The Nottingham and Nottinghamshire
Integrated Care System



Everyone's different, everyone's equal

All-age integrated mental health and social care strategy

2019-2024

Nottingham City Council

Nottinghamshire County Council

NHS

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OUR VISION

This vision was identified by the stakeholder and service user engagement group.

A whole system, all-age, person-centred approach, driven by access to physical and mental health and social care in the same place at the same time, with no wrong door, where prevention is at the heart of all we do.

We will reduce inequalities and narrow the gap between Serious Mental Illness (SMI) life expectancy and the rest of the population by 3 years and increase healthy life expectancy by 3 years.

"The costs of mental ill health – whether to the individual, their family or carer, the NHS or wider society – are stark. People can, and do, recover from mental ill health. The evidence is clear that improving outcomes for people with mental health problems supports them to achieve greater wellbeing, build resilience and independence and optimise life chances, as well as reducing premature mortality. But moreover, the evidence is equally clear on the potential gain for the NHS and wider public sector from intervening earlier, investing in effective, evidence-based care, and integrating the care of people's mental and physical health. Mental health should be an intrinsic element of every ICS – threaded throughout and not an afterthought."

The Five Year Forward View for Mental Health, published 2016

"Mental health problems often develop early and, between the ages of 5-15, one in every nine children has a mental disorder. Half of all mental health problems are established by the age of 14, with three quarters established by 24 years of age. Prompt access to appropriate support enables children and young people experiencing difficulties to maximise their prospects for a healthy and happy life...

Over the next five years, the NHS will therefore continue to invest in expanding access to community-based mental health services to meet the needs of more children and young people. By 2023/24, at least an additional 345,000 children and young people aged 0-25 will be able to access support via NHS funded mental health services and school or college-based Mental Health Support Teams...

Mental illness is a leading cause of disability in the UK. Stress, anxiety and depression were the leading cause of lost work days in 2017/18. The cost of poor mental health to the economy as a whole is estimated to be far in excess of what the country gives the NHS to spend on mental health. So reducing the impact of common mental illness can also increase our national income and productivity."

The NHS Long Term Plan, published 2019





Executive summary

Following widespread engagement, we are delighted to publish this integrated mental health and social care strategy, aiming to transform mental health and wellbeing in Nottingham and Nottinghamshire.

This document considers mental health across the whole age range but excludes dementia which will be the subject of a separate strategy. This strategy builds on the many positive aspects of services provided by NHS and local authority partners in our area, and the improvements already being made in support of NHS England's *Five Year Forward View for Mental Health* and latterly the *NHS Long Term Plan*.

Mental health and wellbeing is a continuum across the lifespan. Following a workshop in 2018 with all relevant stakeholders, we were given a clear steer to create an all-age strategy; this approach was supported by the Sustainability and Transformation Partnership (STP) Board (known since December 18 as the Integrated Care System (ICS) Leadership Board). An outline strategic approach was agreed by the STP Leadership Board in August 2018. Further work has been ongoing since to streamline and simplify the strategy and provide more focus on key actions required to achieve our vision.

The strategy represents our system's commitment to the re-shaping of services and other interventions so that they better respond to the mental health and care needs of the population. Our ambition was to develop a mental health strategy for Nottingham and Nottinghamshire that aligns health and social care, provides the framework for more detailed, collaborative work, and delivers in accordance with the *Forward View and Long Term Plan*. Ultimately we wish to seek a material transformation in the mental health landscape across the ICS, and importantly, a transformed experience for service users, carers and staff, with improvements in outcomes within a transformed system.

This strategy fully integrates with social care, reflecting a social model not just a medical model. It considers the crucial role of prevention, the interaction between mental and physical health needs, and the mental health impact of physical conditions. It considered a number of actions at ICS level, mindful of work already being advanced at other levels of the system.

There has been significant engagement with the public, patients, staff and partner organisations at all stages of the process. Using existing channels of engagement and special events, we have heard people's views and are acting upon them. This is in line with the common principles set out in the *Forward View*, emphasising co-production with people with lived experience of services, their families and services, working in partnership, and seeking to identify needs and intervene at the earliest opportunity. In particular, we are focused on designing and delivering person-centred care, underpinned by evidence, which supports people to lead, fuller, happier lives.

The process has involved stakeholder workshops, focus groups, a review of evidence, analysis of existing services, and a review of existing strategies in partner organisations. We have considered best practice from other areas of the country and how our emerging strategic framework fits in with the national direction of travel. From all this we have established a shared vision. Our vision is:

A whole system, all-age, person-centred approach, driven by access to physical and mental health and social care in the same place at the same time, with no wrong door, where prevention is at the heart of all we do.

