

# Joint Mental Health Commissioning Strategy for Adults 2014-2019



Developed in partnership with:

NHS Ipswich and East Suffolk CCG, NHS West Suffolk CCG, Suffolk Constabulary and Suffolk County Council



**You said:** GPs lack the time. Sometimes there can be a long wait to see them when help is needed immediately. Doctors naturally reach for prescription medicine rather than counselling or information.

**You said:** to prevent crises from happening we need easy access to appropriate support from skilled multi-agency teams.

**You said:** we need 24 hour access to care and support that is closer to home; help in understanding what the early warning signs are; detailed care plans and barriers to other services removing; services in A&E need to improve.

**You said:** it was difficult to get back into services unless you were in crisis.

**You said:** you want to be listened to. I know best what I need to feel better and what works for me.

**You said:** carers and patients need access to courses in Recovery Colleges.

**You said:** we need 24/7 responsive services available - telephone staffed by skilled people.

**You said:** we need a safe place to go in crisis.

**You said:** that there is a stigma attached to mental illness and that mental health needs to be normalised.

**You said:** we need quick access to support for significant life events, alcohol or substance misuse. We need up to date care plans and GPs need access to up to date information.

**You said:** we want to see all services in crisis becoming more joined up. Communication still needs to get better.

**You said:** recovery should not just be the responsibility of people in secondary care. More partner organisations need to be involved.

**You said:** stimulating therapy such as art, drama and play should be utilised. There should be recovery courses and a recovery college.

**You said:** feelings of isolation exacerbate mental illness.

**For Consultation only**

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**By noon on 7 June 2015**

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**(2014 – 2019)**

**Developed in Partnership with  
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Constabulary and Suffolk County Council**

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## 1.1 Executive Summary

There is “no health without mental health”. Mental wellbeing is fundamental to a person’s quality of life. It is linked to good physical health, better cognitive and physical functioning, increased productivity, better interpersonal relationships, longer life expectancy and a greater capacity to deal with stress and adversity.

The strategy is prepared jointly by Ipswich and East Suffolk and West Suffolk Clinical Commissioning Groups, Suffolk Constabulary, Suffolk County Council and people who use mental health services on behalf of the people of Suffolk. We continue to be committed to people’s mental health needs so that they have independence, choice and control in how they live their lives. The strategy is integral to and designed to complement the overarching Suffolk Health and Care Review carried out in 2013/14. The strategy will drive commissioning, planning and decision making processes for people with mental health needs in Suffolk.

Our vision is to *provide excellent, safe, sound, supportive, cost effective and transformational services for people with mental health needs that in turn promote independence and are empowering, wellbeing, and choice that are shaped by accurate assessment of community needs.*

We will bring this vision closer by improving outcomes for mental health in seven strategic domains between 2015 and 2020.

- More people will have good mental health
- More people with mental health problems will recover
- More people with mental health problems will have good physical health
- More people will have a positive experience of care and support
- Fewer people will suffer avoidable harm
- Fewer people will experience stigma and discrimination
- More people from ethnic minority backgrounds will have access to local mental health services.

What we know:

- Locally there are strong links between social deprivation and mental ill health. There is a clear correlation at practice level between severe mental illness and deprivation, according to Quality Outcomes Framework data.
- The most recent mortality data shows that among residents of Suffolk in calendar year 2013, there were 67 deaths from self-harm. In Suffolk analysis has shown a significant association between death rates and deprivation.

Mental ill health can negatively affect an adult's ability to work and to live a full life. It also affects their wider health and over a half of older people in acute hospitals for a physical problem also have a mental health condition. At any one time one in six adults has a mental health problem and the proportion affected is much higher for those who are in prison. This is important in Suffolk where three prisons are based, one of which is the largest in Europe.

Mental illness still has a stigma and is often not recognised. For example it is believed that a quarter of people over the age of 65 living in the community have symptoms of depression serious enough to warrant intervention, but only a third of them discuss it with their GPs, and only half of those get treatment. Research has identified that many vulnerable adults experience complex health and social problems, including mental health issues, and there is evidence of poor mental health as both consequence and cause of inequalities and exclusion.

It has been estimated that for every £1 invested in early identification, treatment and /or care for mental health problems up to £7.89 is saved. The majority of these savings sit outside the NHS or social care. Improving the mental health and wellbeing of those in Suffolk will enhance the lives of individuals and families and also increase economic prosperity within Suffolk.

In summary this strategy will drive a partnership approach to developing support for people with mental health needs in Suffolk. It will ensure we sustain the best possible quality of life for them and their families. We will do this by focusing on the following key priorities:

- Mental health prevention and early intervention including improving quality in services offered locally and at surgeries
- Integrated operating models and responses for example people from different agencies working better together
- Crisis Care and suicide prevention
- Rehabilitation and recovery including supporting people with complex needs

There are also key links to other areas that have been identified as priorities. These include:

- Children and young people including the transition from childhood to adulthood
- Substance misuse including alcohol.
- Those with Learning Disabilities and/or autistic spectrum disorders.

## **Minority Populations**

Research shows men from Black Caribbean, Black African, and other Black groups are more likely than other groups to be detained under the Mental Health Act. Research also shows that the highest levels of depressive episodes are reported by Pakistani women and Indian women. The reasons for these differences need to be understood and effective support made available.

The public sector has a duty to ensure that there is equal access to mental health services for all minority populations (Equality Act 2010) including migrant populations, Black and Minority Ethnic communities and travellers.

In general, according to the Mental Health Foundation people from BME communities are:

- More likely to be diagnosed with mental health problems
- More likely to be diagnosed and admitted to hospital

- More likely to experience a poor outcome from treatment
- More likely to disengage from mainstream mental health services, leading to social exclusion and a further deterioration in their mental health.

The report by the Joint Commissioning Panel for Mental Health recommends that *“Commissioners need to fully understand the mental health needs of BME communities, and their experience of the local mental health system. Commissioners also need to recognise that the organisational culture and structure of NHS care can act as a barrier to overcoming health inequalities among BME groups”*.

It is a fundamental expectation that the mental health workforce will have the necessary cultural competence to be able to support all users including BME communities and understand the impact of racism and discrimination has on their wellbeing, and to effectively embed a human rights approach in practice.

Clinical commissioning groups (CCGs) and Suffolk County Council (SCC) have the responsibility for commissioning the best possible services for their patients and local population. As this includes populations that are diverse and multicultural, a single and uniform model of mental health care may not be appropriate. Instead, cultural differences and ethnic diversity in the local population will require services that are customised to varied needs. This is arguably more important in mental health than in any other aspect of health care – culture, language, religious beliefs and ethnicity will all have a disproportionate impact on the origin, manifestation, experience and treatment of mental ill health.

This strategy also considers the mental health needs of military veterans both the elderly and those more recent veterans. The most common disorders among recent or younger veterans are depression, anxiety disorders, Post Traumatic Stress Disorder (PTSD) and substance misuse most notably that of alcohol.



## **Section 1.2 Introduction**

1.1 The importance of mental health and wellbeing cannot be understated. It affects and influences the lives of individuals, families, communities and societies. Those who work in mental health services and live with long term conditions are well aware of this, and are keen to get on to make changes. Change like this take time, however with a clear strategy the whole population can benefit as this strategy comes to life.

The purpose of this strategy is to improve the mental health and wellbeing of the population of Suffolk so reducing health inequalities, improving physical wellbeing, social interactions and job prospects.

1.2 This strategy seeks to implement national drivers to promote parity across mental and physical health care, good mental health and wellbeing, whilst further improving the quality and accessibility of services for people who have mental health problems. It also seeks to co-produce with providers, the public and service users to devise local approaches to mental health services.

1.3 Good mental health and wellbeing for all is at the heart of our strategy and we will develop services that are individually tailored, aim to prevent mental ill health and crisis and responsive in nature. This will include promoting mental health through awareness raising in universal services, delivering targeted information and support to marginalised community groups, and information and signposting to individuals to support self-help.'

It will also include thinking about new ways of delivering mental health interventions that:

- Promote mental health through early access to good information, effective treatments as well as a 'whole population' approaches to support good mental health.
- Work together to maximise opportunities for new models of service to offer more comprehensive and coordinated approaches to helping people with mental ill health.
- Support people to access the services they require and services need to be available to offer prompt and early treatments.

- Ensure people with mental ill health are able to access support for other long term conditions (e.g. diabetes, coronary heart disease) in the same way that someone with a long term physical health problem should be able to access mental health support.
- Make sure a person's mental health is considered as part of the assessment of everyone's health.

