in good health

The Norfolk and Waveney Health and Care Partnership

# Norfolk and Waveney Adult Mental Health Strategy

## March 2019

# Contents

**Foreword**

As we become more aware of the challenges faced by people with mental health needs we know that, in one way or another, these issues touch the lives of every person in Norfolk and Waveney. Although you may not have a mental health condition yourself, you will know someone who does. It could be a member of your own family, a friend, colleague at work or someone you see out and about in your community.

This strategy sets out a long term vision for mental health services available locally, and what we need to do to get there. It has been written alongside people that use mental health services, carers and professionals, and is rooted in the things people told us needed the most attention.

You have told us what is not working, and where people are not getting the support they need. We know that to improve mental health support and treatment locally, we need to work together as a whole system to come up with solutions to effectively use what resources we have both now and in the future.

We know that many mental health problems are preventable and most can be treated. If supported in the right way, most people can recover or learn to manage their condition and this means they can lead a happy, healthy and productive life.

We also know that some people will need long term support, and expert clinical treatment – we need to develop clear, accessible services that are wrapped around the needs of people, recognising that their mental wellbeing can be linked to their physical health and the relationships and circumstances in their lives.

We have to deliver truly integrated services: understanding the importance of accessing health professionals at the right place and time, but also linking seamlessly with the expertise of colleagues in social care, district, city and borough councils and the voluntary sector.

We recognise the strategy will need to constantly evolve. In order for it to remain relevant regardless of the climate we find ourselves in, we will need to routinely review the document and refine where appropriate. By doing so we can turn this strategy into action, working in true coproduction with people that use mental health services and the communities they live in to deliver effective, compassionate mental health care for everyone.

**Frank Sims, Mental Health Lead, Norfolk and Waveney Sustainability and Transformation Partnership**

**Dr Tony Palframan, Chair, Norfolk and Waveney Mental Health STP**

## Introduction

We have spoken to thousands of local people about services and support available across Norfolk and Waveney for adults with mental health problems; people with mental health issues, families and carers, professionals in the field, and volunteers. These have been productive and often very tough conversations because we have heard some difficult stories. We have also been told very clearly that the current provision of local support and services simply isn't working in the way people want and need it to.

In this strategy we reflect on those conversations and set out six commitments in areas where we have been told we need to make the most significant changes and improvements. These six commitments are as follows:

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

In this document you will find more information about how we have worked with local people to develop this strategy, and how we are now taking this work forward. You should not consider this strategy a finished piece of work, but the start of an enormous programme of change. Each of our six commitments is now an active workstream with a team of professionals, service users, carers and volunteers working to deliver real change but also to reinforce those parts of the service we have been told are working well.

We want you to continue talking to us as this work develops and will be offering regular opportunities for these conversations to happen. Thank you for your help and support in developing this strategy.

**Who We Are**

The Norfolk and Waveney Sustainability and Transformation Partnership (STP) is one of 44 STP's nationally, established to ensure the NHS, social care and key partners worked together to better deliver health and social care. We are a partnership of local health and care organisations working together to build healthier communities in Norfolk and Waveney.

Our partnership includes local GP practices, hospitals, community care, social services and mental health teams, and together we provide services to more than a million people.


Our partnership has 13 key members, listed below, but we also work closely with our local Healthwatch organisations, the police and emergency services, education, district councils, the voluntary, community and social enterprise sector and others.

NHS Great Yarmouth and Waveney CCG
NHS North Norfolk CCG
NHS Norwich CCG
NHS South Norfolk CCG
NHS West Norfolk CCG
James Paget University Hospitals NHS Foundation Trust
Queen Elizabeth Hospital King's Lynn NHS Foundation Trust
Norfolk and Norwich University Hospitals NHS Foundation Trust
Norfolk County Council
Suffolk County Council
Norfolk and Suffolk NHS Foundation Trust
Norfolk Community Health and Care NHS Trust
East Coast Community Healthcare CIC

## Objectives of the Mental Health review and the purpose of this document

A major piece of work commissioned by the Norfolk and Waveney STP was a review of local adult mental health services. Individuals with mental health issues look to health and social services to provide support and care at points of difficulty and vulnerability in their lives. We know local mental health services are under great pressure and face a significant challenge to deliver the quality of care that service users require.

We started this review in order to understand the views of adult service users, their families and carers, staff and volunteers. We wanted to review the performance of current services, analyse system issues and develop a long-term strategy to ensure sustainable delivery of high quality adult mental health services across the area. Child and Adolescent Mental Health Services (CAMHS) are subject to a separate review, as are learning disabilities and autism. However our strategy will link with that work, as well with the national strategic aims outlined in NHS England's Five Year Forward View for mental health. It will also develop alongside the work underway in Suffolk to review and redevelop mental health services there.

We started the review of adult services in May 2018 with a large public event called 'Breaking the Mould' and also carried out a public survey through the autumn. This work highlighted a wide range of issues with current mental health services and support with important feedback from people who actually use those services. We also heard from their carers and family members, whose lives are also impacted by the quality and availability of local services.

Working with partners, including the Public Health team, we also looked at a significant amount of data to give us an idea of how our local services compare with others across the country and how things might change in the coming years. This showed an increasing public awareness of mental health issues will likely result in an increasing demand for mental health services in Norfolk and Waveney. It also revealed a mixed quality picture with some services below national benchmarks or targets.

We also have to accept that we are operating in a constrained financial environment as we attempt to meet current and future demand. This makes it critical to design services in the most effective way possible, to make best use of available resources to support the well-being of people of Norfolk and Waveney

This document summarises the key findings from the many conversations we had with the public, stakeholder and staff and the analysis of relevant system data. It also gives more information about our six commitments and what we are doing next.

**Funding**

Across Norfolk and Waveney there has been increasing demand for mental health services. This has resulted in an increase in waiting lists in most services and high demand growth over all. There is also a new focus that has been driven by NHS England's Five Year Forward View, which means we have to look at current spend and the investment we are making through the Mental Health Investment Standard (MHIS). This means money spent on mental health will increase above funding growth over the next few years.

We are committed to meeting the MHIS but need to ensure we use the available funding as efficiently as we can to get the most from it. In order to provide enough of the right services in the right place, to meet rising demand and to provide new services to address previous gaps, we have to do something different with our money.

We currently spend around £100m on mental health in Norfolk and Waveney but with levels of growth in demand predicted to outstrip current capacity, we need new models of care to bridge the gap. This strategy allows us to provide what we need to within the funding we are expected to have going forward.

## 2 How we talked to you and what you told us

Although we have a lot of system data to help us see what is and is not working, nothing is as important as speaking to those people who use local services. This also includes their carers and families as well as health and social staff, people from the voluntary sector and other organisations involved in providing support and care to the population of Norfolk and Waveney.

These real-life experiences paint a very vivid picture of where we are meeting the needs of local people and where we are not. Their perspectives and ideas have strongly shaped this review and helped us write this strategy. Many of these conversations were face to face either at large public events or smaller group meetings. But we also provided people the chance to comment by writing to us or by completing a survey. We also arranged a number of practical working sessions with people from different organisations to ensure a wide and representative group of people were part of the discussions.

A variety of users, health and social care workers and representatives from other organisations and services helped lead the communications and engagement process to ensure it was fair and unbiased.

In total we either held or attended 42 separate events between August and December 2018 of which seven were with people who use mental health services locally, carers and the public. A further 25 were with health and social care staff and 10 were with community and voluntary groups. We also spoke to hundreds of local people online through a discussion on Facebook. Throughout all of this work we were able to gather feedback, viewed and experiences from more than 2,500 local people.

**Engagement of service users, carers and the public**
The seven events which were for people who use mental health services locally, carers and the public can be split into two categories:

***User Forums across Norfolk and Waveney:*** These were four stand-alone service user forums. This was a way for us to speak to service users early on in order to understand their perspectives. These conversations also helped as design and write the materials we would use at our launch events and conversation we would have with other stakeholders

***Public Launch Events:*** We held three large public launch events (Lowestoft, Kings Lynn and Norwich) which were widely publicised by our primary care teams, local hospitals, voluntary teams, the CCGs and through the media (including on social media). The events reached over 130 people in total and provided an excellent environment for discussion on the key mental health issues facing the system as a whole. These events included a number of presentations and two workshops, as follows:

Workshop One: Your experiences of local Mental Health support and services: What is working? What needs to change? What are the current issues or barriers?

Workshop Two: What should future Mental Health support look like? How would changes make a difference to you?

These events provided an enormous amount of feedback and insight into what was working and what needs to improve - all of this information has been used to help write this strategy.

In parallel, there have been a further four public events for people directly affected by dementia and two further dementia events for professionals. These reached 150 people. These events were run by a separate dementia workgroup to allow a more tailored approach to engaging with people with dementia, their carers and professionals working in the field.