We will reduce inequalities and narrow the gap between SMI life expectancy and the rest of the population by 3 years and increase healthy life expectancy by 3 years.

Within this overarching vision and strategic direction, our stakeholders have identified a set of five key strategic objectives (or 'pillars') that will frame and support our subsequent work to realise our vision. They also seek to bring together key elements in the strategies and plans of our partner organisations, and meet the challenges set out in the *Forward View* and *Long Term Plan*.

We are hugely grateful to all the individuals and teams who have contributed to the development of this strategy. We are however conscious that this is only the beginning of the work required.

If we are successful in delivering this strategy then the people in Nottingham and Nottinghamshire will be able to see the difference it makes to their mental wellbeing. During the life of this strategy we would hope to see

- 170 new patients supported in an Early Intervention in Psychosis service (EiP) each year
- 2670 more Children able to access child and adolescent mental health services (CAMHS) (based on current achievement of 20%)
- Children and young people with eating disorders, if identified as urgent, will be seen within 1 week
- 140 more women supported by perinatal services each year
- All age Rapid Response and Liaison will be available in all Emergency Departments – resourced to meet 1 hour assessment targets.
- Patients would be able to access crisis support within 4 hours every day of the week, with workforce linked to caseloads.
- 66.7% of dementia patients diagnosed – 7925 patients – will be able to access appropriate after care.
- 25% of patients requiring support will be able to access IAPT (Improved Access to Psychological Therapies) services
- 4396 of the 8887 patients identified on the Serious Mental Illness (SMI) register will receive a physical health check (based on 2018/19 figures)
- Eradicate inappropriate mental health Out of Area Placements by 20/21

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

More detailed planning work must now be undertaken to translate our objectives into actionable improvements. We will do this through establishing a small number of delivery groups with defined responsibilities, reporting to the Partnership Board. An initial implementation plan has been developed setting out the actions needed for the groups and how these interact.

This strategy needs to be factored into all relevant aspects of other ICS work if true integration is to be enabled. This includes the parallel clinical strategy work around acute, community and primary care services. This strategy represents our system's commitment to the re-shaping of services and other interventions so that they better respond to the needs of our population. We now need to plan together how to achieve this, including where to focus our combined efforts in the short, medium and longer term. We are seeking a seamless service and a step change in people's mental health and wellbeing. Our strategy seeks to recognise that everyone is different and care and support needs to be personalised accordingly, yet everyone deserves equality (with parity of esteem in all situations and scenarios). With the foundations and strategic pillars in place, we now need to build the rest of the structure. We look forward to widening our conversations further to enable this to take place.

Julie Hankin

Julie Hankin
Medical Director, Nottinghamshire Healthcare

Amanda Sullivan

Amanda Sullivan
Clinical Commissioning Group Chief Officer





Introduction

Many ICS partners already have their own strategies and plans in relation to mental health and wellbeing. This strategy sits above these and takes them into account.

This strategy will allow partner organisations, and others involved in advancing mental health and wellbeing, to overcome barriers they have encountered to progress.

It allows everyone to take advantage of opportunities for advancing the scope or scale of work. It will allow us to take a wider population health perspective and to improve services across the area. Importantly it will provide an overall direction of travel and a framework on which to base decisions.

The Mental Health and Social Care Partnership Board determined that this strategy should be underpinned by 12 key principles:	
1	Good system leadership
2	The individual with their own lived experience of mental health will be at the heart of each and every decision that is made
3	Decisions must be locally led
4	Care must be based on the best available evidence
5	Services must be designed in partnership with people who have mental health problems and with their carers
6	Inequalities must be reduced to ensure all needs are met, across all ages
7	Care must be integrated – spanning people's physical, mental and social needs. Referral pathways should be seamless both within, and between, services (for example, between primary and secondary mental services)
8	Prevention and early intervention must be prioritised, with a core focus on services provided in community settings working with multi-disciplinary teams
9	Care must be safe, effective and personal, and delivered in the least restrictive setting
10	Mental health services are understandable and accessible to all, including groups within the population who currently find services difficult to use for cultural reasons or because they believe the service will not meet their needs
11	The priorities in NHS England's Five Year Forward View for Mental Health must be successfully implemented
12	The right data must be collected and used to drive and evaluate progress.

A stakeholder-developed strategy

The work to develop this strategy did not follow a pre-determined course. It was important that the design process involved a broad range of stakeholders with sufficient experience and understanding to identify the actions that would enable transformation of the local mental health landscape. These stakeholders included those with lived experience of mental health issues and representatives of the NHS, local authorities, and voluntary and community sector. We will seek to further extend engagement in the next phase.

