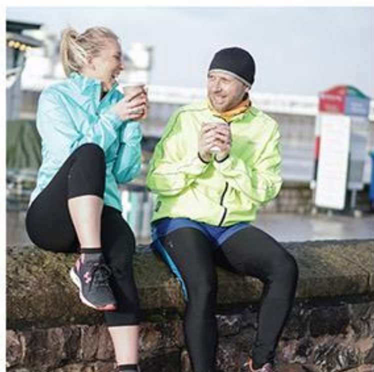
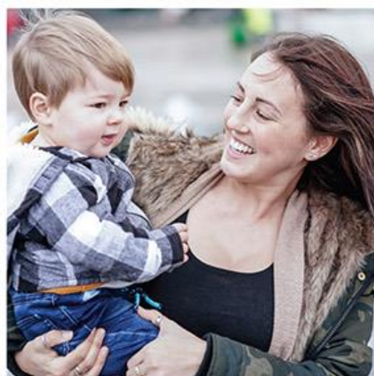
All-Age Mental Health & Wellbeing Strategy

Bristol, North Somerset and South Gloucestershire





DRAFT

Healthier Together System Strategy Group

October 2019

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Foreword

Improving our local population's mental health is a key priority …..

Forward from Prof Geraldine Strathdee

Systems partners compact

Forward contributions from South Gloucestershire Council – Dave Perry

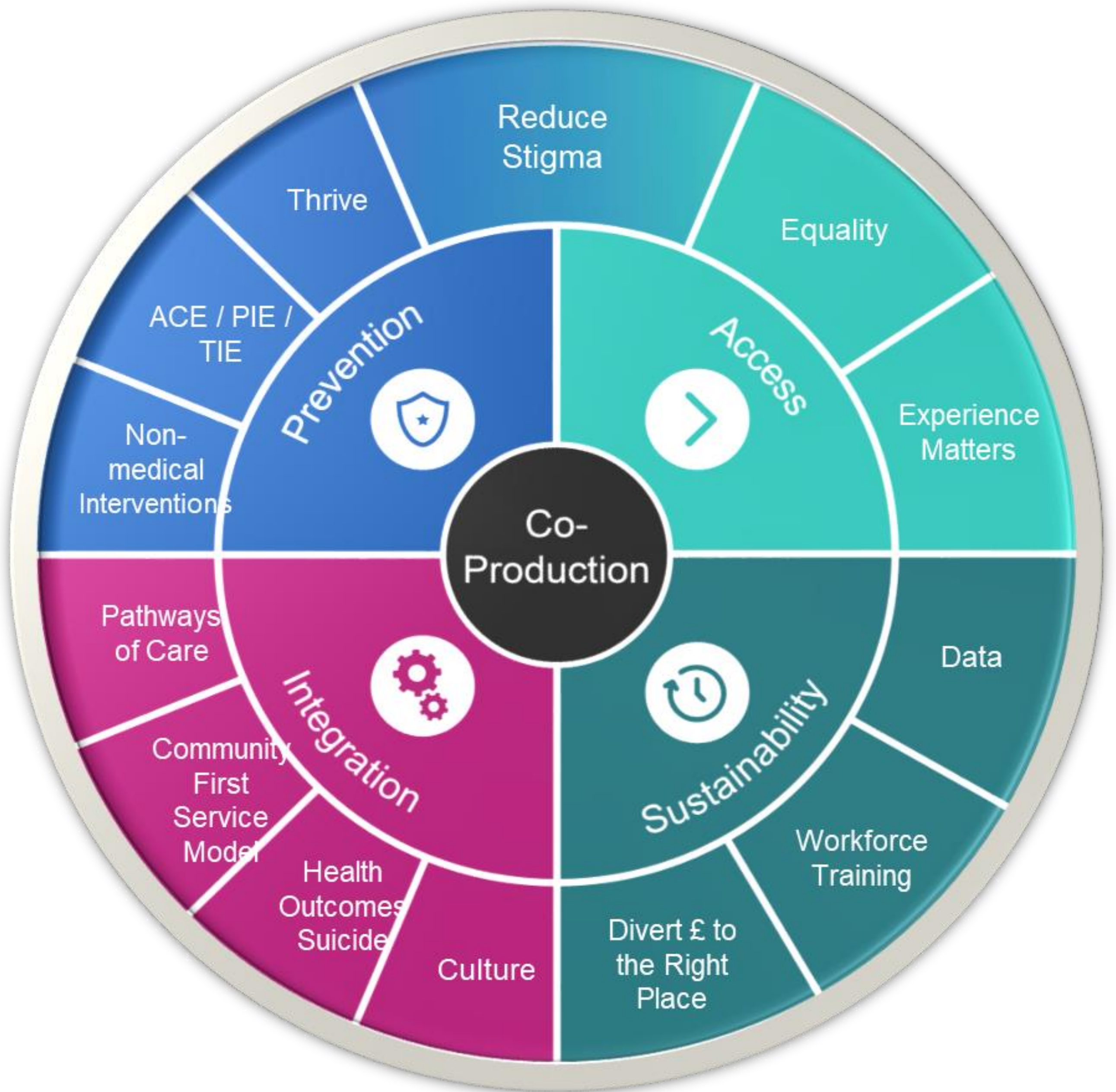
Forward contribution from North Somerset – Jo Walker

Forward from Bristol City Council – Councilor Asher Craig

From AWP

From CCG

IMHN – Tom Renhard



Reduce Stigma
Thrive
ACE / PIE / TIE
Non-medical Interventions
Prevention
Access
Equality
Experience Matters
Co-Production
Pathways of Care
Community First Service Model
Health Outcomes Suicide
Culture
Integration
Sustainability
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Workforce Training
Divert £ to the Right Place

Chapter 1: Introduction to Our Vision

Our Vision

Our vision is to deliver happier healthier and more fulfilled lives for everyone.

This strategy sparks the beginning of a radically different way to drive better mental health and wellbeing in Bristol, North Somerset and South Gloucestershire. Healthier Together partners have been working together to create a new approach that brings together people, communities and organisations who provide and use all types of support and services linked to mental health and wellbeing, to enable our citizens to flourish and live a healthy, happy life.

Delivering this mission is not simple. Many factors contribute to our health and happiness and these will be different for individuals and families in each of the vibrant and diverse communities across our area. We need to recognize the differences and be able to adapt services. To make sure this strategy focuses on the right things, we have been working with citizens, with people who have lived experience of mental ill health, as well as staff and leaders of existing services across the system. People have shared their experiences, their stories and their hopes.

Clear messages are coming through about what is wrong, but also what works, what helps people to stay well and positive and what people want and need when they are in emotional distress or crisis. We have based this strategy on two key areas of research: what matters most to people, and how we change the landscape so we can shift our resources to deliver better value.

To deliver the support and services that people need, first we have to find out what matters most to them.

We know that emotional wellbeing is critical to health and happiness and we are determined do more to promote good mental wellbeing and prevent poor mental health at every stage of life. We will make sure that access to support and care is equitable and fair, so there is no barrier to support regardless of who needs it or where they live. We need to develop a social model of care (exercise, diet, support networks). Communities need to be mental health resilient and as system partners we need to work together to support this.

Everyone has both mental and physical health. We will stop addressing these as if they are separate - that's why we integrate our thinking, our approach, our services and our workforce and training. We must find ways to meet growing demand and expectations which will last. That is why we are changing the way we approach help and care, for a more sustainable future. We can only do this by taking the time to better understand the real needs of our communities, by co-producing solutions with citizens and those who use services, those with lived experience, and by working more closely with organisations such as our independent mental health networks.

Finally, everything we do needs to be underpinned by best practice, being ready to learn and adjust, understanding and sharing our data and by driving for value.

Developing this strategy has taken time and it has involved many people who have different experiences and views, as well as professionals and organisations who have their own plans, objectives and priorities. We have found we use a diverse set of terms to describe similar or the same things and we have had to find the common threads that connect us, which were not always obvious.

Our mental health and wellbeing is not simple; it's not a single issue or single condition we are looking to address. Through this strategy we are bringing together all aspects of the public sector and the voluntary sector, to listen to and understand the views of our diverse and vibrant population and to turn that into a single galvanizing strategy- one which nevertheless recognizes the different needs across our localities.

We believe this process presents the beginning of something transformational; a journey we have embarked upon together, the creation of a shared vision and how we believe we need to work and focus our shared resources. We are all striving to ensure happier, healthier and better lives for people, whilst optimizing the value we are able to deliver for every pound we spend across BNSSG.

Our Focus on Significant Life Events

This strategy is for all of us across our life course. Significant life events have an impact on our health and wellbeing and we have based the chapters in this strategy around this concept. For example, the experiences of our early childhood, school, education, family and friends stay with us and impact our outlook on the world, influence our confidence and shape our personal hopes and ambitions.

Similarly, the experience of trying to get our first job, becoming financially independent, maybe going to university, having a baby and becoming a parent, dealing with physical illness or disability, and retiring from work are all impactful life events.

The chapters that follow are broadly focused on the life course, considering prevention opportunities, service improvements we need to make, and the actions and changes we want to see happen to drive a real difference.

Common Themes

We have identified a series of four themes that thread through the strategy that apply to all stages of the life course and which are critical elements that will affect the success of any and all new initiatives.

Promoting Mental Wellbeing & Preventing Ill Health

Creating healthy, happy communities and networks which support and nurture us. We'll act together on the things which impact our mental wellbeing, such as social deprivation, housing, debt, trauma and stigma. We'll offer help as early as possible to stop things deteriorating and we'll identify those at highest risk and offer extra support.

Access

We will make sure that advice and support are easy to access and available wherever you are - in your community, your workplace or at school, embedding wellbeing into our daily lives and routines. We will apply the principle of Equality so that everyone, whatever background, age, or lifestyle can find help and will not be excluded. We'll look at where we work, how we work and who we are, to better support you.

Integration

Organisations, citizens and patients have come together and are committed to working seamlessly, integrating services, support and opportunities. This is much more than joint working across agencies, this is about really bringing the focus back to the person, their needs, and the needs of families and carers. There will be no gaps between services, we'll share information to stop duplication, and both physical and mental health will be equally important, just as they are to you.

Sustainability

People want a connected, supported journey through life, and when difficult times or illness arise, people want to be able to find assistance and solutions without the frustration, delay and challenges that can occur today. This isn't going to be easy, but we will work with you to create sustainable solutions which are affordable and which meet expectations and demand.

Our Approach

In developing this strategy, we have undertaken the following activity:

Co-design
Co-designing with people with lived experiences, their families and carers. Commissioned experts with lived experience to author.

Stakeholder Engagement
Stakeholder engagement programme comprising social media campaign, deliberative citizens' panels and focus groups.

Data Sources
Analysing and agreeing data sources and sharing the problems we have to solve.

Mapping
Mapping and connecting work in progress, including our programme of work, the NHS Five Year Forward View for Mental Health, 'Thrive', and drawing on the existing mental health strategies in our local authority partners and the plans and strategies of our providers

Horizon-Scanning
Horizon-scanning for best practice and innovation

Chapter 2: Changing the Landscape

OUR AMBITION:

BNSSG will be a fairer, more inclusive and mental **health** focused place to live. We will develop system-wide principles to galvanize integrated & aligned services. Support will be available across the life course & wherever people are.

There are times in history where the development of an industry, a product or a societal change stops developing incrementally and takes a leap forward. The focus on mental health and well-being in our society and our public sector services has taken a long overdue leap into the spotlight over the last few years. As individual organisations we have all been working hard to improve citizens' mental health, to meet national targets and to improve outcomes, whether that is through prevention and wellbeing in public health, or through mental health services provided in the NHS. But the truth is - we just don't have it right yet.

Through the process of this strategy we have identified areas where we can work smarter together, where the contribution of all partners in the system are required if we are to succeed. All parts of the system are inter-dependent, with a role to play in shifting Bristol, North Somerset and South Gloucestershire from our current state to becoming a place that is renowned as an example of how a system can work together and deliver the best mental health outcomes for people of all ages, a place where mental health professionals want to work and one that has addressed the challenges of doing this in a sustainable way.

Wellbeing and Thrive - A Population Approach

'Thrive' takes a population approach to improve mental health and wellbeing. At its core is a recognition that as little as 10% of a population's health and wellbeing can be linked to access to healthcare. Rather than beginning with treatment, its focus is on the role of organisations such as schools and universities, employers, housing organisations, NGOs, businesses and the police. It highlights the huge importance of tackling stigma and discrimination, and the contribution our relationships, surroundings and access to good food, money and wider resources make in achieving good mental health.

Thrive focuses on prevention and early intervention and works by mobilizing public, private and third sector collaboration and leadership (and resources) across an area. It also aims to simplify and strengthen leadership and accountability across the whole system.

Thrive started in the US, with particular success in New York City. It has been adopted by local authorities across the UK, and Bristol City Council has been an early adopter, developing the Bristol Thrive Initiative.

Bristol Thrive is a whole community endeavour which ensures that wellbeing and mental health are embedded in every part of our lives, where we live, work, go to school as well as where and how we socialize and how we use our spare time.

Mental Illness: the nature of the problem

Mental illness can affect anyone and have a significant effect on the lives of individuals, their families, communities, and wider society. Together with substance misuse, mental illness accounts for 21.3% of the total morbidity (illness) impact in England. According to the Adult Psychiatric Morbidity Survey (2014, released 2016), one in 6 people over 16 years experienced a common mental health disorder (CMD), such as anxiety or depression, in the week prior to the survey. Those in the South West of England are the most likely to have experienced a CMD in the last week (21%, compared with the lowest rate of 14%, reported in the South East). Three quarters of all mental health problems are established by the age of 24. Severe mental illness (SMI), such as psychosis and bipolar disorder, affect an estimated 551,000 people in England and 10,000 people in BNSSG. These individuals have a life expectancy of up to 20 years shorter than the general population and evidence suggests that the mortality gap is continuing to widen.

Poor mental health also impacts wider society and is estimated to carry an economic and social cost of £105 billion a year in England, including £1.9 billion in BNSSG.

Mental illness is closely associated with many forms of inequality, to which people living with SMI are particularly vulnerable. These inequalities are largely driven by complex and interrelated factors, including:

- wider social and environmental determinants of poor health, including poverty, unemployment, homelessness and incarceration.
- stigma, discrimination, social isolation and exclusion, for example, due to disability, ethnicity, or lifestyle.
- behaviours that pose a risk to health such as smoking and poor diet.
- lack of access to health and preventative care.
- diagnostic overshadowing – the misattribution of physical health symptoms to an existing mental health diagnosis, rather than recognition as a genuine physical health problem requiring treatment. Similarly, the misattribution of behavioural and other symptoms may result in exclusion from appropriate mental health services due to assumptions made based upon a pre-existing diagnosis such as learning disability, autism, or head injury. Where mental, developmental or physical health conditions co-exist, the risk of symptom misattribution and under-treatment, is high.

Building on our Foundations

The Government's response to the increased awareness of mental ill-health and lack of parity was set out in 2016 in the 'Five Year Forward View for Mental Health'. Since 2016 there has been significant change to mental health services across England.

In BNSSG we now have a specialist Perinatal Mental Health Community Service. Access for children and young people to get the support they need from mental health services is continuing to expand with digitally enabled support offering innovative ways to access services. Mental Health Liaison services are now available in all our general hospitals. Mental health specialists work alongside police services in Street Triage and Control Room Triage services, ensuring more people in crisis get the right help more quickly. Bristol has been ahead of the curve with sanctuary spaces and crisis cafes.

All our local authority partners have invested in well-being colleagues, healthy living centres and a nationally recognised, trail-blazing voluntary sector - including St Mungos, Golden Key, Off the Record, Barnados and Stand Against Racism & Inequality(SARI), to name a few.

We have well-developed networks for people with lived experience: our Independent Mental Health Network has developed into an integral part of how we work, and, of course, mental health is one of the biggest priorities for our Health and Wellbeing Boards. So, while this strategy is concerned with what we want to do for the future, and areas we need to address, it is important to take a moment to consider that we have much to be proud of and a solid foundation of partnership to build upon.

The Next Stage of Development- The NHS Long Term Plan

The NHS Long Term Plan was published in January 2019, setting out the public commitments made by government and their plans for delivering this transformation.

The development of the BNSSG Mental Health and Wellbeing Strategy was in progress before the NHS Long Term Plan was published, but all of the findings and ambitions highlighted as part of this strategy align neatly with how we will meet the requirements of the NHS Long Term Plan.

The key commitments for mental health from the long term plan are included in this strategy and can be summarized as follows:

- Funding parity with physical health.
- Increased access to services that provide support for anxiety and depression.
- Providing more support for children and young people under 25 including the introduction of waiting times for CAMHS.
- Developing NHS 111 to enable access to mental health care in the community by 2023/24.
- People with SMI getting more choice and control, with new primary and community integrated models of care by 2023/24.
- Prioritization of physical health checks
- Specific waiting times targets for emergency mental health services from 2020.
- By 2023/24, NHS 111 will be the single, universal point of access for people experiencing mental health crisis.
- New mental health transport vehicles will reduce inappropriate ambulance conveyance or by police to A&E.
- Mental health nurses in ambulance control rooms to improve triage and response to mental health calls and increase the mental health competency of ambulance staff through an education and training programme.
- By 2020/21, all acute hospital will have an all-age mental health liaison service in A&E departments and inpatient wards by 2020/21, and that at least 50% of these services meet the ‘core 24’ service standard as a minimum.
- By 2023/24, 70% of these liaison services will meet the ‘core 24’ service standard, working towards 100% coverage thereafter.
- There will be an increase in alternative forms of provision for those in crisis – sanctuaries, safe havens and crisis cafes provide a more suitable alternative to A&E for many people experiencing mental health crisis.
- New staffing roles such as Social Prescribing Link Workers and greater use of peer support.
- Cultural change to engage and attract staff and improve patient outcomes.

The Local Landscape

There is a wide range of health and care services for the 968,314 people who live in the area covered by the Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group and three local authorities. These services include:

- GP and primary care services provided by 85 GP practices.
- Local mental health care services provided by Avon and Wiltshire Partnership and Devon Partnership NHS Trusts, together with a broad range of voluntary and independent sector providers, including Second Step, St Mungo's, Richmond Fellowship and Missing Link.
- Our local authority provision

It is vital that **all** local services are 'mental health competent' and capable of supporting a person with mental health needs, wherever they present in our health and social care system.

That includes services provided by:

- Weston Area Health NHS Trust
- University Hospitals Bristol NHS Foundation Trust
- North Bristol NHS Trust
- South Western Ambulance Service NHS Foundation Trust
- Out of Hours and Integrated Urgent Care (IUC)/111 provided by Brisdoc/Care UK
- Bristol Council
- North Somerset Council
- South Gloucestershire Council
- Community support, home care and nursing and residential care homes
- A wide range of voluntary, community and social enterprise sector organisations.

The Local Landscape: local challenges

The annual BNSSG total health budget is around £1.7BN; our spend on mental health support per head of population is £172. This is a mid-range allocation compared with similar areas. The Public Health and Local Authority spend brings this figure to almost xxx. Funding for the NHS is increasing but cannot keep pace with growing demand for mental health services and it's the same pattern for social care and for public health.

This means we have to do things differently and work more intelligently together to deliver greater value for the funding we have available.

We know that for all health conditions there are times when people who are waiting for services deteriorate while they are waiting. A more intense intervention is then needed which is more costly and could have been avoided, if we had been able to provide support sooner. For mental illness, at present in BNSSG people may be referred on to secondary care, which may mean a long wait, when they could be helped straight away in community settings, and in ways which do not require medical intervention. Research evidence is showing that for some mental health issues, people can achieve similar or better outcomes from non-medical support and services.

Waiting times are too long for children and young people, and for people who need a specialist assessment, for example for ADHD. People tell us that they often undergo assessment without an offer of help afterwards. They have to tell their stories too many times, to too many health and social care workers because our records are not shared.

Across the patch, services for mental illness have historically been commissioned in different ways and against different criteria. We know there are gaps between services, which leave some people without help. Without more appropriate options, some people look to Accident and Emergency departments for help, an environment which is not optimized for mental health care.

We have not capitalized fully on the expertise of the voluntary and charitable sectors and we have not focused sufficiently on how we can positively promote wellbeing for all and prevent some mental ill health from happening at all.

Finally, the separation of workforce, budget and responsibility, between health and social care results in exclusions, duplication, gaps, and different approaches to risk.

In short, our services must become more coherent, joined up and responsive to people's needs.

The Local Landscape: What matters most to citizens

From our Insights work, we know that the people of BNSSG want to see mental health and wellbeing funded adequately to meet their needs. At present, only 13% of total BNSSG health budget is spent on mental health.

> *"More than one quarter of the total budget (28%) would be spent on mental health by a representative sample of BNSSG citizens, split equality between children's and adults' mental health."*

From the Health and Wellbeing Board engagement exercise (2019) we heard that:

- Diagnosis is not always followed by support, and support for carers needs to be improved.
- The length of time taken to receive a diagnosis impacts on both the individual and those caring for them.
- The lack of joined-up services for people with multiple conditions makes things much harder.
- Changes to access to benefits are impacting on individuals and carers' abilities to access services. Increased stress and difficulties accessing the system is exacerbated by the increase in one-off and cyclical assessments, and the short periods that support is available for.
- Workforce issues including lack of available staff, poor information sharing, handover and silo working by services make accessing and using care services problematic
- People want to know what to expect during their treatment journey and during service change and transformation
- Feedback should be asked for on a regular basis, as a minimum, at the end of a piece of support/ discharge from a service.
- Service users and carers need to be involved from the beginning so their involvement can be meaningful.

- Co-design is the gold standard, with change starting from what users need rather than what the service thinks they need.
- Services need to use the feedback, reports and insight already provided.

The Local Landscape: An Overview of BNSSG

Population statistics

- We have a growing and aging population. The total population of BNSSG is 968,314. 17.5% (164,613) of the population lives in the most deprived decile (10%) of areas in England
- A 35,683 (4%) increase in the BNSSG population is expected by 2020. An increase of 9,366 (12.6%) is expected in over 75 year olds and an 11,000 (7%) increase is expected in the 0 to 14 years age group.
- BNSSG is a relatively affluent area, but there is local variation, with significant areas of deprivation. Nearly one in ten (9.3%) of the population is living in the most deprived areas in BNSSG, whilst one in twenty (5%) is living in the most affluent areas.
- BNSSG is an area of cultural diversity, with 87,325 (9.8%) of the population having Black or Asian ethnicity.
- There are two universities in BNSSG - the University of Bristol and the University of the West of England (UWE). The total of 50,957 students represents approximately 5.4% of the BNSSG population and 11.2% of the total Bristol population.
- The homelessness rate is the number of homeless people per 1000 households. This is 2.5/1000 for England; Bristol is much higher at 5.3, the highest in the South West. People with a mental illness are 3 times more likely to be homeless and 80% of homeless people have a mental illness.
- 75% of people with a long-term mental illness are unemployed and only 50% of people with depression or anxiety lasting longer than 12 months are employed.
- The most common causes of premature death in BNSSG are cancer, heart disease, stroke, liver disease and external injury. These main causes of early death are often preventable and amenable to public health interventions. Behavioural and lifestyle factors including smoking, excessive alcohol consumption and poor diet are linked to an increasing number of diseases and conditions.
- Our CCG mental health spend, per head of population, is £172.85, which brings us into the middle of the ranking compared to other areas. This accounts for 13% of baseline CCG budget, using 2018/19 figures. Mental ill health accounts for 23% of total morbidity in England.

Mental Health Access Statistics

- The prevalence of mental health problems disproportionately affects people living in the most deprived areas, with rates of self-harm proving to be a significant issue for some BNSSG localities. In parts of BNSSG, hospital admissions for self-harm are 40% above the England average.
- The prevalence of common mental health disorders in people aged 16-74 is slightly above the England rate at 17.8%, Bristol is higher at 20.7% with South Gloucestershire under at 13.6%.
- Around 10,000 people in BNSSG have a severe mental illness (SMI) which is noted on registers held in GP practices. The SMI register for BNSSG is increasing year on year. 5% of the BNSSG population has a severe mental illness.

- Old age-related mental disorders account for 23% of emergency hospital admissions in BNSSG. There are nearly 11,000 people in BNSSG with dementia, over 30% of whom have not been diagnosed.
- The South West of England has the highest suicide rate of all English regions and in Bristol the suicide rate is nearly double than that of London.
- 53% of all admissions via A&E are linked to drug, alcohol or mental health presentations
- BNSSG has a low mental health inpatient bed base compared to other areas, with an acute adult mental health bed base per 100 000 population of 11.4, compared to a national median of 19.7 (NHS Benchmarking Oct 2019)
- Bed occupancy in our mental health trust is one of the highest in the country, often exceeding 100%- compared with a more appropriate occupancy of 85%. This results in high use of expensive 'out of area' admissions, that adversely impact on the person, family and carers.
- The Crisis Line is often used by people who cannot access support elsewhere in the system. 26 people account for 48% of the call volume.
- Our mental health community team case load is the lowest in the UK at 799, meaning fewer people in BNSSG are in contact with community mental health services at a point in time, than in other areas. Across the UK, contact with mental health services for all ages ranges from 4.4% (Blackburn with Darwen) to 0.8% South Gloucestershire. For ages 0-18 years, contact ranges from 5.5% (Thanet) to 0.1% (Luton). North Somerset reported contact rates of 0.2%. Differing rates may not only reflect variation in the need for services - they are likely to also reflect the nature and extent of mental health service provision. (Mental Health Statistics for England: House of Commons briefing paper 6988, 2018)

Health Outcomes

Overall, people living in BNSSG have a long life-expectancy and good health. However, there are stark inequalities in life expectancy and health outcomes across BNSSG. People living in the more deprived areas experience comparatively poor health, with a lower life expectancy than those living in more affluent areas.

- For men, the difference in average life expectancy between the most and least deprived areas of BNSSG is 9 years. Statistically, the people with the poorest health in our communities have a mental illness and/or learning disability.
- People living with SMI experience a life expectancy of up to 20 years less than the general population.
- People with learning disabilities live up to 20 years less than the general population. Just over half of people with Learning Disability receive an annual health check. People with a learning disability also experience emotional distress and can also have mental health issues.
- People with autism show a higher incidence of suicidality than the general population.
- Our most deprived areas are associated with high rates of obesity and harm from drugs and alcohol. Bristol and North Somerset have high numbers of people with complex presentations, including mental health issues plus substance use and/or homelessness. In North Somerset, people under 75 years are more likely than average to have both mental and physical health problems.
- 50% of mental health problems are established by age 14 and 75% by the age of 24. Evidence shows that the earlier in a child's life we are able to provide the right support and intervention the better their life chances become.
- There are long waits for CYP who need assessment and treatment for mental illness, ranging from 18 weeks to >52 weeks for diagnosis of Autistic Spectrum Disorders. Families reference the lack of intermediate level support: children may be too ill for GPs to manage and not ill enough for CAMHS.

- For children with special education needs and disabilities (SEND) we have to ensure we work together more seamlessly. The process of complicated assessments and CAMHS support is part of what needs to be a fully integrated support offer that makes sense to these vulnerable children and their families. Evidence from our SEND inspections has shown that by focusing in a transactional way on our organizational responsibilities means we fail these children.

