MENTAL HEALTH IN STOCKTON

INTEGRATED MENTAL HEALTH STRATEGY GROUP REVIEW 2018-19

2018-19 REVIEW REPORT OF STOCKTON INTEGRATED MENTAL HEALTH STRATEGY GROUP

Executive Summary

Stockton's Integrated Mental Health Strategy Group plan for 2018-19 included ambitions for the people of Stockton to have the best mental health services available, to stay healthy and to proactively provide the best environment for people to prevent deterioration in general mental health.

To this end, members of the strategy group were drawn from statutory and non-statutory agencies, bringing in expertise to the work programme where required. This was further supplemented by involvement in regional and national programmes that were distilled to address local need.

Activity within the work programme included:

- A focus on family wellbeing and welfare. In addition to supporting activity in the Future in Mind strategy, Stockton Welfare Advice Network have been partering with mental health services and CGL (through the Family Group Conferencing Team) supporting people with drug/alcohol use issues, providing brief advice, support into specialist services and hidden harm. Housing teams and housing providers are also being offered training and information related to Mental Health.

- Volunteering to support community sector organisations but also as a way to improve mental wellbeing, in line with the Five Ways to Wellbeing programme.

- Healthy lifestyle promotion and a focus on closing the health equality gap has seen increased uptake in smoking cessation programmes and health checks in the target group of people with a serious mental illness and this will continue to be a focus through the following year. A Make Every Contact Count approach has been further developed to help ensure that people receive brief advice and interventions to support good mental health and appropriate access and referral to services and activities. This will be further developed as the national programme is expanded in 2019-20.

- The strategy group has ensured that the refreshed information directory contains appropriate signposting, advice and information which will continue to be updated.

- Mental health awareness training has also been a focus of the strategy group with 435 individuals participating in training during the year, 33% of whom work in Stockton on Tees.

During the 2018-19 year, CCGs in Durham, Darlington and Tees have combined their work on mental health (including learning disabilities and autism) in an "accountable care partnership" model. The work of the strategy group, and methodology used to promote activity and improvements to services, has been replicated across the region demonstrating a positive view of the strategy group methodology.

It is anticipated that this will continue through the next financial year and beyond and the strategy group has helped frame the joint strategic needs assessment for the next year, which will have a focus on children and young people's emotional resillience, addressing prevalence of depression, premature mortality and people with co-existing conditions.

THE NATIONAL PICTURE FOR MENTAL HEALTH

It is recognised that no other health condition matches mental ill health in the combined extent of prevalence, persistence and breadth of impact.

Premature mortality presents a particularly stark picture where people with a serious mental health condition wil die, often from preventable conditions, 20 years younger than the general population.

Premature mortality is higher for people with severe mental illness (SMI)

Population aged under 75 in contact with secondary mental health services face a

3.7 times higher mortality rate

than the general population*

The annual cost of mental ill-health in England is estimated at £105 billion.

In comparison, the total costs of obesity to the UK economy is £16 billion a year and cardiovascular disease £31 billion.

Mental health in numbers

1 in 6 adults will have experienced a common mental health disorder in the past week

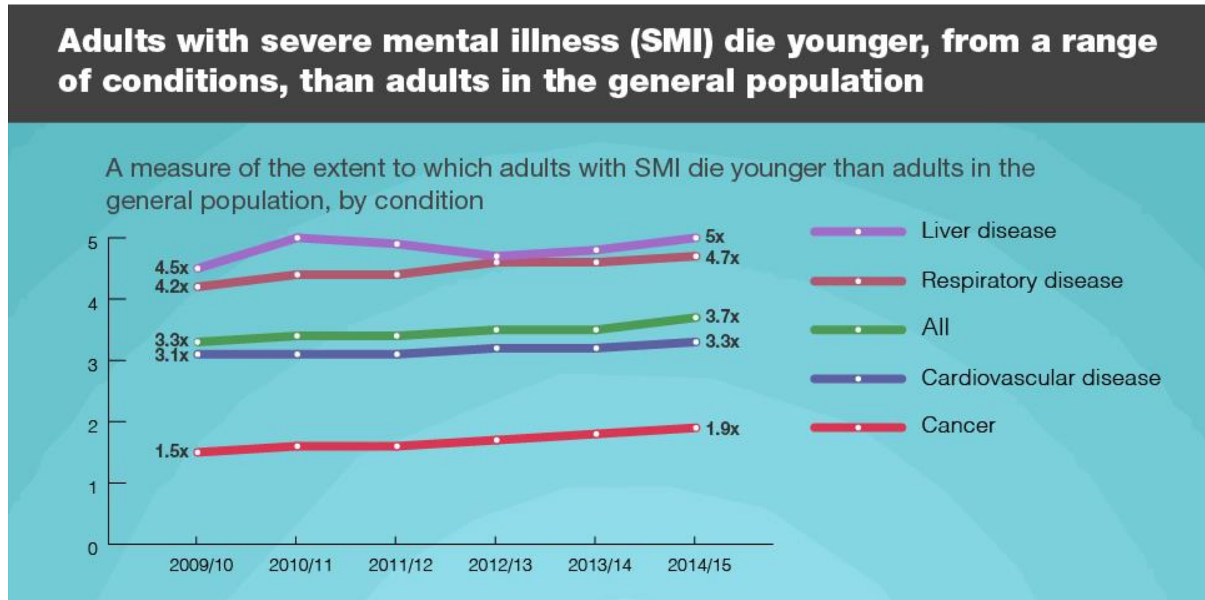
Severe mental illness (SMI) such as **schizophrenia** or **bipolar disorder** affects about

