



Mental health services in east & west Suffolk

This is your chance to input into and influence the future of mental health and wellbeing services.

#AVeryDifferentConversation

East and West Suffolk Mental Health & Emotional Wellbeing 10 Year Strategy 2019-29

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1. FOREWORD

Despite the best intentions and hard work of many people, the system for mental health and emotional wellbeing in Suffolk is failing; despite increased investment, the outcomes for people are not yet good enough. The system we have is also not adequately designed to meet the changing needs of our population. Increasing numbers of young people - especially women - are self-harming; we have a growing elderly population living with dementia; and Suffolk as a whole is becoming more deprived, with growing incidence of associated mental health challenges.

Historically our response has been medical: GPs are now prescribing twice as many antidepressants as they did 10 years ago. Drugs are necessary for some people at some times, but unless we take a more holistic approach we will continue to miss opportunities to support people at an early stage and prevent problems escalating, and could result in people living with worsening mental health symptoms, impacting on their work, family life, physical health and ability to care for others. We have listened to the people of Suffolk, who have told us that they are unable to find or gain access to the mental health support they need - even in moments of crisis. Waiting times are too long, and too rarely are services available within communities.

We are the professionals, families, service users, carers and communities across Suffolk who have been working to do the best we can for people seeking out improved mental health and emotional wellbeing. We share a sense of how complex and challenging this can be. We know that despite our best efforts we sometimes let people down. We also know that we cannot and will not stand idly by whilst this pattern continues. Neither will we disappear into our own professional silos or languish in our old ways of thinking, allowing ourselves to believe that someone else needs to fix this.

We have begun to come together in new ways to have **#averydifferentconversation** and through building better relationships and listening deeply to each other we know that we can find new ways forward, new approaches and new connections between existing practices that can make a significant difference to the lives of local people.

We are clear: people draw firstly on friends, families and neighbours for help, and want this informal

support to wrap around the local provision of therapies, treatment and other types of support. Getting great mental health support means being treated as a person: being listened to and heard, getting the right help in a timely manner as soon as you become unwell, and being supported to live the life you want to continue living. All support needs to respond to context, including recognising the critical role played by families and other carers.

We all know someone who has needed help and support with mental health and emotional wellbeing, and we can all agree that we don't want them or us to be let down by a system that tries hard but simply is not doing enough of the right kind of things to offer the help that is needed, often at an early stage. We know that too often help comes later than it needs to, and sometimes that means people face worry, distress and harm that did not need to occur. We also know that there is sometimes help that can be found and accessed within ourselves, each other, our communities and networks.

So we will transform our system away from one that guards access to professional help with high thresholds and long waiting times to one that promotes and supports emotional wellbeing and the prevention of mental ill-health through promoting self-care. We will make sure people who become unwell can get help quickly, by building support primarily in communities and around primary health. Specialist and crisis support will be easier to access, with step-down (and step-back-up) support built in. To make this happen we are going to have to do some different things, and do some things quite differently.

This new vision is not for a series of mental health services that are better than the old ones. It has to be about how whole lives work, and about how the whole thing fits together, as experienced by people in Suffolk. Our new vision is of a whole system, in which we (everyone who can play a role: citizens, health professionals, schools, local government, police, business, voluntary and community groups etc.) move towards this reality, which depends on more of us joining in the work; playing new and different roles.

The work will not be a straight line or simple task, but it has already started. Join us in **#averydifferentconversation** leading to a very different, and better, future for Suffolk.

2. INTRODUCTION AND CONTEXT

2.1 INTRODUCTION

This section sets out the wider context in which this strategy is being developed before moving on to describe the case for change to transform our mental health and emotional wellbeing services. The case for change sets out a summary of the:

1. Detailed work Public Health Suffolk have led on to develop a comprehensive, evidence based needs assessment
2. Significant amount of work carried out by Healthwatch Suffolk (HWS), Suffolk Parent Carer Network (SPCN), Suffolk User Forum (SUF) and Suffolk Family Carers (SFC) reaching over 4,000 people and with 15,000 plus comments on current services and what our population feel is needed
3. Three system-wide events held in Elmswell across the summer of 2018 to inform the development of the future model. These have consistently involved representation from all parts of the Suffolk system, and sought to put service users and the people who care for them at the centre of conversations.

This strategy describes our approach for improving mental health and emotional wellbeing outcomes in east and west Suffolk. Waveney Plans are included within the Norfolk approach. However, we will continue to work collaboratively and improve joint working across our statutory and geographic borders. This work will continue to evolve over time and be underpinned by co-production and partnership working.

2.2 CONTEXT

Ipswich and East Suffolk, West Suffolk and North East Essex (SNEE) are part of an Integrated Care System (ICS - previously referred to as Sustainability and Transformation Partnerships or STPs). This simply means that the whole system across Suffolk and North East Essex (commissioners, statutory and non-statutory providers, partners and regulators) will be working more closely to support a population of circa one million.

Within the ICS, we will increasingly organise ourselves around 'place'. 'Place' in SNEE is outlined at three broad levels:

- Whole ICS footprint (i.e. SNEE system level) to 1 million population
- Alliance (i.e. North East Essex, West Suffolk and Ipswich and East Suffolk) each to 250-350k+ population
- Locality (e.g. five in west Suffolk, eight in Ipswich and East Suffolk and four in North East Essex of circa 50k population size) - our Connect/ Integrated Neighbourhood Team (INT) areas

The evolving Alliances in east and west Suffolk, including health, local authority and other partner organisations are working closely to develop and agree a common strategy, and begin to share resources and decision-making leading to blurring of boundaries between commissioners and providers and between providers. The Alliance partners are Suffolk County Council (SCC), East Suffolk and North Essex NHS Foundation Trust (ESNEFT), West Suffolk Foundation Trust (WSFT), Norfolk and Suffolk Foundation Trust (NSFT), Suffolk GP Federation and Ipswich and East Suffolk (I&ESCCG) and West Suffolk (WSCCG) CCGs.

It should be noted that this work is evolving all of the time, but this is the landscape in which we set out how we wish our future model of mental health services to be provided. We are one of the first areas in the country to take this approach, which will bring both opportunities and challenges.

We wish to continue to build on the integration journey so far that is taking place in east and west Suffolk - in particular the work on the Children and Young People's Emotional Health and Wellbeing Transformation Plan and the development of integrated community services through the proactive and reactive service models.

The Suffolk Children's Emotional Wellbeing Transformation Plan has been established since November 2015 and refreshed this Autumn. It describes a system-wide response to deliver improved emotional health and wellbeing and includes innovative approaches, including the Emotional Wellbeing Hub that brings together a multiagency team to support service users, the people who care for them and professionals. We would expect similar innovative and integrated models of delivery to respond to our outline future model.

Similarly, as part of the award of community health services to the east and west Alliances in October 2016, a commitment was made by I&ESCCG and WSCCG to support the continued development of integrated and local approaches to how we provide our health and broader community services. This includes the development of Integrated Neighbourhood Teams (INTs) across east and west Suffolk.

2.3 CURRENT CHALLENGES AND FUTURE OPPORTUNITIES

I&ESCCG and WSCCG commission mental health services from a range of NHS statutory and non-statutory providers. The CCGs also jointly commission mental health services with Suffolk County Council (SCC).

Our main local NHS mental health provider is Norfolk and Suffolk NHS Foundation Trust (NSFT). NSFT are awaiting the outcome of a recent Care Quality Commission inspection (September 2018), and are currently rated by the CQC as 'Inadequate'.

This creates challenges for recruiting and retaining our mental health workforce in the county as well as raising concerns with the public related to the access and quality of local mental health services. It also means that additional financial resource cannot always provide solutions, due to recruitment difficulties.

The increased focus on breaking down the barriers across physical and mental health, meaning the need for NHS and other partners to work more closely to support the holistic needs of service users, provides an excellent opportunity for us to redefine how mental health and emotional wellbeing needs can be better provided to our population.

The focus on increased system management of long term conditions and the alignment of national and local policy to promote integrated working for the benefit of the population means the time is right to develop a more cohesive system wide model.

As a whole Suffolk system, beyond statutory organisations there is a vast array of voluntary and community sector organisations that work to support people with their mental health and wellbeing, e.g. Suffolk Mind, whose vision is to make Suffolk the best

place in the world for talking about and taking care of mental health. We need to make sure that when we consider the range of support available in Suffolk, we acknowledge the broad nature of knowledge and support available, not just health interventions.

The cultural change also needs to take account of the views of service users and the people who care for them, as they are the support network and often the main provider of care to the service user. They are often experts in the care of the service user and therefore it is only by including them in care planning that the optimum care can be achieved.

Through this mental health and emotional wellbeing strategy we will improve outcomes for people presenting with mental health and emotional wellbeing issues, support for primary care and development of services across the boundaries of primary and secondary mental health care.

We wish to describe a long term, system-wide approach that captures the hearts and minds of those living across east and west Suffolk in order to really change the life experience and emotional wellbeing of the Suffolk population.

This strategy describes a future state where all organisations and the broader Suffolk community will come together to support and respond to the mental health and emotional wellbeing needs of its population, and recognise the roles that each can play. Our expectation is that mental health and emotional wellbeing will become 'business as usual' for all.



I use the internet to research any changes to my treatment and medication.

Service user or member of the public

3. CASE FOR CHANGE: PUBLIC HEALTH NEEDS ASSESSMENT

3.1 INTRODUCTION AND MAIN MESSAGES

I&ESCCG and WSCCG are working with partners and the community to transform mental health and emotional wellbeing support. As part of this process, Public Health Suffolk were asked to update knowledge on mental health and emotional wellbeing needs across the community. The aims of the needs assessment are:

- To provide a picture of mental health in Suffolk, to inform strategies for promoting mental health, reducing inequalities and commissioning services
- To inform partnership working, with stakeholders and the community, through a shared understanding of needs

The needs assessment has been produced in sections which can be downloaded and updated as necessary ¹ (APPENDIX 1).

The key messages arising out of the needs assessment are set out below:

- Young people have increasing levels of self-harm and suicide which must be addressed
- Emergency admissions for self-harm are significantly higher in Suffolk than England as a whole
- Levels of smoking, exercise and obesity need to be addressed in Suffolk to improve mental wellbeing
- For transgender people, support and treatment (hormone or surgery) improves mental health and social functioning
- Co-occurring mental health and alcohol or drug use (Dual Diagnosis) requires a more holistic approach to care with alcohol and drug use not a barrier to accessing mental health support
- A profile of mental health crisis has identified key issues which should be fed into planning new provision, including increased levels of need in the summer, and between 6pm and midnight and in the east of the county
- Existing mental health services do not clearly meet the needs of service users with personality disorders and the role of mental health services should be clarified
- People with long term physical health problems are likely to have depression, which should be identified and treated

- Mental health and physical health services should be better integrated
- The lives of people with severe mental illness are 15-20-years shorter than the rest of the population
- The physical health of people living with serious mental illness must be improved to reduce deaths
- Older people in the community and residential care have undiagnosed depression which should be treated effectively
- Future estimates may underestimate the mental health challenges of the next five years due to the impact of depression in older people and levels of self-harm in the young
- Future wellbeing will be adversely affected if the needs of children and young people and of the increasing older population are not addressed
- Deprivation is having an impact on levels of mental health and service demand in Suffolk

Housing and Mental Health

The number of households recorded as homeless and in priority need in Suffolk has increased in recent years to 640 in 2017/18. Districts with the highest number of homeless households in 2017/18 were Ipswich (175), St Edmundsbury (138) and Forest Heath (103). Note that Forest Heath has significantly fewer households than other districts and actually has the highest rate of households recorded as homeless and in priority need in Suffolk (at 3.81 per 1,000 households). These figures do not reflect households in precarious housing situations who may have come close to homelessness during this time.

In addition, according to official statistics, the number of individuals sleeping rough in Suffolk has increased by 267%, from 24 to 64. Most rough sleepers recorded in Suffolk in 2017 were in St Edmundsbury (34%) and Ipswich (33%).

A study commissioned by Crisis and undertaken by the University of Sheffield looking at the causes of death in homeless people in England found that they are:

- Seven times more likely to die from alcohol related diseases than the general population
- Twenty times more likely to die from drug misuse
- More than three times more likely to commit suicide than the general population

A report by the Mental Health Foundation stated that:

- In 2014, 80% of homeless people in England reported that they had mental health issues, with 45% having been diagnosed with a mental health condition. Also that studies have reported a higher prevalence of mental health problems in the homeless population in comparison to the general population, including major depression, schizophrenia and bipolar disorder.
- The report found the most prevalent health problems among homeless individuals are substance misuse (62.5%), mental health problems (53.7%) or a combination of the two (42.6%). Also many homeless people cite mental health problems as a reason for being homeless - 26% of homeless people in the UK (this is double the percentage of that in the rest of the EU).

Shelter has undertaken research in 2017 which highlights the link between poor housing and mental health problems:

- 1 in 5 English adults (21%) not only have had a housing issue in the last 5 years, but say that it had negative impacts upon their mental health. This is equivalent to over 8 million people affected in this way.
- One in 20 adults have visited their GP in the last 5 years with a mental health issue related to their housing. One in 40 adults have done so over an issue specifically related to housing affordability.
- 3 in 10 adults who have had a housing problem in the last five years, not only said that it had a negative mental health impact, but also that they had had no issue with their mental health before the housing issue.

Another striking feature of the needs assessment is that deprivation has been demonstrated to impact on admissions for self-harm, suicide and crisis admissions in Suffolk. This is important for considering the location of services.

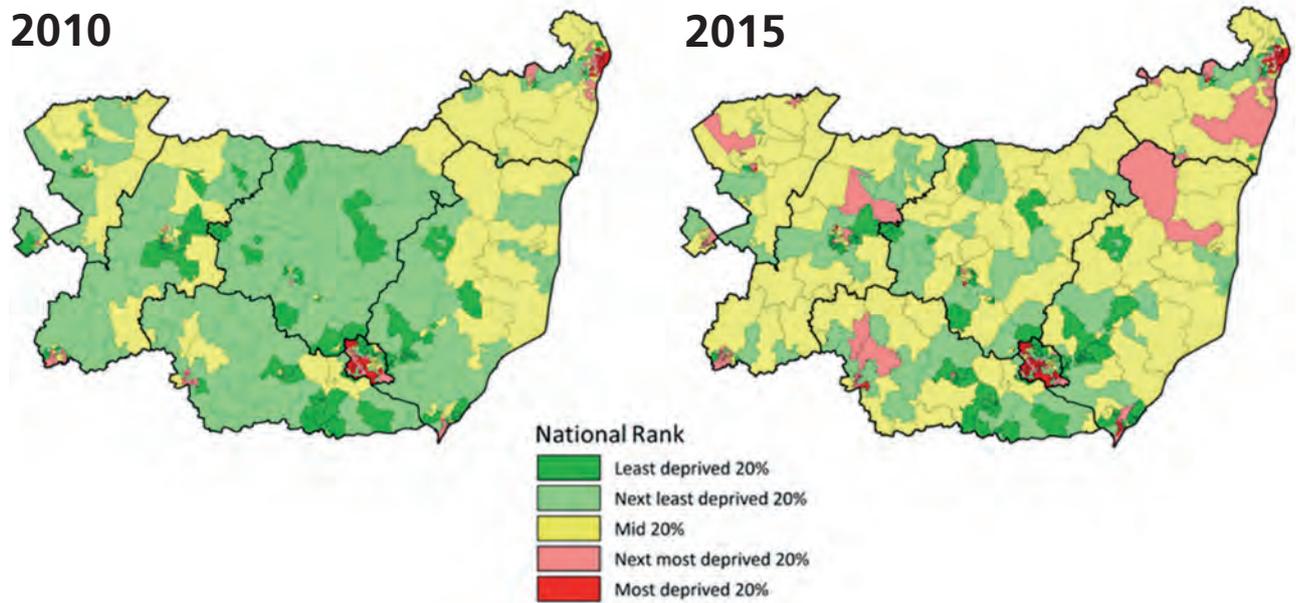
Maps showing the distribution of deprivation in Suffolk and changes since 2010 are shown on the following page.



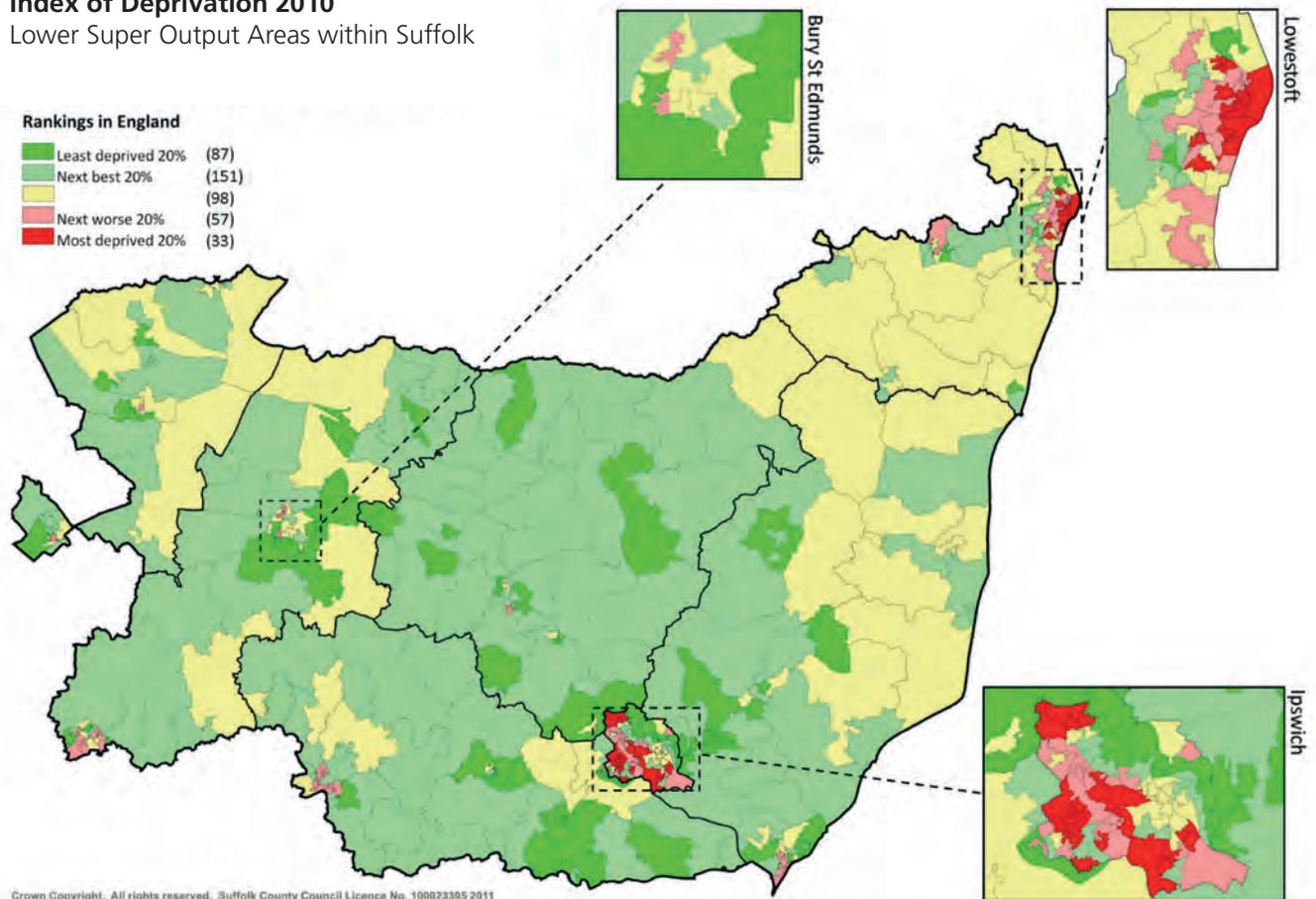
I would like to be able to access services. Too ill for well-being service. Don't fit referral criteria for access and assessment. Now been off sick for 5 months which need not have happened if I had been able to access services when I knew I needed more help.

Service user or member of the public

Fig.1: More areas in Suffolk are now in the 20% and 40% most (relatively) deprived in England

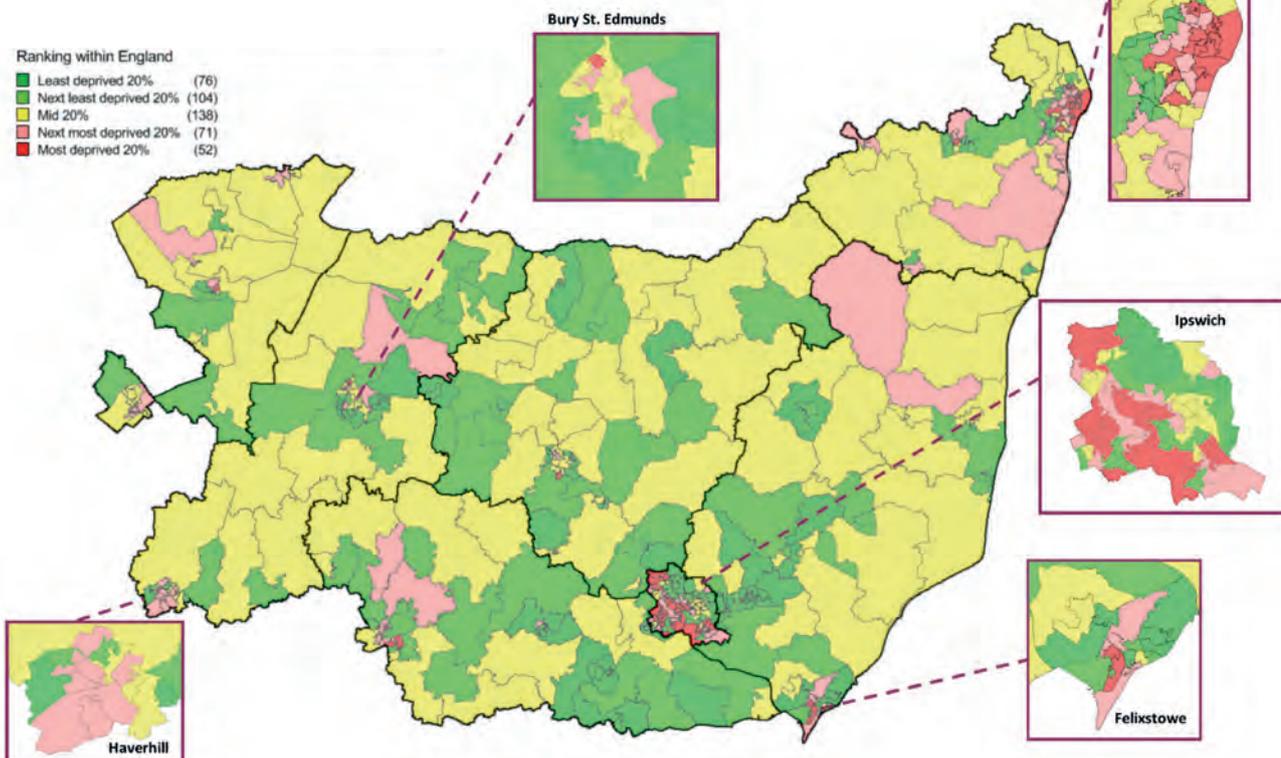


Index of Deprivation 2010
Lower Super Output Areas within Suffolk



Index of Deprivation 2015

Lower Super Output Areas within Suffolk



3.2 ISSUES AFFECTING CHILDREN & YOUNG PEOPLE



We know from the 2011 Census that for young carers doing more than 50 hours of care a week they are five times more likely to report that their health is 'not good' and there is evidence that they have significant levels of mental health need that are not being addressed.

