Nottinghamshire County Council

Nottingham City Council

NHS

The Nottingham and Nottinghamshire Sustainability and Transformation Partnership

Draft All-age Integrated Mental Health and Social Care Strategy

Nottingham and Nottinghamshire STP

August 2018

Contents

1. Executive Summary

The strategic aim of the Integrated STP Mental Health and Social Care Partnership Board is to transform mental health and wellbeing in Nottingham and Nottinghamshire. This strategy document has been prepared under the auspices of the Board and through a process of broad stakeholder engagement. This strategy considers mental health across the whole age range but excludes dementia which will be the subject of a separate strategy.

There are already many positive aspects to the services provided by NHS and Local Authority partners in our area, and a number of improvements continue to be advanced (not least in support of NHS England's *Five Year Forward View for Mental Health).*

There is also compelling evidence (see below) that there is a real opportunity to achieve a step-change in the health and wellbeing of those who are at risk of or who are already living with mental health:

- Front-line experience;
- Analysing a large volume of local data sources (Understanding the Current Position);
- Engaging with people with lived experience, workforce representatives and other key stakeholder groups and using individual organisations engagement reports e.g. Health Watch, CCGs and Local Authorities (see Appendix 3 – Engagement Report).
- Reviewing the evidence base in both academic and 'grey' literature (see Appendix 4 – Building on the Evidence);
- Reflecting on the requirements for implementing NHS England's *Mental Health Five Year Forward View*[1];
- Considering perspectives from other parts of the country and from specialist national organisations, and;
- Working together in a series of three workshops (each with around 60 attendees) to identify the outcomes desired and the actions required to deliver those outcomes

The nature of the step-change that citizens need to experience will vary with their underlying need and associated risk factors. So, this strategy is population-centred and aims to address appropriately the specific needs of each cohort (see Figure 1 below).

[1] https://www.england.nhs.uk/wp-content/uploads/2016/07/fyfv-mh.pdf

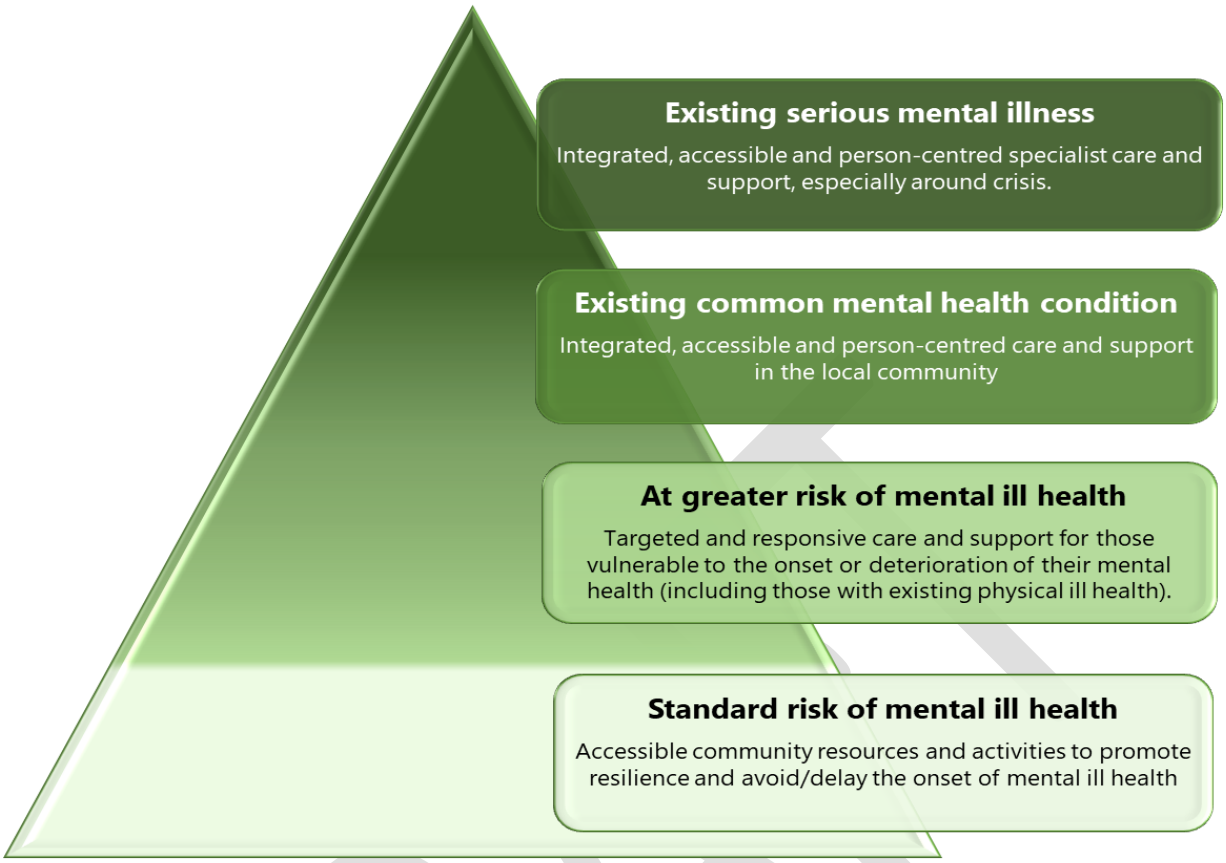


Figure 1 - Broad cohorts of need

Within this overarching vision and direction of travel, our stakeholders have identified a set of five key strategic objectives (or 'pillars') that will frame and support our subsequent work to realise our vision. They also seek to bring together key elements in the strategies and plans of our partner organisations, including NHS England's plans for *implementing the Five Year Forward View for Mental Health*[2]. Those pillars are:

[2] https://www.england.nhs.uk/wp-content/uploads/2016/07/fyfv-mh.pdf

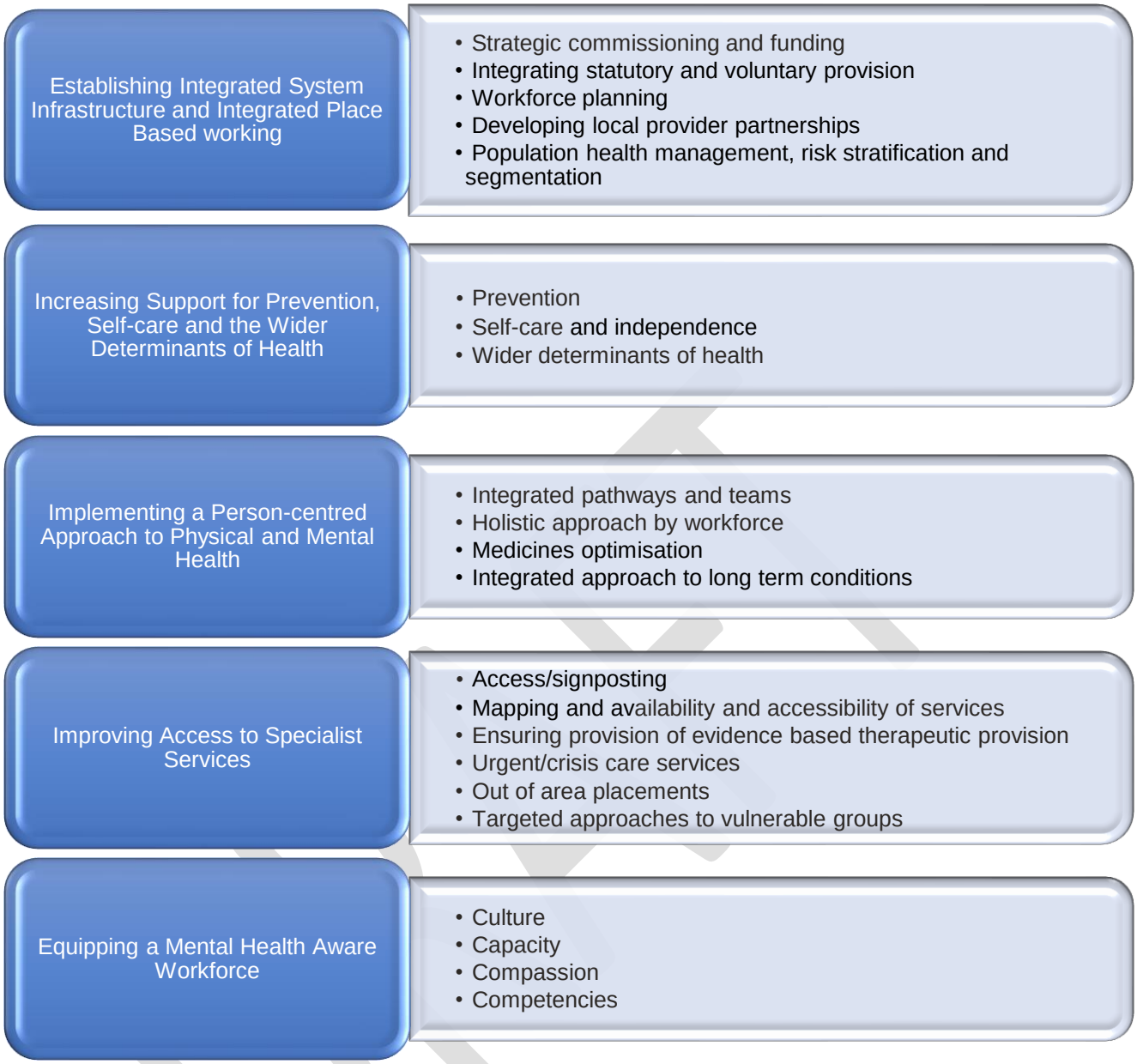


Figure 2 - Key strategic objectives

There are key dependencies between these pillars, and a need to align the delivery of these strategic objectives with the wider work of the STP, and this is detailed in Our Key Strategic Pillars below.

We are clear that this document only represents the beginning of the work need to do.

- Much greater engagement is now required with all our stakeholders but especially those with lived experience of using mental health services. We will ensure that services users are engaged fully in the design of services and that they have maximum choice and control in care and support they access (see Co-design, Choice and Control below). As an immediate first step, the Partnership Board is establishing a standing service user co-design group to inform, check and challenge its ongoing work.

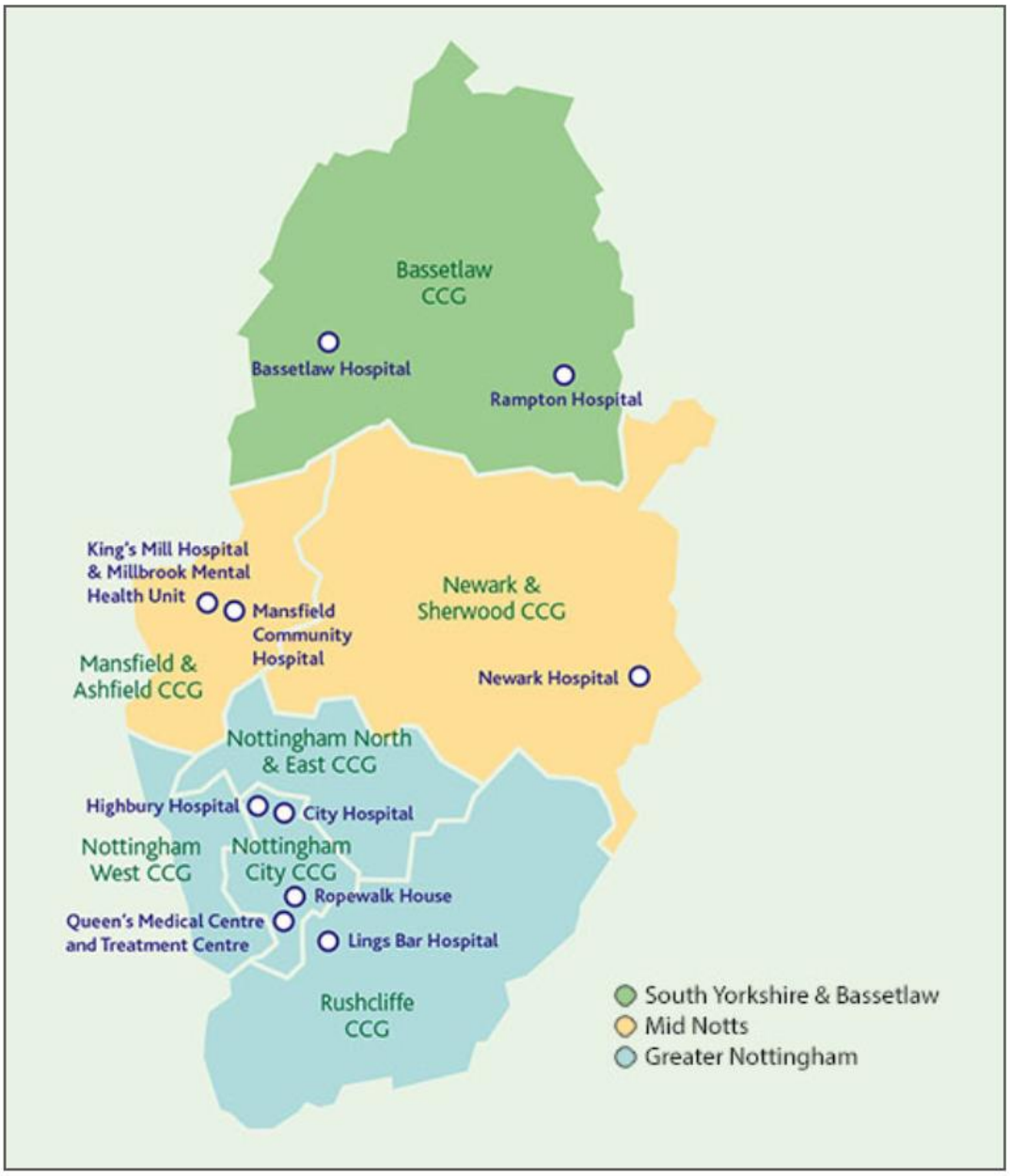
- More detailed planning work must now be undertaken to translate our objectives into actionable improvements (see Next Steps). We will do this through establishing a small number of focused delivery groups that will have defined responsibility for developing and implementing plans for delivering our objectives. These groups will report to the Partnership Board which will ensure that the groups' plans can deliver its objectives and align with wider STP plans. An initial implementation plan will be developed during Q3 of 2018-19 that brings provides an overarching view of the actions each group plans to take and how these interact.
- The strategy needs to be factored into all relevant aspects of other STP workstreams if true integration is to be enabled. This includes the parallel clinical strategy work around acute, community and primary care services.

This strategy represents our system's commitment to the reshaping of services and other interventions so that they better respond to the needs of our population. We now need to plan together how to achieve this, including where to focus our combined efforts in the short, medium and longer term. It needs to interlace with the other elements of the clinical services strategy to ensure that the whole works as one seamless service.

2. Introduction

Mental health problems are widespread: they are sometimes disabling yet often hidden. Mental health conditions are more likely to remain undiagnosed than physical health problems, with one in four adults experiencing at least one diagnosable mental health problem in any given year. People in all walks of life can be affected and at any point in their lives - new mothers, young children, teenagers, adults and older people. Mental health problems represent the largest single cause of disability in the UK. The impact on the wider economy of adverse mental health, including through lost productivity from time off work, is estimated at £105 billion a year.

Sustainability and transformation partnerships (STPs) provide forty-four local vehicles for effecting transformational change across health and social care in England. The Nottinghamshire STP comprises the areas of Greater Nottingham and Mid Nottinghamshire (see Figure 3).



All NHS organisations based in this area, along with Nottingham City Council (unitary) and Nottinghamshire County Council and Districts, together constitute the STP. Its governance structures also include other relevant local and national partners such as Healthwatch and voluntary and community sector organisations (VCS). The Bassetlaw area in the north of the County forms part of the separate South Yorkshire and Bassetlaw STP and is not covered by the strategy. People in that part of the county generally receive services from hospitals and other facilities based in South Yorkshire.

Figure 3 - Map showing STP areas

The STP is currently on a journey to becoming an Integrated Care System (ICS) in which it is envisaged that Greater Nottingham and Mid Notts will each form an Integrated Care Partnership (ICP), each consisting of several Local Integrated Care Partnerships (LICPs) that coordinate the delivery of integrated care in smaller local areas. These three levels broadly align with NHS England's description of system, place and neighbourhood levels (see Figure 4).

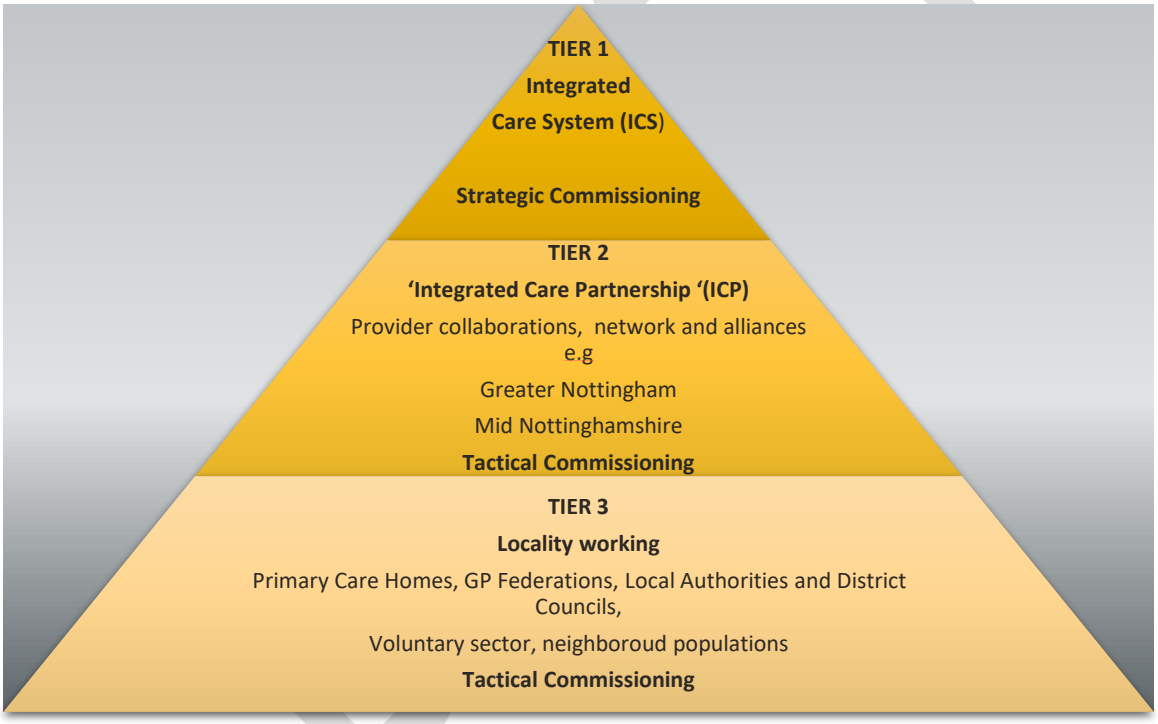


Figure 4 - ICS, ICP and Locality Working

The Nottinghamshire STP has established an Integrated Mental Health and Social Care Partnership Board. As a key part of its work, the Partnership Board has collaborated with other local stakeholders (see Appendix 1) to develop this draft all-age integrated mental health strategy. Separate work by the Board will address dementia and learning difficulties.