half a million

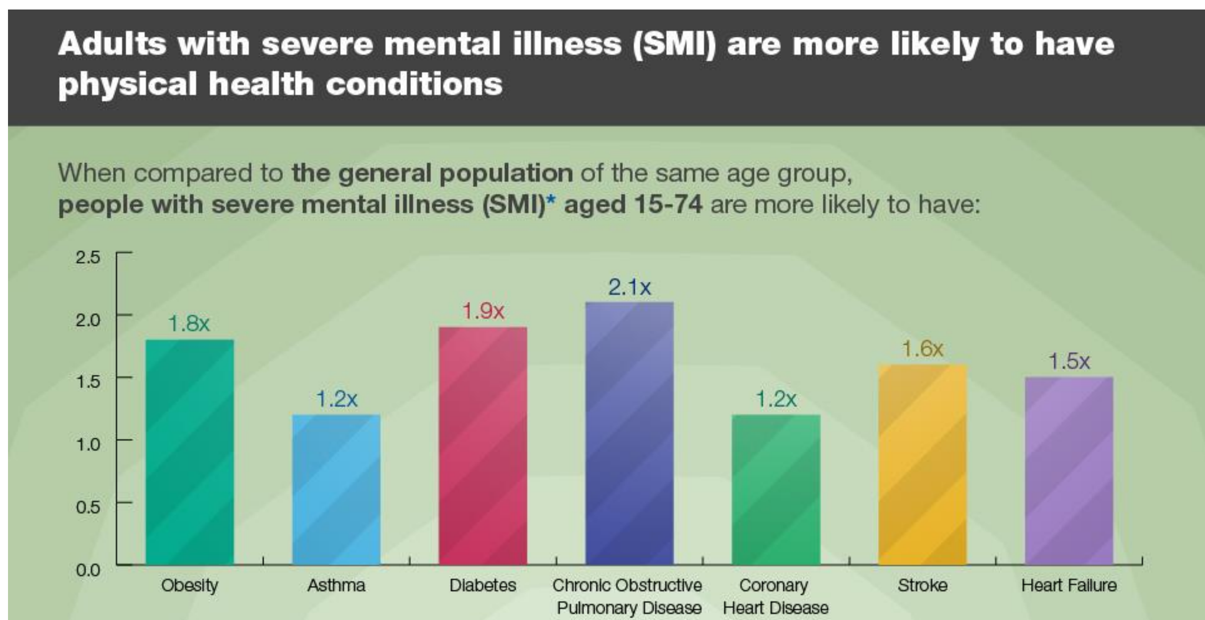
adults in England

GP registers in England estimate that half a million adults in England are affected by serious mental illnesses that reduce a persons quality of life, reduce heathy aging and reduce life expectancy.

The age of death for people with a severe mental illness from common illnesses is considerably lower than the general population.



They are also more likely to have common health issues.



Funding is being made available to address the health inequalities of people with severe mental illnesses in 2019-20.

CCGs and local partners have been aware of these inequalities and are already working to address them within the work programme of the strategy group, including support for people who do not have a severe mental illness but whose mental wellbeing may be preventing access to health services including smoking cessation, obesity programmes, seasonal vaccination and appropriate screening and health checks.

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National Drivers

The CCG Commissioning Plan for mental health services and activities is informed by several national drivers.

The NHS Long Term Plan[1]

The Long Term Plan (LTP) has now been published and includes some very ambitious proposals for mental health over the next ten years. There is a drive to create integrated care systems (ICSs) everywhere by April 2021.

The NHS Long Term Plan makes a renewed commitment, building on the "NHS Five Year Forward View"; to grow investment in mental health services faster than the NHS budget overall for each of the next five years.