Invisible and in Distress: prioritising the mental health of England's Young Carers (Carers Trust, 2016)

Self-harm

Emergency admissions for self-harm are significantly higher in Suffolk than England as a whole. Self-harm is one of the top five causes of acute medical admission and those who self-harm have a 1 in 6 chance of repeat attendance at A&E within the year. Many people (37%) who self-harm do not receive medical or psychological help. Rates of self-harm have more than doubled (across all age groups) since 2000. This particularly impacts on younger women. The highest levels in Suffolk are seen in Ipswich and in women aged 16-24.

Groups that are at greater risk from self-harm include young women as 16-24-year-old women are more than twice as likely to self-harm than young men, people under 60 who live on their own, people who are lesbian, gay, bisexual or gender reassigned linked to bullying at school and to hate crime and fear of hate crime, people with or recovering from drug and alcohol problems and people living in areas of deprivation.

There is a strong association between deprivation and emergency admission rates for self-harm in Suffolk. However young people (aged 10-19) were 23% less likely to be referred to mental health services if they were registered at a practice in the most deprived areas. There is an evident need to address wellbeing in young people and to ensure NICE guidance is followed (see NICE CG133 and 16).

Suicide

There has been a small but significant increase in suicide in young people aged 15-25 in the years 2015-17 compared to 2012-14. This should be addressed through measures to raise wellbeing in young people and specifically address self-harm and suicide. Half of adolescents (10-19) who die by suicide have a history of self-harm; young people who self-harm are 17 times more likely to die (than unaffected 10-19 year olds) by suicide within a year.

Eating Disorders - Prevalence & Models of Care

Symptoms of eating disorders usually begin in childhood (16 and under). Around 25,000 people in Suffolk may have an eating disorder, although estimates vary greatly. Most people do not seek medical help. Eating disorders reduce quality of life, not only for the sufferers but also for their carers and family members, and can result in illness and death. The risk of premature death is 6-12 times higher in women with Anorexia Nervosa (AN) than the general population, adjusting for age. The rates of emergency admissions for eating disorder in children and young people in IESCCG are significantly higher than the rates for the East and for England overall.

3.3 ISSUES AFFECTING ADULTS

Wellbeing

Physical and mental health are inextricably linked. Lifestyle, such as diet, alcohol consumption, employment status and physical activity, affects mental health. Unhealthy lifestyles, such as substance misuse or smoking, can be a response to stress; a way to try to self-manage a mental health condition. Physical activity reduces the risk of mental health disorders including depression, cognitive decline and dementia and improves self-perception of mental wellbeing, increases self-esteem, lowers likelihood of

sleep disorders and enables a better ability to cope with stress.

Recommended guidelines for physical activity in adults are 150 minutes of moderate intensity or 75 minutes of vigorous intensity activity per week, although adults should aim to be active daily. According to latest figures for Suffolk only 61.2% of adults met recommended levels of physical activity (below the England average (62.3%). A more significant challenge is inactivity and/or a sedentary lifestyle, with currently 26% of people in Suffolk doing less than 30 minutes of moderate physical activity a week. In Suffolk nearly two thirds of adults are overweight or obese (63.6%), this is significantly worse than the England value. Smoking rates in adults with depression are approximately twice as high as among adults without depression. In addition, people with depression can have particular difficulty when they try to stop smoking and have more severe withdrawal symptoms during attempts to give up. Almost half of all tobacco is now consumed by people with poor mental health.

Co-occurring Mental Health and Alcohol & Drug Use (Dual Diagnosis)

It is estimated that approximately 22.7% of the Suffolk population aged over 18 drink above the advised limits and 6,571 people in Suffolk are alcohol dependent (estimate for 2014). The latter group are those who are in greatest need of specialist alcohol services.

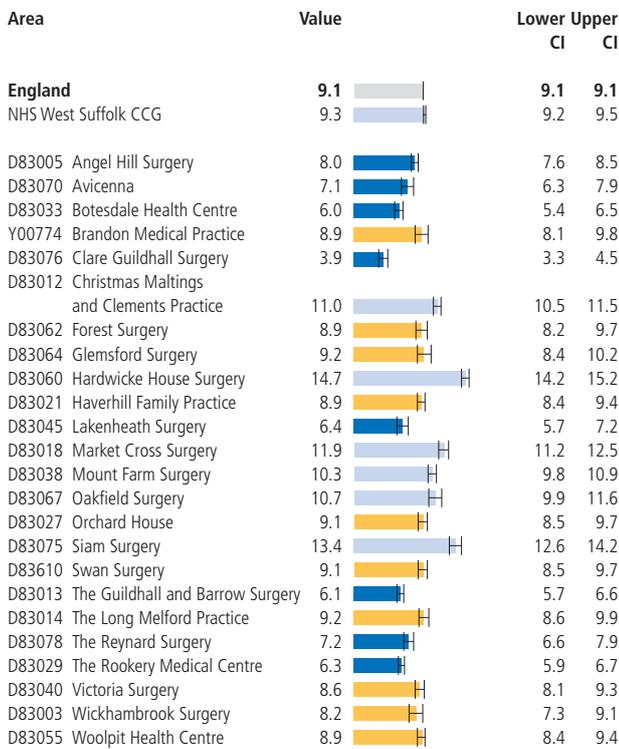
Recreational drugs and misused prescription drugs can adversely affect mental health. As well as dependency, drugs can make the symptoms of mental illness worse and may trigger mental illness. For example there is growing evidence that regular cannabis use increases the risk of developing a psychosis. The prevalence rate of opiate and/or crack cocaine users is estimated as 6.3 per 1,000 population (aged 15-64) in Suffolk, or 2,851 users.

Mental health problems are very common among those in treatment for drug use. Half (50.2%, n=309) of all individuals in Suffolk entering specialist drug misuse services in 2016/17 were currently in receipt of treatment from mental health services for a reason other than substance misuse at the time of assessment.

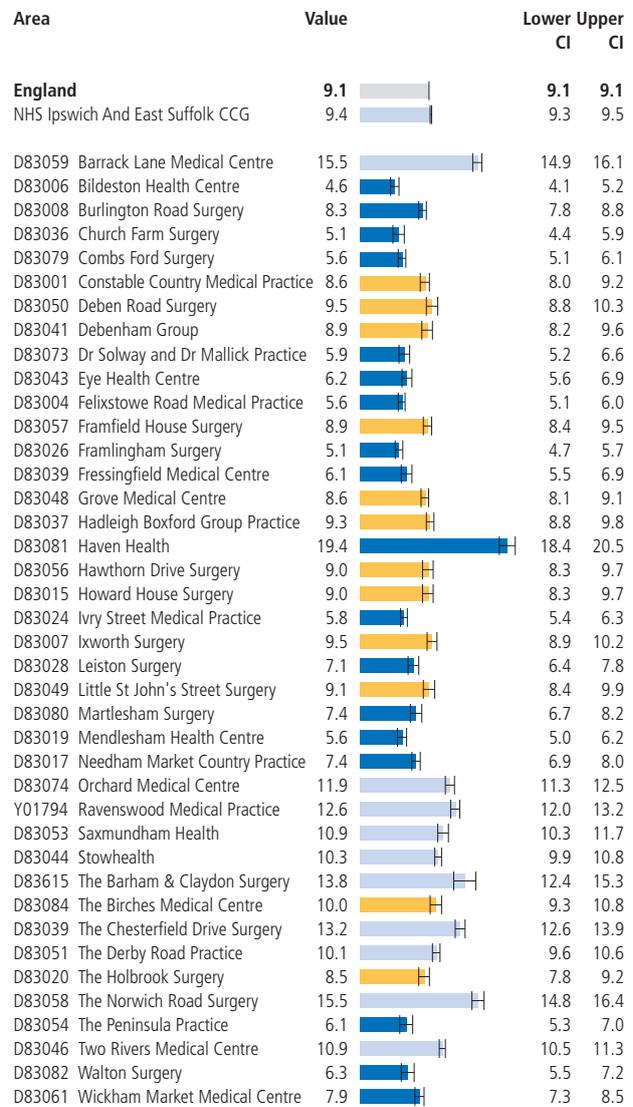
Levels of Mental Ill Health seen in General Practice

It is estimated that 90 per cent of people with mental health problems are cared for within primary care and one in six adults and one in ten children in a practice are likely to have a mental health problem in any year. Antidepressant prescribing in general practice has doubled in a decade. However GP practice data, from the NHS Quality and Outcomes Framework (QOF) data, shows wide variation in Suffolk GP practices. The variation may be due to differences in diagnosis

or in coding of data but the levels seen in GP practices also correlate with deprivation in Suffolk. The average prevalence rates for depression in the Suffolk CCGs (that is the number of people diagnosed at any time) are around 9.5% of registered patients. It is estimated that of the 130 people with depression per 1,000 population, only 80 will consult their GP. Of these 80 people, 49 may not be recognised as having depression at their first appointment. This is mainly because they contact their GP because of a somatic (physical) symptom and do not consider themselves as having poor mental health.



Source: QOF



Source: QOF

Fig. 2: east and west Suffolk Practice Profiles Depression Prevalance

Personality Disorders and the Impact on Individuals and Services

People with a personality disorder may find it difficult to have close relationships, get on with other people, control their feelings and behaviour and listen to others. There are estimated to be around 84,000 people aged over 16 in Suffolk with enough traits of a personality disorder to justify further investigation. People with personality disorders are likely to have other mental health conditions, which must also be treated. Analysis of data for mental health service users in the STP by NHSE identified that people with personality disorder have the highest rate of A&E use compared to other groups.

NICE has published detailed guidance in Personality Disorders, and specifically in antisocial personality disorder (CG77) and borderline personality disorder (CG78). The NICE CG78 guidance states that community mental health teams should be responsible for routine assessment, treatment and management for people with borderline personality disorder. The guidance also recommends the use of psychological therapies in appropriate circumstances and the development of specialist teams.

Transgender Wellbeing

The prevalence of gender dysphoria and those going through gender reassignment are uncertain. Estimates for Suffolk vary from 8-30 trans-females and 2-12 trans-males, to as many as 700 people. Trans-people have a high incidence of mental illness, including: anxiety, depression and self-harm. Attempted and completed suicide is more common. Although good quality evidence is limited, treatment (hormone or surgery) improves mental health and social functioning. A survey of trans-people found that 88% of respondents reported previous or current depression, 80% reported stress and 75% reported anxiety. Trans-people need better access to local mental health services to treat comorbid mental health issues.

Long Term Conditions and the impact of Mental Ill Health

People with physical health problems are more likely to have poor mental health. People with long-term conditions, such as diabetes, coronary artery

disease, Chronic Obstructive Pulmonary Disease, stroke, angina, congestive heart failure, or cardiac disease are two to three times more likely to have depression. People with depression have increased risks of long-term physical conditions:

- Up to 60% increased risk of myocardial infarction
- 34-63% excess risk of stroke
- 1.5-1.9 times more likely to get coronary heart disease
- 60% increased risk of diabetes
- Up to 3.5 times more likely to die from myocardial infarction

Around half of all hospital inpatients have a mental health condition (e.g. depression, dementia, delirium). Social deprivation increases the risk of having both physical and mental health problems. CCGs should prioritise mental and physical health care integration to improve outcomes. Improving mental health can improve the physical health of people with long-term conditions. For example, Cognitive Behavioural Therapy (CBT) can reduce use of health services in people with depression and conditions such as COPD and angina.

Learning Disability & Mental Health

Mental illness is often missed in people with learning disabilities. It is estimated 40.9% of people with a learning disability will have a mental illness. Most people with a learning disability and mental illness will also have a physical illness such as heart disease. People with learning disabilities are five times more likely to get dementia than the general population, and nearly 70% of people with Down's syndrome will develop dementia by the time they are 70. People with learning disabilities die, on average, 15-20 years earlier than the general population, estimated at 18 years shorter for women, and 14 years shorter for men. Some of the excess mortality and morbidity can be attributed to socio-economic factors and to barriers to health service access. Risks can be reduced through:

- support
- effective health promotion
- early diagnosis
- high quality care and treatment

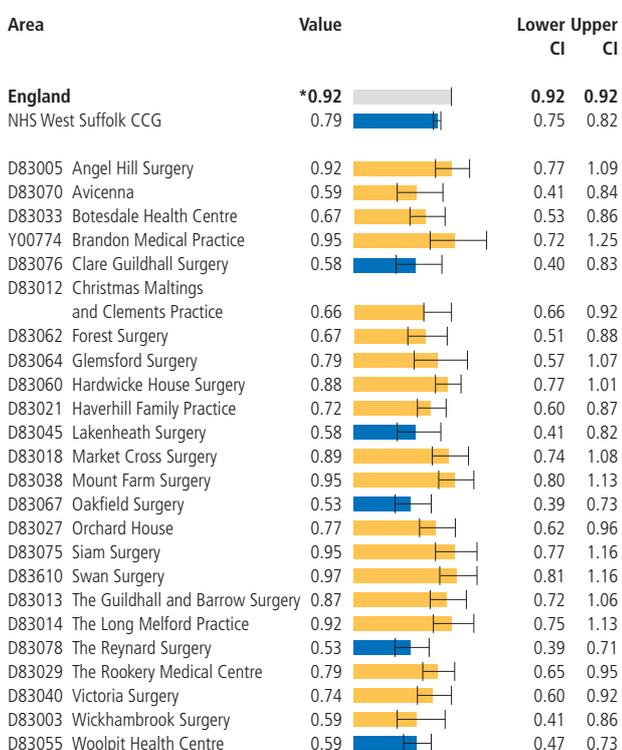
Severe Mental Illness

Severe mental illness includes schizophrenia, bipolar disorder and other psychoses. There are over 6,000 people in Suffolk with a severe mental illness. The lives of people with severe mental illness are 15-20 years shorter than the rest of the population.

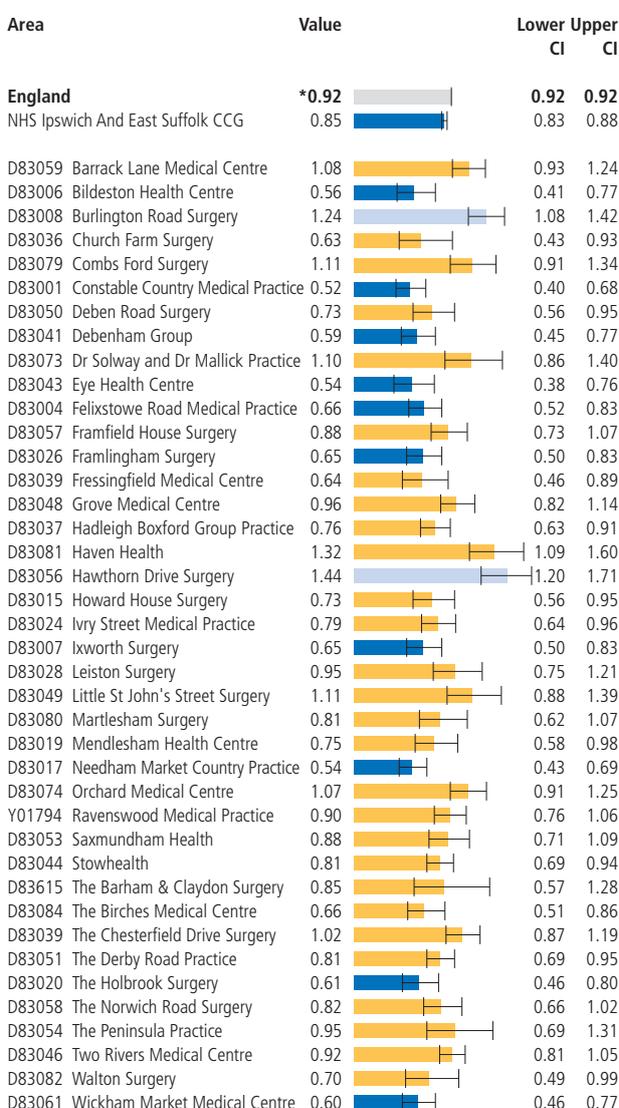
The level of severe mental illness recorded by GP practices varies and half of this variation in the

prevalence can be explained by deprivation. The impact of deprivation on the level of severe mental illness is increasing. It is unclear whether the link is because deprivation leads to severe mental illness, or because severe mental illness leads to reduced economic and social opportunities.

The variation in GP practices in the CCGs is shown below from QOF data.



Source: QOF



Source: QOF

Fig. 3: east and west Suffolk Practice Profiles Severe Mental Illness Prevalance

Metabolic Syndrome is a term used to describe a group of physical health characteristics including obesity, high blood pressure and insulin resistance and people with severe mental illness have three times the risk of metabolic syndrome than the general population. It is important that people with severe mental illness have an annual physical health check in order to address early deaths. Most Suffolk service users with a severe mental illness received a blood pressure check within the last 12 months, but it is not known how many have been diagnosed with metabolic syndrome, or if they are being effectively supported to manage the syndrome.

Mental Health and Medication

Prescription medication can have impacts upon health, through misuse or overdose as well as known physiological side effects. For example, psychotropic (affecting how the mind works) medication can make diabetes more difficult to manage, increase the risk of falls, and increase the risk of sudden death. Polypharmacy (where a person is taking several different medications) can increase the risk of adverse drug events such as side effects or interactions. People with mental health conditions appear to be less able to self-manage their long-term health conditions, such as diabetes, through following treatment advice and attending appointments.

Crisis

A profile of mental health crisis events across the health and care system in Suffolk has been undertaken. A crisis can be defined as 'a situation that the person or anyone else believes requires immediate support, assistance and care from an urgent and emergency mental health service'.

The profile has identified some key issues which should be fed into planning new provision. Emergency department attendances increased in the summer and are usually between the early evening and midnight. Most were female with 47% aged between 15-34 years. Main causes were poisoning, psychiatric and social issues. Ipswich Hospital (IHT) had higher rates and there is a correlation with deprivation.

GP Out of Hours services again show highest levels of contacts in the summer and between 6pm and midnight on weekends. More calls are from women and more callers are aged over 55 years. There are higher numbers of contacts in East Suffolk.

Section 136 episodes, which give the police the power to remove a person from a public place when they appear to be suffering from a mental disorder, to a place of safety, increase in July and August and are predominantly in men.

The Ambulance Service also has more calls from the East of the county and most in June to August; 50% are between 4pm and 11pm. Incidents on the railway network occur most commonly in May to September and tend to be more likely to be young men aged 16-34.

Evidence from research shows that crisis provision should be:

- Integrated and multidisciplinary
- Inclusive of home care and involve the family and carers
- Consistent in their approach
- Available 24 hours a day, 7 days a week

Suicide

The latest review of deaths by suicide has just been completed. Between 2012 and 14 there were 187 deaths and between 2015 and 17, there were 171 deaths and there has been an overall reduction in death rates and among middle aged men. There continues to be a significantly higher death rate in urban than rural areas in Suffolk and Forest Heath and Ipswich Council areas have the highest death rates.

Newmarket continues to have the highest rate among towns and this is significantly above the county average. Males in Newmarket have a significantly raised rate. There has been a small but significant increase in deaths in young people aged 15-24 years. There is a positive correlation between deprivation and death rates.

Armed Forces and Mental Health

Estimates indicate approximately 3,300 serving armed forces personnel in Suffolk. The estimated size of the veterans/ex-forces community in Suffolk is between 33,000-37,000 people. There are a higher proportion of male veterans, and the majority of veterans are 55 and older. Improvements in trauma medicine in the last decade have been significant, which may mean that more care is needed for these life changing injuries. A recent report concluded the majority of serving and ex-service personnel have good mental health. However, in those with mental health conditions the most common are depression or anxiety. National data suggests Post Traumatic Stress Disorder (PTSD) accounted for 6% of mental health concerns. A report produced by the Royal British Legion notes that rates of mental health problems amongst service personnel and recent veterans appear to be generally similar to the UK population, however elevated levels of heavy drinking appear to be an issue. In contrast Public Health England suggests that the serving population is more likely to experience common mental health problems such as depression or anxiety than the general population.²

The location of the United States Visiting Forces (USVF) in west Suffolk should also be noted. Whilst health services are available on base (Lakenheath Hospital), personnel may also access services off base.

A report from the campaigning organisation Forces Watch concluded younger recruits are significantly more likely to suffer PTSD, to drink at levels harmful to health, and to behave violently on their return from war. Those with combat related PTSD may be less likely to engage with civilian targeted services, as they felt that civilian services would not understand them or respond to their needs. No dedicated service is provided for veterans in Norfolk and Suffolk.

3.4 ISSUES AFFECTING OLDER PEOPLE

As well as the issues set out above for adults, there are some specific further issues affecting older people.

Depression

- Between 10-20% of people aged 65 and over will experience depression. Older people

are more likely to have long term conditions, increasing the risk of depression. Depression is more common in women than men, and is associated with increasing age, disability, other medical problems and deprivation. There is evidence that older people living in care homes and in hospital have a higher prevalence of depression, estimated at 20-30%, often in combination with dementia. People with physical illness such as stroke and Parkinson's can have even higher levels, up to 50%.

- Poor physical health increases the risk of depression. Loneliness leads to higher risk of depression and suicide. Together poor health and isolation combine to increase risk further. Depression may present differently in older people, with physical symptoms, and is linked to adverse outcomes in illness such as Myocardial Infarction, stroke and fracture of the hip.
- Research emphasises the importance of physical health, poverty (specifically increasing levels of poverty in older and single pensioners), ethnicity (there are higher rates of depression among Indian and Pakistani women), community participation and social links, retirement and bereavement.

3.5 SUMMARY

The key messages coming out of the needs assessment informing this strategy are:

- Mental health is not just about mental health services and needs to be everyone's business across Suffolk
- Mental health and physical health and social care services need be better integrated across Suffolk
- There is a need to improve the physical health of people living with serious mental illness to reduce deaths
- We need to do more to prevent and support mental health crisis
- We need to continue suicide prevention work
- We need to tackle smoking, substance misuse, problematic drinking, exercise and obesity and, more widely, deprivation, to improve wellbeing

¹ www.healthysuffolk.org.uk/jsna/reports/health-needs-assessments/mhna-2018

² <https://www.healthysuffolk.org.uk/uploads/PTSD.pdf>

4. CASE FOR CHANGE: ENGAGEMENT & CO-PRODUCTION

I&ESCCG, WSCCG and partners wished to conduct its engagement with the Suffolk system in a very different way in order to move away from a traditional engagement or consultation exercise. The real views of the east and west Suffolk population matter to us and we therefore wanted to hear from service users, the people who care for them and professionals.

#averydifferentconversation offered the residents of east and west Suffolk a role in creating a new strategy for how mental health services are delivered. This was an unprecedented opportunity for those whose lives are touched by concerns about mental health to share their experiences of receiving services. This included users of mental health services, carers and professionals involved in the provision of mental health support.