Health Outcomes: Suicide

Between 2006-2016, there were 940 deaths by suicide within BNSSG. 75% of these were men, a proportion comparable to England as a whole. However, in Bristol, rates of suicide are higher than the national average, while North Somerset and South Gloucestershire have similar rates to England as a whole. Factors in BNSSG which may influence suicide rates are known. *(All data from the National Confidential Inquiry into Suicide and Safety in Mental Health BNSSG Sept 2018, for the period 2006-16).*

- There were more people with alcohol-related hospital admission in Bristol than in England as a whole.
- In North Somerset, there were more people living with long term health problems or disability and a higher percentage of marital break-ups compared to England as a whole.
- Bristol and North Somerset have higher prevalence of depression and more people living alone in comparison to England.
- Bristol and South Gloucestershire have a higher percentage of emergency hospital admission for intentional self-harm.
- Citizens who died by suicide were more likely to be aged 25-44, have a secondary diagnosis and have a history of self-harm and drug misuse compared to those in England as a whole.
- There were a higher proportion of patients from BNSSG who died by jumping/multiple injuries compared to England as a whole.
- People from BNSSG were more likely to be under the care of a crisis team, detained under the MHA and have their last contact one week before death, than in England as a whole.
- A lower proportion of people was diagnosed with affective disorders and people were less likely to have initiated their own hospital discharge compared to patients in the rest of England.

Caution is needed in interpreting the differences in BNSSG but these facts do give us ideas how to target our efforts better to reduce the number of suicides. One emerging area of research shows that of adults newly diagnosed with Asperger's syndrome, 66% reported they had contemplated suicide, significantly higher than rates among the UK general population (17%) and among patients with psychosis (59%); 35% had planned or attempted suicide (Cassidy et al 2014). A large-scale population study shows that suicide is a leading cause of premature death in people with autism and that risks are higher in women (Hirvikoski et al 2016).

What will be different?

In light of these challenges and inequalities, we need to work differently to promote wellbeing and prevent mental ill health in BNSSG. This requires a wholesale change in how we work as citizens and as providers, changing behaviours, expectations and outcomes.

We will change quality of life and health outcomes by changing the landscape, from how we work with experts by experience, what we invest in, who delivers health and social care and how we measure change.

You will see:

- A shift to the promotion of good mental wellbeing in our communities and a focus on prevention of mental ill health, starting with recognizing the impact of adverse events in childhood and responding to the social determinants which disadvantages so many. We want people to THRIVE
- We will address Inequality in mental health and care provision, enabling improved access for different groups, including BAME, LGBTQ+, people with learning disability and autism, people with complex needs and others. We will co-produce services with citizens and experts by experience, as our default approach.
- We will recognize the impact of Adversity and Trauma on people's lives and wellbeing, and we will make sure our workforce is trained to respond to these
- More emphasis on non-medical ways to improve wellbeing, the voluntary and charitable sectors and efforts to fight isolation and loneliness
- Joined up, sophisticated use of data to inform future decisions and interventions
- Changes to how we commission services: across health and local authorities, commissioning across pathways of care and different providers, commissioning for outcomes that matter to citizens; Health in All Policies
- Recognition of the community as the default setting for care, more care close to where people live, simpler access to help wherever people present
- An integrated approach across physical and mental health conditions, addressing the needs of the whole person
- Expectations for the whole workforce: mental health is everyone's business and a core skill set is required to meet people's needs

Shift to Prevention

Our current health and social care system is designed to meet the needs of people who have already become unwell. We will shift how we work together to 'first and always' promote wellbeing, to support self-care and to prevent illness from happening in the first place. For those who do become unwell, we will offer support as early as possible, and we will work with you to help you - as the expert in your own health - to prevent re-occurrence, to minimize the impact of illness on your life and to prevent further deterioration.

Through 'Thrive Bristol' and similar in initiatives in North Somerset and South Gloucestershire, we will promote and deeply embed wellbeing within our communities. Wellbeing is the cornerstone of building emotional resilience that helps us manage mental distress and avoid serious illness.

We will actively promote good mental health in communities, schools and workplaces. We want to help individuals, families and schools to develop the characteristics, such as resilience, which protect them. And we want to develop the incredible social capital we already have, for example through social networks, which can protect people and populations from stressors in their lives, under many circumstances.

We will help people to find information about how they can help themselves to be well and stay well. We will target the most vulnerable communities and groups, most at risk of ill health, and work with them to reduce health impacts. This includes an annual physical health check and smoking prevention for people with severe mental ill health, more support

to children and young people to help them remain resilient, and coordinated work to make BNSSG workplaces (including LA and NHS) healthy and supportive places to thrive.

CASE STUDIES: Exercise for Wellbeing, Men in Sheds, Bristol Boxing Clubs

[Add case studies.]

We Will Address Inequality

Some people within BNSSG experience high levels of illness linked to *low income, poor housing or disability.* These three 'social determinants' of health, have major impacts on health and wellbeing. Social determinants affect our populations to the extent that average life expectancy varies by around six years between the most and least deprived areas, with some places in BNNSG seeing a startling 15 years difference.

Addressing social determinants is fundamental to tacking health inequalities. This means we need to develop policies and interventions that address the underlying social factors which shape our physical and mental health outcomes. This is why we will take a 'Health in all Policies' approach across local authorities and health organisations, to ensure we always consider the impact of new policies on social determinants, psychosocial factors and health equity.

Some groups and complex conditions require more, or different, resources to meet their needs. This includes children and young people with mental health issues, people with personality disorder, people experiencing substance misuse and people with a learning disability and/or autism.

Some communities and groups are not well served by current arrangements. For example, black and ethnic communities, those from LGBTQ+ communities, those affected by homelessness and disability, those with both substance use *and* mental health issues, and people with severe mental illness - who experience worse physical health than the general population. All of these inequalities must, and can, change.

Some people's needs fall between what can be supported in primary care and what is provided by specialist mental health services. In effect, some people find there is no support for them. We will close these gaps.

Co-production

We will design support and services in partnership. We will use best-practice evidence to deliver the best possible outcomes for citizens and their families in the most effective and efficient ways. We will ensure people with lived experience are appropriately valued and rewarded for their contributions. This will include developing a consistent framework to manage 'reward and recognition' across the system. We will ensure that the values and ethos of co-production are embedded into everything that we do as a system. This will include developing a more consistent understanding of what co-production is, as well as what it isn't. We will engage with a diverse range of people with lived experience. We will seek to engage people in their communities on their terms. We will take time to understand what really matters the people who make up our vibrant and diverse population.

Adversity and Trauma

We need to acknowledge the significant impact of adversity and trauma on people's lives. From small stresses at work and home, to major traumatic life events and situations, these emotional stressors have an impact on every one of us, on both our physical and mental health. Adverse childhood experiences, or 'ACEs', which affect children and young people, can affect individuals immediately and throughout their lives, which is why we are taking a 'life course' approach to mental wellbeing, working to reduce ACEs and trauma early in life and improving how we understand and respond to trauma throughout life. We will embed this understanding throughout our workforce, all services and treatments.

Voluntary, Community Sector (VCS)

Voluntary, community sector (VCS) organisations play a crucial part in supporting people's mental health and wellbeing in communities across the BNSSG and we know the sector can do more to respond to unmet need. VCS organisations can offer support that is distinctive and complementary to what statutory bodies provide for people's mental health and wellbeing. The NHS Long Term Plan (2019) also presents an ambition for a greater and more significant role in the delivery of mental health care provision. Whether participating in 'Integrated Care Systems' (ICSs), working alongside primary care networks, or expanding coverage of alternative forms of crisis support 'arm in arm' with the NHS, VCS organisations are expected to make an important future contribution to integrating mental health and social care

VCS organisations take a more holistic view of someone's needs, tackling the wider determinants of health, focusing on their strengths rather than problems and not being bound by clinical thresholds. Understanding and responding to the changes that service users want to see in their own lives can be difficult, but VCS organisations are able to bridge sectors and services for people in need and for professionals. VCS organisations are often more able to act quickly and try new approaches; be more values-led, less rule-bound and more able to take certain types of risk, for example in trying new (predominantly nonclinical) approaches to meeting people's needs. They have a distinctive role in local systems that complements statutory bodies.

> ***"We are not there to see someone through a clinical lens; we are there to support them with living their life."***

The trusting, open relationships between service users and VCS organisations can be an asset with groups and communities that have negative experiences of statutory services and don't trust 'the authorities'.

Our VCS organisations are already fully involved in decision making both in provider and commissioner partnerships. Healthier Together, as a current partnership of NHS and Statutory Sector providers, and through this strategy we will embrace and encourage the VCS sector as an equal and valued partner - not an add on - and so will create a broader culture of increasingly diverse voices.

Deliverable: We will enable and sustain a strong vibrant voluntary and charitable sector that recognizes their unique contribution, which will complement the statutory, clinical mental health offer, from prevention through to specialist mental health support.

The principles of population health management and use of data

To guide the promotion of good mental health and the prevention of poor mental health, we will look at Population Health. This is an approach aimed at improving the health of a defined population within a specific geography, reducing unreasonable variation and health inequalities. It includes actions to reduce the occurrence of ill-health by addressing social determinants of health, and the approach highly values working with communities and partners. A key enabler of this approach is 'Population Health Management', which aims to improve population health by using data to drive planning, delivery and evaluation of care for maximum impact. Data from all partners is used to inform the shape and size of services in the area.

This relatively new approach is now possible in BNSSG because we can link information-rich general practice data with other established data-sets, including acute trust and mental health data. 80 out of 82 GP practices in BNSSG have agreed to share the data needed to enable this process. The first outputs from this large data-set will available to primary care networks and localities by mid-September 2019. The first stage of our population health journey is to look at retrospective data to help us shape and design services. Later stages will look at how we can use real time data to minimize harm and distress and will consider the benefits of predictive data to inform commissioning and delivery of services for the future, both at individualized, place-based and system levels.

We will commission differently

We will develop a system model which identifies the level of need and the threshold for intervention, whether universal intervention, primary care or secondary care-level intervention. This model applies equally to mental health as to other health and care conditions. The system will collectively own the task, and the resources needed to deliver.

We will have a joint commissioning strategy which uses values, behaviours and culture as key measures of success. Contracts will be focused on outcomes and complexity and will be informed by measures of equality. We will seek, and consciously accept, evidence from elsewhere, and implement best practice through test and learn, confidence building pilots. We'll take a "Health in all policies' approach across LA and Health, to consider the impact of policies and programmes on wider determinants, psychosocial factors and pathways to health and health equity.

The community will be the default setting for integrated care

We will develop the capacity and capability for expanded wellbeing and mental health support in primary care. This will reduce stigma, offer better support to individuals, families and carers through better continuity of care and personalized interventions. People will receive more holistic care, integrated mental and physical health and social care, with signposts and links to social prescribers and advice on social determinants such as housing, debt and employment.

Workforce

Our whole health and social care workforce, and increasingly workforce in the business and commerce sectors, will receive training to recognize mental wellbeing factors, mental ill

health and mental health first aid. The health and social care workforce, including VCS, will recognize the impact of trauma and adversity on people's lifelong health and wellbeing, will recognize the impact of social determinants on health and will recognize the interaction between physical and mental health. Workers will be able to make appropriate initial responses in any setting.

Conclusion

All of the factors above are driving local health and social care services, voluntary and charitable organisations, local authorities and independent networks - and many others - to work together to build improved communities and environments, workplaces and schools, to create a health and care system to meet the needs of everyone in BNSSG.

We do not believe that the support you can access for your health and wellbeing should depend on *where you live*, *who you are* or *whether you are 'ill enough*'. That is why we want to change the landscape in Healthier Together, to be fairer and more inclusive and why tackling inequality is one of the driving forces underpinning our MHWB strategy.

Our strategy proposes a series of shifts in our focus as a system. It highlights some of our key commitments in areas we believe will make a difference. It marks the beginning of a journey, sets out our shared ambitions for our population and will act as our guide for staying true to the things that matter most to people.

Ian

Chapter 3: Co-Production & Patient-Centered Design

OUR AMBITION:

We will become an exemplar of excellence and advanced practice in co-production and co-design. We will underpin our services with experience-led commissioning to drive value.

Co-production

Co-production is a term that is increasingly used to describe engagement with people with lived experience in the design of health and care services.

However, the interpretations and understandings of what the word itself means can vary across patient groups, service providers, commissioners of health and care, thinktanks and other voluntary organisations (additional resources can be found here or at the end of the chapter). This can often lead to words 'lost in translation', use of terms when really something else is meant and a breakdown in partnerships where understandings diverge.

This chapter, '*Co-production & Patient-Centred Design*', seeks to outline a common language and strategic framework that will form the basis of Healthier Together's ambition to embed effective and meaningful co-production in all that it does, thus building stronger relationships with people who are experts by experience in their own right. This will lead to a better understanding of need and what we need to do to change things for the better through equal and reciprocal relationships.

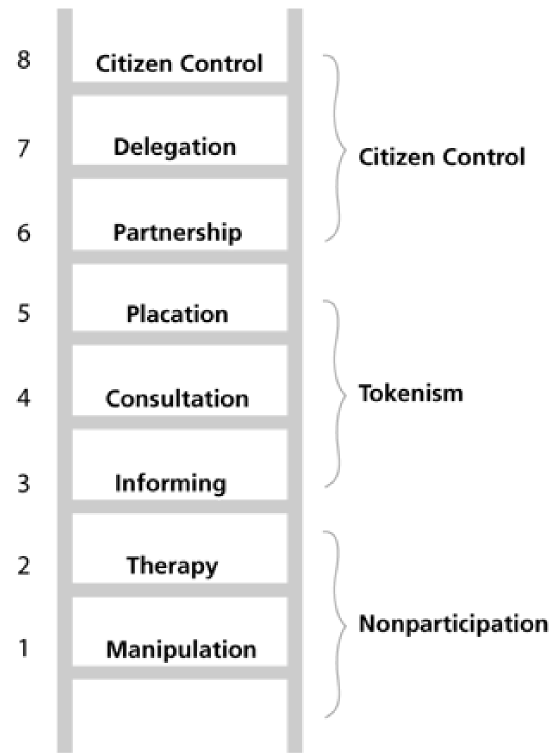
The earliest of the use of the term co-production can be found through *Elinor Ostrom,* an Economist at Indiana University in the 1970s. Ostrom described co-production in terms of balances of power, i.e. a state funded institution (in this case the police), needed the communities it was there to serve as much as the communities may have needed the institution. It highlighted the impact that interdependent relationships can have and how this can then shape eventual outcomes.

Since the 1970s, the conversation has continued to develop, with the term itself going in and out of 'fashion', until a renewed interest from the mid-2000's as the wider mental health user movement and disability movement gained more momentum.

When considering what we mean by co-production, an understanding of active citizen's participation and how this interlinks with the health lens is key. The earliest known model that demonstrates this well was created by Sherry Arnstein in 1969. In this context, Arnstein focused on citizen involvement in planning processes in the United States, showing levels of participation organized as a ladder.

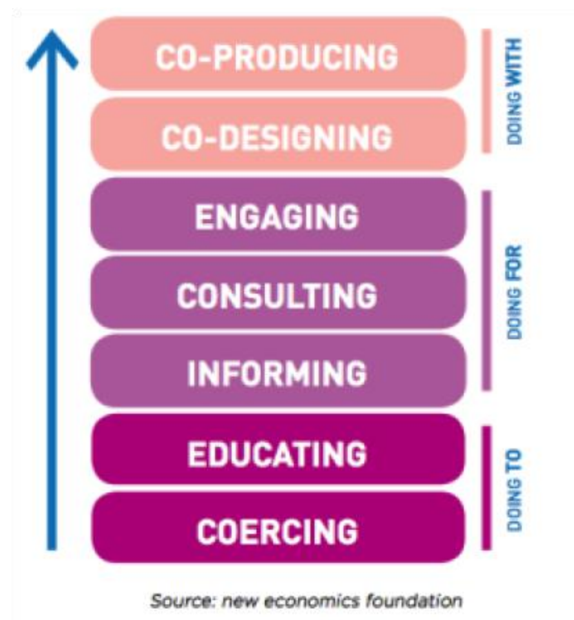
Through each 'step' up the ladder, participation increases, with a more meaningful role for citizens. The model describes activities through which meaningful improvement can be seen and forms an early framework that has since been built on by other organisations.

See Sherry R. Arnstein's "A Ladder of Citizen Participation," Journal of the American Planning Association, Vol. 35, No. 4, July 1969, pp. 216-224.



Arnstein's Ladder (1969)
Degrees of Citizen Participation

One such enhanced model that has developed with a health focused lens can be found via the New Economics Foundation (NEF). It is based on Arnstein's original model.



Source: new economics foundation

As with Arnstein's original model, it clearly defines different levels of increasing participation.

<u>These are outlined in further detail below under the headings described by NEF</u>:

- **Doing to:** “The first rungs of the ladder show services that are not so much intended to benefit the recipients, but to educate or cure them. Recipients are not invited to participate in the design or delivery of the service; their role is limited to being a fairly passive recipient of services and professionals hold all the power, and make all the decisions, within the service.”

- **Doing for:** “As the pathway progresses, it moves towards the involvement of people using services in some form, but this participation may still be within clear parameters that are set by professionals. “Here, services are often designed by professionals with the recipient’s best interests in mind, but people’s involvement in the design and delivery of the services is constrained. Professionals might, for example, inform people that a change will be made to how a service is to be run, or they may even consult or engage them to see what they think about these changes. This, however, is as far as it goes. People are only invited to be heard; they are not given the power to make sure that their ideas or opinions shape decision making.”

- **Doing with:** “The most advanced stages of the pathway represent a much deeper level of service user involvement, which shifts power towards people. These require a fundamental change in how service workers and professionals work with service users, recognizing that positive outcomes cannot be delivered effectively to or for people. They can best be achieved with people, through equal and reciprocal relationships.

“Co-designing a service involves sharing decision-making power with people. This means that people’s voices must be heard, valued, debated, and then – most importantly – acted upon. Co-production goes one step further by enabling people to play roles in delivering the services that they have designed. In practice this can take many forms, from peer support and mentoring to running everyday activities or making decisions about how the organization is run.”

Increasingly, there are toolkits that support doing co-production well. All focus on the basic principle of setting a clear framework for any system aspiring to co-production for meaningful outcomes.

The ambitions of this mental health and wellbeing strategy represent an opportunity to take forwards what has been working well in co-production, whilst continuing to build on this and innovate. If we are to achieve this, we must bring people with us from across diverse demographics. This includes system partners, those using services and people who play a caring or supporting role to those who may at times struggle with mental wellbeing.

Gathering Insights in BNSSG: views on mental health and wellbeing services

There are many mechanisms by which insights are gathered about what people think about services and the support they need. These include methods such as the Friends and Family Test, exit surveys, distance travelled style questions and much more. These often provide valuable insight, although through a very reactive lens.

This year, we have taken the first steps in capturing insights about mental health and wellbeing from people in our communities in much more collaborative ways.

The development of the strategy started with a series of big conversations in December 2018, engaging over 1000 people. This included joint events with professionals, the voluntary sector and people with lived experience.

We ran a series of deep focus events on specific areas such as perinatal and maternal mental health and complex needs. There have been workshops with children in local schools and focus groups with young people including care leavers. A series of conversational 'light bulb innovation forums' where people can share ideas for a new future over lunch were in place over Summer 2019.

We also worked in partnership with the Independent Mental Health Network (IMHN) to design a new comprehensive review of the current perception of Mental Services across BNSSG. Service User Representatives from IMHN identified the key areas for evaluation and worked with insight and engagement experts from the CCG to capture and analyse feedback on our services.

406 patients, carers and service users gave feedback on services between July-September 2019. Service users recognize that some elements of our service provision are working well currently, with 34% praising the value of Talking Therapies. However, overall, only 11% of service users felt that the service "fully met" their needs.

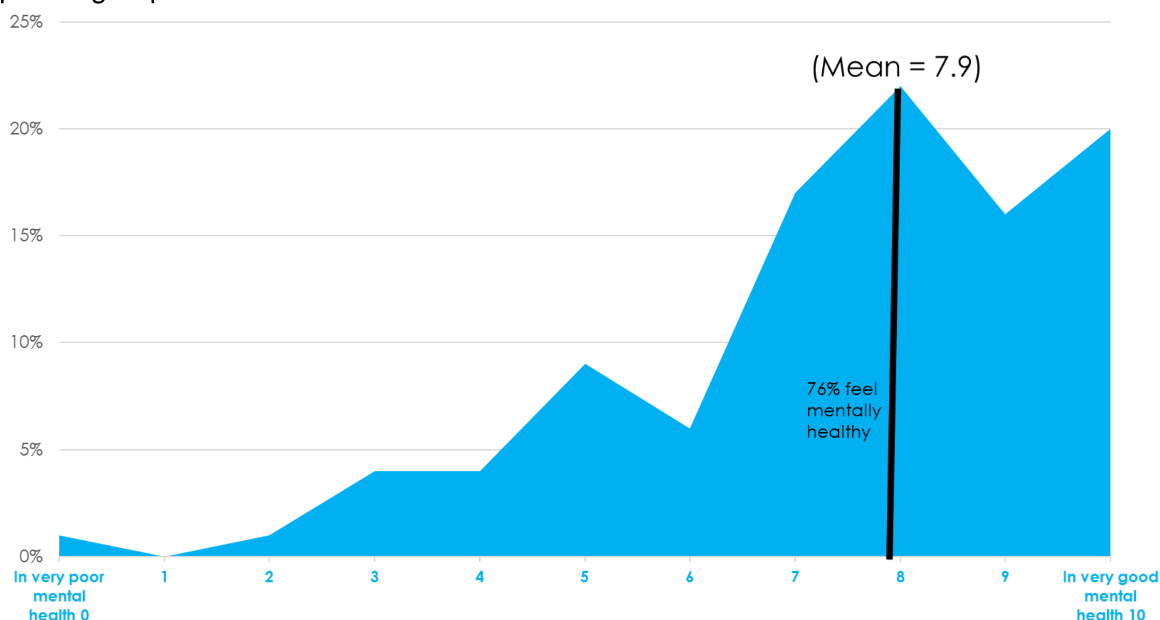
Key themes from the IMHN review:

- **Challenges in accessing support –** around 1 in 4 (24%) identified "waiting times" as a key area for improvement and a further 10% referenced a "complex/difficult referral process" The experience of crisis and the need for earlier intervention, community based services was discussed as one of the key changes people would like to see.
- **Continuity and long-term support –** amongst our survey respondents 44% were patients who had been discharged. Of those, around three quarters (77%) said they were not ready or were unsure if they were ready to be discharged. For many people continuity was a challenge, since building trust with a professional was cited as an important part of the recovery process.
- **Training for staff and attitudes -** particularly when calling the Crisis line and when in A&E departments where the level of awareness or access to mental health professionals is limited.
- **Being fully involved –** when reflecting on the support they received, our service users generally felt safe, listened to and involved in their care planning. However, 61% felt that they were not given enough information about how to get further involved in developing the service

Key themes from the Citizens' Panel

Healthier Together has been engaging with the BNSSG population via a number of routes. Our citizens' panel was set up to be able to understand how the general population feels and thinks about Mental health. The 1,034 strong panel reflects our population in terms of age, demographics, ethnic groups and geography. The results have captured a number of critical insights which have helped to shape our strategy.

We asked our panel ***"How mentally healthy do you feel?"***. The term 'Mentally Healthy' was identified through testing as the term that gave the highest level of understanding. 76% rated their mental health as positive. We saw some variations in geographic areas and specific groups.



- **Geography**: People in: North & West Bristol (8.4), Woodspring (8.2), South Glos (8.2) and Inner city & East (8.1) gave themselves a significantly higher rating for their mental health than those in South Bristol (7.6) and Worle, Weston & villages (7.1).
- **Gender differences:** Males 7.7 feel less mentally healthy than females 8.1.
- **Age Groups:** 65-74 years (8.6) and >75 years (9.4) feel the most mentally healthy compared to other age groups: 16-25 years (8.0), 45-64 years (8.0) and 25-44 years (7.3).
- **Ethnicity:** did not highlight any differences in response to this question.
- **Mental Health and Physical Health**: Those with a serious long-term condition (5.3) feel less mentally healthy compared to those without (8.3).
- **Social Isolation and loneliness:** Those living alone (7.3) and those not working (6.9) feel less mentally healthy

"How would you would take action in the event of a mental health issue?"

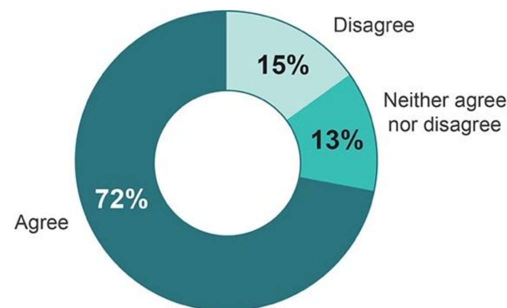
It is important to understand what people would do if they felt they needed support.

Many people with lived experience and groups we engaged with said that they found the process of getting help very challenging and this was an area for significant improvement.

For the general population, over 70% felt they would know where to get help, but there were some significant geographic differences which give us pointers where more targeted support will need to be tested as we deliver the strategy.

Almost half (42%) of the population believe we have more to do in raising awareness and providing information. There was an overwhelming agreement about the additional pressure on young people's mental wellbeing.