1.4 The strategy has been developed through dialogue and co-production with a wide cross-section of mental health service users and carers. It will support the commissioning of fully integrated health and social care services across mental health, physical health, people with autistic spectrum disorders and learning disability. It will ensure there is a seamless transition between care pathways and service boundaries including adolescents moving into services for adults and for adults moving into services for older people. Services will be accessed through a single point and be designed to meet the care needs of our patients based on actual need not their age.

1.5 The strategy is underpinned by the following principles:

- People will understand the importance of good mental wellbeing
- People will have good mental health
- People with mental health problems will recover
- People with mental health problems will have good physical health, and people with physical health problems will have good mental health
- People with mental health problems will be empowered and have the best possible quality of life empowered by a social model of disability.

## **Section 1.3 Strategic Plans**

### West Suffolk CCG

Final refresh of the 2 year operating plan is available on the website at

### Ipswich and East Suffolk CCG

Final refresh of the 2 year operating plan is available on the website at

## **1.1 The Suffolk Health and Wellbeing Board**

The Board has set out a vision for the people of Suffolk to live healthier, happier lives with reduced inequality of life expectancy. They have set four strategic outcomes:

- Every child in Suffolk has the best start in life
- Suffolk residents have access to a healthy environment and take responsibility for their own health and wellbeing
- Older people in Suffolk have a good quality of life
- People in Suffolk have the opportunity to improve their mental health and wellbeing.

## **1.2 Suffolk County Council**

The Council takes responsibilities for caring for vulnerable people very seriously. New operating models are being developed across its social care services for adults and children which have early intervention and prevention at their heart.

In turn, this will enable people to live more independent lives and reduce the need for more intensive and costly interventions later on. Forging strong links with the NHS and the voluntary and community sector will not only help us offer a seamless, holistic approach to meeting the needs of Suffolk's most vulnerable, but also prevent those less in need falling into crisis by supporting them to remain living independently in their community.

A joined-up approach across organisations that considers the needs of the whole person, rather than simply treating a particular condition, will help people that fall into

crisis to quickly get the help they need so that they are able to return to independent living as possible as soon as possible.

**Supporting Lives, Connecting Communities** is based on having a varied market for care and support which offers the people of Suffolk flexibility and choice.

It aims to:

- Influencing communities and people so that it is easier for them to live more independent lives without on-going formal intervention
- Providing responsive short-term support to help people regain independence
- Re-designing the statutory assessment system so that it is streamlined, and offers real choice and control

**The Care Act 2015** has “wellbeing principles” which underpin the entire legal framework and become the defining purpose for care and support. When people need an assessment the focus will be on their strengths capabilities and assets as well as needs.

The council has new universal obligations to all local people to prevent, reduce or delay needs for care and support, to provide information and advice and to promote quality and diversity in the market to meet people’s choices.

Care and support plans will focus on the outcomes people want and create ways they can link to what’s in their community to achieve this without recourse to traditional social care.

When people lack capacity or find it hard to engage the council will have a duty to provide independent advocacy to assist in assessment, care planning and safeguarding. There is also a duty to assess young people and young carers in advance of their 18th birthday and this can and this can be at whatever age is most appropriate. Safeguarding Adults Board will be a statutory body.

For the first time carers will have an equal entitlement to assessment and outcome focused care and support plans and the Act encourages “whole family thinking plans”.

People will be entitled to a personal health budget as part of their care and support plan.

### **1.3 Suffolk Constabulary**

The Police and Crime Plan 2013-2017 outlines the vision and mission of the local Constabulary. It sets out a vision to make Suffolk a safer place in which to live, work, travel and invest. The mission statement goes on to highlight the following key outcomes:

- To reduce crimes causing most harm to our communities
- To reduce anti-social behaviour
- To improve the satisfaction of our customers
- To build the confidence of our communities

The Police and Crime Commissioner has outlined four objectives to achieve this including to care for victims and vulnerable people, including protecting vulnerable families and improving trust and confidence within the criminal justice system. There is also a commitment to support a multi-agency approach in supporting people with mental health needs through delivery of the Mental Health Crisis Concordat (2014)

### **Section 1.4 Equity and Excellence- Liberating the NHS**

The NHS White Paper was published in July 2010 and sets out the Government's long term vision for the future of the NHS. This vision builds on the core values and principles of the NHS- a comprehensive service, available to all, free at the point of use, based on need, not ability to pay. It sets out how:

- Patients will be put at the heart of everything the NHS does;
- There will be a focus on continuously improving those things that really matter to patients- the outcome of their healthcare; and
- Clinicians will be empowered and liberated to innovate with a freedom to focus on improving healthcare services.

The aspirations for mental health are:

- The commissioning of services will be transferred to groups of GPs under the GP consortia with the exception of specialised mental health services that will be the responsibility of the National Commissioning Board

- The White Paper states that choice of both treatment and provider of care will be extended in to some mental health services from April 2011. The importance of this decision to enable effective patient choice is particularly acknowledged for mental health and community services
- A set of payment by results currencies for adult mental health services will be introduced from 2012/13. Payment mechanisms to support the commissioning of talking therapies will also be formulated
- Mental health outcomes will be included in the NHS outcomes framework.

Other key points that will in turn support our local strategy are:

- Further exploration of the potential to use personal health budgets;
- Incentives for quality improvements, and
- Closer working between health and social care.

### **Section 1.5 Think Local Act Personal (TLAP)**

Think Local, Act Personal is the sector wide statement of intent that makes the link between the Government's new vision for social care and Putting People First. It has been finalised as the way forward for personalisation and community-based support. It came into force on 1 April 2011.

Think Local, Act Personal was originally released for comment in November 2010 and asserts that councils, health bodies and providers need to work more collaboratively to personalise and integrate service delivery across health and adult social care by making vital public funding go further. It also recognises the contribution that individuals, families, carers and communities make in providing care and support both to those who are publicly funded and those who either pay for themselves or rely on family carers.

They are:

- **Universal services** - general support and services available to everyone, including transport, leisure, education, health, housing, community safety and access to information and advice;

- **Early intervention and prevention** - support, available to assist people who need a little more help, at an early stage to stay independent for as long as possible. This may include support to recover from the effects of illness and help to manage long term conditions;
- **Choice and control** - self-directed support that means having services available to meet people's needs rather than people having to fit in with the services on offer.; and
- **Social capital** - making sure everyone has the opportunity to be part of a community and experience the friendships and care that can come from families, friends and neighbours.

The direction is clear; to make personalisation and self-assessment, including a strategic shift towards early intervention and prevention, the cornerstone of public services. In social care this means every person across the spectrum of need, having choice and control over the shape of his or her support in the most appropriate setting. This is a challenging agenda, which cannot be delivered by social care alone.

To achieve this sort of transformation across Suffolk it will mean working across boundaries of social care such as housing, benefits, leisure, transport and health. Major transformational change in Suffolk will be delivered through the Health and Care Review made up of key stakeholders across the system and based on the implementation of:

- A health and independence service model including timely access to health and social care.
- Efficient and effective support and care.

These major programmes of work are in progress and include working across the sector with partners from independent voluntary and community organisations to ensure a strategic balance of investment in local services.

There is an expectation that there will be changes in the way people use and access urgent and emergency services. Patients with a long term or chronic condition will be firmly in control of accessing a range of local health and social care services that

meet their own personal needs. Patients will only be treated in hospital settings when this is the best place for them to be. The system is also committed to ensuring there is a parity of esteem for mental health services.

As part of the system wide commitment to the Crisis Care Concordat 2014 people who are detained under section 136 of the Mental Health Act will only be detained in police cells in exceptional circumstances. Suffolk Constabulary will work with partner agencies and organisations to ensure patients receive timely and appropriate care at times of crises. They will predominantly be taken to health based places of safety to ensure they receive this meaning that detention in Police Investigation Centres is only used in exceptional circumstances.

Through strong partnership links Suffolk Constabulary will work to also help those before a point of crises and in periods of recovery to help prevent repeat need and service use. Links into the criminal justice system and police custody areas with health and social care partners will also help to identify and support people with mental health needs.