Many partner organisations to the STP already have, and will continue to advance, their own strategies and plans in relation to mental health and wellbeing. This strategy sits above these and takes account of them. The potential added value that the STP can offer lies in supporting its partner organisations, and others involved in advancing mental health and wellbeing, to:

- Identify and address the things that either currently constitute barriers to improving mental health and wellbeing and/or are critical enablers of it;
- Take advantage of opportunities of scope and/or scale to generate benefits not available to partner organisations working in isolation - for example, through taking successful local innovations and rolling them out at scale across the whole system;
- Provide an overall direction of travel and reporting framework to inform ongoing planning and improvement in local areas (e.g. individual Local Authorities and NHS organisations, the Integrated Care Partnership in Greater Nottingham and Mid Nottinghamshire along with the Local Integrated Care Partnerships covering their constituent neighbourhoods), and;
- Create mechanisms for proactive population health management and service improvement across the whole system.

This draft strategy has been written primarily as an internal-facing document for the STP and its partners. The purpose of this document is to provide a strategic frame and overarching brief for more detailed collaborative work by the STP and other relevant local organisations. We propose the establishment of a number of working groups to develop and implement the more detailed plans in each of the priority areas described in this strategy. We recognise that as plans are further developed and there are further stages of engagement with system partners, service users and other interested parties, the strategic narrative and priorities contained here will need to be re-presented to enable genuine engagement.

At the outset of this work, the Partnership Board determined that the mental health strategy for the STP should be underpinned by twelve key principles:

1. Good system leadership;
2. The individual with their own lived experience of mental health will be at the heart of each and every decision that is made;
3. Decisions must be locally led;
4. Care must be based on the best available evidence;
5. Services must be designed in partnership with people who have mental health problems and with their carers;
6. Inequalities must be reduced to ensure all needs are met, across all ages;
7. Care must be integrated – spanning people's physical, mental and social needs. Referral pathways should be seamless both within, and between, services (e.g. between primary and secondary mental services);
8. Prevention and early intervention must be prioritised, with a core focus on services provided in community settings working with multidisciplinary teams;
9. Care must be safe, effective and personal, and delivered in the least restrictive setting;

10. Mental health services are understandable and accessible to all, including groups within the population who currently find services difficult to use for cultural reasons or because they believe the service will not meet their needs;
11. The priorities in NHS England's Five Year Forward View for Mental Health must be successfully implemented, and;
12. The right data must be collected and used to drive and evaluate progress

As this work has progressed, it has become evident that there is a strong and shared determination across STP partners to create a transformed mental health landscape for the citizens of Great Nottingham and Mid Nottinghamshire. This work is fully aligned with the priorities of NHS England's *Five Year Forward View for Mental Health* which highlights that, although there remain several areas where further action is required across the country, much as already been achieved.

The sections that follow describe our vision for each key pillar of the transformed landscape that we envisage for the Nottinghamshire STP, supported by an initial set of draft outcomes (pending more detailed work and further engagement) and a set of high-level strategic actions required to realise the vision which workstreams will need to develop and refine, and align with other aspects of the STP's planning.

These pillars are founded on:

- A range of stakeholder engagement activities – both targeted focus groups held specifically to inform the development of this draft strategy and summaries of relevant existing engagement activities provided by partner organisations;
- An analysis of existing services and outcomes, and;
- A rapid review of national and international evidence relevant to the scope of this strategy.

3. Understanding the Current Position

The STP is responsible for planning and delivering the health and care for over 1 million people. This is a population that is both growing and changing over time. People are generally living longer despite an increasing number of physical and mental co-morbidities.

At the same time, there are some stark differences in the population across the geographical footprint – Nottingham City and Mansfield are generally younger, more ethnically diverse, experience higher levels of socio-economic deprivation but have good access to services whilst other areas across the county such as Rushcliffe are generally older, better educated and less deprived but may be more isolated and have poorer access to services and amenities.

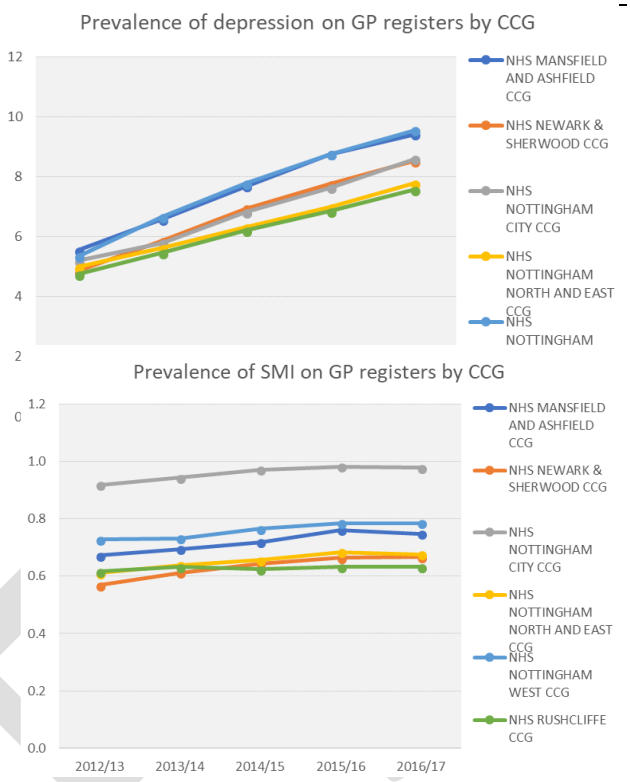


Figure 5 - Prevalence of depression and SMI by CCG

The City also has a very high university population. It is a complex and varied population.

The map below illustrates the geographic spread of current service provision (see Figure 6 - Mental Health service locations in Nottinghamshire). For ease of viewing, these do not reflect exact service locations.

Mental Health in the STP

There are currently 73,000 patients on GP depression registers – an increase of 9,000 from the previous year but lower than the national prevalence.

8,600 patients are on Mental Health registers for schizophrenia and psychosis – an increase of 400 from previous but again, lower than national prevalence.

15,000 people are in contact with adult mental health services and 700 in contact with CYP services.

Each year there are around 2,000 contacts with crisis teams. Liaison services are now identifying over 100 patients a month in ED or inpatient wards suitable for referral to mental health services and local IAPT services are seeing around 25,000 patients of which 50% complete a treatment course.

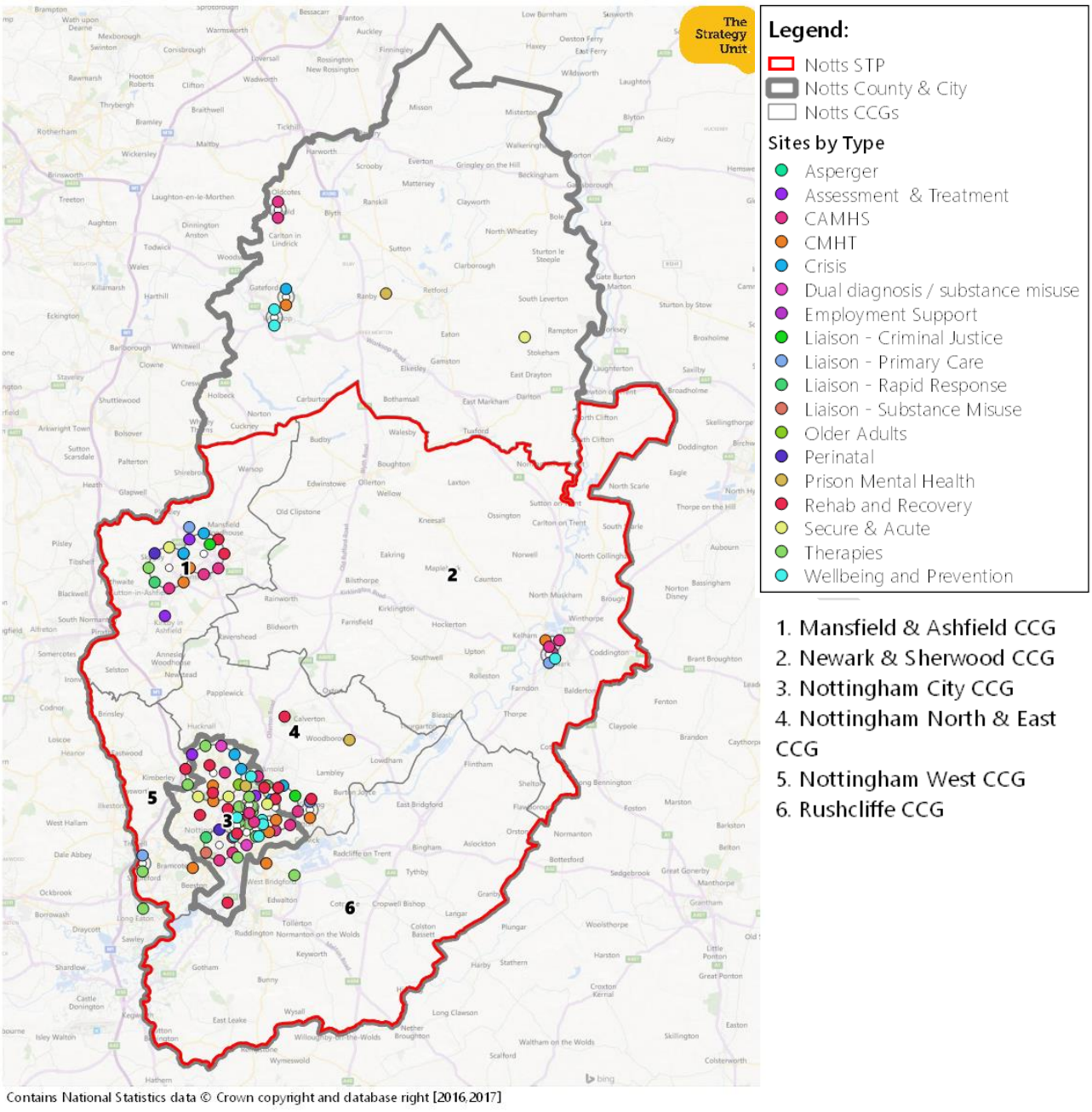


Figure 6 - Mental Health service locations in Nottinghamshire

Social determinants and causes of mental ill health

The following section surveys the Nottinghamshire context in terms of key drivers of mental ill health.

Adverse childhood experiences (ACE)

The health and wellbeing of individuals is materially affected by the nature of the start in life they experience. This is adversely affected by deprivation (see **Error! Reference s ource not found.**[3]) and by a range of other experiences such as multiple types of abuse, neglect, violence between parents or caregivers, other kinds of serious household dysfunction such as alcohol and substance abuse and peer, community and collective

violence. Across the whole STP area, it is estimated that over 500,000 people will have had exposure to at least one ACE, with around 45,000 experiencing 4 or more. Identifying these children, young people and adults and supporting them to manage their mental health will determine how much future reliance they have on specialist and acute services.

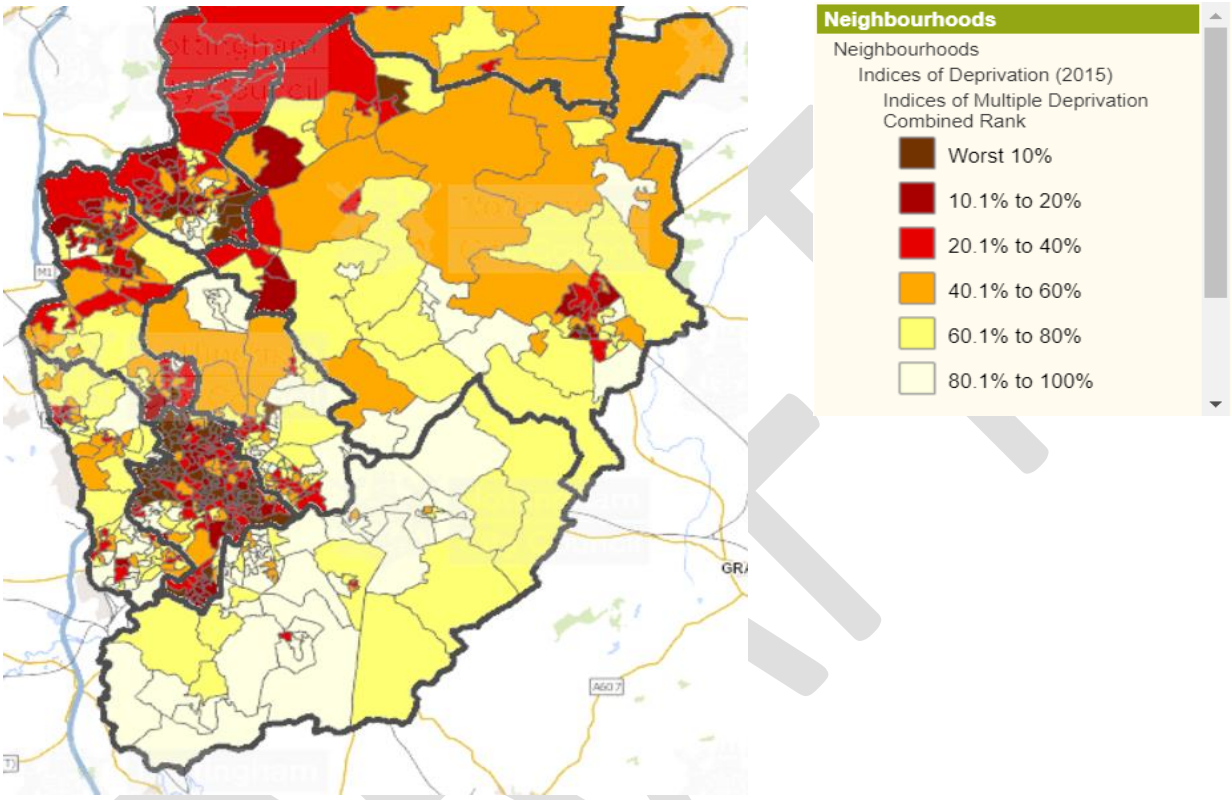


Figure 7- Deprivation in Nottinghamshire[3]

Drugs & Alcohol

The number of persons in treatment for drug and alcohol misuse is rising steadily in the City for all substances but falling steadily in the wider County, demonstrating the distinct social differences between the areas (see Figure 8 & Figure 9[4]). Dual diagnosis services have been decommissioned. Prevalence studies suggest one fifth of those in drug or alcohol misuse services may have some level of psychosis.

Adult Users	12-13	13-14	14-15	15-16	16-17	Yr to End Feb 18
Treatment Completion & Non-representation (% opiate users)	10.25	9.96	7.06	6.27	5.57	5.82
Treatment Completion & Non-representation (% non-opiate users)	40.04	36.36	42.55	44.13	38.66	39.89
Treatment Completion & Non-representation (% alcohol users)	27.03	27.86	33.24	35.64	30.69	38

Figure 8 - City drugs and alcohol indicators

[3] Nottinghamshire County Council. *Investing in the future: making a healthy start.* Director for Public Health annual report, 2017.
[4] National Drug Treatment Monitoring Services (NDTMS). https://www.ndtms.net/default.aspx (accessed May 2018)

Adult Users	12-13	13-14	14-15	15-16	16-17	Yr to End Feb 18
Treatment Completion & Non-representation (% opiate users)	9.43	8.21	7.96	5.36	5.6	6.75
Treatment Completion & Non-representation (% non-opiate users)	52.4	37.23	34.63	28.48	33.57	32.61
Treatment Completion & Non-representation (% alcohol users)	36.82	40.37	39.28	29.8	36.07	36.75

Figure 9 - County drugs and alcohol indicators

Crime

Overall incidents of reported crime have been increasing in Nottinghamshire. They are 27% higher than 5 years ago with particularly significant increases in violent crime and public order offences. Victims of crime are generally highly susceptible to negative impacts on their mental wellbeing without timely and appropriate support.

Type of crime	12mths to May 14	12mths to May 15	12mths to May 16	12mths to May 17	12mths to May 18	Period change
Anti-Social Behaviour	36,477	37,950	39,284	33,284	32,189	-11.8%
Violent	14,738	19,143	19,220	26,286	31,102	111.0%
Other Theft	8,422	8,821	8,162	10,663	12,855	52.6%
Criminal Damage & Arson	9,938	10,362	10,565	11,200	12,160	22.4%
Shoplifting	7,337	7,979	7,682	8,743	10,287	40.2%
Vehicle	6,621	6,791	6,994	7,398	9,547	44.2%
Burglary	8,705	8,465	7,991	8,106	8,358	-4.0%
Public Order	1,792	2,468	2,064	4,896	6,178	244.8%
Drugs	3,639	3,410	2,929	2,812	2,885	-20.7%
Other	767	1,070	1,150	1,571	1,971	157.0%
Bike Theft	2,184	2,038	1,862	1,752	1,337	-38.8%
Robbery	1,068	984	880	916	1,093	2.3%
Weapons	567	600	726	820	929	63.8%
Theft From the Person	1,317	1,228	1,048	915	779	-40.9%
Total	**103,572**	**111,309**	**110,557**	**119,362**	**131,670**	27.1%

Figure 10 - Nottinghamshire crime statistics[5]

Employment

Nottingham City has an overall unemployment rate (9.6 per 1,000) much higher than the national (3.7) and regional averages (3.5). Nottinghamshire County on the other hand has unemployment similar to national rates (3.6 per 1,000). Across the STP area, there are around 4,000 people claiming long-term Jobseeker's Allowance (JSA). Nottinghamshire residents with specialist mental health needs are 70% less likely to be in employment – higher but not statistically different from England. For Nottingham City this gap is

[5] UK Crime stats. http://www.ukcrimestats.com/Police_Force/Nottinghamshire_Police (accessed July 2018). Figures above include Bassetlaw.

significantly lower at 56%, suggesting there may be less employment support and/or opportunities outside of the City (see Figure 11 & Figure 12[6]).