The development of this strategy involved stakeholders attending a series of workshops in which the current position (need, services and strategies) were analysed; a series of emerging priorities identified and refined; and a number of key outcomes and supporting actions proposed under each strategic pillar. External inputs were provided by Mind, the West Midlands Combined Authorities Mental Health Commission and NHS England's Mental Health Team.

We are building on our initial work by forming a service user co-design group to help shape the work of the Partnership Board and are committed to using the principles of co-design, across all the strategic pillars. Stakeholders have highlighted that this needs to include definition of the parameters and expectations around service user involvement. A full report on the engagement inputs to this strategy can be found in appendices.

Organisations involved in the strategy workshops

- Base 51
- Bassetlaw CCG
- Carers Federation
- Derbyshire, Leicestershire, Nottinghamshire & Rutland Community Rehabilitation Company
- East Midlands Ambulance Service
- Framework Housing Association
- Gedling Borough Council
- Greater Nottingham CCGs
- Healthwatch Nottingham and Nottinghamshire
- Let's Live Well in Rushcliffe
- Mid Nottinghamshire CCGs
- NHS England
- Nottingham City Council
- Nottingham CityCare Partnership
- Nottingham CVS
- Nottingham University Hospitals NHS Trust
- Nottinghamshire County Council
- Nottinghamshire Healthcare NHS Foundation Trust
- Nottinghamshire Local Medical Council
- Nottinghamshire Local Pharmaceutical Committee
- Nottinghamshire Office of the Police and Crime Commissioner
- Opportunity Nottingham
- Public Health England
- Rethink Mental Illness
- Royal College of General Practitioners
- Royal Pharmaceutical Society
- Self Help UK
- Sherwood Forest Hospitals NHS Foundation Trust
- The Strategy Unit
- Together Everyone Achieves More (TEAM)
- Tuntum Housing Association
- University of Nottingham

Our population

The ICS is responsible for planning and delivering the health and care for more than one million people. This is a population that is both growing and changing over time. People are generally living longer despite an increasing number of physical and mental health conditions.

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

The population of Nottingham and Nottinghamshire is 1.1 million. Of that population a large percentage will look after themselves and not access mental health services, while some will be cared for by their GPs and not need a referral into secondary care. For some 12,500 people there will be a need for longer term support and care, with some 500 people a year needing inpatient care. Knowing this information about the population allows us to plan and locate services where people most need them – whether that is in their local community, at GP surgeries, in specialist clinics or in hospital. This mapping of services applies as equally to mental health as physical health.

Local mental health needs

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

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

15,000 people are in contact with adult mental health services and 700 in contact with children and young people's services.

Each year there are around 2,000 contacts with crisis teams. Liaison services are now identifying more than 100 patients a month in A&E or inpatient wards suitable for referral to mental health services and local 'talking therapy' services are seeing around 25,000 patients, of which 50% complete a treatment course.

Life expectancy also varies across the footprint and is linked with deprivation. People living in the least deprived areas do on average live longer than those living in areas with higher deprivation. The difference between the most and least deprived areas is almost 8 years for men and 6 years for women across the ICS footprint.





What we know

Mental health service improvement is a national priority, particularly focusing on crisis care, perinatal mental health, children and young people, avoiding inappropriate out of area admissions, ending inappropriate use of police intervention, better access to psychological therapies and parity of esteem (giving equal value to mental and physical health). Building on the NHS Mandate, NHS England has published the Five Year Forward View and the NHS Long Term Plan.

The long term plan builds on the mental health five year forward view. The Plan proposes to increase the budget for mental health, in real terms, by a further £2.3 billion a year by 2023/24. Specific waiting time targets for emergency mental health services will take effect from 2020. It sets out an expansion of talking therapies, new integrated primary care and community provision, a reduction in the average inpatient length of stay to 32 days and an upgrade of the physical environment for inpatient psychiatric care.

Over the next 10 years, NHS 111 will be established as the single point of contact for those experiencing a mental health crisis. There will also be a new Mental Health Safety Improvement Programme, with a focus on suicide prevention.

The Long term Plan sets out a goal that over the coming decade 100% of children and young people who need specialist mental health care will be able to access it.

Funding for children and young people's mental health services will grow faster than both overall NHS funding and total mental health spending.

By 2023/24, at least an additional 345,000 children and young people aged 0-25 will be able to access support via NHS funded mental health services and school/college-based mental health Support Teams.

Current service models will be extended to create a comprehensive offer for 0-25 year olds that reaches across mental health services for children, young people and adults.