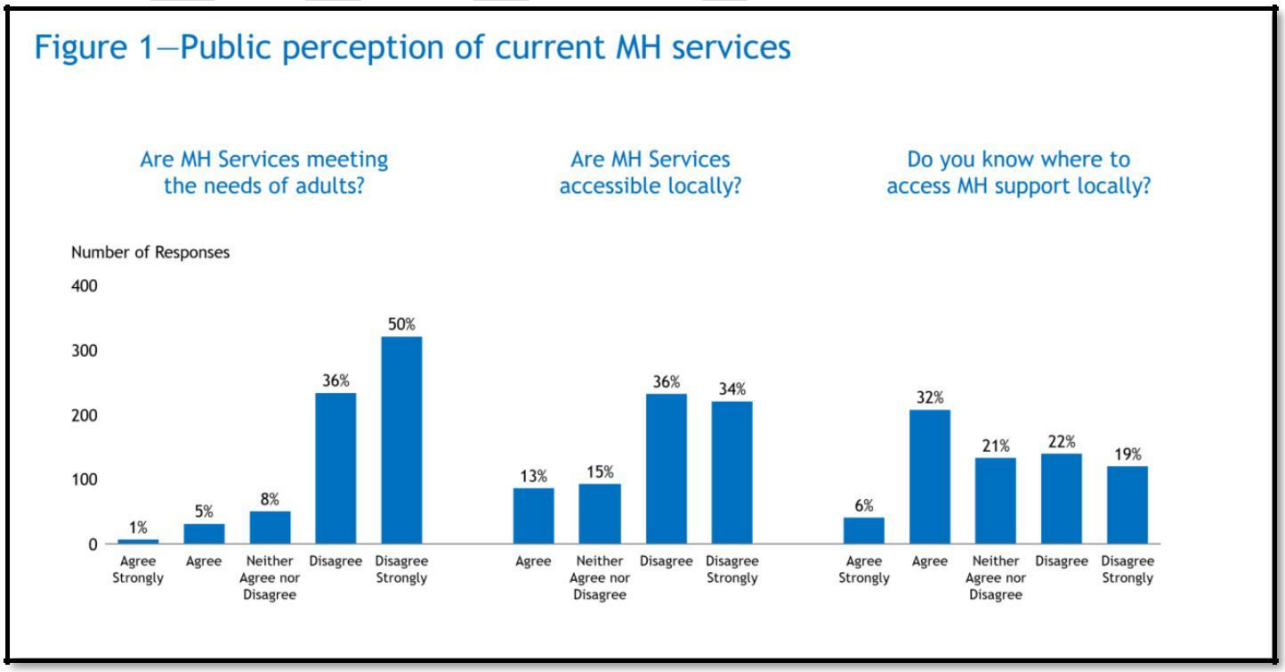
We ensured disadvantaged groups were included throughout the review by making the surveys available in Easy Read form to allow people with learning disabilities to share their views. Additionally we engaged several advocacy forums and organisations who gave feedback on behalf of the communities and individuals they represent. The organisations involved included Opening Doors, a learning disability advocacy organisation, Bridge Plus, GYROS and ACCESS, which are advocacy and support organisations working with black, minority ethnic (BME) and migrant communities.

In addition to these events about 1000 people gave their views through our survey; 62% of these were service users, carers and members of the public who provided a real breadth of service user input; 38% included health and social workers and community and voluntary sector workers giving a view from the people who deliver services or support.

The survey delivered a very clear message that the people of Norfolk and Waveney are largely dissatisfied with the current provision of mental health services in the area:

- 86% of respondents feel that services fail to meet the needs of the mentally ill
- 70% of respondents feel that mental health services are not locally accessible
- 41% of respondents do not feel that they know how to access services

Figure 1—Public perception of current MH services



Although the experience of users was highly varied we could see there were a number of consistent themes emerging about the provision of care and services. These were:

- Services were seen as complex, slow and hard to access and navigate, for example, crisis services
- Services were perceived to be poorly integrated between different organisations
- Quality and consistency was perceived to be highly varied (for example waiting times)
- Provision of care seen needed to be more focused on treatment than prevention
- Service users did not feel community care was being fully utilised

On the next page you can see some of the comments we received from both our events and our survey. These strongly reflect much of the feedback we received.

# Service User Experience

## Complex, slow and hard to navigate

Services can feel overly complicated and difficult to move through for service user, carers and health and care professionals

*"The system is too reliant on individual contacts and personal connections…if you don't have a contact, then it is very difficult to get help, particularly in a crisis"*

Public Event

*"People should only have to tell their story once between UCS support and formal health services"*

Public Event

*"GP's in Norfolk feel confused by and outside of NSFT services. GP's are the first port of call. If they don't understand our services, we are all in trouble."*

Public Survey

*"Since the introduction of the Wellbeing Service more desperate and risky people fall between the gap in service"*

Public Survey

## Poor integration of care

Service users & families find care to be disjointed, fragmented & confusing, with a lack of cohesion and communication between services, resulting in individuals 'falling between cracks

*"There needs to be better sharing of information about individuals, including with the Voluntary sector"*

Public Event

*"More communication - between mental health trusts / hospitals / GPs. They should be able to access current medication requirements and mental health assessments."*

Public Survey

*"Integration of wider determinants of health (housing, benefits, food etc. for those with mental health difficulties). A whole-system approach."*

Public Event

*"There should be a transition pathway for children-to-adults in health and social care"*

Public Event

## Issues with quality and consistency

Services provide inconsistent, slow and poor quality care across Mental Healthcare services in Norfolk & Waveney

*"Mental Health professionals need to provide more personalised care, co-producing each individual's care plan with them. They should also be better at involving family members in an individual's care"*

Public Event

*"People are being discharged from inpatients without consultation with community teams on a regular basis"*

Public Survey

*"Social workers lack skills. Not enough training at well-being centres"*

Public Survey

*"Speedier access to support. Too much medical treatment (anti-depressants) and not enough talking therapy"*

Public Event

## Concentration on treatment rather than prevention

There is a lack of services focusing on preventative measures, with current focus heavily weighted in downstream treatment

*"A crisis never happens suddenly - it is the end result of unmanaged care over a period of time"*

Public Event

*"Support must start young… children peer-to-peer support"*

Public Event

*"Training/education to be delivered by someone with experience and not necessarily by professionals (e.g. peer to peer support)"*

Public Event

*"I feel that you need to be in a crisis to receive any type of health. It would be more beneficial to have a service out there which can help prevent illnesses before they reach crisis."*

Public Survey

## Community care not fully utilised

Service users are signposted to secondary/formal care settings too easily, with a lack of offering of care in less formal, community support settings

*"The public don't know that much about the range of services and support on offer, particularly from the Voluntary sector, for people with Mental Health conditions"*

Public Survey

*"There should be longer-term placements for people with serious conditions, not institutions, but community based approaches"*

Public Survey

*"Home treatment service/health coaching would keep people out of hospital"*

Public Event

*"Professionals should have more faith in the voluntary sector and in social prescribing"*

Public Event

**How we talked to Health, Social care and Voluntary groups**

We knew it was important to talk to those people who provide services and support to individuals with mental health issues across Norfolk and Waveney. As part of these conversations we also spoke to experts from other national and international health systems so they could share with us examples of best practice from around the world. This work included:

- More than 70 one-on-one interviews with individuals from different stakeholder organisations across Norfolk and Waveney relevant to adult mental health and dementia. These were from within the system and outside of the system to help gain an objective view about issues being faced by mental health services and the level of care offered to service users

- A series of 35 meetings with different organisations which enabled us to share findings from prior work and engagement, to develop a compelling case for change and to begin to define potential solutions

- Discussions with community support groups and voluntary organisations to identify key trends in mental health needs nationally, gaps in service provision and additional insights on how collaboration across the system could help to improve mental health services in a more holistic manner

- We received responses from about 400 health & social care workers and community and voluntary workers to the online survey

All of the feedback from service users, their families and carers, professionals and volunteers was used to develop a draft strategy and we published this in December 2018. During January and early February 2019 we asked for comments and feedback on that draft. We were delighted that hundreds of people spoke to us again and told us what they thought.

All of these conversations, comments, stories and experiences have been used to produce the strategy you are reading now. A full list of organisations, groups and forums that responded to the survey are listed in Appendix 1.

# Health and Social Care worker experience

## Complex, slow and hard to navigate

Services can feel overly complicated and difficult to move through for service user, carers and health and care professionals

*"Access to services and Mental Health professionals is difficult. This is true even for other health and care professionals."*

Staff Survey

*"No stream-lining of care. The service is simply ineffective with people sitting on caseloads due to no direction of care and no provision of services. "*

Staff Survey

*"There are significant issues with fragmentation of the mental health pathways in Norfolk, with multiple providers, using different systems, and somewhat internal focus. "*

Staff Survey

## Poor integration of care

Service users & families find care to be disjointed, fragmented & confusing, with a lack of cohesion and communication between services, resulting in individuals 'falling between cracks

*"There is little in the way of communication from Mental Health teams to GPs - sometimes patients are being seen, but we aren't written to & kept informed of plans. "*

Staff Survey

*"There is not yet sufficient joint working between NHS, social care, and third sector providers to meet the needs of the hardest to reach in society, such as those who are homeless, trapped in a cycle of criminal justice pathways, or vulnerable to drug and alcohol use"*

Staff Survey

*"Inconsistent/inappropriate referrals from primary care."*

Staff Survey

## Issues with quality and consistency

Services provide inconsistent, slow and poor quality care across Mental Healthcare services in Norfolk & Waveney

*"The staffing levels are inadequate to provide a safe level of care. Funding cuts means there is not enough money to provide care at the appropriate time its needed or to the quality it should be."*

Staff Survey

*"Lack of appropriate placements for those with the diagnosis of personality disorders resulting in unhelpful prolonged hospital admissions. "*

Staff Survey

"Lack of staffing which puts patients of greater risk"

Staff Survey

## Concentration on treatment rather than prevention

There is a lack of services focusing on preventative measures, with current focus heavily weighted in downstream treatment

*"threshold begin very high, no earlier intervention/lower level of mental health support."*

Staff Survey

*"Lack of support after discharge and lack of investment in prevention. "*

Staff Survey

"(Lack of) *Education and preventative support in schools, colleges and with families"*

Public Event

## Community care not fully utilised

Service users are signposted to secondary/formal care settings too easily, with a lack of offering of care in less formal, community support settings

*"Lack of third sector support outside of specialist mental health services"*

Staff Survey

*"Mental health / social prescribing / community charitable organisations and social services should go back to working jointly and they all should share information with GPs"*

Staff Survey

*"Loss of specialist teams and robust community resources"*

Staff Survey

**How we listened to different views on using local services**

It was important we listened to many different people and their own experiences as a user of local services. To this end we set up a "Task and Finish Group" which included a mix of individuals including health and social care professionals, voluntary sector representatives, commissioners and service users. This group has met more than 20 times in recent months and played an important role to ensure this strategy reflected the entire system as a whole. The group had an opportunity to shape this approach, review findings and input on a regular basis into the emerging findings and recommendations. It included 22 individuals from 13 different organisations and was instrumental in shaping the initial fact-finding exercise and in outlining the direction of our strategy at a high level.