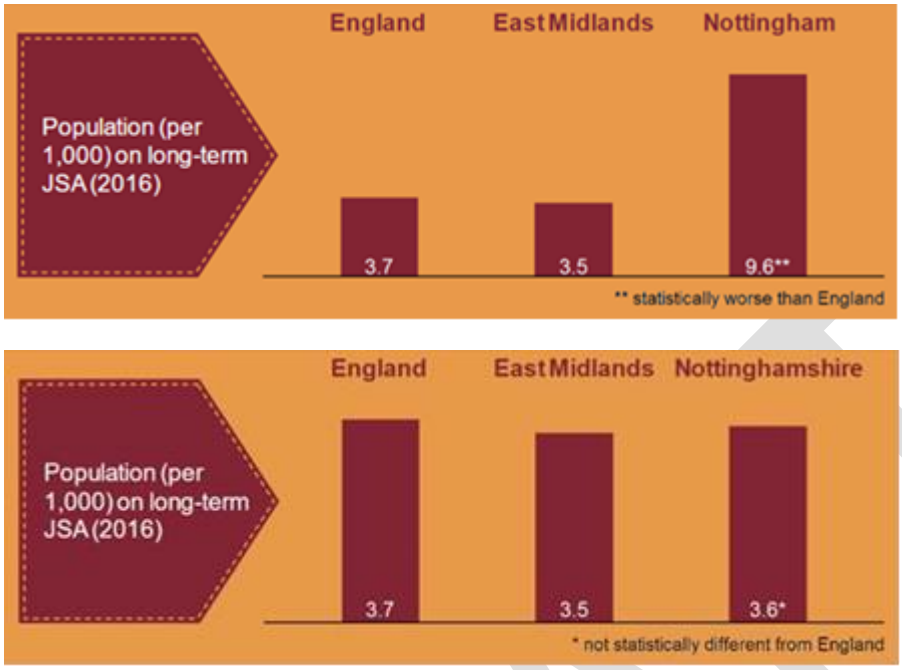


Figure 11- Employment in Nottingham and Nottinghamshire

Figure 12 - Employment of Mental Health service users in Nottingham and Nottinghamshire

[6] Public Health England. *Work, Worklessness and Health: Local Infographic Tool*. June 2018

Homelessness

It is estimated that around 20% of homeless people with mental health issues are not receiving any support or treatment for those issues. Clearly, there is an opportunity for statutory, third sector and voluntary organisations to work together to improve outcomes for this vulnerable population.

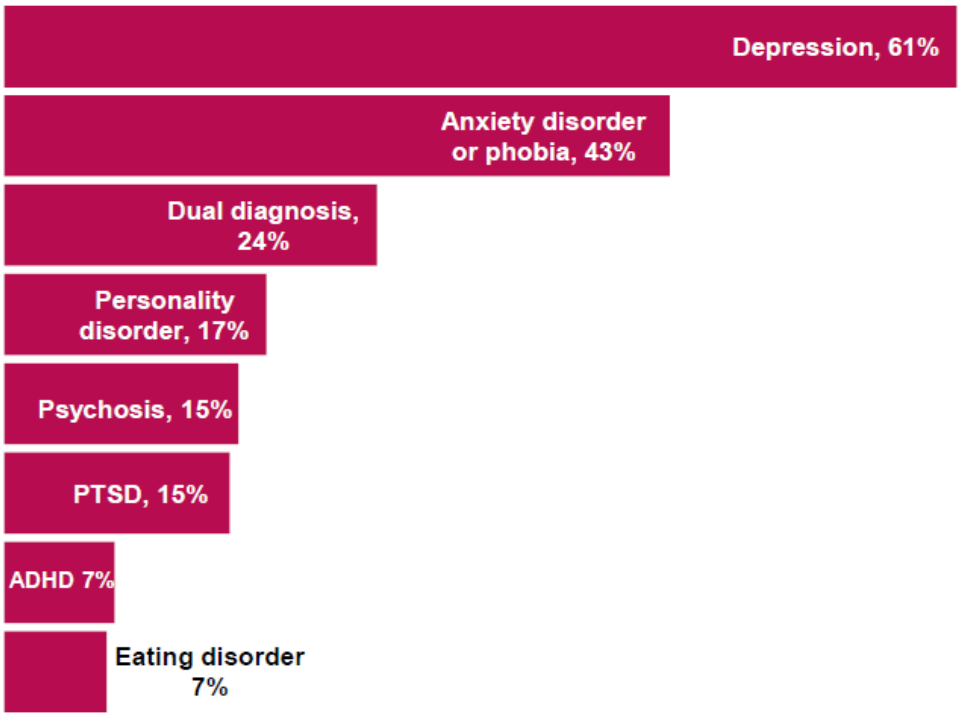


Figure 13 - Mental Health needs of the homeless in Nottingham[7]

Physical and Mental Health[8]

In the Nottinghamshire STP area there is an unacceptable life expectancy gap of 17 years for men and 15 years for women between users of specialist mental health services and the rest of the population. Mental health services users are also 2-3 times more likely to die from cancer, circulatory or respiratory disease that the rest of the population.

Whilst 7% of the total population has been in contact with mental health services over a 3-year period, 19% of all A&E attendances and 26% of all non-elective hospital admissions can be attributed to this same cohort (particularly to those living with psychosis or a personality disorder).

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[7] Centre for Regional Economic and Social Research. *The Mental Health needs of Nottingham's homeless population.* April 2018.
[8] The Strategy Unit. *Making the case for integrating mental and physical health care: an analysis of the physical health of people who use mental health services – life expectancy, acute service use and the potential for improving quality and using resources more efficiently*. May 2017.

This suggests that there is an opportunity to improve physical health outcomes and experience for mental health service users.

Current workforce

The latest STP submission to Health Education England reveals an NHS mental health workforce comprising 6,242 funded posts in 2016: 2,588 (41%) of which were for professionally qualified clinical staff and 484 (c.8%) of which were vacant at the time of submission (see Table 1 below).

Funded Posts - 2016

	Medical	Nursing and Midwifery	Allied Health Professional and Scientific, Therapeutic and Technical Staff	**Total Professionally Qualified Clinical Staff**	Support to Clinical Staff	Administrative and Infrastructure Staff	**Total**
CYP	9	74	62	145	21	37	202
Adult IAPT		4	118	122	14	14	150
Perinatal	2	18	1	21	9	4	34
Crisis - CRHTTs		53	9	62	21	8	91
Liaison MH		20	1	21	3	2	25
EIP			5	5	2	4	10
Liaison & diversion		11		11	7		17
Total T.A.s	***10***	***179***	***196***	***386***	***76***	***69***	***531***
Core Acute	212	660	179	1,050	1,613	541	3,204
Core Community	38	565	549	1,152	731	625	2,508
Total Core	***250***	***1,224***	***728***	***2,202***	***2,344***	***1,166***	***5,711***
TOTAL	260	1,404	924	2,588	2,420	1,235	6,242

Table 1 - NHS funded mental health posts in the STP, 2016

Meeting the HEE plan for 2021 would anticipate funded posts increasing to 6,455 (3.4% above 2016. This increase is currently projected to be achieved through a combination of:

- 1,282 locally-hired replacement non-clinical staff;
- 1,076 retained clinical staff that might otherwise have left;
- 556 newly qualified clinical staff from training, and;
- 219 new clinical roles such as nurse associates, physician associates and crisis telephone triage staff.

These changes, if achieved, would more than offset the expected number of clinical and non-clinical leavers during this period (2,780 or c.45% of the current workforce).

We recognise, however, that these plans will need to be revised in the light of this strategy and the implementation plans that flow from it. It is not currently possible to determine whether the existing plan will provide an NHS workforce of the scale and nature necessary to deliver this strategy.

Whilst the focus of the review exercise was to identify areas in which more investment of time and potentially resources should be focused (a deficit approach), we also noted a wide range of current strengths in mental health services. The STP – or some part of it – is currently a favourable outlier in relation to:

- Physical health checks for serious mental illness (SMI);
- IAPT treatment rates and outcomes;

- Suicide rate reduction;
- Life expectancy gap for male mental health service users (reduced by 4 years since 2006/07);
- The lowest mortality rates amongst STP peers in the mental health cohort for circulatory disease and cancer;
- The inclusion of housing and employment status in patient assessments and long-term employment of those in mental health services;
- Overall patient experience of using community mental health services – contact points and communication;
- Low emergency re-admission rate, and;
- Low psychiatric intensive care unit (PICU) length of stay.

Furthermore, organisations across the STP have received recognition or budgetary awards for:

- New Models of Care;
- Extension of psychiatric liaison;
- Fulfilling Lives funding;
- School mental health first aid;
- Investment in Hopewood facility;
- Time to Change hub;
- Student services team at Nottingham Trent University;
- NIHR grant for developing Virtual reality therapy;
- 'On-the-ball' community initiative, and;
- Street triage partnership award.

Beyond these areas of strength, however, several themes emerged as a result of the initial data review based on at least one of the factors below combined with the apparent absence of a clear and explicit plan to address the issue:

1. They have been identified as challenges in Joint Strategic Needs Assessments across Nottinghamshire County Council and Nottingham City Council;
2. They are identified multiple times in different sources, or;
3. There is scope for improvement when benchmarked against other rates and/or recent trends moving in a negative direction.

The resulting issues are set out in Table 2 below, cross-referenced to the key strategic pillars described later in this document. Stakeholders reflected on these issues as part of the strategy development process (alongside summaries of the evidence base and of wider stakeholder engagement), to inform the content of those pillars. As the delivery plans are developed they will need to demonstrate clear plans of action against each of these issues

	Emerging Issues	Pillar
1	CCGs in the STP spend £123k more on primary care prescribing for MH than might be expected	1, 3
2	Alcohol mortality (City higher, County lower)	2
3	High proportion of homeless will also have substance misuse and addiction problems	2
4	Insufficient support in schools for prevention /early intervention (City)	2
5	Limited workplace programmes for mental wellbeing	2
6	Long-term employment down but employment and support allowance claims increasing	2
7	Violent crime on the increase	2
8	MH service users generate 19% of all A&E attendances and 26% of all unplanned admissions to hospital. Usage is especially high in those with personality disorders.	2, 3, 4
9	Significant gaps in Life Expectancy for mental health service users compared to rest of the population	2, 3
10	NHS111 calls for MH are higher across most of STP	2, 3, 4
11	'Awaiting care package in own home' (CPN/Therapy) and Housing not covered by NHS and Com Care Act most common delay and increasingly so (NHFT)	4
12	Around 1/3 did not feel cared for in services and communication was not good	5
13	At least 9 out of 10 opiate users re-present to services after completion of treatment.	2, 4
14	Carer QoL for MH patients lower than average (City one of lowest)	4
15	Child protection plans higher than average but spend decreasing	2,4
16	Contacts with CRHT per head of population lower than national rate	4
17	Crude rates of OAP approx. 3 times higher than national (Nov 16-Feb18)	2, 3, 4
18	IAPT outcome measures all comparably good –completion and improvement however access rates below target	4
19	Increasing numbers with addiction across City.	2, 4
20	One of lowest access rates for CYP services across country.	4
21	Patients detained or subject to MHA higher than national average	4
22	Patients with SMI in psychiatrist hospital higher than national average	4
23	People on CPA, crisis plans and stable accommodation lower than average	4
24	Rate of LAC per population are very high (vs national) in City and increasing, low for rest of County and decreasing	2, 4

	Emerging Issues	Pillar
25	Repeat child protection cases increasing	2, 4
26	Successful completion of drug or alcohol services lower than national avg.	2, 4
27	Waits for EIP are greater than expected	4
28	Awareness training for front-line staff (City)	5
29	Mental Health First Aid training not routinely offered to employers (Adult MH County)	2, 5
30	Workforce capacity and skills deficit (County)	5

Table 2 - Emerging Issues from Baseline Data

4. Co-design, Choice and Control

The foundation for this transformative work is engagement, co-design, co-production, involvement, and collaboration with those who have lived experience of mental health in its design, delivery and evaluation. This person-centred foundation needs to underpin future work on all the pillars of this strategy, and it underlies their successful delivery.

In this section we report the engagement work that has directly informed the development of the strategy and we set out an approach to ongoing engagement that emerged from a series of broad stakeholder workshops. The stakeholder organisations that contributed to the development of this draft strategy have also built up a significant stock of knowledge in relation to service user views on various issues.

A stakeholder-developed strategy

The work to develop this strategy did not follow a predetermined course. It was important, therefore, that the design process involved a broad range of stakeholders with sufficient experience and understanding to identify the strategic actions that could enable a transformation of the local mental health landscape. These stakeholders included those with lived experience of mental health issues and representatives of the voluntary and community sector as well as Local Government and NHS bodies. As this work moves to the next stage of its development, it will be crucial to extend that engagement further to all those who can contribute to the development of robust, collaborative plans under the strategic pillars described in this document. This should include a strong stakeholder input into how priority actions under each pillar are identified and addressed.

The development of this draft strategy involved stakeholders attending a series of workshops in which the current position (need, services and strategies) were analysed, a series of emerging priorities identified and refined, and a number of key outcomes and supporting actions proposed under each strategic pillar. External inputs to the strategy development process included those from national Mind, the West Midlands Combined Authority's Mental Health Commission and NHS England's Mental Health Team. We were also able to build on the foundation of all the knowledge built up within partner organisations from ongoing service user engagement. We recognise, however, that service users remain concerned that are not yet involved in a sufficiently planned, consistent and comprehensive manner. This is why we are immediately forming a service user co-design group to help shape the work of the Partnership Board and are making issues of co-design, choice and control priorities across all the strategic pillars set out in this strategy. Stakeholders have highlighted that this needs to include definition of the parameters and expectations around service user involvement

A full report on the engagement inputs to this strategy can be found in Appendix 3.

A stakeholder-driven system

Ongoing involvement in system and service design

The STP needs to enable meaningful, multi-level involvement throughout the workplans that will be developed for each pillar.

Third sector, Voluntary Sector and Citizen engagement is a core principle of the STP and this strategy, as well as a key component of services at all levels. Citizens (including experts by experience) will be involved in co-design, co-production and in evaluation activities, as well as recruitment and governance, from the outset. Their contributions will be valued and will inform service decisions. For this to operate effectively, there need to be clear governance structures in place to ensure engagement is conducted in a coordinated manner, with some element of personal development benefits for the citizens involved.

We need to ensure that involvement and engagement includes people from Black and Minority Ethnic (BAME) communities, carers, students, ex-military personnel and the homeless – especially people who are over-represented in second tier mental health services and tend to bypass primary services.

To enable involvement and engagement documentation will be designed to be accessible, and will carefully consider the use of terminology, so it is easily understood by service users but also provides adequate detail for them to make informed contributions to the co-design, co-production and evaluation processes of this strategy and the system.

Work on the foundations must begin with a plan for engagement and involvement. This plan, to be developed under the Integrated Mental Health and Social Care Board, will cover a clear set of short, medium and long term aims, as well as the purpose of the collaborative partnership with citizens and clarity on differing roles within this partnership. Governance processes and terms of reference and accountability will also be covered in this plan, as will guidance on cultivating personal development benefits for citizens involved in engagement. This plan will provide a standardised process that can be employed by services and partnerships at all levels. Lessons on engagement methodology can be drawn from the Kings Fund Collaboration Model which has already been tested and piloted in Nottinghamshire.

There needs to be oversight of engagement activities to ensure they are operating appropriately and effectively. A charter or code of conduct may help towards this. Expertise in engagement and involvement of citizens should also be readily available for services across the system.

An initial workshop may prove useful for introducing the principle and plan for citizen engagement. This workshop should be attended by key stakeholders from services who will be coordinating citizen engagement and citizens who may be interested in being involved. This workshop should pave the way for subsequent service-specific engagement work, dictated by a tailored engagement plan for each service. It is acknowledged that

there is already much expertise in this area locally, including through the work of the Practice Development Unit - a partnership between Opportunity Nottingham and Nottingham CVS.[9]

More specifically, the Mental Health Partnership Board will recruit service users into a standing co-design group that will be able to check and challenge the Board's ongoing work, including the implementation of this strategy.

Choice and control in accessing support

We are concerned that our work in this area should not be confined simply to engaging citizens in the shape and content of strategies and plans, as important as this is. A key feature of the transformed mental health landscape that we envisage for the STP is that citizens will also be enabled and empowered to exercise the maximum appropriate choice and control in the support they access, including how, when and where they do so.

All service users will have a care plan (including advance crisis planning) that is coproduced and will be accessible to all relevant parties, including service users themselves, carers, families and key staff. Care plans will be based on a holistic approach to health and care, including both clinical and other approaches to care and support. The plans we develop will also be able to take advantage of the opportunities provided by technology and digital health solutions to increase the ways in which people will be able to access support.

Choice should be incorporated into service delivery and service user care plans. Citizens will be empowered to make choices and decisions regarding their own health and wellbeing and these choices and decisions will be informed and considered. More detailed planning under each strategic pillar will also consider the potential to facilitate direct access to defined services so that our system can become more person-centred and less service-centred.

[9] www.pdunottingham.org

5. Our Key Strategic Pillars

The work to develop this strategy led stakeholders to develop a broad consensus about the areas on which partner organisations should focus together in order transform mental health and wellbeing for our population. That consensus flowed from:

- Sharing front-line experience;
- Analysing a large volume of data sources;
- Engaging with service users, workforce representatives and out key stakeholder groups;
- Reviewing the evidence base in both academic and 'grey' literature;
- Reflecting on the requirements for implementing NHS England's *Mental Health Five Year Forward View*[10];
- Considering perspectives from other parts of the country and from specialist national organisations, and;
- Working together in a series of three workshops (each with around 60 attendees) to identify the outcomes desired and the actions required to deliver those outcomes.

The resulting pillars should not be treated in isolation from one another. Pillars must not become new silos. As we move towards defining and effecting the detailed actions we will need to take to advance our strategy, we must remain attentive to the unavoidable overlaps and complex interactions of the territory in which we are operating.

The workstreams that we propose for taking forward this work will need to be mindful of all the pillars of this strategy, not only those for which they are given a responsibility. In the same way, advancing this mental health strategy needs to be seen as just one component of wider STP developments, and therefore to liaise closely with other areas of STP work as appropriate.

To better understand integration in mental health services and processes for transformation, policy documents, empirical and experiential evidence were consulted to generate key recommendations to inform the future mental health strategy for Nottingham (see Appendix 4 – Building on the Evidence).