Milestones for mental health services for adults

- New and integrated models of primary and community mental health care will give 370,000 adults and older adults with severe mental illnesses greater choice and control over their care and support them to live well in their communities by 2023/24.
- By 2023/24, NHS 111 will be the single, universal point of access for people experiencing mental health crisis. We will also increase alternative forms of provision for those in crisis, including non-medical alternatives to A&E and alternatives to inpatient admission in acute mental health pathways. Families and staff who are bereaved by suicide will also have access to post crisis support.
- By 2023/24, we will introduce mental health transport vehicles, introduce mental health nurses in ambulance control rooms and build mental health competency of ambulance staff to ensure that ambulance staff are trained and equipped to respond effectively to people experiencing a mental health crisis.

The case for change

The national picture



Mental health problems are common and **exist throughout life** affecting children, adults and older people.

Based on national estimates, more than

175,000 adults

aged over 16 and more than

5,000 children

aged 5-16 living within the ICS are experiencing mental health conditions.



Recent estimates put the full cost of mental health problems in England at **£105.2 billion,** accounting for about 13% of the total NHS spend.

Those with serious mental illness are experiencing inequality in life expectancy, dying on average



17 years (for men) and



15 years (for women) earlier than the general population.

In Nottinghamshire

Overall Nottinghamshire has a range of social factors that mean we are more likely to see a higher incidence of mental health illness than elsewhere:



Overall incidents of reported crime have been increasing, **27% higher than five years ago**.



20% of homeless people with mental health issues are not receiving any support or treatment. A high proportion will have substance misuse and addiction problems.



There are approximately between **33,000 to 49,000 people** with long term conditions and co-existing depression.



Across the ICS it is estimated that more than **500,000** people will have been exposed to **at least one adverse childhood experience**, with around **45,000 experiencing four or more.**



Nottinghamshire residents with specialist mental health needs are **70% less likely to be in employment**, suggesting there may be less employment support and/or opportunities.

In Nottingham

While this is significant, Nottingham has other issues that will influence mental ill health including:



High rates of **alcohol and drug misuse** and high rates of **alcohol related mortality**

High rates of people living with **multiple and complex needs** (a combination of homelessness, offending, substance misuse and mental ill health)



Higher levels of **socio-economic deprivation**

Spend per 50,000 population in 2017/18 only slightly higher than national average (0.2m) but is **£2m higher in Nottingham City CCG.**





An overall **unemployment rate (9.6 per 1,000)** higher than the national (3.7) and regional averages (3.5).

Services

Our services are not keeping pace with demand as evidenced by patterns of commissioning and service utilisation/expenditure:



Mental health service users account for **19% of all A&E attendances** and result in **26% of all unplanned admissions to hospital.**



The ICS has one of the **lowest access rates for Children and Young People's Services across the country** - 17.6% against 32% expected performance.



Contacts with Crisis Resolution and Home Treatment Team per head of population **lower than national rate.**

3x

Crude rates of out-of-area placements approximately **three times higher than national average** (Nov 16-Feb18).



Challenge in sustainably **meeting the constitutional standards**.



A challenge in meeting the Health Education England workforce plan for 2021.



Mental Health First Aid training is not routinely offered to employers.

Our workforce

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

Funded Posts - 2016							
	Medical	Nursing and Midwifery	Allied Health Professional and Scientific, Theraputic and Technical Staff	Total Professionally Qualified Clinical Staff	Support to Clinical Staff	Administrative and Infrastructure Staff	Total
CYP	9	74	62	145	21	37	202
Adult IAPT		4	118	122	14	14	150
Perinatal	2	18	1	21	9	4	34
Crisis - CRHTTs		53	9	62	21	8	91
Liaison MH		20	1	21	3	2	25
EIP			5	5	2	4	10
Liaison & diversion		11		11	7		17
Total T.A.s	10	179	196	386	76	69	531
Core Acute	212	660	179	1,050	1,613	541	3,204
Core Community	38	565	549	1,152	731	625	2,508
Total Core	250	1,224	728	2,202	2,344	1,166	5,711
TOTAL	**260**	**1,404**	**924**	**2,588**	**2,420**	**1,235**	**6,242**

Figure one: NHS funded mental health posts in the ICS, 2016

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

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

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

We recognise, however, that these plans will need to be revised in the light of this strategy and the implementation plans that flow from it.

Strengths and weaknesses

While the focus of this review was to identify areas where we should focus more resource, we can acknowledge our current strengths. Some of these are:

- Suicide rate reduction
- Life expectancy gap for male mental health service users (reduced by four years since 2006/07)
- The lowest mortality rates among ICS peers in the mental health cohort for circulatory disease and cancer
- The inclusion of housing and employment status in patient assessments and long-term employment of those in mental health services
- Overall patient experience of using community mental health services – contact points and communication
- Low emergency re-admission rate
- Low psychiatric intensive care unit length of stay
- Special recognition and awards for local projects including new models of care, extension of psychiatric liaison, and Fulfilling Lives funding.