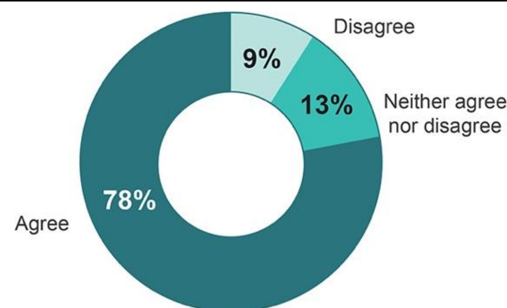
If I became worried about my mental health and wellbeing ***I am confident that I know the steps I need*** *to take to do something about it (680).*



15% disagree, of whom:

- Students 38%
- Inner City & East 32%
- Warle/Weston 20%

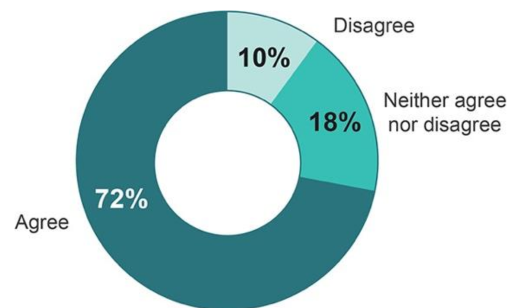
I feel that it's much ***easier to talk openly*** *about mental health and wellbeing these days (680).*



9% disagree, of whom:

- BAME 28%
- Inner City & East 21%
- Students 18%

I am personally very concerned about the ***mental health pressures*** *on children and young people these days (680).*

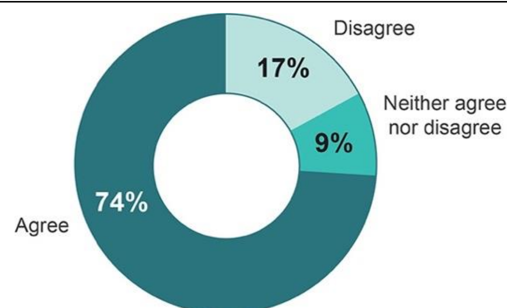


72% agree, of whom:

- 25-44 years 83%

10% disagree

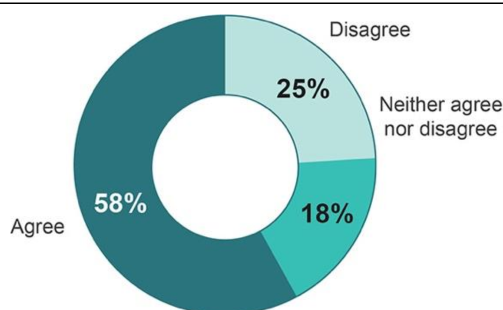
As a parent, I know what I would do *and where I would go for help if I was worried about my child's mental health (parents only, 232).*



17% disagree, of whom:

- Severe LTC 41%
- Worle / Weston 39%

I believe that there is a sufficient amount of ***awareness building and information*** *about mental health and wellbeing (680).*



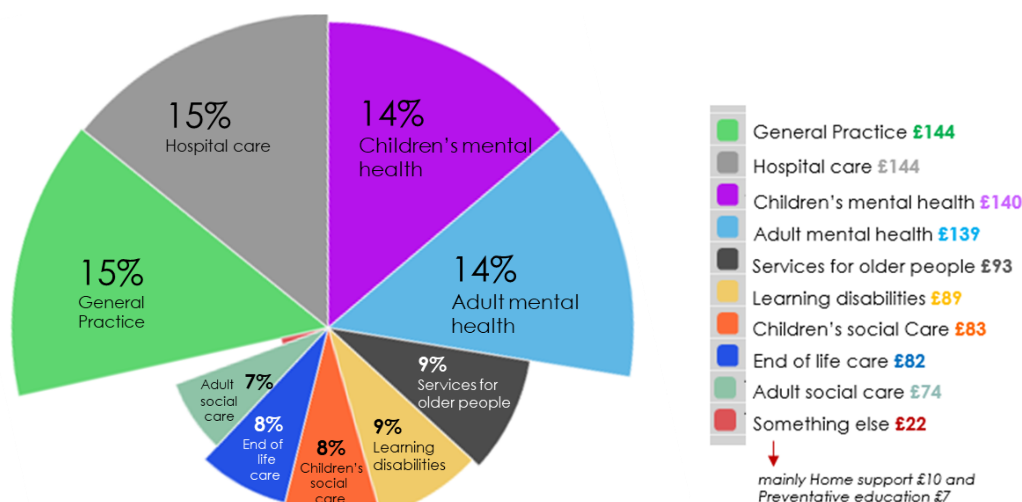
25% disagree, of whom:

- Inner City & East 64%
- Students 44%
- Living Alone 34%

Gathering Insights in BNSSG: how should our money be spent?

How we spend our money across health and care is guided by planning and prioritizing centrally. Nonetheless, we were keen to understand how the public felt the money should be spent as a way of understanding their priorities. The chart below shows the outcome. It should be noted this wasn't qualified with detailed understanding of how much things cost but rather a way of understanding relative priorities expressed by our population.

As outlined in the chart below, more than a quarter (28%) of the budget they allocated would be spent on Mental Health (split equally between adult and children's mental health. We have seen some interesting variations in the priorities by sub-groups; unsurprisingly those aged under 24 and those with children at home would spend more on children's mental health, whereas those who were unemployed would prioritize more spend on adult mental health. Overall, it is clear that mental health is a consistent priority for all of our citizens.



Gathering Insights: people with lived experience

The issues and themes raised by the citizens' panel point to requirements for a better funded and resourced mental health service model:

- **Easier and Faster access** with the default position being prevention and early intervention, especially for Crisis services and first contact with services. Need to avoid people being bounced back or between services and minimize occurrence of crises.

- **Longer term support and greater continuity** with better interface and closer working between services. In particular, when discharged from a service or finishing a course of therapy, many patients may need further support or treatment to ensure they don't regress. Rather than a new lengthy referral, could there be a fast track transfer route?

- **Broader range of services** tailored to individual needs and provided by knowledgeable health care professionals (HCP). Services and therapies that are suited to the needs of patients, rather than patients attending available options.

- **Open and responsive organizational culture** the desire is for HCPs who listen, are open and inclusive. The need is for consistency in both understanding and responsiveness to the needs of service users and carers alike.

Co-production: where are we now?

The importance of involving people with lived experience in the commissioning of well-being and mental health services is understood and accepted. However, there are seldom opportunities to undertake this in an integrated and meaningful way, ways that acknowledge and address the challenges, and which enable people to navigate their way through complicated infrastructures and which then result in significant change.

We are fortunate that across Bristol, North Somerset and South Gloucestershire there are a range of diverse, passionate communities all committed to making a difference and who have willingly supported development of this strategy.

- We developed the Vision with representatives of the statutory and voluntary sector across BNSSG and incorporated the views of people with lived experience of mental health services and their carers, via a wide range of meetings, forums and social media.
- We have used user experience journey mapping (addressing complex needs and perinatal mental health).
- We have started to do more to embed people with lived experience into designing strategies (this BNSSG Mental Health and Well Being strategy), as members of project boards and in taking part in commissioning and procurement activity (Community Services, IAPT).
- Further work has been done through 'mental health conversation events' focusing on particular system priorities. So far, these have included housing, homelessness and mental health; debt, welfare and mental health; and the mental health strategy itself.
- There is a strong and growing network of active people with lived experience that are shaping services through all phases of the commissioning cycle. This includes research / analysis, service specification development, procurement and the ongoing contract management of services.

The contribution of people with lived experience to the work of this strategy has been invaluable. People have welcomed the opportunity to be part of the development and have commented on feeling more like an equal partner. While developing the strategy and the plan is important, it is even more important for us build on our mutual cooperation as our foundation and that co-production remains an essential and embedded tenet of our work.

I want people to see me for who I am not judge me by their version of what my life should be: Mental health stigma is sadly still alive and well.

Why is there only a one size fits all offer in our mental health services? In other parts of my life I am important enough that I get to choose. Even buying a coffee I can personalise it!

Our Commitment to Co-production: Our Co-production Manifesto

We will design support and services in partnership. The work we have done to create the strategy will continue so we can achieve the vision in partnership. We will use best-practice evidence to deliver the best possible outcomes for citizens and their families in the most effective and efficient ways.

We will focus on making sure the investment of public money is made into areas where it will make the most difference to people, making sure we address inequalities and making sure that we factor in the social determinants that are often at the root of people feeling anxious and distressed.

We will ensure people with lived experience are appropriately valued and rewarded for their contributions. This will include developing a consistent framework to manage 'reward and recognition' across the system.

We will ensure that the values and ethos of co-production are embedded into everything that we do as a system. This will include developing a more consistent understanding of what co-production is, as well as what it isn't.

We will strive to operate at the highest level of co-production at all times where it is possible to do so, recognizing the hugely valuable role people with lived experience bring to the table.

We will engage with a diverse range of people with lived experience. We will seek to engage people in their communities on their terms. We will take time to understand what really matters the people who make up our vibrant and diverse population.

Key Deliverables Co-Design and Co-Production

DELIVERABLE 1: Production of Training and Awareness Materials. We will work with lived-experience-led organisations and individuals drive innovative approaches to co-production. The first test advocated by users is to utilize a Citizen's Jury model.

We will develop a toolkit and training materials to support employers, communities, health and care staff across the system to develop their knowledge, skills will be developed and designed by people with lived experience. This will include training opportunities that can be

extended to smaller organisations and businesses wishing to engage in the Thrive, mental health and wellbeing and co-production agenda.

DELIVERABLE 2: Experience informed commissioning as part of value-based commissioning. We will embed the unique perspective of co-production at every stage of the commissioning cycle for mental health services.

Lived experience representatives will be involved at all stages, including the development of experience KPIs to embed into value-based commissioning, ongoing contract management, and performance improvement of service providers.

DELIVERABLE 3: STP-Wide Mental Health Lived Experience Advisory Board. We will develop an STP wide lived experience led working group that will influence the ongoing development of the strategy and its implementation phase over the next 10 years.

The group will include up to 25 individuals reflecting a representative sample of the population. This group will provide links to the health and wellbeing boards ion each of the local authority areas as well as links to other STP work-streams where required.

An example of the aims of the group, as requested by our lived experience team:

- Strengthen the engagement and empowerment of local diverse communities in the development of mental health support across BNSSG.
- Increase and improve co-production in the delivery of the mental health strategy throughout the implementation phase.
- Act as a forum to advise system leaders on key matters relating to mental health and wellbeing. Connecting the reality of 'on the ground' with senior strategic system leaders.

The group will support the STP's work in relation to Patient and Public Involvement (PPI) and its ongoing commitment to co-production in the development, delivery and ongoing monitoring of mental health support across BNSSG.

What measures will we use?

- We will use a consistent set of both quantitative and qualitative system measures to assess what levels co-production happen at (on a ladder or equivalent bespoke model to be designed for the system). This will include clear and transparent reporting by all system partners at regular intervals, providing case studies on what co-production has been done, how it took place and the difference it has made.
- We will use clear feedback tools to understand a person's experience of working in a co-production process, including what worked well, what didn't and how things could be done differently for the future. We will share learning across system partners to increase knowledge exchange.
- We will measure the number of individuals taking part in co-production across the system and report on this annually. This will include summary reporting on demographics to better understand who is taking part and any key demographics that are missing.
- We will ensure a 360-review process takes place with lived experience led organisations and we will gather feedback on their perspectives of what is working well, what isn't and what needs to be done differently.

- We will continue to involve people with lived experience in designing the measures and the final decisions on what measures to use and how to apply them.

Chapter 4: Carers

OUR AMBITION:

We recognize the vital role that carers play and we will improve their support.

At a national level, the statistics on the mental and physical health impacts for carers of individuals with a mental illness make difficult reading. They demonstrate that the role carers undertake is demanding, not only on a daily basis, but of their own health in the longer term. The Mental Health Foundation[1] compiled a summary of some of the most notable statistics (2016) as follows:

- Looking after a family member with a mental health problem can have a significant impact on carers' own mental health. Mental health problems of carers include emotional stress, depressive symptoms and, in some cases, clinical depression.[1]
- 71% of carers have poor physical or mental health.[2]
- Carers UK's annual survey (2015) with over 5,000 carers across the UK revealed that 84% of carers feel more stressed, 78% feel more anxious and 55% reported that they suffered from depression as a result of their caring role, which was higher than findings in 2014.[3]
- 38% of young carers report having a mental health problem, yet only half report receiving additional support from a member of staff at school.[4]

In 2016, Healthwatch completed a report on the local experiences of this group of carers in BNSSG[2]. The findings were an insight into the current situation. There were reports of positive experiences in Primary Care where individuals were able to access the same GP consistently who was familiar with their circumstances and the history of the individual being cared for. This was however, not happening in many cases and carers felt that they were often repeating themselves to strangers without any continuity of care. Carers also felt that at times they were not listened to by services or kept informed about important developments in care planning.

Access to community services, respite and local activities for individuals with a mental illness was felt to be limited; and carers had to keep people at home with variable and often little support. This is very challenging both mentally and physically for the carers.

There was also a lack of access to any specialist support for carers, although some had found useful help from the Care Forum, and Young Carers organisations. Mental health support for carers was not easily accessible and could require outside support to enable a carer to attend a session.

This needs our better attention as a health and social care system to support our remarkable carers. BNSSG will recognize the vital role of carers as 'partners in care' and experts in the care of their loved one. To do this we will adopt the 'Triangle of Care Model' *developed by the Carers Trust for this cohort as a best practice approach.

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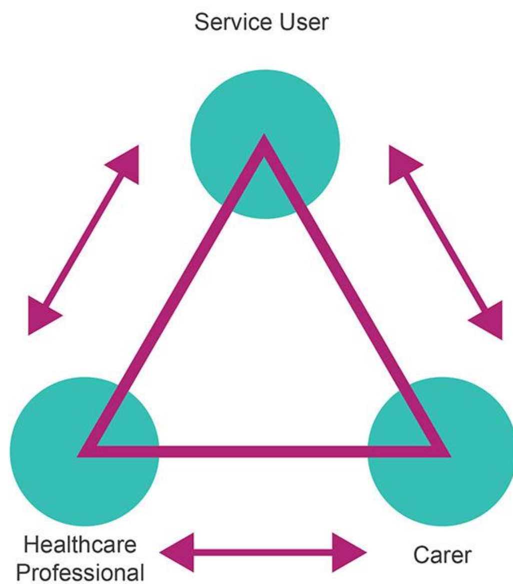
[1] https://www.mentalhealth.org.uk/statistics/mental-health-statistics-carers

[2] https://healthwatchbristol.co.uk/wp-content/uploads/2016/06/HWB-Mental-health-carers-08nov16-1.pdf



*Used by kind permission from Carers Trust

"The concept of a triangle has been proposed by many carers who wish to be thought of as active partners within the care team. It is seen when there is collaboration between the mental health professional, service user and carer.

The link between the professional and patient often defines the service, but in most cases the bond between patient and carer has pre-existed.

An effective Triangle of Care will only be complete if there is a willingness by the professional and carer to engage." [3]

The six key standards to achieve best practice state that:

1) Carers and the essential role they play are identified at first contact or as soon as possible thereafter.
2) Staff are 'carer aware' and trained in carer engagement strategies.
3) Policy and practice protocols re: confidentiality and sharing information, are in place.
4) Defined post(s) responsible for carers are in place.
5) A carer introduction to the service and staff is available, with a relevant range of information across the care pathway.
6) A range of carer support services is available.
7) In addition to the above, there also needs to be regular assessing and auditing to ensure these six key standards of carer engagement exist and remain in place."

By 2022-23, Bristol One City plan will ensure all unpaid carers are identified, assessed, supported and valued in their caring role, recognised and respected as 'expert partners in care.

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3 https://professionals.carers.org/sites/default/files/thetriangleofcare_guidetobestpracticeinmentalhealthcare_england.pdf

DELIVERABLES

We are committed to meet the requirements of the NHS Long Term Plan for Carers. We will always enquire after 'Carer status' wherever people present in the BNSSG Health and Social Care system. We will roll out carer passports (piloted in Bristol and recognized nationally) that provide bespoke rights, support, discounted parking and catering. We will listen to Young carers, raise awareness of their experiences among health professionals and share information to help our workforce provide better support.

We will meet the standards of the NHSE Quality Markers for primary care which describe best practice in carer identification and support. We will pro-actively offer carers advice on how to stay well, access services, and avoid illness themselves.

We will include people with lived experience, and/or carers, as members of our governance and business meetings as the norm. Proactive encouragement for (people and) carers to engage in research improves wellbeing.

We will improve the knowledge and capability of our care navigators and co-ordinators to support carers as well as individuals with a mental illness. We will compile a guide to local services for carers with our voluntary sector partners and review any gaps that prevent access to support.

We will baseline and then measure the numbers of carers who develop mental health issues, sharing information across our system to monitor whether our new interventions are having a positive impact. Carers are an equally important piece of our health and social care system and deserve our respect and support for their difficult role.

Chapter 5: Perinatal and Infant Mental Health

OUR AMBITION:

Every mother and partner will have fast access to the right level of support to minimize the impact of perinatal mental ill health on parents, children and families.

Having a baby and becoming a parent is an important part of life. As well as the joy of a new baby there is much to adjust to – parents may experience sleepless nights and worry and anxiety people feel becoming new parents and feeling unsure of what to do, dealing with the change in lifestyle, money worries how to work thought childcare and having a new life to take responsibility can feel overwhelming. Making sure that people are aware of support and how to access help early has become part of the preparation process for pregnancy, birth and becoming a parent in the early years. There are many online resources social media feeds and discussion groups that are designed to help people cope and enjoy pregnancy and parenting.

For 20% of women perinatal mental health issues occur during pregnancy or in the first year following birth. The illness may present as a wide range of conditions with differing degrees of severity. If left untreated, a mother's perinatal mental ill-health can affect children, other parts of the family unit, including the parent who is not bearing the child.

- One in five mothers suffers from depression, anxiety or psychosis during pregnancy or in the first year after childbirth.
- Around 3,000 women a year in BNSSG need help with perinatal mental health problems.
- Around 700 women in BNSSG have serious perinatal mental health problems including psychosis, bipolar, severe depressive illness and PTSD.
- 90% of women diagnosed with maternal mental health needs are cared for in primary care.
- National figures estimate that 50% of perinatal mental health is not detected and of those that are detected 50% are not treated.

In order to drive out some of the health inequalities and address the higher levels of prevalence we have to focus on supporting the next generation. Evidence is becoming more compelling that the impact of perinatal mental health problems can have long-standing effects on children's emotional, social and cognitive development.

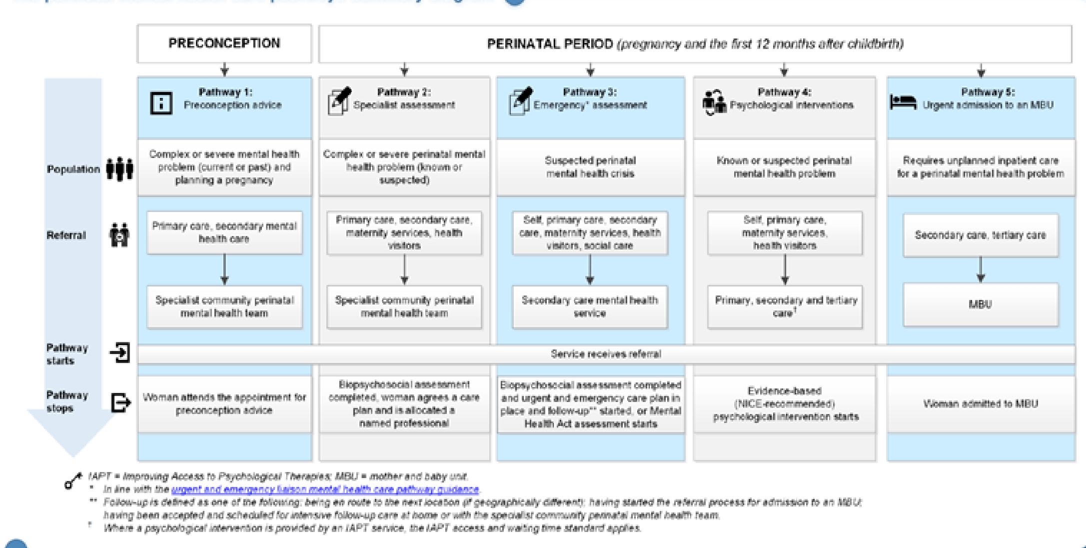
BNSSG was one of the regions in the country to develop a perinatal community mental health service this was set up for Bristol as part of the Five Year Forward View. We know from the co-production we have done together that there are some key factors to support women better

Accessing the Right Support at the Right Time

Considerable work has gone into developing our local Perinatal Mental Health Pathway but there is more to do women still report the gaps and having to repeat themselves to multiple different people through their maternity journey and into early years. A specialist community Perinatal Mental Health service was commissioned by the CCG in 2016/17 and was successful in getting funding from Wave 1 of the national Community Service Development Fund to bring it up to the capacity recommended by the Royal College of Psychiatrists. We are now able to offer support to those women with the most serious mental health needs during and after pregnancy.

All three community midwifery services screen women at booking, and between them refer 50- 60 women per week with some level of mental health need or distress to specialist Obstetrician/Nurse led clinics at NBT and UHB. This suggests that around 3,000 women per year or 25% of all pregnancies need support for moderate to more serious mental health needs.

Our priority is to ensure that there are pathways and support in place for women who experience mild to moderate perinatal mental health issues, including Post Traumatic Stress Disorder, pathological fear of pregnancy, and other forms of distress. This work will involve partners including primary care and the voluntary sector. In line with the national guidance set out below.



Increasing Access to Psychological Therapies (IAPT) services have been recommissioned across BNSSG and Bluebell are a core partner, and as such we are confident that we will be able to improve the support that is offered to mums and partners through this service. We are also supporting our very effective voluntary sector services including Mothers for Mothers, Bluebell Care, Homestart and Rockabye, which are able to provide support for those women who are unable or unwilling to access statutory services. Bluebell Care and Mothers for Mothers are led by women with lived experience and are actively involved in service review and development.

Groups such as Bluebell already offer peer support to new and expectant mothers in a warm and welcoming environment which is located alongside maternity services. However, we still have more to do to provide the right level of access as part of our co-production work several key themes have emerged:

- Access
- A place to go to get support
- Importance of peer support
- Awareness, education and training

DELIVERABLE 1: We will explore how we create a more accessible pathway of support including links via Maternity teams and Health Visitors, and how we increase the expertise provided via IAPT services to support perinatal mental health and peer support services

The Role of Primary Care

Primary care provides support for 90% of cases so the advice for GPs in supporting perinatal mental health is key. We will be driving up awareness linked to the RCGP focus on perinatal mental health. The NHSI perinatal tool kit was developed in 2015 but has had limited usage to date. The advice and guidance (below) is simple and easy to use, to try to give some insights and basic considerations.

Maternal Factors for Poor Detection	**GP Factors for Poor Detection**
• Stigma • Putting on a brave face • Fear of being thought a 'bad mother' • Fear the baby may be taken away • Not knowing what is 'normal' • Not knowing if treatment will help	• Not asking • Time constraints • Lack of training or confidence • Lack of access to specialist service • Normalising or dismissing symptoms

As a GP what could I do?

- ☐ Be proactive
- ☐ Ask open and interested questions about how she is finding being a mother, even if she is smiling!
- ☐ Ask every time you see her; don't assume someone else has asked
- ☐ Consider asking the 2-question depression test and GAD-2 (please go to the bullet points in recommendation 1.5.4)
- ☐ Consider using the wellbeing plan to recognize, support disclosure and engage with women
- ☐ Respond to 'cues' (e.g. poor eye contact, tears, not sleeping when baby sleeps, reporting feeling overwhelmed)
- ☐ Remain vigilant throughout the first year following birth
- ☐ Recognize the exceptional opportunity of the 6-8 week maternal postnatal examination
- ☐ This may be the only time you, as a GP, see a mother in the entire pregnancy and postnatal period
- ☐ Consider asking about possible mental health illness BEFORE focusing on the

physical tasks

- Consider doing the mother’s postnatal at a different time from the baby check
- Disclosure is a ‘red flag’. It’s so difficult for a woman to raise this with a GP; if she says she has a problem, assume she does. Do not dismiss her.

DELIVERABLE 2 – We will work with the Maternal Health Alliance, embedding the use of the toolkit and the learning from the RCGP GP Perinatal champions work.

In direct response to the co-production work through the strategy, a perinatal high impact team has been set up for 2019/20 which will focus on mental health issues that affect the family unit in the first two years after birth – extending beyond the ‘first 12 month’ definition applied nationally to explore if there is further insight and support that can be provided. This constitutes deliverable 3 for Perinatal Mental Health.

DELIVERABLE 3 - For Perinatal HIT we will seek to understand and provide additional guidance on the following areas:

- Produce guidance on prescribing anti-depressant drugs during pregnancy and complete analysis of largest study in this area.
- Improve support for women with low mood/mild depression/anxiety by assessing the role of children centres as a place of support. Analysis of children centre survey data and responding to the voices of people highlighting the need for a place to go.
- Improve service provision for women who do not have a child, whether through perinatal death or having their child taken into care.

Patient Quotes

On Co-location & Welcoming Environment

I shouldn't have had to go to A&E there should be appropriate support [for me].

Connecting with other mums who were going through the same thing.

On Peer Support

Those who have had long-term mental health issues are the experts.

Extra Support to Existing Services

GPs are amazing, but so overworked […] You wait half an hour for your appointment, you are shoehorned in, asked questions […] Get your prescription and off you go.

Increased Awareness & Education

Doctors and midwives don't know much about [services such as Bluebell], so I didn't know what to expect. Would make it easier if they knew more and could tell you. I was quite anxious coming here [to Bluebell] the first time.

Chapter 6: Children and Young People

OUR AMBITION:
We will ensure that every child has the right to grow up and be educated an environment which nurtures their mental health with support available when it's needed.

Adverse Childhood Experiences (ACEs)

At the centre of our strategy is the belief that many mental health problems are preventable and that there is far more scope for interventions that reduce the likelihood of people developing mental health problems and increase the potential for sustained recovery for those that do.

One of the starkest examples of how a lack of preventative or early intervention work can have on a person's physical and mental health is Adverse Childhood Experiences (ACEs). ACES are stressful events occurring in childhood including:

- domestic violence
- parental abandonment through separation or divorce
- a parent with a mental health condition
- being the victim of abuse (physical, sexual and/or emotional)
- being the victim of neglect (physical and emotional)
- a member of the household being in prison
- growing up in a household in which there are adults experiencing alcohol and drug use problem

The more ACES experienced, the greater the impact on mental health. The prolonged stress experienced as a result of ACEs can disrupt early brain development and compromise the functioning of the nervous and immune systems. In addition, the coping behaviours adopted by those who face ACEs to deal with the resulting stress can lead to depression, alcoholism, eating disorders, substance abuse and long-term physical conditions such as cancer and chronic diseases.

People who have experienced six or more ACEs are 35 times more likely to die by suicide.

Evidence shows that people with multiple ACEs who do not receive timely support will experience regular mental health crises requiring emergency interventions, and develop lifelong mental health conditions requiring long-term care. Every ACE left unaddressed therefore represents a missed opportunity to prevent mental illness, build resilience, improve life chances and reduce later public expenditure.

Other childhood risks: bullying, gangs and school absenteeism

There is some evidence that bullying, being a member of a gang, and being absent from school for long periods can undermine mental health. Young people in gangs face particularly high rates of mental illness.

- 40% of youth justice entrants who were also gang members showed signs of severe behavioural problems before the age of 12.
- One in three female and one in ten male gang members are considered at risk of suicide and self-harm.

Children and young people who are not in education, employment or training (NEETs) have more mental health and substance misuse problems than their non-NEET peers; the younger the NEET, the more detrimental the impact on mental health.

BNSSG prevalence and response

Using our Joint Strategic Needs Assessments we have identified that:

- In Bristol 16% of children and young people live in some of the most deprived areas in England
- 23.2% of children and young people in Bristol live in low-income families, compared to an England rate of 20.1%
- The number of 16-18 year olds Not in Education, Employment or Training (NEETs) is significantly higher in Bristol than nationally
- There has been an increase in recorded domestic abuse in Bristol over the last 2 years
- 2% of children and young people in Bristol are registered as a ‘cause for concern’ compared to the England rate of 37%
- In South Gloucestershire, deprivation rates are broadly in line with the England average, but admissions for mental health needs have increased significantly from 2010-2015.
- North Somerset has a higher than national rate of permanent exclusions from education
- North Somerset has a higher rate of children in care than the England average
- Like Bristol, 41% of children and young people in North Somerset are registered as a ‘cause for concern’

Based on national evidence and best practice, we can see that a high proportion of children and young people in our communities are at risk of ACEs. We must therefore focus on building the right early help, intervention and ongoing treatment support to mitigate the impact of these experiences on their lifelong mental health and wellbeing.

What are the challenges we face in improving children and young people’s mental health and wellbeing?

While we have made changes to Children and Young People’s Mental Health Services (CAMHS) over the last 3 years, we need to take the next step in transforming our care provision if we are to achieve measurable improvement in outcomes.

We know that children and young people have had less favourable access to support for mental illness when compared with adults. We have already increased resources by applying transformation funding from NHS England, however this is not yet sufficient to achieve consistently low waiting times for services. We know that we need to focus much more on prevention and wellbeing and increase access if we are to address rising demand.

