 5 areas may have a different number of bases, and different types.

Each will ensure robust and safe clinical management mechanisms are in place.

May offer treatment and support on site, and some will offer drop in service.

Each will serve a local patch, actively creating links with its local community, providing all of the services needed for their locality.

Shared expertise and resource will be used effectively from each member agency.

Features in each locality

The service will operate 8am - 8pm and include "crisis service" within these times. Each locality will develop its local offer based on local needs.

The ability to meet CYP&Fs in community venues or their own home when needed

Clear joint working arrangements with Early Help teams, including colocation/shared staff

At least one central base with appropriate clinical rooms, meeting rooms and space for staff offices, training and development

A clear set of interventions that are age appropriate for children and families and young people and staff with different age specialisms

A clear process and resource for involving CYP&Fs in the development and design of service – roles for peers, lived experience, young leaders.

Drop in centres for 14+, dependent on demographic size and need

A named nurse liaison for GP practices

A named liaison and support for schools

Early Adoption Ideas

Early Adoption ideas	Notes	Project Area
1. Online therapeutic service	• Test of procedures and operation whilst managing waiting lists • Offering as choice to select number of new service users	Service Development
2. Outcomes Framework	• Testing and learning elements of the new framework at Point 1	Data & Reporting
3. Joint Triage	• Firming up and developing procedures for jointly triaging new service users.	Service Development
4. Shared Assessment Tool	• Adopt and test shared assessment to support joint triaging across appropriate teams.	Service Development
5. Primary Care MHP	• Primary Care piloting Mental Health Practitioners, all age mental health 'portal'. • Working differently in pilot areas, using joint assessment tool	Service Development
6. Schools	• Emerging development / liaison with Education, providing support to primary and secondary schools • Early Years Transformation Academy liaison	Thriving / Universal, & Service Development
7. Mental Health Support Teams	• Trailblazing pilot funding for Kings Lynn and North Norfolk for school based practitioners	Service Development
8. LAC Cohort	• Using LAC Cohort as specific demographic to test new ways of working. • Utilising digital solutions	Service Development

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NSFT Update

Current Provision Performance

NSFT where inspected by CQC over a four week period in October 2019.
The over all rating has increased to ‘required improvement’ and the rating for the ‘caring’ domain was rated good.

Of the 11 core services inspected, the ratings are listed below:

- Four rated as good- Community LD and ASD/ Older Peoples Wards/ Older Peoples Community Services/ Forensic and Secure Services
- Five requires improvement- Adult Acute wards and PICU/ Adult Community/ LD In patient services/ CRHT and 136/ Long stay wards
- One service was outstanding- Child and Adolescent Mental Health Ward
- One inadequate- Specialist community mental health services for children and young people

NSFT Performance.

Adult Services

- All targets are below target for adult service line- but are increasing month on month

Areas of immediate action

- Safety Plans- based on service user feedback, specifically community teams
- Vacancies now reduced- reviewing current triage process and moving to face to face or routine referrals
- Reviewing paperwork under QI methodologies for adult services to look at freeing clinical time. Review CPA under new national guidance.
- Roll out of Trauma Focused Training (PD Strategy) to continue to improve culture/ quality of care and responsiveness

CFYP

- All targets are below target for CFYP service line but there are some areas of improvement. Rapid Action Group in place following recent CQC report to support improvement across CFYP.

Areas of immediate action

- Waiting times to assessment and treatment for urgent and routine referrals received for both children and young people.
- CPA quality performance.
- Current team skill mix for review alongside review of current triage processes.
- Reviewing paperwork under QI methodologies for CFYP services to look at freeing clinical time. Review CPA under new national guidance.