The group identified "six strategic pillars", which have since become our six commitments. We now have teams including service users and relevant staff mobilised behind each of these commitments. Their role is to set the ambitions for each commitment, including goals and milestones. These teams will also ensure there are even more conversations with the broader public and service users to ensure this work can adequately meet the needs of local people. This level of co-development continues to ensure that representative teams are taking ownership of the strategy and are also being adequately supported to do so effectively.

As part of their work we agreed to create a Dementia workstream as a key sub-group. This is particularly advanced having already facilitated about 100 discussions specifically about the dementia pathway at 22 focus group events. This level of co-development is expected to continue with several Interactive workshops being scheduled to further engage other key stakeholders.

To support the delivery of the six workstreams aligned to each commitment, a Coproduction Advisory and Assurance Group has been convened, involving people with a lived experience of mental health services, carers, voluntary sector representatives, clinicians, mental health professionals and commissioners. This group meets monthly, and scrutinises the work of each workstream, and ensures that coproduction opportunities are developed and promoted at their earliest stages. If you are interested in joining the Coproduction Advisory and Assurance Group, please contact snccg.communications@nhs.net

## 3 How we used data

In many ways, "Mental Health" is an umbrella terms which covers a wide spectrum of different conditions. These range from Common Mental Illness (CMI) and Severe Mental Illness (SMI) to Dementia. Within Norfolk and Waveney we have five NHS Clinical Commissioning Groups (CCGs) and there are variations across each CCG area. For example there are key differences between urban areas like Norwich and Great Yarmouth and areas which are more rural. We obtained data from Public Health England, Fingertips and the Office of National Statistics (ONS), which allowed us to complete comprehensive analysis across the CCG areas.

### Prevalence

Across Norfolk and Waveney the level of mental illness is broadly similar to levels in other parts of the country. However there is a higher prevalence of Dementia reflecting the older demographic in certain areas. Importantly the level of unmet need is higher than the national CCG average, driven by high levels of unmet need relating to common mental illness (anxiety and depression). The number of people with common mental illness is expected to grow at about 1.4% year-on-year further compounding the issue. We also know that suicide rates are slightly above the national average (10.6 suicides vs 9.6 per 100,000 nationally) although progress has been made in recent months to reduce that disparity.

### Outcomes

We looked at data on the quality of local services and the outcomes they deliver for local people, and how they compare to national services. Through this we were able to identify a number of local challenges. The provision of care for people with common mental illness is falling below national targets. For example only 83% of patients gained access to IAPT (Improving Access to Psychological Therapies) services within six weeks (compared to the national average of 90% of patients), suggesting capacity challenges across both primary care and the wellness services.

At the same time, there are issues with the way that people are supported. For example, only 77% of SMI patients received blood tests in the past 12 months. This suggests there are issues with the ongoing monitoring and prescriptions for psychosis which exceeds the national average by 29%. It's important to note, however, that Norfolk and Waveney is positively above the national average in some areas; for example, the blood test records scores 3pts better than national in relation to dementia. However, there is still potential for improvement since the dementia care review scored 7pts below than the national average in the past 12 months and the quality of residential and nursing beds scored 10% lower than the national average across Norfolk and Waveney.

It has been widely reported that our region's largest provider of Mental Health services, the Norfolk and Suffolk Foundation Trust (NSFT), is also experiencing a number of challenges as highlighted by the most recent CQC report released in November 2018. This rated the trust as inadequate for the third time and outlined a range of areas for improvement. This includes staffing levels, care plan updates, leadership and the management of patients on waiting lists

As the Norfolk & Waveney Adult Mental Health strategy is developed in greater detail it will be important to tailor the overarching approach to the specific requirements of the different CCG areas. **For further details of prevalence per CCG area please see Appendix 1**

## 4 Key issues we need to address

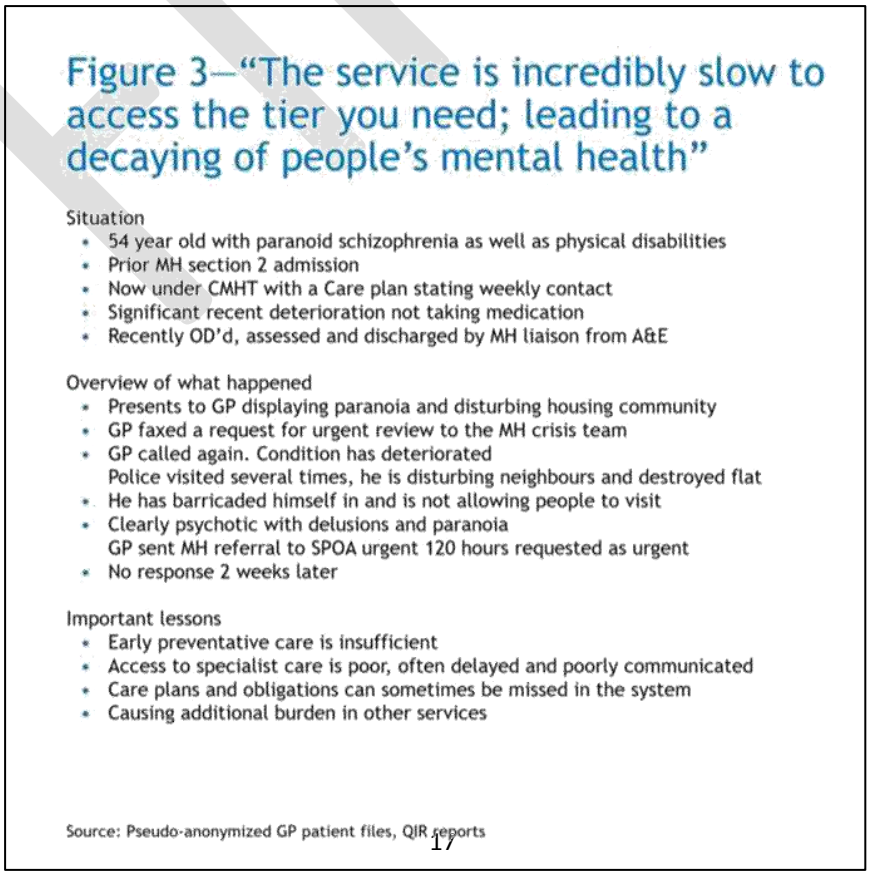
All of this work has shown there are significant issues with current mental health service delivery in Norfolk and Waveney, which are likely to worsen in the future. People who use these services predominantly have a low opinion of them with feedback forming consistent themes across the system. Objectively Norfolk and Waveney performs below national benchmarks on a number of quality and outcome measures, has a dissatisfied workforce in some areas (resulting in staffing difficulties), has challenges meeting current demand, and faces financial challenges. We need to tailor a solution which tackles the underlying drivers. These include the following:

> ***"We need to focus on prevention of mental health problems and keeping people healthy and well."-*** *Public Event*

We've heard about the stigma associated with mental health issues, a lack of awareness and education about the issues and insufficient focus on preventing mental health issues including dementia. Prevention tends to have less funding than most believe is necessary, contributing to a greater focus on managing the consequences in higher cost settings. Many people that use mental health services felt they did not get the attention they needed before the onset of mental illness. The wellbeing of older age patients living with Dementia was also raised as an area of concern.

> ***"The service is incredibly slow to access the tier you need; leading to a decaying of people's mental health –*** *Public Survey*

People who use these services and health and social care workers both told us they struggle to access specialist mental health services when needed. Access issues came across strongly from users and primary care physicians. The current model results in significant frustration for service users and health and social care workers. The Dementia working group has also revealed issues with accessing the right care for service users experiencing the initial signs of dementia resulting in high levels of distress and poor levels of care in some elements.



***"Lack of holistic care 'don't connect the dots' between physical, MH and social" –*** *Public Event*

Services users, their carers and staff have both told us the system is not operating in an integrated fashion. Service users feel they too often get "lost in the system" or "fall between the cracks". There are also frustrations from those who provide services with accessing and communicating with other services within the local system. There are capacity issues across acute beds which are made worse by issues with integration across regions. Service users say they are being managed in a way that does not meet their needs due to how services operate separately. This lack of integration results in limited accountability across the service user journey and a poor service user experience.

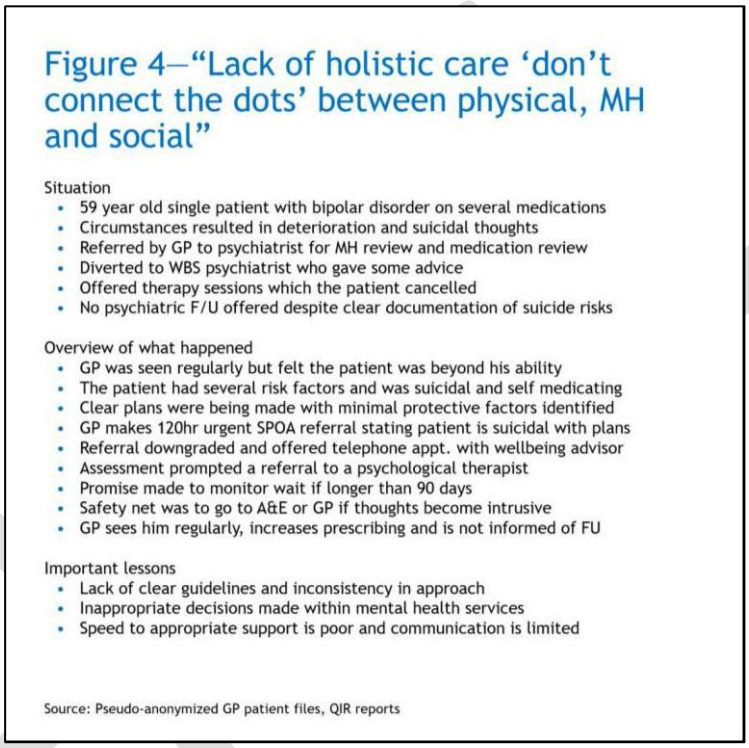


Figure 4—"Lack of holistic care 'don't connect the dots' between physical, MH and social"