Through our engagement work we have received feedback which shows:

- We need to improve the links between education and health, so that we take every opportunity to promote wellbeing and resilience, intervene early and support children and young people who are recovering from mental ill health.
- Parents report that there is a significant gap between each tier, meaning that the transition from early help and intervention to more targeted services for example can feel like a 'cliff edge'.
- Our support for children and young people is different in each of our council areas, resulting in different access and outcomes and confusing referral pathway.
- We have not consistently involved children and young people in decision making, resulting in a culture where children and young people may fear disclosing issues, or when they do, may feel that they are not taken seriously enough.
- Bristol and South Gloucestershire CAMHS are provided by a partnership of local providers; North Somerset CAMHS are provided by Weston Area Health Trust. This means that opportunities to integrate services and teams are not uniform across BNSSG.
- CAMHS services are currently designed to treat the 0-18 year age range. The NHS Long Term Plan extends services to meet the needs of young people aged 0-25years.
- Thresholds to receive help from CAMHS services are high, meaning that children and young people are not always able to access the right services, or any services, to help them.
- Young people report that transition to adult services is not always well-managed, and may not provide for sufficient support for ongoing mental ill health into adulthood.

How do we intend to transform children and young people's mental health services?

Our vision is to enhance and develop support and services for children and young people across BNSSG. We want to help our children and young people to thrive, giving them the ability to live full lives and to continue confidently into adulthood, managing their own mental health and wellbeing successfully.

Our ambition is to drive change in service provision through the consistent and successful implementation of the i-THRIVE framework, developed by the Anna Freud Centre and which has been adopted across our system already.

This framework is not just about providing health interventions, but also about changing our collective approach to children and young people's mental health and wellbeing.

Underpinning all aspects of our strategy, it a commitment to continued engagement, participation and service design and a co-produced partnership between commissioners, statutory health and social care providers, the voluntary sector, children, young people and their families with lived experience

Prevention and Promotion – Building a Thriving community

At the heart of the i-Thrive approach is a focus on prevention and promotion, supporting and enabling children and young people to manage their own mental health and wellbeing. We know that making this a reality will involve repurposing some of our current resources to support preventative and early intervention approaches as well as providing high quality care to people that already have more significant or longstanding mental illness.

Prevention operates at different levels:

- **Primary prevention** - Stopping mental health problems from occurring in the first place by using 'upstream' approaches or interventions.
- **Secondary prevention** – Identifying the earliest signs that mental health is being undermined and ensuring early intervention is available to minimise progression into a more serious mental health problem.
- **Specialist/Tertiary prevention** - Working with people with established mental health problems to ensure the earliest path to sustainable recovery and to reduce the social, economic and health impacts often resulting from living with a mental health problem.

We also need to think more about how we focus our preventative interventions progressively, supporting those most at risk. This is where we believe that population based approaches such as 'iThrive' can work in conjunction with more specific health and care system strategies such as the NHS Long Term Plan, the Five Year Forward View for Mental Health and our own BNSSG Mental Health Strategy.

- **Universal**: seeking to influence a whole population or groups within institutions such as workplaces, schools, colleges.

- **Selective:** seeking to reach individuals or subgroups based on known areas of generally higher risk, including those who may not be showing signs of developing a mental health problem but live in circumstances or with discrimination & stigma known to be corrosive to mental health (eg children and young people from BME communities, children and young people who live in unstable housing, and children and young people with learning disabilities).
- **Indicated:** targeting people at the highest risk of mental health problems and potentially showing early indications such as children whose parents have a serious mental health problem.

Across BNSSG, we will collaborate to promote wellbeing, replicating the support given to schools and children's centres, into (for example) youth clubs, voluntary sector run groups, sport and arts clubs. Our work is founded on strong collaboration and partnership between all health, social care, education and third sector organization. Since we have three Local Authorities within our system, our approach to prevention and promotion of mental wellbeing is multi-faceted and aligned with each geography. Key areas of focus for each area are:

- Encouraging schools and colleges to improve mental health amongst the whole school community
- Targeted support from Bristol City Council for the schools with the highest level of need according to the Pupil Voice health survey and community health data
- Ensuring that parents are able to take up the offer of parenting support, by reviewing the current provision and by working with parents to identify barriers to accessing support.
- Developing and monitoring specific service provision for identified, vulnerable groups: looked after children, care leavers, young offenders, children and young people affected by domestic abuse, and other minority groups
- Developing an evidence-based training programme in emotional wellbeing, mental health, relational trauma and child development for the wider workforce
- Improving the IT infrastructure to enable electronic healthcare records and the recording and analysis of emotional wellbeing and mental health data to inform a robust JSNA (Joint Strategic Needs Assessment).

Our focus in all of the above is creating the right services, wrapped around children and young people, to improve overall mental wellbeing and enabling them to thrive.

Thriving: Getting Advice

Where children and young people do need additional support, we will implement a range of actions that ensure that support earlier intervention, specifically:

- We will embed mental health support teams in schools, implementing the requirements of the CAMHS Green Paper
- We will create a consistent digital offer, building on our existing Kooth platform and combining this with other digital solutions that support children and young people so that they can learn how to protect and manage their own mental health and wellbeing.
- We will learn from the Adverse Childhood Experiences HIT and improve our approach when supporting children and young people who have experienced childhood trauma that may affect their mental health.

- We will increase the knowledge and understanding of children's mental health among primary care professionals, providing them with a comprehensive Directory of Services to which children and their families can be directed for early advice and support.

Thriving: Getting Help

For children and young people who do require the input of secondary mental health services, we will make changes to our current model:

- We will ensure that the core CAMHS offer is consistent across BNSSG and that children and young people have equitable access to all services
- We will extend current service models to create a comprehensive offer for 0-25 year olds that reaches across mental health services for children, young people and adults. The new model will deliver an integrated approach across health, social care, education and the voluntary sector, such as the evidenced-based 'iThrive' operating model which currently covers around 47% of the 0-18 population and can be expanded to 25 year olds.
- We will reduce waiting times for CAMHS, delivering earlier access to the 'right help, first time', for children and their families, and meeting the requirements of the Long Term Plan.
- We will improve our CAMHS IAPT offer, increasing access and recovery rates. Alongside this, we will develop a Primary Care Mental Health service for children and young people.

Thriving: Getting More Help

For those children and young people who require specialist intervention, our focus will be on managing them out of hospital and as close to home as possible, avoiding lengthy stays away from their families and carers:

- We will develop existing CAMHS Eating Disorders services further, investing in new models that enable more children and young people to be treated in an outpatient setting.
- We will review our approach to children and young people with severe mental illness to create a model of care that addresses their more complex needs.
- We will always co-create care packages with children and young people, and their families.
- We will ensure that people needing more extensive treatment are supported in achieving their goals and recovering.
- We will increase access to Specialist CAMHS to meet 32% of local need by 2019/20, with a specific focus on children and young people waiting for an Autistic Spectrum Condition assessment

Thriving: Getting Risk Support

We know that we have not consistently provided good access 24/7 for children and young people in crisis. Children and young people are admitted to general acute and mental health inpatient units as a result, and we are keen to change this:

- We will continue to develop and improve an integrated 24/7 crisis response for children and young people, aligned with all providers and working alongside, our inpatient services, primary and community, social care and VSE.
- Some key improvements are already happening From September 2019, we will have 24/7 CAMHS crisis support weekends via the Intensive Support team.

Measuring Success

We have heard directly from children, young people and their families about their current experiences of services, and it is our ongoing dialogue with them that will provide the evidence of our success.

Over the course of our strategy we will co-develop and co-produce a suite of outcomes-based measures, which will include specific standards including:

- Increased access to services, with shorter waiting times.
- Reductions in the number of children and young people presenting with deliberate self-harm, with a corresponding reduction in the number of children and young people with mental health needs presenting to physical health services.
- Reduction in referrals to CAMHS services, with more children managed proactively in the community by a wider range of partners.
- Reduction in children and young people admitted to general acute units
- Increased use of digital offers by children and young people, and their families.
- Reduction in children and young people presenting in crisis and requiring admission to an inpatient unit.

Extending services – 16-25 year olds

The commitment in the Long Term Plan to extend children and young people's services from 0-18 to 0-25 is expected to increase demand. BNSSG has a high population of young people aged 16-25, driven in part by the 42,000 students in two universities in the city. Improving student mental health services has been identified as a particular need. We are working closely with NHS England and Universities UK, via the Mental Health in Higher Education programme, to build the capability and capacity of our universities to improve student welfare services. We will improve access to mental health services for higher education students, focusing on suicide reduction, improving access to psychological therapies and groups of students with particular vulnerabilities.

We are also keen to improve outcomes for children and young people who are leaving long-term care, many of whom have often had difficult lives and who have had to start being independent earlier than a lot of their peer group. Research shows that nationally, young people who have been looked after often face difficult social challenges. Evidence also demonstrates that there is a proportionately higher percentage of care leavers who are homeless, become teenage parents, self-harm in adulthood and or who have contact with the criminal justice system. There is a significantly higher gap between the educational and employment achievements of care leavers and other young people.

Historically, the Department for Education has only collected data for Care Leavers aged between 19 and 21; this has now been extended to 17 and 18 year olds, with local authority

tables covering this wider age range. The North Somerset data, published in December 2016[4], show that there were 20 care leavers aged 17 and 18 years old of whom 55% were in Education, Employment or Training (cf 61% England), with 40% Not in Education, Employment or Training (NEET) 'for other reasons' (cf 25% England), with less than 5% NEET due to 'illness/disability'.

There were 110 care leavers aged 19, 20 and 21 of whom 46% were in Education, Employment or Training (cf 49% England), with 16% NEET due to illness/disability (cf 10% England), 22% NEET for other reasons (cf 23% England), and 8% NEET due to pregnancy or parenting (cf 7% England).

We know from local data that there are a significant number (n=20) of North Somerset Care Leavers aged between 17 and 21 years old who are Not in Education, Employment or Training (NEET) and have been assessed as not being fit to work due to mental health issues.

Keep on Caring seeks to enact (ie in the *Children and Social Work Act*[5]) for the first time what is expected from a local authority in its role of a 'good corporate parent'. We will work with partners across our system to implement the commitments set out in this document, specifically:

- creating a new care leaver covenant;
- introducing a new legal duty on local authorities to consult on, and publish information about, services for care leavers; and
- extending existing entitlements so that all care leavers will be able to access support from a local authority Personal Adviser to age 25.

As part of the extension of our services, we will ensure that we achieve the following outcomes for our care leavers so that they are:

1. Better prepared and supported to live independently
2. Have improved access to education, training and employment
3. Experiencing stability and feeling safe and secure
4. Have improved access to health support [with a focus on mental health]
5. Able to achieve financial stability

Transition

Transition to adult services has been a focus of service change and improvement in recent years. We will continue this work as part of our strategy, recognizing that we will need to change and adapt current models taking into account the increased age span of our existing services. We will continue to use NICE guideline NG43 *Transition from children's to adults' services for young people using health or social care services* (NICE, February 2016) as the

[4] https://www.gov.uk/government/statistics/children-looked-after-in-england-including-adoption-2015-to-2016

[5] The Children and Social Work Bill passed its Second Reading on 5 December 2016 http://services.parliament.uk/bills/2016-17/childrenandsocialwork.html

foundation of our transition improvements. This will include continued implementation of their recommendations to:

- Co-produce transition policies and strategies with young people
- Deliver developmentally appropriate transition
- Provide strengths-based and person-centred transition support;
- Work in partnership across health and social care to develop a joint mission statement and vision for transition and jointly agreed and shared transition protocols, information-sharing protocols and approaches to practice.

> We will take an age-less approach to transition: individuals mature at different rates so we will ensure transition is needs-led and not based on age alone. Transition will be individualized and based upon need.

Moving to a transitional approach to safeguarding

The evidence points to a need to consider a new way of working wherein existing safeguarding systems and services for children and adults become more aligned, more fluid and more responsive to the dynamic needs of adolescents and young adults.

Outlining the case for 'transitional safeguarding'

It is important to note upfront both the financial realities facing the sector and the financial case for innovation in this area. The financial constraints facing local areas make it difficult to undertake any work considered non-statutory, and enacting many of the points raised in this briefing would indeed require local services to provide support to young adults that are currently not receiving a safeguarding response.

However, investing in preventative and recovery- oriented work to promote people's safety and wellbeing can play an important role in avoiding the costs of later intervention.

Evidence from the UK and international contexts suggests that failing to help young people recover from harm and trauma can mean that problems persist and/or worsen in adulthood, creating higher costs for the public purse (Chowdry and Fitzsimons, 2016; Kezelman et al, 2015). Adults facing multiple problems and adversities can then find that local services are not able to meet their needs effectively, meaning this group of adults 'end up living chaotic and expensive lives' (see the work of the MEAM Network for more information on how local areas are seeking to address this7).

The challenge for local areas, as with other 'invest to save' activity, is to demonstrate which parts of the system benefit from this investment, in order to incentivise and sustain investment. This relies on cost data analysis capacity, highly effective collaboration across partners and a systems leadership approach.

There are several reasons why a more fluid and transitional safeguarding approach is needed for young people entering adulthood. These are summarised as:

a) Adolescents may experience a range of risks and harms, and so may require a distinctive safeguarding response.
b) Harm, and its effects, do not stop at the age of 18.
c) Many of the environmental and structural factors that increase a child's vulnerability persist into adulthood, resulting in unmet needs and costly later interventions.
d) The children's and adults' safeguarding systems are arguably conceptually and procedurally different, and governed by different statutory frameworks, which can make the transition

to adulthood harder for young people facing ongoing risk.
e) Young people entering adulthood can experience a ‘cliff-edge’ in terms of support.

Above copied from: ‘Transitional Safeguarding - adolescence to adulthood’ 2019
www.rip.org.uk

Chapter 7: Complex Needs, Severe Mental Illness & Personality Disorder

OUR AMBITION:

People with complex needs will not fall between the gaps or bounce between services. Services will respond to individual need with coordinated care packages that promote independence and personal recovery

- In England, severe mental illness (SMI) reduces life expectancy by 20 years - and this gap is increasing.
- Of national regions, the South-West has the lowest performance for physical health checks in SMI (NHSI Q1, 2019-20)
- Mental ill health is the largest single cause of disability in the UK.
- Mental health problems account for 23% of UK ill health.

As challenging as these statistics are, they mask the shocking health outcomes for people who experience both physical and mental ill health, who experience severe and enduring mental illness or personality disorder. In BNSSG there are 10,000 people with SMI in 2019; they have some of the poorest health outcomes and are trapped by a health and care system that simply isn't designed to meet their needs.

From the co-production work we have been doing, we know it is vital that as we support someone, we remain aware that that person is likely to have a history of trauma. People want and need consistent, unconditional support. They need to co-produce their own personal long and short terms goals focused on individual strengths and preferences. People with complex needs are likely to experience multiple social deprivations, including homelessness, poverty and substance misuse and need non-medical support to improve quality of life and stability. These wider determinants cannot be ignored, even if direct influence and resolution is not immediately possible.

The story for many people in this cohort of the population is pretty bleak. They have early experience of trauma, which too often goes unrecognized. They are dealing with multiple issues and may become chaotic, seeking contact with services only at crisis point. Once they are at crisis often wanting or demanding a response to an urgent and immediate need. Many of these same people with the most complex needs may only be able to tolerate only limited contact at any one time; they are anticipating and expecting rejection and just the process of interacting with services is one they describe as extremely stressful.

In the context of rising demand, services have tended to disengage from clients, or project responsibility onto the person for failure to engage or comply. For these reasons, while experiencing multiple deprivations, some people may be excluded from receiving the very support they need. In seeking support for multiple challenges, some people move in and out of contact with crisis mental health services. Some people with multiple deprivations are likely to be frequent users of the Emergency Department and other emergency services.

Where are we now?

Golden Key estimated in 2012 that there are approximately 1,000 individuals with complex needs in Bristol alone. The Golden Key Programme has time limited funding but for now is delivering a service co-ordination team in Bristol including peer support. The co-coordinator team is achieving successful outcomes: 90% of the client group are now receiving mental health support, with a reduction in A&E attendance by 72%, evictions reduced by 65%, arrests reduced by 17%, face to face contact with drug and alcohol services increased by 12%. Bristol Public Health, together with Golden Key, is due to produce a needs analysis this autumn for the CCG area.

Golden Key is an example of an effective services for people with complex needs in Bristol, but there is much less provision across North Somerset and South Gloucestershire. Services across BNSSG are fragmented, do not have security of funding and are limited by little or no access to shared data. We have some solid foundations to build upon the work in Bristol on the ACE service that provides one-to-one engagement support, complementing Golden Key is beginning to show early promise.

> *"I need someone that's on the journey with me."*

> *"It's about having the right accommodation and a safe environment."*

People's needs are overlapping and interrelated, combining to become unmanageably complex. We found that 28% of time in golden key was spent supporting clients to manage tenancy and accommodation. Golden Key is also delivering a small Housing First pilot project. Bristol Homeless Health GP Service works with the most vulnerable homeless people, without mental health expertise within the team. We are now seeing results that are on par with other housing first initiatives with over 80% of tenancy agreements being retained. Previously this was between 20-30%.

Specialist approaches are needed for women with multiple needs: Fulfilling Lives, is a programme running in Bristol one of 12 partnerships around the country looking test approaches that work to join up services for people with complex mental health needs. On entering the programme, women are more likely to have poor mental health, greater risk of self-harm and to be more at risk from others. Experience of sexual violence or partner abuse is also more prevalent among women with multiple needs. Substance misuse combined with mental ill-health are the most commonly experienced needs in this complex population, with a high incidence of both – 90% of Fulfilling Lives clients experience both (2019).

Unconditionality

> *"He knows what it's like to be in a real mess – because [the worker] hadn't heard from me he just gave me a ring."*

Being treated Like a person

> *"I'd love more training for staff in attitudes and how to treat people as human beings… not to think of people's behaviours as being difficult."*

Co-Produce Solutions

“My current care co-ordinator will evolve plans with me which I like and I respect her for that.”

Spaces

Dislike “rooms which feel like a cell – all special alarms, you are being watched.”

This is why our priorities for change are to:

- Deliver trauma informed, psychologically informed and ACE informed support
- Work as an effective system, seamlessly, blending social care, health and VCS
- Create effective data sharing across all providers including the VCS
- Create trusted assessments across services, sharing our approaches to risk
- Develop a stable and secure approach to Commissioning for Complexity, with clear system outcomes

What do we plan to do?

- Create a “My Team around me” – a wrap-around long-term team, including a coordination/navigation service, and peers, in-reaching into touch points and offering drop-ins.
- Enable client facing staff to fund packages of support taking advantage of ‘Windows of Opportunities’
- Expand the Housing First project to create stability to facilitate recovery, working with our local authorities. Explore other housing options such as a Complex Needs Housing Project
- Create trauma informed and dual diagnosis treatment packages tailored for this client group
- Develop a specialist navigator team with Urgent Care to intervene with individuals accessing A&D, 111, GP services to understand wider needs and support access appropriate services and social deprivation factors

What measures will we use?

- Reduction in use of crisis services (A&E, police, S136,)
- Reduction in rough sleeping and homelessness
- Increased planned engagement in mental health and drug and alcohol services
- Reduction in NDT score (chaos index)

Personality Disorder

We recognize that the term ‘personality disorder’ is a term that may be unhelpful for an individual and also for services. We need to change our language so that it is experienced as compassionate, and helpful, however for the purposes of clarity in this strategy we will continue to use the term with an ambition to co-produce a new way of describing this group of people that is more acceptable but which will not impair our ability to design services to meet their needs.

Personality disorder affects 4% of the adult population and the treatment of people with personality disorder remains one of the most challenging areas. In part, this is due to the recognition of personality disorder being missed or not understood. Because of the nature of the disorder, it is usually more obvious to other people than to the individual themselves. The impact of personality disorder on the person and on services can be significant. The good news is that now there are recognized ways of supporting and treating people, with new interventions under development. The understanding of trauma and early childhood development is informing further approaches.

Where are we now?

The needs of this group of people can often go unsupported, unrecognized, and undiagnosed. There is a lot of stigma attached to personality disorder and it can be met with judgement. Staff training is required. BNSSG CCG has funded ‘Knowledge Understanding Framework’ training in the past and the main secondary care provider, AWP NHS Trust has developed a Personality Disorder Strategy. The STEPPS programme is offered in North Somerset. There is the introduction of structured clinical management approach.

What we know: data and feedback

Co-production (including carers) is absolutely key to developing better, more effective services, as is continuity of relationships and care. Peer support can be especially effective as can the development of self-management skills.

There are good practice areas to learn from: Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust; and Oxfordshire Health NHS Foundation Trust, which runs a therapeutic community approach with strong peer involvement.

What are our priorities for change?

- Establish a pathway for people with personality disorder across primary and secondary care, taking a tiered approach to work as a whole system, including a shared risk approach
- Ensure a trauma, psychological and ACE informed approach, training all staff
- Build and strengthen pilots
- Develop a strong peer offer and self-management

What do we plan to do?

Our key deliverables are as follows:

- Adopt a structured clinical management care approach across client group to ensure a whole team approach to care to reduce the impact of high intensity behaviours.
- Deliver NICE guidance DBT interventions, and EMDR and CBT treatments
- Develop pre-diagnosis behavioral support as early as possible including supporting children
- Provide case management for those with high impact users.
- Ensure STEPPS groups offer across BNSSG
- Develop self-management skills for clients
- Therapeutic community – peer groups

What measures will we use?

- Quality of Life measure demonstrate client experience is better
- Less reliance on services, especially crisis/urgent care, should release system savings
- Reduced inpatient admissions
- Reduced staff sickness
- Increased staff satisfaction.

Suicide Prevention

There are key vulnerable groups in our area: middle age men, students, and young women who self-harm. The rate of suicide in Bristol and North Somerset was 11.0 per 100,000 population from 2016-18, which is greater than the national average for England. South Gloucestershire has a lower rate of suicide, at 7.4 per 100,000 population.

In general, suicide rates have shown to increase with age and peak in 'middle age', 45-49 years. This remains the case, but there has also been an increase nationally in suicide rates of younger people aged 20-24 years. Compared with 2017, suicides of males aged 20-24 increased by 31% from 12.9 deaths per 100,000 in 2017 to 16.9 in 2018. The suicide rate among females aged 10 to 24 years has increased by 83% since 2012 from 1.8 deaths per 100,000 females to 3.3 in 2018. Evidence is being gathered about the impact of austerity on increase in suicides.

A key risk area for mental health trusts is the transition between inpatient and community services.

NCISH UK reports that over ten years to 2017 vulnerable mental health patient groups are over 75s, women under 25, homeless people and online risks.

Where are we now? / Challenges

Each local authority has a suicide prevention strategy, with the CCG leading a Suicide Transformation programme. We are delivering the HOPE project across BNSSG focused on middle aged men who are struggling with debt, housing, and employment issues. One year into the service demand is high, with most referrals coming from Psychiatric Liaison.

Debt is one of the highest factors (75%). From October 2019 there will be a pilot debt support in the HOPE service. 99% of Hope clients are not using mental health services at the time of referral. Many men were not seeking help through their GPs. The challenge is how to reach these very vulnerable people.

Student suicide is also an important area of risk. The CCG is working closely with the two main universities who are developing their approach and services.

Currently there are no specific services for other emergent risk groups such as LGBTQ+.

What we know

Hope has developed a very responsive service: using text, calls, some face to face methods, often several times a day, to stay in contact with clients. Isolation is one main factor for individuals. Bristol University is evaluating the project with data to be available in October.

“My friend got me in touch with the Hope project and I met Joe. He knows more about me than me. He’s been a real help. I can see things can get better now. I’ve stopped drinking and I’m getting everything sorted, I want to get my job and put money in the bank.”

What is our vision?

- As a system all partners will have signed up to the Zero Suicide Alliance.
- Our vision is that we no longer have avoidable death caused by suicide.
- Our shared mission is that we will reduce suicide by 10% by 2022, with reduction targets year on year until 2029.

What do we plan to do?

- Continue to deliver the HOPE project and develop interventions for the other client groups that help us to understand better how to intervene earlier and to support the underlying causes of crisis, hopelessness and suicide.
- Work with public health to drive up mental health awareness campaigns targeted at particular vulnerable groups.
- We will have an overarching Suicide Prevention Plan that reflects an integrated approach building on the strengths and contributions of each partner agency
- In time we will use population health data to connect early to people who might be at risk to ensure they are supported

What measures will we use?

- Regular all agency annual reporting against our suicide prevention plans, working with public health and the wider community.
- Reduction in inpatient deaths

Through the crisis concordat bring together real time data that will help us understand risks and respond earlier e.g. Population health and GP data, social care, housing etc

Chapter 8: Crisis Pathways

OUR AMBITION is to reduce the level of crisis in our system. When crisis happens, we will ensure there is a clear pathway, designed to meet the needs of individuals, which consistently delivers the right support at the right time.

Supporting people in crisis and at the point of crisis

The best way to respond to crisis is early - before that person is in an emergency situation. But there are times when crisis can't be avoided. There are times when the onset of a mental health crisis is fast, when a person experiences a sudden impact. It might be linked to an existing mental health problem, a life event, a new situation - or there may be no single cause that is easily explained.

In this strategy we distinguish between the 'crisis pathway' (services and interventions), the early signs a crisis is beginning, and the point at which 'mental health crisis' escalates to become a 'mental health emergency'. Crisis is subjective; the person in crisis may have a different view to professionals, and we recognize how difficult it can be when individuals and families feel they are not being listened to and subsequently don't get the service they urgently need.

Our vision is to reduce the level of crisis in our system for the people we serve, and their families. We want to avoid the frightening experience of a mental health emergency whenever possible. But when it does happen, we will ensure there is a clear pathway, designed to meet the needs of individuals, which consistently delivers the right support at the right time.

The pathway will recognize that mental health crisis and mental health emergency are two of the most frightening experiences an individual and their family can have. The pathway will be supported by appropriately trained staff, in fit-for-purpose physical environments, with the joined-up communication across organisations that is essential for high quality care. This is particularly important in a mental health crisis as, unlike physical health emergencies, crisis is not something which can be picked up by a blood test or an x-ray. The only way to understand a mental health issue is through the person explaining what is happening and how they are feeling. And yet when individuals are experiencing a crisis or emergency, that ability to explain may be lost.

Our whole strategy is based on the premise that if we work together as integrated agencies, to avert and avoid crisis, the experience for everyone will be vastly improved. We will be able to invest the funding we save from expensive crisis pathways into new and innovative preventative support and services for people, contributing to better outcomes and happier lives.

> *A mental health crisis often means that you no longer feel able to cope or be in control of your situation. You may feel great emotional distress or anxiety, cannot cope with day-to-day life or work, think about suicide or self-harm, or experience hallucinations and hearing voices.*
>
> **- NHS.uk**

Having a mental health crisis can mean different things to different people, but can include:

- *thinking about suicide or acting on suicidal thoughts*
- *having an episode of psychosis (where you might experience or believe things that others do not), or*
- *doing something that could put yourself or other people at risk. You may know better than most when your relative is having a mental health crisis. Both you and your relative might notice early warning signs that that their mental health is getting worse. It is good to try and get help at this stage to prevent a crisis*

Rethink

Unlike an urgent physical health condition, a mental health crisis can be very personal and so it is not easy to have one definition that works for everyone.

A mental health crisis is an emergency that poses a direct and immediate threat to your physical or emotional wellbeing. There is no one set definition of what a crisis entails; it is highly personal to each individual case.

