



## **Norfolk and Waveney**

### Adult Mental Health Strategy

December 2018

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## Foreword

We have reached a moment of immense significance in the development of adult mental health services across Norfolk and Waveney. As a partnership across the STP and working alongside service users, stakeholders and the public, we have produced an early and initial draft of a strategy for improving mental health. At the same time we have also reviewed Child and Adolescent Mental Health Services (CAMHS) and worked closely with our Suffolk colleagues, who have been conducting their own review of mental health services.

Listening to service users, carers, staff and other stakeholders so far, we are taking the bold, and correct step to share our initial draft with the public. We commit to listening to feedback from local people and organisations to check we are heading in the right direction and to co-design the final version for public sign off in February 2019.

This commitment to openness and co-design is entirely consistent with the need to focus on how we all have a role to play in delivering safe, effective and easily accessible care and support for mental health. It is not a finished document, nor is it the final polished or easy to read version we will have in February, but that is the point: this is about working together to make sure we get the best strategy we can.

Based on what we have heard so far, our vision is to develop and deliver 'place based' services wrapped around primary care through integrating mental and physical health in each of our localities: Great Yarmouth & Waveney, North Norfolk, Norwich, South Norfolk and West Norfolk. In addition, 6 central pillars have been identified for future work and the intention is to co-design the detailed plans that sit behind this, again with service users, stakeholders and the public. The pillars are worth highlighting, as this comes straight from what we have heard about where the current services need to be improved:

- Focus more on prevention and wellbeing
- Ensure clear routes into and through services and make these transparent to all
- Support the management of mental health issues in primary care settings
- Provide appropriate support to those in crisis
- Ensure effective in-patient care for those that really need it
- Ensure the system is focused on working in an integrated way to care for patients

As well as taking forward the work to make sure these are the pillars for our strategy, it will be important to examine how organisations work together to deliver services in the future. Key to this is taking a 'whole system' approach to improving mental health and wellbeing, working with; schools, police, housing, employers, the voluntary sector and other partners.

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

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. Yet in Norfolk and Waveney today mental health services are under considerable pressure and face a significant challenge to deliver the quality of care that service users and patients require.

- The 'Breaking the Mould' event in May 2018 and the public survey conducted through the autumn of 2018 highlighted a wide range of issues with current Mental Health services from a service user perspective
- Demographic trends and the increasing public awareness of mental health issues is expected to lead to increasing demand for Mental Health services in the years to come
- Public Health data reveals a mixed quality picture with services below national benchmarks or targets on important dimensions
- Like all public services, the Norfolk & Waveney STP (sustainability and transformation partnership) operates in a constrained financial environment in which 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 & Waveney

This review was commissioned by the Norfolk & Waveney STP in mid-2018 to understand the views of adult service users, their families and carers, staff and volunteers; to review the performance of current services and analyse system issues; and to develop a long-term strategy to ensure sustainable delivery of high quality adult mental health services across Norfolk & Waveney and improve public well-being. A separate review is ongoing focusing on the mental health of children and adolescents across Norfolk and Waveney and future work will build on the two documents to shape an all age strategic direction for the region.

This document summarises the key findings from the broad public, stakeholder and staff engagement the analysis of relevant system data, and provides information on the six provisional strategic pillars that currently underpin the emergent adult mental health strategy across Norfolk and Waveney. These are:

1. *Focus more on prevention and wellbeing*
2. *Ensure clear routes into and through services and make these transparent to all*
3. *Support the management of mental health issues in primary care settings*
4. *Provide appropriate support to those in crisis*
5. *Ensure effective in-patient care for those that really need it*
6. *Ensure the system is focused on working in an integrated way to care for patients*

Further activities will build on the work done to date focusing on co-developing, shaping and refining this emergent strategy into tangible plans through a number of working sessions and engagement events.

## 2 Approach to Engagement

Service users, carers and families, health and social staff, the voluntary sector and other key organisations involved in providing support and care to the population of Norfolk and Waveney were widely engaged to understand service user and service provider experiences and views on current service provision. Their perspectives and ideas have strongly shaped this review and informed the proposed Adult Mental Health strategy that flows from it.

This broad range of opinions has been gathered through a number of different activities and events, including individual interviews, formal public engagement sessions, an online survey and practical working sessions with people from different organisations to ensure a wide and representative group of people could be engaged.

A variety of users, health & social care workers and representatives from other organisations and services helped lead the communications and engagement process to ensure fair and unbiased representation and engagement throughout. This team included service users and service user representatives in addition to individuals from the Clinical Commissioning Groups (CCGs), Primary Care, NSFT, Health watch Norfolk, Community Action Norfolk, Voluntary Norfolk, Lowestoft Rising and others.

In total 42 separate events have been facilitated from August 2018 to December 2018, of which 7 targeted users, carers & the public, 25 targeted health & social care staff and 10 targeted community & Voluntary Groups, reaching over 2500 people in total.