The commitment is to investment in mental health services, which will grow faster than the overall NHS budget, creating a new ring-fenced local investment fund worth at least £2.3 billion a year by 2023/24.

Children and young people's mental health features prominently in the plan, with a commitment that funding for these services will grow faster than both overall NHS funding and total mental health spending.
The main commitments relating to mental health are:

- The NHS will ensure that a 24/7 community based mental health crisis response for adults and older adults is available across England by 2020-21
- Expanding age-appropriate crisis services for children and young people
- Ensure anyone experiencing mental health crisis can call NHS 111 and receive appropriate support by 2023/24
- Mental health liaison services will be available in all acute hospital A&E departments and 70% will be at 'core 24' standards in 2023/24, expanding to 100% thereafter.
- Set up clear standards for access to urgent and emergency specialist mental health care
- Provide post-crisis support for families and staff who are bereaved by suicide
- Increase in alternative forms of provision for those in crisis e.g. sanctuaries, safe havens and crisis cafes
- Specific waiting time targets for emergency mental health services will take effect from 2020.
- By 2023/24 NHSE will introduce new mental health transport vehicles to reduce inappropriate conveyance by ambulance or by police to A&E; ambulance staff will be trained and equipped to respond effective to people in crisis; and NHSE will introduce mental health nurses in ambulance control rooms

Mental Health Investment

Following publication of the LTP, the Operational Planning and Contracting Guidance was published. The guidance reiterates the LTP commitments to increase investment in mental health services and includes guidance around the Mental Health Investment Standard (MHIS). It states that:

[1] NHS England. 2019. The NHS Long Term Plan.

- For 2019/20 CCGs are required to increase spend by at least their overall programme allocation growth plus an additional percentage increment to reflect the additional mental health funding included in CCG allocations for 2019/20.
- To deliver the service expansions planned for 2019/20, CCGs will (other than by local exception requiring prior agreement with NHS England) also need to increase the share of their total mental health expenditure that is spent with mental health providers.
- As in 2018/19, each CCG's achievement of the mental health investment standard will require governing body attestation and in every case will be subject to independent auditor review.
- Spend on Children's and Young People's (CYP) mental health must also increase as a percentage of each CCG's overall mental health spend. In addition, any CCGs that have historically underspent their additional CYP allocation must continue to make good on this shortfall.
- STP/ICS leaders, including a nominated lead mental health provider, will review each CCG's investment plan underpinning the MHIS to ensure it covers all of the priority areas for the programme and the related workforce requirements.
- Where a commissioner fails to achieve the mental health investment requirements, NHS England will consider appropriate regulatory action, including in exceptional circumstances imposing directions on the CCG.
- To support the assessment of mental health investment plans, NHS England will also look at mental health spend per head, and as a percentage of CCG allocations.
- NHS England will continue to develop prevalence indicators and performance data to measure outcomes that can be monitored alongside financial investment levels to give a more rounded picture of improvements in mental health. Providers should make full and timely returns to the Mental Health Services Data Set to support this.

Mental Health Deliverables for 2019/20

There are a number of deliverables for mental health in the Operational Planning and Contracting Guidance that are relevant to both commissioners and providers, including:

- At least 95% of people referred to the IAPT programme should begin treatment within 18 weeks of referral.
- At least 56% of people aged 14-65 experiencing their first episode of psychosis should start treatment within two weeks.
- At least 34% of children and young people with a diagnosable mental health condition should receive treatment from an NHS-funded community mental health service, representing an additional 63,000 receiving treatment each year.
- Continued reduction in out of area placements for acute mental health care for adults, in line with agreed trajectories.
- Nationally, 3,000 mental health therapists should be co-located in primary care by 2020/21 to support two thirds of the increase in access to be delivered through IAPT-Long Term Conditions services
- Nationally, 4,500 additional mental health therapists should be recruited and trained by 2020/21.
- There are further deliverables that must be delivered during 2019/20 including all age crisis and liaison services

There are a number of appendices to the Operational Planning and Contracting Guidance and many of these will useful information. Annex B: Guidance for Operational and Activity Plans: Assurance Statements is particularly relevant to CCGs.

NHS Five Year Forward View[2]

The NHS Five Year Forward View acknowledged that physical and mental health are closely linked – people with severe and prolonged mental illness die on average 15 to 20 years earlier than other people.

The NHS's ambition over the next five years is to drive towards an equal response to mental and physical health, and towards the two being treated together.