The following table sets out our five key pillars, highlighting the likely areas of interaction with other pillars in this strategy as well as their alignment with other areas of STP work and with the delivery priorities of NHS England's *Five Year Forward View for Mental Health*.

[10] https://www.england.nhs.uk/wp-content/uploads/2016/07/fyfv-mh.pdf

	Key Strategic Pillar	Interdependencies	Wider STP Alignment	5YFV Alignment
1	**Establishing Integrated System Infrastructure (i)** • Strategic commissioning and funding • Integrating statutory and voluntary provision • Workforce planning **Establishing Integrated Place Based Working(ii)** • Developing integrated care partnerships • Population Health Management	• Support for all other pillars where system-level enablers are required	• System infrastructure and standards (ICS, ICP, LICP level mechanisms) incl. CCG re-specification of community and MH services • STP Finance Directors' work on payment mechanisms and incentives • Connected Nottinghamshire work on IT integration, interoperability and data-sharing • HR collaborative • STP Workforce workstream • STP Primary Care workstream	• Mental health investment standard • Complete and accurate data • Effective workforce

	Key Strategic Pillar	Interdependencies	Wider STP Alignment	5YFV Alignment
2	**Increasing Support for Prevention, Self-care and the Wider Determinants of Health**	• ICP/LICP delivery mechanisms (pillar 1) • Reducing adverse interactions between physical and mental health (pillar 3) • Prevention before crisis (pillar 4)	• Ongoing work on prevention self-care and independence as part of the STP prevention, person and community centred approaches work stream • Link to troubled families, CYP service development • Health and housing work stream • Suicide prevention group	• Prevention • Co-production and addressing inequalities • CYP access
3	**Implementing a Person-centred Approach to Physical and Mental Health** • Integrated pathways and teams • Holistic approach by workforce	• Integrated commissioning/funding flows (pillar 1) • Integrated local teams (pillar 1) • Workforce skill mix (pillar 1) • Preventing mental health conditions leading to physical health issues, and *vice versa* (pillar 2) • Workforce culture and behaviours (pillar 5)	• Urgent and emergency care work stream (high volume service users and A&E attendances, self-harm admissions) • Re-specification of community and mental health services to integrate physical and mental health teams. • STP Clinical Services Strategy	• MH everyone business, not just MH & PH workers • All age mental health liaison in every acute setting, plus core 24 • Increase SMI access to physical health checks and interventions

	Key Strategic Pillar	Interdependencies	Wider STP Alignment	5YFV Alignment
4	**Improving Access to Specialist Services** • Access and Signposting • Availability and accessibility of services • Urgent/crisis care services • Out of area placements • Targeted approaches to vulnerable groups	• Integrated commissioning (pillar 1) • Funding flows (pillar 1) • Workforce culture and behaviours (pillar 5) • Prevention (pillar 2)	• IAPT access is being developed across the county, including more links with physical health conditions – included in CCG plans • Urgent and Emergency Care workstream • Out of area placements task force	• Increased access to CYP interventions – Future in Mind • Increase access to perinatal MH Care • Increase access to IAPT & IAPT LTC • 10% reduction in suicide • Increase in number of people with SMI accessing Individual Placement and support • Improved crisis care • IAPT LTC & mental health co-location • First episode psychosis – 60% accessing care within 2 weeks • Eliminate inappropriate out of area placements • CAMHS T4 beds
5	**Equipping a Mental Health Aware Workforce** • Culture • Capacity • Compassion • Competencies	All pillars	• Workforce workstream has access to OD and HR networks and will take forward work as specific requirements emerge • OD is being considered for multi-sector teams	• MH everyone business, not just MH & PH workers

Table 3 – Five key pillars

6. Pillar 1: Establishing Integrated System Infrastructure

Overview

We understand system integration to be about organising care around the needs of the individual, with system structures and mechanisms being configured to facilitate that focus. We believe that there will be more than one way of integrating to meet the needs of the population.

This pillar is focused on creating the integrated system infrastructure required to support the transformation and enable the more effective delivery of mental health and wellbeing across the STP. It will clearly need to be aligned with wider work on STP architecture and applies to both the system (STP/ICS) and place/neighbourhood (ICP/LICP) levels, involving collaborative and inclusive working between any organisations and groups who can add value to the delivery of our desired outcomes.

There is an increasing evidence base that co-ordinating plans, integrating delivery and aligning incentives across currently separate organisations and sectors presents opportunities to make transformational improvements in health and care outcomes, through higher quality and more efficient services.

This move towards systems thinking is a change from recent policy history, with its emphasis on competition and market mechanisms. There are very prominent examples in global commerce where providers have created systems that allow greater benefits to flow and enable new value to be created. The challenge for us as STP partners is to design and deliver a system that integrates the contributions of individual organisations such that the overall impact is greater than the sum of its parts. We need to ensure that we have strong networks and communication channels, more 'joined-up' working and a mutually supportive culture.

Strategic commissioning and funding at STP/ICS level

One element of this will be a strategic commissioning function for mental health services that overrides condition-specific services and, where appropriate, standardises specifications across the STP. This would be supported by data sharing and IT interoperability, intelligent information systems that help to identify where system resources are best focused (for example, on those who are intense users of multiple services) and mechanisms that enable funding to be applied as a common resource in delivering agreed system outcomes (such as a shared outcomes framework and risk-gain share agreement).

Current contractual arrangements and the associated money flows create barriers and perverse incentives. These need to be identified and addressed, allowing funding to be

shifted between services to give the maximum impact in terms of cost effectiveness and clinical impact, to deliver win-win outcomes for service users and system partners. Without this, the shared ambitions of local partners may not be achievable. Areas of duplication needs to be evaluated and wherever appropriate minimised or avoided.

Integrated Place Based Working

At the same time, the notion of 'place' has become increasingly important in health and care policy. The fundamental notion being that thinking about 'a place' when planning and delivering services can be helpful to the task of integrating care and improving resource use, outcomes and experience. While not new to those in Local Authorities, the NHS is still exploring what 'place-based' really means in terms of the delivery of healthcare but in this pillar we apply it to the two lower levels of the STP system – ICPs and LICPs.

Integrated working in places (ICPs) and neighbourhoods (LICPs)

Two key features of emerging (local) integrated care partnerships are:

a) An integrated multidisciplinary team in each locality, built around Primary Care operating at scale, that coordinates the provision of holistic care. This can be a key mechanism for shifting care from secondary to primary and community delivery, subject to financial flows reflecting the evolving model of care. The multidisciplinary team should consist of representation from all sectors who can contribute to effective health and social care provision for the patients. With a focus on integrated working at the local community level, there may be a need to build up a workforce that can offer a support function to the mental health staff in health and social care settings, as well as the wider mental health agenda. Community referral should be utilised where possible, drawing on existing local assets.

b) The intelligence and information systems that enable teams to proactively identify and then coordinate the care management of specific service user cohorts. This latter is a broader approach than simple risk stratification: it includes the intelligence that informs both individual patient care and ongoing service improvement, supporting (L)ICPs to become self-improving systems. It should include utilisation reviews and other outputs from existing STP population health analysis. For a multidisciplinary team to work effectively, compatible IT systems and data sharing agreements need to be put in place. The workforce also needs to be well informed about the services on offer at a whole system level. Knowledge sharing is imperative for this and may warrant a mobile phone application that can provide easy access to a catalogue of services, including key contacts.

The integrated and holistic provision of anticipatory and response care should also be 'trauma-informed'[11], adopting a locally-appropriate approach based on national and international evidence.

Integration with non-statutory services

As well as its role in being a system integrator for statutory health and social care services, the STP can also play a key part in nurturing and harvesting the impact of the third sector and the voluntary and community sector as full partners in the transformation sought by this strategy. Sometimes this will be through fully including partners from these sectors within planning and delivery processes; at other times it may involve the allocation of resource where those organisations are best placed to generate the greatest impact.

A first step would be to better understand the resources that are or could be available in charitable and local community organisations. Much of the detail of this would rightly form part of the Integrated Place-based Working pillar but there will be aspects that are best addressed at the overall system level.

In a similar way, there will be some aspects of the wider determinants of mental health and wellbeing that can be more effectively addressed at the overall system level, without taking anything away from what should continue to be advanced in local places.

Workforce

Another area of focus for system-level intervention is in relation to the mental health workforce. Developing greater mental health awareness in the wider workforce is addressed through a separate pillar.

In order to create a sustainable workforce for the future, there needs to be a focus on training and development to address shortages in skills and to explore the potential for new roles, focusing on the competencies required rather than solely on established disciplines and professional groups. This should ideally begin with an exercise to map the skills of the workforce across all teams and to identify the key gaps. Local training providers will clearly need to be engaged, as well as relevant professional bodies, to help define the training required for the roles envisaged. Joint training opportunities may provide a useful forum for networking and knowledge sharing across the workforce. Clear career pathways need to be developed, and staff should be supported with their progress. In addition to a focus on continuing professional development, pastoral care should be encouraged in order to support staff with their developmental needs, workload pressures and other issues of concern.

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[11] *Realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma clients, families, staff, and others involved with the system; responds by fully integrating knowledge about trauma into policies, procedures, and practices; and seeks to actively resist re-traumatization.* https://www.samhsa.gov/nctic/trauma-interventions

There should be recognition and acknowledgement of key achievements, successes and progress made by staff and their patients. These should be shared widely. Looking forward, links with Universities should be utilised to recruit staff and build the future workforce. A plan also needs to be put in place to effectively utilise the additional capacity resource for primary care highlighted in NHS England's *GP Forward View*.

These initial mapping exercises should inform and support the development of an STP workforce organisational development strategy, working with the wider STP Workforce workstream.

Our work under this pillar should also consider alternative workforce solutions that move beyond traditional roles. For example, health, social and voluntary sector teams could consider utilising peer support workers as part of their workforce approach to service delivery; building on a developing national and international evidence base. There is also potential for the development of support roles such as non-medical prescribing and non-medical responsible clinicians, along with non-social worker approved medical practitioners (AMPs). Collaboration between services will be key to building a sustainable workforce that has a shared interest in mental health. There are innovative examples locally that can be built on such as the work between Nottinghamshire Police and mental health services.

What will this mean for people who use services?

People who use services report a strong feeling that they are often passed between services where there are questions about which service criteria they best fit, and some people's needs do not meet the criteria of any existing service. An integrated system needs to develop ways of meeting the needs of those who either fall between or span the different criteria of separately commissioned services that are generally focused on a single specific condition rather than the whole person. There is a tendency for services to treat discrete symptoms rather than address underlying health needs, and service users then bounce around the system between services. One service user has described this experience as being caught between being 'too mad' for one service yet 'not mad enough' for another. There are gaps in provision here that are only likely to lead to people presenting in a more advanced condition. Access to services needs to be both improved and simplified, and consideration should be given to integrated access mechanisms such as a single point of access.

Key outcomes

At its core an integrated system infrastructure requires funding arrangements that allow finances to be shifted between services to give the maximum clinical impact in a cost-effective way. The perspective of mental health services must contribute to overarching STP work on system financial flows, including contracting models and risk-gain share mechanisms.

There needs to be shared responsibility across all partners - including, health, social and voluntary sectors- with equal involvement in system re-design consultation and resource decisions. There is a joint responsibility for service users, particularly those that may not fit the criteria of a service and may therefore require more tailored support. Given the financial constraints faced by the voluntary/community services, the STP has a role to play in developing, enabling and strengthening the sector as an equal partner in delivering mental health and wellbeing.

The outcomes we want to generate under this pillar are that:

- Those accessing the services in the system report that:
    - They understand the system, it is clear, they know who is responsible for their care, and it is easy to navigate,
    - They are experiencing improvements from the care they receive in terms of outcomes and clinical effectiveness,
    - They feel that services are flexible in meeting their needs, rather than their needing to access multiple different services, and
    - They have a positive experience of using the services in the system.
- There is increasingly joint and integrated commissioning against a shared set of outcomes metrics;
- Health outcomes are improved within the available resource levels;
- Appropriate service-user information is accessible to providers across the system, enabling the most appropriate, holistic response in line with agreed plans (including in crisis);
- The system is financially stable and mental health funding targets are met or exceeded;
- Contractual arrangement and financial mechanisms are in place that enable the right care to be provided at the right time without service users being passed between services;
- There is a comprehensive service offer which is fit for purpose;
- There is clear governance and decision-making at neighbourhood, place and system level, and clarity about the services to be delivered at each level;
- There is a proactive, universal service offer for low-level mental health conditions;
- The increased integration of the voluntary and community sector in service provision increases the impact of the sector on service user outcomes and provides a source of innovation for the wider system;

- A mental health workforce plan is in place that is providing the workforce currently required and building the roles required in the future.

Key actions

Many of the actions under this pillar will need to be advanced in harmony with wider STP work on developing the required system infrastructure and supporting mechanisms. In order to generate the outcomes defined above, the following key actions will need to be advanced:

1. An outcomes framework will need to be defined that informs how services are shaped, how funding flows and how further improvement efforts should be focused. It will be important this this framework directs attention to the indicators most closely associated with the transformation required and that provide actionable insights for frontline teams.[12] Where systems are injudicious in what they include in outcomes frameworks they risk creating a new industry of monitoring and reporting, along with the perverse incentives that often accompany multiple targets. This could simply replace the current contracting industry rather than enabling the components of the system to orient themselves towards a relatively narrow set of useful indicators. These indicators should include key interactions between mental and physical health;
2. The role and function of each level of the system (ICS, ICP, LICP) needs to be defined in terms of mental health service provision. Alongside this there needs to be clinically-led work into the geographic and/or population level at which specific services would be best provided. Linking to the outcomes framework, this should include the identification of mechanisms through which interventions that are proving successful in one place can be considered for rolling-out across the whole system;
3. Plans should be developed identifying and implementing effective strategic commissioning arrangements that support the delivery of this strategy's vision and outcomes. Siloed commissioning generates siloed services constrained by access criteria that create gaps into which vulnerable people fall. More joined-up commissioning also has the potential to drive service improvement more effectively, including through standardising high-quality, effective care. This could be achieved through moving towards a single, integrated commissioning function. Linked to 2. above, there is also a need to make clear the distinction between strategic

[12] Guidance and examples (such as NHS Oxford CCG's mental health outcomes framework) can be found in https://www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/02/mh-quality-outcome.pdf. The Dudley MCP outcomes framework – linked to 10% of the overall contract value - also includes a number of mental health indicators: http://www.dudleyccg.nhs.uk/wp-content/uploads/2016/11/Outcomes-Framework.docx.pdf.

commissioning at ICS level (including an assessment of alternative contracting models) versus tactical supply-chain management at ICP level. Gaps and duplications in services should be analysed and addressed.

4. A workforce retention and development plan needs to be developed, building on the existing HEE work, that also embraces the workforce beyond NHS and other statutory sector employees. There is a significant opportunity here, not least in terms of the interaction between physical and mental health, to develop new roles and a specialist workforce that is better equipped to be more responsive to citizen's need. This should be an integrated exercise with social care, the voluntary sector and the wider public sector, recognising the knowledge and expertise of all staff and defining the inclusion/exclusion criteria of each service. Workforce mapping should sit alongside the community asset mapping proposed under the Integrated Place-based working pillar in order to provide a comprehensive picture of any gaps/disparities that can then be appropriately addressed;

5. Effective integrated working, and the system feedback loops that can support its organic development, will be heavily dependent on gathering and appropriately sharing actionable data and information. As part of wider STP work through Connected Nottinghamshire, there is a need to detail what that information is and to whom it should be made available, subject to service user consent. Effective and efficient data sharing will be critical to the delivery of an integrated service and system. Interoperable IT systems and data sharing agreements should support integrated working between health, social care and other services;

6. Genuinely integrated working will require action in relation to –

    a. Population health intelligence that generates clinically actionable insights – to support both service planning and care planning and coordination. This pillar should support identification and appropriate targeting of approaches to distinct cohorts through GP practices, to offer holistic support (looking at physical and mental health, as well as their social needs). Care should be wrapped around the person, with co-location and easy access – either virtually or physically.

    b. The membership, role, culture and practices of integrated multidisciplinary teams will need to be determined, and in ways that support the holistic care of patients across their physical and mental health. Colocation of services across all levels may also be worth considering as a way of improving cohesion between partners at all levels. Agreements between partners could be based upon a mental health charter that defines the purpose, vision and values underlying partnership working.

    c. Ownership by all system partners of the model for integrated working in local communities. By involving service users early on, this will equip the system

with valuable knowledge about needs and preferences and should culminate into a person-centred system at the local community level.

d. A model of care for local places that reflects the pillars of this strategy, not least its focus on prevention, trauma-informed care, community referrals, advanced care planning and service user choice and control.

7. Although relations with community and voluntary bodies are likely to be developed and maintained at ICP/LICP levels, there is also likely to be benefit from a system-wide approach to engaging with these bodies and better enabling their potential impact. In some cases this may take the form of market development (where there are contracted services they might supply); in others it will be less transactional support and development interventions (such as mapping and providing easily accessible information about community assets). There should be an emphasis on joint working with the voluntary sector and the utilisation of social interventions as alternatives to clinical options. System partners should work together to develop joint inclusion criteria that are underpinned by shared responsibility and ownership and function to ensure no service user falls through the gaps, and;

8. Investment in mental health services is due to be increasing at a greater rate than for other services. In making investment decisions, however, local strategic commissioners will need to develop a comprehensive picture of the current scale, focus and impact of spending on mental health. That analysis, alongside the intended outcomes of this strategy, will inform priorities for future investment. Alongside questions of the scale and focus of investment (including service decommissioning where appropriate), consideration also needs to be given to the most appropriate funding mechanisms that are able to support integrated partnership working and remove perverse incentives. Examples of such mechanisms include alternative contractual forms (alliance, lead provider, integrated care organisation), pooled budgets, participatory budgeting and/or risk-gain share agreements.[13] Mechanisms need to be put in place so that savings generated by opting for community services over secondary care can be invested into sustaining community initiatives. Integrated funding should support integrated commissioning and thereby create a system of integrated delivery across health and social care.

There are aspects of system working where the STP is already in the vanguard nationally. Equally, there are other aspects where there is much to be learnt from other systems. Examples cited of the latter include:

[13] http://www.strategyunitwm.nhs.uk/publications/risk-and-reward-sharing-nhs-integrated-care-systems

- The Rushcliffe vanguard which represents an example of effective service delivery directly in the home of service users;
- Fully integrated budgets and teams in London;
- The Shropshire ‘psychological’ GP model;
- The iCOPE service, delivering trust IAPT services in primary care settings;
- The Consultant Connect model in Stockport;
- The Primary Care Psychological Medicine vanguard project;
- Service integration through Forward Thinking Birmingham, and;
- The County Durham consultation process for integration and design in partnership with third sector.