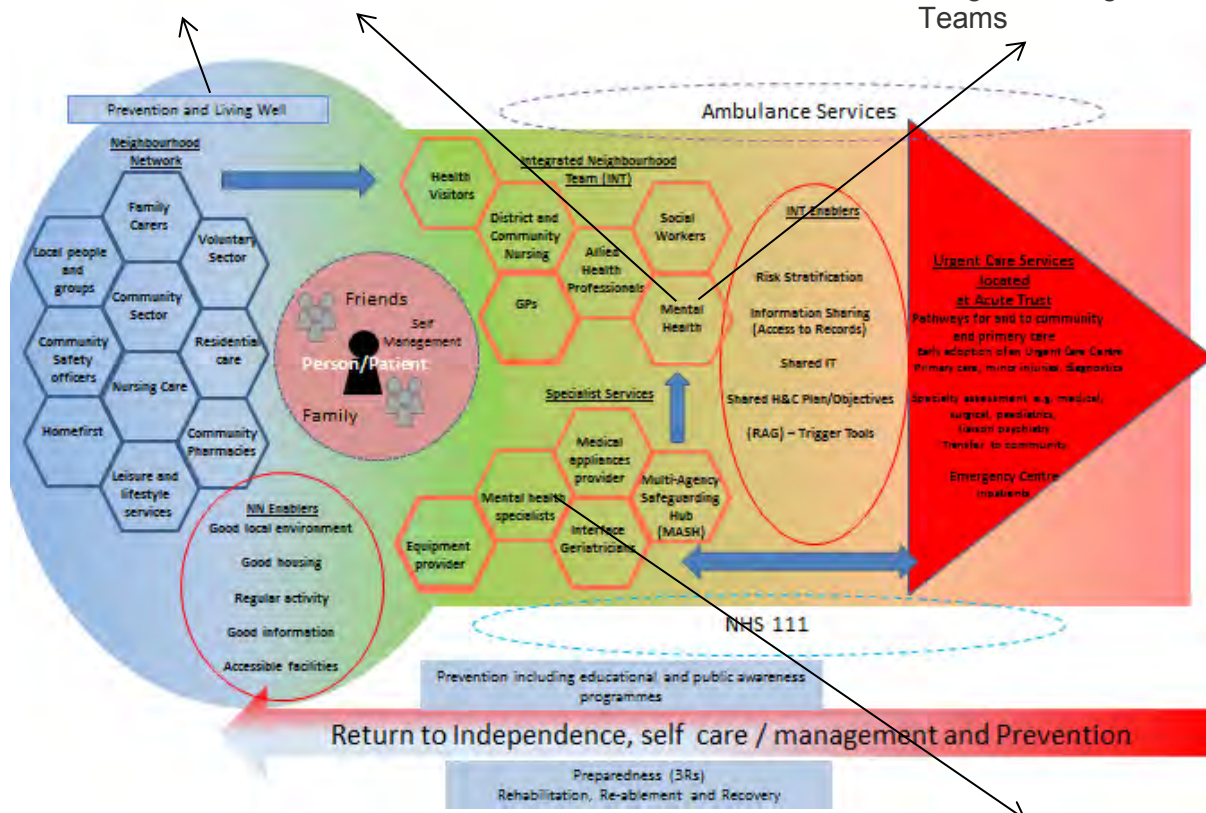
## Section 2: Local and national provenance

The Joint Mental Health strategy sets out the vision for Mental Health services in Suffolk. The strategy is consistent with the approach being taken within the context of the Suffolk-wide Health and Care review and will be delivered with the Urgent Care and Health and Independence Programme Boards, which both had membership including clinicians and Healthwatch Suffolk.

### Integrated Health & and Care Service Pathway

**Prevention & early intervention** – a mental health clinicians in the community working in multi-agency teams

**Recovery** – services that enable people stay in control of their life despite their mental health problem within the Integrated Neighbourhood Teams



**Crisis and suicide** – specialist services and urgent care to support people with severe and enduring mental health problems to prevent patients reaching crisis including emergency access to crisis inpatient care.

## 2.1 National Context

Mental illness is the single largest cause of disability in the UK and each year about one in four people suffer from a mental health problem. The cost to the economy is estimated to be around £100 billion annually – roughly the cost of the entire NHS.

- **No Health without Mental Health - February 2011:** aims to improve mental health and wellbeing and to improve outcomes for people with mental health problems. The following strategic outcomes have been defined:

### **1. More people will have good mental health**

More people of all ages and backgrounds will have better wellbeing and good mental health and fewer people will develop mental health problems

### **2. More people with mental health problems will recover**

More people will have a good quality of life – greater ability to manage their own lives, stronger social relationships, a greater sense of purpose, improved chances in education, better employment rates and a suitable and stable place to live

### **3. More people with mental health problems will have good physical health**

Fewer people with mental health problems will die prematurely and more people with physical ill health will have better mental health

### **4. More people will have a positive experience of care and support**

Care and support, wherever it takes place, should offer access to timely, evidence-based interventions and approaches that give people the greatest choice and control over their own lives, in the least restrictive environment; and should ensure people's human rights are protected

### **5. Fewer people will suffer avoidable harm**

People receiving care and support should have confidence that the services they use are of the highest quality and at least as safe as any other public service

### **6. Fewer people will experience stigma and discrimination**

Public understanding of mental health will improve and, as a result, negative attitudes and behaviours to people with mental health problems will reduce

- **Closing the Gap - January 2014:** aims to bridge the gap between long term ambition and shorter term action. It describes how changes in local service planning and delivery in the next two or three years will make a difference to the lives of people with mental health problems. It sets out 24 areas where people can expect to see, and experience, the fastest changes. These will define our priorities within the context of this strategy.

They are about mental health care and treatment, work across the entire health and care sector to reduce the damaging impact of mental illness and improve mental wellbeing. In addressing these priorities, we will also define our commitment to working with many partners across the voluntary sector – from national charities to local community groups.

The 24 areas are as follows:

1. High-quality mental health services with an emphasis on recovery should be commissioned in all areas, reflecting local need
2. We will lead an information revolution around mental health and wellbeing
3. We will, for the first time, establish clear waiting time limits for mental health services.
4. We will tackle inequalities around access to mental health services
5. Over 900,000 people will benefit from psychological therapies every year.
6. There will be improved access to psychological therapies for children and young people across the whole of England
7. The most effective services will get the most funding.
8. Adults will be given the right to make choices about the mental health care they receive.
9. We will radically reduce the use of all restrictive practices and take action to end the use of high risk restraint, including face down restraint and holding people on the floor
10. We will use the Friends and Family Test to allow all patients to comment on their experience of mental health services – including children's mental health services
11. Poor quality services will be identified sooner and action taken to improve care and where necessary protect patients
12. Carers will be better supported and more closely involved in decisions about mental health service provision
13. Mental health care and physical health care will be better integrated at every level
14. We will change the way frontline health services respond to self-harm.
15. No-one experiencing a mental health crisis should ever be turned away from services
16. We will offer better support to new mothers to minimise the risks and impacts of postnatal depression.
17. Schools will be supported to identify mental health problems sooner
18. We will end the cliff-edge of lost support as children and young people with mental health needs reach the age of 18
19. People with mental health problems will live healthier lives and longer lives.
20. More people with mental health problems will live in homes that support recovery
21. We will introduce a national liaison and diversion service so that the mental health needs of offenders will be identified sooner and appropriate support provided.
22. Anyone with a mental health problem who is a victim of crime will be offered enhanced support.
23. We will support employers to help more people with mental health problems to remain in or move into work.
24. We will develop new approaches to help people with mental health problems who are unemployed to move into work and seek to support them during periods when they are unable to work.

- **Mental Health Crisis Care Concordat - February 2014:** describes how we work in partnership with others to improve outcomes for people experiencing mental health crisis. It is a national agreement between services and agencies involved in the care and support of people in crisis. It focuses on four main areas:
  - Access to support before crisis point – making sure people with mental health problems can get help 24 hours a day and that when they ask for help, they are taken seriously.
  - Urgent and emergency access to crisis care – making sure that a mental health crisis is treated with the same urgency as a physical health emergency.
  - Quality of treatment and care when in crisis – making sure that people are treated with dignity and respect, in a therapeutic environment.
  - Recovery and staying well – preventing future crises by making sure people are referred to appropriate services.
  
- **Five Year Forward View - October 2015:** describes how over the next five years the NHS must drive towards an equal response to mental and physical health, and towards the two being treated together. For the first time, there will be waiting standards for mental health. Investment in new beds for young people with the most intensive needs to prevent them being admitted miles away from where they live, or into adult wards, along with more money for better case management and early intervention.
  
- **Achieving Better Access to Mental Health Services by 2020 – October 2014:** People of all ages with mental health problems should receive at least the equivalent level of access to timely, evidence-based, clinically effective, recovery focused, safe and personalised care as people with a physical health condition.
  