- MIND, Mental Health Taskforce

The role of family/friends is critical when someone is in crisis. They are able to help others to understand how the person is different from usual and can help clinical and professional staff to understand the risk to the person themselves and to others.

The crisis may not be a new mental health issue but may be an emotional response to another crisis. Life situations such as debt, unstable housing, a relationship breakup or a bereavement create significant emotional distress. Like with any illness, managing the symptoms and working towards recovery is linked to understanding and responding to the cause. Uncommonly, a crisis may result from an underlying medical condition, for example confusion or delusions caused by an infection, or it may be linked to drugs or alcohol.
As in the case of infection, where we treat symptoms with medication but urgently seek the source of the infection in order to prescribe the appropriate antibiotics, so it is imperative in mental health crisis to recognize the symptoms and also understand the context.

The Picture in BNSSG

In BNSSG our population is experiencing a high level of mental health crisis, most pronounced in the Bristol area. Occupancy of local inpatient beds can be as high as 110 % (counting people in hospital and people who are trying temporary leave at home) and there are frequently problems providing local inpatient beds for people who need admission to a mental health hospital. A contributing factor may be the low acute adult mental health bed provision in BNSSG, namely 11.4 per 100 000 weighted population compared with a national median of 19.4 (mean 19.9) for England as a whole (NHS Benchmarking report, October 2019)

Through analysis we are also seeing an emerging pattern: 80% of the people who are admitted into the Psychiatric Intensive Care beds (PICU: a small ward, offering intensive support, with higher staff-patient ratios, supporting severely unwell or disturbed behaviours) are already known to services. This may suggest that current community support and placements do not work well enough to maintain good mental health.

When we have looked at the route into BNSSG acute adult beds we have found that 80% of admissions follow detention under the Mental Health Act; 60% of these are initially detained by police under Section 136 and the remaining 20% are detained following attendance at an A&E department. This is very different from other similar areas where only 30-34% are through these routes enabling PICU to be used for shorter lengths of stay.

Through our initial crisis pathway work we have identified a need to share more data across the system, since maintaining an individual organizational view of data is not enabling us to fully understand and diagnose the root cause of this admission pattern.

People with lived experience have told us that they feel they become more unwell as time goes by, as there is so little community support available in BNSSG.

"You have to be really unwell to get support even if you self-harm you sometimes don't get anyone to respond."

This view from service users is consistent with the low Community Mental Health Team (CMHT) working-age adult caseloads: 700 per 100,000 population compared with a mean of 1,464 nationally (NHS Benchmarking 2019). This may be linked to the commissioning decisions taken with regard to Mental Health Community services several years ago. These took an innovative approach to VSC organisations but may have been at the expense of adequate support to CMHT caseloads.

The police service covering BNSSG, Avon & Somerset Constabulary, reports a significant increase in mental health related crisis calls over the last few years. These now account for 8% of all calls. Of 36,000 calls related to Mental Health, 1300 involved Section 136 powers; 51% involved ambulance attendance. There has been significant reduction in the use of S136 over the last 2 years, but the need to work together with ambulance services and wider mental health services remains critical. To date, the BNSSG approach to crisis is mediated through individual organisation perspectives. We still have gaps in our knowledge about the nature of the activity, demand and need in our area. Without a complete picture, we cannot be confident we have the right resource in the right place, nor make necessary changes. And we know that people have poor experiences of care in a crisis and unacceptable issues persist relating to safety and quality.

It is also vitally important we distinguish between demand and activity. Activity - the measure of service we were able to provide - does not measure how many other routes a person may have tried in order to access support. The anecdotal view held by professionals, managers and people with lived experience, is that an inability to access support services in one area leads to the displacement of demand onto other services, and may result in an avoidable crisis. As a system we agree this is not acceptable and we are committed to working together to develop a crisis system with the right capability, capacity and processes to end avoidable crises. We are determined to find ways, including through co-production, to provide the population with a better, safer, faster service when they experience a crisis.

Commissioners and providers have now convened the Crisis Concordat and the BNSSG Agency Crisis Group AACG, which includes people with lived experience, public sector partners, (including police and ambulance services), clinical and professional staff from across the system, and voluntary and charitable sector representatives.

DELIVERABLE 1: We will establish a crisis system 'all agency compact' that commits us to this challenge and which is underpinned by real-time shared data. This will enable all agencies to understand root causes, undertake collective planning and understand the impacts of specific initiatives.

Designing the crisis system and pathways that are right for people

People with lived experience tell us that for early intervention to avoid a mental health crisis, and for the best support during a crisis or emergency, there are a number of critically important factors:

- ensuring there is somebody they know and who knows them, someone that they trust. The best experiences are achieved when a care co-ordinator or navigator has been on the journey with them and understands them. This continuity of care is implemented in other areas of health and has shown improved results - despite being challenging to implement. Continuity of care has been shown to lead to a more rewarding role for staff.
- People need to be highly skilled in developing a psychologically safe environment and a therapeutic relationship. A high level of trust is key to the success of the relationship.
- 'No waiting', 'give support early', 'someone to talk to who you can access quickly'.
- People often talk about reaching a point at which they don't know what to do, a time when they feel like they can't go on – this sometimes also includes family and carers. Making sure there are services that people can understand, clearly saying what is being offered and making services easily accessible, are all vital to good care.
- Once in crisis, people want to be able to share information about themselves which will help professionals support them – for example specific advance directives and information about specific personal triggers.
- There is also further information emerging about places and spaces. In the same way that we developed S136 suites and a new system-wide S136 pathway, we need to consider comprehensive pathways to enable crisis avoidance and avoidance of mental health emergencies.
- After the immediate crisis has passed i.e. when intense symptoms of the crisis have passed, this is a critical point in the recovery journey at which people should be connected with opportunities to help support recovery and plan for the future.

Deliverable 2: We will design an improved crisis pathway that improves safety and ensures we get the right help to the person, in the right place, fast. We will optimize capability across the system – co-producing with the NHS, Social Care, VCS, Primary Care, 111/ Integrated Urgent Care, Police, Ambulance services and people with lived experience. The pathway will build on street triage and control room triage and will be connected to services via A&E which is covered in more detail in chapter xx

The GP as the first point of call when a crisis starts

We believe it is critical to consider how primary care is equipped to support and intervene early in crisis, given that for 58% of our population their first point of call if they were worried would be going to a GP; this rises to 80% in South Gloucestershire. Mental health or mental health related appointments may comprise up to 48% of a GP workload. GPs have identified that more training for them, as well as access to more services, such as crisis cafes and peer support services, will be important to the development of an integrated, whole system approach to crisis. The contribution of Primary Care will be explored further in Chapter 10.

> *The best support when you start to get into crisis is being able to talk to someone who knows you. It took me a long time to trust people but it now really works for me.*

> *I think that if I had got support earlier the awful experience of being sectioned could have been avoided for me, for the service, for my family, for everyone.*

> *We want the people who plan services to know that– waiting a month for support feels like an eternity when you are not sure if you can carry on for another day…*

Developing new services to support people in crisis

The concept of crisis cafés and sanctuaries has been around for a number of years. The evidence base for their value has grown and the Long Term Plan stipulates that systems develop and invest in these types of services as alternatives to A&E or Secondary Care services. Bristol was an early adopter and at the vanguard of developing these services and models. Although it is the personal experience that matters, nevertheless, it is important to create safe therapeutic environments, where people can meet others they relate to. This has been shown to be of great value in delivering positive outcomes.

The CCG review of community MH services has analyzed commissioned services in the Bristol area, in order to both build on current strengths and identify areas that require improvement. Key themes have emerged which include a need to extend opening hours and forming stronger connections with primary and secondary care services so that risks can be better managed.

A new crisis café is being set up in Weston and is due to open in April 2020.

CASE STUDY: New Service Development: Healthy Weston Crisis Centre

The Healthy Weston Crisis Centre is a community-based service in the centre of Weston, available in the evenings and at weekends. It aims to support people experiencing acute emotional distress associated with a mental health problem (which may or may not be diagnosed) and provides a holistic alternative to the A&E department. The service works with individuals to create plans and strategies to manage their mental health and wellbeing and prevent future crisis.

The service is available to anyone over 16 years within BNSSG, although it is expected it will be utilized mostly by those from North Somerset, and predominantly Weston, given the geographical location. The idea for a North Somerset enhanced 'out of hours' mental health service came from initial scoping of the Healthy Weston model at the start of 2018. During public engagement and stakeholder workshops, discussions included a 'crisis café' style model which would allow people to access out of hours mental health support with elements of social care support such as housing, benefits and citizens advice. The 'crisis café' model has been implemented in numerous places in England and is a nationally recognized alternative to emergency departments for people experiencing acute emotional distress.

We have been working with colleagues in Aldershot, Devon and Leeds to develop and design the service for the Weston locality. Prior to the new service, there was high and repeat demand for the hospital's emergency department, the police and ambulance services, and poor outcomes for this group of patients. The new service complements existing mental health services in the area and reduces the number of patients attending A&E by providing better support elsewhere. The service is staffed by voluntary sector staff who are skilled at supporting people experiencing acute emotional distress, with or without a diagnosed mental health condition.

Designing mental health access into NHS 111 and the Integrated Urgent Care Community access service

NHS 111 has been providing an urgent care telephone service since 2013. In April 2019 the BNSSG Integrated Urgent Care Community Access Service (IUC CAS) went live for the first time, bringing GP out of hours and the NHS 111 services together in a dedicated service for the BNSSG population. Mental health calls into NHS 111 usually account for **7%** of all calls, however a national research study in 2017 reported that if the definition of a 'mental health' call to NHS 111 were widened to include calls with a psycho–social component, this increases to **48%**. An ability to support people with mental health needs has been deliberately designed into the IUC service.

During mobilization of the IUC, we held our first 'NHS 111 for mental health' design meeting. This set out a series of requirements supporting how the IUC and secondary care mental health provider will work together:

- The process of setting out the clinical protocols

- The development of clinical joint working and training opportunities
- The importance of the psycho-social component of many calls
- The need to be able to connect (not just navigate) to a range of services beyond the traditional services commissioned by the CCG. The design for mental health was identified as a 2019/20 priority

As part of this process a review of the NHS 111 Directory of Services (DoS) was undertaken which further highlighted the paucity of mental health services that callers could be connected. The development of the DoS to cover a greater range of services has been technically assured. During the next phase, we will deliver the capability to book people into other services and will collate a broader range of health and social care services into the DoS, such as those highlighted via Wellaware and care direct.

The User Experience of Calling Services

From talking to service users, we learned that the complexity of telephone-based access is linked to several common themes previously identified for NHS 111, the existing Crisis Line as well as VCSE services:

> *"I don't know who to call so I call any number I can find."*

> *"I am often disappointed the staff who take the calls don't know how to help me."*

> *When I call I feel like they are just trying to 'get me off the phone 'they say they don't have time but feels like another rejection'.*
>
> *(Samaritans was the exception in this response)*

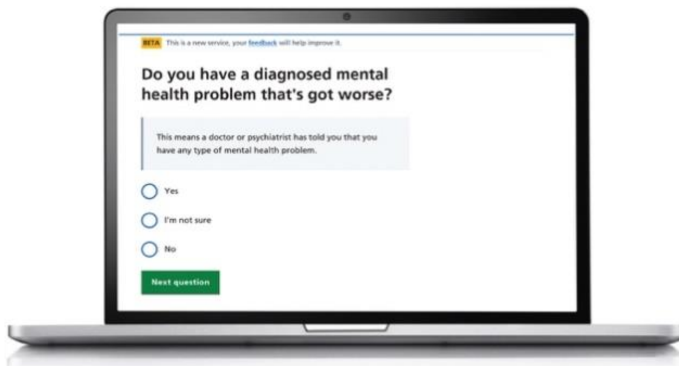
The BNSSG crisis line

The crisis line has been consistently highlighted by users as a poor service that adds no value. However users reported they called as there was nowhere else to call. This repeat usage is evidenced by data which shows that 40% of calls to the service are made by only 26 people. The reviews undertaken with staff have also highlighted that they feel unable to provide the level of support that callers are looking for.

AWP review of access routes

There are currently 15 AWP access route into services. This not only creates confusion for users but is potentially costly and inefficient.

Digital access to mental health triage



NHS 111 online has been recently extended to cover mental health. While the functional capability is developing, it is critically important that our services and support are specifically designed to respond.

Developments in other Areas

Cambridgeshire and Peterborough have been operating a Mental health specific option for callers to NHS 111 for a number of years. The critical component is that users have true ‘Single point of contact’ and are able to access the range of services through this single number (see below).

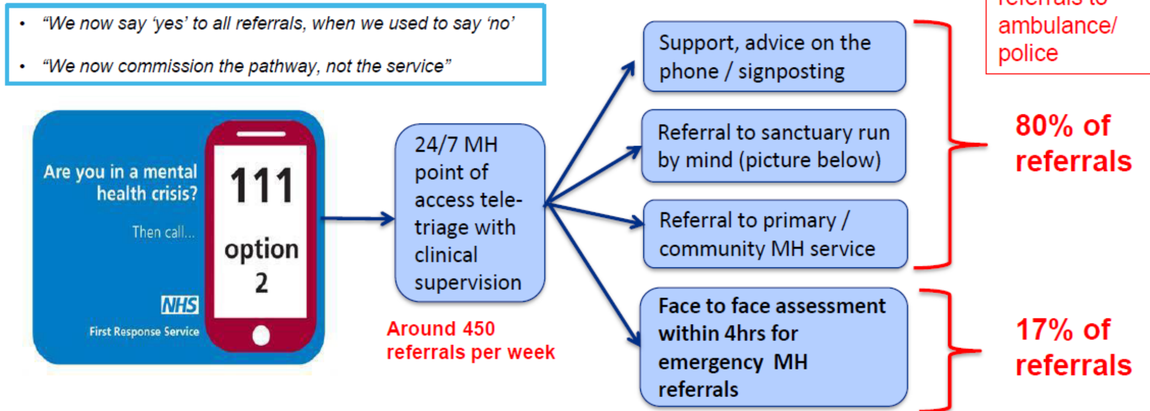
An important consideration in developing this service is that this must not become a route to bypass existing services for routine care. (*Ipsos MORI Research Report 2016, NHSE).*

DELIVERABLE 2: We will have a single telephone route via 111 for people to get support in a mental health crisis.

CASE STUDIES: Cambridge and Peterborough

[Add case studies.]

Case study, community crisis response: Cambridge & Peterborough First Response Service + Sanctuary (all ages)



Activity in first 6 months of FRS
- **25% reduction** in A&E MH attendances
- **19% reduction** in emergency admissions
- **26% reduction** in ambulance see, treat, convey
- **39% reduction** in OOH GP
- **45% reduction** in NHS111
- **Reduction in MH demands for Police**
- **20% reduction** in home treatment caseloads

Costs: £3.2m (£3.1m for FRS + £360k sanctuary) (878,000 pop)
Savings: £4m (including £2.8m reduction in CCG tariff payments to acute). Business case made for recurrent funding following 1 year of pump prime / set up costs

Patient experience
- **72% of people report a good or excellent** experience of the first response service.
- This compared to **only 14% of people nationally** who report a positive experience of crisis services (CQC, 2015)

Sanctuary is a preferable environment to A&E for many people with mental health needs

This service will be developed as a partnership across secondary care mental health providers, acute emergency department mental health services, primary care, the IUC provider, BNSSG Care Direct Services, the IAPT provider and the voluntary sector. It will be underpinned by a joint health and care directory of services and will be accessible online where this is deemed clinically safe and appropriate.

We will create seamless clinical and professional teams with shared protocols and training. The focus will be on connecting the person with the support they need. The service will have access to a person's crisis record, advanced directives and any wellbeing and recovery plans (WRAP).

We will create a mental health professional access route to support police, ambulance services and general practice to ensure that we are able to provide people with the support they need as far as possible in the community and close to where they live.

When People Access Services

Through the strategy we have started to break down organizational boundaries and help people understand the utility and opportunities for working as a system.

Opening hours of crisis cafes have been an issue and for that reason the new Weston Crisis Café is open 24 /7.

The busy times for organisations are not the same, for example from the police perspective the prevalence in the presentation over the course of the day highlights that the people mental health crisis call 999 starts to rise between 1 pm and 3 pm this begins to level off and

at 10 pm starts to decline. But for GP out of hours services however they start to see the rise after 6 pm and the decline is not until 2am.

DELIVERABLE 4: We will develop a whole system activity, availability and demand capability. In time this will become a control centre type real-time dashboard, but initially we will start with joining up the data we have defining the services available across the system.

How will we share information about the person to support the person?

The data and digital agenda for MH has been behind that of our primary care and acute services. Through the strategy and the partnership working on Connecting Care BNSSG is an exemplar for shared records but remains behind the curve on mental health

DELIVERABLE 5: We will ensure that crisis plans are available via connecting care, we will also explore the mental health patient first access as the priority use case for the patient facing digital programme.

When people go to A&E and the Ambulance Service

Our A&E departments and ambulance vehicles are designed explicitly to save lives but to focus on physical health. There are many bleeping machines alarms and alerts going off through the night. Ambulances with flashing lights and gurney trolleys are designed to keep people alive on the way to A&E. These elements of our health and care system have never been designed for mental health emergencies.

DELIVERABLE 6: We will we will explore how we develop the existing emergency services better to ensure that we create settings that are conducive to mental health emergencies.

Chapter 9: Substance Misuse

OUR AMBITION:

Psychologically informed, social determinant aware, services, recognising those with both MH and substance misuse issues and increasing skill levels in community teams and primary care.

Drugs, Alcohol & Addiction

1 in 5 of our population have a substance misuse issue and 1 in 4 a mental health need.

The relationship between the use of drugs and alcohol in our lives and the impact on our mental health is complex. Having ‘a drink’ is often linked to how we unwind after a tiring day, have fun with friends, but for some it is the only way they feel they can deal with daily pain or trauma they experience.

People tell us they often use drugs or alcohol to manage stress, the symptoms of mental illness or distress and anxiety – some have even referred to misusing substances because they could not get access to support services when they needed them. There is clear evidence that the use of drugs can increase the risk of serious mental ill health and for people with both mental health and drug or alcohol addiction, they feel that services are not supporting them.

“You can’t access mental health services until you are sober, and you get excluded from rehab due to behaviour linked to mental health issues.”
Service User

The data we have today to understand the full impact of addiction and MH on people, communities and our services is limited and is currently not linked together but there are some significant insights that different agencies have reported.

1. The impact of drug and alcohol on families and our communities is significant over the last 12 months there were 286 police call outs to disturbances across BNSSG. Of those calls 211 were linked to people know to excessively use drugs and or alcohol but only 9% of these individuals were reported to being supported by drug and alcohol services. We know that particularly in Bristol there are issues around demand and access to services, with 10% of people waiting longer than 3 weeks compared to the national average of 2%.
2. In 2018 across BNSSG over 50% of people admitted into hospital through Accident and Emergency had some reference to drugs, alcohol or mental health linked to their admission. Our LAPE scores across BNSSG show we have more alcohol related urgent admissions when benchmarked with other similar areas.

3. Death caused by drug misuse and alcohol related mortality in Bristol and North Somerset is above the national average. Death due to drug misuse in Bristol is > 50% more than the national average. This becomes even more significant for people leaving the justice system.
4. The connection between addiction and homelessness
5. GPs and Pharmacy often see the initial stages of addiction. This may not be as a direct presentation by the individual but both pharmacy and primary care are potential areas where people can access help or be nudged to get support early.

Whilst there is significant work in progress to support people, and innovative, nationally recognized schemes being developed, we believe there is so much more we can do by becoming more joined up. The way we commission services currently means we have a separation between drug and alcohol services and wider health services. The data we collect across agencies such as public health, police, schools, voluntary sector and the NHS is not joined up. Each agency has its own perspective of the issues but there is no central forum to bring these collective insights together. People tell us it remains challenging to get the support they need when they need it.

As part of this Mental Health and Wellbeing strategy we are determined to develop a more seamlessness offer for people. One of the primary objectives, in line with the overarching spotlight on crisis, is to develop a greater understanding of how drug and alcohol and mental health impacts the use of our emergency and crisis services.

DELIVERABLE 1 - We will connect data from across agency partners to create a life course, geographically referenced single view of drug and alcohol and related MH impacts.

This will cover data such as:

- related crime rates;
- links with schools and exclusions
- homelessness
- access to drug and alcohol rehab services
- use of private rehab services
- Recovery rates
- Related GP/ Community presentations/ appts
- related 111, A&E and mental health crisis service presentations
- people leaving justice system

Of course, the best way to reduce harm from substance misuse is avoiding drugs and excessive alcohol consumption in the first place and the work already in schools is delivering positive results.

For many people the solution is more complex and needs to focus on creating a much more connected integrated way of supporting needs. This is particularly true for our most

vulnerable citizens who often have a combination of unstable housing or homelessness, difficult experiences in childhood (ACEs), serious mental illness and substance dependence. They don't trust services and are expecting to be let down, disappointed and or excluded.

Designing and commissioning the right services to support our most vulnerable people is an important area if we are to improve mental health and well-being across BNSSG.

DELIVERABLE 2 - We will create a more person-centred approach for our population starting with our most vulnerable high intensity users. This will move beyond the traditional approach where people face a cycle of rehab and relapse where their accommodation is contingent on staying in recovery and the instability affects their mental health and well-being.

- We will build on innovative schemes such as the Bristol Housing First pilot as set out in the Bristol One City Plan. The core principle being a focus on housing as a primary right rather than a reward for 'good behaviour'. Our first step as a system will be to develop a robust economic case to demonstrate the value of a housing first type model to improve lives and outcomes.
- Alongside stable housing we know that the support people really benefit from may not be to access a standard service. Through our engagement with people and communities we have seen examples where pet therapy, employment support, green therapies and simple things like learning to cook have been hugely beneficial for certain people. We will evolve personal health and care budgets to develop support around the person.

We also need to consider the support that people with less complex addictions need and how we can make it as easy as possible to access. At present the majority of support is provided by the voluntary sector under the AA, NA or Smart Recovery type programmes.

DELIVERABLE 3 - As part of the redesigned Primary Care Mental Health services, we will include services such as these as part of the social prescribing cohort. This will develop closer connections and understanding between less conventional services that provides as many opportunities as possible for people to transition from the GP appointment to an evidence-based but non-medical support and recovery model.

Chapter 10: Older People

OUR AMBITION:

Radical changes to how we support mental health & wellbeing of older citizens. Mental health, frailty and dementia strategies will be 'joined up', functional illness will be treated in the community, focus on social interaction and networking.

40% of older people in GP surgeries have a mental health problem, rising to 50% of older people in general hospitals and 60% of those in care homes. (*Social Care Institute for Excellence, 2006*).

On an average day in a 500-bed hospital, older people occupy 330 of the beds. Of these, 220 will have a mental health disorder of some kind: 100 will have depression, 100 – dementia and 66 – delirium (*Burns & James, 2015*).

Depression is the most common mental health problem for older people, affecting around 22% of men and 28% of women aged 65 or over and 40% of older people in care homes (*Age UK, 2016*). Anxiety disorders affect 1 in 20 older people (*Bryant et al, 2008*). Less commonly, patients present to services with psychosis due to bipolar disorder or a psychotic disorder.

We propose radical changes to how we support the mental health and wellbeing of older citizens in BNSSG.

This strategy proposes a renewed focus on the needs of older people, to positively promote good mental health, to provide accessible specialist support for older people with mental ill-health, and greater support for carers.

We also recognize that there is a false separation in how the health and care system responds to the diagnosis and treatment of people with mental ill health and those with dementia.

This is why our mental health, frailty and dementia strategies will be 'joined up', with better support for people with dementia who get depressed or anxious.

Why is mental health in the elderly population important?

Aging Population

Like elsewhere in the country, the population of BNSSG is ageing. The population aged 65 and over will account for 23% of the total population on England by 2035. For example, the pressure on the care home market for BNSSG by 2026 are highlighting an increase in demand of a staggering 126% by 2024.

The most common, and most treatable, mental health issue in older age is depression. Up to a quarter of older people in the community have symptoms of depression serious enough to warrant treatment (HM Government, 2011). Depression figures double in the presence of

physical illness and treble in hospitals and care homes. Depression also doubles, and sometimes trebles, natural death rates (Ryan, 2008), impairs the ability to function independently, increases the likelihood of admission to long-term care and worsens the outcome of other medical conditions (*Alexopoulos, 2006; Wanless et al, 2006; Licht-Strunk et al, 2009)*.

50% of people with Parkinson's disease suffer depression, 25% following stroke, 20% with coronary heart disease, 24% with neurological disease and 42% with chronic lung disease

Suicide

Depression in later life is *the* major risk factor for suicide – 80% of people over the age of 74 who die by suicide have depression (*Conwell et al, 1998; Hawton & Harriss, 2006*). A suicide attempt in an older person is more likely to be successful than in younger people.

Specific Factors and Bias

There are some particular challenges for this section of our society. Older people may find it more difficult to talk to others about their emotional wellbeing. They may describe their symptoms using 'physical' language rather than 'psychological', and they (and some professionals too) may assume that poor mental wellbeing is an inevitable part of aging, or not likely to improve, even with help.

This results in the mental health needs of older people being under-recognized and under-treated. And although the proportion of older people with mental health issues is broadly the same as in other age groups, older people are unable to access the same level of support.

Comorbidity

We may be living more years, but these are not necessarily healthy years. There is a complex interaction between physical and mental wellbeing, such that each can impact the other. Physical illness, and medications, can have a psychological and emotional impact on a person while poor mental health can exacerbate physical symptoms and worsen treatment outcomes and most people over the age of 65 live with at least one chronic physical illness, while most people over the age of 75 experience two or more (*Barnett et al, 2012; Melzer et al, 2012*). Around 10% of people aged 65 and over currently live with frailty, rising to between 35% and 50% of those aged over 85 (*Age UK, 2017*).

To enhance the wellbeing and mental health of older people in BNSSG, we have to stop focusing our support on either physical or mental health and focus on the whole person.

Social change and social determinants

Our expectations for life are changing too. We may want or need to stay in employment for longer. More than half of us will live alone at age 75 and too many of us will experience loneliness and social isolation. These are key contributors to poor mental wellbeing and depression, and they are things we can change.

What this means

- Older people with common mental health conditions are more likely to be offered drug therapies and less likely to be offered psychological (talking) therapies compared to younger groups, even though recovery rates are similar
- Older people may be reluctant to seek help – with fewer than one depressed older person in six discussing it with their GP.
- Depression is *the* key risk factor for suicide in older people
- Suicide rates for older people are similar to those in younger age groups [reference] and suicide attempts made by older people are more likely to succeed.
- Older people are proportionately higher users of health and social care, incurring both stress and cost.

Current Challenges

Over time, the way we provide mental health support to older people in BNSSG has changed. In Bristol, there are separate teams providing support to people with dementia and to older people with 'non-dementia' mental illness (also known as 'functional' illness), such as depression.

The innovative Dementia Wellbeing Service is an example of secondary care expertise in a primary care setting, facilitating expert elderly care at home. It has brought improvements to how people with dementia, and their families, are supported at home. Since it started, far fewer people have needed admission to hospital, and over 98% of patients have said they would be extremely likely (88%) or likely to recommend the service to others. The Dementia Wellbeing service is delivered in primary care and so is integrated with general practice and community physical health care. It employs general nurses as well as mental health nurses. This means that people's physical health needs can be met as well as their mental health needs.