Beyond these areas of strength, however, we have identified several areas of concern. Stakeholders reflected on these issues as part of the strategy development process to inform the content of the strategic pillars. As the delivery plans are developed they will need to demonstrate clear action plans against each of these emerging issues.





Our shared vision

Our vision

Based upon stakeholder engagement, our strategic vision is:

A whole system, all-age, person-centred approach, driven by access to physical and mental health and social care in the same place at the same time, with no wrong door, where prevention is at the heart of all we do.

Our aims

We will seek to:

- Reduce inequalities and narrow the gap between life expectancy for people with serious mental illness and the rest of the population by three years
- Reduce depression and anxiety prevalence
- Deliver the mental health workforce plan set out by NHS England with an additional 384 whole time equivalent posts in mental health by 2020
- Deliver mental health awareness training to all health care professionals
- Improve the patient experience of services and produce a formal mechanism for training service user evaluators
- Ensure everyone can access mental health services in the right place, at the right time
- Deliver parity of esteem – so that mental health is placed on a par with physical health
- Have one strategic commissioner and one system control total for mental health services across the ICS with an outcome-based contract
- Achieve all performance and transformation assurance standards

Our commitment

If we are successful in delivering this strategy then the people in Nottingham and Nottinghamshire will be able to see the difference it makes to their mental wellbeing. During the life of this strategy we would hope to see

- 170 new patients supported in an Early Intervention in Psychosis service (EiP) each year
- 2670 more Children able to access child and adolescent mental health services (CAMHS) (based on current achievement of 20%)
- Children and young people with eating disorders, if identified as urgent, will be seen within 1 week
- 140 more women supported by perinatal services each year
- All age Rapid Response and Liaison will be available in all Emergency Departments – resourced to meet 1 hour assessment targets.
- Patients would be able to access crisis support within 4 hours every day of the week, with workforce linked to caseloads.
- 66.7% of dementia patients diagnosed – 7925 patients – will be able to access appropriate after care.
- 25% of patients requiring support will be able to access IAPT (Improved Access to Psychological Therapies) services
- 4396 of the 8887 patients identified on the Serious Mental Illness (SMI) register will receive a physical health check (based on 2018/19 figures)
- Eradicate inappropriate mental health Out of Area Placements by 20/21

Our strategic pillars

We have identified a set of five key strategic pillars that will frame our work:

1. Increasing support for prevention, self-care and the wider factors that affect people's health
2. Implementing an approach that focuses on the individual (physical and mental health)
3. Improving access to services
4. Equipping a mental health-aware workforce
5. Establishing a truly integrated system

It is important that these pillars are not considered in isolation of each other. The following table sets out our five key pillars, highlighting the likely areas of interaction with other pillars in this strategy as well as their alignment with other areas of ICS work and with the delivery priorities of NHS England's Five Year Forward View for Mental Health.

1

Increasing support for prevention and the wider factors that affect people's health



Overview

We need to:

- Work with citizens in a personalised manner to increase awareness and understanding of mental health and wellbeing so that resilience is increased and the onset of ill health is avoided or delayed
- Work with local communities to promote and increase the local assets that can support those with mental ill health in managing and improving their conditions
- Work with wider system partners, including business and industry, to promote mental resilience and wellbeing and to address the wider determinants of mental ill health
- Meet our local stakeholders' position that we should place greater priority on children and younger people, especially those who suffer adverse childhood experience. This aligns with recent findings of the Mental Health Policy Commission which noted: "*a compelling case for investing in the positive mental health of young people in order to build a resilient generation for the future*"
- See a systemic culture change – moving to a system that takes a longer-term view and thinks about prevention rather than treatment alone
- Address transition points (for example, from child and adolescent mental health services to adult mental health) and to focus on areas that need strengthening (such as suicide prevention, social isolation, and vulnerable groups such as people leaving prison)
- Ensure that in children and young people's services, every contact with a child should discuss wellbeing
- Ensure that the prevention of mental ill health is a consideration for all age groups, not only for children and young people, so a 'life-course' approach to prevention is needed
- Provide better wraparound services in each locality to enhance self-care, independence and resilience
- Support the community and voluntary sector to further extend its impact on outcomes through initiatives such as ending social isolation
- Increase access to low level, responsive support to stop people's needs from escalating, as well as action to prevent suicide and self-harm
- Link with PHM workstream with regards to risk stratification of mental health population cohort including quantification and characterisation of cohorts
- Address the known causes of mental illness.