No Health without Mental Health: A cross-government mental health strategy for people of all ages[3]

The publication of "No Health without Mental Health" in February 2011 drew together the wider principles that the government laid down for its health reforms, including patient-centred care and locally determined priorities and delivery. At a national level, the strategy sets out the 'high level' objectives to improve the mental health and wellbeing of the population.

These are:

1. More people will have good mental health
2. More people with mental health problems will recover
3. More people with mental health problems will have good physical health
4. More people will have a positive experience of care and support
5. Fewer people will suffer avoidable harm
6. Fewer people will experience stigma and discrimination

Resulting from this, an implementation framework has been developed and sets out how progress will be monitored through the outcomes frameworks and made a series of recommendations for local and regional organisations to take forward.

These included providers and commissioners of mental health services, primary, acute and community health providers, the new health and wellbeing boards, social services, children`s services, public health services, housing organisations, schools and colleges.

The position statement of the Royal College of Psychiatrists states:

- No other health condition matches mental illness in the combined extent of prevalence, persistence and breadth of impact
- Mental illness is consistently associated with deprivation, low income, unemployment, poor education, poorer physical health and increased health-risk behaviour

Mental health practice should aim to put the person's needs at the centre of care planning and service delivery. No Health without Mental Health encourages recovery based approaches; this is further reinforced in the NHS Outcomes Framework as well as the Social Care Outcomes Framework.

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[2] NHS England. 2014. NHS Five Year Forward View.
[3] Department of Health. 2011. No Health without Mental Health: A cross-government mental health strategy for people of all ages.

No Health without Mental Health states that a good start in life and positive parenting promotes good mental health, wellbeing, self-esteem and resilience to adversity throughout life. Parental mental health is an important factor in determining the child's mental health and secure attachments with parent or care-givers are associated with better outcomes for the child, including improved learning and academic achievement. As adults, those who are securely attached tend to have trusting, long-term relationships, higher self-esteem and supportive social networks.

A mental health dashboard was developed which brings together relevant measures from a wide range of sources to show us the progress being made against these objectives and to give a clear, concise picture of mental health outcomes as a whole.

The dashboard draws only on existing, publicly available sources of information and is not intended to hold individual organisations to account.

The dashboard covers the full, wide scope of the strategy and aims to provide a balanced picture across all six of the strategy's objectives. It therefore focuses not only on mental health services, but also on the mental wellbeing of the whole population, the physical health of people with mental health problems, people's experience of care and experience of stigma and discrimination.

The measures which make up the dashboard have been chosen for their relevance to these objectives and include those measures which are most relevant or important for mental health outcomes as a whole, not necessarily those which will be easiest, or even possible, for specific organisations (public services or other organisations) to affect. It focuses primarily on the outcomes we want to achieve, rather than how they will be achieved, or by whom.

The main purpose of the dashboard is to bring the best information we have about mental health outcomes together in one place, as a resource for everyone with an interest in improving these outcomes.

The Care Act 2014[4]

The Care Act 2014 consolidated social care law along with best practise and created a new obligation on local authorities to deliver the personalised agenda. Duties and requirements were introduced around assessments for carers with Independent Personal Budgets for all adults who have eligible social care needs.

The Act set out a clear legal framework for how local authorities and other parts of the health and care system should protect adults at risk of abuse or neglect.

Children & Families Act 2014[5]

The Children & Families Act gave greater protection to vulnerable children and young people, a new system for under 25s who have special education needs and disabilities and set out choice and control and help for parents to balance work and family life. It underpins wider reforms to ensure that all children and young people can succeed, no matter what their background.

[4] HMSO. 2014. Care Act 2014. Chapter 23.
[5] HMSO. 2014. Children and Families Act 2014. Chapter 6.

Closing the Gap: Priorities for essential change in mental health[6]

Closing the Gap supported the measures in the national mental health strategy; No Health without Mental Health, the Mental Health Implementation Framework and the Suicide Prevention Strategy. It bridged the gap between long term strategic ambitions and short term actions through the 25 priorities for action.

The document included the introduction of the Crisis Care Concordat, which is a commitment from organisations to prevent crises through prevention and early intervention, and is a mechanism to promote partnership working. It emphasises the government's intention for parity between mental and physical healthcare as set out in the NHS Mandate.

A Call to Action: Achieving Parity of Esteem; Transformative ideas for Commissioners[7]

In July 2013, NHS England launched A Call to Action, which began a programme of engagement and evidence collection that encourages everyone to contribute to the debate about the future of health and care provision in England. It also signalled the beginning of a process to develop a new strategy for the health service.

