Ambition 4: Transforming Mental Health Services

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"Our aim is to ensure that people of all ages can access timely and responsive support for all their emotional wellbeing and mental health needs. Working together with partners across health, care, VCSE and our experts with lived experience, we will offer person centred care at an earlier stage, and provide services that are compassionate, holistic, and responsive guiding people towards better mental health".

Dr Ardyn Ross,
Clinical Mental Health Lead, N&W ICB

"We look forward to being equal partners in the implementation of the JFP, using lived experience insight to ensure better mental health outcomes for everyone. The JFP will be delivered alongside existing services and builds on current and ongoing improvement plans. We hope the JFP will lead to joined-up, timely, ongoing care and personalised support for the people in our communities. Including addressing mental health inequalities for people who have little or no support. We hope the JFP will mean more people, including unpaid carers and staff, are more connected to wellbeing support and the right care for them."

N&W ICS Mental Health Transformation Expert by Experience Reference Group, May 2023

Our objectives

a) We will work together to increase awareness of mental health; enable our population to develop skills and knowledge to support wellbeing and improve mental health; and deliver a refreshed suicide prevention strategy. This will prompt early intervention and prevention for people of all ages, including those who experience inequalities or challenges to their mental health and wellbeing.

b) Mobilise an adult mental health collaborative and a children and young people's collaborative so that partners work as one to deliver better health outcomes for our people and communities.

c) Establish a Children and Young People's (0-25 years) Emotional Wellbeing and Mental Health 'integrated front door' so all requests for advice, guidance and help are accepted, and the appropriate level of support is given to ensure that needs are met.

d) We will see the whole person for who they are, developing pathways that support engagement, treatment and promote recovery for people living with multiple and complex needs, with a focus on dual diagnosis and Complex Emotional Needs (CEN).

What would you like to see in our five-year plan for health and care services? What matters most to you?
People with experience of mental health services and others who responded to a recent survey said, 'We must put more focus on prevention and invest in this area, including de-stigmatising mental health - we must see looking after our mental health the same as eating 5 fruit and veg a day'. They also told us:

- They want to be empowered to access intervention and holistic wraparound care, which supports long-term recovery.
- They want to "experience person-centred care, and be treated as an individual, rather than as a diagnosis".
- They want choice in how care is delivered and a focus on "what matters to me", instead of "what's the matter with me".
- They want their diagnosis to be only one part of their health journey. Their other physical and/or mental health conditions, as well as life events, may impact on their current state, which needs to be considered.

Children and young people have developed a Mental Health Charter and have told us that what matters to them is that services will care, staff will support and be well supported themselves, the right help, right time, right way, treatment will be personalised to meet individual needs, communication will be effective and young people will have a voice.

Why we chose these objectives
Mental health conditions can have a substantial effect on all areas of life, such as school or work performance, relationships with family and friends and the ability to participate in the community. People with mental health conditions often experience human rights violations, discrimination, and stigma. Key vulnerable groups who may be affected by poor mental health include children, young people and families, people who experience long term conditions and men experiencing financial and economic constraints and/or relationship breakdown. Improving the offer of proactive and preventive support is a priority outcome for this ambition, where we aim to intervene quickly and broaden the range of specialist support offers to enhance recovery.

Objective 4a We will work together to increase awareness of mental health; enable our population to develop skills and knowledge to support wellbeing and improve mental health; and deliver a refreshed suicide prevention strategy. This will prompt early intervention and prevention for people of all ages, including those who experience inequalities or challenges to their mental health and wellbeing.

What are we going to do?

1. Develop a structure for mental health literacy, to enhance and expand skills and knowledge on emotional wellbeing and mental health
2. Co-produce, implement and promote tools and capacity to support good mental wellbeing
3. Co-develop a refreshed Norfolk and Waveney Suicide Prevention Strategy and action plan

How are we going to do it?
Building on the targeted grant programme for vulnerable groups and the health promotion campaign 'Take 5', we will develop two complementary workstreams that will empower our people and communities to look after and improve their wellbeing:

A community mental health literacy workstream will be developed to inform our workforce, people and communities about wellbeing and mental health. This will promote activities to keep people well and enable them to access services if needed. Training and resources will be aimed at:

- Increasing skills to recognise and address wellbeing concerns
- Enabling individuals to effectively manage their own wellbeing
- Building capacity across the wider system, including in the VCSE sector to manage wellbeing within the community.

This will build on existing approaches focussed on children and young people.

The development of a Resilience Framework will provide our workforce, people and communities with the tools to increase and maintain wellbeing. This framework will focus on wellbeing initiatives such as a targeted sleep campaign to provide practical solutions in managing mental health and wellbeing.

