The Nottingham and Nottinghamshire
Integrated Care System

APPENDICES

Everyone's different, everyone's equal

All-age integrated mental health and social care strategy

2019-2024

Nottingham City Council

Nottinghamshire County Council

NHS

Appendix 1 – Contributing Organisations

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

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

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

Appendix 2 – Case Studies from the Evidence Base

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

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

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

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

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

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

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

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

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

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

6. **The RAID model**

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

7. **Paediatric Unscheduled Care Pilot**

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

8. **North West London Optimal Model**

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

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

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

10. **Oxford Psychological Medicine Service**

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

11. **Psychological Medicine Services in Hull**

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

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

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

13. **LIFT psychology in Swindon**

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

14. **Joint working with police**

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

15. **Partners in Paediatrics**

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

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

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

17. **Paediatric Unscheduled Care Pilot**

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

18. **Connecting Care for Children**

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

19. **Wessex Healthier Together**

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

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

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

Appendix 3 – Engagement Report

APPROACH

Stakeholder workshops x 3

Analysis of existing services and outcomes

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

Previous organisational engagement events

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

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

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Design

Current

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

Future

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

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Delivery

Current

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

Future

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

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Management

Current

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

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

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

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

Future

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

Accountability of providers was expected to be through:

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

Enablers of delivery were suggested to be through managing:

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

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People and Communities

Current

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

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

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

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

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

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

Future

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

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

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Workforce

Current

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

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

Future

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

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

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

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

Leadership

Current

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

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

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

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

Future

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

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

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Technology and Innovation

Current

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

Future

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

Knowledge and Learning

Current

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

Future

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

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Appendix 4 – Building on the Evidence

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

Methodology

Bibliographic databases and other key sources were searched for grey literature, guidance and empirical evidence from the UK setting, covering the last 5 years (2013-2018). Evidence pertaining to the transformation of mental health services towards improved integration was extracted and reported against a meta framework of eight key elements (see Figure 1, developed by the Strategy Unit as part of the realist synthesis on primary-care led integrated care models[1]. It provides a useful lens for exploring what works for integrated care and understanding how change might happen from strategic and operational perspectives.

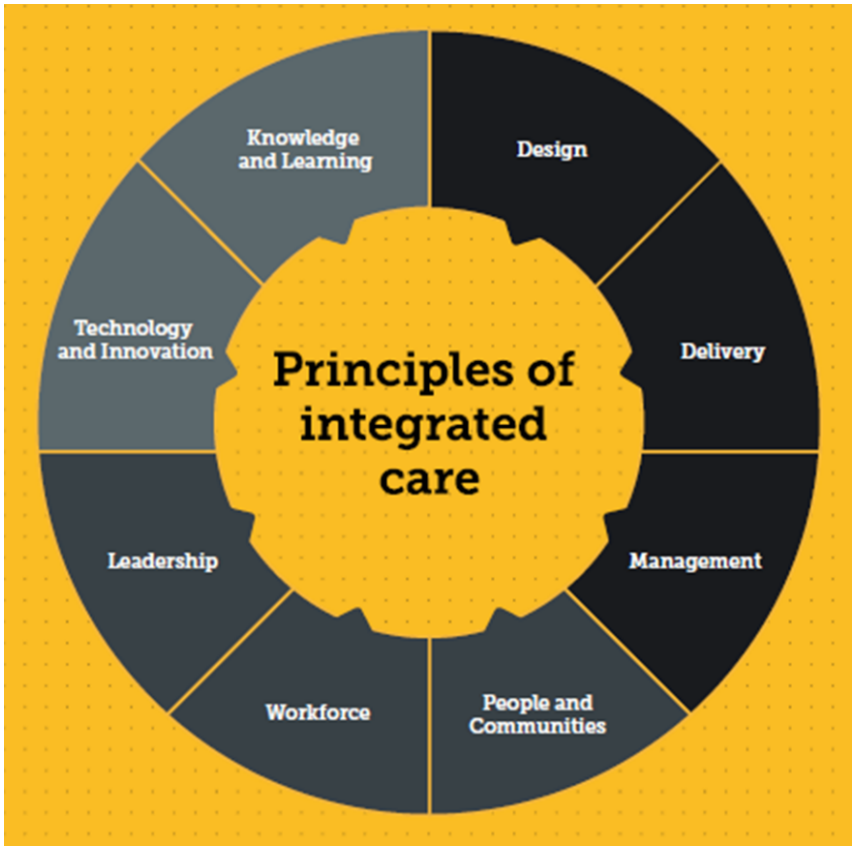

Figure 1 - Principles of integrated care

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

Results

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

Challenges

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

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

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

Despite being a less favourable option, out of area placements have increasingly been used where there is a lack of beds locally. Perinatal service capacity also remains underdeveloped. Use of the Mental Health Act is on the rise and the pressure to reduce suicide rates is ongoing.

Recommendations

Design

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

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

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

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

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

Delivery

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

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

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

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

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

Management

Commissioners should ensure that local services have clear leadership, both clinical and managerial, and that services comply with professional and service standards. Shared governance structures that facilitate joint responsibility and accountability are encouraged to ensure: 1) greater continuity and higher quality of care; 2) better communication and more successful coordination of an integrated approach and; 3) better outcomes. Integrated governance also requires effective communication between stakeholders. To manage integration effectively, colocation of primary care and specialist mental health services is also encouraged as a facilitator of an improved integrated response to patient needs.

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

A shared approach should also be employed to problem-solving and learning, as part of an evolving system. Commissioners, managers and practitioners should have equal responsibility for suggesting improvements to systems, practices and service provision. To this end, stakeholders should understand their respective roles and responsibilities as part of an integrated approach. For example, lessons can be drawn from guidance on the transition of children and young people to adult services, which suggests senior executives are best suited to developing and publishing transition strategies/policies, whilst senior managers should be accountable for implementing, monitoring and reviewing transition strategies/policies. Local transformation should also reflect the lessons learnt from the recent HSIB *Investigation into the transition from child and adolescent mental health services to adult mental health services.*[2]

People and communities

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

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

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

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

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

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

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

Workforce

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

The evidence recommends various roles and responsibilities which should contribute to an integrated system. The named coordinator is suggested as a useful resource to help patients navigate the system, the various services and opportunities on offer. GPs with special interests are another option for the provision of mental health services in primary

care. Guidance recommends however, existing and new workforce must operate on a shared set of values and goals that are favourable to patients and their families/carers.

Shared knowledge and awareness across the wider system contributes to effective integration. The workforce need to be aware of each other's services and remits. Information needs to be readily accessible by staff about health and social care services available to patients, so these can be offered appropriately.

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

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

Technology

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

Leadership

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

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

Knowledge

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

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

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

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

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