A discussion paper was developed which focused on valuing mental and physical health equally. This resource focuses on one of the outcome ambitions set out in the strategic planning framework: to achieve ‘parity of esteem’ and stimulated debate between Clinical Commissioning Groups and local partners to think about changes that can be made.

There was a stated ambition for the NHS to put mental health on a par with physical health.

The following 10 Facts are taken directly from A Call to Action: Achieving Parity of Esteem and are the reasons why there should be a move to achieve parity between physical and mental health:

1. Mental health problems develop at a young age. 1 in 5 children have a mental health problem in any given year. First experience of mental health in those suffering lifetime mental health problems: 50% by 14 years old and 75% by 25 years old.
2. Mental health is widespread and common. Every year 1 in 4 adults experience at least one mental disorder.
3. Mental health is a significant burden. Mental illness is the single largest cause of disability in the UK.
4. Mental health impacts on life expectancy. Average life expectancy in England and Wales for people with mental health problems is behind the national average. 68 years for males and 73 years for females for people with mental health problems. 79 years for males and 83 years for females for everyone else.
5. People with mental health problems have worse physical outcomes. People with mental illness are at increased risk of the top five health killers, including heart disease, stroke, liver and respiratory diseases and some cancers. People with Schizophrenia are twice more likely to die from cardiovascular disease and three times more likely to die from respiratory disease.

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[6] Department of Health. 2014. Closing the gap: priorities for essential change in mental health.
[7] NHS England. 2013. A Call to Action: Achieving Parity of Esteem; Transformative ideas for Commissioners.

6. When people with long term conditions also have mental health issues the cost of treatment can rise significantly. 1/3 of people with long term conditions also experience mental health problems increasing treatment costs by around £8–13 billion a year.
7. The mental health of people with serious physical health problems is often overlooked. ½ of terminally ill or advanced cancer patients suffer from depression, anxiety and/or an adjustment disorder, yet less than half receive treatment for their mental health.
8. Mental health problems affect the likelihood that people will be compliant with their treatment. Depression co-morbid patients are three times more likely to be non-compliant with treatment recommendations than non-depressed patients.
9. There are often long waits for mental health services. 1 in 10 people wait over a year for access to talking therapies.
10. There is a wider economic impact of mental health. The full costs of mental illness in England have been estimated to be £105.2 billion a year.

Crisis Care Concordat

The Crisis Care Concordat aims to improving outcomes for people experiencing mental health crisis.

The Concordat is a shared agreed statement, signed by senior representatives from all the organisations involved. It covers what needs to happen when people in mental health crisis need help – in policy making and spending decisions, in anticipating and preventing mental health crises wherever possible, and in making sure effective emergency response systems operate in localities when a crisis does occur.

The Concordat is arranged around:

- Access to support before crisis point
- Urgent and emergency access to crisis care
- The right quality of treatment and care when in crisis
- Recovery and staying well, and preventing future crises

The Concordat expects that, in every locality in England, local partnerships of health, criminal justice and local authority agencies will agree and commit to local Mental Health Crisis Declarations. These consist of commitments and actions at a local level that will deliver services that meet the principles of the national concordat.

On Tees, the Concordat has also taken on recommendations from the Crisis Prevention Concordat.

Better Care Fund

The Better Care Fund (BCF) is a National programme spanning both the NHS and Local Government which seeks to join-up health and care services, so that people can manage their own health and wellbeing, and live independently in their communities for as long as possible.

The BCF has been created to improve the lives of some of the most vulnerable people in our society, placing them at the centre of their care and support. The Stockton-on-Tees BCF Plan 2017-19 aims to facilitate the integration health and social care services, that intend to provide an improved experience and better quality of life for the residents of Stockton-on-Tees.

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There is a clear economic case for investing in public mental health and some of the returns on the investment can be realised in the relatively short-term.

The type of savings that can be made from public mental health actions have been highlighted in a number of reports, including the Government's Mental Health Strategy, a report by the Personal Social Services Research Unit at the London School of Economics (LSE) for the Department of Health and the Joint Commissioning Panel for Mental Health's guide to commissioning public mental health services.