7. Pillar 2: Increasing Support for Prevention, Self-care and the Wider Determinants of Health

Overview

We cannot achieve a material transformation in the mental health landscape of the STP without acting earlier to reduce the burden of mental ill health on our population. This pillar comprises the following critical areas for action:

- Working with citizens in a personalised manner to increase awareness and understanding of mental health and wellbeing so that resilience is increased and the onset of ill health is avoided or delayed;
- Working with local communities to promote and increase the local assets that can support those with mental ill health in managing and improving their conditions, and;
- Working with wider system partners, including business and industry, to promote mental resilience and wellbeing and to address the wider determinants of mental ill health.

Improving holistic support for prevention & self-care

Our local stakeholders have been very clear that prevention should be a key priority within this strategy, and that action on prevention should have a particular focus on children and young people, especially those who suffer adverse childhood experience (ACE). This aligns with the recent findings of the Mental Health Policy Commission[14] which observes that

> *The root causes of mental health problems can often be traced to adversity in childhood or adolescence, but the effects can have a life-long impact on well-being and the ability to live a satisfying and productive life throughout adulthood. The personal, social, and economic costs of poor mental health are huge, with the cost to the taxpayer alone being estimated at £70 billion to £100 billion per year (4.5 per cent of the UK's GDP). The Commission sees a compelling case for investing in the positive mental health of young people in order to build a resilient generation for the future.*

[14] Burstow, P., Newbigging, K., Tew, J., and Costello, B., 2018. *Investing in a Resilient Generation: Keys to a Mentally Prosperous Nation. Executive Summary and Call to Action.* University of Birmingham. https://www.birmingham.ac.uk/Documents/research/policycommission/Investing-in-a-Resilient-Generation-report.pdf

We understand prevention in the following terms:

- Preventing the development or exacerbation of mental ill health across the population;
- Preventing mental ill health in those with physical health problems;
- Preventing physical ill health in those with mental health problems, and;
- Preventing mental health service users from falling between gaps between services.

We see a need for a systemic culture change – moving to a system that takes a longer-term view and thinks about prevention rather than treatment alone. In this system, there would be empowered communities with resilience in individuals, families and communities. People could speak to anyone about mental health and difficult conversations would be normalised.

Anticipatory interventions that seek to build resilience have the potential to create a significant impact, and opportunities for these should be considered from post-natal care and pre-school care and education onwards. Nottingham City, for example, was an outlier identified in our baseline review in terms of providing insufficient support in schools for prevention/early intervention. It is vital to get this right with children and young people so co-design is at least as important here as in other pillars.

Where children and young people have experienced ACE, we know that this can impact their long-term mental health but also that early intervention can mitigate this. This means that children and young people services need to be quickly and appropriately accessible to children and young people in need. Such support needs to recognise that some children and adults develop personal resilience in response to ACEs and that, if built upon, this can be empowering in an approach that fosters self-care, and enables self-awareness, self-reflection and self-efficacy.

Within this work, there is a need to look at transition points (e.g. CAMHS to adult mental health) and to focus on areas that need strengthening (e.g. suicide prevention, social isolation, vulnerable groups such as people leaving prison).

Stakeholders noted the potential to draw on expertise within CAMHS services and schools to address some of the factors that contribute to mental health difficulties. In children and young people's services, every contact with a child should discuss wellbeing. The impact on children of adults in the home environment struggling with mental health problems or substance use also needs to be considered and could be incorporated into assessments. There is also a need to ensure young people who are not in education are not missed.

The prevention of mental ill health is a consideration for all age groups, not only for children and young people, so a 'life-course' approach to prevention is needed.[15] There needs to be a high-level commitment to the prevention agenda across the STP and its wider partners, to drive a consistent approach. There need to be better wraparound services in each locality to enhance self-care, independence and resilience, and Primary Care staff (not just GPs) can be key to much of this. In addition, the community and voluntary sector needs appropriate support to further extend its impact on outcomes. As well as targeted mental health support, the sector provides a huge range of local activities that can improve citizen's mental health and wellbeing, including through reducing isolation. Community referrals should be a commonly used alternative to clinical options. There also needs to be increased access to low level, responsive support to stop people's needs from escalating, as well as action to prevent suicide and self-harm.

Addressing wider determinants

It is important to identify opportunities for the effective use of resources upstream to further reduce pressures on health, social care, criminal justice and other services downstream. There is a large body of evidence, for example, which highlights the link between poor quality, unaffordable or insecure housing and mental health. Similarly, alcohol issues transcend all areas of mental health: Mid Notts is an outlier for alcohol related harm and people fall through the gaps in the system.

Whilst some aspects of the wider determinants of health may benefit from a whole-STP approach, much of the infrastructure and relationships for doing this exist at other levels. Our two ICPs and their constituent parts are best placed to facilitate integrated partnership working across sectors to mutual benefit. We know, for example, that those who are out of work are more at risk of experiencing adverse mental health and therefore to generate additional demand for health and other services. We also know that adverse mental health impacts the wider economy not just the individuals concerned. In a recent study for the Black Country and West Birmingham STP[16], it was estimated that an investment around £2 million to better support 20% of the working-age population with a common mental health conditions (18,500 people) could lead to an £8 million increase in economic output through reduced absence and supporting people back to work, and a reduction in benefit payments by nearly £1 million. There is mutual benefit to be won for local communities and the system as a whole.

Key outcomes

The outcomes we want to generate under this pillar are that:

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[15] https://www.mentalhealth.org.uk/publications/better-mental-health-all-public-health-approach-mental-health-improvement

[16] http://www.strategyunitwm.nhs.uk/publications/economic-impact-nhs-spending-black-country-full-version

- The overall demand for services, including secondary exacerbations, is reduced especially in crisis situations, as a result of work on prevention, self-care and the wider determinants of health;
- Mental health needs are being identified and addressed at an earlier stage, especially for children and young people;
- Those accessing the services in the system report
    - Feeling more empowered to manage their condition and to access the right additional support when required,
    - Receiving integrated care and support across their mental and physical health needs,
    - Being able to access primary and community mental health services in a timely manner, reducing their need to rely on crisis services
    - Experiencing a smooth and effective transition between child and adult services;
- At a perinatal stage, service users will experience improved access to support and efficient pathways for referral;
- More people with mental health conditions are able to access/remain in employment, improving wellbeing and increasing economic productivity.

Key actions

In order to realise these outcomes, collaborative action will be required in a number of areas:

1. Each local community (LICP and/or Local Authority District) will be best placed to coordinate local work to address the wider determinants of health. This will require a scale of open, collaborative working that goes beyond the integrated team working required for delivering health and care services. A wider partnership, including local businesses, will be required to identify locally-appropriate ways of increasing opportunity, wellbeing and economic value.
2. An STP-wide, life course approach to prevention should be agreed for application in each local area. This should include a particular focus on engaging children and young people, and those who work with them, to promote awareness and resilience (such as mental health first aid type approaches) and to make routine enquiries into adversity in childhood (supporting early disclosure and enabling early intervention). The STP should also facilitate the further development of accessible resources that detail community assets – both for direct access by citizens and to inform community referrals. All of this will need to be based on robust evidence.

3. The earlier identification of need has to be complemented by the accessibility of appropriate services where external support is required. Each locality is likely to need to develop a granular understanding of population need and to assess its service capacity in the light of this. Consideration should be given as to where direct access to certain services can be provided, especially where this is specified in agreed care plans. Opportunities to provide more specialist services locally should also be explored.

Capacity in primary care can be augmented with support from Community Psychiatric Nurses, self-care/life coaches, befrienders and assertive outreach roles, amongst other mental health professionals. Where possible, peer support/ peer networks, life coaching and experts by experience should be offered to service users to supplement clinical support. Community crisis cafes have already been established across the country and have been well received by service users as a means of receiving support. This could be replicated in Nottingham. Self-management should also be encouraged and supported, with a defined post-crisis recovery plan jointly developed with the service user. Clear detailed pathways for post discharge transition into the community need to be designed with input from community partners. Offers of alternatives to hospital admission need to be developed. Lessons can be drawn from the Edwin House accommodation model for homeless people currently available in Nottingham.

Community support services have a role to play in offering service users advice around housing, finances and education. Service users should ultimately know where to go and what to access based on what is available. Care coordinators, link workers or community navigators can support service users to access community services to address their needs. Alternatively, with such a diversity of community services available, a single point of access and effective signposting procedures may need to be put in place to ensure service users can effectively navigate the system autonomously.

Co-design/co-production will be of crucial importance to this work and should involve the voluntary/community sector and independent advocates: there needs to be a shift in language and behaviours away from the ‘medical model’ for this to be successful, and an approach that is adaptive and builds on the evidence of what is working well. Potential areas of focus could include early intervention services, loneliness, housing, parental difficulties, substance misuse, childhood trauma, crime (especially victims of sexual violence) and homelessness[17].

As local models are developed, there is a range of examples on which they can be built, for example:

- The Leicestershire model of ‘social prescribing’;

[17] The City Council has been working on a Homelessness Prevention Strategy that might support this work.

- Bradford's primary care MDT for frequent users, long term conditions and those with medically unexplained symptoms;
- The PRISM service in Cambridgeshire & Peterborough that allows step-up from primary care or step-down from secondary care with rapid re-access, and;
- The Blackpool model for frequent users of services.

In addition, work on this area will need to align with and build on:

- Existing NHS and Local Authority prevention strategies, and;
- Local Transformation Plans for Children and Young People's Mental Health (LTPs).

8. Pillar 3: Implementing a Person-centred Approach to Physical and Mental Health

Overview

This pillar addresses the need to move towards parity of esteem and practice in relation to the physical and mental health needs of citizens. The differentiation of need into mental and physical categories is an historically established framing device but one that does not reflect underlying human reality. Moreover, it can inhibit a full understanding of the causation and interactions in the mental and physical health of an individual or a definable cohort. The model below suggests a basic way of differentiating cohorts of need (see **Error! Reference source not found.** 14). As the STP develops its population health m anagement capabilities, these should inform a more holistic view of cohorts of patient need that are not constrained by historic service-based silos.

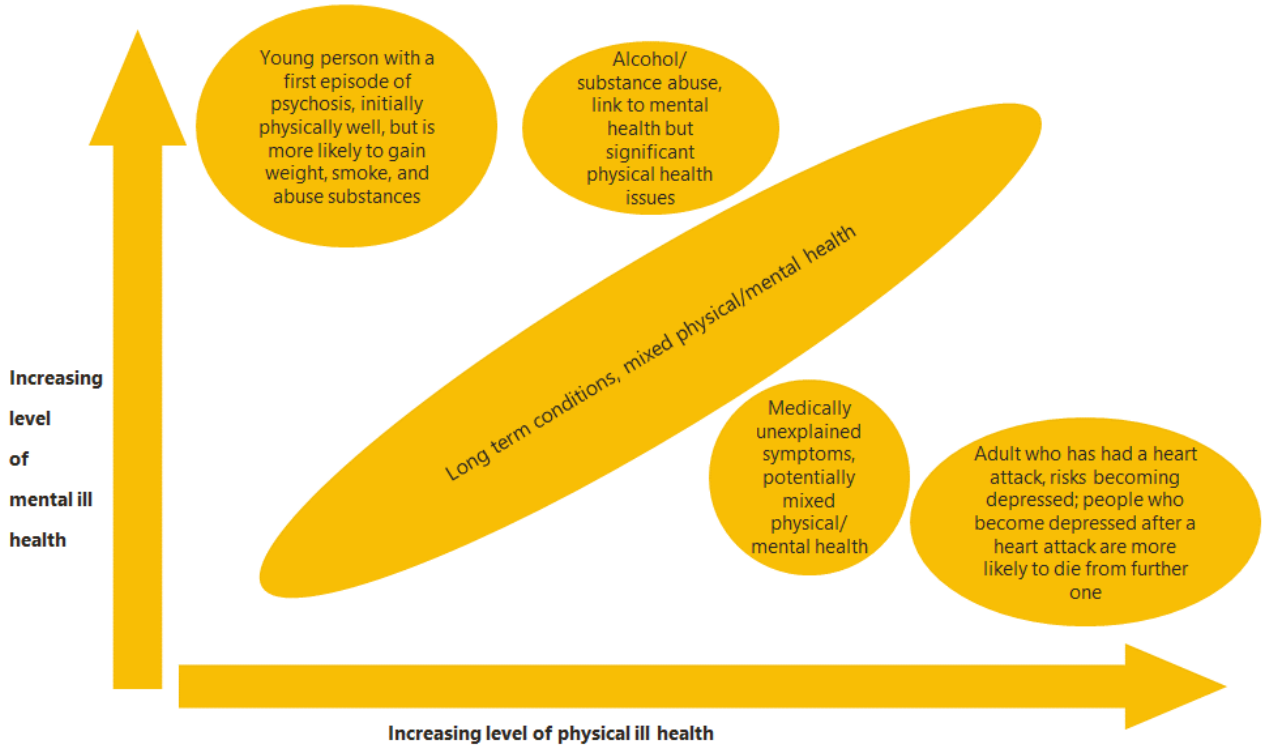


Figure 14 - How physical and mental health interact - a basic model[18]

Our baseline analysis identified that the STP has significant gaps in life expectancy for mental health service users compared to rest of the population (although this gap is

[18] https://www.strategyunitwm.nhs.uk/sites/default/files/2018-05/How_physical_and_mental_health_interact__A_basic_model.pdf (adapted)

smaller than in comparable STPs). It also demonstrated that mental health service users generate 19% of all A&E attendances and 26% of all unplanned admissions to hospital. Usage is especially high in those with personality disorders.

There need to be coherent pathways of care for people, integrating mental well-being, mental health and physical health. These pathways begin with supporting physical and mental health for people in the community, such as community support groups for people with diabetes, community referrals, self-care and self-management, and screening.

In primary care and community services all staff need to be skilled and feel confident to have conversations with patients about mental and physical health. A community nurse dressing an ulcer might ask the person about their mood, and a mental health nurse giving a depot injection might ask the person about their blood pressure and drinking.

Across the secondary physical and mental health system, acute admission pathways need to be strengthened. Trauma has a significant impact on entry and exit from emergency/acute care and on elongated periods of treatment. People are not getting timely admission to hospital and ambulance response times are 4-6hrs. The police are regularly called to A&E where patients have become distressed by waiting times combined with the environment and either leave or become volatile. This may lead to the use of the Mental Health Act, or in some high-risk cases, raises the risk of suicide or other harm.

Work in this area needs to go beyond a simple focus on reducing A&E pressures, however, as the model above illustrates. Integrated, holistic approaches appropriate to the need of each identified cohort should be defined.

To deliver effective joined-up physical and mental health care it is crucial to design joined up care pathways across the services including general practice. These can only be delivered within a commissioning and funding structure which is built on ‘triple wins’: for the service users whose mental health and physical health needs are met together; for the services who do not waste time bouncing people around the systems, and; for the commissioners in being able to utilise resources more effectively.

Thinking with regard to Long Term Conditions needs to develop in order to understand how we can manage the increasing physical and mental health comorbidity in terms of complexity and better understand and work with the interactions between the two rather than treating them as separate entities.

Key outcomes

There should be focus on parity of esteem between physical and mental health, such that all health and care staff consider and assess mental health and wellbeing alongside physical health in all services and contacts. This is key to prevention as well as coordinated, effective and efficient care.

Integration should be seamless across community, primary, secondary and acute care services. This could include the colocation of a broad range of services (not just within health and social care) within locality hubs in order to provide holistic, 'one-stop shops'. The potential for whole-system, integrated crisis management responses could also be explored to reduce levels of conveyance to A&E in favour of more suitable 'crisis house' responses.

Stakeholders described a person-centred, bio-psycho-social model in which:

- Health and care professionals are alert to the broad range of service user concerns and needs;
- Services are flexible to meet needs, with co-produced care plans that embrace the multiple factor affecting individual health and wellbeing and;
- Relevant service user information can be proactively shared between services appropriately.

The logic model below (see Figure 15) is taken from a national analysis of the potential benefits of an integrated approach to mental and physical needs.[19]

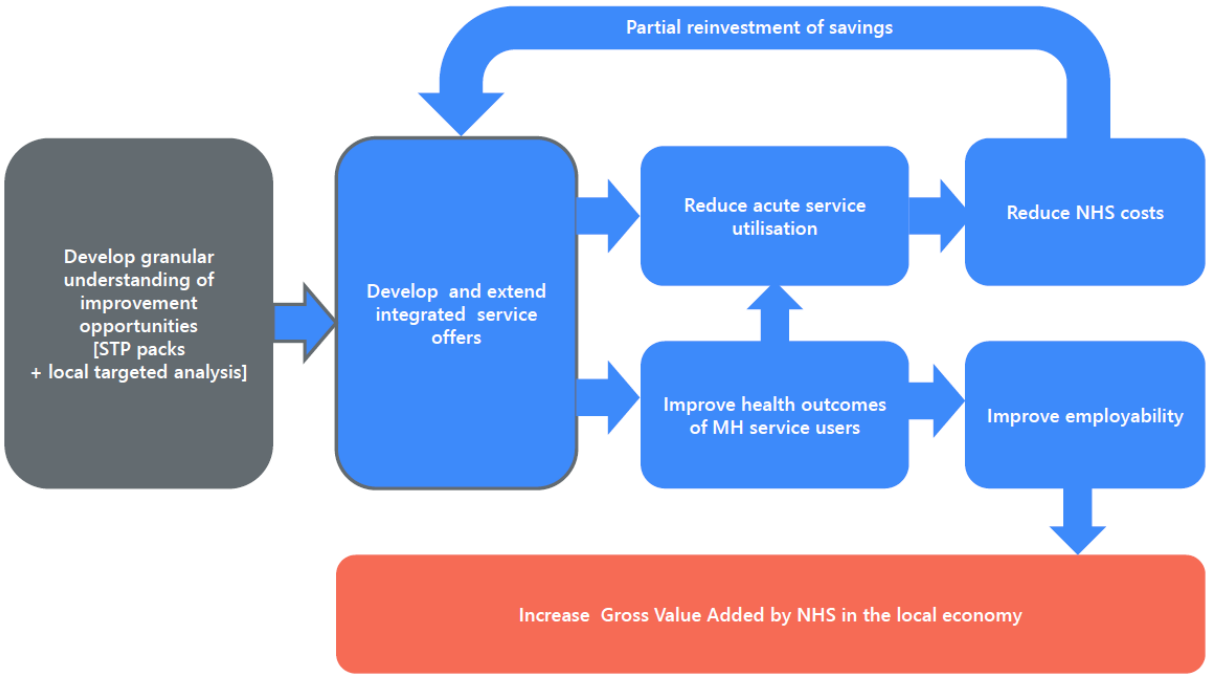


Figure 15 - Strategy Unit integration logic model

[19] http://www.strategyunitwm.nhs.uk/publications/making-case-integrating-physical-and-mental-health-services-england-national-overview

It provides a frame around which more specific local outcomes can be developed for each of the cohorts identified in Figure 15 above. Additional outcomes could include:

- Citizens report that their needs have been met 'holistically, specifically including physical and mental health;
- Citizens report higher levels of engagement in community activities which support their health, and;
- Staff report confidence in asking about both physical and mental health.