Over a period of three months, service users, carers and professionals were invited to feedback about mental health services through a variety of methods including online surveys and group engagement events. People were encouraged to talk about what was working well and what could be done better.

SUF, SPCN and SFC led on the engagement and have held a programme of events over the summer of 2018, reaching over 4,330 people. HWS has facilitated the co-design of the survey, analysed the gathered data and authored a report ([APPENDIX 2](#)), as commissioned by I&ESCCG and WSCCG. The collaboration included NSFT as the key provider of mental health services in the county.

Healthwatch Suffolk (HWS)

The aim of this large-scale engagement exercise was to gather the views of mental health service users, carers and professionals across east and west Suffolk on what a good, effective mental health service would look like. It was intended that the intelligence gathered would be used to inform a refresh of the county-wide mental health strategy and system model, and suggest options for commissioners and their partners to consider when planning what mental health services could look like in the future.

Suffolk Parent Carer Network (SPCN)

SPCN's team agreed with partners that we would focus on primary schools and public drop-in

sessions and so we went out to libraries, schools, supermarkets, fun days, fetes, car boot sales etc. We spoke to hundreds of people to gather their views and ask them to take the time to fill in the survey. For us, it was also about raising awareness of mental health and emotional wellbeing and we had so many people stopping to chat and share their experiences. It was a very hectic but amazing few months. The hard work of all the transformation partners and the energy everyone has put into this has been fantastic and enabled us to go out to communities and ask them what they want.

Suffolk Family Carers (SFC)

We were excited about being part of the Mental Health Transformation Engagement Partnership for two main reasons. First, we want mental health services in Suffolk to be focused on what people want and need; second, we are totally committed to enabling the voice of carers and people in general to be heard on issues that matter to them. The commitment to co-production within this partnership has been inspiring and something that SFC wanted to support wholeheartedly.

Our contribution to this partnership has been primarily through promoting the engagement work and the surveys through our networks and contacts. We were in touch with approximately 4,000 family carers directly, as well as more widely through our social media platforms and website. We communicated with over 3,000 community groups through Community Action Suffolk, encouraging them to complete the survey. We also contacted all the schools that we work with to get involved. Where we were working with people in communities, such as through the IAGES (Information, Advice, Guidance and Emotional Support) partnership, we encouraged carers and service users to have their say. We have encouraged key voluntary sector organisations to inform the discussion and to help shape the discussions about what is needed in Suffolk.

The commitment and dedication shown by all the partners involved in this piece of work has been remarkable and has demonstrated the value of strong partnership working and co-production. We look forward to continuing to work in this way, ensuring that the views of family carers and service users become integral to the development of mental services in the future.

Suffolk User Forum (SUF)

SUF is the user-led mental health charity for east and west Suffolk. SUF is led by mental health service users and family carers. SUF aims to deliver an inclusive, trusted mental health user-led network that values, promotes and strengthens the user voice for positive change, independence, human rights, choice and control. We work closely with individual mental health service users and their families to give people:

- A voice that is heard within a supportive, safe place
- Understanding of their personal experiences of mental health care
- Advocacy, where we will speak up on their behalf
- The opportunity to come together with other people
- The opportunity to contribute to a forward-thinking vision for service delivery and commissioning developments leading to improved outcomes in mental health and wellbeing support for the communities we serve

SUF has a proven track record in bringing about positive and innovative changes in commissioning for mental health services, through coproduction over the last few years, delivering feedback; making recommendations, both locally and nationally.

The opportunity to be a key partner in this transformative, system-wide collaboration called **#averydifferentconversation** has ensured that service users and family carers have been at the very heart of this transformation. There has been a growing commitment to ensuring real coproduction; in this first stage, focusing on what people in Suffolk want from their mental health services.

Our role within this work has enabled SUF to build on award-winning model of coproduction through our 'Stepping Forward Events' which have facilitated open dialogue with as many people as possible, valuing equal partnerships between people who use services, family carers and professionals to ensure the person with lived experience, their needs and wishes are at the heart of this transformation, identifying 'what people need'.

Through the strength of the transformation partnership, collaborative working model, is that we have been able to extend the involvement of people across east and west Suffolk, working together positively to explore new ideas, new approaches for recovery and wellbeing; to draw together many views and ideas to inspire changes in service policy/design, to achieve forward thinking with a new vision.

ACE

Ace is a user led independent advocacy organisation based in Suffolk. Ace support people to have a powerful & effective voice.

They support people to be in control of their lives and in control of the support they get. Ace support people to speak up and make decisions in all areas of their life.

Ace were contacted in late August, and were commissioned to talk to 50 people with learning disabilities and/or Autism about their experiences. Across a four week period, Ace had direct contact with nearly 120 people.

The purpose of the engagement sessions and survey was to listen to the experience of the Suffolk population and request feedback on our future model to inform our case for change. The themes set out in our survey questionnaire were informed by previous mental health feedback and engagement with the Suffolk population, as we did not wish to lose this intelligence:

1. Open-ended questions
2. Travel
3. GP Services
4. Communication
5. Crisis
6. Discharge
7. Self-care
8. Information
9. Community
10. Digital
11. School, College and University
12. Transition
13. Parents / Carers / Support
14. Professionals

The key findings of the mental health engagement carried out by a collaboration of SUF, SFC, SPCN, HWS, I&ESCCG, WSCCG and NSFT for [#averydifferentconversation](#) are set out below.

The aim of the engagement has been to find out what people would like from mental health services. This was achieved using three methods:

1. Ace, SUF, SPCN and SFC collected data from groups, meetings and engagement events across Suffolk. These events collected unstructured data from a diverse range of groups and on a number of different topics and engaged with an estimated 4,000-5,000 people.
2. Three separate surveys were co-produced by the partnership and distributed online and at engagement events. There was one survey for service users, one for carers and one for professionals. There were 768 responses to the surveys. 444 were from service users and members of the public, 169 were from carers and 155 were from professionals and staff.
3. Data from My Health Our Future (MHoF), HWS research with 7,088 young people in schools in Suffolk, aged from 11 to 19 has been included to include young people's voice in the transformation. This data is available in a separate section of the full report, and the full standalone MHoF report will be available at the end of November.

The large amounts of data generated from the surveys and the summaries of group feedback were thematically analysed by HWS. Thematic analysis involves looking through the responses to each survey question or source of data and looking for repeated points or ideas. This was carried out using Nvivo qualitative analysis software.

The themes below appear in multiple sections of the report. The final three themes, digital support and support in schools and transitions to adult services relate to specific sections of the survey.

- 1. Lack of access and unmet needs** - one of the largest and most commonly repeated themes throughout the survey and the group responses was service users and carers stating that they received no support for their mental health, that they could not access services, or that there did not appear to be any support available in Suffolk for mental health. Besides general references to a lack of support, service users and carers also reported that their GP was unable to provide them with access to services for their mental health. Many stated that they received no support in a crisis, that there was a lack of support following discharge and that there was no support available in their local community. Lack of access to services was referred to by all three groups in the surveys, however, comments about a lack of access were particularly prominent from service users and carers.
- 2. Access** - Service users and carers also commonly stated that waiting times for services were long or that there was a need for more local services. Waiting times were particularly important in comments about crisis care and were mentioned 142 times in total across all surveys. A number of service users said that they would like services to be available in their GP surgery or community hub.
- 3. Support in the community** - Service users and carers said that the types of services that they would like to receive or find useful were:
 - Professional support such as social workers, care-coordinators, community psychiatric nurses, psychiatrists or GPs
 - Talking therapies, including counsellors, therapists, psychologists and cognitive behavioural therapy
 - Qualitative interpretation of mentions of support in the community suggest that people generally find informal support from friends, family and neighbours and voluntary and community sector support useful or important.
- 4. Information and signposting** - Service users and carers responses to the questions about the types of information which they found useful or would find most useful were:

- Information about what services are available, how to access services and what sources of community support are available.
- Information about their mental health condition or treatment and how to manage or improve their mental health.
- Professionals, service users and carers all said that professionals need more information about what support is available and how to access it.

5. Continued support - Service users and carers often said that they would like follow-ups from treatment and more support following a crisis or discharge. Many said that if they had been in recent contact with services, they would like easy access back into services if they had a need. Professional's suggestions for what a good discharge process would look like included:

- A post-discharge plan with details of what to do in a crisis (21)
- Discharge should be co-produced with the service user and family carers (13)
- Discharge should be planned from the start of care (6)

6. Listened to and understood - Service users and carers often said that they would like to be listened to and their needs understood in terms of their mental health or mental health care, by both professionals and the wider public. This theme was extremely important for service users in response to the questions about communication, with 119 mentions. Professionals also mentioned the importance of treating service users and carers in this way. Some people also stated that they would like to see the stigma around mental health reduced.

7. Quality of services - Quality of care was used to refer to a number of themes around the way in which people receive treatment, including from mental health services directly or other health services such as GPs. Service users and carers commonly stated that they wanted mental health treatment to be effective or to alleviate symptoms. They also said that it was important for them to have continuity and consistency in their care, and for their care to be tailored to their personal needs. Some service users and carers also mentioned or

wanting to be offered treatment other than medication.

8. Integrated care - All three groups, but particularly professionals, commonly mentioned the need for integrated care. For example, in the questions about communication, there were 78 mentions of integrated care by professionals. Key topics within integrated care include the need for mental health services to work more closely together, to work with communities and the voluntary and community sector and the need for a centralised and accessible system for patient records.

9. Resources - Funding and staff capacity was mentioned by all three groups within the survey responses. This theme was mentioned by service users in response to being asked what they would like from mental health services (48) and in professional's comments in response to questions about crisis (27) and wait times (31).

10. Support for carers - A number of service users who were parents (77) said that they did not receive any support or that there was a lack of support for them to look after their own mental health. 29 respondents to the carers' survey also said this. 71 service users who were parents and 41 carers said that there was a lack of support for them to support the person who they cared for. Service users commonly mentioned using or wanting professional support. Carers commonly mentioned using sources of voluntary and community sector support. Throughout the surveys, there were a number of mentions by carers of wanting to be better informed and involved in the care of the person who they care for.

11. Digital support - In response to the questions in the survey about digital support for their mental health or emotional wellbeing, service users and carers most often said that they use or want apps (163), websites (84) and social media (70). The most commonly reported use or desired use for digital support for all three groups was information and signposting (123). Some service users and carers reported using digital technology or wanting more digital support for self-help such as mindfulness (57). 57 said that they used or would like to use digital technologies for peer support,

SYSTEM WIDE EVENTS - ELMSWELL

Between June and October 2018, three system-wide sessions were held in Elmswell, Suffolk to hear from the Suffolk system on key issues identified by all of the groups above. The sessions were also used to share the emerging themes arising from the Public Health Mental Health Needs Assessment, introduce provocations from service users and the people who care for them, professionals and good practice from elsewhere. The sessions focused on building relationships and sharing knowledge. Service users, the people who care for them and professionals were put at the centre of the dialogue to empower and remind us all why we were there. The need for a 'movement for change' was established and agreement reached that this needs to continue beyond November 2018. A commitment was made to follow through on true co-production following the case for change document. The sessions also focused on testing and receiving feedback on the emerging future model.

WORKSHOP ONE:

'Rethinking Emotional Health and Wellbeing for Suffolk' - 6 June 2018 (APPENDIX 3)

- Event focused on Self Care from the quadrant model
- System came together to agree a new 'we'
- We agreed we needed to work differently to get somewhere new together
- We talked about different language and agreed it was ok to talk about difficult things
- Agreed shared values which unite us
- Shared emerging messages on the need of Suffolk from the Public Health Needs Assessment
- We heard moving stories from service users and the people who care for them
- We worked to describe our future Suffolk
- Provocations from City & Hackney moving from Inpatient to Community based care
- Feedback on Imaginative recovery based support for self-care
- Discussion on what needs to change
- Improved understanding of 'all' that is available - what the entire system has to offer, education, VCS etc.
- Social Prescribing - a cultural change for service users and practitioners

- Built relationships, confirmed shared expectations, non-crisis collaboration took place

WORKSHOP TWO:

'Rethinking Emotional Health and Wellbeing for Suffolk' - 11 July 2018 (APPENDIX 4)

- Event focused on Primary and Community Support for EWB&MH from the quadrant model
- Continue to grow sense of community and agreeing our shared purpose to transform services for EWB&MH
- Provocation on Professional Practice and Patient Experience covering Health Coaching, Cambridge and Peterborough PRISM and Cambridge and Peterborough IAPT LTC Pathways
- World Café approach focusing on service user and professional relationships, Physical and Mental Health, Recovery and Additional Support - conversation split 0-25 years and 25 years+
- Making service user focused care real and bespoke
- Investing time early
- Shifting power between service users and professionals towards partnership and equality
- Recognising the role of non-clinical support in future models
- Conversations covered features for a future Suffolk, underpinning values and design principles, next steps
- Three Service User Provocations - courage and resilience identified importance of continuity of care and good trusting relationships
- Keep conversations challenging, be open and honest, continue to raise awareness and develop prevention

WORKSHOP THREE:

'Rethinking Emotional Health and Wellbeing for Suffolk' - 9 October 2018 (APPENDIX 5)

- Focused on Specialist Secondary Mental Health Services from the quadrant model
- Continued to grow our sense of 'Suffolk' community and shared purpose to transform mental health and emotional wellbeing outcomes

- Led by service user and clinician led focused provocations
- Listened to the needs of people with serious mental ill health
- Begin to describe approaches that would enhance people's lives, drawing on the different perspectives in the room
- Focus on design for acute specialist support and crisis support (and the range of things that might exist in the community to help make crises less likely)
- Group discussions on six case studies curated by mental health professionals focusing on the need for integrated responses
- Consolidate insights and actions for whole system transformation (reflecting on our whole journey and planning our next steps)
- Discussion and agreement of design principles if we are to work differently to create a new system

GP Events

As part of the engagement with our workforce, two events were held specifically for GP colleagues in June 2018 for east and west. We heard from Cambridge and Peterborough CCG about their approach for mental health in primary care (PRISM) and their Mental Health Crisis First Response Model, for which they are recognised nationally.

At both meetings, the GPs had the opportunity to reflect on the innovation from Cambridge and were able to feedback, consider and contribute to the development of how a mental health model based in GP practices could work in Suffolk.

A visit also took place to East London NHS Foundation Trust in July 2018 to discuss their Primary Care Mental Health Service and learn from their recent work in developing community facing services, and increasing joint working with other agencies.

Co-occurring Mental Health & Alcohol/Drug Use Conditions (Dual Diagnosis) Event

Co-occurring mental health and alcohol/drug conditions (commonly known as Dual Diagnosis) refers to the condition of suffering from a mental illness and a co-morbid substance abuse problem. Service user

experience often indicates being unable to access the right treatment at the right time which may lead to more episodes of crisis. HWS, SUF, Public Health Suffolk and the CCGs hosted a workshop in October 2018 for health and social professionals from mental health, substance misuse, primary care and social care. Ideas to support better treatment for these service users were developed. This will form part of the offer to service users throughout the four quadrants outlined in this strategy, to ensure that service users can get the right care when they need it.

CCG Engagement Activities

Both I&ESCCG and WSCCG put mental health transformation at the front and centre of their annual engagement events. In July 2018 the I&ESCCG Patient Conference offered 108 delegates the opportunity to share their views on Mental Health services by running facilitated table top discussions asking the questions - what does good mental health look like? How can alliance working support this? The responses to these questions were collated by CCG staff members and fed into the data analysis at HWS.

WSCCG dedicated half of the September 2018 Patient Revolution Event to the discussion of mental health services. 60 members of the public were supported to complete the short survey in groups of eight. This information was all entered onto the online survey to capture the responses for HWS to collate.

Engagement with those living with Severe and Enduring Mental Illness

It was acknowledged by the partners that the voices of those living with a severe and enduring mental illness are rarely heard in large scale engagement activities. Therefore specific focus was given to enabling this population to contribute to the process. Working in partnership with Suffolk Mind and Julian Support supported housing services, the views of 17 adults living in 24 hour supported housing, or community supported living were gathered through small group and 1 to 1 sessions to assist with the completion of the short survey.

BAME Engagement

The BAME populations of Suffolk were targeted via

the Healthwatch Suffolk BME and Diversity Sub-group. This group is a forum for sharing information, networking and gathering feedback from different communities about local health and care services. A range of voluntary organisations are members as well as statutory partners. Members of the mental health transformation partnership attended the group to promote the survey and request the support of the group in reaching out to its members.

Rough Sleepers and Homelessness

Rough sleepers were supported to engage with the short version of the survey in west Suffolk. The Housing Options team in west Suffolk councils promoted the survey and the engagement partnership attended their team meeting to gather feedback. Feedback was received by seven of the 24 identified entrenched rough sleepers in the west. Because of the challenges involved in engaging with this group it was felt that skilling up the rough sleeping co-ordinators to have conversations with individuals was the most effective approach.

Conversations were also held with Health Outreach and their support in engaging their service users with the survey was requested.

LGBTQ Engagement

Members of the engagement partnership attended the Trans Gender Task and Finish Group and received a number of responses to the survey - a group rarely captured in traditional engagement activity.

The survey was promoted via the LGBT Network and GenderXplored groups.

NSFT Workforce Engagement

The partnership facilitated a number of specific engagement sessions for the NSFT workforce. These were intended to offer those clinicians the opportunity to discuss the themes of the survey and to complete the survey in small groups with the support of facilitators from the engagement partnership. Sessions were held in Ipswich, Bury St Edmunds and Stowmarket. 43 members of NSFT staff attended these events and contributed their views to the survey questions.

A specific session was held in Stowmarket in July 2018 to meet with the NSFT medics to inform them of the mental health transformation work and to encourage their involvement in the process. Following this meeting, two further engagement sessions were held in the east and west of the county. 23 medics were engaged throughout the three sessions. In addition a number of discussions have taken place with groups of clinicians through a wide range of forums to ensure staff were aware of the Transformation work being undertaken and how they could contribute.

Children's Emotional Wellbeing Group (CEWG)

The CEWG is well established and is responsible for producing and delivering the Local Transformation Plan which details how the system will work together to improve emotional wellbeing and mental health support for the 0-25 year age group. This group, with members from across the public, voluntary and community sector and those who represent the voice of service users have been responsible for developing the elements in this strategy that focus on children and young people. The detail of which is reflected throughout this document. However a re-refresh of the Local Transformation Plan is also annexed which draws together the focus on children, young people and their families. Based on our co-production and engagement approach through **#averydifferentconversation**, through our three system wide Elmswell events and other collaborative discussions we have worked up a shared vision, principles and set of outcomes for east and west Suffolk. These are set out in the next section and capture the views of our partnership.

The draft east and west Suffolk Mental Health and Emotional Wellbeing Strategy was well received at the November 2018 CCG Governing Body. In the intervening six week period (29.11.18-10.01.19), our co-production partners supported an engagement process to share the draft strategy with the Suffolk system, and invited responses to a survey hosted by Healthwatch Suffolk. The objective of this survey was to establish whether we had missed anything and whether people felt engaged with the process.

The key findings of the survey are outlined below:

Quantitative Responses

There were 153 responses to the survey. The response to the quantitative questions has been very positive as 3 questions had more than 50% of respondents agree or strongly agree with the question.

Q1: This feels like a very different conversation

154, 1 skipped

- Strongly disagree or disagree: 13%
- Neither agree or disagree: 30%
- Agree or strongly agree: 57%

Q2: I am influencing or contributing to this piece of work

155 answered

- Strongly disagree or disagree: 17%
- Neither agree or disagree: 30%
- Agree or strongly agree: 53%

Q3: The strategy will make a positive difference

153 answered, 2 skipped

- Strongly disagree or disagree: 9%
- Neither agree or disagree: 35%
- Agree or strongly agree: 56%

Qualitative Responses

There were 78 text narrative submissions, of which four were group feedback and six stated 'Inpatient West wards' and will be analysed separately and contained in the final feedback report. This leaves 72 valid survey responses which are set out below.

Qn: 'Has anything been missed?'

Three key themes have emerged in the responses:

- Mentions of the implementation of the strategy and the future direction of mental health services (33)
- Mentions of wider social factors or policies that may not be being addressed (17)
- Mentions of gaps in services (43)

Implementation of the strategy and the future direction of services

This group of themes are all about how services will be shaped in the future, either by the strategy or more widely.

- Six responses mentioned *service leadership and culture*
- Four responses mentioned *a new model of mental health treatment*, a move towards a *"trauma informed"* model and challenging the *biomedical model* of mental "illness". There were two mentions of the need for *improved leadership* of mental health services
- Five responses mentioned funding and the need for increased funding to implement the strategy
- One said that *people needed to be involved* in services
- Five responses requested more detail on how the strategy would be carried out in practical terms. "People need a clear understanding of what services they will be offered, in what timeframe" "This is a really good strategy but how are we going to actually do this?"
- Six people mentioned wanting to know more about the future of Norfolk and Suffolk Foundation Trust
- On implementation of the strategy, people referred to a need for qualified staff and training for staff (four), a need for integration or joined up working to implement the strategy (three) and a desire for continued co-production (two)

Wider Social Factors & Inequality

This group of themes are all about how social factors or institutions other than health services themselves impact mental health.

- Five people mentioned the impact that childhood experiences, families and parenting have on children and young people's mental health and emotional well-being.
- *"More emphasis should be placed on parental support for children - parents need to be held responsible for their children's wellbeing not just schools who are left to pick up the pieces."*
- Six people mentioned the impact of poverty, debt or socio-economic inequality on mental health and there were two mentions of the impact of housing:
- *"More emphasis on the social conditions that make people ill - debt, housing, trauma etc, as well as long term conditions."*
- Four people mentioned a need for greater support for mental health in schools. Two of these talked specifically about the pressure which school places on young people impacting on mental health.
- *"There should be far more focus on young children in schools. More support should be given to schools to provide this support for children. It should not be as hard or as expensive to access training or outside agency support for the children who require it."*
- Two people mentioned the needs of black and minority ethnic groups.

Gaps in Services

This group of themes refer to comments where the respondent said there was a need for more or improved services.

- Eight people mentioned a need for additional services or awareness for people with specific needs or diagnoses. Three of these comments referred to support for people with mental health needs co-existing with a diagnosis of autism or ASD. One mentioned support for ASD more generally. Other services mentioned include: those for Deaf people, people with a diagnosis of Personality Disorder, specialist talking therapy and psychosexual therapy. *"These are very much a Venn diagram of overlapping conditions and need specific strategies and expertise."*
- Four people mentioned that they had been unable to access services or that there was a lack of support available for them but did not mention a specific service. *"We have been*

getting very little help from the mental health services and been pushed away from any help that is offered and out there."

- Two people made specific mentions to a lack of support for people with long term or severe and enduring mental health needs. *"There are clients who have severe and enduring mental health problems who require long term, skilful intervention and treatment. A very different conversation seems to under-represent the needs of this specific client group and it appears to me that Youth work and people with a personality disorder have greater voice and choice."*

Group Data

There were nine pieces of group or other feedback submitted through the survey link and via email. Numbers recorded in the comments show that these contain the views of just over 100 people.