Wider factors that affect people's health

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

While some aspects of the wider determinants of health may benefit from a whole-ICS approach, much of the infrastructure and relationships for doing this exist at other levels. Our ICPs and their constituent parts are best placed to facilitate integrated partnership working across sectors to mutual benefit. We know, for example, that those who are out of work are more at risk of experiencing adverse mental health and therefore to generate additional demand for health and other services. We also know that adverse mental health impacts the wider economy not just the individuals concerned.

Key outcomes

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

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



2

Implementing an approach that focuses on the individual (physical and mental health)

Overview

We need to:

- Move towards parity of esteem and practice in relation to the physical and mental health needs of citizens. The differentiation of need into mental and physical categories is an historically established framing device but one that does not reflect underlying human reality
- Provide coherent pathways of care for people, integrating mental wellbeing, mental health and physical health. These pathways begin with supporting physical and mental health for people in the community, such as community support groups for people with diabetes, community referrals, self-care and self-management, and screening
- Ensure all primary care and community services staff are skilled and feel confident to have conversations with patients about mental and physical health
- Strengthen acute admission pathways across the secondary physical and mental health system, including reducing waiting times in Emergency Department
- Re-commission based on 'triple wins' - for the service users whose mental health and physical health needs are met together, for the services who do not waste time bouncing people around the systems, and for the commissioners in being able to utilise resources more effectively
- Understand how we can manage people's increasing physical and mental health long term conditions in terms of complexity and work with the interactions between the two rather than treating them as separate entities

Integrated place based working

The notion of 'place' has become increasingly important in health and care policy. The developing Primary Care Networks will provide:

a) An integrated multi-disciplinary team in each locality, built around primary care operating at scale, that co-ordinates the provision of holistic care. The multi-disciplinary team should consist of representation from all sectors who can contribute to effective health and social care provision for the patients.

b) The intelligence and information systems that enable teams to proactively identify and then co-ordinate the care management of specific service user cohorts. This latter is a broader approach than simple risk stratification: it includes the intelligence that informs both individual patient care and ongoing service improvement, supporting Primary Care Networks (PCNs) to become self-improving systems.

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

Key outcomes

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

- There should be a focus on parity of esteem between physical and mental health, such that all health and care staff consider and assess mental health and wellbeing alongside physical health in all services and contacts.
- Integration should be seamless across community, primary, secondary and acute care services. This could include the co-location of a broad range of services (not just within health and social care) within locality hubs in order to provide holistic, 'one-stop shops'. The potential for whole-system, integrated crisis management responses could be explored to reduce pressure on Emergency Department

Stakeholders described a person-centred model in which:

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

3

Improving access to services



Overview

We need to:

- Provide the right care in the right place and ensure that service users get the support they need when they need it
- Ensure from the service user perspective that there is 'no wrong place' where they would be turned away without being helped to access the right support
- Reduce unwarranted out-of-area placements driven by capacity issues rather than clinical need (this currently affects over 30 people across the ICS)
- Focus on the urgent care system which was perceived as failing currently by stakeholders. Any proposed changes would need to consider previous business cases (for example the 'blue light' hub), the crisis concordat and social care proposals where significant work has already been undertaken
- Improve access to children and young people's services (Nottinghamshire has one of the lowest rates of access nationwide)
- Make sure that people with multiple and complex needs are able to access help from local services, particularly among vulnerable groups such as the homeless and victims of sexual violence
- Address the transition from children's to adult services, re-visiting how services are configured
- Create a system that provides integrated 24/7 access for service users, including those with multiple complex needs. No service user should fall through the gaps between services or their operating hours.
- Ensure that citizens have access to the right services when they need them – especially when approaching or enduring a crisis phase. Particular care needs to be taken to ensure that this is the case for more vulnerable citizens including those who are homeless, victims of abuse or sexual violence, at risk of suicide or self-harm, living with a dual-diagnosis, veterans, students (especially around transition issues), black or minority ethnic, refugees, or within the criminal justice system
- Provide mental health services based on a model of 'care and place', addressing the housing as well as care needs of service users, particularly during periods of transition to the community
- Ensure that person-centred care that is recovery focused should be delivered by a compassionate workforce at the first instance, wherever and whenever needed

Key outcomes

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

- Timely access to inpatient beds, reduced out-of-area placements and reduced delays in transfers of care
- Reduced use of the Mental Health Act
- Proactive, holistic care for higher-risk cohorts
- Clear pathways for care, with routes in and out of them, which may not need to go thought GP gatekeeping, but which can flex to meet individual needs
- Users involved in the design of the pathways and/or networks of care
- Care co-ordination along defined pathways, underpinned by a coherent single IT system
- Effective crisis structures in place across the system
- Improved access to services for children and young people
- Improved access to Early Intervention in Psychosis services
- Reduced inappropriate out of area placements.