The Bristol adult community, or Recovery Teams, work to an 'ageless' specification, with skills to meet the non-dementia/functional mental health needs of any adult, regardless of age.

In North Somerset and South Gloucestershire, people with dementia and people with functional illness are supported by the same, secondary care, community mental health team for older people.

This difference in service provision is complicated for citizens and professionals alike, and is not a fair provision for everyone in BNSSG.

As our population ages, the way we provide now support will not keep pace with either demand or the complex interactions between physical and mental health conditions.

Our care homes team estimates that by 2026, today's 6,900 care home beds will need to increase by 129% to meet demand, requiring approximately 16,000 care home beds. This is an impossible and unwanted trajectory, especially given the trend for care home closures.

Our offer for older people is neither holistic nor flexible enough; there are barriers to access, including transport and stigma. We need to more to care for people in their communities where carers and social networks remain strong.

There are many opportunities already available, from charities, neighbourhood groups, networks and societies, which can help people to live well and stay well, but these are fragmented and not always known about.

CASE STUDY: The Cote Lane Retirement Village Study

An intergenerational experiment with a collaboration of St Monica Trust and a local nursery school. Filmed for Channel 4 showed the development of both 11 older people and 10 four year-olds. Across the 6-week study the social skills and confidence of all the children was measurable and for the 11 older people there was an increase mood, physical strength and physical activity.

DELIVERABLE 1 - Focus on wellbeing, access and integration
We will deliver a whole system approach that draws together the expertise of health and social care agencies and those in the voluntary sector, to deliver a comprehensive, balanced range of services, which place as much emphasis on **prevention**, through options that promote independence, as on care services. This approach will be embedded in the **primary care** multidisciplinary team, delivered locally to where you live and will link closely with social prescriber and age-well practitioners [I made that up]. The new approach will take learning from the successful Dementia Wellbeing Service and will work closely alongside.

DELIVERABLE 2 - Focus on Equality - We will apply the principle of equality to older people's physical health needs *and* mental health needs.

This means that older people will have equal access to psychological and other treatment options. We'll look for the bias which can skew the diagnoses given to older people. We'll make sure that our HT workforce has the skills to care for older people. We will ensure that **all** services cater for the needs of older people, including liaison psychiatry services in our general hospitals, and crisis support services. In the general hospital setting, all patients with multi-morbidities, with or without dementia, will have expert assertive treatment of any mental illness. All care plans will be psychologically informed and collaboratively developed with people and their families.

We propose to standardize the way we support older people across BNSSG. People in North Somerset, Bristol and South Gloucestershire should all expect to access the same level and types of support. We will extend the reach of the Dementia Wellbeing service and will align the support for older people with functional mental illness with both the dementia and frailty strategies.

Separating dementia and other mental health services for older people is unhelpful and was described in the national dementia strategy as a 'false dichotomy' (Department of Health, 2009).

DELIVERABLE 3 - Focus on Sustainability
To meet the needs of older people positively and holistically, we need to stop focusing on 'whose responsibility is this?' and overcome the boundaries which separate social care needs from health issues.

We need a new compact with care homes and their workforce: we will offer more secondary expertise and support, enhanced training so that care home staff feel, and are recognized, as the vital part of our care system they undoubtedly are.

DELIVERABLE 4 - We will explore the development of intergenerational activity as part of Thrive, embedded in our best lives and better homes projects as well as within our NHS services

What will we do?

Social isolation and poor physical health are risk factors for depression in any age group, but they are particularly common in older people. Nearly half of all people aged 75 and over live alone, nearly a quarter of pensioners do not go out socially at least once a month, and 1.2 million people aged 65 and over in England are chronically lonely (Age UK, 2017b).

Chapter 11: Mental Health Care in Primary Care

OUR AMBITION:

We will develop a new model of Primary Care Mental Health that is fully integrated with community services, and is able to provide the integrated physical and mental health care that our communities and population need.

Primary care is, for most people, the entry point for the treatment of illness. Along with A&E, the GP surgery is the most recognized and well understood service in the NHS. Over the years we have seen an 85% increase in the proportion of GP appointments that include discussion of mental health, with figures of 48% being reported (MIND, 2017).

In addition to the case mix the workload has increased for all of primary care, along with rising patient expectations and the complexity of comorbidity. In 2017, GPs reported an 85% increase in the number of people who discussed a mental health concern with them, highlighting how managing mental health conditions has become a significant part of GP workloads

Patient views of mental health in primary care:

- Little information about the support available
- Mental and physical health needs are still treated in isolation
- Not always getting the same level of service, services very variable between the GPs
- Waiting too long to access mental health services and receive a diagnosis
- Non-mental health trained professionals do not always have the information and training they need
- Not feeling listened to or involved in decisions that affect them

BNSSG specific insights

- From our citizens' panels in BNSSG we have local evidence that people with long term and chronic conditions are less likely to report feeling in 'good mental health': 58% as opposed to 76% in the general population.
- The mortality for people with mental health and physical health conditions is alarming - with people dying 20 years earlier than their counterparts without a mental health condition.
- A recent study by NHS England into the impact of mental health and physical health for BNSSG highlighted that there were a potential £19.2 million in savings that could be made across the system from better integrated services.
- Integrating mental health services into primary healthcare will be an important solution to address the human resource shortages to deliver mental health interventions.
- According to CCG figures, there is a seven-fold variation in the prevalence of mental illness between GP practices in BNSSG, that is between 0.3% and 2.1%. The prevalence of SMI similarly varies between 0.1% and 1.2%. This is likely to represent a variation in awareness, education and recording rather than prevalence of illness alone. This is important, because those who are on the register are more likely to receive good physical health screening, including cervical smear, lithium, TSH, creatinine and record of alcohol consumption in the previous 6 months.

- In areas of South Gloucestershire the social prescribing service with Age UK was able to demonstrate a reduction in use of A&E but importantly a reduction in reported feelings of social isolation and improvements in wellbeing.

The case for integrated mental health care and primary care

The concept of integrated primary care and mental health care is not new. The 2007 WHO report identifies the following advantages that align strongly with our ambitions in BNSSG and with the views of our population:

- **Reduced stigma and easier access to support for patients and families**
  GP practices are not associated with specific health conditions so are not linked with the stigma which still may accompany attendance at dedicated mental health service buildings. GP practices are multiple and embedded within communities so that attendance minimizes disruption to normal daily life, employment and family. Attending a primary care setting may reduce burden on families and care-givers when travelling to appointments - one of the many issues that families have told us they struggle with, particularly in deprived communities.

- **Physical and Mental Health**
  Integrated physical and mental health care leads to improvements, both in terms of access to mental health services and treatment outcomes for physical and mental health conditions. Mental ill-health co-exists with all physical health problems and is frequently associated with cancer, HIV/AIDS, diabetes and respiratory issues. While we are committed to ensure annual health checks for people who have severe mental illness and/or learning disabilities, we have far greater ambitions for what can be achieved from integrated mental health and primary care. World Health Organization evidence shows that when primary healthcare staff have confidence and competence in assessing and addressing mental health, and the time to support the physical health needs of people with mental ill-health, this leads to better health outcomes, better patient experience and significant cost savings.

Models of integrated primary care mental health

We need a new model of 'all-age' primary care mental health service that is fully integrated, with a workforce embedded in primary care, a workforce which provides first contact for people with mental health needs and which promotes mental ill-health prevention and mental wellbeing. This is our opportunity to create a primary care offer which wraps the right clinical and non-clinical professionals around the individual, in their community.

CASE STUDIES: West London Community Living Well; Hillingdon Primary Care Plus

[Add case studies.]

The key principles of the most successful integrated primary care mental health models include:

- General practices and Primary care Networks provide a 'menu' of support which can be wrapped around the individual and the gaps in services are defined systematically so that alternative solutions can be quantified and provided in the community
- Well-developed partnerships and co-production with the voluntary and charitable sector and NHS providers, to maximize operational efficiency.
- A workforce which is embedded in primary care and which acts as first point of contact
- Explicit aims of improving the mental health, physical health and wellbeing of those with serious and/or long-term mental health conditions. Equal weight is given to physical and mental health. The physical health check for people with severe mental illness includes onward referral to appropriate services, some of which may be bespoke, and targeted prevention, for example, smoking cessation interventions.
- The general practitioner is at the heart of integrated mental health care in primary care with flexibility to offer extended appointment times if needed.
- Models dictated by local population need and clinical profiling. They are not service-based.
- The mental health model is based on the principles of hope, recovery and resilience.

West London CCG have reported that 48% of people on the GP SMI Register could be supported with a non-clinical, social intervention.

Workforce considerations for mental health care based in primary care

In emerging integrated primary care models, there are both primary care professional teams and case management support. The teams comprise social workers, primary care and mental health nurses, step 2,3 and 4 IAPT practitioners and primary care psychiatrists (or linked psychiatrists in secondary care). Integrated models play to professional strengths by combining expertise in new ways. Caution is required in recruiting to current clinical mental health roles or social worker roles without the primary care integrated model and at the expense of local secondary care and social care services.

The core impact will be from the inclusion of non-clinical, but appropriately trained, teams of mental health support workers. These are skilled mental health roles which provide more intensive support, over and above generic social prescribing services. Non-clinical teams also include peer workers and employment coaches. These teams play to non-clinical strengths and create a new local social environment.

Operating under the supervision of the clinical team in the practice, support workers will enable more support to be provided directly to patients. Recovery Navigators or link workers may provide:

- recovery support,
- facilitated access to other services or expert advice and guidance,
- a means to recognize the impact of wider determinants of health
- facilitated system navigation.

DELIVERABLE 1: As set out in the Mental Health Locality transformation schemes, we will develop high quality, integrated primary care mental health support for the local population.

CASE STUDIES: Pier Health

[Add case studies.]

This work has already started, with multi-disciplinary team approaches being tested in practices around BNSGG.

We have a tremendous opportunity as new models of general practice develop, for example Pier health, who have exciting ambitions to be at the forefront of new ways to deliver primary care.

Turning challenges to opportunities

Referrals from primary to secondary care

GPs in BNSSG have raised concerns relating to the increasing complexity of mental health presentations, limited community mental health team capacity, waiting times for secondary care mental health input, (in particular CAMHS), and the frequency with which referrals to secondary care mental health services fail to meet service thresholds.

From the perspective of secondary care services, 60-70% of referrals for adults and 50% of referrals for children and young people are assessed as ‘not needing, or not appropriate’ for secondary care services.

“When patients need more than IAPT but are not eligible for acute services, we struggle to find ways to support them.”
GP

These two service perspectives highlight a significant gap which is the subject of polarized opinions over the true root cause or causes. While BNSSG is not the only area to be experiencing this gap, it is imperative that we resolve our understanding of need and close the gap for those people who currently receive little or no support, and who fall into the gap.

This will require a whole-system focus to achieve a shared understanding - but the prize is to find ways to release the time currently spent on assessment or managing ‘rejected’ referrals, and to redirect that towards treatment and recovery.

Primary Care Plus models are designed to address the gap between primary care and secondary care services - either to provide extra care when people have left hospital, to ensure they are able to continue their recovery journey, or to avoid the need for hospitalization in the first place.

[insert Camden Case study]

To date, analysis of referral patterns in BNSSG has focused on process, using extant data sets. Despite the high 'turn away' rate, in many cases, the person referred received several sessions of support as part of the assessment process. But the gap is real, both in terms of expectations of, and level of, support. We will seek to understand the gap, focusing less on process ('who refers and how many') and more on clinical presentation ('who is referred and why') and the unmet (health and socioeconomic) needs within these referrals. This understanding will require new data sets and will inform how best to meet these needs in the future. Analysis to create a shared understanding of the gap will be a key aspect of Mental Health Investment Standard spend.

DELIVERABLE 2: We will establish a programme to analyse primary care mental health referrals focusing on the clinical clustering, end to end case reviews. This will be part of the design process for Primary Care Mental Health services and informing PCNs and locality development.

Advice and guidance from secondary care

While the 'ideal world' view for many GPs is to have someone with mental health expertise on site in the practice, accessible and part of the team, there is recognition that the scarcity of mental health workforce renders this approach untenable. There is appetite for an alternative 'advice and guidance' service. As we develop primary care mental health, this is likely to become an important component, enabling primary care to take a shared approach to clinical management and risk, to develop practice and clinical knowledge and to be supported by mental health specialists

Two routes to enable 'advice and guidance' are proposed as part of this strategy. The first is to use the NHS '111 *9' professional telephone line, which routes enquiries to mental health services. The second route is to ensure that electronic referrals into mental health services are designed and implemented with the incorporation of an advice and guidance capability .

DELIVERABLE 3: We will develop advice and guidance services linked to secondary care that support the development of Primary Care Mental Health.

Developing a proactive approach

The first time a GP discovers that a patient has had a mental health crisis may be as a result of notification of assessment under the Mental Health Act or on receipt of a hospital discharge summary. As highlighted earlier, the most successful models of primary care mental health care are built on the foundations of risk stratification and population health data to design services. BNSSG has made a good start: some secondary care crisis plans are shared via the **Connecting Care** platform, enabling GPs to access them. But this approach is retrospective and requires a GP to search for information or read correspondence between surgeries. A proactive approach will ensure that we identify people at risk of crisis and support them before the crisis develops.

Primary care needs a system of shared records that prompts the GP when there is a change for a patient that may imply increasing or new risk and which proactively prompts early support to avert deterioration.

Proactive systems would allow the GP to see specific real time alerts, for example a patient is in an ambulance or has been admitted to hospital.

A proactive system would share data with social care, for example, in the case of a person with severe mental illness where any change in life's stabilizing factors may precipitate a crisis, an alert from social care alerts the GP that greater support may be required to avoid a crisis. During our engagement, many people have told us of times when their GP or nurse called to check on their wellbeing and the major impact this can have on recovery. Small acts of support in these situations may avoid or alleviate significant harm and distress.

A proactive system would allow all members of a multi-disciplinary team (whether real or virtual) to share information and events pertaining to clients for whom they share responsibility. 'Care Flow' is a clinical communication platform which enables better co-ordination of care through secure messaging, task management, handover, referral and escalation of events through notifications to team or virtual team members, whatever their daily work team.

With reference to all of the above possibilities, we will take full advantage of the opportunity afforded to us by the award of the Local Shared Record Exemplar (LCHRE) to the South West, to drive the specification of data and technology capabilities to transform primary care to deliver proactive care. These developments are not years away - they are already in operation for some physical health services in our system or have been developed in other areas of the NHS. It's time for people with mental health issues to benefit from these 21st century technologies.

DELIVERABLE 4: We will promote primary care engagement with the LCHRE specification and will develop a series of specifications for future developments in Connecting care and other systems

Chapter 12: Mental Health Care in Acute Hospitals

OUR AMBITION:

Everyone has the right to support if they are in crisis and people have the right to urgent help if they are considering taking their lives. People with severe mental ill health have the right to experience good physical health, quality of life and life-expectancy, the same as the general population

The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) looked at how acute general hospitals manage mental health problems in patients admitted for a physical health issue. Its report, Treat as One (Muir, D. 2017), shows that co-existing mental health conditions are often overlooked or under-treated in acute hospitals.

People with a physical health problem are 2-3 times more likely to have a mental illness than the general population (Parsonage et al, 2012) and people with mental illness are more likely to have physical health problems. Thus the proportion of people in a general hospital bed or attending out patient appointments, who have co-morbid mental and physical health conditions, is high.

As a group, mental health users utilize emergency services and diagnostics disproportionally to their representation in the population. As a sub-group, people with personality disorders have the highest access rates across most points of acute delivery. This strongly suggests a lack of more relevant/more appropriate supports elsewhere in the system.

In BNSSG:

- the mental health user population (5%) utilizes 14% of A&E attendances, compared with national figures of 7% and 17.2% respectively.
- Mental health service users (5% of population) utilize 20% of non-elective admissions, compared with 23.7% nationally.

For both A&E usage and non-elective use, BNSSG figures are in the highest groupings nationally, showing a ratio of usage by mental health users >3 times (A&E) and >4 times (NEL) that of the general population.

If BNSSG were able to offer alternative supports, so that mental health users utilized A&E and non-elective services at the same rate as the general population, savings of 17.7M could be available for reinvestment into wellbeing promotion and mental ill-health prevention. The greatest savings by specific group would be for cognitive impairment and dementia, where the avoidance of A&E attendance and admissions could release >11M. People in this group do better when their needs are met closer to home.

Current Challenges

In BNSSG, Liaison psychiatry is recognized as a key part of the care for people with any form of mental ill health in an acute hospital setting.

According to the NHS Improvement Emergency Care Improvement Programme (ECIP) reviews, parity for mental health is being achieved in UHB, but services in other acute providers are still developing, with variations in staffing composition and seniority.

The need for awareness of mental health issues does not reside solely with specialized teams - **all** staff require core competencies to recognize, and take account of, mental health issues - in order to provide high quality, holistic mental and physical health care. Awareness of medications, which may impact on an individual's presentation, mental health diagnoses, and care plans, is vital. 'Treat as One', (NCEPOD, Muir, 2017) found that:

- 21% of patients admitted to general hospital did not have mental health diagnoses recorded.
- 23.3% patients were not referred to the liaison psychiatry team in the emergency department, but should have been.
- Medicines reconciliation occurred at the initial assessment in only 70.8% and in only 68.2% at the consultant review, yet mental health medicines were prescribed in 72%.
- Mental health risk issues were recorded in 33.8%; of those not recorded, 53.6% should have been
- All practice should be informed by an understanding of the impact of social determinants and trauma, on people's health presentation. In BNSSG general hospitals, there are variations in the provision of education for both the whole workforce and for key departments.
- Attendance at A&E and admission to hospital are key moments in which to offer opportunistic health and lifestyle advice, and to signpost to sources of support.

DELIVERABLES

At all points of care, including in the acute physical care setting, care plans will be psychologically informed; made to optimize wellbeing and autonomy, and tailored to specific life stages. This will reduce the chance of those people dev eloping mental illness, with the concomitant impact on physical health

All acute providers will deliver parity of esteem for physical and mental health care focusing on the 1 hour and 4-hour standards with breaches being reported daily through the standard system and escalation calls

Treatment for complex somatic illness and medically unexplained symptoms will be delivered by integrated mental and physical health teams.

When people with a serious mental illness are treated in the acute setting a review of their physical health (including investigations and monitoring) will be undertaken opportunistically.

People who have a serious mental illness and are treated in the acute hospital will have access to an ageless, integrated, specialized, Liaison Psychiatry service to deliver a holistic approach. Teams will be skilled to manage multi-morbidities to achieve the best physical and mental health outcomes.

All staff who work in acute trusts will have access to education and support to allow them to care for people with SMI with confidence, kindness and consistency. Areas of specific need will be identified by specialist teams and a programme of education implemented as a proactive measure.

People who present to the Acute hospital after self-harm or suicide attempt will be treated in an appropriate and timely way, their own needs being at the forefront of care. Assessment and care will be psychologically informed and will include access to support to address social determinants.

People who repeatedly attend ED in crisis or with self-harm will be proactively identified and prioritized. A collaborative care plan addressing both mental and physical health problems will be written - with the patient. Digital platforms will enable sharing of information to enhance safety and care.

People who need to attend an acute setting after self-harm or a suicide attempt will have collaborative, joined up care. Acute care staff will be given training on managing the psychological and well as physical consequences of self-harm. Everyone who wants to be seen will be seen (where appropriate).

Chapter 12: Secondary and Specialist Mental Health Services

OUR AMBITION:

People with mental illness will have timely access to specialist care that is safe, person-centered, recovery focused and delivered within pathways of care that span organization / professional boundaries.

Severe mental illness (SMI) affects between 0.5 and 1% of adults. People with severe mental illness, such as schizophrenia, severe anxiety, depression, psychosis or bipolar disorder, often experience poor physical health and may die up to 20 years before other citizens. These illnesses have a profound effect on individuals and their families, and early, effective interventions are important and beneficial.

People with SMI face multiple disadvantage: they may experience difficulty gaining and retaining housing and employment, maintaining stable relationships or achieving reasonable income. They face inequality when it comes to both their mental and physical health: historic underinvestment impacts on timely access to evidence-based mental health treatment while social disadvantage results in a greater likelihood of poor nutrition, obesity and smoking-related diseases, all of which contribute to premature death.

The Five Year Forward View for Mental Health (2016) has enabled some improvements in mental health care. The NHS Long Term Plan reaffirms government commitment to further improve mental health. New investment aims to make services more accessible, available earlier, more often delivered in communities and more often delivered close to home with fewer people requiring inpatient care in hospitals far from home. There is a commitment to crisis care for people of all ages as well as increased investment in young people's mental health and support to maintain employment.

Mental Health Access Statistics

- The prevalence of mental health problems disproportionately affects people living in the most deprived areas, with rates of self-harm proving to be a significant issue for some BNSSG localities. In parts of BNSSG, hospital admissions for self-harm are 40% above the England average
- The prevalence of common mental health disorders in people aged 16-74 is slightly above the England rate at 17.8%, Bristol is higher at 20.7% with South Gloucestershire under at 13.6%.
- Around 10,000 people in BNSSG have a severe mental illness (SMI) which is noted on registers held in GP practices. The SMI register for BNSSG is increasing year on year. 5% of the BNSSG population have a severe mental illness.
- Old age-related mental disorders account for 23% of emergency hospital admissions in BNSSG. Population estimates predict there are nearly 11,000 people in BNSSG with dementia. Numbers from GP records suggest that over 30% remain undiagnosed.

- The South West of England has the highest suicide rate of all English regions and in Bristol the suicide rate is nearly double than that of London.

Secondary and Specialist Mental Health Care

Just as serious physical illness may require an intensive, specialist approach, provided by specialist teams in the community and in hospital, serious mental illness requires intensive, specialist support to reduce suffering, keep people safe and help them recover.

'**Core'** mental health services include a range of community and inpatient services to meet the mental health needs of children and young people, adults and older adults. Core services across BNSSG are provided by Avon and Wiltshire Mental Health Partnership NHS Trust (AWP), with additional services from a range of other providers. This includes the voluntary and charitable sector which plays a crucial role in helping people to access personalized care and to enable recovery.

Specialist services

'**Specialist'** care and treatment is also available for people with highly specific needs, including:

- Secure (forensic) services for people with a mental health disorder who pose a risk to others, and where that risk is usually related to their mental disorder
- Eating Disorder services for people who have an eating disorder and who require specialist inpatient- or community-based treatment
- Drug and Alcohol services for people who have a drug or alcohol dependency and who may need inpatient detoxification and treatment or community-based care, which is often delivered in partnership with third sector colleagues
- Perinatal services for women who have mental health needs arising from pregnancy and childbirth, provided both in the community or in an inpatient Mother and Baby Unit
- Specialist services for people with learning disabilities who experience mental ill health
- Child and Adolescent Mental Health Services (CAMHS) for children and young people requiring community support in Bristol and South Gloucestershire and specialist inpatient care for children and young people from across the South West
- Veterans Mental Health Services for armed forces personnel who have been, or are about to be, discharged from service and who have a mental health need
- Specialist services for deaf people with mental health needs. Services are accessible and care plans are provided in British Sign Language.
- Autistic Spectrum Disorders

Some of these highly specialized services are delivered in partnership with a wider group of providers through a provider collaborative which serves the South West region. Working in this way has increased the number of specialist beds available for people requiring the above services and as a result, has enabled more people to be cared for closer to home. Other developments underway include Community Forensic teams to support rehabilitation and care for people who do not, or who no longer require secure inpatient care.

CASE STUDY: The South West Regional Secure Services

On 17 June 2016, Devon Partnership NHS Trust submitted an application on behalf of a collaborative of eight providers, across the NHS (including AWP NHS Trust) and independent sector. The application was successful in meeting the following principles:

- A transformative clinical model, reshaping both inpatient and community services
- Improved outcomes for South West individuals, as a result of integrated evidence-based care and prevention
- Services closer to home and elimination of avoidable out of area placements
- Savings will be achieved and invested in local services, creating community forensic services and viable alternatives to secure care
- Strong clinical support and leadership - the South West clinical network designed the transformative model of care

Significant transformational progress has been achieved, including:

- 131 individuals repatriated back into region, receiving care closer to home
- 81% of individuals are now treated in-region; from < 50% at the start
- Women receiving care in-region has increased from 20% to 62% with further improvements expected
- Prisoners' needs are met more appropriately, accommodating a threefold increase in admissions during 2018/10, made possible through reduced length of stay and other clinical efficiencies
- No patients are waiting to step down from high secure care, abolishing the initial backlog

It is expected that other highly specialized services will be provided through this provider collaborative, including adult eating disorders, Tier 4 CAMHS, inpatient perinatal care

Service Pressures

General Practitioners report that 48% of consultations now have a mental health component and that the number of people discussing a mental health issue has increased by 85% (MIND 2017). GPs describe limited options, beyond IAPT services, to signpost people for care and support. In the absence of options for mental health support in primary care, people look to the wider system, including A&E attendance and referrals to community mental health teams.

There has been an increase in referrals, however, a relatively small percentage of these referrals meet the threshold for secondary mental health care. There has also been a 13% increase in intensive team caseload which may be suggestive of increased acuity of illness in the community, or lack of community team capacity. High intensity users account for approximately 28% of overall activity in BNSSG and around 80% will have a mental health need.

Approximately 88% of admissions to BNSSG inpatient units are patients who have been detained under the Mental Health Act (against a national average of 75%). This may support a hypothesis of increasing acuity or may suggest that we are not intervening early through primary and community options.

BNSSG has a low mental health inpatient bed base compared to other areas, with an adult acute mental health bed base per 100 000 population of 11.4, compared to a national median of 19.7 (NHS Benchmarking Oct 2019)

Bed occupancy in our mental health trust is one of the highest in the country, often exceeding 100%- compared with a more appropriate occupancy of 85%. This results in high use of expensive 'out of area' admissions, that adversely impact on the person, family and carers. High occupancy rates, combined with high levels of acuity create a challenging environment for patients and staff alike. This may lead to high rates of workforce sickness, in turn resulting in reliance on agency staff - which has implications for safety and continuity of care, therapeutic outcomes for service users, and cost.

People with SMI are more likely to have difficulty accessing physical health services, resulting in poorer outcomes. Ensuring people have access to timely and appropriate physical health checks is essential if we are to achieve better overall health for people living with severe mental illness.

What people tell us about services

- Information on services is either absent or difficult to find and can be confusing, particularly for those with social, cultural or learning needs and those from ethnic minority backgrounds.
- Services are inconsistent, with geographical variations: the same support is not available everywhere due to variations in funding levels and previous commissioning arrangements.
- Services are not coordinated within the NHS and across the community, voluntary and social care sectors causing confusion and delay, ultimately exacerbating mental health problems due to feelings of despair and hopelessness.
- Services are inaccessible compared to services for physical conditions: the right support is not available to everyone at the right time.
- Some service users have a poor experience of care, lack of respect and sometimes discrimination and stigma.
- Services are not equipped to respond to complex needs or cope with co-morbidity.
- Services are not managing the increase in demand from children and young people, leaving people with a lifetime 'career' in mental health services.
- Services are too focused on medical interventions and neglect non-medical therapies and practical advice and support for daily living.
- There is insufficient knowledge, understanding and skills in supporting people with mental health needs amongst the wider health professional community

Our Ambition

We will focus on what matters to people to improve people's experience of mental health services.

We will deliver improved health outcomes for everyone who uses secondary mental health services.