The Department of Health report highlighted that, for every £1 invested in a public mental health programme, the net savings were:

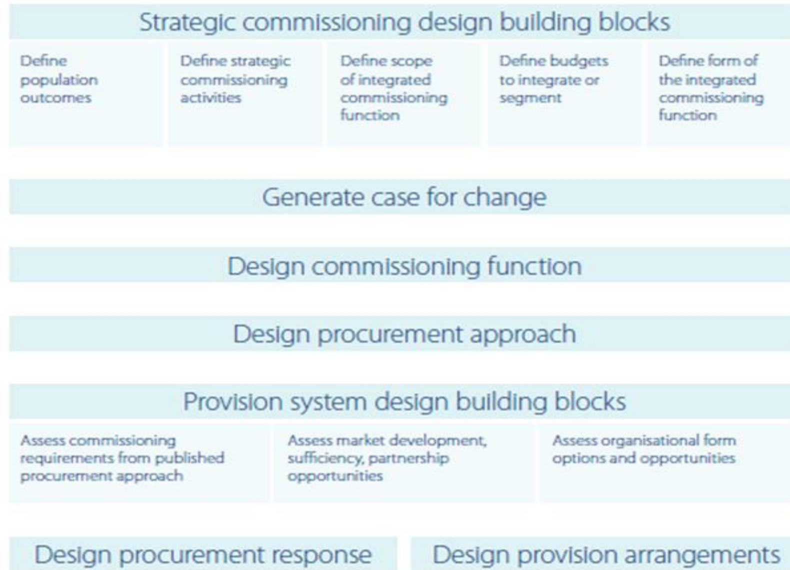
- £84 from school-based social and emotional learning programmes
- £44 from suicide prevention through GP training
- £18 from early intervention for psychosis
- £14 from school-based interventions to reduce bullying
- £12 from screening and brief interventions in primary care for alcohol misuse
- £10 from work-based mental health promotion (after one year)
- £10 from early intervention for pre-psychosis
- £8 from early interventions for parents of children with conduct disorders
- £5 from early diagnosis and treatment of depression at work
- £4 from debt advice services

REGIONAL PARTNERSHIP

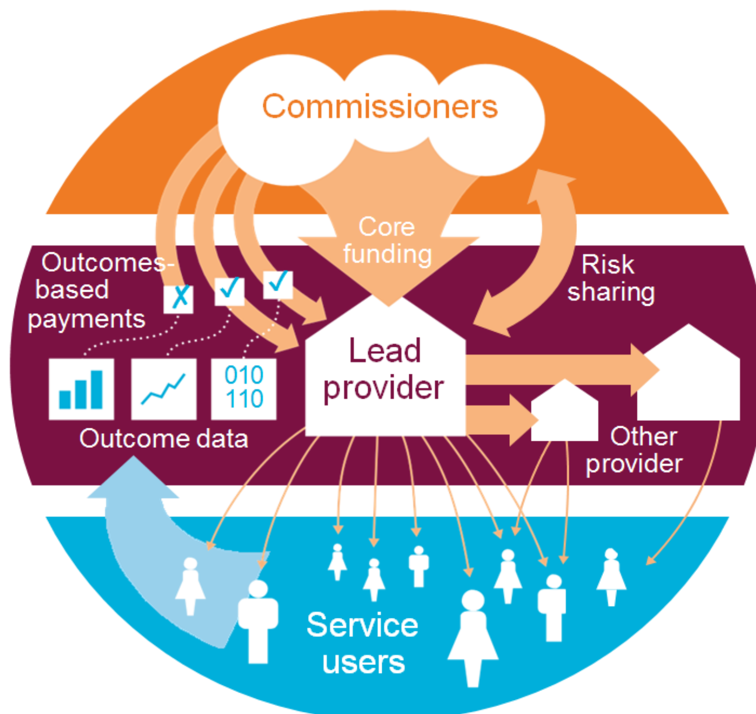
In 2018, the CCGs across the Tees Valley and County Durham formed an accountable care partnership with Tees Esk and Wear Valleys NHS Trust as lead partner.

The vision was:

> *"The Accountable Care Partnership will work together as one responsive system to plan, buy and deliver high quality, best value health services for those living with learning disability or mental health needs"*



The Durham, Darlington and Tees Mental Health and Learning Disabilities Partnership (The Partnership) was designed to be an outcomes-based Accountable Care Partnership Model.