- **The Annual Report of the Chief Medical Officer Public Mental Health – Investing in the Priorities – October 2014:** The CMO advises Commissioners should follow the WHO model and prioritise evidence-based

interventions for mental health promotion, mental illness prevention, treatment and rehabilitation.

The report states that the aims of care, across all sectors should be:

- Safe integrated mental and physical health care
- To achieve parity of esteem and outcomes in physical and mental health

This includes the mental health of people with physical illness and the physical health of people with mental illness. Services should be planned to meet the integrated mental, physical and social care needs of their populations. High risk groups should be prioritised for prevention.

The CMO advises that:

- Patient experience and experience of services whether are effectively integrated, around their health and social care needs, should be recognised and measured.
  - Commissioned services should ensure the needs of older adults are met as mental health problems in older adults are often underdiagnosed and require specialist support of physical, psychological and social problems.
  - The report advises, building on success of hospital liaison, community services should be enhanced so that community staff can refer patients with complex physical and mental health problems to specialist for advice.
- 
- **‘Preventing Suicide in England’ September 2012:** defined objectives and areas for action nationally, whilst highlighting the responsibility at Local level to coordinate and implement work on suicide prevention.
- 
- Payment by Results – Finance/Contracting to complete
  - Choice – Quality to complete
  - Personal Health Budgets – Quality to complete

## **2.2 Regional Context**

- Quality, Innovation, Prevention and Productivity (QIPP) programme
- East of England Mental Health Clinical Network

## **2.3 Local Context**

In order to plan, commissioners of mental health services need to understand the level of mental illness now and the future estimates. In doing this services commissioned can be designed to meet the needs of the local population and provide value for money.

The Joint Strategic Needs Assessment (JSNA) review of mental health has considered levels of mental illness in Suffolk and projected future needs.

Further detail can be found at:

<http://www.suffolkobservatory.info/JSNASection.aspx?Section=146&AreaBased=False>

A summary of the level of mental illness in Suffolk now is described below.

### **Anxiety and depression**

Estimates suggest there are around 83,000 people in Suffolk, aged 16-74, with anxiety, depression or both at any one time.

### **Children & Young People**

There is an existing joint commissioning strategy covering services for 0-18 years that compliments this adults strategy- The Appropriate Place Joint Suffolk Emotional Health and Wellbeing Strategy (2013) (0-18 years)

### **Distress and minor mental health issues**

Estimates for levels of distress and minor mental health issues including sleep disturbances, irritability, worry and stress related symptoms suggest up to 29% of adults aged 16-74 experience these problems. For example: Around 5800 people aged 16-74 in Suffolk will have obsessive compulsive disorder (OCD) compared to up to 29,000 having some obsessive concerns. Around 9000 people will have severe Phobias compared to an estimated 23,000 with minor problem or fear. Panic

disorder affects an estimated 3690 compared to at least 10,500 experiencing some form of panic

### **Severe mental illness**

Severe mental illness which includes psychotic disorders that lead to disturbed thinking and perception and bipolar disorder are estimated to affect 0.4% of the population in real terms this is 2,000 to 3,000 people in Suffolk aged between 16-74 years old.

### **People with personality disorders**

Personality disorders are a complex group of conditions identified through how an individual thinks, feels and behaves. People with a personality disorder may find it difficult to:

- Make or keep close relationships
- Get on with people at work, and friends and family
- Keep out of trouble or control their feelings or behaviour
- Listen to other people
- Avoid becoming unhappy or distressed and upsetting or harming others

Prevalence of personality disorder is estimated to be around 24,000 people aged 16 to 74 in Suffolk. More men are affected than women although the type of personality disorder which is most prevalent varies between men and women.

Antisocial personality disorders lead to disregard for others and can be associated with irresponsible or aggressive behaviour. The latter is fairly rare and was identified in 0.6% of men and 0.1% of women.

### **Autism**

Locally prevalence data (Brugha et al, year) indicates 1% of population will have autism this equates to about 7500 adults and children in Suffolk. Of those 7500 between 25% and 30% will also have a learning disability. However many people with autism will have multiple needs such as ADHD, anxiety, depression and may present to various services with another primary diagnosis.



## **Armed Forces health and post-traumatic stress disorder**

The Armed Forces Covenant defines the community as:

- Regular personnel who are individuals currently serving
- Reservists - volunteers in the services
- Veterans - those who have served for at least a day
- Families of regular personnel, reservists and veterans
- Bereaved, the immediate family of service personnel and veterans

The majority of serving and ex service personnel have good mental health. However in those with mental health problems the most common are depression or anxiety. There are high levels of heavy alcohol consumption among serving personnel.

Estimated of levels of post-traumatic stress disorder suggest that between 4-6% of returning personnel suffer. However younger recruits are significantly more likely to suffer post-traumatic stress disorder (PTSD), to drink at levels harmful to health, and to behave violently on their return from war. It also claims that young recruits from disadvantaged backgrounds are at greatest risk and more likely to lack strong social support when they leave the forces in order to manage their problems.

Delayed onset PTSD is estimated to occur in 3.5% of personnel.

Suicide rates are also of concern in males aged under 20.

There is little direct research on how this impacts on families.

## **Perinatal mental health**

Mental health problems occurring during pregnancy or in the first year after birth are referred to as *perinatal*. Mental health disorders may start at this time or may be pre-existing conditions that may relapse or recur. Problems may range from anxiety to severe mental illness, including psychosis.

It is estimated that between 10 and 15% of women experience some mental health problems during pregnancy (compared to 5% of non-pregnant women). However psychiatric disorders lead to up to 15% of maternal deaths (in pregnancy and six months post-delivery).

Post-natal depression is estimated to affect 2% of women. Post-traumatic stress disorder is estimated to affect up to 7% of women after delivery. Post-natal psychosis is rare, estimated to affect 1-2 per 1000, and there is an increased risk in women with a pre-existing serious mental illness. Those with severe and enduring mental illnesses have a 50% chance of relapse during or after pregnancy

These estimates suggest up to 1500 women in Suffolk per year may experience depression and anxiety during and after pregnancy. A further 40 will experience serious mental illness or psychosis.

### **Self-harm & suicide**

The most recent data shows that, among residents of Suffolk in the calendar year 2013, there were 67 deaths from self-harm and injury. Of these 54 were men and 13 women. (Source of data: ONS Annual District Death Extract)

The main risk factors for suicide are:

- Being male
- Living alone
- Unemployment
- Drug or alcohol misuse
- History of mental illness.

Self-harm is not usually a suicide attempt but a way of expressing emotional distress and can result from traumatic events or situations and relationship problems. Usually there is destructive or dangerous behavior involving cutting or misuse of drugs. It can be associated with alcohol and substance misuse. Self-harm increases the risk of later suicide and can be associated with other mental health problems

For all age groups the annual prevalence is about 5%. However in 15-16 year olds the figure is 10% of girls and 3% of boys.

Around 60% of hospital admissions for self-harm are for female patients of which 89% are admitted after self-poisoning. There has been an upward trend locally in admissions, increasing in line with national trends.

Recent national and international work has highlighted the importance of monitoring

those who very frequently access primary care services, along with those using multiple medications, and the risks associated with substance and alcohol use when combined with mental illness. Linking services to ensure that they are responsive to these hard to reach groups is key. Finally restriction of firearms ownership is important in preventing suicide. Suffolk has the fourth highest rate of firearms ownership in England and Wales.

### **Future mental health needs**

Detailed tables for depression, dementia, personality disorder and psychosis are included in the JSNA. The projections are based on estimated population change, including the aging of the population.

The increases estimated appear small but it is important to note that these do not fully factor in issues which affect levels mental health including:

- Economic impacts on deprivation
- Inward migration
- Household changes

## **2.4 Legal Framework**

- The Care Act (2014)
- Section 47(2)
- Disabled Persons (Services and Consultation and Representation) Act (1986)
- Mental Health Act (2007)
- Mental Capacity Act (2005)
- Equality Act (2010)
- Safeguarding Vulnerable Groups Act (2006)

## **Section 3: Case for Change**

### **3.1 Socio-Economic**

- The need to tackle the low aspirations and emotional distress associated with severe deprivation at a population level.
- Prevention and early detection integrated primary care and mental health model that would pick up individuals in the population that may fall under the radar of acute services e.g. people who feel lonely, isolated or have low self-esteem and have associated physical health problems.
- Improving access to and the infrastructure for referrals to low-intensity mental health and wellbeing services.
- Development of a primary and community care delivery model with signposting, and building within that capacity to respond to individuals and their families. It includes those who have complex needs, are socially excluded, such as homeless people, alcoholics and those presenting with medically unexplained symptoms and frequent and persistent attendees
- Improving the engagement of primary care and creating more joined up models for provision.
- Challenging the more dominant psychiatric disease model through the development of a bio-psychosocial approach

### **3.2 Co-production: People's Voice and Choice**

Local commissioners committed to ensuring that the strategy was developed in partnership with local people who used local services. A number of workshops to influence this strategy were organised by members of the Suffolk Mental Health and Learning Disability Joint Commissioning Group (MHJCG). A reference group known as the Thurston Group agreed the following principles of engagement.