### Engagement of service users, carers and the public

The 7 public events targeting users, carers and the public can be split into 2 categories:

**User Forums:** 4 stand-alone service user forums held across Norfolk & Waveney to engage service users early on, understand their perspectives and shape materials that would go on to support the launch events and further engagement with other stakeholders

**Public Launch Events:** 3 facilitated public launch events were held in key locations, including Lowestoft, Kings Lynn and Norwich. To ensure the public had an opportunity to attend one of these events the events were widely publicised by primary care teams, local hospitals, voluntary teams, the CCGs and through the media (including on social media). The events reached over 130 users in total and provided an excellent environment for discussion on the key mental health issues facing the system as a whole. Working sessions were facilitated which reflected on the following key questions:

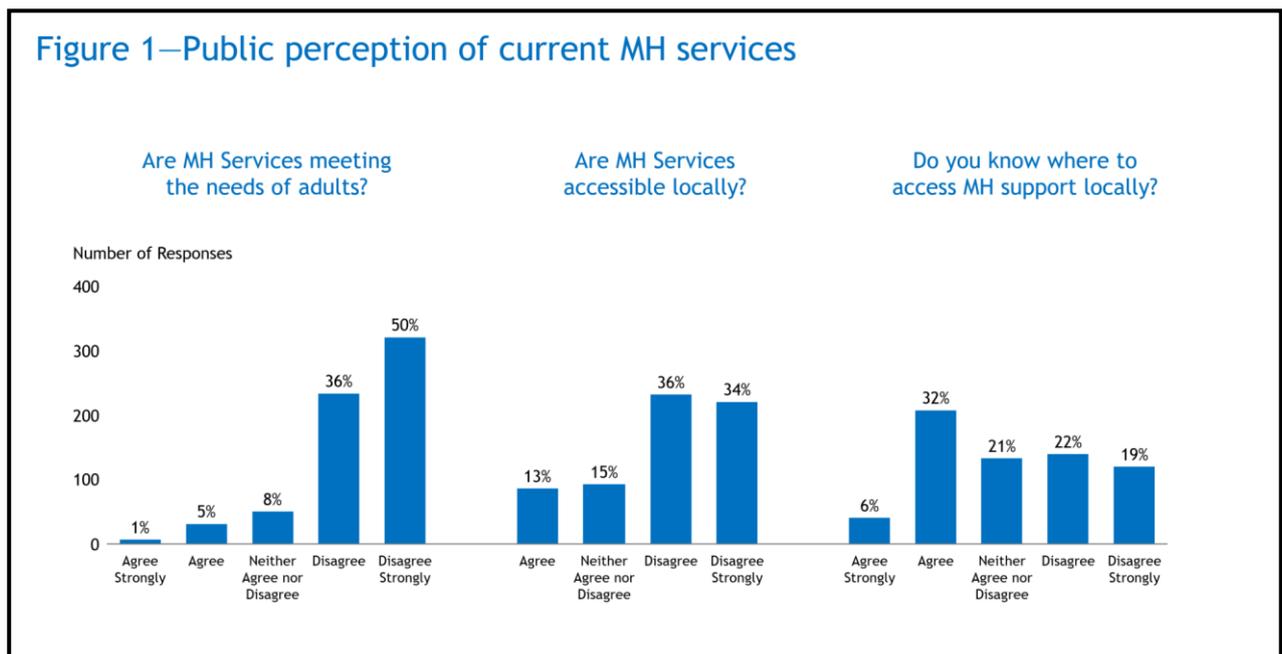
- Workshop One: Your experiences of local Mental Health support and services: What is working? What needs to change? What are the current issues or barriers?
- Workshop Two: What should future Mental Health support look like? How would changes make a difference to you?

In parallel, there have been a further 4 STP-wide public events targeted at people directly affected by dementia and 2 further dementia events targeted at professionals reaching a total of 150 people. These events were run by a separate Dementia workgroup to allow a more tailored approach to user engagement for this service.

In addition to public events, ~1000 people were engaged through an online survey. 62% of respondents were service users, carers and members of the public, providing real breadth of service user input, and the remaining 38% included health and social workers and community and voluntary sector workers.

Across the service user feedback in the survey, there was a very clear message that the people of Norfolk & Waveney are largely dissatisfied with the current provision of Mental Health services in the area. The online survey showed that:

- ~95% 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
- ~40% of respondents do not feel that they know how to access services



We ensured that disadvantaged groups were included throughout the review by making the survey 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.

Although the experience of users was highly varied, consistent themes emerged about the provision of care and services, with five main themes:

1. Services seen as complex, slow and hard to access and navigate, for example, crisis services
2. Services perceived to be poorly integrated between different organisations
3. Quality and consistency perceived to be highly varied, for example waiting times
4. Provision of care seen to be more focused on treatment than prevention
5. Service users do not feel that community support is fully utilised

## 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

*“GPs in Norfolk feel confused by and outside of NSFT services. GPs 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

## **Engagement of Health, Social care and Voluntary groups**

In addition to the public and service user engagement the review engaged broadly with individuals who provide services and support to individuals with mental health issues across Norfolk & Waveney. The team engaged external experts from other national and international health systems to share best practice examples from other parts of the world. Their own views and experiences and their reflections on service user feedback has helped shape the strategy and define a practical path forward to address the underlying issues. As part of the review the team conducted:

- Over 70 one-on-one interviews with individuals from different stakeholder organisations across Norfolk & Waveney relevant to adult mental health and Dementia, 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, develop a compelling case for change, and 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
- Received responses from ~400 health & social care workers and community & voluntary workers to the online survey.