These commitments work with existing prevention initiatives such as digital wellbeing tools, support for schools and families, Family Hubs, Community Wellbeing Hubs and NHS Talking Therapies.

The Suicide Prevention Partnership will coproduce a refreshed five-year Suicide Prevention strategy, with anticipated key themes for action around Self Harm, Bereavement and Primary Care pathways for people with depression – as informed by audits. While this work is underway, we continue to raise awareness, deliver campaigns to reduce stigma, provide accessible training, and invest in community support for at-risk groups. There is commitment to continue monitoring outcomes through Suicide Prevention Audits, and real time surveillance on self-harm and suspected suicides.

How are we going to afford to do this?
We will explore opportunities to use existing resources to deliver this provision. We will seek to identify what can be achieved through improved partnership working at no/low cost and scope where additional resource would improve delivery.

What are the key dates for delivery?

There are three priority activities with the following milestones:

Year 1 April 2023 – Sep 2023
- Explore opportunities to introduce a mental health literacy framework to the system.

Year 1 Oct 2023 – March 2024
- Publish a co-developed refreshed suicide prevention strategy, with agreed monitoring.
- Agree on a system approach for delivery of the mental health literacy framework.
- Develop a trajectory for improvements, against agreed baseline Measures (below).

Year 2 April 2024 – Sep 2024
- Begin implementation of the targeted workstreams in the action plan of the refreshed suicide prevention strategy.
- Ensure monitoring is established.

Year 2 Oct 2024 – March 2025
- Co-produce and promote a system wide resilience framework for and with communities.
- Launch implementation of the mental health literacy framework

Year 3 April 2025 – March 2026
- Year 3 and 4 - Implement the resilience framework and deliver initiatives i.e., impact of sleep and tools to improve sleep quality

Year 4 April 2026 – March 2027
Year 5 April 2027 – March 2028
- Review the suicide prevention strategy.

How will we know we are achieving our objective?

- There will be a measurable change in self-reported mental wellbeing – the number of people reporting high anxiety, low happiness and low worthwhile scores.

Suicide Prevention

- Rates of suicide and self-harm will decrease

Objective 4b Mobilise an adult mental health collaborative and a children and young people's collaborative so that partners work as one to deliver better health outcomes for our people and communities.

What are we going to do?
Establish an adult Mental Health (MH) system collaborative and a Children and Young People (CYP) system Collaborative and participate in the Suffolk Mental Health Collaborative to help plan services for CYP in Waveney.

Adult Mental Health System Collaborative:
Identify opportunities to work collaboratively, using available data, intelligence, and insights, which focus on improving mental health and wellbeing of adults and older people.

Children and Young People System Collaborative:
Implement the Thrive model through close working between the Norfolk and Suffolk MH CYP collaboratives, which are on a county council footprint. Making the structural, operational, and cultural changes required to deliver community based multi-disciplinary teams, working across organisations, to ensure collective support to meet the emotional wellbeing, mental and physical health needs of the child or young person and their family.

How are we going to do it?

Embedding a new approach that:

- focuses on early intervention and prevention – moving the resource and support further upstream, providing support to more people at an earlier stage and freeing up specialist support
- focuses on 'place' and the development of support within local communities – with less reliance on specialist settings, clinics, or institutions
- moves away from a focus on a clinical model to one which builds understanding and resilience of community-led early support, and which develops the skills and resources of people, families, and communities to help themselves.

How are we going to afford to do this?
We intend to make use of existing resources in a different way. For example, existing community-based teams would be upskilled to support people and families with early dementia, which will free up capacity within the specialist teams to support people with more complex needs and reducing the existing specialist waiting lists. This process will be repeated for other conditions and for children and young people too.

What are the key dates for delivery?

Year 1 April 2023 – Sep 2023

- Adult MH System Collaborative and CYP System Collaborative Core Executive groups and associated delivery groups launched.
- Rolling programme of engagement/co-production established (to inform the specific work of the collaboratives as they seek to redesign clinical pathways).
- Establish delivery groups drawn from the wider membership to develop and implement the redesign agreed by the core executive; considering available data, information, and insights to understand enablers i.e., workforce, and identify and agree resource.

Year 1 Oct 2023 – March 2024

- Gaining commitment of individual organisations to work together to achieve the new ways of working
- Achieving tangible action; setting an action plan and agreeing local metrics to measure impact
- Review arrangements

Year 2 April 24 onwards

- Building and strengthening on the Year 1 foundation activity; expanding goals as the programme progresses, recognising success and reflecting on lessons learned.
- Continued checking back with older people and their families living with dementia, delirium and depression and children, young people and families with emotional wellbeing, mental and physical health needs that the transformed services are meeting their needs.