## **Coproduction: Key themes**

Feedback at the events found a number of recurring themes that are really important.

- Funding for services
- Better education and awareness raising of mental health including young people
- People feeling isolated
- Preventing crisis from occurring
- Removing the stigma around mental health – particularly the ‘huge stigma’ attached to black and minority ethnic (BME) groups and the gender split over opening up
- Using the voluntary and community sector or ‘third sector’ to help identify people
- Having support services that are less fragmented
- People having to repeat their past history with every relapse
- Dementia and the difficulties older people face

### **The Thurston Group asked:**

#### **How do we afford this?**

##### **Contributors said they wanted to see:**

- a commitment locally to demonstrate that is in line with the increased need for MH services.
- improved communication through better use of technology
- duplication reduced or stopped; all partners and agencies can each contribute to pay for services.
- increased staffing in frontline services by employing people with different skills and asking if they all need to be expensive trained staff.

#### **What do we stop doing if we cannot afford it all?**

##### **Contributors said we should:**

- Stop reorganising services.

- Prioritise and withdraw those services that are used less frequently and reduce duplication.
- Improve locally provided community services
- Reduce unnecessary reassessments

### **What are the priorities?**

#### **Contributors said:**

- Invest more in prevention as it reduces crisis and releases savings
- Every service user should have a comprehensive, person-centred wellbeing/recovery/crisis plan. This should include those people with multiple problems involving carers and families.

### 3.3 Financial challenge

#### Changing mental health investment profiles

- Mental illness costs the country as much as £100 billion each year through lost working days, benefits and treating preventable illness but these plans are expected to make huge savings:
- It is estimated that improved access to talking therapies will help tackle the £70 million working days lost annually due to mental health problems.
- Early treatment for people with psychosis could save the NHS £44 million a year in reduced hospital admissions through people reaching crisis point;
- Improved psychiatric liaison services in A&E departments could save each hospital an average of £5million a year by cutting down on admissions and length of stay.
- Currently most health resources are tied up at inpatient specialist services. But many of the quality and efficiency actions needed to change the profile of future demand rely on a connected approach, addressing population and public mental health, prevention, early intervention, personalisation and social care.
- Delivery of government policy for mental health and wellbeing, coupled with the quality and productivity challenge for the NHS and the need to improve value for money in local authorities, requires a double shift in investment. Overall spend has to be reduced through increased productivity, and a proportion of the investment currently funding acute, specialist and other secondary care services (covering all tiers of provision) needs to be moved upstream, where appropriate, to preventive and early intervention services, in order to reduce demand on these downstream services in the longer term.
- In this way, it will be necessary to free up resources in order to both deliver efficiencies in the short term and to re-invest in public mental health, social care, employment, housing, psychological therapies, prison health care, the criminal justice system and other areas. Such investments have the potential to deliver further medium and long term reductions on the demand side.



### 3.4 Local profile

Ipswich and East Suffolk CCG's present spend on mental health is forecast to be £45.5m for 2015-16. This includes expenditure from acute mental health care providers (both primary and secondary care), including out of area placements and joint placements with Suffolk County Council, but excludes spend in acute hospitals, community providers and Continuing Healthcare packages.

In 2014-15 the CCG invested in the following services:

- Increased Memory Assessments
- Children's Autism
- Children's Emotional Wellbeing (Additional Primary Mental Healthcare Workers)
- Mash(Safeguarding for Adults and Children)

In 2015-16 the CCG will be investing in the following services:

- Investment in Police Car Service
- LD Dual Running of pilot
- Safer Staffing Levels
- ADHD
- Access & Assessment
- Recovery Colleges

Ipswich and East Suffolk CCG will continue to invest in the general recovery approach, working in collaboration with other CCGs, the Local Authority, GPs, Mental health clinicians, family, friends, carers and service users. Supporting service users to move to a more fulfilling role within the community.

## **Section 4: Delivering Better Outcomes**

This section sets out what we will do to help improve the mental health and wellbeing of the population, with a focus on improving outcomes for all and ensuring best value for money.

### **4.1 Strategic Priorities and Outcomes for Mental Health**

#### **1. Strategic Priority One: More people will have good mental health**

More people of all ages and backgrounds will have better wellbeing and good mental health; and fewer people will develop mental health problems

Key areas of focus to achieve this high level objective are:

- Starting well
- Developing well
- Living well
- Working well
- Ageing well

#### **2. Strategic Priority Two: More people with mental health problems will recover**

More people who develop mental health problems will have a good quality of life. They will have a greater ability to manage their own lives, stronger social relationships, a greater sense of purpose, the skills they need for living and working, improved chances in education, better employment rates and a suitable and stable accommodation.

#### **3. Strategic Priority Three: More people with mental health problems will have good physical health**

Fewer people with mental health problems will die prematurely, and more people with physical ill health have better mental health.

**4. Strategic Priority Four: More people will have a positive experience of care and support**

Care and support, wherever it takes place, should offer access to timely, evidence based interventions and approaches that give people the greatest choice and control over their own lives, in the least restrictive environment, and should ensure that people's human rights are protected.

**5. Strategic Priority Five: Fewer people will suffer avoidable harm**

People receiving care and support should have confidence that services they use are of the highest quality and at least as safe as any other public services and protecting people from avoidable harm..

**6. Strategic Priority Six: Fewer people will experience stigma and discrimination**

Public understanding of mental health will improve and, as a result, negative attitudes and behaviours to people with mental health problems will reduce.

## Section 5: Making it happen

### 5.1 Early Intervention and Prevention

Services will be seamless, multi-agency, and serve the needs of patients suffering with common mental health problems. This will begin with public health interventions, focussed especially on those with complex health related problems, deprivation, or alcohol and substance issues. Patients will be able to access alcohol, drug and physical and mental health services appropriate to their needs without prejudice and without barriers.

You said: People are precious about budgets; the public purse should be treated holistically – not 'health' or 'social'. The Health and Care Review should seek to better align budgets. Existing services are fragmented and there is a need for better integration.

The Wellbeing Service will continue to provide evidence based interventions that span the range from providing positive life skills for those feeling stressed, to structured psychological interventions for severe depression and anxiety.

You said: The self-referral Suffolk Wellbeing service is not visible or well known

Self-referral is seen as a vital part of this service, so that patients experience no barriers to access, and reflect more accurately the ethnic and demographic make-up of the community. We will make sure people are aware that they can self-refer.

Early intervention and prevention traditionally takes place in a primary care setting. GPs are well placed to intervene early in the course of a mental illness through identification, medication, and signposting to other services, and should be seen as the next step following self-management. We will deliver education programmes spanning the population as a whole, working specifically with GPs, midwives, district nurses, social workers, teachers and Health Visitors to ensure that the workforce is well trained and equipped to carry out their roles in the new service.

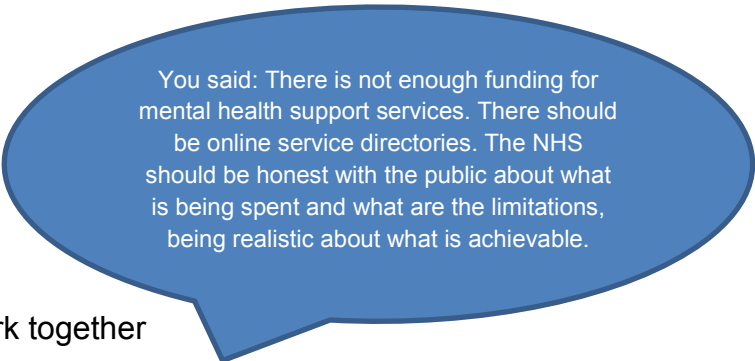
You said: Education about mental health needs need to start from an early age. Early education could play a large role in prevention.

The NHS cannot do it alone.