## 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

### Bringing a range of different perspectives on the service user experience

This process has been led by a mixed team of individuals that include health, social, voluntary service, CCG and service user representation. This group was formed to ensure the strategy was being developed in an integrated way, taking a full system approach to the process and to the solution development. This “Task & Finish” group has met more than 20 times in recent months ensuring that the majority of stakeholder groups had an opportunity to shape the approach, review findings and input on a regular basis into the emerging findings and recommendations. This group, which included 22 individuals from 13 different organisations, has been instrumental in shaping the initial fact-finding exercise and in outlining the high level direction of travel which will be the focus of further work.

### Initial work on the future direction, co-developed across cross-organisational teams

The “Task & Finish” group have identified six strategic pillars that set the direction of travel of the future strategy. Teams including service users and members of staff from key provider groups have been mobilised behind each of these pillars forming working groups and sub-groups responsible for further outlining the ambition, goals and subsequent milestones for delivery. These groups will in turn lead broader public and service user engagement to ensure these strategic pillars can adequately meet the needs of the population, iterating and refining as needed. This level of co-development continues to ensure that representative teams are taking ownership of the strategy but are being adequately supported to do so effectively. A Dementia Workstream has been initiated as a key sub-group focusing on the Dementia pathway. This is particularly advanced, having already facilitated ~100 pathway specific discussions through 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.

**Figure 2—Workstream Group Co-operation**

 Workstream	 Attendees	 Workstream Leader Role
A	8	Director of Commissioning, Norwich CCG
B	7	Commissioner, West Norfolk CCG
C	5	GP and Chair of the Mental Health Board
D	6	Director of Operations, Norfolk and Waveney
E	7	Head of Mental Health Community and Integrated Care at West Norfolk CCG
F	6	Director of Operations, Norfolk and Waveney

### **3 Analysis of public health prevalence and outcome data**

As in the rest of the country, Mental Health covers a wide spectrum of different types of condition, ranging from Common Mental Illness (CMI) to Severe Mental Illness (SMI), to Dementia. Prevalence and outcome profiles vary across the 5 CCG areas, for example between urban areas like Norwich and Great Yarmouth, and more rural areas. 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's.

#### **STP prevalence**

Across Norfolk & 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 ~1.4% year-on-year further compounding the issue. Suicide rates are slightly above the national average with a rate of 10.6 suicides vs 9.6 per 100,000 nationally. However, we understand that progress has been made in recent months in reducing that disparity

#### **STP outcomes**

Comparison of local quality and outcome measures with national benchmarks highlight a number of 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 6 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 last 12 months, indicating issues with ongoing monitoring, and prescriptions for psychosis exceeding the national average by 29%. On some dimensions Norfolk & Waveney is above the national average – 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 the STP.

The largest provider of Mental Health services in the region, 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. The report outlined a range of areas for improvement,

including staffing levels, care plan updates, leadership and 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 to address

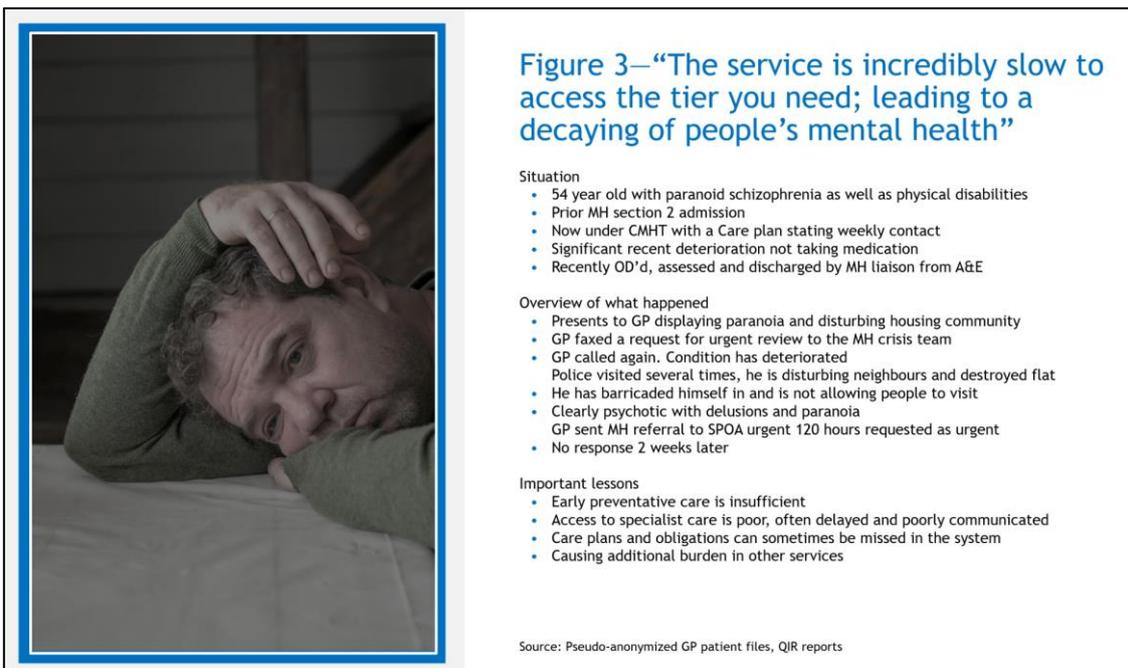
There are significant issues with current Mental Health service delivery in Norfolk & Waveney, which are likely to be exacerbated in the future. Service users predominantly have a low opinion of the service, user engagement highlight consistent themes across the system. Objectively Norfolk and Waveney 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. A tailored solution is required 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