Situation
- 59 year old single patient with bipolar disorder on several medications
- Circumstances resulted in deterioration and suicidal thoughts
- Referred by GP to psychiatrist for MH review and medication review
- Diverted to WBS psychiatrist who gave some advice
- Offered therapy sessions which the patient cancelled
- No psychiatric F/U offered despite clear documentation of suicide risks

Overview of what happened
- GP was seen regularly but felt the patient was beyond his ability
- The patient had several risk factors and was suicidal and self medicating
- Clear plans were being made with minimal protective factors identified
- GP makes 120hr urgent SPOA referral stating patient is suicidal with plans
- Referral downgraded and offered telephone appt. with wellbeing advisor
- Assessment prompted a referral to a psychological therapist
- Promise made to monitor wait if longer than 90 days
- Safety net was to go to A&E or GP if thoughts become intrusive
- GP sees him regularly, increases prescribing and is not informed of FU

Important lessons
- Lack of clear guidelines and inconsistency in approach
- Inappropriate decisions made within mental health services
- Speed to appropriate support is poor and communication is limited

Source: Pseudo-anonymized GP patient files, QIR reports

***"Access to services must be simpler and pathways clearer" –*** *Public Event*

There is pressure on mental health acute beds which are running over-capacity in many areas. Pathways are unclear to those outside the acute environment but also between professionals within the acute environment. This results in a great variation in how mental health acute resources are used. GPs have told us they feel unsupported in the community and this may drive higher levels of referrals, which means acute resources are often spent on patients awaiting social and community care. Service users tell us the system focuses too much on treatment rather than alternative means of support in the community, putting significant strain on mental health acute resources in the area.

> ***Crisis Team seems to only be available once someone has actually attempted suicide****"- Public Survey*

Users, carers and professionals all raise issues with the management of patients in crisis. They do not feel crisis services respond fast enough when needed or support patients as they step down from crisis. This results in service users accessing services that are not necessarily the most appropriate for their needs, meaning they receive sub-optimal care as a consequence.

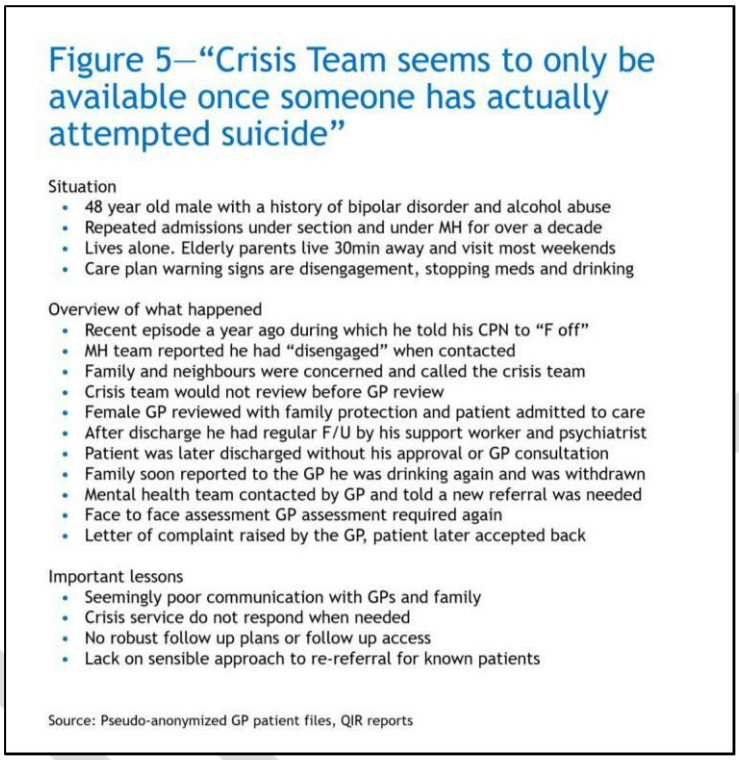


Figure 5—"Crisis Team seems to only be available once someone has actually attempted suicide"

Situation
- 48 year old male with a history of bipolar disorder and alcohol abuse
- Repeated admissions under section and under MH for over a decade
- Lives alone. Elderly parents live 30min away and visit most weekends
- Care plan warning signs are disengagement, stopping meds and drinking

Overview of what happened
- Recent episode a year ago during which he told his CPN to "F off"
- MH team reported he had "disengaged" when contacted
- Family and neighbours were concerned and called the crisis team
- Crisis team would not review before GP review
- Female GP reviewed with family protection and patient admitted to care
- After discharge he had regular F/U by his support worker and psychiatrist
- Patient was later discharged without his approval or GP consultation
- Family soon reported to the GP he was drinking again and was withdrawn
- Mental health team contacted by GP and told a new referral was needed
- Face to face assessment GP assessment required again
- Letter of complaint raised by the GP, patient later accepted back

Important lessons
- Seemingly poor communication with GPs and family
- Crisis service do not respond when needed
- No robust follow up plans or follow up access
- Lack on sensible approach to re-referral for known patients

Source: Pseudo-anonymized GP patient files, QIR reports

> ***Sharing data between organisations is really difficult"*** **–** *Public Event*

The absence of high quality data means there is a lack transparency between organisations around each patient's history, their needs and current treatment status. This makes it harder to hold the system to account and limits the ability of different services to work jointly across the healthcare system.

> ***Not enough funding, not enough trained staff" –*** *Public Survey*

We have a growing population and know we are not meeting the needs of local people. But we also have significant financial restraints and must ensure resources are managed carefully. There are also emerging workforce issues in Primary Care and in specialist secondary mental health provision. These challenges have resulted in our work having less impact than anticipated. We know we need to redesign how the system works as a whole and create new models of care in order to drive that important and much needed change.

## 5 What we have learnt from others

The conversations we have had locally with service users, staff and the wider public and the analysis of local data has highlighted several areas of mental health care and support that potentially needs a new model of delivery. These were;

a) Mental health support for GPs in a primary care setting

b) Crisis response/urgent care

c) Focus on prevention of mental illness in the broader population

d) Suicide reduction

e) Wellbeing services for individuals with Common Mental Illness

f) Waiting times and responsiveness

We know that locally, nationally and internationally there are many innovative projects aimed at tackling the same issues we are facing in Norfolk and Waveney. We focused on the above six areas to search for examples of best practice that have the potential to deliver high impact initiatives and interventions for us here in Norfolk and Waveney. We reviewed more than 80 initiatives across a broad spectrum of mental health services and also spoke to a number of respected international experts. Here are five models which have been developed both nationally and internationally, with strong evidence bases, which we can learn from in Norfolk and Waveney.

1. **Collaborative Care Models:** Multi-disciplinary/agency team led by primary care provider delivering population-based Mental Health care using evidence based interventions

2. **Multi-disciplinary/agency crisis response teams:** Community & acute based, multi-disciplinary/agency teams for Mental Health crisis intervention, including much closer working with the emergency services

3. **Whole-Population Health Management Approaches:** Data driven approach targeting prevention and care, which builds feedback and incentives based on a system wide outcomes framework

4. **Zero Suicide Strategies:** Cross-organizational commitment to reducing the level of suicides through a holistic approach to public safety

5. **Digital Cognitive Based Therapies:** Technological interventions for people that use mental health services users through a range of digital therapies. Examples include Medefer's 'virtual hospitals' which reduces hospital attendances through virtual consultations and Alluceo's app for patients and providers, which is an integrated digital platform for appointment scheduling, in-app communication, self-care materials and patient outcome tracking among other tools.

We assessed these five models as the most relevant interventions to Norfolk and Waveney. However we have considered these alongside local examples of good practice.

It is also worth mentioning that collaborative care models have already been introduced locally for different severities on mental illness. Here are some examples:

**Low Level Mental Illness**: A partnership between Beccles Medical Centre and Great Yarmouth & Waveney Mind has been developed to alleviate pressures on Primary Care staff by providing a caseworker to work with the centre to support patients with Mental Health issues.

**Moderate to Severe Mental Illness:** The PRISM service, set up by Cambridgeshire and Peterborough NHS Foundation Trust (CPFT), puts specialist Mental Health staff in GP surgeries so patients with moderate to high Mental Health conditions can be seen in a familiar environment with less bureaucracy.

**Severe to Crisis Mental Illness:** Norwich Escalation Avoidance Team (NEAT) is a single point of access for urgent, unplanned health and social care needs where a multi-disciplinary team work together to coordinate an integrated response. However the service requires professional referrals and does not solely target Mental Health.

Many of these examples focus on building treatments much more explicitly around the person using the service, making full use of multi-disciplinary working and new technology. This general approach will be relevant for Norfolk and Waveney as we plan ahead and define the specific changes we are going to make to the way services are provided.

## 6 Our Six Commitments

To date in Norfolk and Waveney there has been no overall strategy or long term plan that sets out what our mental health priorities should be or defines a clear and measured approach to delivering the improvements we must make.

That is now going to change. Based on all the work we have done including conversations with thousands of local people including those who use mental health services, their families and carers, and professionals, who either deliver or commission services, we know there are areas where we need to focus our attention.

From this we are making six commitments which form the basis of this strategy. These commitments are:

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

Over the following pages we set out our six commitments in more detail and explain what happens next.

Each of the six commitments is now an active piece of work in its own right. Service users and carers, staff and people from the voluntary sector will be working with us to develop a plan for each. You can get involved….

Each plan which will give detailed information about timeframes, changes, resources, targets and – importantly – how we are going to measure and evidence success.

## COMMITMENT 1: TO INCREASE OUR FOCUS ON PREVENTION AND WELLBEING

We are using this strategy to define our priorities for wellness and the prevention of mental illness. Our teams in Public Health and Social Care have an important role to play, and they are already driving a number of separate but related projects such as initiatives around suicide prevention. However, we need to do more and, importantly, we need to do more *together*.

A vital component of our strategy is the health of our local population and the resilience of our communities in taking better care of the mental health needs to local people by focusing on reducing the stigma attached to mental health conditions including dementia.