By working in partnership, we will deliver a broader range of support to help people achieve full and satisfying lives.

We will intervene early, making sure that those with complex needs are not ‘bounced’ between organisations, receiving multiple assessments but little or no support to get well.

We will deliver more care in the community, working in partnership with GPs, NHS, VCS and private sector partners. We will support people to remain at home, where they are networked into their communities with the support they need.

Our services will respond to complex needs and will be able to provide community and specialist inpatient care to meet people’s highly specialized needs, in areas such as personality disorder, eating disorders, perinatal mental health and forensic mental health services.

If a person requires hospital admission, they will be admitted to a hospital near home. Their admission will be as short as possible with evidence-based, effective treatment and care. Hospitals will keep people safe when they are most unwell.

Suicide Prevention
We will deliver multi-agency suicide prevention plans, working to achieve a 10% reduction in suicides by 2020/21. This includes putting plans are in place to meet a ‘zero suicide’ ambition for mental health inpatients

We will create a business case based on the findings of the HOPE suicide prevention programme which targets middle aged men

To make this a reality we will:

- Undertake a rapid review of inpatient demand and capacity to determine how we respond to current and future need to prevent people being placed in a hospital far from home.
- Prioritize data analysis from all sources, including all secondary care providers, in order to properly inform the development of a Primary care mental health service
- Review (and where appropriate, redirect) investment in mental health to ensure services are sustainable, able to respond to changing demand, deliver value and achieve the outcomes that matter to people.
- Develop a model of care for mental health in Primary Care that:
    - Provides increased support to GPs, including access to specialist advice and support and case work supported by multidisciplinary teams
    - Widens the support available to help people access information and support through the developing Primary Care Networks and IAPT services. The voluntary sector will be an important partner in creating a network of support within communities. Peer Support and Mental Health Support Workers will provide accessible support at an earlier stage to prevent poor mental health deteriorating to crisis.
    - Works with Sirona Community Care Provider and other partners to integrate physical and mental health.

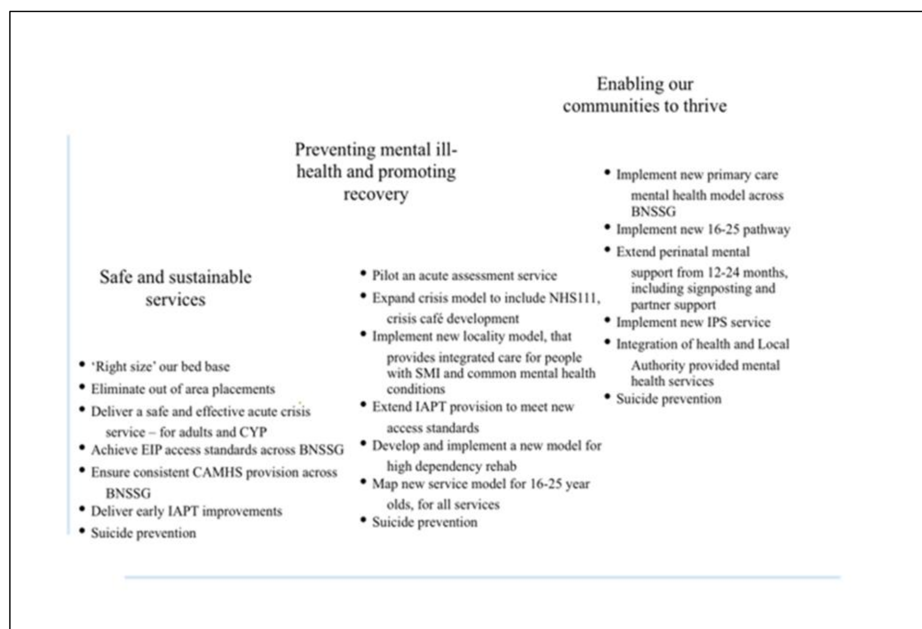
- Review the Crisis Care Pathway and introduce a single point of access for all mental health needs to better respond to individual need and ensure appropriate sign posting.
- Make sure all services are visible, well connected and integrated. This will include a digital directory of services, and access to resources to monitor and manage mental health issues.
- Develop 'End to end care pathways' which will be measured using outcome measures co-produced with service users and partners to improve quality of care and experience. Care Pathways for people with complex needs, such as the diagnosis of personality disorder, will be prioritised.
- Make sure that workforce across the whole health and social care community is confident in understanding and responding to need, recognizing the impact of social determinants and delivering personalised and trauma-informed care.
- For highly specialised services such as eating disorders, forensic mental health and perinatal care we will work with partners across the South West of England through the provider collaborative to embed specialist expertise alongside core services.

Long Term Plan deliverables

System partners have committed to invest both existing and new resources to deliver our three LTP objectives: **providing safe and sustainable services**, **preventing mental ill-health and promoting recovery** and **enabling communities to thrive.** Investment of £3.84m in mental health services in 2018/19 has started to impact on core provider services. Our investment has enabled us to:

- Develop a second crisis café in North Somerset
- Develop a CAMHs crisis service in North Somerset and a reduction in CAMHs waiting times in Bristol and South Gloucestershire by xxx%,
- Implement the Kooth online platform for young people across BNSSG
- Improve equity in provision of IAPT services through recommissioning to a clear service specification
- Expand the specialist integrated homeless support team in Bristol Royal Infirmary

Our detailed prioritization exercise has resulted in the following phased approach:



How we will know we are making a difference?

- Patient Reported Experience Measures
- Mental Health Access Standards
- Reduced number of people going into crisis
- Reduced admissions to the Health Based Place of Safety
- Elimination of avoidable out of area placements
- National average (or below) length of stay in inpatient units
- Reduced length of stay on community team caseload
- Reduced inappropriate referrals to secondary mental health services
- Reduced occupancy in inpatient units to 85%
- Reduced number of crisis admissions
- Reduced number of people needing Psychiatric Intensive Care (PICU)
- Zero inpatient suicide

Liaison Psychiatry is a subspecialty of psychiatric practice that concerns itself with that gap between physical & mental healthcare, working at the mind-body interface in an acute hospital setting. Liaison Psychiatry services that are based in acute hospitals play an integral role in the ambition of facilitating people with mental illness to have timely access to specialist care that is safe, person-centred, recovery focused and delivered along pathways of care that span organization and professional boundaries.

Outwardly from an acute hospital setting Liaison Psychiatry services offers a vital age inclusive urgent / emergency service for rapid face to face mental health assessment and onward signposting onto the appropriate care pathway. Inwardly, Liaison Psychiatry into the acute hospital provides support for -many of the patients who have long term condition and who experience co-morbid mental health disorders, who are complex elderly, and where there is an uncertain synergistic interplay between mental health and physical illness (i.e. medically unexplained symptoms)

Our vision is to have BNSSG Liaison Psychiatry services in an acute setting that offers parity of esteem to allied areas of physical healthcare, which are also of high quality and offer specialized holistic care when most needed. As well as parity of esteem we also aim for parity of high quality Liaison Psychiatry care across BNSSG, with cross-system outpatient facilities augmented by shared specialisms, skills and knowledge driving up quality across the three acute hospital sites.

We want to ensure that by 2023/24, that our Mental Health Liaison services in our acute hospitals meet the principles of the ‘core 24/7’ standard not only for adults and older adults, but children and young people will can access to 24/7 crisis, liaison and home treatment services.

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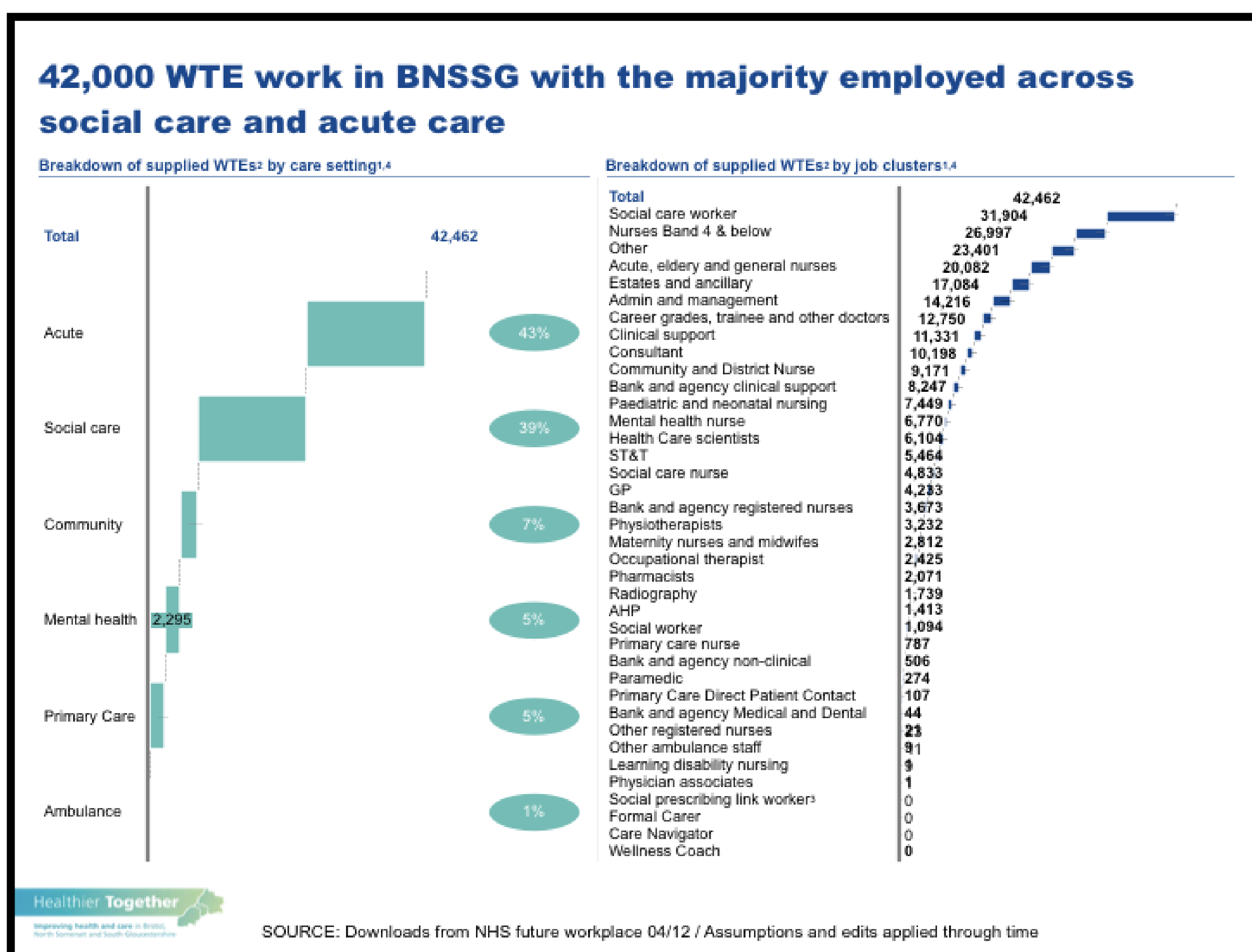
walking
for health
WALKING
FOR HEALTH

Chapter 14: Our Workforce

Delivering the ambitions of this strategy will require a collective workforce and partnerships that respond to changing times, and a working environment based on openness - where talking about our mental wellbeing is an everyday part of what we do.

Our current workforce approach results in the development of different protocols, training, attitudes to risk, priorities and skills. Although mental and physical issues co-exist in the same person, our treatment approaches are often fragmented, overlapping or separate, conflicting and repetitive. Much of our workforce has trained and worked in professional silos. At best this represents inefficiency, at worst, it creates confusion, worse health outcomes and frustration. The historical separation of mental and physical health providers fails to robustly challenge stigma– which is focused not only on mental health service users but also on the mental health workforce. The future will be very different.

While mental illness accounts for 23% of morbidity in England, and therefore a similar fraction in BNSSG, the mental health workforce accounts for only 5% of the total health and social care workforce. There is no future in which the mental health needs of the population can be met by a specialist mental health workforce alone.



Instead, our ambition is that every member of the future BNSSG workforce will value discussing mental health and wellbeing and will be knowledgeable about the opportunities to

intervene, advise and signpost. We will also find better ways to nurture the mental wellbeing of our workforce – organisations in Healthier Together should be exemplars for workplace wellbeing.

In order to truly address the needs of the whole person, every member of our workforce will:

- Seek to understand the person, their social context and their life-experiences in order to offer high quality, psychologically-informed support.
- Fulfill their responsibility to promote both physical and mental wellbeing.
- Work across professional, organizational and sector boundaries, in an integrated system
- Understand their role in advancing equality for all population groups, including the consideration of social determinants and the need for reasonable adjustments to enable full access to support.
- Know how and where to find help to support their own wellbeing.

Psychologically-Informed Support

Our services and workforce will understand the impact of adverse childhood events and trauma throughout the life course and will take account of the need for reasonable adjustments. At all points of care, including in the acute physical care setting. Care plans will be psychologically informed, made to optimize wellbeing and autonomy, and tailored to specific life stages.

Promotion of Physical and Mental Wellbeing

We need our BNSSG workforce to take every opportunity to promote mental wellbeing and prevent mental ill-health, wherever they work and whatever their role.

Training staff with the knowledge and skills to improve mental health and wellbeing and prevent mental illness and suicide is a specific recommendation within the NHS Five Year Forward View for Mental Health and Public Health England's public mental health leadership and workforce development framework.

We will train our workforce, increasingly through shared training and with experts by experience, in the core skills they need to opportunistically promote wellbeing. Every member of the workforce can consider how they might support preventative measures, both primary and secondary.

Making Every Contact Count (MECC) is a workforce and service redesign initiative to equip all staff with the necessary competencies and skills to support behaviour change. It aims to meet the challenge set out in the NICE guidance (2007) by developing 'standards' for these skills. The MECC approach recognises the public-sector provider contribution that is made through commissioning for workforce transformation and quality outcomes. Workforces across the public sector and beyond are our greatest asset and mobilising the workforce can achieve large scale change and delivery of improved health and well-being. Additionally, MECC can become a cornerstone of staff and workplace health and wellbeing programmes. Healthier Together identified MECC as a key part of workforce transformation and we now need to escalate our adoption and spread across workforces.

Holistic Care in an Integrated System

'Stepping forward to 2020/21: the mental health workforce plan for England', (Health Education England) focused on the mental health workforce while acknowledging that social care, housing, community and third sector organisations provide invaluable services and whose workforce also needs to be considered in the context of the government plans for better mental health. It also acknowledged that a longer term, integrated health and care workforce strategy would be necessary and invaluable.

To deliver these services, '*Stepping Forward to 2021'* described the plan for the NHS to establish 21,000 posts and employ 19,000 additional members of staff by 2020: 11,000 to be drawn from 'traditional' pools of professionally regulated staff, e.g. nurses, occupational therapists, or doctors.

New roles, such as Peer Workers, Graduate Mental Health Practitioners, Nursing Associates, Assistant Practitioners and Physician Associates are emerging to support the delivery of integrated care. Some of these new roles have integration at their core, while others build on established roles to facilitate integration. These roles aim to enable more holistic care and facilitate continuity and co-ordination of care across organizational boundaries.

Some notably innovative examples are Care Navigators and Community Facilitators, who enable individuals and, in some cases, professionals to access and navigate the range of support available from health, social care and the wider community. This includes recognizing and addressing barriers to access which arise from social determinants and deprivation, and includes enabling support for those issues, for example housing, employment, debt, domestic violence and so on.

These new roles to support integrated care are only effective when they are part of a system-wide process of integration. The support of senior leaders across BNSSG is therefore crucial if we are to establish a framework for integration which legitimizes new ways of working and which ensures work culture and working processes are aligned to encourage this to develop.

> *"All our staff need to be highly skilled in partnership working, integrating care and co-production with those who access mental health services and their carers; technologically-adept; values-driven; and able to provide physical as well as mental health care."*
>
> - "**Stepping Forward to 2021", HEE**

Improving the mental health and wellbeing of a population will require us to take a wider focus, a broader reach and more innovative thinking, beyond the traditional mental health workforce. It will require a cultural shift towards holistic and integrated 'mind & body' care and a relentless deep focus on enabling prevention, addressing the social determinants of ill-health and individual vulnerability.

Moving forward, our BNSSG workforce will be able to work flexibly in multi-disciplinary teams, in the community or in specialist environments. Skills in communication, management and creating relationships are vital and will be required by professional and non-professional groups alike. Interdisciplinary training, training of managers as well as

practitioners, and cross-boundary placements will help develop and spread the necessary skills and competencies.

Supporting Workforce Wellbeing

Deliverable: Healthier Together workplaces will become exemplars for workforce mental wellbeing

Mental health problems affect one in six British workers each year and mental health is the leading cause of sickness absence. 15% of people at work have symptoms of an existing mental health condition. The annual cost of poor mental health to employers is between £33 billion and £44 billion, or 3.6% of the total national pay bill. This cost arises from 'presenteeism' where individuals are at work but significantly less productive due to poor mental health, as well as from sickness absence and staff turnover. Most crucially, 300,000 people with a long-term mental health problem lose their jobs each year. (Thriving at Work – the Stevenson/Farmer review of mental health and employers, 2017)

Money spent on improving workplace mental health shows a consistently positive return on investment. Addressing mental well-being is known to reduce staff sickness, increase retention and productivity in organisations, including both local authorities and health organisations. Sickness absence rates and sickness costs per employee are higher across the public sector compared with the private sector. Within the health sector specifically, these costs are even higher, potentially averaging more than £2,000 per employee per year.

It is in the interest of all employers in BNSSG, including those in local authorities, health, social care and VCS, to prioritise improving workforce and workplace mental health and wellbeing. This must include support for all employees to thrive, and more targeted and tailored support for those who may need it

We propose to adopt the standards of 'Thriving at Work – the Stevenson/Farmer review of mental health and employers' (2017) across Healthier Together. All employers will adopt 6 core standards and 4 enhanced standards:

Core standards
1. Produce, implement and communicate a mental health at work plan
2. Develop mental health awareness among employees
3. Encourage open conversations about mental health and the support available when employees are struggling
4. Provide your employees with good working conditions
5. Promote effective people management
6. Routinely monitor employee mental health and wellbeing.

Enhanced standards
1. Increase transparency and accountability through internal and external reporting.
2. Demonstrate accountability
3. Improve the disclosure process
4. Ensure provision of tailored in-house mental health support and signposting to clinical help

The Current Workforce

The national picture shows that the net effect of staff turnover in mental health nursing is currently negative, which means there are fewer mental health nurses employed each year (-4% each year compared to +2% for Adult Nursing).

Since 2013, the registered nursing workforce in England has grown by 2% but the majority of this growth has been in acute, elderly and general hospitals. From May 2010 to September 2016 there were an extra 12000 nurses employed in acute hospitals while mental health and learning disabilities services have seen reductions in nursing posts of 13% (5,142) and 36% (1,926) respectively.

Although training courses for mental health nursing are currently oversubscribed and the attrition rate is comparable to other branches of nursing, the *growth* of nursing posts in mental health has not kept pace with other professions to date and 11% of these are vacant (2017). Data from Health Education England shows that while mental health nursing and learning disabilities nursing is experiencing a slight increase in BNSSG, there is a reduction in supply for the South West overall, a factor that impacts on recruitment and retention.

Furthermore, although the medical workforce in mental health, including consultants, has grown in recent years, there has been lower growth in the numbers of psychiatrists employed relative to the wider medical workforce.

Healthier Together workforce position as of August 2019

(Workforce Transformation Steering Group dashboard, August 2019)

- For all staff in health and CIC providers, the gap between funded establishment and employed staff is increasing (Aug 2018 - Aug 2019). For registered nurses in all health and CIC providers, the gap is stable or increasing.
- Vacancy rates for registered nurses are highest in secondary care mental health, at 25.3% (202 WTE) compared to other health and CIC providers (range 7.4% to 25.3%)
- Vacancy rates for all staff are highest in secondary care mental health (18.1%) compared to other health and CIC providers (range -2.4% to 18.1%)
- Turnover for all staff in health and CIC providers ranges from 8.3% to 18.1%
- Sickness absence ranges from 3.7% to 6.5%
- BNSSG Social Care (Care workers) have the highest vacancy rates (10.8%) and lowest turnover rate (39%) of 7 STPs in the South West
- National Freedom to Speak Up Index 2019: UHBT 79%, AWP 76%, NBT 75%, WAHT 75%

Developing the Workforce

We know that we need to attract new people and retain our current staff to have sufficient resource to deliver our plans. To achieve this our ambition, we need to make our health and

care system the best place to work, by improving career pathways, flexible working and training opportunities together.

We are already working with local schools to attract the next generation of workforce, from all backgrounds, into health and care roles. We are using technology and social media platforms to attract and facilitate new recruits into health and social care.

We will develop the workforce to enable them to identify the knowledge, skills and confidence citizens and patients have to take action to improve and manage their own health and care - including ensuring all organisations within the system have a Making Every Contact Count plan.

Many staff live within our region and we want to enable them to be healthy and well through a range offers to improve physical and mental wellbeing. We need to consider new 'old' ways to attract and retain people, such as providing key-worker accommodation.

We are also committed to developing our voluntary workforce to work alongside our employed staff, to help support patients, releasing more time for our professionals to provide the high-quality care they have been trained to give and provide rewarding opportunities for volunteers. We have secured funding from Voluntary Partnerships England to enable us to develop protocols to ensure that safety and safeguarding are at the heart of working with the voluntary sector, and to develop models and approaches to attract, train and develop volunteers to work with our patients and staff.

Healthier Together Workforce goals from Workforce Steering Group
Goal 1: Make health and care in BNSSG the best place to work: We must make the NHS and social care employers of excellence – valuing, supporting, developing and investing in our people.

Goal 2: Improve our leadership culture: We need to improve our leadership culture in BNSSG. Positive, compassionate and improvement focused leadership creates the culture that delivers better care.

Goal 3: Prioritize urgent action on nursing shortages: There are shortages across a wide range of health and care staff groups, however, the most urgent challenge is the current shortage of nurses. We need to act now to address this.

Goal 4: Develop a workforce to deliver 21st century care: We will need to grow our overall workforce, but growth alone will not be enough. We need a transformed workforce with a more varied skill mix, new types of roles and different ways of working, ready to exploit the opportunities offered by technology and scientific innovation to transform care and release more time for care.

Goal 5: Develop a new operating model for workforce: We need to continue to work collaboratively and to be clear what needs to be done and ensure that we have the governance to deliver this, creating the architecture for a truly integrated workforce.

DELIVERABLES

Improved Workforce Data - We will commit to collecting better data, to better understand the social care, primary care and independent sector workforce.
We will develop a strategy to identify and develop clinicians who may be able to take on leadership roles in relation to integrated care. Having a board-level champions for physical health care in mental health trusts, and vice-versa, can be a key enabler of integration.
We will test a range of approaches in pilot sites to develop the workforce to be able to support integrated working, in particular through inter-professional training and skills transfer. We will create opportunities for different groups of professionals to learn from each other during the course of routine practice.
Healthier Together workplaces will become exemplars for workplace mental wellbeing: reducing stress and improving wellbeing, supporting staff who develop mental health problems and welcoming them back to work when they are ready. We will implement the standards of Thriving at Work to make it easier for all members of our Healthier Together workforce to ask for and receive help, and every employer will sign up to Time to Change by (date tba).
We will support our workforce to have the necessary skills and confidence to raise lifestyle choices with patients and with each other, through Make Every Contact Count (MECC).
We will raise the awareness of mental wellbeing amongst NHS staff, and work with General Practitioners to encourage GPs to enhance primary care mental health skills through post-qualification experience or secondment in psychiatry.
Mental health staff, particularly those based in the community, will be given opportunities to enhance their skills in prevention and improving physical health.

The investment from the LTP will enable us to transition from current workforce models to future models that we design in our long term plan response.

Chapter 15: Digital

OUR AMBITION:

We will harness the use of digital technology to connect with people, to improve efficiency and safety of services to expand choice and the quality of experiences for people.

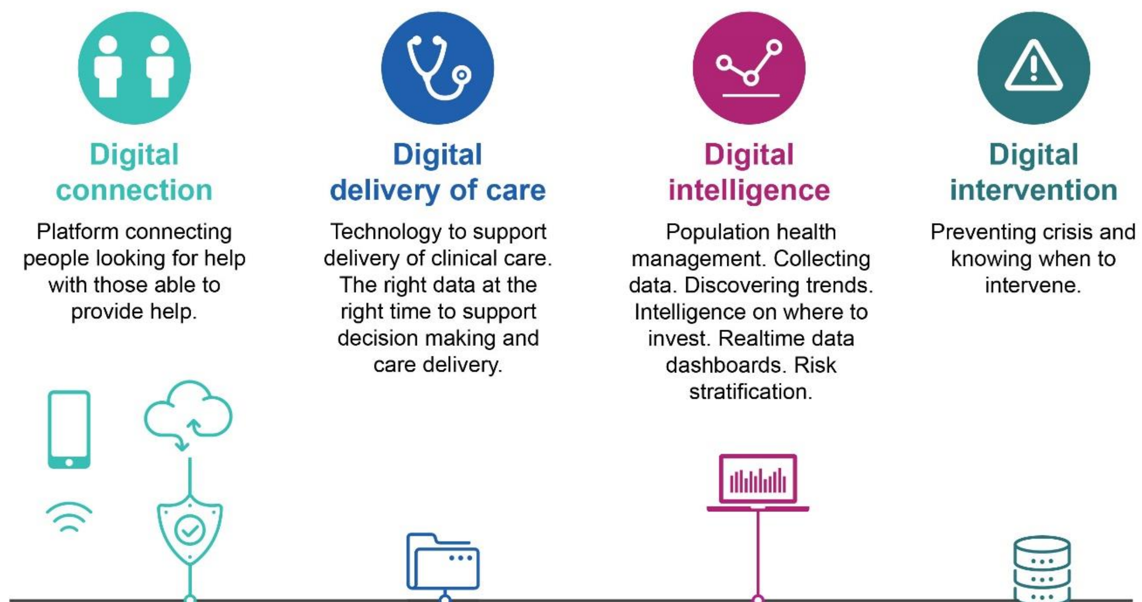
Technology makes new services possible. It allows simple solutions to long standing problems, it is pervasive in our everyday lives yet when it comes to our health and care services and particularly in across mental health we are more than 10 years behind. Of course, digital technology is not a stand-alone activity but rather one that enables many aspects of our strategy. There are several components of digital that have been identified as we have gone through the process. These form four key digital programmes.

Digital Connection: This is intended as a 'Thrive Platform' an online capability designed to link people with the support or wellbeing opportunities as well as being a way to offer or get connected to give support. This will be a dedicated co-production project engaging across the population. Bringing together the existing digital estate for mental health and wellbeing into single space for BNSSG

Digital Delivery of Care: covers the existing work in our services and provision of digital capabilities and is detailed in annex xx

Digital Intelligence: Will be the mental health focus of our existing population health programme, linked up with the many data driven deliverables a part of the strategy

Digital Intervention: This is a discovery project beginning to explore the use of IOT, wearables and other devices that we can use in partnership with the person to consider how we can prevent crisis.