Service user feedback highlights 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 users feel they lack the attention they need before the onset of mental illness. The wellbeing of older age patients suffering 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

Service users and health and social care workers struggle to access specialist mental health services when needed. Access issues came across strongly from user group feedback and the experiences of 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**

The system does not operate in an integrated fashion. Service users have expressed a frustration with moving between care providers and report “getting lost in the system” or “falling between the cracks”. There are also frustrations across Provider groups both with accessing other services and in sourcing reliable communication and feedback. There are capacity issues across acute beds which is exacerbated by issues with integration across regions. Service users see themselves being managed in sub-optimal locations due to siloed operating practices. This lack of integration results in limited accountability across the service user / patient ‘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

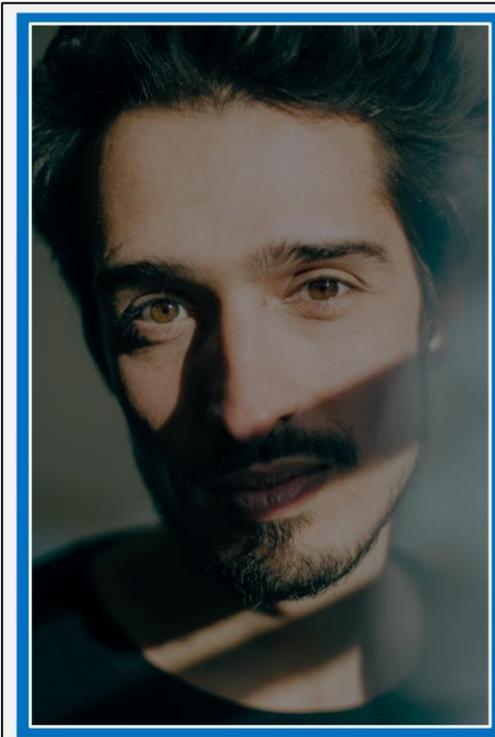
Source: Pseudo-anonymized GP patient files, QIR reports

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

Mental health acute beds are pressured and 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 high variation in behaviours and in utilisation of mental health acute resources. GPs feel unsupported in the community which may drive higher levels of referrals and acute resources are often spent on patients awaiting social and community care. Amongst all this service users report that 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 report issues with the management of patients in crisis. Crisis services are perceived to not respond when needed, to not respond fast enough and to not support patients as they step down from crisis. This results in service users presenting in services that are not necessarily the most appropriate and receiving 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 the service lacks transparency between organisations around patients’ history, needs and current treatment status, and making it harder to hold the system to account. The lack of robust data limits the ability of different services to work jointly across the healthcare system.

**“Not enough funding, not enough trained staff”** – Public Survey

The system is operating in a constrained financial environment despite a growing population and significant unmet need. This means funding is tight and resources must be managed carefully. Furthermore there are emerging workforce issues in Primary Care and in specialist secondary mental health provision. This limits what can be done with the current model of care delivery. These challenges have resulted in local operational efforts having less impact than anticipated. System solutions and new models of care will be required to drive change.

## 5 Learnings from best practices from other sources

In thinking about the future design it can be helpful to investigate what others have done and found to be impactful. As part of this review, over 80 best practice examples from local, national and international experience have been examined across a broad spectrum of mental health services, as well as a series of engagements with international experts.

Both the system wide engagement with service users, staff & the wider public and the outcomes benchmarking analysis highlighted several areas of mental health care/support that potentially needed alternative approaches/model of delivery, namely;

- Mental health support for GPs in a primary care setting
- Crisis response/urgent care
- Focus on prevention of mental illness in the broader population
- Suicide reduction
- Wellbeing services for individuals with Common Mental Illness
- Waiting times and responsiveness

The above areas were used as a high level screening tool to identify potential high impact initiatives & interventions that should be considered in the future design for mental health services in Norfolk & Waveney. The below models have been developed both nationally and internationally, with strong evidence bases, which Norfolk & Waveney can learn from:

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 delivered direct to service 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.

Collaborative care models have already been introduced locally for different severities on mental illness, some examples include:

- **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 treatment models much more explicitly around the user, making full use of multi-disciplinary working and new technology. This general approach will be relevant for Norfolk & Waveney as the system plans ahead and defines specific changes to make to the way services are provided.

The shortlist of best practice models highlighted 5 of the most relevant interventions to Norfolk & Waveney. However in the design phase the review considered these best practice interventions alongside local examples of good practice.