Suffolk County Council and the CCGs are committed to working

more closely together. We will work together

to make sure that we are not spending money on the same things. We will also design services together to prevent fragmentation. We will work with the third sector and voluntary organisations to ensure we get value for money and high quality outcomes for patients and their carers.

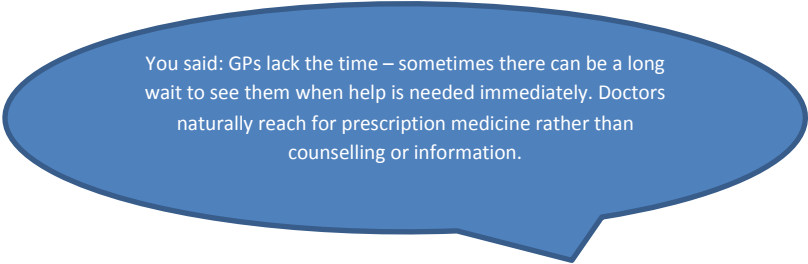


You said: There is not enough funding for mental health support services. There should be online service directories. The NHS should be honest with the public about what is being spent and what are the limitations, being realistic about what is achievable.

There will, however, be difficult choices to make about what the NHS can afford to do and what it cannot afford to do. As such prevention and early intervention will include an element of self-help and an expectation that patients will be proactive in managing their own care where it is appropriate. In order for patients to be able to do this and so that they can begin treatment with evidence-based treatments immediately we will develop services that can be provided in other settings for example in libraries, via the Internet and on mobile devices.

We will also integrate mental health services into other NHS settings for example community services including Integrated Neighbourhood Teams, Ipswich Hospital Trust and West Suffolk Foundation Hospital Trust building on the Psychiatric Liaison Services that are already established and into healthy lifestyle services such as smoking cessation. We will also make sure people with long term conditions are routinely offered access to wellbeing services.

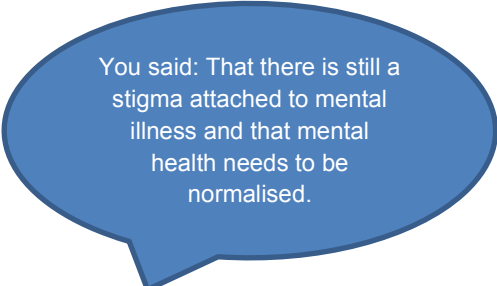
If this type of self-help does not work or if symptoms are more severe patients will be able to access care in more local settings for more formal diagnosis, followed by medication advice and prescription as and when appropriate. We will work with our GPs to ensure they have sufficient time and the right skills to do this.



You said: GPs lack the time – sometimes there can be a long wait to see them when help is needed immediately. Doctors naturally reach for prescription medicine rather than counselling or information.

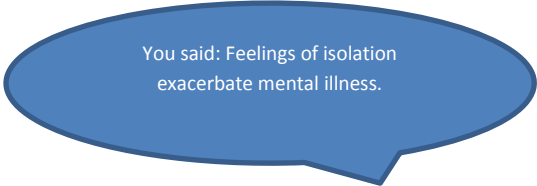
GPs and other key professionals working in primary care will also have access to expert

advice on challenging cases, with immediate referral onwards if needed. There will be rapid access to a crisis response.



You said: That there is still a stigma attached to mental illness and that mental health needs to be normalised.

For prevention and early intervention to be effective we realise that we need to work more closely with other services. There will be targeted support for issues such as housing, work, unemployment, debt and deprivation. Services will be made accessible to everyone who needs them regardless of any other underlying health or social care need. We will work with patients and their carers to remove stigma and put co-production at the heart of everything we do.



You said: Feelings of isolation exacerbate mental illness.

We will not be able to prevent everyone from experiencing loneliness and we know that not everyone recovers fully

however despite that we can ensure our services are linked into others that can help people live independent and fulfilling lives. For example, we will improve our links with the voluntary and community sector, look to use alternative settings in the community to deliver care, provide more support for carers, develop befriender schemes and improve access to peer support in our recovery colleges.

## 5.2 Crisis



A crisis looks and feels different to everyone. It is based on the perception of the individual experiencing the crisis. What feels manageable for one person may, for another, feel overwhelming. Similarly people's response in how they react and manage a crisis is individual and personal to them.

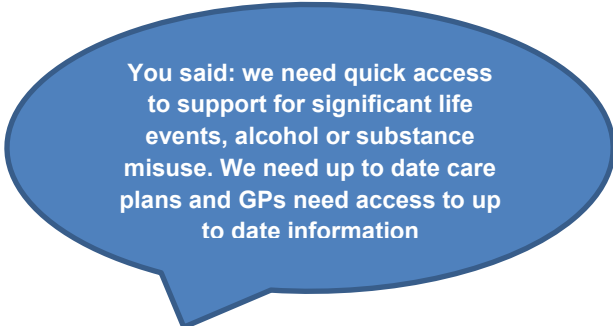
As such our services need to be able to offer a flexible and individual response in a safe place that is best for the patient and their carers. The primary aim should be to prevent a mental health crisis occurring. Where we are not able to do this our services will support people and their families/carers during a crisis. They will keep people safe and provide access to the support people need – whatever the circumstances. Where appropriate services will be integrated ensuring people get access to the right care and advice at the right time and that meets their individual needs.

We will deliver services that promote early intervention and prevention so that people receive the best care and treatment possible, at the earliest opportunity so they are able to live their lives as independently as possible.

### 5.3 Crisis Prevention


The Crisis Care Concordat advocates a firm focus on access to support before crisis point, which includes urgent and emergency access to crisis care. In responding to crisis, local services will ensure that the response offered is provided in way that supports people staying well, recovering, and reduces the likelihood of further crisis.

We will provide a local mental health crisis helpline which will be available 24 hours a day, seven days a week, 365 days a year with links to out of hours alternatives and other services including NHS 111.



You said: we need quick access to support for significant life events, alcohol or substance misuse. We need up to date care plans and GPs need access to up to date information

People will have access to all the information they need to make decisions regarding crisis management including self-referral. As commissioners we will facilitate and foster strong relationships with local mental health services including local authorities and the third sector.




You said: to prevent crises from happening we need easy access to appropriate support from skilled multi-agency

Training will be provided for GPs, practice nurses other community staff regarding mental health crisis assessment and management. We will provide a specialist short stay service to support under 18s in crisis.

### Place of safety

We will provide a place of safety where there is emphasis on person centred care. The people working there will have access to individual care plans and medication regimes. It will be available 24/7 and provide a space that is calm, neutral and non-judgmental. Staff will be suitably qualified, have the right personal skills and have the time to listen. There will be access to multi-agency support. We will not be able to do this alone so we will involve volunteers and peer support.



You said: we need a safe place to go in crisis.

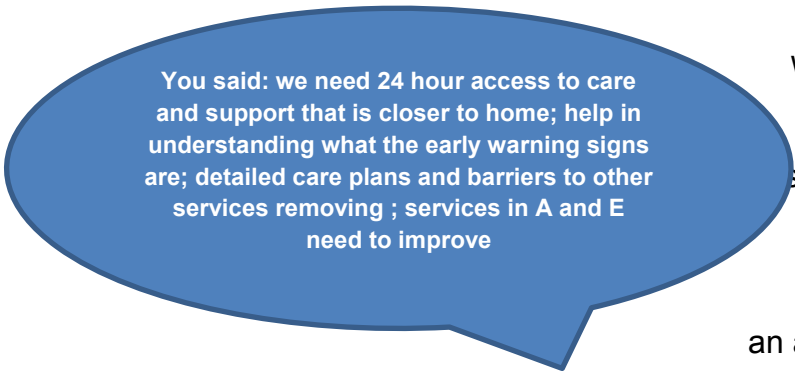


## 5.4 Crisis Care and Support

People in crisis do on occasions require treatment in a hospital setting and there is a clear need for hospital care. Admission to a hospital setting will only happen when it is absolutely necessary. Patients will be admitted to and have access to the most appropriate environment for them based on and depending on their needs at the time. For example assessment wards that can provide rapid and intensive assessment and immediate and others that cater for specific groups of people with very individual needs such as Mother and baby units.

People will only stay in hospital for as long as they need to and when they are discharged they will be actively involved in their discharge planning and provided with intensive care at home to support discharge and prevent readmission.

In some circumstances it is recognised that mental health crisis can be successfully managed at home or in alternative settings providing the right level of support and specialist advice and treatment is accessible. We will always ensure that individuals experiencing severe mental distress are served in the least restrictive environment and as close to home as possible.