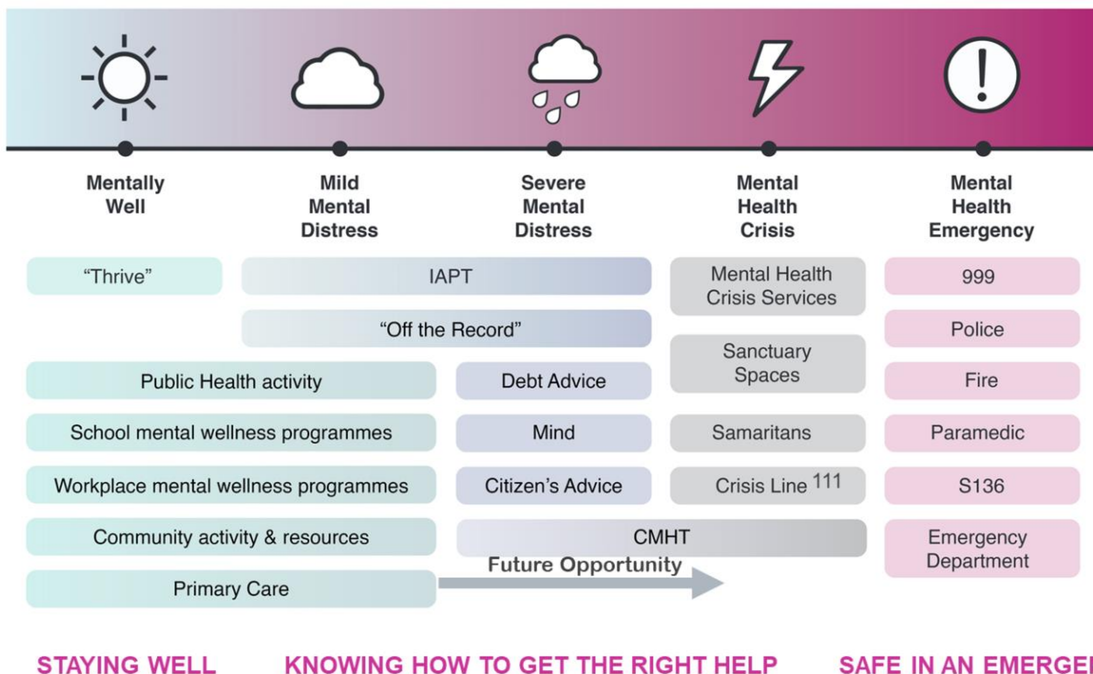
Chapter 16: Sustainability and Next Steps

Our Ambition: that the vision and direction set out in this strategy drives a fully integrated delivery programme for Mental Health and Wellbeing. We will develop a delivery programme that connects us together to solve some one of the biggest challenges we face as a system, creating sustainability to meet the challenges of the future.

This strategy has identified just how many complex elements impact on the mental health of our population. It highlights how the services and support we have in place, despite our efforts and best intentions as providers and commissioners, don't work well enough to address the big challenges or to change people's prevailing experiences.

We have many green shoots where services, teams and groups of people in our community are doing incredible work. We need to find a way to focus on the big problems whilst allowing the smaller, creative, sometimes ground-breaking developments to thrive, too. We want to be sure that in future people know there is support available and how to find it. We heard too many times through the co-production of this strategy that people felt alone and hopeless and didn't find out there was support available until late in their journey.

Our Thrive Platform will cover the whole spectrum of support and will be the public facing view of our developments.



Sustainability means doing more of what's right and less of what's not

We face significant financial challenges. All existing services are sustaining cost pressures, staffing pressures, waiting times and variable patient experiences. And yet we know that the areas in which we spend our money are not always the areas that add the most value.

For example:

- For every person prevented from entering a ‘crisis’ pathway, we could avoid/save up to £180,000 and inestimably reduce suffering.

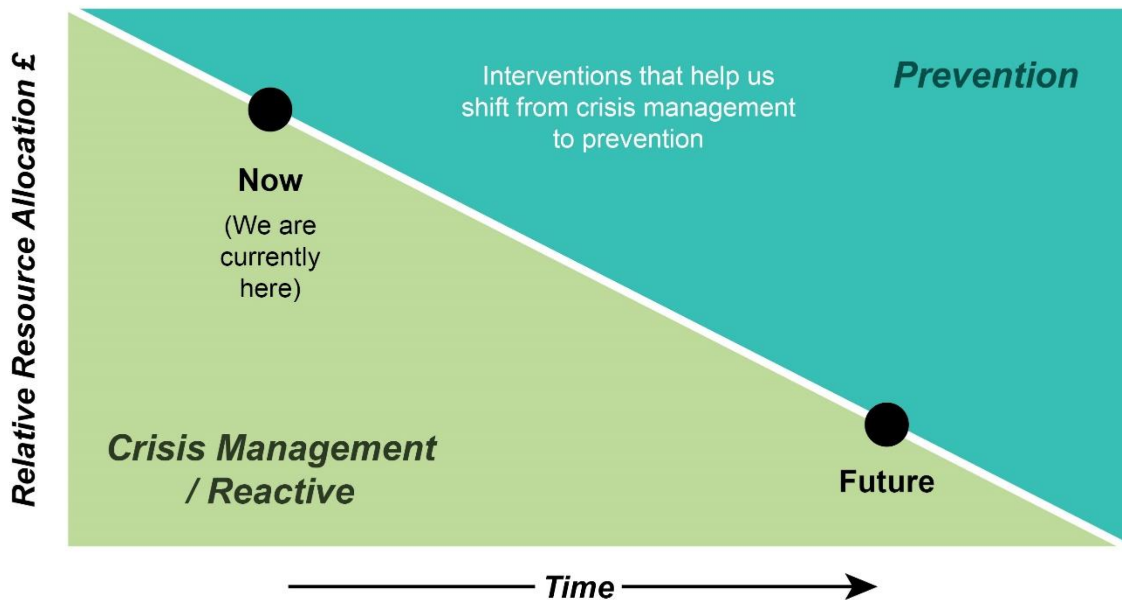
- For every individual *not* subject to Section 3 MHA detention (and some forensic MHA detention orders), we can avoid both lifelong stigma and the possible lifelong cost of Section 117 Aftercare support - which can be up to £100,000.

- We have heard stories where the allocation of a personalised health budget and investment of a few hundred pounds has potentially given a person a better life, kept them from harm and saved thousands of pounds in crisis pathway costs. We need to make this our default outcome.

- We rely too often on costly Out of Area Placements (admissions to distant hospitals) that can be devastating for people and their families. While we rebalance our system towards prevention, better crisis support and increased capacity, we need to consider interim approaches that quickly give us escalation capability in our mental health system. We know this is an essential component of our urgent care system. The right mental health escalation capability and capacity will reduce the likelihood and trauma of travelling to a distant placement, result in better health outcomes and reduce the cost of care. Within BNSSG, we do not have enough of the right market provision to support all of our Section 117 Aftercare needs locally. Until we create or enable the right provision, we will continue paying for services that don’t always deliver the value and experience we want for people.

A Sustainable Future

Whilst there is some additional investment for mental health in the coming years we cannot rely on external injections of funding. We will fully invest new monies to improve services in line with the NHS Long Term Plan. Our investment plan will utilize the growth in mental health spend mandated through the Mental Health Investment Standard (MHIS) to stabilise current core community services. Nevertheless, our system spends too much failing to prevent mental ill health and crisis - and then responding to it. We need to focus on areas where there is evidence which will enable us to reduce reliance on late, expensive interventions - so that in future we will be able shift spending from crisis response to prevention and to the mental wellbeing of the next generation of children and young people.



Finding the best way to prioritise - when there is so much need - is difficult. This strategy proposes that we align round three key foundations.

1. As a system - we need every organization to adopt, promote and engage with a BNSSG wide Thrive programme
2. From an NHS perspective - we need a new model of primary care mental health and sustainable secondary care mental health provision
3. As a health and social care system - we need an integrated, end to end, and responsive crisis offer that will enable the journey for people in crisis to be fast, safe and positive. This offer needs to encompass a series of pathways which together reflect the needs of people and the experiences we want them to have

Our work to deliver the NHS Long Term Plan, on Thrive, reviews of community services, the existing crisis and suicide concordats, as well as the crisis pathway programme, is underway. All of these pieces of work are aligned along their core priorities. Once the strategy has been endorsed by partners, our next step is to develop clear co-production plans, delivery plans to which we can assign resources, business cases, describe the right measures of value, benefits and impacts of the changes we make from this point onwards.

Annex 1: Recommended deliverables (version as at 30.10.19)

Chapter	Deliverables by chapter	Suggested delivery parters or lead organization
2 Changing the Landscape	DELIVERABLE 1: We will enable and sustain a strong vibrant VCS sector that recognises their unique contribution, which will complement the statutory, clinical mental health offer, from prevention through to specialist mental health support.	Healthier Together partners BNSSG CCG, VCS (via Care Forum?)
3 Co-production and patient-centred design	DELIVERABLE 1: Production of Training and Awareness Materials. We will work with lived experience led organisations and individuals drive innovative approaches to co-production. The first test advocated by users is a Citizen's Jury model. DELIVERABLE 2: Experience informed commissioning as part of value-based commissioning. We will embed the unique perspective of co-production at every stage of the commissioning cycle for mental health services. DELIVERABLE 3: STP-Wide Mental Health Lived Experience Advisory Board. We will develop an STP wide lived experience led working group that will influence the ongoing development of the strategy and its implementation phase over the next 10 years.	IMHN and others Citizen's panel? Co-ordinating partner from within HT BNSSG CCG IMHN and others Mental Health Steering group to oversee development
4 Carers	DELIVERABLE 1 We are committed to meet the requirements of the NHS Long Term Plan for Carers. • We will always enquire after 'Carer status' wherever people present in the BNSSG Health and Social Care system. • We will roll out carer passports (piloted in Bristol and recognized nationally) that provide bespoke rights, support, discounted parking and catering. • We will listen to Young carers, raise awareness of their experiences among health professionals and share information to help our workforce provide better support. DELIVERABLE 2: We will meet the standards of the NHSE Quality Markers for primary care which describe best practice in carer identification and support. • We will pro-actively offer carers advice on how to stay well, access services, and avoid illness themselves. DELIVERABLE 3: We will include people with lived experience, and/or carers, as members of our governance and business meetings as the norm. Proactive	Mental Health Steering group to oversee delivery All Healthier Together partners Lived experience representatives Primary Care Networks All Healthier Together partners

	encouragement for (people and) carers to engage in research improves wellbeing. DELIVERABLE 4: We will improve the knowledge and capability of our care navigators and co-ordinators to support carers as well as individuals with a mental illness. • We will compile a guide to local services for carers with our voluntary sector partners and review any gaps that prevent access to support. DELIVERABLE 5: We will baseline and then measure the numbers of carers who develop mental health issues, sharing information across our system to monitor whether our new interventions are having a positive impact. Carers are an equally important piece of our health and social care system and deserve our respect and support for their difficult role.	VCS/Care Forum Local Authority Thrive representatives
5: Perinatal Mental Health	DELIVERABLE 1: We will explore how we create a more accessible pathway of support including links via Maternity teams, Health Visitors, increase the expertise provided via IAPT services to support perinatal mental health and peer support services. DELIVERABLE 2: We will work with the Maternal Health Alliance, embedding the use of the toolkit and the learning from the RCGP GP Perinatal champions work. DELIVERABLE 3: For Perinatal HIT we will seek to understand and provide additional guidance on the following areas: • Produce guidance on prescribing anti-depressant drugs during pregnancy and complete analysis of largest study in this area. • Improve support for women with low mood/mild depression/anxiety by assessing the role of children centres as a place of support. Analysis of children centre survey data and responding to the voices of people highlighting the need for a place to go. • Improve service provision for women who do not have a child, whether through perinatal death or having their child taken into care.	UHBT, NBT, WHAT, AWP, primary care, Bluebell and others, Vita Health Lived experience representatives UHBT, NBT, WHAT maternity representatives Maternal Health Alliance RCGP Bristol Health Partners PerinatalHIT partners
6 Children & Young People	DELIVERABLE 1: Getting Advice: Where children and young people need additional support, we will implement a range of actions that ensure opportunities for earlier intervention, through schools, digital platforms and better information DELIVERABLE 2: Getting Help: For children and young people who require input	Mental Health Steering Group to co-ordinate AWP NHS Trust

	from secondary mental health services, our services will be geographically consistent, available for CYP 0-25 years, integrated with partners who engage with CYP and be more available with shorter waiting times.	South West Regional Provider Collaborative BNSSG CCG VCS and lived experience representatives
	DELIVERABLE 3: Getting More Help: For those children and young people who require specialist intervention, we will expand services to be available closer to home, more often in the community rather than hospital, and co-designed with CYP and families.	AWP NHS Trust South West Regional Provider Collaborative BNSSG CCG VCS Lived experience and family representatives NHS England
	DELIVERABLE 4: Getting Risk Support: We will build on our recently expanded weekend crisis support for CYP to develop and improve an integrated 24/7 crisis response for children and young people, aligned with all providers and working alongside our inpatient services, primary and community, social care and VCS.	AWP NHS Trust Local Authorities Safeguarding Boards VCS
	DELIVERABLE 5: Getting Consistent Help: CYP services will develop to meet the needs of people 0-25 years, but no-one will transition from children's to adult services based on age alone. We will create CYP and adult services which respond to need, not age. Transition will take place when people are ready.	AWP NHS Trust Safeguarding Boards (Transitional Safeguarding response) VCS Local Authorities (benefits, housing, employment, education response)
7 Complex needs, SMI and PD	**COMPLEXITY**: DELIVERABLE 1: We will create the right environment so that no-one falls through the gaps. We will work as an effective whole system, seamlessly, blending social care, health and VCS. We will: • deliver trauma-, ACE- and psychologically-informed support through leadership, staff training and audit • create effective data sharing across all providers • create trusted assessments across services, sharing our approaches to risk • develop a stable and secure approach to 'commissioning for complexity', with co-produced system outcomes	Healthier Together Learning Academy Partner L&D or OD representatives HT Workforce workstream HT Digital work stream All HT partners BNSSG CCG Lived experience representatives

	DELIVERABLE 2: We will deliver trusted and consistent support, teams and key workers who will work alongside people for the long term. To do this we will:	
	• create a “My Team around me” – a wrap-around long-term team, including a coordination/navigation service, and peer workers.	?
	• with Urgent Care, develop a specialist navigator team to support individuals who frequently access A&E, NHS 111, and GP services but whose needs may be better met by addressing aspects of social deprivation.	BNSSG CCG VCS partners Urgent and Emergency Care steering group Local Authorities
	DELIVERABLE 3: We will ensure fundamental needs are met, acknowledging that people with complex needs have multiple deprivations. To do this we will:	Local Authority to co-ordinate
	• enable client-facing staff to fund packages of support, taking advantage of ‘windows of opportunity’’	
	• work with local authorities to expand the Housing First project and explore other housing options such as a Complex Needs Housing Project	
	• create trauma-informed, dual diagnosis treatment packages tailored for this client group	
	PERSONALITY DISORDER: DELIVERABLE 1: we will build a consistent, system-wide team approach to improve quality of life. To achieve this, we will:	
	• ensure a trauma, psychological and ACE informed approach, training all staff • adopt a consistent, structured, whole-team, clinical management care approach, to reduce the impact of high intensity behaviours. • provide case management for high impact users.	Mental Health Steering Group to co-ordinate
	DELIVERABLE 2: We will provide the right support and interventions, at the right time, consistently. We will: • establish a pathway for people with PD across primary and secondary care, taking a tiered approach, working as a whole system, and including a shared approach to risk • develop a strong peer offer, including groups and self- management	Learning Academy support as above
	• deliver NICE compliant DBT interventions, EMDR and CBT treatments	BNSSG CCG

	• develop pre-diagnosis behavioural support as early as possible, including supporting children at risk of developing PD • learn from pilots and expand STEPPS across BNSSG • offer self-management skills development to clients • explore other interventions and service offers such as a therapeutic community **SUICIDE PREVENTION** Our vision is for zero avoidable deaths caused by suicide. DELIVERABLE 1: We will embrace an ambitious vision to reduce suicide: • All partners will sign up to the Zero Suicide Alliance by xxxx. • We will work reduce suicide by 10% by 2022, and set annual reduction targets to 2029. • We will have an overarching Suicide Prevention Plan that reflects an integrated approach, building on the strengths and contributions of each partner agency DELIVERABLE 2: We will deliver targeted and tailored services to those most at risk. • We will learn from the HOPE project and develop interventions which enable us to intervene earlier and to address the underlying causes of crisis, hopelessness and suicide. • We will work with public health to drive mental health awareness campaigns targeting at-risk groups. • We will use population health data to connect early with people who might be at risk (what does this mean in practice?)	IMHN AWP NHS Trust Local Authorities/Thrive links All Healthier Together partners Mental Health Steering group to co-ordinate Second Step Directors of Public Health HT Digital workstream
8 Crisis pathways	DELIVERABLE 1: We will establish a crisis system, all- agency compact that commits us to this challenge, is underpinned by real-time shared data that enables all agencies to understand the root cause. We will undertake collective planning and understand the impacts of specific initiatives. DELIVERABLE 2: We will design an improved crisis pathway that: improves safety,	Urgent and Emergency care steering group HT Digital work stream U&EC steering group

	ensures we get the person to the right place fast and optimises the capability across the system - including the NHS, Social Care, VCS, Primary care, 111/ IUC, Police, Ambulance services and people with lived experience. This will build on street triage, control room triage and is connected to services via A&E which is covered in more detail in chapter xx DELIVERABLE 3: We will have a single telephone route via 111 for people to get support in a MH crisis. DELIVERABLE 4: We will develop a whole system activity, availability and demand capability. In time this will become a control centre type real-time dashboard, but initially we will start with joining up the data we have defining the services available across the system. DELIVERABLE 5: We will ensure that crisis plans are available via connecting care, we will also explore the mental health patient first access as the priority use case for the patient facing digital programme. DELIVERABLE 6: We will we will explore how we develop the existing emergency services better to ensure that we create settings that are conducive to mental health emergencies.	Avon Somerset Constabulary SWAST LA Social care Care Forum HT Digital Workstream IMHN Lived experience representatives U&EC steering group AWP NHS Trust
9 Substance Misuse	DELIVERABLE 1 - We will connect data from across agency partners to create a life course, geographically referenced single view of drug and alcohol and related MH impacts. DELIVERABLE 2 - We will create a more person-centred approach for our population starting with our most vulnerable high intensity users. This will move beyond the traditional approach where people face a cycle of rehab and relapse where their accommodation is contingent on staying in recovery and the instability affects their mental health and well-being. DELIVERABLE 3 - As part of the redesigned Primary Care Mental Health services, we will include services such as these as part of the social prescribing cohort. This will develop closer connections and understanding between less conventional services that provides as many opportunities as possible for people to transition from the GP appointment to an evidence-based but non-medical support and recovery model.	HT Digital workstream Substance misuse providers High intensity outreach team/workers Local Authority (housing, benefits, employment) Primary Care Networks VCS
10 Older People	**Older People** DELIVERABLE 1 - Focus on wellbeing, access and integration We will deliver a whole system approach that draws together the expertise of health	 Primary Care Networks to lead AWP NHS Trust

	and social care agencies and those in the voluntary sector, to deliver a comprehensive, balanced range of services, which place as much emphasis on prevention, through options that promote independence, as on care services. This approach will be embedded in the primary care multidisciplinary team, delivered locally to where you live and will link closely with social prescriber and age-well practitioners. The new approach will take learning from the successful Dementia Wellbeing Service and will work closely alongside. DELIVERABLE 2 - Focus on Equality - We will apply the principle of equality to older people's physical health needs and mental health needs. DELIVERABLE 3 - Focus on Sustainability To meet the needs of older people positively and holistically, we need to stop focusing on 'whose responsibility is this?' and overcome the boundaries which separate social care needs from health issues. DELIVERABLE 4 - We will explore the development of intergenerational activity as part of Thrive, embedded in our best lives and better homes projects as well as within our NHS services	DP NHS Trust VCS BNSSG CCG All Local Authority Thrive leaders
10 Mental Health Care in Primary Care	DELIVERABLE 1: As set out in the Mental Health Locality transformation schemes we will develop high quality, integrated primary care mental health for the local population. DELIVERABLE 2: We will establish a programme to analyse primary care mental health referrals focusing on the clinical clustering of referrals, end to end case reviews. This will be part of the design process for Primary Care Mental Health services and informing PCNs and locality development. DELIVERABLE 3: We will develop advice and guidance services linked to secondary care providers, VCS and others that support the development of Primary Care Mental Health. DELIVERABLE 4: We will drive up primary care engagement with the LCHRE specification and develop a series of specifications for future developments in Connecting care and wider systems	Primary Care Networks BNSSG CCG AWP & DPT NHS Trusts Sirona HT Digital Workstream Primary Care Networks AHSN Digital worktream
11 Mental Health Care in Acute hospitals	DELIVERABLES • At all points of care, including in the acute physical care setting, care plans will be psychologically informed; made to optimise wellbeing and	UHBT NBT WHAT Sirona

	autonomy, and tailored to specific life stages. This will reduce the chance of those people dev eloping mental illness, with the concomitant impact on physical health • All acute providers will deliver parity of esteem for physical and mental health care focusing on the 1 hour and 4-hour standards with breaches being reported daily through the standard system and escalation calls • Treatment for complex somatic illness and medically unexplained symptoms will be delivered by integrated mental and physical health teams. • When people with a serious mental illness are treated in the acute setting a review of their physical health (including investigations and monitoring) will be undertaken opportunistically. • People who have a severe mental illness and are treated in the acute hospital will have access to an ageless, integrated, specialised, Liaison Psychiatry service to deliver a holistic approach. Teams will be skilled to manage multi-morbidities to achieve the best physical and mental health outcomes. • All staff who work in acute trusts will have access to education and support to allow them to care for people with SMI with confidence, kindness and consistency. Areas of specific need will be identified by specialist teams and a programme of education implemented as a proactive measure. • People who present to the Acute hospital after self-harm or suicide attempt will be treated in an appropriate and timely way, their own needs being at the forefront of care. Assessment and care will be psychologically informed and will include access to support to address social determinants.	Vita Health

	• People who repeatedly attend ED in crisis or with self-harm will be proactively identified and prioritised. A collaborative care plan addressing both mental and physical health problems will be written - with the patient. Digital platforms will enable sharing of information to enhance safety and care. • People who need to attend an acute setting after self-harm or a suicide attempt will have collaborative, joined up care. Acute care staff will be given training and psychological support to manage the psychological and well as physical consequences of self-harm. Everyone who wants to be seen will be seen (where appropriate).	
12 Secondary and Specialist Mental Health Services	DELIVERABLE 1: We will produce Training and Awareness Materials. At all points of care, including in the acute physical care setting, care plans will be psychologically informed; made to optimise wellbeing and autonomy, and tailored to specific life stages. DELIVERABLE 2: Care Planning for Frequent Attenders. People who repeatedly attend ED in crisis or with self-harm will be proactively identified and prioritised. A collaborative care plan addressing both mental and physical health problems will be written - with the patient. Digital platforms will enable sharing of information to enhance safety and care. Closing the reality Gap: We will develop Patient Experience Measures and Patient outcome measured for MH and well being services	UHBT NBT WAHT Lived experience representatives Secondary care providers Primary care networks Siri a Digital workstream
13 Our workforce	DELIVERABLE 1: We will commit to collecting better data, to better understand the social care, primary care and independent sector workforce, so we can work together better DELIVERABLE 2: we will champion integration, through clinical leadership, explicit board-level responsibility and inter-professional training and working DELIVERABLE 3: we will co-produce new roles with current workforce representatives, and experts by experience DELIVERABLE 4: we will create mentally healthy workplaces where people are able to ask for help. All HT employers will sign up to Time to Change	All HT partners HT Digital steering group Learning Academy HT workforce steering group

	Deliverable 5: Staff will have the skills they need to offer holistic care, including wellbeing and prevention enquiries, to improve physical and mental health	
14 Digital	Deliverables appear in Annexe	
15 Sustainability and next steps	To be decided Open Book accounting on MH spend MHIS additional investments will support sustainable core MH services Better data analysis of mental health need to inform development of pro I Mary care mental health services	

Annex 2	Embedding Digital Practice	Population Health & Shared Care Records	Patient Facing Digital Health Care
LTP 19-20	• MH Digitisation Investment Plan - Gap • Digital Care Plan Preparation • E-correspondence 18/19 • E-Referrals – Gap • Test Digital Pathways	• MH Benchmarking for Investment Gap	

19-20			
	• Clinical Risk Summary Development • SNOMED – Interventions • AWP Website Procurement • Care Planning Review Preparation • BNSSG & BSW IAPTUS Consolidation • Mobile Device Management (MDM) Solution • Device Programme (inc Fax removal) • Single Sign On • Case Management Tool • Digital Dictation (Extended Pilot) • Appointment Reminders • E-Correspondence – Discharge Summaries and Outpatient Letters • Weston CAHMS System (IAPTUS or RiO TBD) • Infrastructure Improvement – Network, Servers & WiFi • Business World – Procurement / Finance Reporting	• NBSSG Connecting Care – Real Time MH Records • BSW Graphnet - Real Time MH Records	• Virtual Reality Psychological Therapy (Pilot) • Data Opt Out • Appointment Reminders • Review of NHS Apps

LTP 20-21	• Digital Leadership & Workforce Gap • Cyber Security • MH GDE Blueprint Gap • DQMI • MHMDS v4.0 • SNOMED	• NHS UK Including Crisis Services - Gap	• Patient Access to Care Plans - Gap
20-21	• Telephone Systems • Cloud / Servers • SNOMED – Diagnoses etc • CAHMS Onto RiO • Consultant Connect (BSW) • Care Flow Connect (BNSSG) • Patient-Level • Community Mobile Devices • HR App • E-Referrals • Care Planning • Section 12 App • EPMA Inpatient • Business Process Systems • Happy App • WinDip Replacement	• LHCRE (South West) • Shewd (BSW) • Almanac (BNSSG) • BI Tool (BSW) • Population Health (Both STP) • Quality Dashboard	• Crisis Café's (Both STP) • Physical health App • Mental health Portal (Thrive Gateway) - Phase 1 Signposting

Annex 3 Mental Health & Wellbeing Strategy Programmes

	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020	April 2020			
Bed capacity	Business case 18/20	Decision →				Go live → ROI? KPI: reduce OOA			
Crisis Pathway	Adult pathway inc. operational Data & capacity & demand	Dashboard CAMHS crisis KPI? NHS111 & 999s & ED							
Integrating Community MH project	Community MH review	Specification							
Dementia service	Community MH review								
Crisis avoidance/high intensity users	Link to popn health Dashboard design People at risk South Glos MDT project →	System crisis call inc CAMHS Start weekly Cost? Test & Learn							

Primary Care MH/Community Framework	South Glos MD Pier Health E'consult	Primary Care pathway Data: capacity & demand Dashboard							
CYP • Ageless transition • Waiting times	North Somerset 24/7 crisis response	CMHT for 0- Transition MH in schools	Co-design Identify x schools and LAC	Account for ACE	T&L	E-project			
Substance Use		Design phase		Business case development for new models eg Housing First	Costs?				
Workforce project • Clinical risk and primacy	Protocols library for clinicians	Led by AWP/MP?							
Workforce project • Core MH skills	Training System partners Sign charters	Engage HEI, peer educators and public		Co-design course and framework		Learning Academy to deliver?			

		health							
	Communicate	Co-design	Campaign						
Mental Health/Public Health	Health Checks in SMI & LD Start in Primary Care?								
Perinatal Mental Health • **Prevention** • **Better Births**									