## 6 Emerging Adult Mental Health Strategy

Based on the input from service users and the analysis of current services and issues in the system, six specific pillars of the future strategy are emerging:

1. *Focus more on prevention and wellbeing*
2. *Ensure clear routes into and through services and make these transparent to all*
3. *Support the management of mental health issues in primary care settings*
4. *Provide appropriate support to those in crisis*
5. *Ensure effective in-patient care for those that really need it*
6. *Ensure the system is focused on working in an integrated way to care for patients*



### 1. Focus more on prevention and wellbeing

The Mental Health of a population is influenced by a wide range of different factors including socioeconomic deprivation, housing, employment and the strength of community. These factors are hugely important for both the prevention and success of treatment, management and recovery. For example, research shows that Common mental illness are over 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.

However these broader population based factors are challenging for any single organisation to influence or control, the outcomes are hard to immediately quantify and the services that support them are typically underfunded. This results in some of the most impactful potential interventions in mental health not receiving the support and backing

they need. Given the time frame and the significant impact population health based measures can have it is critical that the Strategy for Adult Mental Health commits sufficient cross-organisational resource and energy into addressing these issues in a 'joined-up', impactful way.

Public Health and Social Care clearly have an important role to play. Although there are several separate related interventions being driven by public health and social care (for example, initiatives around suicide prevention) there has been no overall strategy or long term plan that sets out the Mental Health priorities and defines a clear, measured approach. The future strategy needs to define the priorities for wellness and prevention of mental illness to strengthen population health and community resilience to better care for our Mental Health needs. The future strategy needs to focus on reducing the stigma attached to mental health conditions including Dementia.

**Emerging ambition:** To develop a layered approach to wellness and prevention of mental health issues focusing on

- **Enabling individuals to take more ownership of their health and wellbeing:** To ensure the individual is equipped to promote their own wellness and that they are supported to make positive lifestyle choices as well as improving individuals' emotional literacy
- **Building more community resilience:** To enable the community and voluntary sector to play a stronger role in supporting people with mental health issues and helping to reduce stigma, focusing specifically on local education and support to ensure that prevention and promotion of wellbeing become a shared aspiration within communities
- **System wide strategy and accountability:** To define a long term public health and social care approach and plan for mental health related issues, building stronger partnerships with central organisations to better serve the population (e.g., housing services, job services and the justice system)

**Emerging priorities:** Focus on interventions likely to have the largest impact based on the known available data and national priorities:

**Enabling individuals to take more ownership of their health and wellbeing:**

- Supporting the development of a public facing MH portal that provides information and self-access points for health, social and voluntary services to promote service user access, increase transparency and improve wellbeing

**Building more community resilience:**

- Organise and run public campaigns on mental health stigma, loneliness and wellness including supporting the Norfolk Loneliness Strategy
- Invest in training for high risk stakeholder groups; including training programmes in schools and in the workplace and targeted sessions for families and carers.
- Partner with employers and build "back to work" schemes to support rehabilitation and recovery for those with mental health conditions
- Invest behind specific targeted schemes for key issues across Norfolk & Waveney- for example zero suicide strategies and more comprehensive addiction and drug and alcohol awareness programmes

- Roll out the ABCD (Asset Based Community Development) approach by building stronger links with VCS (Voluntary & Community Sector) and increasing their visibility to those suffering with Mental Health so that care and treatment can be actively sought in other settings

**System wide strategy and accountability:**

- Develop a multi-agency approach to tackle some of the highest impact broader determinants of health over the medium to long term (e.g., allocations of funding for social housing, provision of benefits and support, the way the Department for Work and Pensions and the justice system work)

**2. Ensure clear routes into and through services and make these transparent to all**

Many service users and mental health workers reported issues accessing mental health services and confusion associated with navigating through the system. Some felt “lost” and others felt that “people were slipping between the cracks” The experiences of primary care physicians suggest that their ability to access the system on behalf of their patients was highly variable and the quality of care offered at the point of entry was inconsistent across cases with limited feedback on the rationale for specific decisions. 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 variability that is hard to manage and can result in users receiving poor care which in turn causes them to feel let down by services.

Standardised paths through the system is a common practice used nationally to improve the quality of care delivered for physical conditions (e.g. in Trauma & Orthopaedics and Colorectal Surgery). Although several pathways already exist for Mental Health, such as Anxiety and PD (Personality Disorder) Pathways, very few have gained traction across Norfolk & Waveney in a meaningful way. Clarifying paths through the system, defining clear access criteria and setting the expectation for levels of services for patients passing through the system is the first step in providing a consistent level of quality care for our service users. Beyond that it is critical that service providers can be held accountable for these standards through robust data, systems, tracking and management. Service users should also have visibility of what they should expect from services. This will enable them to take more ownership of their care pathway and hold their services to account more formally. It is essential that Pathways leverage third sector skills and voluntary resources more effectively to increase provision of community based services such as residential rehabilitation, supported housing and outreach teams to help combat the current strain on capacity.

This workstream seeks to clarify and standardise other 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 delivery to patients. Significant work is already underway to transform Dementia pathways which seeks to improve fundamental social and economic structures in order to decrease barriers into the system and improve support throughout the pathway.