You said: we need 24 hour access to care and support that is closer to home; help in understanding what the early warning signs are; detailed care plans and barriers to other services removing ; services in A and E need to improve


Where it is possible we will provide Crisis Care in alternative settings such as local Crisis Houses.

We will provide Admission Prevention Services (APS) as an alternative to hospital admission

for people in crisis. Home Treatment Teams who will work closely with the APS to support people through periods of crisis. They will create a link between referring agencies and other mental health services, acting as a gatekeeper to other services for people at the point of crisis. APS will have the capacity to provide intensive interventions and support in the early stages of the crisis. They will work in a time

limited way with service users and with sufficient flexibility to respond to differing levels or types of need. Needs will be assessed by skilled staff and recorded in individual, shared crisis plans. Families and carers will be involved and kept informed with the patient's permission if they are able to give it. They will remain involved with the service user until the crisis has resolved and they are linked into on-going care where this is deemed appropriate.

Care plans will be accessible, where appropriate, to everyone involved in delivering care and be written in a language that everyone understands.

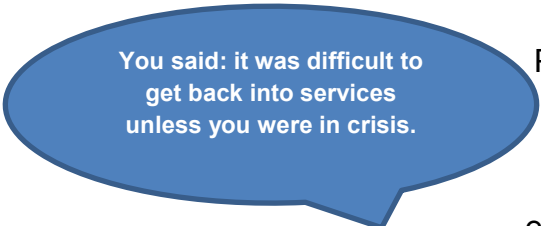


You said: we want to see all services in crisis becoming more joined up. Communication still needs to get better.

Patients should not have to repeat their story more than necessary. We will adopt approaches which use the learning from crisis to support contingency planning to reduce the likelihood of future crisis. This will include the early identification of factors leading to crisis and the development of management plans with the involvement of the whole social support network.

Mental health professionals will be trained to understand the use and purpose of crisis care plans and be trained in their design. Crisis care plans will:

- include information regarding the 24 hour help line and how to access crisis care services out of hours
- be accessible to health professionals immediately when a service user presents in a crisis (including GPs, Emergency Department staff, NHS 111, GP out of hours)
- focus on individual strengths, networks of support and service user defined recovery outcomes
- be reviewed regularly and kept up to date, particularly following any crisis presentation, admission or significant change in an individual's circumstances
- identify factors which potentially could precipitate a crisis and what steps can be taken to reduce the likelihood of a crisis in such circumstances




You said: it was difficult to get back into services unless you were in crisis.

People will be able to access services in a timely manner in the same way people who have physical health care needs do. We will ensure services provide rapid timely response

following referral.

Access to Crisis Care will be available 24/7 seven days a week including to people within their own homes with a view to resolving the crisis in the context in which it occurred. Out of hours services will be supported by a Crisis Line and 111 services that will have access to specialist mental health advice. We will continue to develop Psychiatric Liaison Services in our acute hospitals and accident and emergency departments.



You said: we need 24/7 responsive services available-telephone staffed by skilled people

Through the delivery of the Crisis Care Concordat we will work collaboratively with partners such as the police and in Criminal Justice settings including the Courts and

Police Investigation Centres to ensure people with mental health needs are supported and given the appropriate care. We will ensure that patients are not detained unnecessarily. We will also ensure that staff are equipped with the right skills and training to do their jobs.

## **5.5 Suicide Prevention**

There is a clear ambition in Suffolk to prevent incidents of suicide. The factors leading to someone taking their own life are complex. No one organisation is able to directly influence them all. It is vital that agencies in Suffolk work together and co-ordinate activities together with the voluntary sector and other statutory sectors as well as businesses, industry and the media. It is recognised that to be effective it is vital that communities and individuals whose lives have been affected by the suicide of family, friends, neighbours or colleagues are involved.

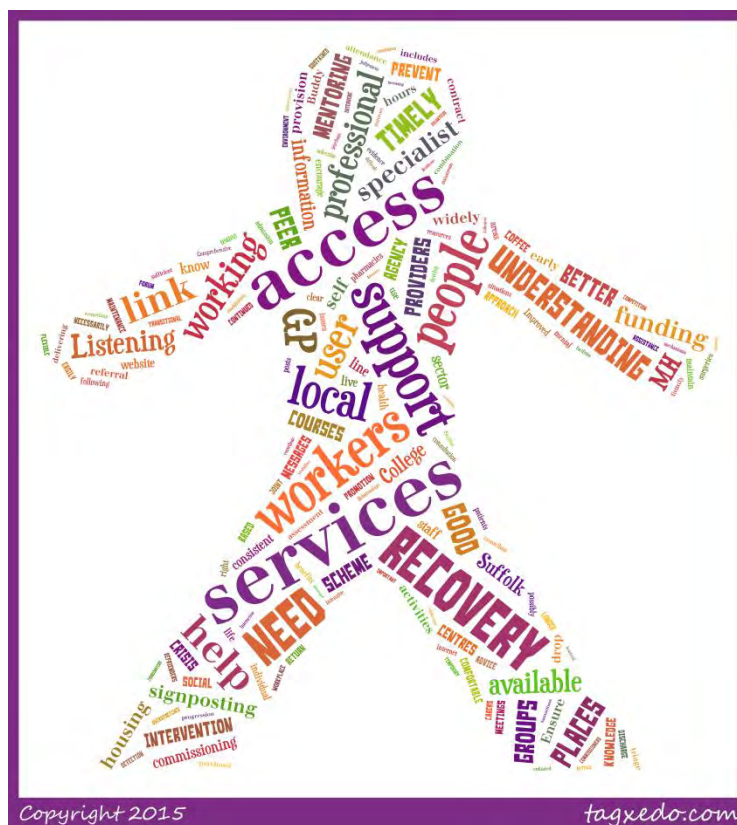
In April 2013 public health transferred from NHS and into local government. As a consequence, suicide prevention became a local authority led initiative working closely with police, CCGs, NHS England, coroners and the voluntary sectors. We will work alongside these key stakeholders in developing a local suicide prevention plan with the inclusion of those families bereaved by suicide and mental health trusts.

A county wide suicide prevention group will enable current practice and service provision needs to be mapped out with any gaps forming the basis of an action plan. This group will have strong links with local Health and Wellbeing Board (HWB) to ensure mental health, suicide and self-harm data is captured and fed into local joint strategic needs assessments and joint health and wellbeing strategies.

The Suicide Prevention Group will seek to provide a framework of recommendations taken from national policy, and local evidence that aim to impact on known suicide risk. The Suicide Prevention Group will oversee and support development and delivery of actions plans to include:

1. A Zero Suicide pledge
2. A reduction in the risk of suicide in key high- risk groups
3. Tailored approaches to improve mental health in specific groups
4. A reduction in access to the means of suicide for example we know Suffolk has the fourth highest rate of legal firearms ownership per head of population in England and Wales.
5. Multiagency working on firearms applications and ownership
6. Training for front line workers on the importance of reducing access to means of suicide
7. To provide better information and support to those bereaved or affected by suicide.
8. Support the media in how to report sensitively in cases of suicide and suicidal behaviour.
9. Support research, data collection and monitoring.
10. Agree common, simple, cross-organisation literature for those at risk, which includes crisis planning for individuals
11. Training for GPs and other frontline staff and carers

## 5.6 Recovery and self- management



Recovery from mental illness does not always refer to a process of complete recovery in the same way as when we may recover from a physical health problem. For many people 'recovery' is about staying in control of their life despite experiencing a mental health problem. Supporting people in recovery often means focusing on building the resilience of people with mental health problems, not just on treating or managing their symptoms.

Health professionals, friends and families can be overly protective or pessimistic about what someone with a mental health problem will be able to achieve. Services will therefore recognise that Recovery is about looking beyond those limits to help people achieve their own goals and aspirations.

You said: You want to be listened to. I know best what I need to feel better and what works for me.

Services will work with individuals to foster good relationships; financial security; satisfying work and personal growth. They will work together to ensure people have access to the right living environment. They will also recognise and develop a person's own cultural and spiritual beliefs and build up resilience to future adversity and stress.

Patients will be:

- Believed in
- Listened to and understood
- Given explanations for problems or experiences
- Have the opportunity to temporarily resign responsibility during periods of crisis.