- Events listed include the I&E CCG patient engagement event, SUF event of a screening of 'CrazyWise', SUF engagement with service users (including SUF at Ipswich library) and staff at Woodlands. The analysis of the group data is in its very early stages, but comments which support the themes found in the survey responses include:
- Concerns about pace of implementation
- A need for increased investment and to understand existing service costs
- *"Doesn't mention anything about parent support/assessments/training which I think is crucial for young people."*

In addition to the feedback survey, co-production partners supported drop-in sessions in Kesgrave (East) on 8 January 2019 and Elmswell (West) on 9 January 2019 to provide an opportunity for the Suffolk population to hear about the strategy and contribute to the ongoing dialogue. Co-production partners also worked with their networks to promote the strategy and encourage participation in the survey.

Clinical leads from the CCGs and NSFT have also been meeting with NSFT teams across the localities to further promote the strategy and invite feedback.

Please see Appendix 6 for an overarching summary of [#averydifferentconversation](#)

5. VISION, PRINCIPLES AND OUTCOMES

5.1 INTRODUCTION

I&ESCCG, WSCCG and NSFT have led a joint programme of transformation across 2018, culminating in this document. Working with partners as described in the previous section, we have developed a shared vision and aligned system principles of working to ensure that mental health and emotional wellbeing is everybody's business, which are described below.

We believe that, in order to achieve excellent mental health and emotional wellbeing, our vision for the population of east and west Suffolk is that **everyone should get the right support, at the right time, from the right people, in the right place and in the right way.**

Our principles are:

- **Everyone's views matter** - at a system level, we will ensure that the voice of service users and the people who care for them are at the centre of decision making, service planning etc. We will listen to, empower and acknowledge peoples roles and be open, honest and transparent. We will not blame or criticise and we will share risk. Co-production happens when service providers and service users recognise the benefits of working in true partnership with each other. This process is adopted from the start, when planning, developing, implementing or reviewing a service. It means that all the right people are around the table right from the beginning of an idea, and that they are involved equally to shape, design, develop, implement and review services, work together right from the start of the process through to the end.
- **We will make children and young people's mental health and emotional wellbeing the foundation of our strategy** - we will continue building on our current system-wide Children and Young People's programme of work, which will improve outcomes for future generations.
- **System-wide responsibility to deliver and support resilient communities** - this can only succeed if all partners play their vital and contributing role. We will work with the voluntary sector, education, health and care

and community leaders to improve the mental health and emotional wellbeing of our east and west Suffolk population. We will actively support the needs of service users and the people who care for them in order to build wellbeing and resilience across the whole network of support.

- **Additional Investment** - our future mental health and emotional wellbeing model needs to be sustainable, appropriately resourced and deliver care which is safe, effective and evidence based. This means that we will need to change the way that we work as a system, and develop increasingly integrated and innovative approaches.
- **Prevention and early intervention is as important as treatment** - we will prioritise our focus on ensuring that we tackle mental health and emotional wellbeing as early as possible to try and prevent problems before they arise and improve outcomes for the population of east and west Suffolk.
- **People should be supported to care for themselves** - we will build a system that will support each person as an individual and the people that care for them to enable and empower people affected by mental health and emotional wellbeing to make their own choices, feel in control of their lives and live well. At an individual level, we recognise that it is individuals themselves who drive and sustain their recovery when relationships between professionals, service users and others are collaborative.
- **Physical and mental health will be integrated** - we will develop services which consider and support mental health and emotional wellbeing, physical health, long term conditions and the wider contributing factors of mental health and emotional wellbeing together.
- **Services will be needs led** - the strategy will seek to address the mental health and emotional wellbeing needs of the population of east and west Suffolk irrespective of where they present and their level of need. Responses may be clinical or include other interventions depending on individual circumstances.

- **Digital and Technology** - we will utilise all opportunities to make services more accessible and better integrated for the local population building on the Suffolk and North East Essex Digital Roadmap. Professionals must be able to access, view and share patient records across primary care, acute hospital, mental health and community services to avoid duplication and repetition.
- **Recovery focused approaches** - we will develop communities which empower people to live well, whilst recognising that individuals will require additional support from time to time. Everyone should aspire to recover, from mild depression and anxiety to people with serious mental illness (SMI) conditions.
- **Normalising mental health and emotional wellbeing** - we all have mental health and emotional wellbeing. We will continue to raise awareness of this across the system in order to challenge stigma and promote social justice and social inclusion.
- **Supporting the Workforce** - the workforce within our system, including experts by experience, are our most valuable asset and the key to future success. The new model will require changes in approach and new developments. We wish to provide training and development opportunities for staff to facilitate these and to motivate our staff to build confidence and pride. Our staff will provide a compassionate and effective service that meaningfully integrates physical and mental health interventions. This may lead to different ways of working with partners to enhance service delivery. There will be system-wide learning opportunities that support the integration of the workforce and approaches to care that benefit service users.

5.2 OUTCOMES FOR SERVICE USERS, THE PEOPLE WHO CARE FOR THEM & PROFESSIONALS

We recognise that measuring outcomes is an important part of evaluating the success of our future Suffolk model, and the development of a culture of quality improvement. Use of outcome measures will help prioritise the use of resources and ensure that the interventions provided are

effective. Outcome measures must be meaningful, useful and add value. We commit to co-produced, quality focused evaluation processes, including Key Performance Indicators, to ensure governance, usefulness and effectiveness. In addition to service focussed outcome measures, there will be system-wide outcome measures that facilitate system-wide quality improvement and celebration of success in the development of resilient communities.

Governance will be applied to the use of outcome measures, for example, every measure used will be in response to a clear and meaningful question, data will be collected in resource friendly ways, all data collected will be used, a range of methods will enable inclusion of responses from the all, data will be analysed and reported by those with the required expertise. There will be a culture of openness and transparency about the sharing of outcomes across the system.

Access to Services

The Suffolk system has told us they wish to have increased timely access to support from universal through to specialist services, reducing existing waiting times which are either high or hidden at times depending upon how services are recorded and presented.

Evidence Based Interventions and Improved Outcomes

All interventions should be evidence based in order to ensure outcomes and value for service users and professionals are maximised. We should increase and develop different approaches, including peer support where beneficial, which focus on improving wellbeing. We wish to move away from transactional counting measures and instead focus on measuring improving wellbeing.

Broader Determinants of Mental Health: Physical, Emotional and Environmental

We require a full system response and commitment to raise awareness and understanding if we are ultimately going to improve our population's emotional health and wellbeing. Suffolk has many partners who contribute to the agenda through an individual's life course affecting physical, emotional and environmental factors.

Recovery

Recovery does not always mean full recovery from a mental health problem, and neatly illustrates some of the distinctions between mental and physical health. All service users should be able to strive to take control of their life and recover 'more than once'. Recovery can include 'the recovery model' and relates to supporting people to build their resilience, not just treat or manage symptoms. It is possible for people to regain a meaningful life, despite serious mental illness.

The following statements will be further informed through our period of engagement between November 2018 and January 2019. 'I' statements reflecting key themes identified in [#averydifferentconversation](#):

Lack of access and unmet needs (especially in crisis)

'I want to access services which meet my needs.'

Access (increased waiting times)

'I want to access services in a timely manner.'

Support in the Community

'I want to access services in the community and closer to home.'

Information and Signposting

'I want to access information to support my emotional health and wellbeing and understand what services are available and how to access them.'

Continued Support (especially post discharge)

'I want to be supported to stay healthy, especially when discharged from services.'

Listened to and understood

'I want services to be compassionate, to listen to me and my family/parents/carers.'

'I and my family/carers want to be involved in deciding how services are planned for me.'

Integrated Care (opportunities)

'I want services to work together to better meet my overall needs.'

'I don't want to fall between different services.'

Resources

'I would like more funding to be invested in mental health and emotional wellbeing services.'

Support for Carers

'I want the needs of carers to be a priority for services.'

Digital Support

'I want to be able to access services online and through apps.'

'I want support to be available online and through other digital means.'

Schools (lack of support)

'I want schools to prioritise and support my emotional health and wellbeing.'

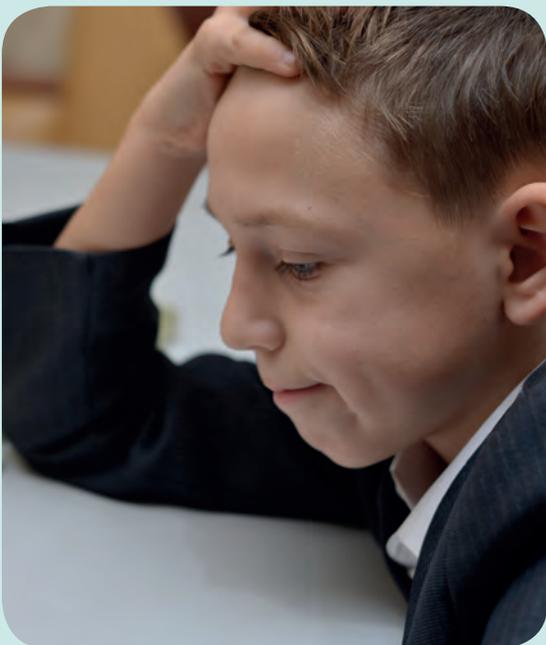
Transition from Child to Adult Services

'I do not want to fall between child and adult services.'



Lack of understanding about how it affects everyday life especially at school. A teacher commented about 'trying to snap out of it.'

Carer



5.3 PUBLIC HEALTH LED WORK TO DEVELOP SYSTEM WIDE KEY PERFORMANCE INDICATORS FOR MENTAL HEALTH

Since January 2017, Public Health Suffolk has worked with the two Alliances within the SNEE STP to develop an outcomes framework that is useful to all partners. The framework was co-produced with Alliance partners including districts and boroughs. A first draft used logic models, producing eight outcomes, and nearly thirty supporting “I/we” statements. The Alliances then asked Public Health Suffolk to review and reformulate this work to focus on fewer higher level measures and to capture the risks and benefits of alliance working. The original outcomes and statements became ‘guiding principles’ and the new OPERa framework covers the original outcomes (and some new ones) in four domains:

- **Outcomes** - health and care outcomes for our population improve
- **Processes** - we maximise the opportunities available to us through Alliance working to improve health and care processes
- **Experience** - local people have an excellent experience of care and support
- **Resources** - resources are used for best effect across the Alliance

Mental health was one of the first themes to be considered, and now has a suggested set of indicators for each domain (shown as radar charts in [APPENDIX 7](#)). The indicators may be available at different geographies (STP, CCG, County); for different periods; be calculated locally or published nationally. Work continues to identify what metrics should be included, particularly from partners’ own information which can show variation at a sub-county level, be more up to date, and enable greater analysis than figures published nationally; but which cannot be easily used for benchmarking or comparative purposes. Public Health Suffolk are also continuing to consider how best to present the information to maximise engagement and ease of use.

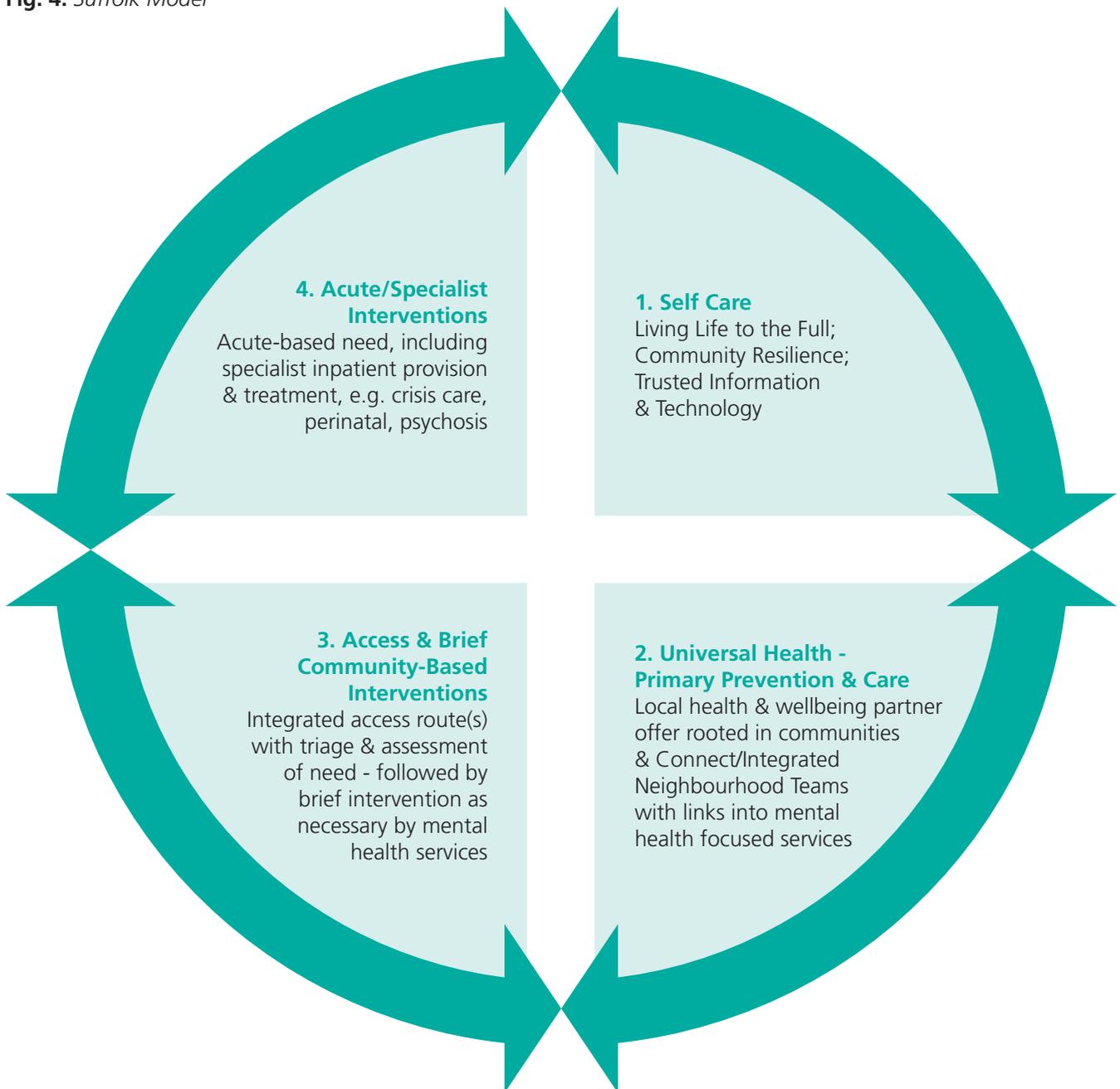
6. OUR PROPOSAL FOR MENTAL HEALTH & EMOTIONAL WELLBEING

6.1 INTRODUCTION

Our future model (Fig. 4) is based on four quadrants which, taken together, describe a system-wide response to supporting the mental health and emotional wellbeing of the population of east and west Suffolk.

This model will only work if organisational leaders unite in this commitment, build trust, strengthen relationships and create a culture within which this new model can thrive and the ambition of optimum individual and community resilience for people of Suffolk can be fulfilled.

Fig. 4: Suffolk Model



Whilst describing the system-wide response, the model also sets out the expectation specifically of mental health services across the four quadrants of care. This includes a specific requirement to work increasingly in the future with partner agencies in order to integrate mental and physical health services.

Our mental health services need to work seamlessly from primary and community services into specialist mental health services where required in order that service users do not fall through gaps in provision. We wish to move away from a place where standalone mental health services can only be accessed through meeting clinical thresholds to one in which we meet the needs of our service users and understand how these conditions have been created.

Whilst we see the real opportunities to better integrate our statutory providers of care, we also want to explore the further opportunities that present themselves to consider the services on offer from other areas of the system including the voluntary sector and social prescribing for example and how these can contribute to improving the population's emotional health and wellbeing.

We recognise that the system around a child and family will be different to that of adults. Schools and other education settings play a crucial role, the need to support the child and young person as part of a family unit and consider their social care and education needs alongside their mental health will be an important part of how we deliver services in the future.

6.2 KEY OVERARCHING THEMES

The key overarching themes that underpin our model and will need to be delivered against are described below:

A. System-Wide Leadership and Culture

The mental and physical health and wellbeing of the people of Suffolk is directly influenced by the way in which the workforce of all statutory and non-statutory organisations work together at every level. Commitment to a new system-wide culture of true collaboration and innovation is required in order to strategically develop sustainable ways

to meaningfully enable prevention and recovery. By working together with a shared commitment, there will be new and greater opportunities to more effectively and systematically understand, prevent and intervene where there are vulnerabilities within our communities.

Leaders within our system must create sustainable ways to:

- collectively make decisions about how services are planned and delivered for local people
- decide on priorities together
- ensure that, at every level, staff will consider themselves part of a statutory and non-statutory family with a shared purpose rather than operating separately within the confines of their organisations
- everyone will be respectful of, and compassionate towards, constraints and challenges of their partners and work together to deliver services better
- make best use of collective resources, including financial resource
- have a shared and balanced commitment to both prevention and recovery
- ensure that the views of local people are included
- understand prevention and recovery need in every locality
- respond to need in a timely way with a 'no wrong front door' mentality

This will require a shared culture of compassion, collaboration, courage, learning, determination and commitment to Suffolk people and Suffolk communities.

B. Service User, Carer & Professional Input Into Services

We want to create an environment where people and their families can help plan the services and interventions they receive in order that they are central to their individual circumstances, personal to them and places them in a position where they can determine and plan their own whole life, recovery aspirations and vision.

People who care for service users need to be considered within the care needs of the service user

for their own wellbeing. Carers UK released research in 2018 that revealed that ‘almost three quarters (72%) of carers in the UK said they had suffered mental ill health as a result of caring’. This makes it doubly important to include the views and needs of people who care for service users in care planning.

Suffolk Family Carers

Suffolk Family Carers works with young carers and young adult carers between the ages of 5-24 years. For the last six years we have been providing support in schools / colleges and also running a course known as ‘Be Your Own Best Friend’. Through experience we know that young carers and young adult carers often struggle with mental ill health and wellbeing issues, so our Young People’s Advisers have been trained by Suffolk Mind in their CARES training (Crisis, Advice & Recovery - Emotional Support) which provides a toolkit of practical skills and knowledge to help support a young person with mental health and wellbeing issues. Our ‘Be Your Own Best Friend’ (BYOBF) course was designed by a Suffolk Mind counsellor along the Suffolk Needs Met model. Both these aspects of our work have supported young people to self-care. In particular, the BYOBF course has changed lives:

Today has given me new coping methods for dealing with stress and what I can use to help me with self-love ... Today has opened up my thinking to how I think and why I might go straight to negative thoughts and how to prevent it.

Young Adult Carer, BYOBF feedback

We have heard about a number of approaches that can support this cultural change and shift historic relationships between professionals and service users towards compassion, partnership and equity.

Open Dialogue³ is an approach pioneered in Finland that has been raised through our engagement work, initially developed to work with people experiencing a mental health crisis, which from the outset includes a recovery focused approach involving families, professional (health and care) and community networks. All treatment is carried out via a whole system/network meeting approach and always includes the user. The approach has seen promising results in terms of reduction in inpatient admissions, reduced use of psychiatric medication and improved vocational outcomes. We believe that Open Dialogue may offer the possibility of improving outcomes for users with mental health problems.

The aim of **Health Coaching** is to enable people to thrive by feeling more motivated, confident and in control of managing their own health and care. Health coaching originated in England under the NHS England Innovation Accelerator programme:



Great conversation is more than just exchanging information - it can transform relationships and health behaviours to benefit patients, staff and the organisations we all work for. Talking to people in a way that acknowledges their expertise, and puts them in the driving seat, helps people better manage their own health and helps the NHS by reducing demand and costs.

NHS England Innovation Accelerator Programme (www.betterconversation.co.uk)

Shared Decision Making (SDM)⁴ ensures that individuals are supported to make decisions that are right for them. It is a collaborative process through which a clinician supports a service user to reach a decision about their treatment. The conversation brings together the clinician's expertise, such as treatment options, evidence, risks and benefits and what the service user knows best: their preferences, personal circumstances, goals, values and beliefs

WSCCG launched a Patients in Partnership Steering Group to oversee a programme of work to give people the materials and information they need to help them make decisions about their own health. This is the ultimate aim of increasing service user satisfaction, reducing follow-up appointments and reducing complaints. What is evident from work carried out to date, nationally and locally, is the collective ambition to support dialogue with people around SDM within primary care. Those conversations were progressed and strengthened by integrating and introducing additional decision-making aids to further embed SDM into everyday clinical practice, enabling service users to make more informed and considered decisions about their own care and treatment.

Trusted Assessment⁵ is part of the development of the Integrated Neighbourhood Teams (INTs) for health and social care, a Trusted Assessment and joint care model is being implemented. The agreed definition of trusted assessment for this is 'a trusted assessment is an agreed approach to assessing the needs of a person that is applied across organisational and service boundaries'. The hallmarks of such an approach are:

- Trust between organisations and professionals as to the validity of assessment carried out across the system
- A focus on maximising the independence of the people assessed, including the use of community and family based support
- A customer driven conversation, with the person regarded as the expert in their own needs to regain or maximise independence
- An assessment that can be updated by a range of practitioners as the needs and circumstances of the person change

Health Coaching

In the East of England, a train-the-trainer model was established in 2012 and a wide range of professionals have been trained to use health coaching in their caring interactions by a team of Physiotherapists, initially focusing on the West Suffolk Hospital workforce. Recognising the growing evidence base and the alignment with the wider public sector agenda for personal empowerment and a new relationship between citizens and services, in 2017 the Suffolk Public Sector Leaders agreed funding for a three-year programme to increase the training capacity and establish health coaching as a common approach in community-based services across Suffolk.

As well as bringing benefits to clients, and evidence that increasing self-management improves the efficiency of services, professionals commonly report that health coaching has a positive effect on their own wellbeing, decreasing feelings of overwhelm or burnout. The trainers can also provide advice on how to capture and measure this at a service level. Next steps involve Health Coaching leads from West Suffolk NHS Foundation Trust proposing to incorporate it into a West Suffolk Leadership Summit scheduled for December 2018. The topic is workforce resilience, and the event will be opened up to the whole system for the purpose of presenting Health Coaching firmly in the context of looking after the workforce.

Service users and clinicians in east Suffolk joined forces to create a suite of resources to further improve the care available to people reaching crisis point.

The 'Listen' project has seen people with first-hand experience of services work alongside clinical staff to develop posters and badges, which act as a reminder for anyone working with someone in a high state of distress.

They carry the acronym:

- Listen and look
- Involve and inform
- Share understanding
- Time and availability
- Empathise, encourage and evaluate
- Next steps in treatment

L	I	S	T	E	N
Listen	Involve	Shared	Time	Empathise	Next
and validate concerns Look at crisis / care plan and general options	and Inform the service user and carer of the immediate options available	understanding achieved and Safety issues established	be clear about your availability and be aware of your Tone of voice	and Encourage responsibility then Evaluate what has been agreed	steps made clear and Never end the contact without a plan

LISTEN was developed by service users, carers and clinicians in East Suffolk, to help those who work with people in distress

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Norfolk and Suffolk 
NHS Foundation Trust

Fig. 5: LISTEN graphic

6.3 IMPROVED ACCESS TO SERVICES

Lack of access to services was a strong theme emerging from the engagement exercise undertaken for this strategy. Our future model will breakdown the thresholds for initially accessing services and the barriers between services so people can get the right care at the right time. We will create a model where service users are easily able to access mental health services 24/7 including at times of crisis from a range of statutory and non-statutory partners.