4

Equipping a mental health-aware workforce



Overview

This pillar is about all staff in health and social care, not just specialist mental health staff . We believe that the proposed change in the non-specialist workforce needs to include:

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

Key outcomes

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

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

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



5

Establishing a truly integrated system

Overview

We need to:

- Create an integrated system that supports the more effective delivery of mental health and wellbeing across the ICS – this would see a move towards one ICS/ICS integrated commissioning function
- Over-ride condition-specific services and standardise specifications across the ICS – as people are currently reporting that they are being passed from service to service
- Design and deliver a system that brings together the work of individual organisations such that the overall impact is greater than the sum of its parts
- Improve our strategic commissioning and funding so that we obtain the maximum benefits in terms of cost effectiveness and clinical impact
- Make better use of the voluntary and community sector as full partners – gaining a better understanding of what resources are available
- Make care more integrated – involving multi-disciplinary team meetings and using population health management

Workforce

- In order to create a sustainable workforce for the future, there needs to be a focus on training and development to address shortages in skills and to explore the potential for new roles, focusing on the competencies required rather than solely on established disciplines and professional groups
- Workforce skills need to be mapped with gaps identified, leading to training and knowledge sharing
- Clear career pathways need to be developed, and staff should be supported with their progress
- There should be recognition and acknowledgement of key achievements, successes and progress made by staff and their patients
- A plan needs to be put in place to effectively utilise the additional capacity resource for primary care highlighted in NHS England's *GP Forward View*
- These initial mapping exercises should inform and support the development of a ICS workforce organisational development strategy, working with the wider ICS Workforce workstream
- Alternative workforce solutions need to be considered that move beyond traditional roles, such as peer support workers or non-social worker approved medical practitioners

Key outcomes

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

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



Immediate next steps

1. Increasing support for prevention, self-care and the wider factors that affect people's health

- Link with PHM workstream with regards to risk stratification of mental health population cohort including quantification and characterisation of cohorts
- Map staff training offer and uptake - prioritise and provide training
- Link with prevention, person and community-centred workstream to implement social prescribing (picking up debt, loneliness and low level anxiety/depression), personal health budgets to be introduced for people with a personality disorder, expand shared decision making, alcohol prevention and making every contact count.
- Liaise with Suicide Prevention Partnership to identify priority areas for support, working towards a 10% reduction in suicide by 2020/21
- Each CCG should ensure increased access to NICE concordant community-based specialist perinatal mental health services (in secondary care settings) for at least 4.5% of their population birth rate, equating to an additional 20,000 women nationally
- Link with homelessness group to develop and implement action plan for homeless citizens
- Expand programme of individual placement support into Mid Nottinghamshire
- Begin to scope work being undertaken across county and city for adverse childhood experiences.

2. Implementing an approach that focuses on the individual (physical and mental health)

- Identify services in place to deliver annual physical health checks and follow up care for people living with serious mental illness
- Link with primary care workstream in the development of place-based multi-disciplinary teams, sharing responsibility for monitoring and managing the physical health of people with serious mental illness between primary and specialist mental health services
- Undertake actions identified in IAPT access recovery plans to achieve current IAPT standard. Action plan required for delivery of IAPT long term conditions and IAPT 22% access rates by end 2019/20.
- Target cognitive behavioural treatments and social interventions for those at risk due to their long term physical condition
- Link with primary care workstream in the development of integrated mental health support with primary care and chronic disease management programmes
- Scope appropriate pathways for patients with co-existing mental health and substance misuse issues
- Scope feasibility of expanding current Time to Change activity into county.

3. Improving access to services

- Implement crisis/liaison and out-of-area placements/urgent care action plan
- Complete review and reconfiguration of current Crisis and Home Treatment Teams and mobilise new care model to ensure services meet the minimum functions
- Spread coverage of liaison mental health teams through sustained commissioning of core 24 teams by 2020/21. Progress plans for acute hospitals to have mental health liaison services that can meet the specific needs of people of all ages, including children and young people and older adults by 2020/21
- Work to ensure crisis teams meet core fidelity standards by 2020/21
- Develop new care model for local mental health teams and local multi-agency urgent response
- Implement improvement plan for the Nottinghamshire Crisis House
- Implement findings of the liaison psychiatry service models, ensuring continued core 24 compliance
- Children and young people (CYP) – undertake actions articulated in CYP recovery plan. Develop actions to support the 2019/20 requirement of increasing access to 34% of estimated 2004 CYP prevalence