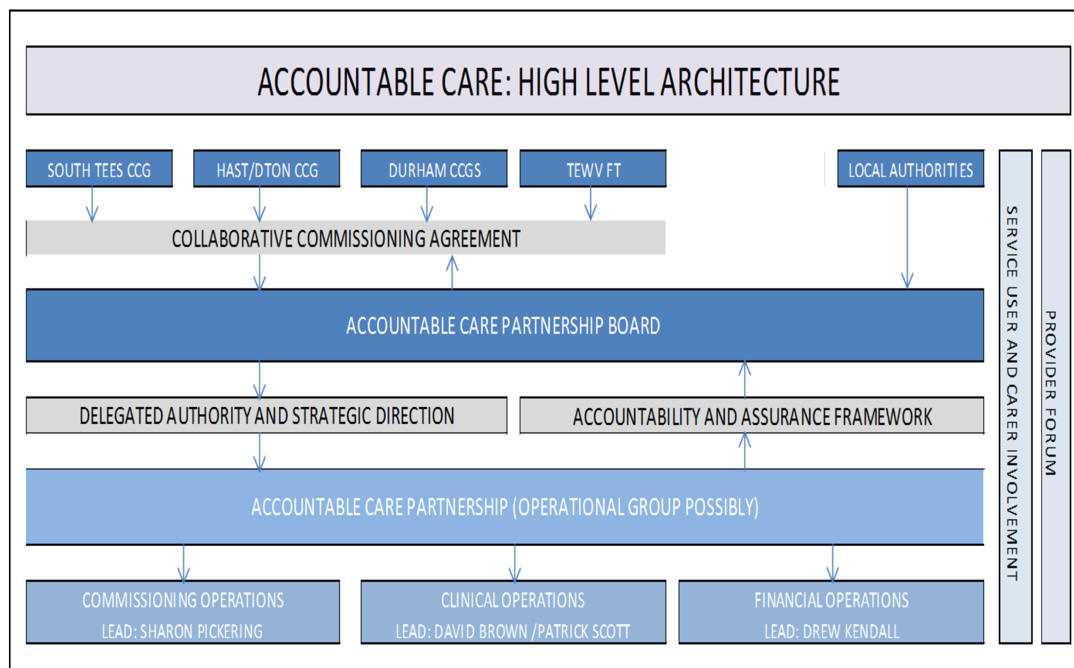
The drivers for the development of this approach were:

- Lack of assurance on quality
- Need to bring together the expertise –most complex people
- Want to get it right for the future
- Emptying beds but not checking back
- Pressure to deliver transforming care requirements (enhanced high cost community services)
- Fragmented system (multiple providers, multiple commissioners)
- Challenge to deliver system transformation in context of above
- Escalating cost pressures in LD (CHC, IPOCs, sec 117s)
- Mental Health 5yr FV asks for greater transformation and integration

The model is designed to ensure:

- Clear focus on outcomes not process
- Enhanced MDT oversight of all cases
- Enhanced people and system outcomes
- Increased assurance on most complex packages
- Better flow and transition from Spec comm.(NCM)
- Increased quality assurance
- Moving investment to community focussed services including voluntary and community sector providers
- Enhanced contract management
- Enhanced performance management

In order to achieve these outcomes, the architecture (below) was created:



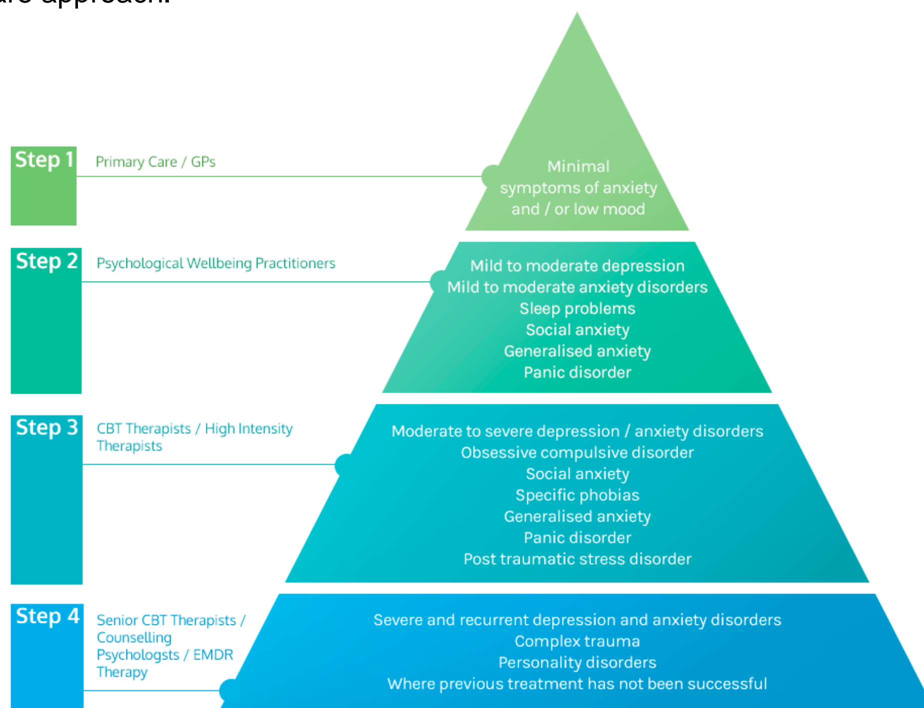
It is assumed that all NHS commissioning responsibilities for mental health and learning disability services, for both individual and populations, will be undertaken by the Partnership.