Key actions

Access to physical health, mental health and social care should be available in the same place at the same time for every routine enquiry into both mental and physical health needs. The locality model, i.e. the concept of a locality hub, may prove useful for improved integration between physical and mental health.

1. There needs to be integration of physical and mental health practitioners into unified teams. Primary care and secondary care should have in-house specialist support from mental health practitioners (liaison psychiatry services) to supplement physical health care delivery. The workforce should be supported to develop skills and expertise in mental and physical health to support delivery in these areas. This includes mental health staff developing knowledge of physical health care and making it the responsibility of all professional staff to ask the necessary questions and signpost appropriately. Lessons can be drawn from the Rushcliffe vanguard where significant work has been done to integrate mental and physical health care services, and national guidance is available on improving physical health care for people with severe mental illness in primary care.[20]
2. Shared and integrated pathways between mental and physical health care should be developed and understood by staff across the system. It may be necessary to utilise the skills of pathways design teams to ensure seamless links between services. Access to beds and timely conveyance should be considered as part of the pathway redesign. Shared care records or a 'health passport' that constitutes details of mental and physical health care needs, diagnoses and treatment should also be developed for use by the service user and staff across the system.
3. There is a need to better understand the local pressures on A&E and hospital admissions relating to mental health service users. This investigatory work (drawing on existing analysis where it is available or involving a bespoke audit where it is not) should inform future work on admission avoidance strategies. One potential solution

[20] https://www.england.nhs.uk/wp-content/uploads/2018/02/improving-physical-health-care-for-smi-in-primary-care.pdf

is the use of a 24/7 mental health/wellbeing 'hub' at A&E for adults as well as children and young people who do not need admission but are in crisis. The hub would provide a support function to service users, setting them up with appropriate community support post crisis. Housing officers, in-reaching to acute mental health admission wards may also prove a useful option to address housing needs of service users. Careful consideration needs to be taken however, to minimise dependency on crisis support through improving access to primary and community services.

4. There is a need to recognise that 95% of people with mental health problems are prescribed medicines. Medicines optimisation needs to be a key theme within the workplan. Priority areas appear to be:
   - Prescribing and communication across the interface i.e. admissions and discharges e.g depot antipsychotics and melatonin.
   - De-prescribing and polypharmacy
   - Procurement.

5. Effective and efficient funding arrangements need to be put in place for successful integration of mental and physical health care services. This is discussed in more detail under Pillar 1: Establishing Integrated System Infrastructure. For there to be an effective and efficient emphasis on parity of esteem in service delivery, there need to be consistent specifications/service models commissioned across the system.

6. An 'ask' scheme, where services working on the physical/mental health interface can ask and offer each other help to develop their shared learning and expertise, should also be considered.

Stakeholders also felt there should be consideration of:

- Diet and wellbeing;
- Impact of childhood experiences on physical health and mental health;
- Impact of professional training, such as separation of specialisms;
- Leadership that emphasises the 'whole person';
- Management of expectations/time/permissions;
- Assessment of outcomes and impact;
- Wider community support for health and social needs, and;
- The potential for two-way identification of problems (e.g. families in children and young people's services and trauma informed care).

9. Pillar 4: Improving Access to Specialist Services

Overview

Providing the right care in the right place and ensuring that service users get the support they need when they need it is a clear priority for this pillar. We also heard from stakeholders of the need for a culture in which, from the service user perspective, there is 'no wrong place' where they would be turned away without being helped to access the right support. Its focus is on the provision of services beyond the local level, including effective pathways into and out of more specialist services. An example of this is unwarranted out of area placements driven by capacity issues rather than clinical need. This currently affects over 30 people across the STP: it risks adversely impacting service user outcomes; incurs unnecessary additional costs on commissioners and on carers, and; disrupts the provision of locally integrated care. Resolving this issue requires collective action.

Stakeholders felt that the first priority here should be on the urgent care system as this is perceived to be failing currently. Any proposed changes would need to consider previous business cases (for example the 'blue light' hub), the crisis concordat and social care proposals where significant work has already been undertaken. There was also an ambition to explore population health in more depth, so that conversations became more about total value rather than narrow financial impact.

Our analysis of the current position identified Nottinghamshire as having one of the lowest rates of access to children and young people's services across the country. This is clearly then an issue where this strategy could generate significant impact. This is a challenge that needs to be advanced with ICPs, and across the age-spectrum, so that more services become available more locally and can be accessed more quickly (where the need dictates). This could include increasing the specialist input available in local communities, as well as increasing access to low level, responsive support to avoid conditions escalating and to prevent suicide or self-harm.

Local services need to make sure that people with multiple and complex needs aren't excluded from accessing help. These are some of the most vulnerable people. There need to be targeted approaches to reaching vulnerable groups such as the homeless and victims of sexual violence, and these approaches will need to be flexible, innovative and tailored to specific needs (including the needs of black and minority ethnic citizens[21]). Local partnerships will also need to take a broad view of access that isn't limited to a

[21] Some work is already underway through a Community of Practice formed as a result of work by the City Council's Health and wellbeing Board.

single service because we know that access issues in one service lead to pressures manifesting in another service (e.g. A&E).

Local services also need to be designed and managed so that people with multiple and complex needs are not excluded from accessing help. We need to be certain that there is adequate provision of evidence based therapeutic options for the whole population and that we continuously evaluate and build our own evidence base in order to improve.

Issues of transition between services also need to be addressed, particularly the transition from children to adult services. This is not simply about smoothing the path from one set of services to another but revisiting how services are configured in the first place. Where services are family-based and person-centred, the issue of transition between age-based services falls away.

The aim here is to create a system that provides an integrated mechanism for facilitating 24/7 access for service users, including those with multiple complex needs. Whilst this may not equate to direct 24/7 access to every service, it needs to provide a safety net such that no service user will fall through the gaps between services or their operating hours. There will be collective, system wide ownership of the service user and responsibility for their needs and preferences. This will be delivered as part of a wider system approach that crosses borders and boundaries. We need to ensure that citizens have access to the right specialist services when they need them – most especially when approaching or enduring a crisis phase. Particular care needs to be taken to ensure that this is the case for more vulnerable citizens including those who are:

- Homeless[22];
- Victims of abuse or sexual violence;
- At risk of suicide or self-harm;
- Living with a dual-diagnosis;
- Veterans;
- Students (especially around transition issues)[23];
- Black or minority ethnic;
- Refugees, or;
- Within the criminal justice system.

[22] The City Council has been working on a Homelessness Prevention Strategy that might support this work.
[23] 1 in 3 students experience clinical levels of psychological distress and 75% of all mental health difficulties develop by mid-20s.

Mental health service provision should be based on a model of 'care and place', addressing the housing as well as care needs of service users, particularly during periods of transition to the community.

Person-centred care that is recovery focused should be delivered by a compassionate workforce at the first instance, wherever and whenever needed. Stakeholders highlighted a need to support and train the mental health workforce to deliver on a core set of expectations for the service in every place. This would require everyone in the system to acknowledge ownership of mental health, creating a social movement which leads to culture change (see also Pillar 5: Equipping a Mental Health Aware Workforce below).

Overarching STP infrastructure (see Pillar 1: Establishing Integrated System Infrastructure) will need to provide leadership in support of this work, including clear mechanisms for escalation and resolution when there were complex multi-organisational system issues.

Key outcomes

Key outcomes sought from delivering the right care in the right place are:

- Timely access to inpatient beds, reduced out of area placements and reduced delays in transfers of care;
- Reduced use of the Mental Health Act;
- Proactive, holistic care for higher-risk cohorts;
- Clear pathways for care, with routes in and out of them, which may not need to go thought GP gatekeeping, but which can flex to meet individual needs;
- Users will have been involved in the design of the pathways and/or networks of care;
- Care coordination along defined pathways is underpinned by a coherent single IT system, and;
- There will be effective crisis structures in place across the system.

Key actions

Action will be required in a number of key areas to ensure better provision of the right care in the right place:

1. Map current service provision, including the third sector and voluntary agencies, and look to expand call for care to include mental health as well as physical ensuring people are signposted to the right place.

2. The workforce will play a key role in ensuring this pillar is implemented successfully. For right care to be delivered in the right place, the workforce needs to be aware of what the system is capable of offering at all levels. Protocols may support effective delivery by the workforce, particularly around people with multiple complex needs. Joint training across the system will also ensure consistency in service delivery, whilst also encouraging knowledge exchange and shared learning. Capacity and capability of the workforce must also be assessed and supported as expectations of service delivery rise. Stakeholders highlighted a need to move towards a culture of 'pull' rather than 'push away' of service users, and the Nuka system in Alaska provides an example where there has been significant progress made around workforce culture.

3. Whilst the workforce will play a role in ensuring service users do not fall through the gaps, the service user will also be expected to manage elements of their own care. For this to happen effectively, service users need to be equipped with wider knowledge of services available in the community. Engagement of service users will facilitate their knowledge of the system and will ensure the system is designed to be better understood and easily accessible by service users. Care for service users should be centred around key milestones and goals to ensure services can support provision of right care at the right time;

4. Clear pathways will need to be adopted across the STP that are supported by

    a) Funding flows that do not introduce barriers to access or perverse incentives, and

    b) Information systems that facilitate coordinated care in line with agreed pathways and individual care plans, and that support the identification of specific cohorts of need.

5. Work will need to be undertaken to better understand and manage the urgent care pathway in order to address the level of out of area placements currently being experienced. Lessons can be drawn here from the utilisation management work undertaken for CAMHS beds in Birmingham that was targeted at reducing out of area placements;

6. A specific focus will be required on a number of vulnerable groups: a 'perfect' pathway that fails to reflect the reality and complexity of their circumstances will rapidly fail. There is a need to confirm a set of priority groups whose experience should be more closely attended to. Pathways can then be reviewed and enhanced so that the most vulnerable experience the best targeted services.

10. Pillar 5: Equipping a Mental Health Aware Workforce

Overview

We recognise that in order to create a transformed mental health landscape across the Nottinghamshire STP – with more responsive services that enable easier access and improve service user outcomes and experience – we need to enable a step change in the impact of our workforce on those citizens who have emerging or ongoing mental health issues. The change that is required is not limited to those working in mental health services – or even to those working in wider health and social care services – but to the majority of those working within statutory and voluntary sector organisations. Action in this area will support prevention, enable earlier intervention, reduce stigma and improve experience. 'Mental Health First Aid' provides an example of the approaches that can be taken, and stakeholders highlighted that the Department for Work and Pensions has been pursuing this with its workforce. Similarly, for children and young people, approaches such as 'Routine Enquiry about Adversity in Childhood' (REACh) piloted in Blackburn and Darwen offer ways of enabling earlier disclosure and, hence, earlier intervention by the appropriate specialist service. Public Health England has reviewed a range of approaches in its *Mental health promotion and prevention training programmes* publication.

Wider challenges around recruitment and retention in existing and emerging specialist mental health roles are addressed under the Integrated System Infrastructure pillar. Both elements will also need to be taken forward in partnership with the STP's overarching workforce workstream.

We believe that the proposed change in the non-specialist workforce needs to include:

- A **cultural** shift so that all staff see the mental health of citizens as their business – understanding the issues people face, the support they may need and the resources available to provide that support;
- The protection of adequate **capacity** in defined roles (e.g. 'front door' staff in GP surgeries, job centres, housing departments) so that staff are practically able to respond more appropriately to those with mental health issues;
- The promotion of an ethos of **compassion** for those coping with mental ill health (including the mental health impact of physical health conditions), and;
- The development of core mental health **competencies**.

Key outcomes

This pillar is focused on generating a shift towards the improved recognition of, and responsiveness to, mental health issues across the public, charity and voluntary sector workforce. For this pillar to be a successful component of the overarching strategy, we

know we must work closely with key partner organisations to engender broad and enduring local commitment.

The aim is to create a workforce that operates on a person-centred approach, keeping the citizen's holistic needs at the centre of all interactions. There is a particular need to embed this approach in services more likely to be working with vulnerable groups who are more at risk of mental health issues developing or becoming exacerbated. This includes the unemployed, the homeless, victims of crime (especially sexual violence), those within the criminal justice system and children and young people.

The outcomes we wish to generate under this pillar are that:

1. Those accessing public and voluntary sector services report that
    - their mental health needs were appropriately considered
    - they were treated with compassion;
2. Staff report feeling more comfortable and better equipped to respond appropriately to citizens with mental health issues;
3. The development or exacerbation of mental health conditions is prevented;
4. Specialist mental health staff report receiving more appropriate referrals;
5. Users of mental health services report
    - experiencing reduced stigma in accessing other public/voluntary services
    - being actively signposted to other appropriate sources of support
    - being helped to access specialist help in a timelier manner.

Key actions

In order to generate the outcomes defined above, the following key actions will need to be advanced:

1. System partners will need to work together to define the workforce groups that should be prioritised for support in enhancing mental health awareness, understanding how best to demonstrate compassion to those with mental health conditions and knowing where to signpost them for further support (including how to report serious concerns to relevant statutory services). The skills set expected of defined workforce groups will need to be established. These groups are likely to include front-line and front-door staff but should also include senior executives and service managers;
2. Mindful of the workforce groups to be targeted and the outcomes to be achieved, partners should work together with service users and those with lived experience of mental ill health to develop, pilot and roll-out appropriate evidence-based training

programmes. The piloting phase should consider the capacity impact of the approach being tested so that treating citizens with compassion is not in tension with employees' own health and wellbeing. The programmes adopted might replicate existing approaches - such as Mental Health First Aid, Routine Enquiry about Adversity in Childhood and Making Every Contact Count – or novel local approaches might be co-designed. System partners should also the consider the potential for providing the programme(s) developed to private sector employers on a contractual basis, building on Chamber of Commerce work around workforce wellbeing. There is a demonstrable economic case for improving workforce mental health, with relatively small investment generating material productivity benefits.

3. In addition to the development and delivery of agreed workforce interventions, there will also be a need to undertake significant workforce, service user and public engagement around this pillar. This should link to the wider communications work of the STP.

4. In order for non-specialist staff to best support those with mental health issues, there needs to be an easily accessible and up-to-date source of information about where to go for help with specific needs, across the statutory and voluntary sectors. Linking to work under Pillar 1: Establishing Integrated System Infrastructure, systems partners will need to ensure that comprehensive information about the community assets available in different areas of the system. In certain circumstances, local partners might consider colocation of relevant support services.

5. There is a need for STP partners not only to instigate new approaches but also to introduce mechanisms that support them in creating a self-improving system. This means that there should be appropriate monitoring of the delivery and outcomes of the approaches agreed, as part of an overarching evaluation plan. The benefits from this would not only further improve the Nottinghamshire experience but also inform the work of STPs that are less developed in this area.

11. Next Steps

We believe that this draft strategy represents a major step forward in our collaborative work to transform the mental health landscape in Nottinghamshire. We have identified a key set of priority actions (our pillars) for us to take forward together as STP partners. In the process of doing so, we have strengthened and enriched the bonds between us.

At the same time, however, we recognise that this strategy only sets the frame for the detailed work that we now need to undertake together if we are to deliver the envisaged transformation.

We need to enlist the support of key colleagues from across the system who will, under the Integrated Mental Health and Social Care Partnership Board, form a number of delivery groups to work together in turning this strategy into realistic, robust and actionable plans. During Q3 of 2018/19 we will, therefore:

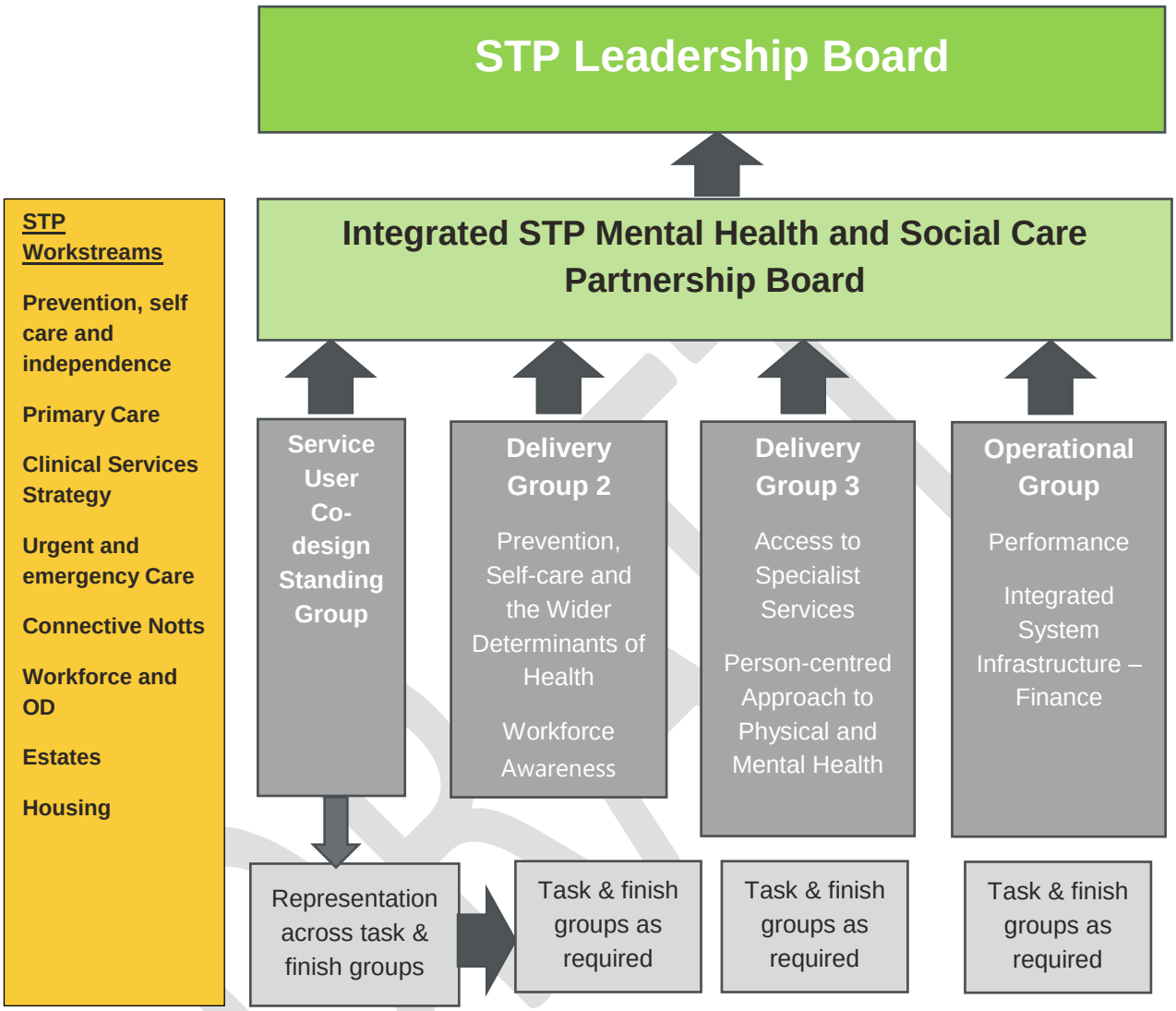
- Constitute our strategy delivery groups;
- Continue engaging with stakeholders and citizens around the approach set out in this strategy, and;
- Develop an integrated delivery plan that brings together the work planned by each of the proposed delivery groups.