We will learn and build from the single point of access created for children and young people which gives children and young people, parents and carers and professionals a single point of access for emotional wellbeing and mental health support.

6.4 INTEGRATION OF PHYSICAL AND MENTAL HEALTH

There is a huge opportunity for mental health and other health, care and wellbeing services to work in a more integrated fashion to support service users and the people who care for them with physical and mental health conditions. As the needs assessment described, more than four million people in England with a long-term physical health condition also have mental health problems, and many of them experience significantly poorer health outcomes and reduced quality of life as a result.

In terms of NHS spending, at least £1 in every £8 spent on long term conditions is linked to poor mental health and wellbeing - between £8-13billion in England each year. *'Long-term conditions and mental health: The cost of co- morbidities⁶⁷'* (Naylor, 2012), published jointly by The King's Fund and the Centre for Mental Health, suggests that care for a large number of people with long term conditions could be improved by integrating mental health support with primary care and chronic disease management programmes improving the provision of liaison psychiatry services in acute hospitals providing health professionals of all kinds with basic mental health knowledge and skills. We would expect our local services to explore all opportunities to better join up approaches for long term condition management such as diabetes, coronary artery disease, COPD, stroke, angina, congestive heart failure and cardiac disease.

CYP Emotional Wellbeing Hub (EWH) (Emotional Wellbeing Gateway)

Launched in April 2018, the Emotional Wellbeing Hub is a phone and web-based service, offering a central point of contact and information for anyone who is concerned about the mental health or emotional wellbeing of a child or young person under the age of 25 in east and west Suffolk. The vision for the multi-agency Emotional Wellbeing Hub is that no child, young person or their family will be turned away without being offered the appropriate help, information or advice they need.

The Hub features a number of best-practice elements within its design, including:

- A single phone number for children, young people, parents, carers and professionals to get help and advice on emotional health and wellbeing
- Open for self-referral and parent/carer referral
- Direct access to a new multidisciplinary team of highly skilled, sensitive and empathic Emotional Wellbeing Practitioners who will provide therapeutic support, guidance and triage in relation to concerns about a young person's wellbeing and mental health.
- Every referral receives a response - no wrong door
- Hand-holding to get to the right service for Early Help, Wellbeing Suffolk, Integrated Delivery Teams and other community service providers
- Peer support and volunteers as part of the team
- Extended hours, offering morning and early evening access to support
- Co-located at Landmark House with the existing Suffolk County Council Early Help Triage team and Suffolk Multi-agency Safeguarding Team (MASH)

Learning Disabilities and Transforming Care

Moving forward our aims are:

- To ensure a timely and coordinated response when people's needs are escalating to support them and their family, carers and support workers to enable them to stay safe and well at home. We will ensure that there is access to the right care and support at the right time in the right setting
- To ensure that there is good access to specialist inpatient assessment and treatment when health interventions need to be delivered in a hospital setting
- When someone needs a hospital admission, we will ensure there is a co-ordinated response so that the right package of care and support is available so that they can leave when they are ready
- To ensure equity of access to health and social care services to promote greater life expectancy
- We will work together to develop a local autism partnership that will improve the experience of people with autism - this needs to include improving the experience of and access to services
- We will ensure that our care and support providers have staff who are skilled in meeting complex needs and are committed to working in a person centred way that promotes choice, control and progression
- We want people with autism and people with learning disabilities to have equal access and effective treatment and will use the Green Light Toolkit to support this
- We will take a transformational approach to ensure that our mental health services for people with learning disabilities and autism are aligned and work in partnership with our learning disability and autism social work teams

Mental Health services for people with Autism

We have heard how difficult it can be for people of all ages to access mental health services if they also have a diagnosis of Autism. We want to change this so that they have access to specialist, **expert** mental health services from professionals who are trained in both mental health and autism. We know that early diagnosis can make a huge difference and we are

trying to address this through the development of the neurodevelopmental pathway for children and young people. We also know that we need to do more to help the system understand more about autism and provide support, including meeting sensory needs and providing reasonable adjustments and it is our aim to do this as part of the strategy.

Suffolk Needs Typing Approach

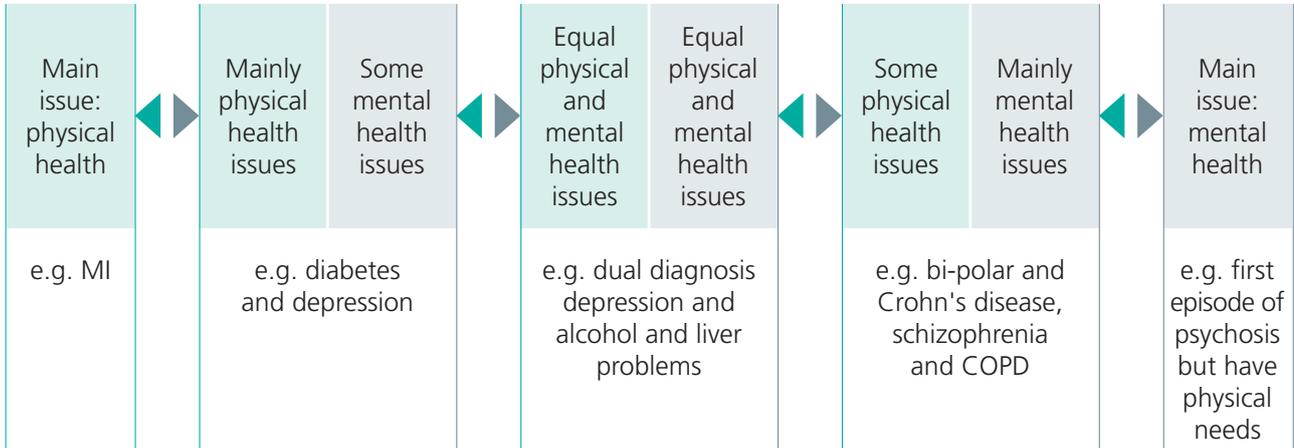
There is a wide variety of co-morbid physical and mental health conditions. An individual can present to primary care with one problem but have an associated, sometimes underlying sometimes secondary, difficulty that at times is not addressed. For example, a presentation for an ongoing physical problem (e.g. chronic asthma) which could have contributed to a worsening mental health condition (e.g. clinical depression). All too often the secondary problem can be ignored.

In order to simplify issues and to attempt to develop appropriate pathways that can be followed for appropriate intervention, it is easier to consider needs of service users as opposed to diagnoses. These can be separated into physical health needs and mental health needs (see Figure 6 overleaf).

Depending on predominance and/or urgency at specific times, different needs will give rise to different interventions provided by different agencies, e.g. service users whose physical health needs predominate but have an associated mental health issue could be managed in primary care with advice from mental health clinicians.

In addition, service users whose mental health issues are acute but also have physical health difficulties could be managed primarily within the mental health system until the acuity of mental health diminishes. 'Needs Typing' is an approach that can better support professionals to determine the best course of action to meet their needs.

Fig. 6: Needs Typing



There is a strong evidence base for systems to better understand how mental health and physical health are co-dependent, and also how the broader determinants of mental health all contribute to the population's mental health and wellbeing. Fig. 7 below illustrates the strong relationship between mental and physical health.

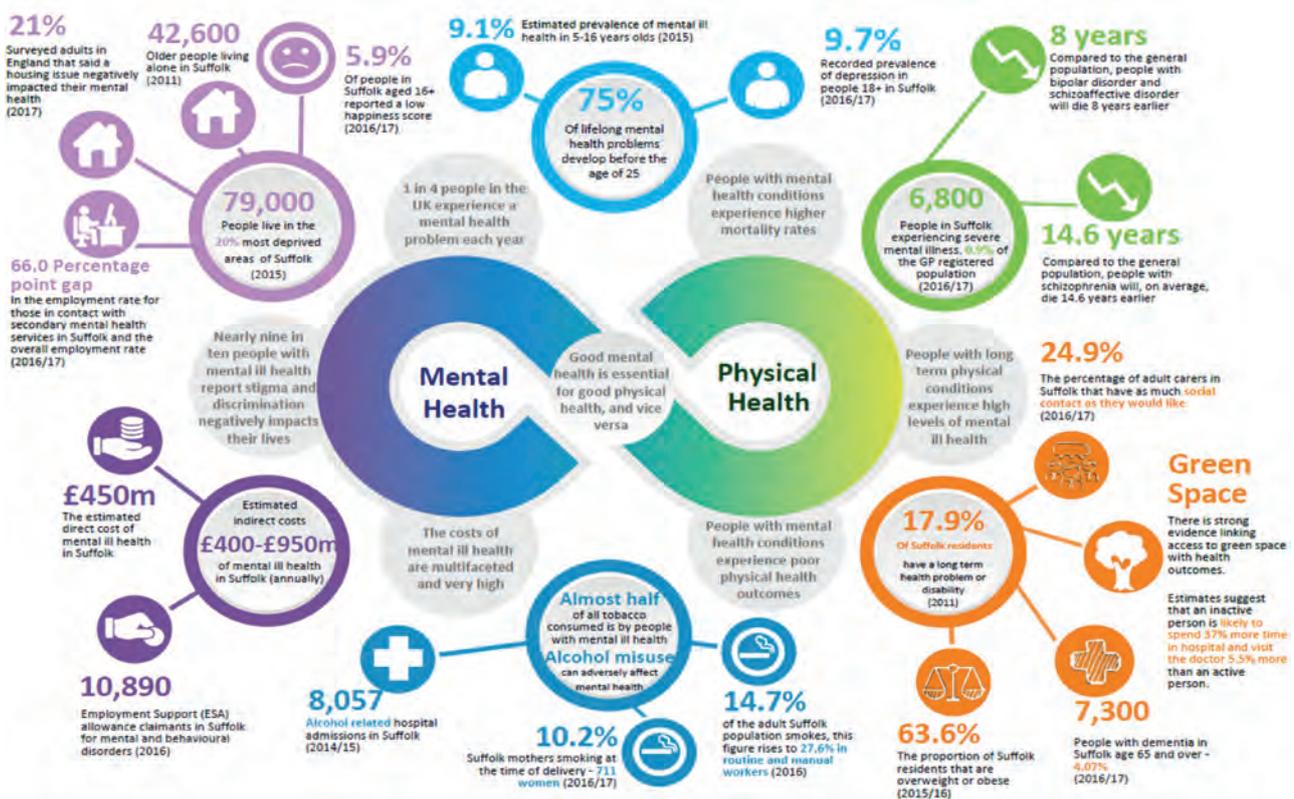


Fig. 7: Interlinked relationship between management of physical and mental health & key statistics

6.5 FOCUS ON CHILDREN AND YOUNG PEOPLE

We have heard clearly the importance of putting the emotional wellbeing and mental health needs of children and young people at the heart of our approach to mental health. We know that offering help and support early can protect healthy development and prevent problems later in life.

We have also heard that children and young people need a different approach to adults, taking into account their unique needs. This includes understanding:

- Physical, emotional, social and psychological development and how help and support might need to change as young people transition into adulthood
- The networks of important people, including family members, carers, role models, school staff and peer groups⁷
- Behaviour and other non-verbal ways of communicating emotional distress and coping with stress
- The role of social media and digital forms of communication as they relate to emotional wellbeing

This includes understanding the relative vulnerability of young people and their dependence on others to help safeguard their safety, health, wellbeing and opportunities for learning.

The Children's Emotional Wellbeing Group (CEWG) has articulated the model for delivering mental health needs of children and young people using the THRIVE model. This is consistent with the four quadrants model proposed within this strategy and aims to replace traditional concepts of service delivery based on severity or complexity with one that is based on needs-based groupings.

It is recognised that an integrated approach for mental health support for children, young people and families is different. There is a need for a far closer relationship with education and children social care settings and as articulated in the Green Paper, 'Transforming Children and Young People's Mental Health Provision' (DoH & DfE, 2017). This puts schools and colleges at the heart of prevention and early intervention of mental health difficulties

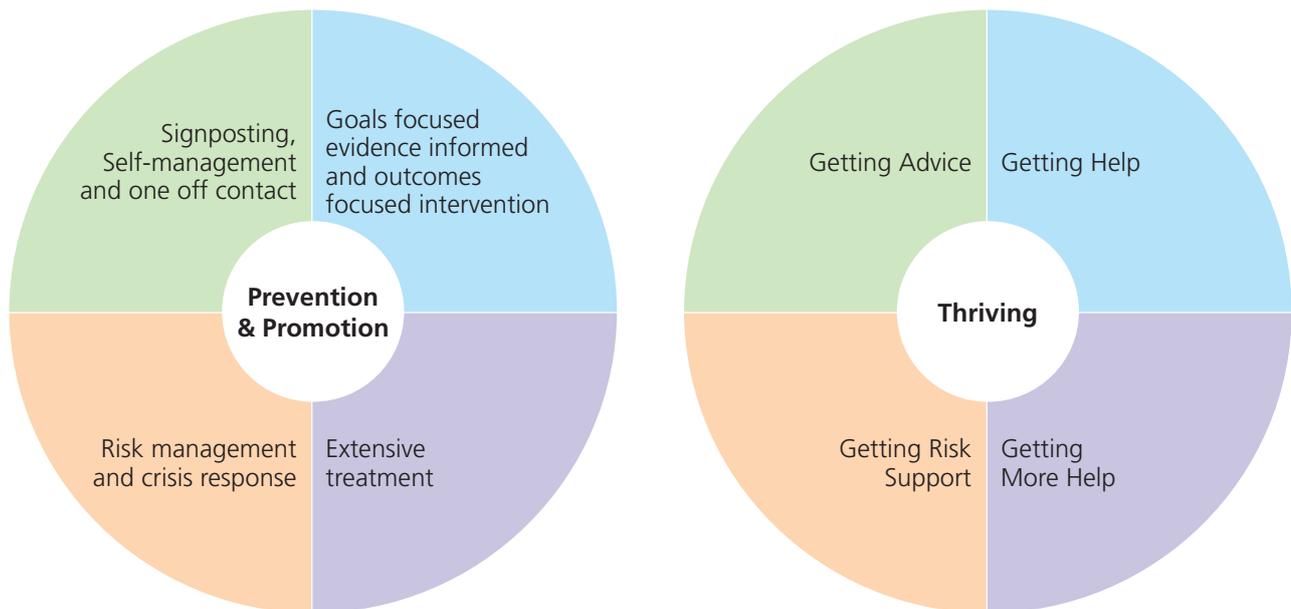
in young people. The Government wants children and young people to be able to access high quality mental health and wellbeing support linked to their school or college.

The CEWG decided to base its thinking on the Thrive Model, developed by the Anna Freud Centre (Fig.9). This model is consistent with the four quadrants and aims to replace traditional concepts of service delivery based on severity or complexity with one that is based on needs-based groupings, in an effort to address the lack of coordination between services in the face of rising need in key groups of young people and the increase in waiting times for specialist mental health services. Whilst the traditional four tier model has been helpful in describing the existing structure and remit of mental health services, the Thrive framework offers an approach that is based on the identified needs of children and young people. This approach is illustrated on the following page:



The circle on the right describes five themed groups of needs across the range of presentations. These groupings are not identified with type or severity of problem, but they are linked to the five groups of supportive activities shown in the circle on the left.

Fig. 9: Thrive Model



A particular service provider may offer support across different groups, but the Thrive model offers a 'whole system' view of the proportion of overall service resource required for each group (percentages indicated below).

- **Thriving (Universal / 15% of total service resource)** - prevention and promotion initiatives within the population aimed at keeping people well, promoting emotionally healthy environments and preventing psychological harm
- **Getting Advice (30% of need / 8% of total service resource)** - community, school-based and self-help support for children, young people and families adjusting to life circumstances, with mild or temporary difficulties
- **Getting Help (60% of need / 56% of total service resource)** - deploying focused, evidence-based interventions with clear aims and criteria for assessing whether aims have been achieved in supporting recovery
- **Getting More Help (5% of need / 14% of total service resource)** - extensive or intensive treatment for conditions such as Eating Disorders, Psychosis and complex presenting symptoms
- **Getting Risk Support (5% of need / 7% of total service resource)** - supporting children, young people and families who are currently unable to benefit from evidence-based treatments but remain a significant concern and risk

We will develop our approach to supporting the emotional wellbeing of our young population that recognises the need to provide support across all elements of the Thrive model. As well as ensuring our specialist mental health services are able to deliver timely, quality and compassionate support, we acknowledge the need to increase our focus on how we create the conditions that ensure that children and young people are able to thrive and get help early. Our partners play a critical role in helping us to achieve this.

We will ensure that in supporting the emotional and mental health needs of children and young people, we recognise the important role of parents and carers and we will consider and support the child as part of a family unit, which will include support to both fathers and mothers as part of the perinatal mental health provision.

We will work with those organisations and services who already provide support children and families to integrate the mental health and emotional wellbeing offer, taking every opportunity to provide early support and intervention from age 0-25 years. We want to make sure the mental health and emotional wellbeing needs of our children and young people and families are met, irrespective of a diagnosis.



Follow up appointments to see how they are still doing and perhaps being phased into being discharged to ease them into it.

Professional

Mental health and emotional wellbeing exist on a spectrum and we have heard that we need a way of providing mental health support that is flexible and responsive to the changing needs of all children and young people. We recognise that there are some children, young people and families who have circumstances that make them particularly vulnerable to mental ill health and we will work proactively to develop forms of mental health support that ensure their needs are met.

We know that the need for effective mental health support for children, young people and families is recognised as a key priority within a number of national and local strategies. We need to work more effectively with all those who provide support to make sure those in need get the support they require to be resilient and recover, irrespective of whether this is provided by the public, private or voluntary and community sector.

The need to take a curious and holistic approach to supporting a child and young person will be at the heart of how we understand and respond to need. We will develop ways to provide an integrated service delivery offer that take into account the emotional and physical health, social care and education needs.



She feels like whoever she talks to doesn't understand what's going on and they just want to fix her with tablets.

Carer

We will ensure that in supporting the emotional and mental health needs of children and young people, we recognise the important role of parents and carers and we will consider and support the child as part of a family unit.

The need to take a curious and holistic approach to supporting a child and young person will be at the heart of how we understand and respond to need. We will develop ways to provide an integrated service delivery offer that take into account the emotional and physical health, social care and education needs.

As part of developing the Mental Health and Emotional Wellbeing Strategy, the Local Transformation Plan for Children's Emotional Wellbeing has been refreshed⁹ (APPENDIX 8).

6.6 PEOPLE WITH SEVERE AND ENDURING MENTAL ILLNESS (SMI)

It is recognised that people with Severe and Enduring Mental Health problems often have complex difficulties that can include barriers to accessing support and treatment and have a reduced life expectancy compared to the general population.

Our response and support for people with SMI is therefore a priority for our new model of mental health. We will provide a safe, compassionate, assertive and enabling recovery focused service that will collaborate with service users, carers and peers to develop care plans that will meet their needs, delivered by a sufficiently resourced workforce with the appropriate skills and knowledge. This will include access to appropriate biopsychosocial evidence based care, treatment and interventions, Physical Health Checks and Individual Placement Support (IPS). IPS has been identified by the Department of Work and Pensions and NHS England as a promising intervention to address unemployment within mental health. IPS is a replicable, evidence-based, supported employment programme that has been shown to deliver superior employment and health outcomes for people with severe mental health problems.

6.7 ISSUES AFFECTING OLDER PEOPLE

Suffolk's increasing population aged over 65, alongside the dementia and long term conditions prevalence, will require an integrated approach to developing and providing high quality mental and physical health care. Our aim is to ensure that interventions and support are offered, where appropriate, at a person's home or place of residence. Admission to hospital can be damaging to long term recovery, and those with long term conditions are best suited to be cared for in their communities. To achieve this, professionals will be required to work collaboratively with service users and their carers to produce clear treatment plans that are adhered to and jointly owned.

We know that depression and loneliness in the elderly requires more attention in terms of both detection and treatment. Those with long term conditions such as COPD and Diabetes have a much higher risk of depression and need to be offered a variety of interventions that are proven to benefit. The elderly are not currently accessing psychological therapies as much as is needed, especially if they are housebound or living in residential or nursing care homes.

Dementia is a key priority for our Suffolk system which spans the four quadrants of our new service model. Extensive work has already been undertaken across Suffolk to improve services, including early support for individuals and carers, access to diagnosis, and providing dementia friendly environments.

As a system we can explore the opportunities for our physical and mental health services to work more collaboratively in the future to meet the needs of the older population of Suffolk. The aspiration for Suffolk is to provide a facility where people can easily access a multi-agency approach where service users and families can access timely diagnosis, support and interventions required especially when people are experiencing cognitive problems, and in particular when they receive a diagnosis of dementia.

Dementia Together

Dementia Together is commissioned from Sue Ryder, providing a comprehensive bespoke service to support people living with dementia, their carers, families, friends and professionals to empower them to live independently longer. The services is for anyone in Suffolk who is curious or concerned about dementia. The service can be accessed via self-referral or via a professional, and provides the following:

- The service ensures that the person only tells their story once
- Working in partnership with general practice, hospitals, memory clinics, schools, voluntary sector, councils, boroughs, other dementia organisations and dementia action alliances
- Raising awareness in the community and helping to reduce the stigma of dementia
- Promoting early intervention and offering support to those prior to diagnosis, during and throughout their journey, as well as supporting independent living
- Promoting access to wellbeing, physical, mental and emotional health and signposting to local services
- Offering age inclusive bespoke support for those diagnosed with dementia, including Dual Diagnosis
- Working with the hospice to provide support for those living with other long term conditions and dementia, together with their families.

6.8 PERSONALITY DISORDERS

There are estimated to be around 84,000 people aged over 16 in Suffolk with enough traits of a personality disorder to justify further investigation. People with personality disorders are likely to have other mental health conditions, which must also be treated (i.e. anxiety disorder, depression). Key challenges for this group include managing relationships, including seeking support from care agencies. Feeling overwhelmed, vulnerable and unsafe are also features of personality disorder. Analysis of data for mental health service users in the STP by NHSE identified that people with personality disorder have the highest rate of A&E use compared to other groups including presentation in extreme distress and with self-harm. There is also a greater risk of suicide in this cohort, compared to the general population. Diagnosis of Personality Disorder can lead to stigmatisation and exclusion from services.