How will we know we are achieving our Objective?

Access to support is streamlined, responsive and coordinated for:

- Older people and their families living with dementia, delirium, and depression
- Children or Young Person with emotional wellbeing, mental and physical health needs.

The impact will be measured by actively seeking feedback from our people and communities, families and carers, and workforce, before and after any change that is implemented.

Objective 4c Establish a Children and Young People's (0-25 years) Emotional Wellbeing and Mental Health 'integrated front door' so all requests for advice, guidance and help are accepted, and the appropriate level of support is given to ensure that needs are met.

What are we going to do?
We are launching an Integrated Front Door (IFD) to support Children and Young People (CYP) aged 0-25 with an emotional wellbeing or mental health need to access the right support at the right time. This will be a 'needs led' single integrated access point for all emotional wellbeing and mental health enquiries and requests for support. The aim is that children and young people and their families will have immediate guidance and/or timely support based on an understanding of need, to allow them to flourish.

It will provide:

- **Self-Care** support, through digital resources and tools, including guided self-help, with a 'request for support' process that automatically leads to suitable resources
- **Improved access to advice and guidance** through a single telephone number, and offering timely, single session interventions where clinically appropriate
- **Request for Support** – One trusted pathway for children, families, and professionals to ask for emotional wellbeing and mental health support. The IFD clinical team will assess every request for support and promptly allocate to the most appropriate service offer to meet the needs of children and young people.

How are we going to do it?
System partners work collaboratively within a strategic alliance, ensuring that services are committed to working together to provide the best possible care and support for CYP and their families. This is in line with the Thrive principles, with children and young people at the centre of delivery and resources wrapped around them, enabling them to Flourish.

How are we going to afford to do this?
The IFD programme is fully resourced through identified mental health service development funding (SDF) and is factored into medium term financial plans. Any efficiencies gained through implementation of the IFD will be re-invested into enhancing the range of emotional wellbeing and mental health service offers and capacity available.

What are the key dates for delivery?

Year 1 April 2023 – Sep 2023
- Launch interim arrangement for mild-moderate emotional wellbeing and mental health requests for support
- Coproduce and launch a health and wellbeing website specifically aimed at young people

Year 1 Oct 2023 – March 2024
- Launch the Integrated Front Door to include all emotional wellbeing and mental health pathways (0-25 years) of support (except crisis, which will continue to be accessed through 111 mental health option)

Year 2 April 2024 – Sep 2024
- Launch the Professional Therapeutic Pathway through the IFD
- Refine data and reporting processes (including real-time reporting on system waits and coding) to ensure an improved experience for service users and professionals

Year 2 Oct 2024 – March 2025
- Develop and embed Artificial Intelligence (AI) and machine learning solutions to improve efficiencies across the IFD

Year 3 April 2025 – March 2026
- Work with system partners to scope additional CYP and family support services that could be accessed via the IFD and plan for implementation

Year 4 April 2026 – March 2027
Year 5 April 2027 – March 2028

How will we know we are achieving our Objective?

We will be able to measure an increase in the number of children and young people accessing the right support to meet their emotional wellbeing and mental health needs. This will be evidenced through the CYP Mental Health access metric within the national Mental Health Services Data Set (MHSDS) and through patient reported outcome measures.

Objective 4d We will see the whole person for who they are, developing pathways that support engagement, treatment and promote recovery for people living with multiple and complex needs, with a focus on dual diagnosis and Complex Emotional Needs (CEN).

The term Dual Diagnosis in this Objective, is used to define the experience of those with Mental Illness and substance misuse.

What are we going to do?

Complex Emotional Needs*:

1. Implementation of Complex Emotional Needs (CEN) Strategy, including the development of a collaborative pathway.
2. Increasing access to psychological therapy for people with complex emotional needs, wherever they present.

Dual Diagnosis:

3. Develop a recognised dual diagnosis pathway - with consideration to other issues, social or physical that are commonly associated with experience of Mental Illness and substance misuse.

*We are using the term Complex Emotional Needs to encompass people who have previously been described as having a diagnosis of personality disorder or experience of complex Post Traumatic Stress Disorder (PTSD).

How are we going to do it?
Providers and stakeholders will engage those with lived experience at all stages, from design to delivery, to improve access and care for people with dual diagnosis and Complex Emotional Needs, inclusive of those with Neuro Diversity.

A "no wrong door" approach will be developed with system partners Make pathways inclusive, accessible and flexible to promote recovery and independence. Partners will work collaboratively to cover unmet needs.

We will continue to develop mental health provision in primary care, embed the CEN strategy and pathway, and assist system partners to work collaboratively to support people with dual diagnosis.