As this work advances, each delivery group will also need to maintain close liaison both with other Mental Health delivery groups and with other relevant STP workstreams (including those advancing parallel strategic work in relation to clinical services in the acute, community and primary care sectors). The leads of the delivery groups will come together to form an overarching steering group, led by a senior person designated by the Partnership Board. This is complex work involving a significant amount of liaison, so there will need to be agreement amongst STP partners about providing the required leadership and supporting resources.

To maintain coherence, focus and drive, we are proposing that there is a small number of delivery groups, each comprising a limited number of key senior staff from across the STP. Some groups will address a number of our strategic pillars because of their particular linkages and interdependencies. We also recognise, however, that these groups will need to work with a wide variety of other individuals and organisations. We envisage this happening through a combination of focused task and finish groups that will be commissioned by each delivery group from time to time, and the service user co-design group being formed by the Partnership Board.

As plans develop, the delivery groups will undertake Equality Impact Assessments as appropriate.

The figure below sets out the initial structures proposed for moving from strategy to delivery (see Figure 16). This strategy, including the key interdependencies and alignments highlight earlier (see Our Key Strategic Pillars above) form the overarching project initiation brief for the delivery groups.



Appendix 1 – Contributing Organisations

The following organisations participated in the Mental Health Strategy development workshops.

	Organisation
1.	Base 51
2.	Bassetlaw CCG
3.	Carers Federation
4.	Derbyshire, Leicestershire, Nottinghamshire & Rutland Community Rehabilitation Company (DLNR CRC)
5.	East Midlands Ambulance Service
6.	Framework Housing Association
7.	Gedling Borough Council
8.	Greater Notts CCGs
9.	Healthwatch Nottingham & Nottinghamshire
10.	Let's Live Well in Rushcliffe
11.	Mansfield & Ashfield CCG
12.	Mid Notts CCG
13.	NHS England
14.	Nottingham City CCG
15.	Nottingham City Council
16.	Nottingham CityCare Partnership
17.	Nottingham CVS
18.	Nottingham University Hospitals NHS Trust
19.	Nottinghamshire County Council - Adult Social Care, Health & Public Protection - Nottinghamshire Health & Care STP - Public Health & Commissioning Manager - Public Health NCE - SNB Programme Manager
20.	Nottinghamshire Healthcare NHS Foundation Trust
21.	Nottinghamshire Local Pharmaceutical Committee
22.	Nottinghamshire Office of the Police and Crime Commissioner
23.	Opportunity Nottingham
24.	Public Health England
25.	Rethink Mental Illness
26.	Royal College of General Practitioners
27.	Royal Pharmaceutical Society
28.	Rushcliffe CCG
29.	Self Help UK
30.	Sherwood Forest Hospitals NHS Foundation Trust
31.	The Strategy Unit

	Organisation
32.	Together Everyone Achieves More (TEAM)
33.	Tuntum Housing Association
34.	University of Nottingham

Appendix 2 – Case Studies from the Evidence Base

1. **Living longer lives: Bradford standardised physical health template**

   NHSE Guidance for CCGs (2018) Improving physical healthcare for people living with severe mental illness (SMI) in primary care: Supporting Annexes.

2. **City and Hackney Primary Care Psychotherapy Consultation Service**

   The King's Fund (2016) Bringing together physical and mental health: A new frontier for integrated care

3. **Integrated persistent pain pathway in Oldham**

   The King's Fund (2016) Bringing together physical and mental health: A new frontier for integrated care

4. **3 Dimensions of care for Diabetes (3DfD)**

   The King's Fund (2016) Bringing together physical and mental health: A new frontier for integrated care

5. **Enhanced support in primary care- Greater Manchester case management**

   The King's Fund (2016) Bringing together physical and mental health: A new frontier for integrated care

6. **The RAID model**

   NHS England Guidance (2016) Achieving better access to 24/7 urgent and emergency mental health care- Part 2: Implementing the evidence-based treatment pathway for urgent and emergency liaison mental health services for adults and older adults- Appendices and helpful resources

7. **Paediatric Unscheduled Care Pilot**

   Nuffield Trust (2016) The future of child health services: new models of care

8. **North West London Optimal Model**

   NHS England Guidance (2016) Achieving better access to 24/7 urgent and emergency mental health care- Part 2: Implementing the evidence-based treatment pathway for urgent and emergency liaison mental health services for adults and older adults- Appendices and helpful resources

9. **Primary care for secure inpatient units in west London**

   The King's Fund (2016) Bringing together physical and mental health: A new frontier for integrated care

10. **Oxford Psychological Medicine Service**

    The King's Fund (2016) Bringing together physical and mental health: A new frontier for integrated care

11. **Psychological Medicine Services in Hull**

    The King's Fund (2016) Bringing together physical and mental health: A new frontier for integrated care

12. **Physical health liaison service in Highgate mental health unit**

    The King's Fund (2016) Bringing together physical and mental health: A new frontier for integrated care

13. **LIFT psychology in Swindon**

    The King's Fund (2016) Bringing together physical and mental health: A new frontier for integrated care

14. **Joint working with police**

    NHS Clinical commissioners briefing (2015) Commissioning for crisis care and recovery

15. **Partners in Paediatrics**

    Nuffield Trust (2016) The future of child health services: new models of care

16. **City and Hackney Primary Care Psychotherapy Consultation Service**

    The King's Fund (2016) Bringing together physical and mental health: A new frontier for integrated care.

17. **Paediatric Unscheduled Care Pilot**

    Nuffield Trust (2016) The future of child health services: new models of care

18. **Connecting Care for Children**

    Nuffield Trust (2016) The future of child health services: new models of care

19. **Wessex Healthier Together**

    Nuffield Trust (2016) The future of child health services: new models of care

20. **Collaborative and integrated Local Care Record (LCR)**

NHSE Guidance for CCGs (2018) Improving physical healthcare for people living with severe mental illness (SMI) in primary care: Supporting Annexes.

Appendix 3 – Engagement Report

APPROACH

Stakeholder workshops x 3

Analysis of existing services and outcomes

Analysis of existing service outcomes and a rapid review of national and international evidence

Previous organisational engagement events

Focus groups STP Advisory Group, CRG, Social Care and other providers and people with lived experience

Relevant documents/strategies from partner organisations e.g. homeless review carried out by Nottingham City County Council, mental health strategies.

4

Design

Current

- Most participants were clear that the current system was in need of improvement as it was felt to **not be** '**fit for purpose for the time**'.
- Provider representatives considered the current system to be fragmented and with unmanageable levels of demand. They conceived any transformation that did not directly address these fundamental issues to '**border on the irrelevant**'
- Participants across the focus groups described the various inequities they perceived in service delivery and access. This included:
    - Less integrated services commissioned by the City CCG compared to the County CCG.
    - Differences in support services provided by general practices resulting in a '**postcode lottery**' for people accessing Mental Health services. For example the General Practices that were part of the Rushcliffe Vanguard
- Many participants commented on the lack of clarity and transparency around specific investment for change. Advisory group representatives viewed service redesign initiatives to be unsustainable without planned funding. Workforce representatives commented that the savings from bed closures had not been reinvested in the community as expected.

Future

- The future mental health strategy was requested to have a clear vison and actions. The vison should '**mean something to everyone**', allowing everyone to sign up to it. The strategy should be mindful of national direction and not cherry pick elements.
- There was a desire for '**vibrant**' Mental Health services for those delivering the services and those accessing them. Further changes to Mental Health services should consider:
    - A single accountable body that is accountable for the mental health service
    - A coordinated response with services focused on the patient pathway.
- Future services should be **equitable** for the population with an emphasis on
    - prevention
    - acute need (social prescribing for non-acute)
    - physical health needs
    - aligning service offer with patient flows
    - alternatives to admission
    - targeted support for areas of deprivation (Opportunity Nottingham should be examined as a model).
    - equal/relevant distribution of workforce
    - Transition from children to adult services
- There needs to be appropriate and sustainable investment across the system. This requires an '**investment to save**' mindset, and longer term funding plans.

7

Delivery

Current

- Participants were able to point to good Mental Health services currently in operation but were frustrated that these were only available in some areas:
  - Nottingham City has a wraparound Mental Health early assessment and specialised support services. The service was in high demand but challenged by limited resource.
  - Principia Partners in Health as a MCP vanguard was able to offer enhanced mental health services across primary care in Southern Nottinghamshire. National investment in vanguards ended in March 2018.
  - Community psychiatry liaison teams, social reablement and supported living services were perceived to be working well despite their limited capacity.
- All services had to '**raise their game**' to exist in an unstable environment. This was in parallel to additional demand for current services.
- The lack of a single point of access, clear pathways and high demand was linked with patients '**ping-ponging**' or '**bounced around**' different services.
- There is a long waiting list for any available Mental Health service (and no support within the waiting period). Crisis services for older adults and support following first diagnosis were singled out for improvement need.

Future

- Practitioners across health and social care reflected that their previous usual way of joint working (which had ended with austerity pressures) could be used to rebuild the culture of collaborative working. Specific recommendations included:
  - Improving relationships between team members, including through contractual mechanisms. Getting to know the people in the different services. Cultivation of individual level relationships between different organisations is required
  - Shared goals. Move away from a threat system which encourages protectionism behaviour by leveraging relationships
  - Reinstate joint assessments so that there are dual health and social care assessors to avoid '**just passing the buck**'.
  - Colocation of health and social services or physical proximity to enhance working relationships.
  - More involvement of the third sector was advocated, especially in prevention.
  - The ability for professionals to access one another's organisation in a timely way
- To enable the service user to access appropriate care there were a number of suggestions:
  - A "named worker" to support the patient in community settings, especially following discharge
  - The presence of specialist mental health (as well as social care) within the general practice to provide routine mental health support, for example to those with long term physical conditions at risk of depression or to manage the first contact with health services more appropriately for those with mental health concerns.
  - A 24/7 service for the prevention-crisis pathway
  - A patient-centred pathway, such that staff flexibly meet needs such as visiting patients in their homes or being more persistent when patients Do Not Attend their appointments
  - Better community transport links to ensure equitable access.

8

Management

Current

The current management of the Nottinghamshire mental health system was perceived to be complicated by multiple players. This further challenged the coordination of services and their governance especially as the different commissioners had differing priorities and funding streams. Specific concerns raised were:

- A perceived lack of interest from health commissioners to engage in Mental Health matters.
- Management of demand when there are fewer beds in the system
- The financial implications for bed closures as savings don't appear to have been reinvested in community

Clinical workforce representatives were highly critical for Mental Health Trusts' management of workflow. An external consultancy Meridian) had provided a process for time and motion analysis, which awarded points for appropriate time utilisation on specified tasks.

Whilst the intent for efficiency was commended, the utility of was **'toxic'** to staff morale as it was stated to be used to performance manage. As discretionary effort was not only unrewarded, but penalised with respect to time, staff were unwilling to spend time in activities that did not have points associated with it. Further criticism was the burden it placed on team managers especially as it required paper and pencil data entry **'when everything else is in RiO'**

Future

Advisory group representatives were best placed to comment on how to create a future **stable commissioning environment**. They recommended a pooled health and social care budget for the Mental Health system in parallel to strengthening relationships across system commissioners and providers.

Accountability of providers was expected to be through:

- Key Performance Indicators
- Patient experience data which was used for decision making
- Outcomes based commissioning contracts such as crisis teams being paid by the number of people they keep out of hospital (example of South of England).

Enablers of delivery were suggested to be through managing:

- Perverse incentives
- Aspects which need disinvesting – e.g. those that only exist because of national targets
- Robust Mental Health specifications for secondary care.
- Structural improvements – e.g. through commissioning IAPT services comprehensively to meet the need of the system

9

People and Communities

Current

Most participants were in agreement that engagement and consultation activities with the public was in need of improvement; co-production was in the main, absent.

Those involved as service users felt that their involvement was **tokenistic, they weren't listened to and they were not representative**

For practitioners, the ability to offer choice was felt to be very limited, there were few if any options to offer. Where there are options, staff don't feel they had time in the consultation or assessment to explain these options.

For some, the ability to provide patient-centric services were constrained by contractual obligations.

There was lack of training and support for service users and carers to self-care, despite the national rhetoric for health to be the responsibility of individuals.

It is known that where families are supported, individuals are more engaged in their own care. Courses should be run outside of working hours Future services in hub models should be community based (accessible to all) and in welcoming places

Future

To improve engagement and co-production the main recommendation was to develop a culture of working with the community. A number of recommendations were given for this:

- Engagement/co-production has to be a core component of a system change, and has to be resourced. The previous focus on enduring relationships between professionals and person should be reinstated.
- The spectrum of mental health need should be incorporated: one size doesn't fit all, and often requires tailored support, especially following the first stage of diagnosis. Creativity and flexibility should be rewarded, for example in 'liaising and linking' on behalf of the patient
- Commissioners need to act on their consultation exercises, by contracting against what people want. They can and should manage expectations by being transparent about the difficulties of the services, including cuts and pressures.
- Community champions can be used better to talk to peers and develop material for health and social care literacy.
- Schools need to be utilised for the prevention agenda by offering education in behaviour and stigma.
- There should be more opportunities for self-referral and for people to take some degree of control in their own health.

10

Workforce

Current

It was clear from the health, social and voluntary sector staff perspectives that workforce issues impacted on the delivery of timely and relevant care. Some of the issues uncovered included:

- First points of access for those seeking mental health support are increasingly the wrong ones, that is with untrained staff. For example people with anxiety issues are presenting at pharmacies.
- Health providers were currently facing significant loss of experience, especially with some consultants leaving to go elsewhere and others retiring leading to perceived **'millions lost'** on locum doctors.
- Statutory services have been withdrawn to internal teams due to financial pressures, whereas previously voluntary sector was invested in to deliver resulting in ***"Ever more specialist services with ever less specialised staff"***
- Collaborative relationships further diminished because training for health and social care is no longer joint: signposted **'for health staff only'**.

Future

Participants of the focus groups recommended that the future workforce planning be matched with the profile of patient need, including those of an older population. Specific considerations should be:

- Safer staffing and better skill mix: the role should match the requirement through inclusion of a variety of professionals that can be accessed at a community central point for triage.
- More opportunities for training to improve skills and their application for their current workforce.
- Training for private care providers should be available – their skills should be similar to public sector providers.
- recruitment and retention strategies need to be developed

There were also a number of considerations for the primary care workforce:

- A role for key workers in general practice to support delivery of first point of call mental health services. Essential skill required would be of empathy and would act in a befriending capacity.
- Presence of mental health support professional in hubs or primary care practices (that is the onus in not on the GP, can refer in-house)
- Existing general practice clinicians need further trainimg for listening skills; opportunity to engage patient is lost when just giving a number.
- Training for GPs should include a rotation for Mental Health – at the moment this is optional, and insufficient when GPs are often the first point of call.

Leadership

Current

Participants were of the view that leadership across the system needed to be strengthened. In particular insufficient time and attention was given to patient engagement activities.

The advisory group found the STP to have little visibility **'it's a myth'**, 'As there was little perceived action, and neglect of previous work (strategies, visons for Mental Health services), any known activities of the STP were viewed as a **'talking shop'.**

Both advisory group and clinicians were frustrated by the lack of consistency and communication across CCGs **'they don't know what they are doing'**. Workforce representatives felt their input during consultation exercises was not valued.

Within the clinical workforce, leadership positions were stated to be are filled by **'lots and lots'** of secondments. Over the course of redesigns, the departmental clinical advisor roles had been lost and replaced by less experienced general managers who did not have the same credibility. This was especially difficult in the context of an overarching **'bonkers'** organisational structure for doctors in mental health trusts which allowed them to exert power and control as a profession.

Future

It was felt that the delivery of a unified Mental Health service necessitated cultural change. This change in mindset would be enabled by:

- Ownership by everyone, including first responders such as police, fire and ambulance **'We need a whole system approach, so we need to get everyone on board'**
- Consistent messaging from system leaders which encourages health and social care collaboration, such as social care joining a general practice, and are valued as members of the team.
- One organisation to lead the establishment of a local system
- Leadership which is clinical and patient outcomes led, and not based on financial decision making.
- Appropriate use of the partnership in the STP board **'get in a room'**

Technology and Innovation

Current

- Innovation was not forefront of focus group participants' mind. From a system level there was more of a call to rollout and invest in successful pilots that had already begun for equitable access rather than developing new innovations for service delivery.
- Some participants were of the view that the use of technological aids with service users has undermined the interpersonal relationships required in mental health services – e.g. online counselling was felt to be counter-productive.