The mental health of a community is influenced by a wide range of different factors including levels of deprivation, housing, employment and the strength of that community. These factors are hugely important for both the prevention of mental health issues and the success of treatment, management and recovery. For example, research has shown that common mental illness are more than twice as high among homeless people compared to the general population, and 90% of people in prison have mental health problems, drug or alcohol problems.

It is an important point to bear in mind, however, that these broader factors are challenging for any single organisation to influence or control. It is hard to swiftly predict and plan for the impact these factors may have on a community, and so it is not unusual for the services that support them to be underfunded. This means some interventions which could have the most impact in mental health don't always get the right support.

However if we are to do better and deliver positive change in a timely and measurable way, we have to ensure this strategy has the right amount of resource committed to it by all the partner organisations. We must tackle these issues together in a joined-up way that actually has an impact.

In order to deliver on our commitment to increase our focus on prevention and wellbeing, there are a number of practical steps we can focus in straight away such as:

- **Enabling individuals to take more ownership of their health and wellbeing.** We are going to ensure individuals are equipped to promote their own wellness and that they are supported to make positive lifestyle choices as well as improving their own emotional literacy
- **Building more community resilience:** We are going to enable the community and voluntary sector to play a stronger role in supporting people with mental health issues and the people who support them, like carers and families. We aim to reduce stigma with a specific focus on local education and support to ensure that prevention and promotion of wellbeing become a shared aspiration within communities. Many people have told is this education needs to start much earlier, in schools, and that is going to be an important part of this work.
- **System wide strategy and accountability:** We are going to define a long term public health and social care approach for mental health related issues which will build stronger partnerships with central organisations to better serve the population. This will include building relations with services which are not specifically mental health services such as housing, job services and the justice system.

Our **emerging priorities** are to focus on those interventions which are likely to have the largest impact based on national priorities and what we know locally. Therefore to increase our focus on prevention and wellbeing, we will:

**Enable individuals to take more ownership for their health and wellbeing**
We will support the development of a public facing Mental Health portal that provides information and self-access points for health, social and voluntary services to promote access to people that use services and carers, increase transparency and improve wellbeing.

**Build more community resilience**
We will organise and run public campaigns on mental health stigma, loneliness and wellness including supporting the Norfolk Loneliness Strategy.

We will invest in training for high risk stakeholder groups. This will include training programmes in schools and in the workplace and targeted sessions for families and carers.

We will partner with employers across Norfolk and Waveney and build "back to work" schemes to support rehabilitation and recovery for those with mental health conditions.

We will invest in specific targeted schemes for key issues across Norfolk and Waveney. For example, Norfolk's Suicide Prevention Strategy and more comprehensive addiction and drug and alcohol awareness programmes.

We will roll out the ABCD (Asset Based Community Development) approach by building stronger links with voluntary and community organisations and increasing their visibility to those suffering with mental health conditions and those who support them, so that care and treatment can be actively sought in other settings.

**System wide strategy and accountability**
We will develop a multi-agency approach to tackle some of the related issues we know have the highest impact on health over the medium to long term. This includes allocations of funding for social housing and the provision of benefits and support.

**COMMITMENT 1: TO INCREASE OUR FOCUS ON PREVENTION AND WELLBEING**

**Short-Term Priorities (1-6 Months)**

- Develop a multi-agency approach to broader determinants of health
- Invest behind targetted schemes. For example, a Zero-Suicide scheme.
- Invest in training for high-risk groups, including carers

**Medium Term Priorities (6-24 Months)**

- Organise public campaigns on stigma, loneliness and wellness
- Partner with employers to build back-to-work schemes
- Roll out Asset Based Community Development (ABCD) approaches
- Support development of a public mental health portal for people that use mental health services and their carers and families

**Longer Term Priorities (2-10 years)**

- Execute against the broader determinants of health plans

**COMMITMENT 2: ENSURE CLEAR ROUTES INTO AND THROUGH SERVICES AND MAKE THESE TRANSPARENT TO ALL**

Many service users and mental health workers have told us there are difficulties in accessing mental health services and also confusion associated with navigating the local system. Some felt lost, and others felt that "people were slipping between the cracks".

The experiences of Primary Care physicians, such as your local GP, suggest their ability to access the system on behalf of a patient was highly variable and the quality of care offered at the point of entry was inconsistent across cases. Even mental health specialists reported inconsistent views on what constitutes best practice across their services and colleagues.

There is clearly confusion about what level of care to expect and who in the system is accountable for the patient at various stages of their journey. This lack of transparency across the system results in variations that are hard to manage. This may result in users receiving poor care which in turn causes them to feel let down by services.

We know that for physical conditions it is commonplace to have a standard pathway for patients and this improves the quality of care. And although this already happens in some areas of mental health (such as anxiety and Personality Disorder) it remains rare across Norfolk and Waveney.

It is important for service users, their carers and family – and also for staff – that we have clear pathways through the system. We need to better define from the outset which services people can be offered so that we can better manager their expectation and also provide a consistent level of quality care for all service users. Also, it is critical that we hold service providers to account for these standards by reviewing data, systems, tracking and management.

People who use mental health services and their carers and families should have a clear idea what they can expect from those services. This will enable them to take more ownership of their own care pathway and hold their services to account more formally. It is essential that these pathways also utilise skills from the third sector and voluntary organisations far more effectively as this will increase the provision of community based services. These could be, for example, residential rehabilitation, supported housing and outreach teams to help combat the current strain on capacity.

Therefore our commitment, and the work we will be doing, aims to clarify and standardise key treatment pathways across service providers, improve their visibility and ensure services and individuals can be held accountable for their performance and the level of care they deliver to patients and service users.

Significant work is already underway to transform Dementia pathways as we seek to decrease barriers into the system and improve support throughout the pathway.

There is much to do but our ambitions are high and, we believe, deliverable.

- To increase the standard of care offered to all service users in Norfolk and Waveney by embedding best practice treatment pathways that ensure reliable, high quality and timely care to those suffering with mental illness, spanning all age groups to ensure successful transition between children and adults.
- To clearly communicate to health and social care workers and service users the expectations of care delivery across the system
- To improve accountability for delivering holistic system based care in an integrated fashion across the region supported by data systems and tools

Our **emerging priorities** are to identify the most impactful treatment pathways through the system and build multi-agency teams around them, tasked with developing best practice approaches with clear guidelines, criteria and standards. Where possible we want these to become national examples of best practice.

We want to identify 'fast track' pathways for service users with established high need and those that are known to the system already. We also want to develop an online internal tool to track pathway-based outcomes and share performance with all relevant stakeholders through intuitive digital dashboards.

We aim to build a single digitally accessible directory of services that people that use mental health service, the people that support them and health and social care workers can use. We will also publish pathway approaches at a simplified level alongside outcomes to ensure all those involved have transparent expectations. This will enable users to take more ownership for their care and to hold services to account.

We will ensure sites are pro-actively maintained by the services.

We are going to launch an internal and an external communication drive to ensure that all our teams fully understand the new expectations and approach to tracking and monitoring. We will also continue to progress and build from work already underway to transform Dementia pathways using it as an exemplar to drive change across other system pathways.

We also need to ensure suitable aftercare is available for those at the end of a course of treatment. Aftercare can include almost anything that helps an individual live in the community, such as Help with specialised accommodation, social care support, day centre facilities and recreational activities. It could also include ensuring that arrangements for housing needs are made, particularly if an individual is likely to be homeless when discharged from hospital or can't return home for some reason. The above factors also include support for families and carers in supporting a person's discharge from mental health care and ongoing recovery in the community.

**COMMITMENT 2: ENSURE CLEAR ROUTES INTO AND THROUGH SERVICES AND MAKE THESE TRANSPARENT TO ALL**

**Short-Term Priorities (1-6 Months)**

- Identify most impactful service user journeys and build multi-agency teams around them
- Identify fast-track pathways for high risk service users
- Identify immediate improvements to support people's ongoing care after discharge from mental health services

**Medium Term Priorities (6-24 Months)**

- Build a directory of services and publish pathway based expectations for people that uses services and carers
- Develop an internal tool to track outcomes across pathways
- Launch and workforce and public communications initiative

**Longer Term Priorities (2-10 years)**

- Continued iteration of digital tools based on user feedback
- Hold teams accountable to pathway based outcomes and improve services
- Integrate additional pathways into the approach
- Transition commissioning into pathway based approaches

## COMMITMENT 3: SUPPORT THE MANAGEMENT OF MENTAL HEALTH ISSUES IN PRIMARY CARE SETTINGS

Primary Care services provide the first point of contact in your local healthcare system. It essentially acts as the 'front door' of the NHS and includes your local GP practice and community pharmacies. As such, Primary Care is often the first port of call for those suffering with emotional distress.

Primary Care plays an essential role for the whole health and care system in effectively managing the mental health of the community and ensuring individuals are referred to the most appropriate services. Up to 30% of a primary care physician's caseload can be directly attributed to mental health issues. We also know a high proportion of people with common mental illness - who are often best supported in a Primary Care setting - are not having their needs met.

Primary Care services in Norfolk and Waveney are under increasing pressure. Up to 9% of patients seeking appointments with general practitioners cannot secure one at a time of their choosing. There are many different reasons for this and these include higher expectations from the public, increasing demand from the population and a declining Primary Care workforce.

On top of this, Primary Care teams do not feel adequately supported by secondary care, which is also experiencing issues with demand and capacity. GPs across Norfolk and Waveney have commented that they are being forced to take on more responsibility than they are trained to do, which can result in sub-optimal levels of care being offered to mentally ill patients. This incudes high levels of anti-psychotic prescribing.

These issues are not unusual and in many ways Norfolk and Waveney is simply reflective of national challenges. Certainly there is a national push to address these issues through new models of care which are typically based around multi-agency approaches centred on specific neighbourhoods or localities. This enables services to be customised around the needs of local communities and for limited resources to be better used to meet the specific needs of the population in that given area.

This type of model has worked well elsewhere and many examples exist that demonstrate how these models can improve both physical and mental health outcomes. The 'Collaborative Care' approach (multi-agency supporting teams embedded in Primary Care) is one such model that has shown documented benefits in the treatment of mental health.