- CCGs should ensure there is a crisis response 24/7 which combine crisis, liaison and intensive community support functions, meeting needs of under 18-year-olds
- CYP - Deliver against regional implementation plans to ensure that by 2020/21, inpatient stays for children and young people will only take place where clinically appropriate, will have the minimum possible length of stay, and will be as close to home as possible to avoid inappropriate out of area placements, within a context of 150-180 additional beds by 2020/21
- CCGs to ensure the 2018/19 commitment for NICE concordance for early intervention in psychosis from the implementation plan is met; deliver against the further ambition for 50% of services to be graded level three by end 2019/20.

4. Equipping a mental health-aware workforce

- Each CCG should work closely with their NHS and non-NHS provider partners and arm's-length bodies locally to deliver against workforce plans, including expansion and enabling of training and retention schemes. Workforce requirements should form part of finance and mental health investment plan discussions to ensure alignment with CCG financial submissions
- Continue work to deliver expansion in the capacity and capability of the CYP workforce, building towards 1,700 new staff and 3,400 existing staff trained to deliver evidence-based interventions by 2020/21.

5. Establishing a truly integrated system

- CCGs to create a single commissioning function, ensuring that people's needs are met no matter where they come into contact with services
- Align local authority strategic commissioning resource
- Develop outcomes framework
- All CCGs to meet the Mental Health Investment Standard (MHIS). Full information is in section 3.6 of the NHS Operational Planning and Contracting Guidance 2019/20
- Commissioners to develop a comprehensive picture of current activity and spend on mental health cohort
- Single patient record and integrated systems.

Governance, Communications and Engagement

This strategy represents a major step forward in collaborating to transform the mental health landscape in Nottinghamshire and meet demand. Five strategic pillars have been identified to achieve our vision for mental health and wellbeing. We can take some short term action now to obtain immediate gains:

- The ICS Leadership Board has recognised this is a vital piece of work and have already committed key resources in terms of joint senior responsible officer (SRO) leadership and a programme director to drive forward this work
- Identifying director level SROs for the delivery of each strategic pillar
- We will work with those involved in this strategy to communicate and engage with them on implementation.



Conclusion

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

Third sector, voluntary sector and citizen engagement is a core principle of the ICS and this strategy, as well as a key component of services at all levels. Citizens (including experts by experience) will be involved in co-design, co-production and in evaluation activities, as well as recruitment and governance, from the outset, underpinned by clear governance structures.

We need to ensure that involvement and engagement includes people from Black and Minority Ethnic (BAME) communities, carers, students, ex-military personnel and the homeless – especially people who are vulnerable individuals who are not well served by the current delivery of services. in second tier mental health services and tend to bypass primary services.

Work on the foundations must begin with a plan for engagement and involvement. This plan, to be developed under the Integrated Mental Health and Social Care Board, will cover a clear set of short, medium and long term aims, as well as the purpose of the collaborative partnership with citizens and clarity on differing roles within this partnership. Governance processes and terms of reference and accountability will also be covered in this plan, as will guidance on cultivating personal development benefits for citizens involved in engagement. A charter or code of conduct may be developed to help with oversight of engagement activities.

An initial workshop will be held to introduce the principle and plan for citizen engagement. This workshop should be attended by key stakeholders from services who will be co-ordinating citizen engagement and citizens who may be interested in being involved. This workshop should pave the way for subsequent service-specific engagement work, dictated by a tailored engagement plan for each service. It is acknowledged that there is already much expertise in this area locally, including the work of the Practice Development Unit - a partnership between Opportunity Nottingham and Nottingham CVS. More specifically, the Mental Health Partnership Board will recruit service users into a standing co-design group that will be able to check and challenge the Board's ongoing work, including the implementation of this strategy.

Choice and control in accessing support

We are concerned that our work in this area should not be confined simply to engaging citizens in the shape and content of strategies and plans, as important as this is. Citizens will also be enabled and empowered to exercise the maximum appropriate choice and control in the support they access, including how, when and where they do so.

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

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

In the life of this strategy we hope to achieve our vision of:

A whole system, all-age, person-centred approach, driven by access to physical and mental health and social care in the same place at the same time, with no wrong door, where prevention is at the heart of all we do.

We will reduce inequalities and narrow the gap between SMI life expectancy and the rest of the population by 3 years and increase healthy life expectancy by 3 years.











The ICS Office
Riverside Suite
County Hall
West Bridgford
Nottingham
NG2 7QP

Email: roz.howie@nottscc.gov.uk