Future

- Financial investment specifically for research and innovation should be made available to encourage staff to participate.
- Innovations should consider the population need. There is room for creativity with some groupings, for example young adults would be expect to embrace more readily technological innovations.
- Technological aids to support system delivery is more pressing, there was a strong recommendation a portal, accessible by health, social and third sector staff, (as well as patients, families and carers) for all services available for mental health patients, including third sector services. This portal should be.

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Knowledge and Learning

Current

- The overall knowledge of the system was deemed inadequate by many. For instance, few participants in the advisory group were aware that mental health support services were divided into specialist and geographical sectors and frontline-professionals were not aware of voluntary support services that were available to them. This resulted in those support services with a higher profile being inappropriately used.
- The current data recording burden was viewed to be **'staggering'**, it leads to **'paralysis of person contact'** for practitioners. Where recorded, it was viewed to be of **'poor'**, quality with **'little information'** about the patient's history and what has occurred.
- Data protection rules were a widespread concern; stakeholders worried about what and how much they can share, and with whom. GDPR and information governance were largely viewed to be a barrier to information sharing and therefore collaborative working.
- Independent of the information governance issues, the unlinked patient databases limited professionals from different sectors sharing knowledge of the individual concerned.

Future

- System leaders/STP can be explicit about information sharing across and health and care providers. Participants for the focus groups felt that the public was not as worried about their information being shared amongst professionals especially if they knew that it would lead to less fragmentation and **'save patients having to repeat themselves.'** It was suggested that informed consent from patients, for sharing their information with all relevant service providers, was obtained when they first became service users.
- There was a system-wide recommendation to learn from previous efforts, which required the need to capture lessons in a timely way.
- The need for quantifiable data by commissioners must be balanced with their knowledge of the appropriate measures/outcomes and must not change from year to year. For example, one participant asked **'currently PROMs are being used, how is that information used**?'
- It was acknowledged that Mental Health outcomes are notoriously difficult to measure and attribute but some suggestions were provided for commissioning for improved outcomes:
    - flexible collection of measures developed through engagement with clinicians and that are not too prescriptive, don't promote gaming and include wellbeing.
    - include non-patient measures of quality, community involvement, training and development, recruitment and retention
    - additional data collection may need to be incentivised.

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Appendix 4 – Building on the Evidence

To better understand integration in mental health services and processes for transformation, policy documents, empirical and experiential evidence were consulted to generate key recommendations to inform the future mental health strategy for Nottingham.

Methodology

Bibliographic databases and other key sources were searched for grey literature, guidance and empirical evidence from the UK setting, covering the last 5 years (2013-2018). Evidence pertaining to the transformation of mental health services towards improved integration was extracted and reported against a meta framework of eight key elements (see Figure 17, developed by the Strategy Unit as part of the realist synthesis on primary-care led integrated care models[24]. It provides a useful lens for exploring what works for integrated care and understanding how change might happen from strategic and operational perspectives.

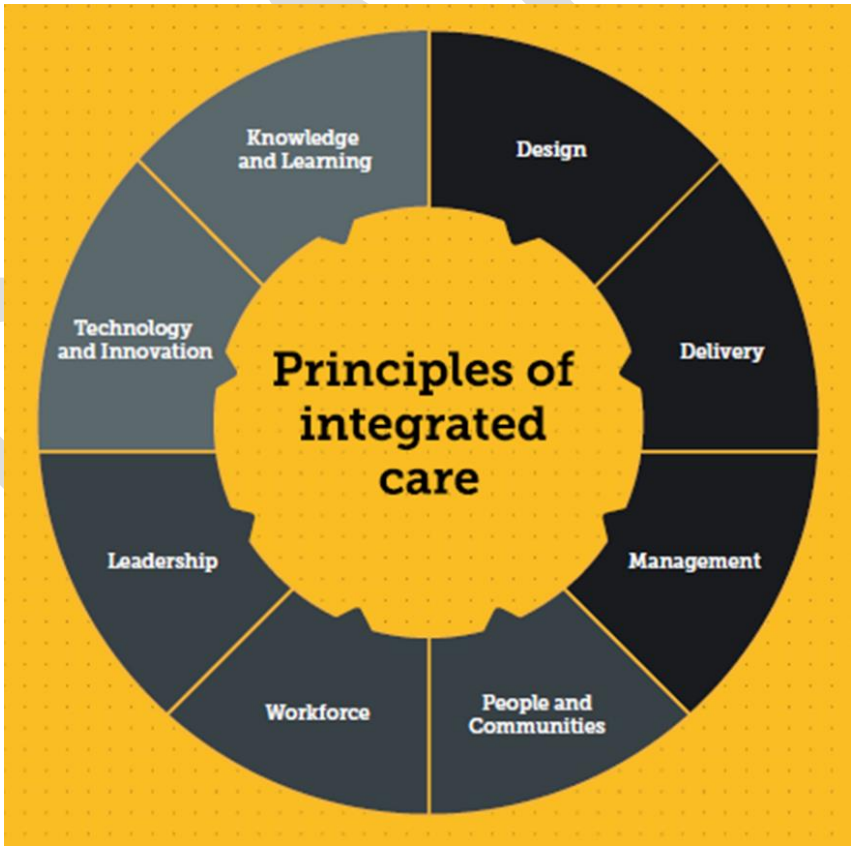

Figure 17 - Principles of integrated care

[24] https://www.journalslibrary.nihr.ac.uk/hsdr/hsdr06250/#/abstract

Results

Findings from the rapid search were presented at the first stakeholder workshop on 12th June. In this section, we present a high-level summary of the findings according to the eight elements of the meta framework, with a focus on the challenges, lessons and key recommendations. Links to case studies which provide useful examples of existing work in the area have also been included for further reading (see Appendix 2).

Challenges

This section rehearses the challenges being faced throughout the country and are not necessarily specific to Nottinghamshire.

High rates of presentation of people with a 'psychological problem' and significant levels of undiagnosed mental health problems in primary care are increasing pressures on service delivery. The rise in numbers of people with a long-term condition or medically unexplained symptom, adds to the problem. Beyond medications, GPs are often limited in the treatment options they can provide. Managing the mental and physical health needs of patients is a challenge without the right expertise, and the risk of anxiety, distress and depression arising from diagnosis of a physical health problem exacerbated the problem. Challenges also persist at a community level, with critically low levels of staff numbers and skills mix in some services, which are culminating in limited supply of services and extended waiting times for some service users. Elements of the National Service Framework evidence-based service models have also disappeared over time. The complexity of patients with long term conditions, medically unexplained symptoms and mental health conditions presenting to community services is placing increasing pressure on numbers, skills, costs and other inputs required to address and support patient needs. There are also added challenges for acute inpatient services for both adults and children and young people. The complexity of patients presenting to inpatient settings is increasingly requiring additional expertise. Patients are presenting with a combination of physical and mental health needs that may be arising as a consequence of underlying causes including:

- Pre-existing mental illness contributing to the development of physical illness;
- A psychological reaction to physical illness;
- The organic effects of physical illness on mental function (e.g. delirium);
- The effects of medically prescribed drugs on mental functions and behaviour;
- Medically unexplained physical symptoms that mask underlying mental illness, or;
- Alcohol and drug misuse.

Despite being a less favourable option, out of area placements have increasingly been used where there is a lack of beds locally. Perinatal service capacity also remains

underdeveloped. Use of the Mental Health Act is on the rise and the pressure to reduce suicide rates is ongoing.

Recommendations

Design

To improve integration across mental health services, the evidence suggests there is value in starting the process with a system wide assessment of need and identification of priorities and key influencers, including wider determinants in the local area. This is exactly what we have done in the development of this strategy.

A collaborative approach is essential, especially one that invests time in cultivating relationships between services, community groups and providers involved in care. All stakeholders should be part of the process of service re-design and transformation. For effective collaboration across multiple stakeholders, the guidance and grey literature recommends the formulation of a joint vision, or a joint mission statement, one that all parties are agreed to. This joint vision should be followed up with joint policies and processes, along with clear shared protocols that outline roles and responsibilities, communication requirements and shared care arrangements, whilst also encouraging joint working and compatibility across various systems.

New capacity and structures to support service delivery at primary care level should be considered, including GP federations, mental health in primary care and potentially reestablishment of the National Service Framework service models, among other evidence-based models. Creative approaches are required to accelerate recovery and discharge from inpatient care. Alternative options to A&E and inpatient care, such as crisis housing should also be planned and developed. The same also applies to alternative models of step down, personalised and supported living options. The prevention agenda also requires some attention starting with the identification of key clinical areas where good mental health has a preventative or life-saving impact.

Models for commissioning should be explored to identify the most effective for the context of local needs. This should inform the service specification. Financial incentives should also be considered where possible, as motivators for achieving change towards desired behaviours. For example, in Bradford and Airedale, commissioners have encouraged provision of physical health checks for people with mental illness by using a locally defined payment system (CQUIN).

Additional resources required to deliver the full package of care should be considered and planned for appropriately to support effective and efficient delivery of an integrated service.

Delivery

The evidence recommends enhanced co-working between specialist mental health serviced and primary/secondary care, for an integrated professional team that addresses

both mental and physical health outcomes. The guidance and grey literature emphasise the presence of specialist mental health services in general practices, to assist with treatment of medically unexplained symptoms, physical health and chronic disease management. In City and Hackney, a psychotherapy consultation service involves a team of mental health professionals attending GP surgeries to assist with patients with complex need. Another alternative is the use of case managers as an additional resource to bridge between physical and mental health care. In Greater Manchester, case management was delivered by trained psychological wellbeing practitioners, with positive outcomes for staff and the physical health of patients.

Liaison services play an important role in facilitating and supporting delivery of integrated health care that meets the mental and physical needs of patents and achieves positive outcomes. For example, the evidence suggests timely psychiatric liaison contributes to reduced length of stay in hospital. Examples of liaison services identified in the evidence base included:

- Liaison psychiatry or psychological medicine services across acute hospitals/physical health care settings to support professionals in managing mental health issues
- Physical health liaison in mental health inpatient facilities and community mental health teams to offer support with physical health care
- Mental health specialists in primary care
- Mental health liaison services for the frail and elderly

There is also an emphasis on collaborative care models including multidisciplinary teams which can reduce hospitalisation and have positive results for treatment adherence. One example is the 3 Dimensions of care for Diabetes service in Lambeth and Southwark, where a diabetologist, psychiatrist, psychologist and community support workers, work together to address the biopsychosocial needs of patients.

Closer working between mental health services and the criminal justice system/ forensic services, as well as other health and social care providers is encouraged to ensure a holistic package of care. In line with implementing the “Five Year Forward View for Mental Health”, prison mental health services should be supported to provide timely access to evidence-based, person-centred care, which is focused on recovery and is integrated with primary care and other sectors.

Management

Commissioners should ensure that local services have clear leadership, both clinical and managerial, and that services comply with professional and service standards. Shared governance structures that facilitate joint responsibility and accountability are encouraged to ensure: 1) greater continuity and higher quality of care; 2) better communication and more successful coordination of an integrated approach and; 3) better outcomes.

Integrated governance also requires effective communication between stakeholders. To manage integration effectively, colocation of primary care and specialist mental health services is also encouraged as a facilitator of an improved integrated response to patient needs.

Service leaders should agree a set of outcomes with commissioners, which they are accountable for achieving. Collection of softer outcomes from staff and patients can prove a useful indicator of the value of the service. Commissioners should ensure that the service providers are working to the agreed outcomes and that information is collected, analysed and presented in an appropriate way

A shared approach should also be employed to problem-solving and learning, as part of an evolving system. Commissioners, managers and practitioners should have equal responsibility for suggesting improvements to systems, practices and service provision. To this end, stakeholders should understand their respective roles and responsibilities as part of an integrated approach. For example, lessons can be drawn from guidance on the transition of children and young people to adult services, which suggests senior executives are best suited to developing and publishing transition strategies/policies, whilst senior managers should be accountable for implementing, monitoring and reviewing transition strategies/policies. Local transformation should also reflect the lessons learnt from the recent HSIB *Investigation into the transition from child and adolescent mental health services to adult mental health services.*[25]

People and communities

The involvement of patients, families and carers in the design, implementation and evaluation of service delivery, is critical to an integrated approach. The evidence base encourages co-production and extends this approach to the local community, including local partners and third sector groups. Careful attention should be given to the process of involvement to ensure no particular group or cohort is marginalised in the process. Advice can even be sought from experts in equality and diversity issues. The evidence base recommends the use of peer support, health coaching and group activities as a way of reducing barriers in engagement, addressing social isolation and supporting behaviour change.

A person-centred approach should be adopted to service redesign, implementation and evaluation to reduce stigma and address any inequity in access to services. People should particularly be involved in decisions surrounding children-adult transition, inpatient-community transition, the mental health assessment process, care planning and crisis care and recovery. There is also a role for patients to play in the recruitment and training of the workforce. Commissioners should consider the utilisation of integrated personal

[25] https://www.hsib.org.uk/investigations-cases/transition-from-child-and-adolescent-mental-health-services-to-adult-mental-health-services/final-report/

commissioning as a way of ensuring that people with the most complex mental and physical health needs experience a coordinated, integrated approach to discussing, planning and delivering care.

A named coordinator can perform the role of a liaison for the person, their family, carers and advocates, and their contact with health, social care, housing and any other community services. The named coordinator should also be responsible for actioning any referrals and supporting the patient to navigate the system of services, ensuring they can access the most appropriate service for their needs, in a timely manner.

Collaboration for integrated service delivery, requires mental health services to cultivate relationships with community partners and thereby create integrated community teams. Lessons can be drawn from Trafford where police have worked jointly with a high-level strategic group of mental health professionals from the local mental health trust and leads from the CCG and local authority. The police have assisted mental health professionals to make simple but effective changes to improve their safety. Staff swaps have helped develop mutual understanding. Meanwhile a band 6 mental health nurse has been seconded to work in the police station. This service has been trialled and is now fully commissioned by the CCG.

Relationship building should extend to schools, where there are opportunities to ensure knowledge of mental health issues including prevention and treatment, are integrated into the education system.

Local authorities should consider gathering and analysing evidence on people's experience of services. This can be done in collaboration with other health and social care organisations serving the same populations to reduce duplication and ensure economies of scale.

Workforce

An integrated workforce is a team drawn from an existing workforce comprising professionals from health care (e.g. primary, community, mental health, palliative care and appropriate specialist care teams), social care, voluntary and charitable sector, and patient groups. The optimum size is 100-150.

The evidence recommends various roles and responsibilities which should contribute to an integrated system. The named coordinator is suggested as a useful resource to help patients navigate the system, the various services and opportunities on offer. GPs with special interests are another option for the provision of mental health services in primary care. Guidance recommends however, existing and new workforce must operate on a shared set of values and goals that are favourable to patients and their families/carers.

Shared knowledge and awareness across the wider system contributes to effective integration. The workforce need to be aware of each other’s services and remits.

Information needs to be readily accessible by staff about health and social care services available to patients, so these can be offered appropriately.

With oversight from commissioners, service providers in all settings should review staffing numbers and skill mix regularly to ensure that staffing and skill levels are sufficient. This also applies at the community level where there is a need to build staff skills and expertise. Up-skilling sessions and masterclasses should be offered to educate and improve knowledge where needed. Training can be delivered through joint consultations, multidisciplinary case discussions, inter-professional supervision groups, informal advice, formal training sessions and online training tools. All staff involved in delivering direct care that involves face to face interaction with people with mental health should be offered training, for example through shadowing. Joint multidisciplinary and multiagency training sessions should involve people from all agencies and the wider workforce in the planning, delivery and attendance.

Joint sessions are encouraged as a means of facilitating knowledge sharing and closer working relationships. Opportunities for reflecting on practice and sharing lessons should be created and sought by the workforce, for example during team meetings, supervision or hand overs. The evidence recommends protected time for staff to access training.

Technology

Sharing of knowledge can facilitate best practice, improve learning and generate better outcomes but the right tools needs to be provided to do this. The evidence base continues to grow for the feasibility of digital technology as an alternative to face to face consultations, including through video conferencing, telephone or via email. Effectiveness of technology is however, dependent upon compatibility of systems and strong internet connections. The King's Fund note the biggest country wide problem is that mental health providers, acute trusts, general practices and other providers use mutually incompatible systems. They recommend work with IT providers needs to continue to improve interoperability between systems.

Leadership

There is a need for clinicians who are willing to take on leadership roles. The evidence highlights key qualities of leaders to include individuals who are: dedicated, passionate, skilled in building relationships and working across professional boundaries. This includes clinicians and non-clinicians skilled in securing buy-in from their relevant associates. Evidence from work with stakeholders suggests health and social care teams felt empowered by having a senior ally at director/board level. Having a board level advocate for physical health in mental health trusts, and vice versa, can aid integration.

Leaders need to give time to building alliances across all stakeholders from health, social and community systems. Leaders should also be willing to take risks provided they employ an iterative approach to service design, evaluating the impact of changes and learning

from practice-based evidence. Leaders need to be willing to experiment and need to give time and thought to innovation and evaluation.

Knowledge

A collaborative approach requires regular communication between all parties involved, including staff from: primary, secondary, social care services, public health, forensic/prison services, care home teams, local authorities and third sector organisations such as voluntary groups, housing, employment and education providers. This includes staff and teams that may be out of area, for patients in out of area placements. Communication must begin with the patient. The care co-ordinator therefore holds responsibility for communicating the needs, wishes and preferences of the patient. Multidisciplinary and multiagency planning and case review meetings must be held annually or more frequently. These are arranged by the care co-ordinator. The presence of all sectors at these meetings should be taken advantage of, to inform children and young people- adult transition/discharge decisions and health and social care arrangements post transition/discharge.

Health and social care providers should be on the same system and should be able to access all information related to a patient. Information must be shared and exchanged between all parties, on a timely basis, without restrictions. Systems need to be put in place to support this and the evidence encourages the use of technology and integrated local databases to facilitate sharing. Consistent, standardised processes should be put in place for the inputting/ extraction of information and system maintenance. The system must be compatible across all organisations.

The information system would also require the ability to anonymise and aggregate health and social care records to inform a needs assessment of the local population, as well as local multi-agency commissioning plans.

Information pertaining to care/crisis plans, risk management plans and mental health assessments should be communicated to all involved in the patient's care. The care plan should also be available on the system for access by anyone involved in health and social care provision for the patient, across primary, secondary, community health and social care services

Appropriate processes need to be put in place to ease identification of mental health patients on primary care systems and registers. Sophisticated analytical capacity needs to be made available to integrate data and draw out key messages for implementation or service redesign.