In order for us to support the management of mental health issues in Primary Care settings, we are looking at how we can build on national recommendations and capture learnings from local and international best practices. This will help us define a new model of care that protects and strengthens the quality of services for our service users.

Our key ambitions are to bring together different organisations to work together in a more integrated way in Primary Care (a multi-agency approach). This means creating and utilising the skills of a mixed team to deliver better support and services to meet the multiple needs of the population. We aim to create an approach that is tailored at the local level to match the diverse needs of different localities in Norfolk and Waveney. We will also ensure Primary Care teams are appropriately supported with the tools and access to specialty secondary care services they need to better treat their population needs.

Our **emerging priorities** are to design and introduce a new model of care with appropriate supporting tools and digital solutions. We will tackle mental distress in a primary care setting with appropriately skilled workers and fully utilise existing staff and teams through appropriate training.

We will deliver care to those with moderate to severe mental illness in a Primary Care setting using specialist teams based on the highly successful PRISM model (a successful model of embedding mental health support for moderate to severe mental illness into primary care). Local teams will include recovery coaches, volunteers, Mental Health support workers / navigators, Mental Health practitioners and carers leads, amongst others.

We aim to improve the quality of advice available to Primary Care teams with designated channels between primary care physicians and mental health specialists. We will ensure plans for well-being hubs are fully linked to the broader mental health strategy with co-location of high impact teams and community based services.

We will simplify data systems across Primary Care so that users can be tracked across the system and standards of care can be tracked and managed. We will introduce digital solutions where appropriate to give service users more control and access to services. Where possible this should build on pilot schemes already underway across Norfolk and Waveney, for example e-consult services and digital cognitive behavioural therapy (CBT) offerings.

We will tackle the workforce issues through a multi-agency approach to recruitment and retention. We will also improve the linkages with other/ existing voluntary services in each neighbourhood to ensure service users can receive the most appropriate and impactful care for their needs. A key part of this commitment is to ensure a workforce training programme is undertaken across all services even those not specifically supporting mental health conditions.

<u>Dementia</u>
Diagnosing dementia and developing sustainable support for people with the condition and their carers and families is a core part of our work across Norfolk and Waveney. Further to extensive consultation in 2018 we now want to develop a whole system approach to dementia support and diagnosis. This will be more responsive, person centred, efficient in its use of public funds, effective in delivery, and clearer to navigate.

We also want to enhance people's experience of dementia support services and continue to work collaboratively and innovatively with the voluntary and community sector in the design and delivery of good quality dementia support.

Our aim is to improve dementia services through:

- A range of measures that improve people's experience of dementia diagnosis and immediate post diagnosis support
- Taking an integrated approach to commissioning dementia support services to ensure anyone living with dementia in Norfolk and Waveney can expect to receive the same level of high-quality services
- Collaborating with programmes and services that provide support to older communities
- Recognising the enormous value of unpaid family carers the voluntary and community sector, as a provider of dementia support and thinking creatively, as an STP system, about further measures to promote and sustain this valuable contribution.
- Focusing on education and training for the wider dementia workforce, and for everyone affected by dementia, their families and carers.

We are committed to ongoing co-production in developing and implementing this ambition.

**COMMITMENT 3: SUPPORT THE MANAGEMENT OF MENTAL HEALTH ISSUES IN PRIMARY CARE SETTINGS**

**Short-Term Priorities (1-6 Months)**

- Improve the quality of advice offered to Primary Care physicians
- Ensure plans for primary care hubs are fully linked to the mental health strategy
- Improve linkages with voluntary services, including carers support services

**Medium Term Priorities (6-24 Months)**

- Deliver care for mental distress in the primary care setting
- Deliver care for moderate to severe mental illness in a primary care setting
- Simplify data system across primary care
- Introduce digital solutions for patient care
- Roll out a multi-agency approach to recruitment
- Integrate and coordinate support for carers and families across health and social care agencies

**Longer Term Priorities (2-10 years)**

- Continue to harmonize data systems and digital reporting in primary care
- Deliver against recruitment plans and workforce strategies
- Continue to digitally transform primary care
- Strengthen partnerships with community care
- Cement new ways of commissioning

**COMMITMENT 4: PROVIDE APPROPRIATE SUPPORT TO THOSE IN CRISIS**

A mental health crisis often means someone no longer feel able to cope or be in control of their situation. They may feel great emotional distress or anxiety, can't cope with day-to-day life or work, think about suicide or self-harm, or experience hallucinations and hearing voices. A crisis can also be the result of an underlying medical condition, such as confusion or delusions caused by an infection, overdose, illicit drugs or intoxication with alcohol. Confusion may also be associated with dementia.

We know that regardless of whether the crisis is the result of a sudden deterioration of an existing mental health problem or something new that is being experienced for the first time, what is required is immediate expert assessment to identify the best cause of action and stop the crisis getting worse. Mental health crises can be as severe as physical health crises, and as such the response should be equally quick, be supported by appropriately skilled staff and have seamless links across other services to ensure service users recovering from crisis can be effectively and successfully stepped back down into the community.

Unfortunately crisis services across Norfolk and Waveney today do not deliver to this standard. There are several incident reports of ineffective triage, inability to access services and steep ramp downs of care resulting in poor outcomes for service users. GPs across the patch do not feel crisis services are adequate and this is echoed by service user feedback. Across the system demand is overflowing into other services causing unnecessary pressure in the wrong areas such as ambulances, A&E and the police.

We must recognise that appropriate care for those who experience mental health crisis must be widely accessible in all care environments and must include both the acute response and the "tapered step down" support as the crisis resolves.

Our commitment to provide appropriate support to those in crisis is focused on delivering effective crisis care both as a stand-alone service but also in areas where people in crisis may impact on other services if their needs are not being met.

Our key ambition is to develop a 24/7 crisis management service which is able to perform and respond to patients as an emergency service irrespective of their care setting. Our **emerging priorities** are to find a full-service solution that will deliver effective triage, multi-agency response and post-crisis support for the person experiencing crisis as well as their family and carers, with the tools and systems required to enable it.

If we are going to offer **triage and immediate multi-agency response** we will need to ensure specialist level care can be accessed effectively and, importantly, quickly. We can do this by introducing or expanding existing helplines tailored to specific high need groups. This could be a Crisis Resolution and Home Treatment (CRHT) helpline, a Personality Disorder (PD) specific helpline, and / or a helpline for patients in crisis and the people that have concerns about their safety and wellbeing.

We will need to provide pre-emptive support to people that use service who are considered high risk and their carers to avoid the escalation into crisis. We can do this through appropriately staffed teams and this may include linked registers and co-ordinated working with embedded primary care teams.

It is important to note that we also have examples of success already underway in the area. For instance, we want to build on the highly successful Norwich Escalation Avoidance Team – known as NEAT. This ensures people in crisis are treated quickly by a multi-agency team that is capable of addressing a full range of acute needs such as health, social and community support. We also need to provide fast-track access for high-need users that are known to the system, and to expand psychiatric liaison services to reach high intensity areas - and hold them accountable for the service provided.

Many service users and their carers and families say we need to do more in terms of **post-crisis support.** To do this we will need to provide ongoing post-crisis support as close to patients as possible by fully utilising primary care hubs and co-located specialist community teams.

We will ensure crisis teams are more effectively linked to primary care and community teams so that service users can be appropriately and seamlessly stepped down into the community or into a primary care setting. To do this we will need to support workers in practices, alongside PRISM-like models. We will strengthen links with secondary inpatient care beds for higher intensity step down as and when needed. We will also partner with voluntary services who provide continued care following management in a secondary care setting.

In order to **enable** this work, we will harmonise patient records so that crisis response teams can access the information they need to deliver effective care. This will mean that patients will receive an effective response from the start. We will also define clear outcome measures and ensure that reporting methods are supported with digital tools to better monitor and manage performance. We will hold teams accountable for standards

**COMMITMENT 4: PROVIDE APPROPRIATE SUPPORT TO THOSE IN CRISIS**

**Short-Term Priorities (1-6 Months)**

- Provide pre-emptive support to high risk individuals and the people that care for them
- Provide fast-track access to high risk users
- Augment Psychiatric liaison
- Build a mental health crisis response unit building on NEAT

**Medium Term Priorities (6-24 Months)**

- Develop specific helplines for high risk patient groups
- Offer post-crisis support for people that use services and their carers in primary care and community settings
- Strengthen crisis team linkages
- Partner with voluntary and carers support services
- Regularly review carers assessments for people supporting people with serious and long term mental illnesses

**Longer Term Priorities (2-10 years)**

- Ensure the standard of crisis response is standardised across Norfolk and Waveney

***Commitment 5: Ensure effective inpatient care for those that need it most***

Inpatient care refers to patients whose condition requires a stay in a hospital bed or another health or care facility. Across Norfolk and Waveney the provision of inpatient specialist mental health services struggles to meet the demand placed upon it.

Demands on beds are typically above nationally recommended levels in both adult acute and in older adult beds. This means costly out-of-area placements have been rising. We are already struggling to meet demand and, if things do not change, we will not be able to meet demand within the next five years. There is a financial cost to this and there is also an impact the ability of the Norfolk and Suffolk Foundation Trust (NSFT) to deliver high quality, cost-effectively care to the broader Norfolk and Waveney population.

It is essential that specialist acute mental health services should be available for those who need them the most. To do this we need to minimise the number of patients managed in this setting and make sure that, when appropriate, a patient can be cared for in a community environment, ideally in their own home. This is in keeping with other regional Adult Mental Health strategies and national recommendations. Not only is this better for the individual but it is also far less expensive. It also means specialist inpatient beds can be used for those with the greatest need for them.

Our commitment to ensure effective inpatient care for those that need it focuses our attention on ensuring that in-patient beds are available for the severely ill patients that need to be cared for in that environment.

Our **emerging priorities** are to develop new models of care focusing on delivery in Primary Care and community environments. Mental health providers will deliver improved in-patient care focused on those service users who require specialist treatment in that environment. By delivering moderate to severe support in a Primary Care setting, mental health clinicians can support multi-agency teams capable of managing moderate to severe mental health issues.