**Emerging ambition:**

- 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 STP supported by data systems and tools

**Emerging priorities:**

- Identify the most impactful treatment pathways through the system and build multi-agency teams around them to develop best practice approaches with clear guidelines, criteria and standards. Where possible build from national exemplars.
- Identify sensible 'fast track' pathways for service users with established high need and those that are known to the system already
- Develop an online internal tool to track pathway-based outcomes and share performance with all relevant stakeholders through intuitive digital dashboards.
- Build a single digitally accessible directory of services that service users and health and social care workers can view. 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. Ensure sites are pro-actively maintained by the services
- Launch an internal and an external communication drive to ensure that teams are fully across the new expectations and approach to tracking and monitoring
- 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

**3. Support the management of mental health issues in primary care settings**

Primary care is often the first port of call for those suffering with emotional distress. Up to 30% of a primary care physician's caseload can be directly attributed to Mental Health issues. In addition to this we know there is a high proportion of unmet need for common mental illness across Norfolk & Waveney, affecting people who are often best managed in a primary care setting. As the main gatekeepers to the wider healthcare system, the primary care service offering is critical to effectively managing the mental health of the population and to ensuring that individuals are referred on to the most appropriate services.

However, despite its pivotal role, 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. Factors contributing to this include higher expectations from the public, increasing demand from the population and a declining primary care workforce. Compounding the demand and capacity mismatch primary care teams do not feel adequately supported by secondary care (who are also experiencing issues with demand and capacity). General Practitioners

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 (e.g. high levels of anti-psychotic prescribing).

An under pressure Primary Care service is not a challenge that is unique to Norfolk & Waveney. Central NHS bodies have made recommendations to implement new models of care to address this issue which are typically based around a multi-agency approaches centred on specific neighbourhoods or localities. This enables greater local customisation of services and better utilisation of resources to meet the specific needs of the population in a 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. This workstream looks at how we can build on national recommendations and capture learnings from local and international best practices to define a new model of care that protects and strengthens the quality of service delivery for our service users.

**Emerging ambition:**

- Bring together different organisations to work together in a more integrated way in primary care (a multi-agency approach), setting up and utilising the skills of a mixed team to deliver better support and services to meet the multiple needs of the population.
- To create an approach that is tailored at the local level matching the diverse needs of different localities in Norfolk & Waveney
- To 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

**Emerging priorities:** To design and introduce a new model of care with appropriate supporting tools and digital solutions:

- Tackle mental distress in a primary care setting with appropriately skilled workers. Fully utilise existing staff and teams through appropriate training
- 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 and Mental Health practitioners amongst others
- Improve the quality of advice available to Primary Care teams with designated channels between primary care physicians and mental health specialists
- 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
- Simplify data systems across primary care so that users can be tracked across the system and so that standards of care can be tracked and managed
- 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 & Waveney, for example e-consult services and digital cognitive behavioural therapy (CBT) offerings

- Tackle the workforce issues through a multi-agency approach to recruitment and retention
- 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

#### **4. Provide appropriate support to those in crisis**

Mental health crises can be just as severe as physical health crises. 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 (e.g. Ambulance, A&E and Police).

The system must recognise that appropriate care for those that 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 state resolves. This workstream is focused on delivering effective crisis care both as a stand-alone service but also in areas of overflow where crisis patients can have broader system impacts.

**Emerging ambition:** 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

**Emerging priorities:** A full service solution delivering effective triage, multi-agency response and post-crisis support with the tools and systems required to enable it

#### **Triage and immediate multi-agency response:**

- Ensure specialist level care can be accessed effectively and quickly by introducing or expanding on existing helplines tailored to specific high need groups (e.g. a CRHT (Crisis Resolution & Home Treatment) helpline, a PD (Personality Disorder) specific helpline and a helpline for the remaining patients in crisis)
- Provide pre-emptive support to high risk service user groups to avoid the escalation into a crisis state through appropriately staffed teams (may include linked registers and co-ordinated working with embedded primary care teams).
- Build from the highly successful NEAT service that has launched in Norwich ensuring that people in crisis are treated quickly with a multi-agency team that is capable of addressing the full range of service users acute needs (e.g. health, social and community support)
- Provide "fast-track" access to high-need users that are known to the system
- Expand psychiatric liaison services to reach high intensity areas and hold them accountable for the service provided.

**Post Crisis Support:**

- Provide ongoing post-crisis support as close to patients as possible by fully utilising primary care hubs and co-located specialist community teams.
- 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 primary care setting (support workers in practices, alongside PRISM-like models at a place level)
- Strengthen links with secondary inpatient care beds for higher intensity step down as and when needed
- Partner with voluntary services who provide continued care following management in a secondary care setting

**Enablers:**

- Harmonise patient records so that crisis response teams have the access and information they need to deliver effective care and so patients receive an effective response at the point of presentation
- Define clear outcome measures and reporting dashboards supported with digital tools to monitor and manage performance. Hold teams accountable for standards

**5. Ensure effective in-patient care for those that really need it**

Across Norfolk & Waveney the provision of inpatient specialist Mental Health services struggles to meet the demand placed upon it. Occupancy levels are typically above nationally recommended levels in both adult acute and in older adult beds and costly out-of-area placements have been rising. Capacity struggles to meet demand today and will be out-stripped by demand within 5 years given the current model of care delivery. This inability to meet demand costs the Trust financially and impacts the acute provider's ability to deliver high quality care, cost-effectively to the broader Norfolk & Waveney population.