Our future system should seek to provide increased compassionate, non-judgemental consistency of approach whereby the needs and challenges of this group are better understood and supported by the care system. This may include:

- Better education and awareness raising for universal staff (including GPs, A&E)
- Early identification and intervention within Education and other settings
- Skills development for individuals, their families and carers (e.g. involvement of experts by experience)
- Access to quicker professional support from mental health professionals (i.e. Psychologist to GP)
- Availability of Psychological Therapy (including Dialectical Behaviour Therapy - DBT) where appropriate
- Access to support for educational, work and leisure opportunities that give a sense of connectedness, hope, identity, meaning and empowerment (CHIME)
- Access to crisis prevention and crisis intervention services (e.g. Night Owls Service)

Suffolk Night Owls

The CCGs and Suffolk County Council jointly commissioned 'Suffolk Night Owls' service, which commenced in January 2015 with the aim of providing telephone support to enhance the quality of care for individuals with Borderline Personality Disorder (BPD), and to reduce inappropriate usage of the NSFT Crisis Line and NHS 111 line, A&E and acute hospital admission and police involvement. The telephone help-line is operational four nights a week between Thursday and Sunday night, between the hours of 8pm and 2am. The staff on the helpline:

- Support the person with their immediate crisis and assist them to develop strategies to deal with life events and gain insight regarding their mental wellbeing
- Suggest techniques for reducing anxiety and negative thoughts
- Focus on keeping the client safe and encouraging them to develop self-help strategies and resilience
- Signpost to the relevant service if deemed necessary
- Call in the support of emergency services if required

Public Health Suffolk carried out evaluations of the service in 2016 and 2017, including a survey of people using the service which showed that people found the service helpful and reassuring. Early findings from data analysis were encouraging and showed a reduction in A&E attendances, calls to 111 and to the NSFT crisis line for those receiving services.

6.9 DIGITAL

We wish to make the most of all digital opportunities to improve services for service users, families and carers and professionals. This means enabling technology and infrastructure to support clinicians to work across different care settings, and in new ways. It also means enabling technology to support service users to access services and support more effectively. The focus on digital services will building on work already underway in the county, including at WSFT who are a Global Digital Exemplar, meaning they have been given funds to transform the way they care for service users.

We expect our future health information systems to work towards full interoperability across services to better support professionals and service users. This will include GP systems in primary care, hospital and community services, and mental health joining up. In practical terms this means:

- Moving towards more shared records between practitioners and organisations is part of the first and most basic building block. Work is underway to ensure this is understood at all levels and within all organisations.
- Remote access to information & communications (e.g. to enable Virtual MDTs).
- Multi-agency view of crisis & care plans can (and should) be achieved using in situ technology (such as SCRai) - NHSE have stated it is a requirement.
- Capabilities to empower service users such as person-centred technologies. These could include apps, wearable technologies, and other digital health options.¹⁰ These technologies must be clinically led to ensure any proof of concept applications are safe and have clearly defined benefits for service users.
- The priority is to ensure all parts of the system have these basic capabilities to free up time to care, and to empower service users to support their own care where possible.

Patient Records

Our vision is to move towards a single patient record, whereby all health and care professionals who need to see it, can. The record should follow patients, who can also see it. The ability to have a shared patient record gives wider system benefits such as ensuring patients do not have to repeat information unnecessarily, and can protect vulnerable patients. For our clinicians and care staff throughout the system it will enable better efficiencies, and less administrative 'chasing' for information. An additional benefit in bringing the data together would be to start to understand disease patterns and outcomes, and would help with aligning the needs of the population with commissioning outcomes.

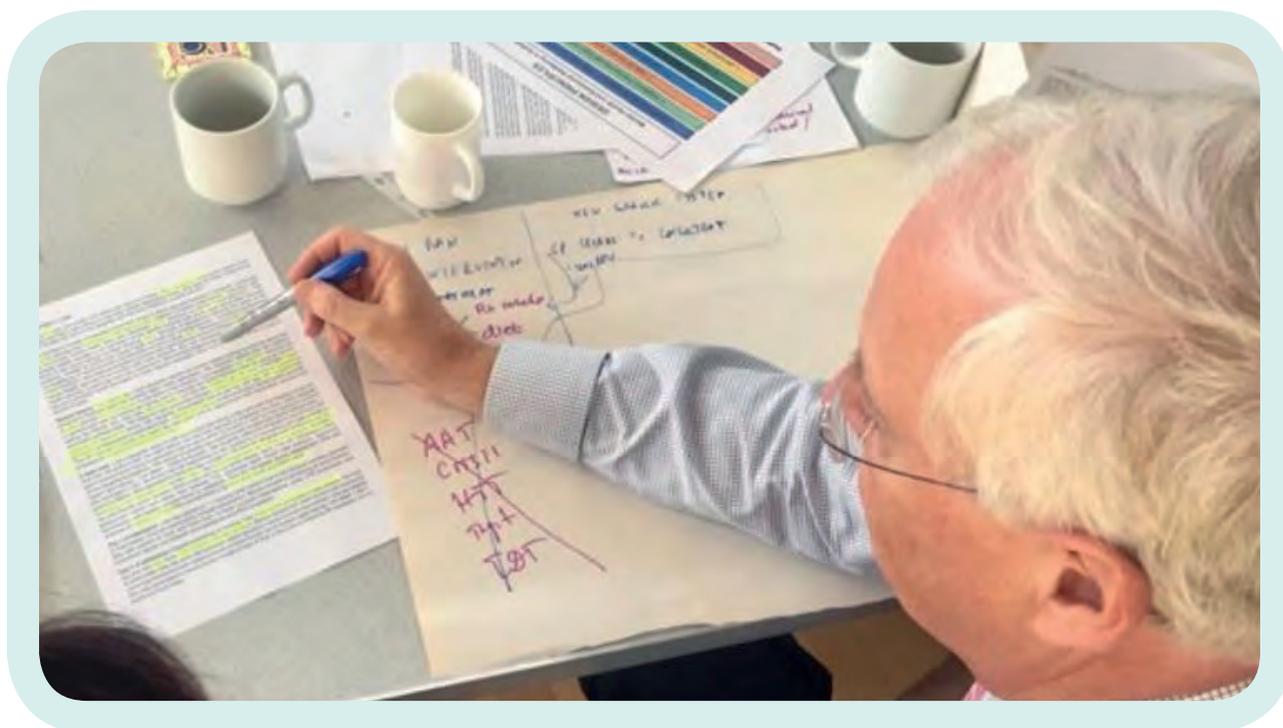
The richest source of patient information currently sits within the GP record, though there are many other services who also input into this record, or other disparate patient record sources. GPs also administrate the Summary Care Record (SCR), which contains basic patient information such as the medicines you take and any allergies you might have. Nationally, only SCR is currently shared out (unless patients have specifically opted not to share). However, potentially vital extra additional

information can also be added to the SCR and shared with other health professionals, this is called SCR with additional information (SCRai).

Within Suffolk, sharing your health record means consenting to share both an SCR with additional information (SCRai) and your GP record. A patient's decision about sharing, or not, is added to the GP system, which then enables other health professionals to access the information. In an emergency, this additional information could be lifesaving.

The NHS in Suffolk is continuing a publicity campaign which aims to raise awareness of the advantages of agreeing to 'opt in' to share your health record and your SCRai. At present, while the SCR are shared across all health settings, in line with patient consent, the ability to see all elements of a patient record is not currently available.

From a specific mental health perspective, there is a need to support patients with additional physical conditions / comorbidity. In order to support these patients, a single patient record would ensure clinicians are able to treat those patients more effectively.



Wider Digital Technology Use

The CCG is keen to further explore the use of digital technology to support better service user care, and in 2019 will be launching a pilot for the use of an online life skills course for service users age 16 and above registered with a GP practice in east and west Suffolk areas. This will help service users to easily access support and treatment for common mental health conditions at times convenient to them. The course will enable quick access into IAPT if required and includes support from mental health professionals to use the materials and reach recovery.

Other areas of digital technology, such as use of social media information, self-help facilities and the potential to use online consultations are all under review to improve access and signposting into available services, taking into account the need to ensure that services are accessible to all regardless of their technological literacy and abilities. e.g. Turning Point emodules to support people seeking treatment for substance misuse

Population Health

One example of the work already underway in Suffolk to begin work on the management of trends and wider service user planning is within the WSFT health platform.

This draws from other electronic patient records. The platform aggregates and distils the data, cleanses it, then produces a record for viewing, data for analysis and the ability for service users to view their own record. WSFT have enough funding to undertake this programme for the west Suffolk population (275,000).

This work is in its early stages; however, we believe system-wide benefits will come from the algorithms and artificial intelligence used to ask questions of the data, which will enable system-wide questions to be asked and analysis drawn to provide valuable information for clinicians.

6.10 DISCHARGE / TRANSITION FROM SERVICES

The service user engagement exercise as a foundation of this document has highlighted that discharge from services can be un-therapeutic and can cause levels of stress and anxiety for the service user and those who care for them. Greater integration and the relationships formed by these connections will allow for service users to transition between the different levels of care based upon their need. In some cases there will be ongoing active engagement for service users with severe and enduring mental illness.

There will be collaborative planning with service users and the people who care for them about how to overcome anxieties about what is needed in the ongoing plan for discharge. Part of this will be clarifying how service users are able to access a higher level of support if they need it.

6.11 SELF-HARM

The Local Transformation Plan for Children's Emotional Health and Wellbeing has a new priority to look at this issue of self-harm amongst children and young people. It will form part of its approach with schools and inform how services are commissioned and delivered going forward.

Appropriate interventions will be available in schools, the Primary Care Mental Health Service and urgent care as appropriate, with an emphasis on community based prevention and wellbeing. More seriously ill people will be fast-tracked towards specialist services.

6.12 SUICIDE PREVENTION

In October 2016, Public Health Suffolk published the countywide suicide prevention strategy, Suffolk Lives Matter¹¹, and launched the Suffolk Lifesavers campaign. Since then a multi-agency team has worked towards delivering the Mental Health Five Year Forward View¹² to reduce suicide by 10% by 2020/21. The work has included piloting a Suicide Liaison service, Amparo Suffolk, to immediately support people bereaved by suicide and the development of the Staying Alive suicide prevention app for Suffolk. Aspirations for the future include rolling out a systematic approach to suicide prevention training, creating a comprehensive intelligence hub and supporting children and young people's emotional wellbeing¹³.

6.13 WORKFORCE

Staff are our most valuable resource and the key to providing a compassionate and effective service that meaningfully integrates physical and mental health intervention. We are therefore committed to ensuring staff are, and feel, valued and supported so that they can provide the ambition we have in mind.

To achieve the aims of the new model the workforce will be developed with potential new roles and engagement with partners to enhance both service delivery and staff aspirations. Examples include increased roles for non-medical prescribers, advanced nurse practitioners, clinical psychologists and psychological therapists. This includes possible introduction of the role of associate psychologist - a role focused on delivery of psychological therapy to an identified client group under the oversight of clinical psychologists to increase access to psychological intervention for those whose needs are not met by IAPT services.

There may also be the introduction of prevention/recovery link workers within primary care settings to help people access social, work, leisure opportunities that enhance sense of connectedness, hope, identity, meaning and empowerment that are the things that help us all maintain better wellbeing. The expectation is that these workers will support people making the transition from mental health to primary care and help ensure that the benefits of treatment are maintained. There will be more roles for people who are experts by experience to enhance governance and quality of care, advocacy and co-production.

There will be system-wide learning opportunities for staff from different organisations to learn together to enhance integration, improve confidence, consistency and quality and support cultural change. We will learn from best practice locally and nationally about learning approaches that effectively support the implementation of the Five Year Forward View.

We will be working closely with the Primary Care Training Hubs to create a system wide approach to innovative training and skill improvement. This will allow a shared knowledge base that will enhance both staff and service user experiences by breaking traditional silos.

We believe that staff sharing skills and experiences will create one NHS working alliance.

We will extend the outcome focused and evidence based interventions approach to working with CYP introduced as part of CYP IAPT principles and continue to support the workforce to participate in CYP IAPT training. Continue to train and develop our CYP Wellbeing Practitioners who are currently working within the Suffolk Wellbeing Service. Training for all workers across the board who are supporting CYP (be they teachers, social workers, GPs, nurses, etc.) is probably the single most important thing coming from young people to ensure that they have the right approach, response, understanding, sympathy/empathy, etc.

The principle of mental health being everybody's business is credible but it means that all parts of the system need to commit to raising awareness amongst its workforce and providing a level of training which can support this expectation. This extends beyond the public sector into the private, voluntary and community sector.

We will listen to what our service users tell us matters most about those who provide them with services and reflect this in the approach to workforce development.

The wellbeing of the staff directly affects the quality of the service people receive. To ensure parity, the workforce will have access to ongoing support in the form of supervision, training in the use of outcome measures, contribution to commissioning processes where appropriate and access to thinking space.

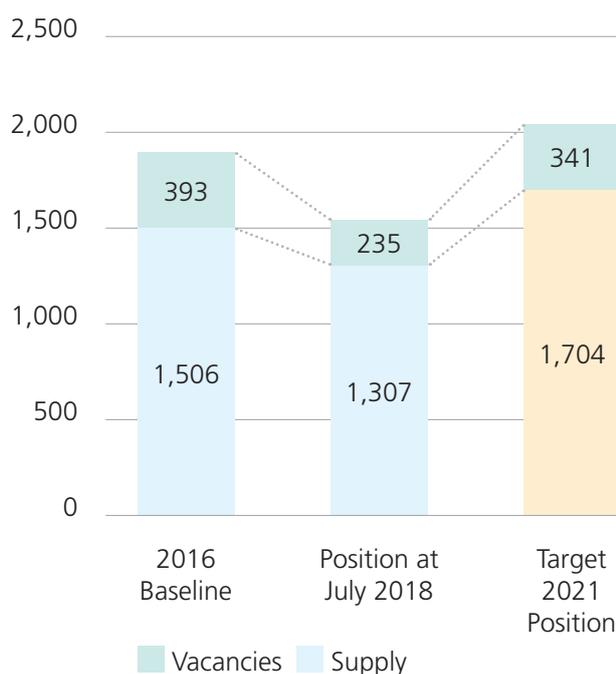
NSFT has had 72 whole time equivalent budget increase between the 2016 baseline and July 2018. However, filling these extra roles, along with the vacancies already in the system has been challenging. They have had a 20 headcount increase in posts in Suffolk since 2016, but their vacancies have grown also. Medical staff and entry level nursing roles are areas where we have the highest vacancy rate. This impacts upon progression into higher bands and overall workforce planning.

Fig. 11: Current NSFT Supply and Demand

NSFT Position	Demand	Supply	Vacancies
2016 Baseline	1470	1287	183
2018 - July	1542	1307	235
Change	72	20	52

Fig. 12: Current Norfolk and Suffolk Growth to 2021

The waterfall highlights the current projected supply and demand for mental health staff in the Suffolk and North East Essex STP footprint.



There will be parity of access to evidence based intervention in similar mental health services across Suffolk. This means that, where there are current gaps in access to NICE guidance informed intervention, strategic plans will be developed to address this.



³ <http://open-dialogue.net/>

⁴ <https://www.nice.org.uk/about/what-we-do/our-programmes/nice-guidance/nice-guidelines/shared-decision-making>

⁵ <https://improvement.nhs.uk/resources/developing-trusted-assessment-schemes-essential-elements/>

⁶ Naylor, Chris and Parsonage, Michael and McDaid, David and Knapp, Martin and Fossey, Matt and Galea, Amy (2012) Long-term conditions and mental health: the cost of co-morbidities. The King's Fund, London, UK.

⁷ This includes understanding the relative vulnerability of young people and their dependence on others to help safeguard their safety, health, wellbeing and opportunities for learning.

⁸ https://www.annafreud.org/media/2552/thrive-booklet_march-15.pdf

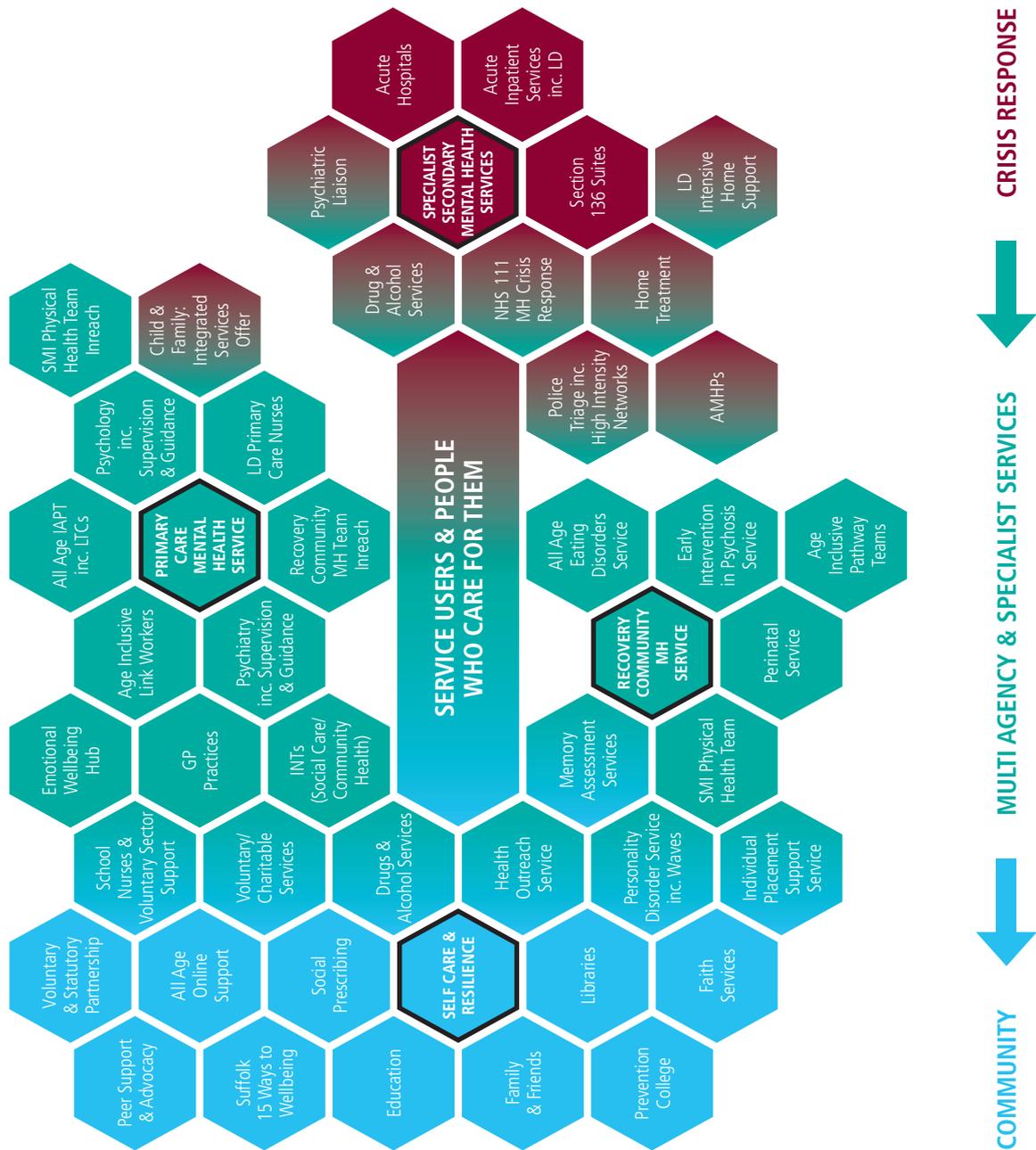
⁹ <http://www.westsuffolkccg.nhs.uk/wp-content/uploads/2018/11/Suffolk-Local-Transformation-Plan-Oct-2018.pdf>

¹⁰ www.ncbi.nlm.nih.gov/pmc/articles/PMC5682364/
¹¹ <https://www.healthysuffolk.org.uk/projects/suffolk-lives-matter>

¹² <https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf>

¹³ www.healthysuffolk.org.uk/suffolklivesmatter

Fig. 13: The Suffolk Model
Suffolk Mental Health & Emotional Wellbeing Hive



7. THE FUTURE SUFFOLK MODEL



7.1 INTRODUCTION

The Suffolk Mental Health and Emotional Wellbeing Hive diagram (Fig. 13) on the preceding page illustrates the range of Suffolk mental health and other complimenting services/functions that are in place to support mental health and emotional wellbeing in east and west Suffolk. The diagram indicates the range of services that can support individuals and their families/carers through the four quadrants of Self Care, Universal services, Additional Community Support and Specialist Services. The diagram also illustrates the complimenting and interdependent nature of system wide services supporting the broader determinants of mental health and emotional wellbeing. A fuller description of the four quadrants in our future model are set out below.

7.2 SELF CARE

When people have the tools, information and advice to self-manage their health, wellbeing and social care needs, the whole system will support service users and the people who care for them at every stage to stay well mentally and physically. This will include information about local community networks e.g. groups, societies, clubs and other services within the community including help for people to link up with them. This will result in better outcomes and quality of life for individuals, families, communities and organisations.

There needs to be a range of materials and interventions using technological solutions where appropriate but being aware that not everyone has access/wants to use technology. Such support should build on what already exists and could include:

- Developing a Suffolk-wide umbrella group for overseeing the broad range of existing peer support and groups available
- Voluntary sector groups offering specific support and courses e.g. Freedom, Shine, Escape the TRAP (for domestic abuse victims), Survivors in Transition, Suffolk Mind
- A directory of resources - by geography/local level - new or improvement on Info link
- Web-based materials
- Greater use of Social Prescribing - different by geography
- Workforce Training i.e. Suffolk Needs Met / Mental Health First Aid
- Greater use of libraries including SAGES
- Further development of peer support
- Public Health commissioned services such as One Life Suffolk and ActivLives
- Smoking Cessation
- Obesity/weight management
- Physical exercise
- 5 Ways to Wellbeing and 15 point diagram
- Suffolk Needs Met
- Reference to Public Health led (Prevention Concordat)
- Local Borough - Leisure and Housing
- Private Provision
- Sports and Leisure clubs and community groups
- Debt Advice
- Employment Advice
- Citizens Advice Bureau
- Brief intervention for substance misuse

Conversations have focused on the role of self-care, accessing additional support from universal and community services through to more specialist support. Feedback has clearly indicated that people should be encouraged to be resilient and take control of their lives where they feel confident to do so, but have quick and timely access to additional support when this is required. For this to happen, feedback from our engagement has indicated that a Suffolk wide (with geographic locality detail) emotional health and wellbeing directory of services needs to be created or at least further developed from existing resource.

Prevention College

The concept of a 'prevention college' should be developed to include access to learning to enhance resilience and reduce vulnerability to mental health and wellbeing difficulties for service users, the people who care for them and staff and the local community overall. Some learning opportunities exist already and this approach could include them in a systematic effort to empower the population of east and west Suffolk. The learning opportunities will be available across

the county and in peoples' homes via digital options where appropriate. Examples of learning to increase resilience could include a focus on knowledge and skills to reduce likelihood of self-harm and drug and alcohol use, and to enhance emotional wellbeing in relation to the use of social media, being a member of a stigmatised group, work and retirement, caring and bereavement. It could enable parents and carers to help their children develop emotional skills that will be protective and members of the community in general to develop skill and confidence in suicide prevention.

Suffolk's 15 Ways to Wellbeing

Health is determined by a complex interaction between individual characteristics, lifestyle and the physical, social and economic environment. Most experts agree that these 'broader determinants' of health' are more important than health care in ensuring a healthy population.

The '5 Ways to Wellbeing' were researched and developed by the New Economics Foundation¹⁴ to set out five steps to support an individual's emotional wellbeing. The Suffolk '15 Ways to Wellbeing' (Fig.14) expands to include the physical, emotional and environmental themes that can contribute to an individual's wellbeing.