The Mental Health Integrated Community Interface (MHICI) will join system partners up in a new way of working to provide this function, helping to improve the experience of people with complex needs.

How are we going to afford to do this?
We will seek to identify what can be achieved through improved partnership working within existing resource, and/or scope where additional resource would improve delivery further.

What are the key dates for delivery?

Year 1 (first half) April 2023 – Sep 2023
Complex Emotional Needs:

- Deliver workshops to map pathways, develop, and integrate the CEN pathway
- Integrate new mental health roles within Primary Care Networks
- Continue to develop the evidence-based therapy offer within place-based communities and secondary care.
- Widen the availability of multi-agency training to system partners
- Agree baseline measures (below).

Dual Diagnosis:

- Establish multiagency pathway leadership and working group
- Engage people with lived experience
- Increase the joint working of mental health and substance misuse teams
- Map and gap analysis of existing provision, considering and exploring digital health initiatives (e.g., virtual consultations)
- Carry out a training audit
- Develop a trajectory so that an increased number of referrals is accepted via the dual diagnosis pathway, against agreed baseline measures (below).

Year 1 (second half) Oct 2023 – March 2024

Complex Emotional Needs:

- Establish regular pathway integration meetings
- Provide a tiered offer of therapeutic interventions for CEN within Primary care.
- Widen the availability of formulation and supported psycho-education workbook training, to system partners.
- Integration of senior clinical roles into the MHICI
- Planning the provision of therapeutic interventions of CEN within primary care and VCSE partners, based on analysis of unmet needs

Dual Diagnosis:

- Establish protocol for local data collection
- Draft a NSFT and Change Grow Live pathway, with formal agreement

Year 2 (first half) April 2024 – Sep 2024

Complex Emotional Needs:

- Identify therapy providers and upskill existing staff to meet therapy gaps
- Pilot the use of new roles such as the Clinical Associate Psychologists to meet therapy needs in primary care

Dual Diagnosis:

- Pathway implementation within financial constraints and/or develop funding proposals, should additional national funding become available

Year 2 (second half) Oct 2024 – March 2025

Complex Emotional Needs:

- Start to deliver therapy appointments closer to home in primary care and close gaps in care provision
- Implementation of CEN Strategy completed.
- Launch psychological therapies at Place level

Dual Diagnosis:

- Explore further pathway work on wider elements of provision

How will we know we are achieving our Objective?

Complex Emotional Needs:

- 300 additional staff trained per year in Knowledge and Understanding Framework, Dialectical Behavioural Therapy, or psychologically informed approaches system-wide
- Increase in numbers of service users able to access a psychologically informed intervention outside of NHS Talking Therapies and secondary care offer

Dual Diagnosis

- Achieve an increased number of referrals (as per Y1 plans and trajectory) accepted via the dual diagnosis pathway
- A reduction in presentations to emergency departments for service users with mental health needs and drug or alcohol problems

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Case Study

Working together to reduce unnecessary hospital admission

John is a 46-year-old man with cerebral palsy and epilepsy who called 999 with a head injury after a fall. John was assessed through the 999-triage process as requiring a category 3 response. This is a lower acuity response with a target response time of 2 hours.

Within the Ambulance Control Room, this case was discussed with partner organisations – 999, Community Teams and the Clinical Assessment Service (CAS) – to determine whether a 999 response would be best, or whether a different service could respond to John in the allocated time.

John lives with his mum and both John and his mum were testing positive for COVID-19 at the time of the call. The Community team had resources available in the area who could visit John and his mum at home. A Community Matron called John prior to visiting to explain it would be the community team who would visit, not an ambulance. John's mum was relieved by this as she said she hadn't wanted to call an ambulance but wasn't sure what she should do instead.

The Community Matron arrived at John's home within two hours and carried out an assessment. A clinical assessment was completed for the head injury, as well as wounds and bruises to the body that were caused during the fall. The Matron was able to dress the wounds and complete a chest examination and COVID-19 assessment. John was found to have no clinical red flags that would be a reason for a hospital admission. The cause of the fall was also assessed and found to be caused be COVID-19 symptoms exacerbating John's existing mobility difficulties. Mobility aids and equipment options were discussed, and equipment from community stores was collected and loaned. Medication advice was given to help with COVID-19 symptoms and some pain from the bruising.

Image kindly supplied by: Norfolk Community Health and Care

John was able to stay at home, which both he and his mum were relived about, as they were concerned about John having to go alone to hospital while his mum was also covid positive. The Matron have advice for what to do and who to contract if the situation deteriorated and a follow up later that week confirmed that John was back to his usual level of mobility, his wounds and bruising was healing and he had no further concerns.