The whole mental health system will improve Primary Care access to psychiatrists to receive timely and specialist clinical advice for complex mental health service users. We will also improve the way professionals in Primary Care and secondary care speak to each other on patient care decisions. This will ensure patients are receiving the right decisions on their care as early as possible. Our aim is to co-develop clinical pathways for high volume Mental Health issues and maintain them regularly to improve transparency and accountability.

Norfolk and Waveney STP will be investing in the effective delivery of community and social care. We will identify community care services which could accommodate patients currently occupying inpatient beds who could be supported elsewhere. We will invest in social and residential care beds to ensure service users who are ready to leave specialist services can do so in a timely fashion. We will also rationalise and standardise policies and protocols for patients admitted to hospital (step up) and discharged from hospitals to return to home (step down).

We will also look at optimising the care delivery offered to inpatients. This means that we will hold clinicians accountable for reducing unnecessary stays in acute inpatient beds. We will introduce continuous improvement cycles to ensure local teams are always looking to improve the services on offer to service users. We will drive cultural change

across the specialist care teams through strong leadership and the appointment of clinical champions tasked with spearheading change. We will also pro-actively reduce our reliance on out of area and specialist placements.

***Commitment 5: Ensure effective inpatient care for those that need it most***

**Short-Term Priorities (1-6 Months)**

- Enhance communications between services
- Begin to co-develop clinical pathways
- Rationalise and standardise step up and step down protocols
- Introduce continuous improvement cycles
- Develop coordinate support for discharge from mental health services, including support for carers

**Medium Term Priorities (6-24 Months)**

- Develop Primary Care support for moderate to severe mental illness and access to psychiatrists and clinical psychologists
- Right size community and social services and invest in beds
- Hold clinicians accountable for treatment pathways
- Begin to embed cultural change

**Longer Term Priorities (2-10 years)**

- Roll out cultural change
- Implement recommended organisational form changes
- Execute against estate plans to prepare for the future

**COMMITMENT 6: ENSURE THE SYSTEM IS FOCUSED ON WORKING IN AN INTEGRATED WAY TO CARE FOR PATIENTS**

Staff who provide services across the system have told us that mental health services are poorly integrated and that care is often delivered in silos resulting in a poor service user experience. People who use mental health service have also told us this. There are many reasons for this including historical behaviours, structural efficiencies but also the nature of the contracts that underpin the system.

We need to create new ways of commissioning mental health services to become more integrated and to deliver high quality of care to the people who use them. We have already outlined our ambition to pursue integrated commissioning to drive more joined-up ways of working and better outcomes for service users.

We have a unique opportunity to trial new ways of working and commissioning that involves the experiences of people who use mental health services, and coproduces solutions based on their needs.

Our commitment to ensure the system is focused on working in an integrated way to care for patients means we need to decide how services are commissioned and contracted. We also need to outline a new way of harmonising data to support integrated system management decisions

Our **emerging priorities** are to define how we commission and contract services. We will be clear about the services and pathways that are suitable for integrated approaches and ensure flexible commissioning to drive the right levels of care across the system. We will ensure performance can be properly measured but allow sufficient flexibility at a local level to enable innovation and the introduction of new models of care. We will strengthen alliances and share financial risks so that providers can focus on delivering the best care to their users. Those who commission services will place greater emphasis on preventative care and review the approach to commissioning voluntary services

We will also look at the better use of data and tracking. We will ensure our data systems are accessible across all mental health providers so that seamless care can be delivered to service users. We will also ensure providers can be tracked and held accountable for effective and high quality service delivery. We will manage this as a system to improve outcomes for the whole population and minimise duplication of data collection and processing by aligning systems and aligning reporting. Free up resource to care for patients.

**COMMITMENT 6: ENSURE THE SYSTEM IS FOCUSED ON WORKING IN AN INTEGRATED WAY TO CARE FOR PATIENTS**

**Short-Term Priorities (1-6 Months)**

- Define integrated commissioning ambitions
- Outline performance based measure and approaches

**Medium Term Priorities (6-24 Months)**

- Strengthen alliances across providers
- Shift commissioning focus to up-stream interventions
- Harmonised data systems and reporting tools
- Minimise tracking and reporting to inform contract discussion

**Longer Term Priorities (2-10 years)**

- Integrate mental health commissioning approaches across the Sustainability and Transformation Partnership

## 7 What do we need to change to ensure success?

There are a number of key factors that we know we need to look at in order to deliver on our six commitments.

**Workforce**
Looking ahead we see three major implications for future workforce plans:

1. Primary Care physicians will be critical to the service but are currently at risk as a workforce group. It is therefore critical that the number of GPs increase in line with the increased demand for their service, or that an alternative model can be found to reduce the strain on GP services and deliver better care to service users. Steps should be taken to ensure appropriate recruitment and retention strategies are in place for GPs. Furthermore, use of alternative staff should be considered.

2. An increase in the secondary care workforce is critical given the need to expand crisis teams, single points of access and increase access to senior professionals. Hence, retention and recruitment of substantive Psychiatrist positions should be top of the agenda, as should the provision of appropriately specialist nursing or support workers in the key interfaces and access points.

3. Clearly staff satisfaction and historical workforce planning has been challenging with a high number of vacancies emerging and a high cost attributed to temporary staffing. To address this in the coming years:
    a. It is critical that temporary staffing spend in secondary care is systematically addressed through robust policies and regular checks
    b. It is also important that focus is given to cultural change across the organisation to ensure staff are motivated to work and to stay
    c. We need to ensure our workforce is properly trained for mental health support. Although this is important for GPs and primary care, it is important for our workforce more broadly as well.

**Information Technology**
As Norfolk & Waveney moves to become a more integrated system, communication and working between data systems and data processes will be critical to success. Currently, a variety of systems are used both within and across provider groups with inconsistent levels of access to the required data. Furthermore, access to specific key performance indicators to support management and commissioning is limited. It is critical that addressing data issues forms part of the future strategy. This is consistent with the direction of travel outlined in the 5-year Forward View but should be accelerated where possible.

This will not be a short term fix. It will require sustained investment, a designated project team and a phased plan for design and implementation. Norfolk & Waveney will need a designated project team to map out this process.

**Estates**
All the modelling done to date suggests that there are already demand and capacity mismatches across the estates footprint. Acute inpatient beds are under pressure and the provision of social and community beds is not meeting current demand.

An Estate strategy for the next 5 years has been submitted by Norfolk & Waveney, which sets out a proposed pipeline for development in order to address the current imbalance in system estate resources and future expected growth in capacity issues.

The strategy focus on redeveloping the Mental Health hospital estate to provide integrated care to patients, provide accommodation for key workers and private residential housing (including some with care) for patients. In addition to building new facilities, the strategy aims to co-locate physical and Mental Health care services together by creating 5 priority locations which will house operational integrated care teams. This is a good start, however further work is required to ensure the funding is secured to further develop the plans set out in the Estate strategy.

**Carers**

Through the course of developing this strategy we have met with many carers including support groups for carers. A consistent message we have heard is that carers feel unsupported and excluded across mental health services.

Each of the six commitments within the strategy has been assessed from a carer's perspective, including a measurement of impact or what would change for carers of people with mental health conditions through the changes outlined against each commitment.

Through the Adult Mental Health Strategy Coproduction Advisory and Assurance Group, carers have an active role in ensuring the needs of carers are reflected through the six workstream plans as they emerge. The workstreams will also ensure carers and carer support organisations and forums are involved in coproducing plans as they are developed.

## 8 What next

The six commitments outlined represent the key areas of system change for adult mental health services in the future but now need to be developed into detailed plans. This will be the focus of the next phase of work.

The workstreams supporting our six commitments have already begun fleshing out their priority areas and agree timelines and key milestones. Key to this work is having good and broad representation from our local system drawing on the experience and views of service users and carers.

Over the coming months each of the work streams will have produced detailed implementation plans which will themselves be subject to further engagement and co-production. These will be key documents in their own right and together will demonstrate how the Adult MH strategy will be implemented, what changes are actually being proposed and the timelines by when this will take place.

In addition further work will be conducted to review the organisational forms required to deliver against the strategic ambition. This will take into account all the work completed to date, the results from other ongoing work and reviews, and feedback from users to determine the most effective model to deliver the best care for service users across Norfolk and Waveney. Further information on this process will follow in due course.

## 9. Appendix 1 – Organisations, groups and forums that gave feedback and helped develop the Norfolk and Waveney Adult Mental Health Strategy

| | |
|---|---|
| Asperger Service Norfolk | Norfolk Constabulary |
| BACT (Community Transport) | Norfolk County Council Adult Social Care Locality Meetings |
| Beccles Town Council | Norfolk Health and Wellbeing Board |
| Breckland Help Hub | Norfolk Older people Strategic partnership Board |
| Breckland Older Peoples Forum | Norfolk VCSE Sector Leadership Group |
| Broadland Help Hub | North Norfolk Community Engagement Panel |
| Bungay Town Council | North Norfolk Help Hub |
| City Reach Health Services Norwich | Norwich and Central Norfolk Mind |
| Crown Prosecution Service | Norwich University of the Arts' Student Support team |
| East of England Ambulance Service | NSFT |
| Equal Lives | NSFT Service User and Carers Forums |
| Great Yarmouth Help Hub | Office of the Police and Crime Commissioner for Norfolk |
| Great Yarmouth Older Peoples Network | OneNorwich GP Alliance |
| Health Visitor CCS | Opening Doors |
| Healthwatch Norfolk | Queen Elizabeth Hospital Kings Lynn NHS Trust |
| Healthwatch Suffolk | Sheringham Town Council |
| Home-Start Norfolk | South Norfolk Help Hub |
| James Paget University Hospitals NHS Foundation Trust | South Norfolk Stakeholder Engagement Panel |
| Like Minds Aylsham | Suffolk County Council - Public Health, Adult Community Services and Children and Young Peoples directorates |
| Lowestoft and North Suffolk branch of National Autistic Society | Tai Chi for Health (Essex, Suffolk, Norfolk) |
| Mental Health Monitoring Group | The Restoration Trust |
| Mental Health Provider Forum | West Norfolk Community Forum |
| National Autistic Society West Norfolk Branch | West Norfolk Help Hub |
| Newmarket House Healthcare | West Norfolk Mind |
| Norfolk Community Health and Care | |

## 10. Appendix 2 – Mental health prevalence profiles by CCG

### Norwich profile

Prevalence
Norwich has a high prevalence of mental illness, with over 30k people estimated to experience a mental health condition. Prevalence of CMI (15.6%) and dementia (0.7%) is broadly in line with national averages, while the percentage of people with SMI (1.6%) is significantly higher than the national average. Norwich also experiences the highest prevalence of psychosis across Norfolk & Waveney – equal to the UK average 0.4%, while also experiencing a suicide rate ~50% higher than the national average (0.014% vs.0.01% of 16+ population)

Outcomes
Quality & outcomes measures for CMI in Norwich broadly fall short of national averages; IAPT waiting times and recovery rates are below the national average, while the area is one of the highest in the country for GP prescribing of antidepressants. Norwich is moderately below national standards on several aspects of SMI care, displaying an exceptionally high cost of prescribing for psychosis (54% above national average) and below the average proportion of people on CPA (Care Program Approach) receiving follow-up post discharge and physical health checks. Norwich benchmarks relatively well on dementia-related public health metrics, displaying lower than expected rates of elderly A&E admissions and above average rates of physical health checks.