Specialist acute Mental Health services must be reserved for those that really need it and that cannot receive appropriate care elsewhere. As a system we should aim to minimise the number of patients managed in this care setting, unless it is necessary and appropriate, and move care into the community environment in keeping with other regional Adult Mental Health strategies and national recommendations. Not only will this lower the overall system costs it will allow the specialist inpatient beds to be used to improve outcomes for those that really need this service and will address service user requests to have more community-based care.

This workstream is focused on ensuring inpatient services are being used to treat patients who really need to be in that environment, leveraging other models of care where necessary.

**Emerging ambition:** To ensure in-patient beds are being reserved for the severely ill patients that need to be cared for in that environment. Adopting more community and primary care based models of care for appropriate service user groups. Improving quality and better meeting the needs of service users.

**Emerging priorities:** New models of care focusing on up-stream delivery (e.g. Primary care and community models). Improved in-patient care focused on those service users who require specialist treatment in that environment

**Delivering moderate to severe support in a primary care setting**

- Support primary care teams with multi-agency teams capable of managing moderate to severe mental health issues (e.g. PRISM models)
- Improve primary care access to psychiatrists to receive timely and specialist clinical advice for complex mental health service users
- Enhance systems of two-way communication between primary care and secondary care on patient care decisions, ensuring patients are receiving the right decisions on their care management as early as possible
- Co-develop clinical pathways for high volume Mental Health issues and maintain them regularly to improve transparency and accountability

**Investing in the effective delivery of cost effective community and social care**

- Identify community care services which could accommodate patients currently occupying inpatient beds that could be managed elsewhere
- 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
- Rationalise and standardise policies and protocols for patients admitted to hospital (step up) and discharged from hospitals to return to home (step down).

**Optimising the care delivery offered to inpatients:**

- Hold clinicians accountable for standardised treatment pathways to reduce unnecessary stays in acute inpatient beds (e.g. step up and step down thresholds, use of day patient models)
- Introduce continuous improvement cycles to ensure local teams are always looking to improve the services on offer to service users
- Drive cultural change across the specialist care teams through strong leadership and the appointment of clinical champions tasked with spearheading change.
- Pro-actively reduce the reliance on out of area and specialist placements

**6. Ensure the system is focused on working in an integrated way to care for patients**

Providers across the system comment that mental health services are poorly integrated and that care is often delivered in silos resulting in a poor service user experience. Service users feel this acutely and have commented on it throughout the engagement sessions. The causes of this are multi-factorial and will include historical behaviours, structural efficiencies but also the nature of the contracts that underpin the system. New ways of commissioning are needed if Mental Health services are to become more integrated and able to deliver high quality of care to service users.

The Norfolk & Waveney STP (sustainability and transformation partnership) has already outlined its ambition to pursue integrated commissioning that can drive more joined-up ways of working and better outcomes for service users. This is therefore a unique opportunity to trial new ways of working and commissioning that may improve the overall service user experience. This workstream has been set-up to inform future contracting and commissioning approaches to deliver an integrated Mental Health system.

**Emerging ambition:** To outline the key principles behind a contracting and commissioning model and approach that will support more integrated ways of working focused on the service user. To outline an approach to accessing harmonised data that will inform integrated system management decisions

**Emerging priorities:**

**Defining the contracting and commissioning principles**

- Be clear about the services and pathways that are suitable for integrated commissioning approaches and ensure flexible commissioning to drive the right levels of care across the system.
- Strengthen outcome metrics to ensure performance can be measured, but allow sufficient flexibility at the local level to enable innovation and the introduction of new models of care
- Strengthen alliances and share financial risks so that providers can focus on delivering the best care to their users
- Commissioners should place greater weighting on preventative care and review the approach to commissioning voluntary services

**Approach to data and tracking**

- Push for data systems that are accessible across all mental health providers so that seamless care can be delivered to service users (e.g. accelerate the electronic patient record programmes)
- Ensure providers can be tracked and held accountable for effective and high quality service delivery. Manage this as a system to improve outcomes for the whole population
- Minimise duplication of data collection and processing by aligning systems and aligning reporting. Free up resource to care for patients.

## 7 Key enablers to ensure success

### **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

### **Information Technology:**

As Norfolk & Waveney moves to become a more integrated system, harmonisation of 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 KPIs 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 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.

## **8 Next steps & Roadmap**

The first draft of the strategic pillars have now been co-developed and articulated through cross organisational teams, drawing on the experience and views of service users from multiple perspectives. The pillars outlined have been designed to 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.

Over the coming weeks this draft strategy will be circulated with the public and with service users for consideration and feedback. This feedback will then be used to iterate on the strategic pillars and subsequently the strategic direction contained within the document.

Service users will also be engaged in the more detailed planning exercise that will be required to convert this strategic document into robust system level plans that can be implemented against over the coming years by local delivery teams.