Fig. 14: Suffolk's 15 Ways to Wellbeing

Physical	Weight - if we are heavier, or lighter, than our ideal weight, we are more likely to have health problems	Be Active - physical activity helps us live a longer, healthier life	Diet - a balanced diet helps keep us healthy and happy	Smoking - smokers tend to live a shorter, less healthy, and poorer life	Drugs and Alcohol - it is safest to drink fewer than 14 units a week on a regular basis, and to avoid recreational drugs
Emotional	Connect - social networks increase our sense of belonging and wellbeing	Be Active - physical activity is one of the most effective ways to improve your emotional health	Take Notice - being aware of what's going on enhances wellbeing	Keep Learning - learning new things at any age helps us remain happy, and confident	Give - helping others is rewarding
Environmental	Employment - regular, fulfilling employment that is paid at a good rate, or voluntary work, increases self esteem, and gives purpose	Housing - we all need affordable, warm, dry, safe and comfortable housing	Family and Medical History - our 'health inheritance' and medical history may mean that we need to take extra care	Pollution - we all need fresh air, inside and outdoors, and clean water	Poverty - if we have enough money to live decently, it is easier to be healthy

The Suffolk '15 Ways to Wellbeing' helpfully outlines why it is everyone's business to support emotional health and wellbeing and why it is that the Suffolk whole system need to look at what they can and do contribute to improving overall emotional health and wellbeing for the population as a whole.

7.3 UNIVERSAL HEALTH - PRIMARY PREVENTION & CARE

Developing The Universal Offer

During 2018/19 the two Alliances in Suffolk have made a lot of progress in their development and delivering significant change to the local population, including now running community health services across Suffolk. Our local alliances are made up of WSFT, ESNEFT, Suffolk GP Federation, SCC and NSFT, alongside a number of wider partner agencies from health, care and wellbeing.

Working closely with the CCGs, our Alliances now have local strategies in place to continue to meet the challenges our local population face and see much closer integration of health, care and wider wellbeing services. The CCGs are committed to working with the Alliances and indeed are playing a key part in the development of delivery plans to ensure the Alliances deliver the ambitions/objectives which are set out below.

The West Suffolk Alliance aims to deliver four interconnecting ambitions:

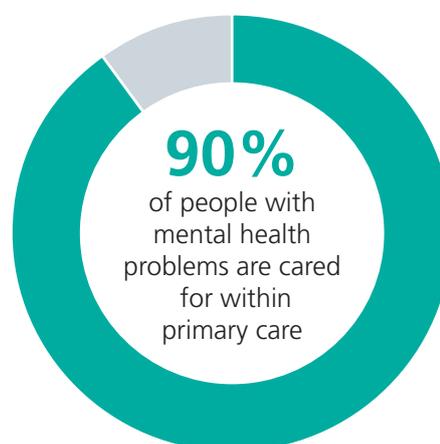
- Strengthening the support for people to stay well and manage their wellbeing and health in their communities
- Focusing with individuals on their needs and goals
- Changing both the way we work together and how services are configured so that health and care services are sustainable into the future and work well for people
- Making best use of Resources

The East Suffolk Alliance has the following objectives:

- To help people to prevent ill health and manage their own care
- To deliver planned, responsive, joined up health and care services
- To deliver innovative solutions supported by technological and digital infrastructure
- To provide services as close to people's homes, as possible
- To create One Team to facilitate the best holistic care and to retain and attract the best talent
- To reduce duplication and waste

- To move resources from acute to community and home settings
- To develop a vibrant, sustainable Alliance between providers and with commissioners

This statistic includes people with serious and enduring mental illness (SMI)¹⁵ (Royal College of General Practitioners). It is therefore vital that General Practice is fully equipped and supported to be able to respond appropriately. This includes training for primary care and quick access to specialist mental health support when needed. Our new model will address these issues.



We need to ensure that primary care provide a consistent offer to service users presenting with mental health issues. All Suffolk Alliance members are deeply engaged in this programme, and are working in partnership with people with lived experience of our services to ensure the best possible join-up of physical and mental health services for people of all ages in our communities.

As part of this programme, system-wide conversations have enabled us to focus on what needs to change in order to meet this challenge locally. We have established that we need better awareness of and systems to find 'what's out there'; real investment in social prescribing (this is a culture change for both practitioners and service users); effort to build communities and reduce social isolation; stronger links between mental health and wellbeing support and other services and to involve the VCS, education, faith communities, businesses, the arts and citizens of Suffolk.

The specific ambitions for Primary Care are safe, local, high quality care delivered by local practices and other organisations working together seamlessly to care for service users effectively and at a sufficient scale to facilitate the provision of an enhanced range of services. In line with the Alliances, there are system-wide commitments to invest resources transparently, in line with the overarching strategy and values. The workforce strategy will develop generic worker profiles, improving career opportunities, sustainability, and training opportunities. Public Health have identified, as part of the Mental Health Needs Assessment refresh, a suite of condition-specific case studies based on prevalence, existing provision and gaps. We seek to address the education gaps and upskilling of primary care staff in order to deliver safe, local high quality care, ensuring that the workforce feel confident and competent to meet this ambition for these service users and the people who care for them.

Average GP list of 2,000 patients will have (at any one time):

352	with a common mental disorder
352	with a sub-threshold common mental health problem
176	with a personality disorder
126	(of 500 with a long-term condition) with a comorbid mental health problem
120	with alcohol dependency
120	with a sub-threshold psychosis
100	with MUS (medically unexplained symptoms not attributable to any other psychiatric problem)
60	with drug dependency
8	with psychosis
7-20	people identifying as trans/non-binary
2	new cases of eating disorder p.a.

We propose to develop an evidence-based programme of mental health and emotional wellbeing educational sessions for primary care staff. The programme will be shaped around the findings of the Suffolk Joint Needs Assessment with sessions to be delivered outside of core hours to enable maximum attendance. They will be delivered in partnership with local providers; by upskilling primary care staff to support more people with mental ill health, this will reduce the demand on secondary mental health care and allow them to dedicate resource to those with severe and enduring mental health and co-occurring conditions with the greatest level of need.

Suffolk User Forum - Desktop Review of GP Websites

SUF have carried out some reviews of mental health information available to service users on GP websites. The initial idea was around understanding that talking to a doctor about mental health problems can feel very difficult for many people, and that many people did not know how to begin this conversation or how to find the range of support that might be available to them in Suffolk. They did not always know that they could self-refer to the Suffolk Wellbeing Service or speak to a mental health professional at their surgery. The review was repeated the following year in order to understand how practices had responded and developed their information about mental health resources. It found that all surgeries were offering some form of online service user information, either through a shared or independent website. This exercise will be repeated periodically to ensure information available to people is up to date, accessible and easy to understand.

Services For People with Severe and Enduring Mental Illness

People with SMI are supported across the four quadrant model. Specialist mental health services will be accessed through the link worker role and/or the Primary Care Mental Health Clinics when a more intensive approach is needed.

SMI Physical Health Checks

We are committed to reducing the premature mortality among people living with Severe Mental Illness. CCGs have received guidance from NHSE to improve the quality of physical health care for people with SMI in primary care to ensure that at least 280,000 people with SMI have their physical health needs met from 2018/19 onwards, and therefore face reduced risk from preventable serious illnesses, including cancer, heart disease and diabetes.

Improving Physical Healthcare for People with SMI¹⁶ details the action and collaboration required by commissioners. The implementation of the CCGs' action plan aims to achieve, by the end of 2018/19, 60% of the population with SMI on the GP register receiving an annual physical health check and appropriate follow-up care. 50% of these checks are to take place in primary care and 10% are to take place in secondary care. People with SMI die on average 15 to 20 years earlier than other people. This is mostly due to physical health problems which are often not diagnosed or managed efficiently and lifestyle factors which negatively affect physical health.

Annual physical health checks for people with SMI provide an opportunity to detect physical conditions and health risk behaviours, and to offer appropriate and timely interventions. Regular physical health checks, which include lifestyle and family medical history and routine tests such as weight, blood pressure, glucose and fats or lipids, can identify potential problems before they develop into serious conditions.

In addition, the CCGs have commissioned a Physical Health Team to provide support to primary care in order to engage with hard to reach service users and provide governance to a team of Clinical Support Practitioners in order to support the 50% primary care and 10% secondary care targets for enhanced health checks.

It is everyone's responsibility and for individual organisations themselves to identify what they can and should be doing to increase parity of esteem and raising the profile of mental health and emotional wellbeing. ESNEFT, one of the local NHS hospital trusts, have committed to be the first hospital in the country to become a 'Mentally Healthy' organisation.

Mental Health Provision in Acute General Hospital Health Setting - East Suffolk & North Essex NHS Trust (ESNEFT)

ESNEFT are making promotion and support of physical and mental health and emotional wellbeing a corporate priority. Focusing on improving education and support for ESNEFT staff and the role of the Psychiatric Liaison Service, they have an aspiration to create and be the first 'Mentally healthy Hospital' kite marked organisation in England. They will provide:

- All new environments which are mental health friendly
- Clinical staff equipped with sufficient base level of emotional & mental health knowledge and training to support service users
- Delivery of care to those who need mental health specialist care, measured by safety, experience, timeliness and environment
- Clearly signed appropriate services to support staff
- Service users with long term mental health conditions have quick access to specialist healthcare services to maximise their physical outcomes



I am a parent of an ASD child who needs mental health support. Years have gone by and he is still waiting for help. I have to support him without support myself.

Service user or member of the public

Mental Health and Emotional Wellbeing Training and Awareness Raising

There are a range of ways in which all organisations can make mental health and emotional wellbeing everybody's business. This can include commissioning of training packages for staff including 'Mental Health First Aid' which is a course that teaches the individual to help someone who is developing a mental health problem or experiencing a mental health crisis. The training helps identification, understanding and tools to help respond to signs of mental illness. The SNEE STP are currently arranging a series of Mental Health Awareness and First Aid Training led by Essex Partnership University NHS Foundation Trust (EPUT).

In early January 2019, members of the I&ESCCG and WSCCG signed the Time to Change employer pledge. This action signalled their commitment to promoting positive mental health in the workplace.

Mental ill health has been cited as one of the main causes of absence at work by Time to Change, a campaign launched in 2007 and championed by national charities Mind and Rethink Mental Health.

The CCGs have developed an action plan outlining how they will meet the new pledge's requirements. The plan includes 24 separate actions, which the CCG will look to carry out. These include carrying out an emotional needs audit across the CCG workforce, as well as mental health awareness training provided by Suffolk Mind.

The next section sets out our future plans for developing our enhanced community service offer for east and west Suffolk.

7.4 ACCESS & BRIEF COMMUNITY INTERVENTIONS

New Primary Care Mental Health Service

We envisage a very different relationship between GPs, Practice staff and mental health and wellbeing services. We expect all practitioners to work in a collaborative way to identify and meet the holistic needs of the local population. The model we are going to describe includes simplified access and an offer of advice and guidance for professionals,

assessment and brief intervention. The service will be age inclusive and with access through schools and colleges as an alternative choice of gateway to services for service users and the people who care for them.

We intend to embed mental health input and dialogue into primary and community care settings so that it becomes a full and integrated part of day-to-day consultation and intervention in the east and west Suffolk system. Our new proposed Primary Care Mental Health Service will be different. It will provide quick access to specialist mental health support for professionals and service users alike in community locations negotiated with clusters of GP practices.

Mental health professionals should liaise with each other and support service user journeys through mental health services as appropriate. We envisage a growing relationship to be developed between mental health services and our Alliance partners, in particular ESNEFT and WSFT to better support a response to mental health and physical health conditions.

We wish to move away from a place where standalone mental health services can only be accessed through meeting clinical thresholds, to one where integrated, locality-based teams work together to meet the needs of service users.

GP Mental Health Link Worker

Each of our CCG member GP practices will have access to a mental health Link Worker who will also be aligned to their local INTs. Link Workers will provide the conduit to mental health services for the GP Practice and will work with other professionals to assess need and provide support as well as:

- Signposting to a resource that can help
- Link to appropriate social prescribing
- Linking with wellbeing navigators
- Liaison with education
- Provide brief time limited interventions and step up/step down care
- Quick access to primary care mental health clinics or acute mental health services

NB: The multi-agency Emotional Wellbeing Hub will continue to support emotional health and mental health self and professional referrals for 0-25 years due to the need to have multiple access points for CYP.

We want a fluid relationship with our mental health services where service users flow seamlessly from Link Workers to community based Primary Care Mental Health Clinics and Recovery Community Mental Health Teams, and access crisis services when required.

Additional Specialist Mental Health Support

The Primary Care Mental Health Service will offer an age inclusive approach with the workforce specialising in meeting the needs of Children and Young People between the ages of 0-25 years and adults 25 years plus. Children and Young People and the people who care for them will have easier access to mental health advice and support within schools and other educational facilities - this will have both a prevention and recovery focus.

Our new primary care mental health model will bring together a collaboration of:

- Primary Care: GPs, Practice Nurses and other staff
- Mental Health Link Workers
- Consultant Psychiatrists, Psychologists and Psychological Therapists, Mental Health Practitioners
- Non-medical prescribers, Substance misuse practitioners
- Social Prescribing and other community/VCS offers
- Improving Access to Psychological Therapies (IAPT) Service
- Support Workers and Peer Support Workers

The teams will serve a cluster of GP practices and provide quick access to specialist mental health support and intervention including for those people with physical health difficulties or long term conditions. It will provide:

- Assessment of need, formulation and care planning
- Specialist assessment for dementia, autistic spectrum disorders, Attention Deficit Hyperactivity Disorder
- Brief intervention, IAPT service and psychological therapy
- People who care for service users - support and intervention

- Psychiatric and psychological consultation to professionals
- Access to recovery college courses
- Access to prevention college
- Access to a broad range of advice services provided by partners aimed at supporting people to address sources of stress, i.e. debt, benefits, housing, relationships
- Advice, guidance and assessment where required to outpatient clinics offering consultation to people with long term conditions - the Practitioners would then liaise with GPs supporting these individuals
- Pro-active joint working between professionals
- Creation of coherent, integrated care pathways where care is provided by different agencies so that service users experience it as one service, for example, Neurodevelopmental conditions and Dementia
- Support and develop local INTs to include mental health and long term condition expertise
- An effective alternative to hospital admission especially in emergency situations, including the effective management of distressed behaviour
- Ways of securing social care input to support individuals who wish to remain in their homes
- IAPT for older people in a way that is acceptable and meets the need of the individual - this is to include detecting depression and anxiety in care homes and or co- morbid mental health problems
- Screening those with long term conditions including Dementia who are at higher risk of depression and supporting to access interventions or treatments
- Substance misuse services must be equipped to support older adults who may be experiencing alcohol and drug use / misuse problems which impact on their health and wellbeing

The Primary Care Mental Health Service will be organised in such a way to have a close relationship with the multi-agency INTs in order to facilitate strong and collaborative relationships between physical and mental health practitioners, and enhance the effectiveness of biopsychosocial approaches that are important to wellbeing. The INTs (13 across east and west Suffolk) are multi-professional teams (virtual and/or physical) defined by local resident populations coterminous with clusters of GP practice registered populations covering social and community health teams.

The aspiration for the INTs is to move to a 7 day service offer covering professionals from different organisations to work together in the best interest of those requiring their support. The INTs support the inclusivity of the totality of care needed irrespective of condition or complaint. The INT model reflects a shift towards prevention, self-care, early intervention and integrated reablement and rehabilitation in partnership with acute services, social care and mental health services.

Links To Psychological Therapy including Increasing Access to Psychological Therapies (IAPT)

NHSE has drawn up guidance (August 2018) to encourage primary care to co-locate mental health therapists in practice¹⁷. Therapists would be integrated into primary care teams and focus on common mental health disorders such as anxiety and depression, particularly where this occurs in service users with a long term physical health condition such as diabetes, respiratory or heart problems. Evidence suggests nine out of ten adults with mental health problems are supported in primary care and broadening the range of services for service users, means local health services are better equipped to deal with service users' physical and mental health needs.

Appropriate psychological therapy will be available throughout the community, to all age groups. This will include, but not only be, the IAPT Service. There are national requirements for IAPT, which we intend to exceed. By 2021 over 25% of people suffering with common mental health problems will be able to rapidly access psychological therapy, starting with instantly accessible computerised treatments, and books in libraries. The therapists will be embedded within primary care, schools, Long Term (Physical) Condition services, the Primary Care Mental Health Service and Recovery Community Mental Health Teams. After 2021 the number of service users able to access therapy will gradually increase further, until demand is met.

Service users with more specialist needs who cannot be supported in the Primary Care Mental Health Clinics will be supported by Recovery Community Mental Health Teams.

Recovery Community Mental Health Teams (Specialist Secondary Mental Health Services)

When service users have more complex mental health needs, which requires a more intense approach from Specialist Mental Health Services they will be supported by a range of Community Mental Health Teams who will deliver a broad range of interventions to meet their needs. The Community Mental Health Teams will have strong relationships with the Primary Care Mental Health Teams, to ensure that service users can be seen in a timely manner, and either in their own homes or locally in a clinic based setting as near as possible to where they live.

The Recovery Mental Health Teams will manage and support an all age community caseload and:

- Provide community pathways which meets the needs of those with MI regardless of age
- Deliver a 0-25 year pathway in line with SEND, ongoing development of Wellbeing Hub
- Supports step down into Primary Care Mental Health Clinics
- Supports step up into and step down from Crisis Resolution and Home Treatment Teams/Mental Health Inpatient Units
- Specialist services will be provided in the community where appropriate i.e. Early Intervention in Psychosis and Perinatal Services

The majority of those supported in Secondary Mental Health Teams will have severe and enduring mental illness, including those with Schizophrenia and Bipolar Disorder. Service users with ongoing need for intensive specialist support will receive robust input. Others who have experienced an acute episode of significant ill health will also receive secondary services as required to ensure stabilisation of their mental health. This latter group may step down to other services once stable, as may some with severe and enduring mental illness. However, it is acknowledged that some people with severe mental illness may require ongoing support by specialist mental health services.

Specialist Community Mental Health services will provide a safe, compassionate, assertive and enabling recovery focused service that will collaborate work alongside with service users, carers and peers to develop care plans that will meet their needs, delivered by a sufficiently resourced workforce with

the appropriate skills and knowledge. This will include access to appropriate biopsychosocial evidence based care, treatment and interventions, Physical Health Checks and Individual Placement Support (IPS). There will be meaningful and effective integration of physical and mental health care. Those presenting with both mental illness and substance misuse issues will receive a comprehensive approach to their care.

Transitions between parts of the care system will be safe and flexible, and will involve collaboration with service users and carers. Where a number of agencies work with the same person and their carers there will be shared care planning where possible. Collaborative transition planning will enable 'be safe/feel safe' moves between different levels of care and changing care relationships with coherent and easy access to step up if deterioration occurs.

It is recognised that people with severe and enduring mental health problems often have complex difficulties that can include barriers to accessing support and treatment. There will be a sustainable and consistent model of care that ensures the most vulnerable, disempowered and difficult to reach people can access support and treatment. The service will be responsive to need and vigilant for signs of change in presentation and deterioration. There will be an emphasis on empowerment at times when there is most risk of disempowerment, for example times of crisis, and ways of working at these times will reflect this, e.g. use of Open Dialogue.

People and the support around them will be understood at the earliest possible point, and the collaboratively produced care plan will be communicated across the system. A recovery-focused approach will seek to work collaboratively with service users to enable the connectedness, hope, identity, meaning and empowerment that is associated with mental wellbeing and recovery from mental health difficulty.

Additionally the teams will provide for those who have had a severe episode of illness who require intensive monitoring and supporting for a period of time. This group, who do not have enduring illness will likely transfer to other services once stabilised. All community mental health teams will work to the following principles:

- Multi-disciplinary team approached
- Recovery focused
- Assertive engagement
- Manageable caseloads
- The expertise provided by the community team will be shared with partners
- The culture of assertive engagement will extend to engagement with partner agencies
- Robust care planning and discharge planning processes will be in place, which includes service users, families and carers
- Workforce with the skills and resources to meet the needs of service users and carers
- Provide holistic care
- Care provided will be in line with NICE guidance
- Physical health care
- Services will be aligned with Integrated Neighbourhood teams

The secondary care offer will include teams that have a specific focus to meet the needs of particular groups, including people with Eating Disorders, those requiring Early Intervention for Psychosis, Perinatal Service, Learning Disabilities Community Mental Health Teams and Forensic Community Mental Health Team. These teams will provide support to those who require intensive specialist services, including care coordination. There will be access to meaningful learning and development opportunities through a developed Recovery College that will be accessible by people using primary care and specialist mental health services.

Early Intervention in Psychosis Service

A new dedicated Early Intervention in Psychosis (EIP) service has been commissioned in line with NICE recommended treatments and the NHSE Five Year Forward View. The service will provide a recovery focused service for people aged 14-65 years, including commencement of a NICE-recommended care package within two weeks of referral of suspected first episode psychosis, meeting of accreditation criteria, family interventions, carer education and support, employment support etc. The placing of the new service alongside the new Primary Care Mental Health model will need to consider the rurality of east and west Suffolk and capture the presentation of service users with psychosis. This may be from acute trusts, police, GPs and other places of presentation.

7.5 ACUTE CRISIS SERVICES (SPECIALIST)

In November 2016, the Mental Health Five Year Forward View set out the necessity for the NHS to provide high-quality, responsive, 24/7 accessible mental health services for people who may be seriously ill and in need of urgent support. To enable this vision for Suffolk, it is essential that there is a change in how the system delivers crisis services, ensure that the capacity is available to cope with the demand in a variety of ways and offer ways to support service users earlier to prevent a crisis occurring.

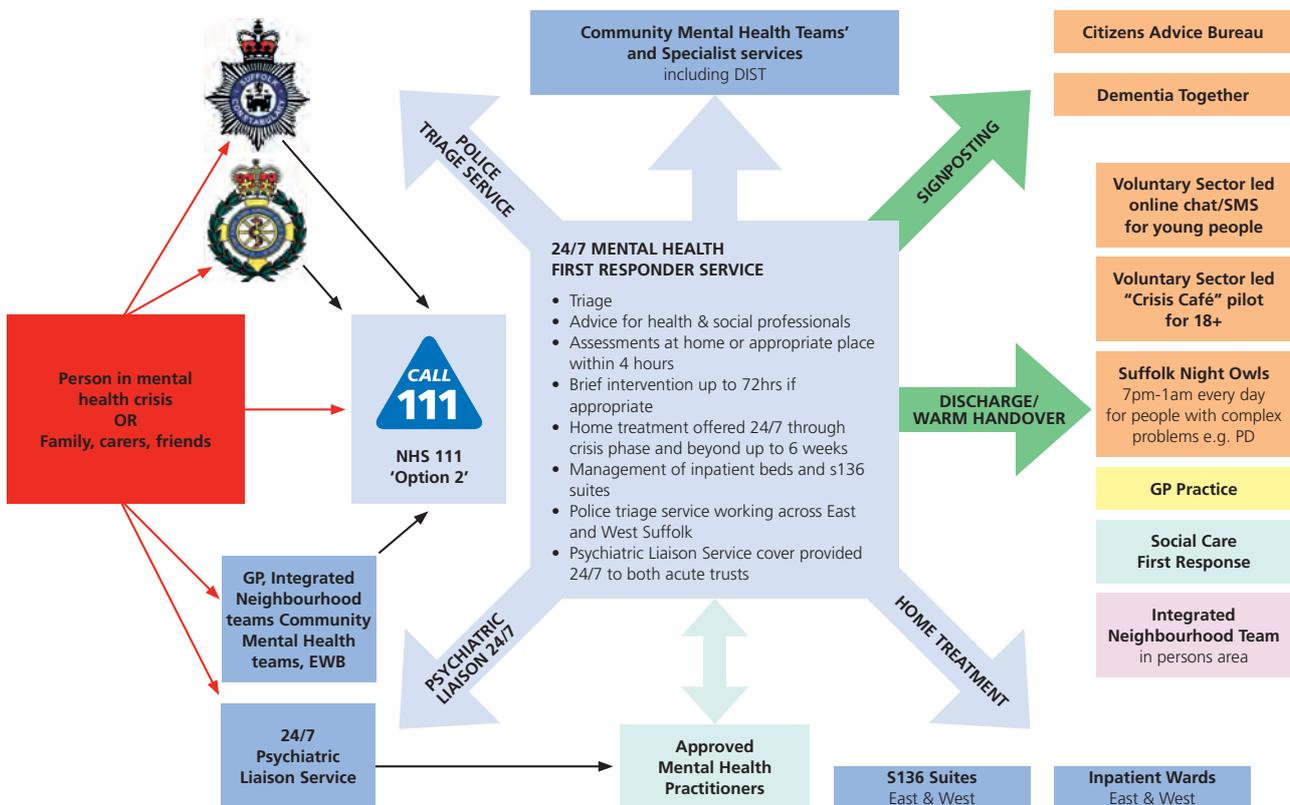
Our future vision is for a mental health system which can offer a response to people in crisis, have the ability to provide timely assessment for those

who need it, have excellent links into Recovery Community Mental Health Teams and voluntary sector services, offer a high quality 24/7 home treatment service and manages the inpatient bed capacity.