### North Norfolk profile

Prevalence
North Norfolk has a moderate prevalence of mental illness, with ~25k people estimated to experience a mental health condition. Prevalence of CMI (15.4%) and SMI is (1.2%) is broadly in line with national averages, while the percentage of people with dementia (1.2%) is significantly higher than the national average.

Outcomes
Quality & outcomes measures for CMI in North Norfolk broadly fall short of national averages; IAPT waiting times and recovery rates are below the national average, while the area is one of the highest in the country for GP prescribing of antidepressants. North Norfolk is moderately below national standards on several aspects of SMI care, displaying an exceptionally high cost of prescribing for psychosis (54% above national average) and is in line with the average for the proportion of people on CPA (Care Program Approach) receiving follow-up post discharge and physical health checks. North Norfolk benchmarks well on dementia-related public health metrics, displaying lower than expected rates of elderly A&E admissions, above average rates of physical health checks. However the quality of care beds in North Norfolk ranked 18% below national average, indicating room for improvement.

### South Norfolk profile

Prevalence
South Norfolk has a moderate prevalence of mental illness, with ~30k people estimated to experience a mental health condition. Prevalence of CMI (15.1%) and SMI is (0.9%) is lower than national averages, while the percentage of people with dementia (0.9%) is marginally higher than the national average.

Outcomes
Quality & outcomes measures for CMI in South Norfolk broadly fall short of national averages; IAPT waiting times and recovery rates are below the national average, while the area is one of the highest in the country for GP prescribing of antidepressants. South Norfolk is in line with national standards on several aspects of SMI care, displaying an average cost of prescribing for psychosis and is in line with the average for proportion people on CPA (Care Program Approach) receiving follow-up post discharge and SMI individuals receiving physical health checks. South Norfolk benchmarks well on dementia-related public health metrics, displaying lower than expected rates of elderly A&E admissions and above-average rates of physical health checks.

## West Norfolk profile

Prevalence
West Norfolk has a moderate prevalence of mental illness, with ~30k people estimated to experience a mental health condition. Prevalence of CMI (15.0%) and SMI are (1.0%) is lower than national averages, while the percentage of people with dementia (1.1%) is marginally higher than the national average.

Outcomes
Quality & outcomes measures for CMI in West Norfolk face major challenges; IAPT waiting times and recovery rates are below the national average, while the area is one of the highest in the country for GP prescribing of antidepressants. Public health data indicates a mixed view for West Norfolk on SMI quality & outcomes; it ranks higher than the national average for % of SMI patients with a Health of the Nation Score on record, but is an outlier for the high numbers of delayed transfers of care for SMI users. West Norfolk benchmarks poorly on dementia-related public health metrics, despite scoring highly on quality rating for residential beds. A&E elderly admissions are 30% higher than expected, and West Norfolk also ranks below average for % of dementia patients receiving physical health checks.

## Great Yarmouth & Waveney profile

Prevalence
Great Yarmouth & Waveney has a high prevalence of mental illness, with ~35k people estimated to experience a mental health condition. Prevalence of CMI (17.8%) and SMI (1.4%) is significantly above national averages, while the percentage of people with dementia (0.9%) is marginally higher than the national average.

Outcomes
Quality & outcomes measures for CMI in Great Yarmouth show significant challenges; IAPT waiting times and recovery rates are below the national average, and the rate of prescribing of antidepressants in the area is moderately above the national average. Public health data indicates significant issues for Great Yarmouth & Waveney on SMI quality & outcomes; it ranks below the national average for % of SMI patients with a Health of the Nation Score on record and is one of the lowest CCG areas for SMI patients receiving physical health checks. Great Yarmouth & Waveney broadly performs well on many public health dementia metrics; elderly A&E attendances are lower than expected, physical health check rates are in line with national averages – however the rate of dementia care review is significantly below national average.

## 11. Appendix 3 - Data driven demand, capacity & workforce assessment

Prior sections talk to the concerns of service users, health and social workers and other key stakeholder and presents objective findings that reflect a system under pressure and struggling to meet the demand placed upon it. To explore some of the underlying issues that drive these findings we have considered the physical and workforce capacity of key provider groups across Norfolk and Waveney focusing on services as they stand today but also projecting into the future. The analysis underpinning this section has been based on available and agreed data sets and therefore although it has broad coverage it does not reflect all aspects of the system. Having said that it does provide valuable insights on what is to come.

**Primary care:**

There is currently an estimated demand for primary care of ~5.4M patient consultations per year of which over 900K (17%) is thought to be attributable to Mental Health. This demand is thought to exceed capacity limits as 9% of the patients report that they are unable to get GP appointments when they want to. This demand and capacity picture comes at a time when the GP workforce is shrinking at ~1% per year. This presents a significant challenge going forward.

The Primary care workforce is already under pressure. GPs currently look after 18% more patients than the national average, which is expected to increase as a result of a growing population (3% growth by 2023), declining GP workforce and increased mental health prevalence. The GP workforce is declining due to high retirement levels and recruitment issues, this is causing the system to rely on a higher than average number of advanced skill nurses (36% of the workforce vs 27% nationally). This is a clear challenge going forward and is likely to worsen if not resolved with demand expected to outstrip supply in the next 2-3 years.

**Norfolk & Suffolk Foundation Trust (NSFT)**

Bed capacity is stretched. Occupancy typically exceeds the 91% best practice standard in Norfolk with challenges managing demand using the available capacity across Norfolk and Suffolk. The Length of stay (LoS) typically exceeds top quartile benchmarks which reflects both operational issues and the capacity of social and community teams to support discharges. If LoS could be brought in line with top quartile thresholds occupancy could be brought in line with national standards but this is a multi-factorial issue that would require a whole-system solution. In any case, when historical growth is projected forwards the capacity of NSFT is exceeded within 5 years given the current model of care. This indicates that either additional estate is required or new ways of working will need to be adopted as a system. NSFT has a relatively low community caseload (number of patients) per head of population when compared to peers but they engage with them more frequently (43% higher than peer average). New models of care could look to re-distribute some of the inpatient workload into the community.

Ongoing issues with recruitment have led to a high level of temporary staff, which account for 19% of NSFT staff costs compared to peer average of 10%.

To add to these issues NSFT remains in special measures and has recently had another critical CQC report demonstrating a worsening position overall. It is currently rated as inadequate for Safe, Responsive, and Well Led categories.

Strategy **Norfolk Community Health & Care (NCHC):**

NCHC's physical bed base appear to be running at good (~91%) occupancy levels with limited opportunity to improve performance through LoS optimisation. However, if growth continues at the anticipated levels capacity will be exceeded in a similar time frame to NSFT. In terms of community contacts 11% of NCHC's overall waiting lists exceed the 18 week deadline, suggesting ~2.7K additional contacts are required to reduce waiting lists. However, NCHC's contact rate exceeds benchmarks already. Again the picture suggests demand will out-strip capacity within 5 years.

The size of the community workforce appears to be falling, despite this being a critical part of the system. There is a particular challenge with intermediate staffing levels, where the level of clinical WTEs per 100k population is below the national average by approximately 10 staff lower than the recommended safe staffing guidelines.

**Social Care:**

DTOC rates (Delayed transfer of care) in NSFT highlight that delayed days consume a significant number of inpatient beds due to a shortage of residential and nursing home beds or bed equivalents. This has knock on effects on inpatient LoS and the care provided to service users. Stronger links with social care should be considered in the future

The social care workforce faces significant challenges. The independent sector, which makes up the majority of the workforce has retention issues, highlighted by a high turnover rate of 37% per year. Home and Nursing care also face retention issues with 48% and 45% turnover per year respectively, which is mainly attributable to patient facing staff. The Norfolk County Council workforce has contracted by 7% in the last 3 years, this rate is expected to increase due to a large proportion of the workforce who will reach retirement age in the next 10 years.

As a result, across the key elements of the system the workforce is stretched and in places dissatisfied with the working environment. The consequence of a contracting workforce combined with increased demand for Mental Health services in the future will cause further issues with service levels and staff engagement.

**Spill-over impact of mental health issues on wider services:**

Due to this mismatch in demand and capacity of mental health services, activity is flowing into other areas less equipped to deal with it, such as the physical acute hospitals, police services and the criminal justice system, ambulance services and wider public services. As a result people suffering from mental health are not receiving the treatment they need and services like the police and ambulance services are not able to meet the needs of the people who they are uniquely designed to serve. This is particularly common when people reach crisis point, too often people in crisis end up in a the physical acute hospitals or in a police cell, detained under the Mental Health Act rather than having access to more appropriate places of safety. Looking forward it is clear more integration is needed between mental health services, emergency services and public agencies to ensure these circumstances are avoided.