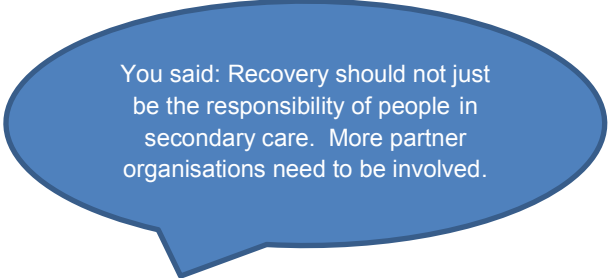
Staff will have the skills required to support people during the recovery process.

We recognise there is a strong link between the recovery process and social inclusion. Services will be holistic and support people to regain their place in the communities where they live and take part in mainstream activities and opportunities along with everyone else.

Providers will work closely together.

This includes the Third Sector and local authority partners. Bridging support will be provided between crisis services and

wider community services e.g. mentoring, befriending, mediation and advocacy providers will work with partner agencies to compile and maintain a directory of local services which can provide support for service users in crisis e.g. women's aid, drug and alcohol services.

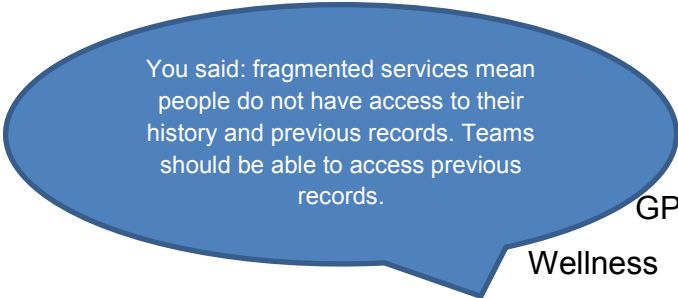


You said: Recovery should not just be the responsibility of people in secondary care. More partner organisations need to be involved.

## Recovery plans

All people under the care of secondary mental health services and subject to the Care Programme Approach (CPA) and people who have required crisis support in the past will have a documented recovery plan including a crisis plan.

Those people who are not subject to CPA will have access to Wellness Plans which will increase the person's sense of control over their mental health problems, increase personal empowerment, improve quality of life and assist people in achieving their own life goals and dreams.



You said: fragmented services mean people do not have access to their history and previous records. Teams should be able to access previous records.

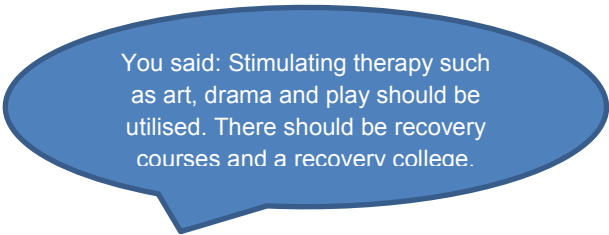
Arrangements will be put in place to ensure that plans are accessible to GP out of hours and NHS 111 teams.

Wellness Plans and Crisis Care plans will be coproduced by the person with mental health problem, his/her carer(s) and the mental health professional(s).

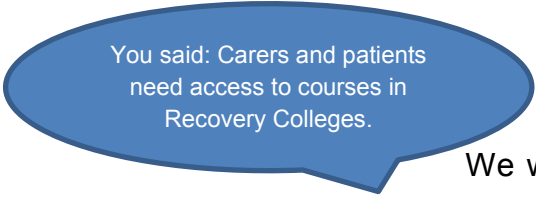
Patients will also have discharge plans in place before they leave hospital and this will include how to access primary care based mental health services that will help to keep them well.

## 5.7 Recovery Colleges

There is a growing body of evidence that demonstrates that taking part in social, educational, training, volunteering and employment opportunities can support the process of individual recovery.



You said: Stimulating therapy such as art, drama and play should be utilised. There should be recovery courses and a recovery college.



You said: Carers and patients need access to courses in Recovery Colleges.

We will ensure that both patients and their carers have direct access to Recovery Colleges.

We will also look to use alternative ways of delivering courses for example through libraries and the use of the internet so services can be accessed locally.

## **5.8 Personal Health Budgets & Integrated Personal Budgets**

Where possible people will be able to use personal health budgets to ensure they have greater choice, flexibility and control over the health care and support they receive. People with complex care needs will also be given the chance to control a merged NHS and social care personal budget to purchase support.

All social care needs will be assessed in the context of a legal entitlement to a personal budget and the person's right to ask for a direct payment.



## **Section 6: Measuring Success -**

*We will make sure that services are safe, effective, and that patients have a positive experience. All contracts with providers include quality indicators that are rigorously monitored to ensure services are up to standard.*

*We are passionate about making sure the services we commission are safe, of top quality and that we provide as good an experience as possible for anyone using them.*

*We aim to promote mental wellbeing as well as early intervention and prevention services; we will look to see reduced reliance on secondary mental health services.*

*We work hard with the organisations that provide those services in supporting them to deliver the very best. We also hold them to account so we and you can be assured that you will be well cared for. We do this through a series of monthly groups where we focus on the safety, quality and experience provided by each organisation. What is more, we do not simply check on the past, we also agree any actions that are needed to continuously improve the services our population receives.*

## **Section 7: Research and Education**

The proposals within the strategy have implications for workforce development, education and training. For example, we are planning training leading to improved awareness of suicide risk in first line clinicians. Training opportunities may be mandatory within partner organisations; commissioned by the partners, for example CCG practice education sessions; or be delivered through training lead organisations such as the Local Education and Training Board.

When considering developments in services, new approaches can be identified from national research outcomes and examples of good practice elsewhere. Therefore awareness of new guidance and policy, including NICE, and horizon scanning, is vital. Also on-going involvement with partners and networks, including the NHS East of England Strategic Clinical? Network, supports on-going development and improvements.

New approaches and proposals require evaluation before they can be fully implemented. For example the psychiatric liaison service and street triage pilots were both evaluated at the end of the initial project.

The partners do not have a primary research function however, where new research is needed, links can be made to partners such as University College Suffolk and King's Fund. The co-production work began as the systems leadership: local vision project which was a collaborative process between Public Health, Local Government Association and the King's Fund.

Audit and quality monitoring, such as the review of serious untoward incidents (SUI), also have an important role in assessing services, particularly where unforeseen or harmful events occur.

### **Education and training**

Both Ipswich and East Suffolk and West Suffolk CCGs provide support to practice education through closure days and through support to in house training. These have

addressed mental health issues and more sessions are planned, for example, assessing risk of suicide and self-harm.

All partners should include some mental health awareness in mandatory training. For example the police have commenced a program of awareness training for frontline staff. Opportunities are also being explored to improve joint training events with all partners including local initiatives where a need has been identified through partnership working. The College of Policing has a responsibility at a national level to advise and produce professional practice guidance to forces with regard to training and development for police officers in operational areas including mental health. Public health has been co-ordinating mental health awareness training for managers across the council which has so far proved successful.

Health Education East (HEE) is the Local Education and Training Board (LETB) for the NHS that covers Norfolk, Suffolk and Essex. The LETB aim is to ensure the security of workforce supply and continuously to improve the quality of education, training and development in the east of England and to respond effectively to the needs of patients, carers and families. The LETB is aiming to develop plans for 2016 through discussions with Workforce Partnerships about workforce priorities and education and development actions and also strengthen the links with commissioning plans. It is therefore critical that the CCGs participate in these discussions.

## **Evaluation**

Evaluation is needed to assess the value of new initiatives. The police and mental health trust have completed the initial evaluation the scheme which sees mental health professionals working alongside police officers when attending incidents in East Suffolk (Street Triage).

The CCG and ACS have jointly commissioned four pilots for support in a mental health crisis. These include the telephone support line for clients of the Mind Waves service and supported beds within the local providers Julian, and Stonham. An evaluation is being undertaken jointly by public health and the providers.

## **Audit and Research**

The public health team has undertaken review of deaths from suicide in the Suffolk community. This has given a valuable picture of the risks and also the health inequalities. The latest review is available on the JSNA website. It would be valuable to continue this process but to link more closely with the police, Coroner's Office, GPs and Norfolk and Suffolk Foundation Trust (NSFT) to ensure lessons continue to be learned. It is recommended that GPs undertake their own review of sudden and unexpected deaths within their practice.

NSFT undertakes investigate of serious and untoward incidents affecting service users and compile an annual Audit report which also has important messages for providers and commissioners.

The JSNA has commissioned a review of the needs of marginalised and vulnerable communities in Suffolk and this will hopefully identify issues of concern to mental health commissioners.

## **Section 8: Recommendations**

**To be completed post consultation**

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**French**

এই লেখাটি যদি অন্য ভাষায় বুঝতে চান তাহলে নিচের নম্বরে ফোন করুন

**Bengali**



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