The diagram below (Fig.15) sets out our new crisis response and acute mental health model will bring together:

- Crisis Resolution and Community Home Treatment Teams
- Police Triage
- Psychiatric Liaison Services
- Voluntary Sector response
- Mental Health Inpatient Units

Fig. 15: Draft Mental Health Crisis Response for Suffolk



Suffolk Crisis Response

The new Mental Health Crisis Response across the whole east and west Suffolk system will be open and accessible to all ages whether people are already known to services or not and will link together the various points through which people access help e.g. Acute Trusts, Police etc. There will be no barriers to accessing support when people need it.

Firstly, it will provide a 24/7 telephone access to a trained mental health crisis response team via NHS

111 option 2. This telephone line will offer access to people of all ages to enquire about support for themselves or for family and friends if they are in crisis. This line will also be available to offer mental health advice and support for health and social care professionals such as GPs, Police and Ambulance. Not all people are able to or wish to communicate via telephone, so other options such as an SMS online chat for younger people will be explored to enable the service to safely reach as many people as possible.

Suffolk Waves Service

Delivered by Suffolk Mind, this service aims to support people who have a diagnosis of Borderline Personality Disorder (BPD), or traits consistent with BPD. It offers support individuals in meeting their emotional needs, helping them to maintain mental wellbeing and achieve personal goals. It is a group-based service with three components, held in Ipswich and Bury St Edmunds:

1. Waves (2 hour skills-development session) for which attendance is mandatory.
2. Waves Action (2 hour session with opportunity for individuals to focus on own goals with staff support, such as lifestyle goals, employment or volunteer applications, or to reinforce skills covered in the morning session). Attendance for this part is optional but encouraged.
3. Waves Plus (2 hour session focused on developing peer support). This session is held within a community space and again, attendance is optional but encouraged.

An evaluation of the service in 2016 found tentative but encouraging findings for both services, suggesting that Waves service users were better able to manage BPD symptoms and meet emotional needs. The evaluation found that Waves clearly promotes self-efficacy and autonomy, recovery and hope, working in a flexible and responsive way which promotes positive engagement. Staff working within the service were found to be non-judgemental, supportive of each other, interested in BPD, and functioning as a team. 41 external stakeholders responded to a survey as part of the evaluation, with the majority of respondents had some knowledge of the service, and half had previously referred service users. Responses were generally positive, with nearly half regarding Waves as a supportive, bounded, safe and empowering place to build self-esteem and confidence, to build peer networks and to work towards personal goals.

Waves are keen to continue developing the service and Suffolk Mind are working with the CCG to look at capacity and locations of the service for the future.

The Mental Health Crisis Response team will triage all calls and assess the needs of each individual person and offer access to a range of support services including:

- Offering advice and guidance with possible transfer to support in their local area e.g. Citizens' Advice
- Signposting or warm transfer to specific voluntary sector crisis support services
- The ability to swiftly and safely carry out a face to face assessment at home or another suitable environment when required 24/7 where a person may be so acutely unwell they require admission to hospital
- Offer brief interventions for up to 72 hours where appropriate
- Tailored follow up for the individual, which may include providing warm handovers to Recovery Community Mental Health Teams for ongoing treatment
- Provision of 24/7 crisis resolution home treatment to support the initial crisis phase and onward home treatment for up to six weeks based upon Core Fidelity standards
- There will be access to emergency community based accommodation as an alternative to hospital admission
- Providing the gatekeeping function for inpatient beds
- Support and facilitation for early discharge from hospital
- Working closely or co-located with Approved Mental Health Practitioners to enable swift access to mental health act assessments and Section 136 suites
- Expert by experience in roles that inform service, support governance and advocacy
- Strong links with Reactive Emergency Assessment Community Team (REACT) in east Suffolk and Early Intervention Team (EIT) in west Suffolk to enable support for people calling in with dementia-related crisis
- Working closely with Learning Disabilities Intensive Home Support Team enabling prevention of admissions for these individuals where appropriate
- Referral for substance misuse

We know that not all mental health crisis presentations will be via the telephone line and there needs to be the ability to offer swift crisis response for spontaneous presentations for people in crisis within the community and ensure they know how to link into the 24/7 crisis response team for action.

The outreach elements of the Crisis Response team for different points of presentation are set out as follows:

Psychiatric Liaison Teams in Acute Trusts

Some service users in mental health crisis will attend the Emergency Departments at ESNEFT and WSFT or may experience a crisis whilst they are an inpatient. There is also the need to support service users on inpatient wards who may be experiencing undiagnosed common mental health disorders such as depression and anxiety to prevent these conditions from becoming more serious.

Therefore it is vital that the existing services are enhanced to offer an all age 24/7 Psychiatric Liaison service is available to cover the hospital sites to offer a swift emergency response in the Emergency Department when required and offer a mental health service on general wards in core hours.

This service needs to support and align with training plans within each acute trust to support the integration of mental health into physical health in the acute trusts.



More joined up working and professionals having a better understanding of each other's roles, responsibilities and services.

Professional

Police Triage Service, Serenity Intensive Monitoring & High Intensity Networks

The refreshed Joint Needs Assessment for mental health indicated that Suffolk Police responded to 4,601 calls in 2017 which related to mental health. To support this route of presentation, a small team of mental health nurses are co-located within Suffolk Police and offer advice and support to Police officers within the Control Room for incoming calls and attend calls with the police to gauge the level of mental health response required. This agility will be available in east and west Suffolk depending on need.

In addition to this, a recent investment of transformation funding has enabled the imminent commencement the NHS Innovation Accelerator project for Serenity Intensive Monitoring and High Intensity Networks in east Suffolk. This project is for a police officer to be seconded into the mental health trust to concentrate on a specific cohort of high users of emergency services who have mental health issues. The role is a mentoring and problem solving role enabling boundaries with the express outcome of reducing high use of services. This role will link up nationally as part of the High Intensity Network which shares learning and intelligence across county boundaries and the country.



Suffolk Mental Health Street Triage

In April 2014, a pilot scheme for mental health street triage began which consisted of a police response vehicle staffed with an officer and a mental health nurse between the hours of 14:00 and midnight, seven days a week. The nurses were based with Ipswich response officers but able to provide advice and assistance countywide if needed. The key objective of the pilot was to improve the care and support to individuals who come into contact with the police, at times of crisis, to develop more appropriate pathways of care and to test whether these changes led to reduction in the number of people with mental health problems who present to health facilities or the police in crisis.

The findings from the evaluation of the pilot carried out in January 2015 were positive and the results were published in Police liaison and Section 136: comparison of two different approaches. As a result the service was jointly commissioned later that year by the Suffolk CCGs and Suffolk Police and was extended to include a mental health nurse within the police control room in addition.

During 2017/18, the small team responds to an average of 473 calls per month some of which include advice to officers via phone or in person, supporting police and ambulance on scene of incidents, support for missing persons and welfare checks to name but a few of the team's range of roles.

Above we have explained how the entry points to the system will be covered - below we describe the pathways for the service user after the initial crisis in more detail:

Voluntary Sector Mental Health Crisis Support Services

The voluntary sector have a crucial part to play in mental health crisis support and have done so in Suffolk for several years. Our vision is to enhance the existing offer to enable a consistent service for service users with complex problems e.g. Personality Disorder and emotional distress. This would include the following:

- A telephone and SMS/email support for service users out of hours 7 days per week between 6.30pm to 1.30am for people aged 18 and over
- An online chat facility specifically for children and young people to offer support for emotional distress out of hours
- A service to support service users with BPD for 12 months with facilitated peer support e.g. Waves
- A pilot of a crisis café for people aged 18+ utilising existing community locations to ascertain demand and need

Crisis Resolution and Home Treatment Teams (CRHTTS)

When a person is experiencing an acute crisis and it is deemed they require a face to face assessment, this will take place within four hours. It is preferable that the assessment is undertaken in the person's own home, and family members are included in the assessment process. A range of interventions will be considered to ensure the most appropriate care is offered if and when required and one of these options may be home treatment.

Home Treatment Teams are multi-disciplinary and will offer service users an alternative to admission to hospital when they are acutely unwell. The team will work with an individual and their family to agree a care plan which will support the person to stay at home and receive a range of interventions to meet their needs and support their recovery at home. The team will provide support up to a maximum of six weeks. During this time, if the person's mental health is deteriorating and admission to hospital is required, the Home Treatment Team will facilitate this. As well as supporting people to remain in their own homes and receive treatment, another key responsibility of this team is to support the early

discharge of service users who are already in hospital, and who would benefit from going home and receiving ongoing care and treatment from the Home Treatment Team.

Meeting the Needs of Children and Young People

In considering the needs of children and young people in crisis, a new pilot initiative will seek to provide professionals with the skills and knowledge to meet the needs of young people in crisis. It will also test a new model of provision for 'urgent response' which will enable the Emotional Wellbeing Hub to deploy support to children and young people in their home to prevent an escalation which may have resulted in the need for a crisis response. The pilot will also provide support for up to 72 hours.

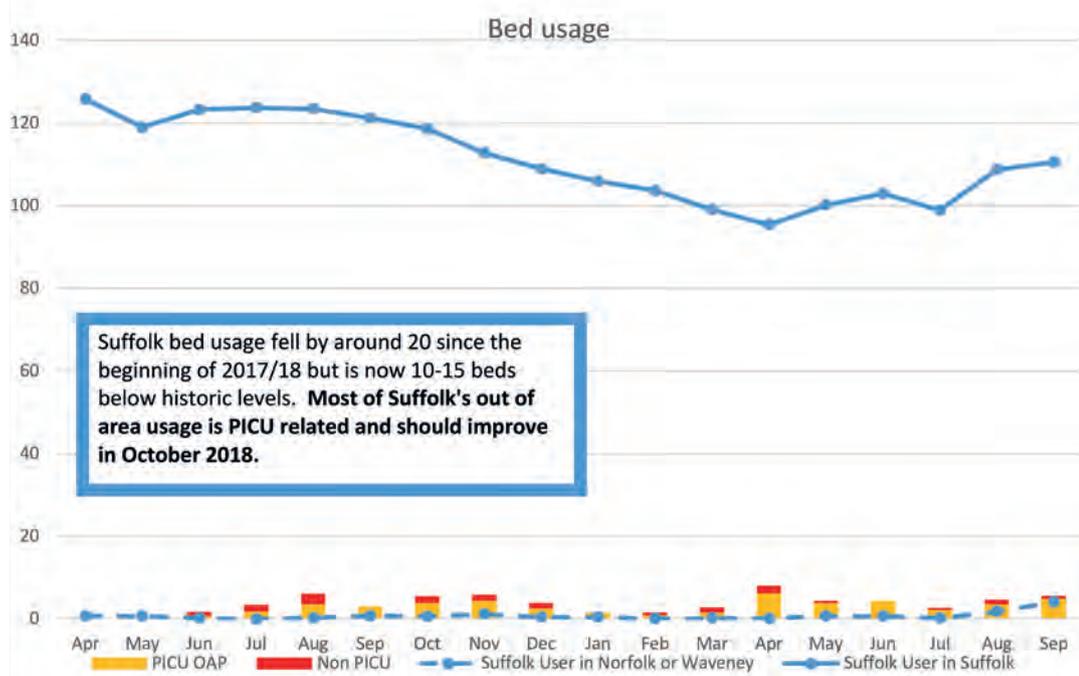
Inpatient Mental Health Services

When all other methods of supporting and treating people in their own homes or other community settings have failed, there may be the need to admit to hospital for a more intense period of assessment and treatment. It is very rare that elective admissions are arranged to inpatient services. The majority of people admitted to hospital will have experienced a crisis, or have been detained under the Mental Health Act¹⁸ and require a period of treatment in inpatient services. Across Suffolk we have an inpatient unit based at Woodlands on the ESNEFT site and an inpatient unit based at Wedgwood on the WSFT site. Both Units currently offer acute admission beds for adults 18 years plus and a small number of specialist beds for older adults. Woodlands also offer a Psychiatric Intensive care ward for those people who require a more intense intervention due to the acuity of their illness. In addition, the Suffolk Rehabilitation and Recovery Service is located in Ipswich but offers a service to those people across east and west Suffolk who have complex mental health needs and require a longer period of rehabilitation to support them towards independent living. A Forensic Inpatient ward is also situated in Ipswich supporting mentally disordered offenders. There is a six bedded unit located in Ipswich which specialises in meeting the needs of those service users with a moderate to severe learning disability, mental health problems and challenging behaviours.

In the future we aim to continue to provide the range of inpatient beds we have across Suffolk, however as part of this review of mental health services an evaluation of the models of service delivery across all inpatient facilities will need to be undertaken to ensure we have a consistent approach that meets the needs of service users. It is essential that we do not look at our inpatient units in isolation, as they are only part of the assessment and treatment process. We must also take into consideration those third sector providers that work alongside secondary care service providers who offer supported accommodation to support those

with SMI to live independently in the community. Historically, the number of inpatient mental health beds in east and west Suffolk has met the observed demand, resulting in fewer service users placed out of area (unless to receive specialist mental health support not available locally). Fig. 16 illustrates below that Suffolk mental health bed usage has been reducing over time but has recently moved back to historic observed levels. We anticipate that the recent rise in the Suffolk use of Norfolk Psychiatric Intensive Care Unit (PICU) beds will reduce with the reopening of the Suffolk Lark PICU ward.

Fig.16: Inpatient Mental Health Bed Usage in Suffolk: (April 2017-September 2018)



Secure Services

Secure Services is the umbrella title within NSFT for the forensic mental health or health and justice services, and are provided to anyone coming into contact with the Criminal Justice System and who may have a mental health concern.

Supporting the inpatient areas are two forensic community teams. There is also a Personality Disorder service in HMP Wayland which consists of

a PIPE (Psychologically Informed Planned Environment) and a Personality Disorder Assessment and Treatment service. This is complemented with a service to Norfolk and Suffolk Probation Trust.

A Liaison and Diversion Service provides experienced mental health practitioners to every Police Investigation Centre and Court in Suffolk, signposting individuals to the most appropriate service to meet their needs. This is a partnership with Julian Support and Project Nova.

All services are provided by a variety of clinical disciplines, predominantly Psychiatrists, Psychologists, Occupational Therapists, Nurses, Social Workers and Support Workers.

It is an essential part of the discharge planning process that we have a variety of providers who are able to meet the needs of those with complex difficulties. We will also explore the provision of alternative opportunities.

There is an opportunity to explore a very different way of working across our community and acute services in the future by considering other models which have been tried and tested internationally. In Trieste¹⁹, Italy, they have completely changed the model of service and reduced the very high numbers of beds they had across their system, by changing the way in which they responded to service users in crisis. Instead of service users having to meet the threshold of what we expect a crisis to look like, they respond to the situation that is causing distress to the client at the point it is raised. This action would often prevent any further deterioration in the person's mental health state. This review offers the opportunity for the Suffolk system to consider how we work together to make sure that people with SMI have access to the best quality service to meet their physical and mental needs in a timely way.

¹⁴ <https://neweconomics.org/2008/10/five-ways-to-wellbeing-the-evidence/>

¹⁵ Position Statement on mental health in primary care (2017). Accessed August 14, 2018. Also cited in the Mental Health Taskforce. The Five Year Forward View for Mental Health. Published 2016. Accessed May 3, 2018.

¹⁶ <https://www.england.nhs.uk/publication/improving-physical-healthcare-for-people-living-with-severe-mental-illness-smi-in-primary-care-guidance-for-ccgs/>

¹⁷ <https://www.england.nhs.uk/publication/guidance-on-co-locating-mental-health-therapists-in-primary-care/>

¹⁸ <https://www.legislation.gov.uk/ukpga/1983/20/contents>

¹⁹ http://www.triestesalutementale.it/english/mhd_department.htm



Need young people to have access to services quicker. In the past I was meeting with mental health nurses who came into schools weekly to work with young people. Since the reorganisation of CAMHS this has not happened.

Professional



8. RISKS

There are a number of inherent risks that present themselves in adopting a system wide approach - even when it feels the right and logical thing to do. These include the separate but complimentary commissioning of services from different agencies including NHSE, I&ESCCG and WSCCG, SCC including Public Health, Local Borough Councils, the Voluntary Sector and local community groups. Priorities may vary between agencies, and financial circumstances dictate decision-making.

That is why the co-production that has driven this strategy wishes to flag some key cultural changes and shifting in mind-set that needs to take place across the Suffolk system if the new mental health and emotional wellbeing strategy is to succeed.

- All agencies need to embrace co-production, listen to and engage service users, the people who care for them and professionals if we are to deliver creative and innovative responses to the model.
- All agencies need to sign up to prioritising emotional health and wellbeing on their collective and individual organisational agendas. Only then will there be consensus to merge and join up commissioning decisions and the prioritisation of 'making mental health everybody's business'.
- The NHS is experiencing workforce shortages at a national level. The ability to both attract new staff to and retain existing staff within Suffolk has proven to be particularly difficult due to a myriad of reasons, including rurality and proximity to Cambridge and London. The 'NHS Workforce in Numbers' report (October 2017) by the Nuffield Trust²⁰ states that the staffing shortages for mental health are particularly severe. To help mitigate the workforce risk, there needs to be excellent leadership and well developed teams, good education and training programmes, consideration of new roles to make a more diverse workforce, wider understanding of common mental health conditions and emotional wellbeing for staff working in physical health enabling them to support more and incentives to attract staff to work in Suffolk.
- Implementing a new model will have financial implications which is why investment is highlighted as one of the key principles in this strategy. If we are to move to a position whereby

mental health is considered in line and alongside physical health historic funding priorities will need to shift. From a CCG health commissioner perspective, the 'Mental Health Investment Standard'²¹ (MHIS) has started to ensure this shift happens. The Suffolk system as a whole however, including health and non-health partners, will need to signal a change in its financial decision - making if emotional health and wellbeing are to be considered shared priorities.

²⁰ <https://www.nuffieldtrust.org.uk/resource/the-nhs-workforce-in-numbers>

²¹ <https://www.hfma.org.uk/docs/default-source/our-networks/faculties/mh-finance-faculty-information/mh-finance-faculty/mental-health-investment-service-2017>



It would be useful to have a directory of services that could be used and an indication of the type of support each could offer. I expect this exists, but it needs to be updated and realistic.

Professional

9. RECOMMENDATIONS

There are some key messages that we ask from the east and west Suffolk system at this stage in the continued development of the ten year strategy:

- **#averydifferentconversation** has developed this strategy in a co-productive manner that has sought to seek the views of service users, those who care for them and professionals. Not only has this shifted our approach to co-production now but there is also a future commitment to continue this approach as we move forward in our journey to transform our mental health and connected services.
- We must put service users, families, carers and professionals at the centre of our conversations.
- We ask the entire Suffolk system to note and respond to the fact that mental health and emotional wellbeing is everybody's responsibility, and that a cultural shift is required if we are to achieve parity of esteem for mental health. We ask that all agencies look at their respective roles to contribute to the improved emotional health and wellbeing of the Suffolk population.
- In the future we wish to develop and provide services in a more integrated way which:
 - Addresses and support the needs of service users and their families/carers
 - Support physical and mental health together
 - Puts the needs of service users before organisational boundaries
- We request the Suffolk system to note the model for mental health and emotional wellbeing:
 - Self-Care
 - Universal Health-Primary Prevention and Care
 - Access and Brief Community Based Interventions
 - Specialist Secondary Mental Health Services

10. GLOSSARY

CBT	Cognitive Behavioural Therapy
CCGs	Clinical Commissioning Groups
CEWG	Children's Emotional Wellbeing Group
COPD	Chronic Obstructive Pulmonary Disease
CYP	Children & Young People
DfE	Department for Education
DoH	Department of Health
EIP	Early Intervention in Psychosis
EPUT	Essex Partnership University NHS Foundation Trust
ESNEFT	East Suffolk & North Essex NHS Foundation Trust
GP	General Practice
HWS	Healthwatch Suffolk
IAPT	Improving Access to Psychological Therapies
ICS	Integrated Care System
INT	Integrated Neighbourhood Team
JSNA	Joint Strategic Needs Assessment
LA	Local Authority
LTC	Long Term Condition
MHIS	Mental Health Investment Standards
QOF	Quality Outcomes Framework
NHSE	National Health Service England
NICE	National Institute for Health & Care Excellence
NSFT	Norfolk & Suffolk NHS Foundation Trust
OPeRa	Outcomes, Processes, Experience & Resources
PD	Personality Disorder
PTSD	Post Traumatic Stress Disorder
RCGP	Royal College of General Practitioners
SCC	Suffolk County Council
SCRai	Special Care Records with additional information
SDM	Shared Decision Making
SEND	Special Education Needs & Disabilities
SMI	Serious Mental Illness
SNEE STP	Suffolk & North East Essex Sustainability and Transformation Partnership
SFC	Suffolk Family Carers
SPCN	Suffolk Parent & Carer Network
SUF	Suffolk User Forum
VCS	Voluntary Care Sector
WSFT	West Suffolk NHS Foundation Trust

11. APPENDICES

11.1	Joint Strategic Needs Assessment for Mental Health - Public Health Suffolk
11.2	#averydifferentconversation Reports - Healthwatch Suffolk
11.3	Elmswell Event 1 - Summary of Conversations
11.4	Elmswell Event 2 - Summary of Conversations
11.5	Elmswell Event 3 - Summary of Conversations
11.6	#averydifferentconversation Summary
11.7	Indicator Diagrams - Public Health Suffolk
11.8	CYP Mental Health & Emotional Wellbeing Transformation Plan Refresh 2018