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.

**Figure 7—High level roadmap | Strategic pillars will land at different times**

	Short term priorities (1-6 months)	Medium term priorities (6 - 24 months)	Longer term priorities (2-10 years)
<b>Strategic pillar 1:</b> Focus on prevention and wellbeing	<ol style="list-style-type: none"> <li>1. Develop a multi-agency approach to broader determinants of health</li> <li>2. Invest behind targeted schemes (e.g. zero suicide)</li> <li>3. Invest in training for high risk stakeholder groups</li> </ol>	<ol style="list-style-type: none"> <li>1. Organize public campaigns on stigma, loneliness and wellness</li> <li>2. Partner with employers to build back to work schemes</li> <li>3. Roll out ABCD (Asset Based Community Development) approaches</li> <li>4. Support development of a public mental health portal</li> </ol>	<ol style="list-style-type: none"> <li>1. Execute against the broader determinants of health plans</li> </ol>
<b>Strategic pillar 2:</b> Ensure clear routes into and through services	<ol style="list-style-type: none"> <li>1. Identify most impactful service user journeys and build multi-agency teams around them</li> <li>2. Identify fast track pathways for high risk service users</li> </ol>	<ol style="list-style-type: none"> <li>1. Build a directory of services and publish pathway based expectations</li> <li>2. Develop an internal tool to track outcomes across pathways</li> <li>3. Launch an internal and external communications initiative</li> </ol>	<ol style="list-style-type: none"> <li>1. Continued iteration of digital tools based on user feedback</li> <li>2. Hold teams accountable to pathway based outcomes and improve services</li> <li>3. Integrate additional pathways into the approach</li> <li>4. Transition commissioning into pathway based approaches</li> </ol>
<b>Strategic pillar 3:</b> Support management of mental health issues in a primary care setting	<ol style="list-style-type: none"> <li>1. Improve the quality of advice offered to Primary Care physicians</li> <li>2. Ensure plans for primary care hubs are fully linked to the mental health strategy</li> <li>3. Improve linkages with voluntary services</li> </ol>	<ol style="list-style-type: none"> <li>1. Deliver care for mental distress in the primary care setting</li> <li>2. Deliver care for moderate to severe mental illness in a primary care setting</li> <li>3. Simplify data systems across primary care</li> <li>4. Introduce digital solutions for patient care</li> <li>5. Roll out a multi-agency approach recruitment</li> </ol>	<ol style="list-style-type: none"> <li>1. Continue to harmonize data systems and digital reporting in primary care</li> <li>2. Deliver against recruitment plans and workforce strategies</li> <li>3. Continue to digitally transform primary care</li> <li>4. Strengthen partnerships with community care</li> <li>5. Cement new ways of commissioning</li> </ol>
<b>Strategic pillar 4:</b> Provide appropriate support to those in crisis	<ol style="list-style-type: none"> <li>1. Provide pre-emptive support to high risk individuals</li> <li>2. Provide fast track access to high risk users</li> <li>3. Augment Psych liaison</li> <li>4. Build a mental health crisis response unit building on NEAT</li> </ol>	<ol style="list-style-type: none"> <li>1. Develop specific helplines for high risk patient groups</li> <li>2. Offer post-crisis support in primary care and community settings</li> <li>3. Strengthen crisis team linkages</li> <li>4. Partner with voluntary services</li> </ol>	<ol style="list-style-type: none"> <li>1. Ensure the standard of crisis response is standardized across the STP</li> </ol>
<b>Strategic pillar 5:</b> Ensuring effective inpatient care for those that need it	<ol style="list-style-type: none"> <li>1. Enhance communication between services</li> <li>2. Begin to co-develop clinical pathways</li> <li>3. Rationalize and standardize step up and step down protocols</li> <li>4. Introduce continuous improvement cycles</li> </ol>	<ol style="list-style-type: none"> <li>1. Dovetail in with Primary care support for moderate to severe mental illness and access to psychiatrists</li> <li>2. Right size community and social services and invest in beds</li> <li>3. Hold clinicians accountable for treatment pathways</li> <li>4. Begin to embed cultural change</li> </ol>	<ol style="list-style-type: none"> <li>1. Roll out cultural change</li> <li>2. Implement recommended organizational form changes</li> <li>3. Execute against estate plans to prepare for the future</li> </ol>
<b>Strategic pillar 6:</b> Ensure the system is focused on working in an integrated way	<ol style="list-style-type: none"> <li>1. Define integrated commissioning ambitions</li> <li>2. Outline performance based measures and approaches</li> </ol>	<ol style="list-style-type: none"> <li>1. Strengthen alliances across providers</li> <li>2. Shift commissioning focus to up-stream interventions</li> <li>3. Harmonized data systems and reporting tools</li> <li>4. Implement tracking and reporting to inform contract discussions</li> <li>5. Minimize duplication of data collection</li> </ol>	<ol style="list-style-type: none"> <li>1. Integrate approaches with integrated commissioning agendas</li> </ol>

## 9 Appendix 1 – 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.

## **10 Appendix 2 - 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.

### **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 acutes 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.