All appropriate staffing resources will be aligned to the Partnership architecture and the functions will encompass all elements of the commissioning cycle

Services Across Tees Valley

This report relates to all-age and adult services. Those services commissioned directly for children or older people are reported separately.

The Hartlepool and Stockton-on-Tees CCG Mental Health Strategy 2014/15 – 2018/19 committed the CCG to implementing a parity of esteem approach. This included raising investment in services for children and young people and supporting a primary mental health stepped care approach.



Community Teams across CCG areas

- Specialist Community Mental Health Teams for Affective disorders (multi-disciplinary service for people with severe and complex mood related mental health problems)
- Specialist Community Mental Health Teams for Psychosis (multi-disciplinary service for people with severe and complex psychotic mental health problems)
- Mental Health Access service (first point of contact for referrers)
- Mental Health Crisis Team (multi-disciplinary service for people with complex mental health conditions who are in crisis requiring an urgent response)
- Mental Health Home Treatment service (multi-disciplinary service to support people in their own home as an alternative to hospital admission)
- Intensive Home Support Service (psychologically led service for Older People in mental health crisis who exhibit complex and high risk behaviours)
- Older peoples Community Mental Health Team (for assessment and treatment of older adults with complex mental health conditions)
- Assertive Outreach service (to offer more intensive ongoing support for people with severe and enduring mental health problems who are vulnerable or prone to rapid relapse)
- Early Intervention in Psychosis service (multi-disciplinary service aimed at people aged between 14 and 35 years who experience a first episode of psychosis, specialising in focussed family work and psycho-education alongside judicial use of antipsychotic medication)

- Acute Hospital Liaison Service (specialist multi-disciplinary mental health service operating 24/7 within the acute trust to assess, treat, and help manage people with mental health conditions who present at the acute hospital, offering signposting to specialist mental health services or other provision where appropriate)
- Carer Support – CCGs contribute towards services which offers support, advice and guidance to carers
- Baby bereavement – emotional support for bereaved parents
- Recovery College24 - A local recovery college has been commissioned to support the recovery approach.
- Community eating disorders service, specialist community team providing treatment and support for people with eating disorders (primarily anorexia nervosa and bulimia nervosa

Inpatient Services

- Adult acute mental health wards for assessment and treatment of complex mental health problems.
- Psychiatric Intensive Care ward for people in an acute phase of mental illness with very high risk behaviours
- Male Locked Rehabilitation for men who exhibit high risk behaviours relating to their mental health problems and require inpatient care for a longer period of time
- Female locked rehabilitation for women who exhibit high risk behaviours relating to their mental health problems and require inpatient care for a longer period of time
- Specialist mental health rehabilitation for people who require longer periods of mental health treatment, up to 18 months.
- Specialist mental health rehabilitation for people who require longer term in-patient treatment, 18 months plus

Inpatient services, including medium and low secure environments are based at Roseberry Park in Middlesbrough with step down units in Lanchester Road Hospital in County Durham and community rehabilitation services for people with learning disabilities at Oakwood in Middlesbrough. Community forensic services including criminal justice liaison services that work across the whole offending behaviour pathway, for example street triage in Middlesbrough and the mental health service within all seven North East prisons are also provided.

The Clinical Commissioning Group also has contracts with independent hospitals both in and out of the area. These provisions are utilised to support the most complex cases and offer a range of interventions.

Physical Health Improvement

In January 2018, the two NHS Mental Health Trusts in the North East, NTW and TEWV, launched a three year health improvement plan *"A Weight Off Your Mind"*.

Over the next 3 years they will:

- Ensure the Trusts have a sound understanding of the cardiovascular risks that impact on service users and ensure these are systematically recorded and reflected in care planning (this is supported by the 2017-19 CQUIN);
- Ensure service users are empowered with the information and tools to manage their weight. Where this involves referral to an additional service, the service user should be fully involved in this decision and be fully aware of why they have been referred and what they can expect;
- Ensure staff have the skills, equipment and support to sensitively and appropriately undertake physical health screening;

- Ensure that service users identified as meeting the Lester tool triggers are referred into the agreed pathways;
- Ensure staff are aware of their role in managing cardiovascular disease and its relation to weight gain, including the relevant cardiovascular/nutritional pathway;
- Ensure Trusts have good communication with primary care regarding physical health checks;
- Provide healthy food and drink for all service users, staff and visitors;
- Work with the CQC, produce Trust guidance on restrictive practice in relation to food and drink including the use of takeaways and portion sizes;
- Support Trusts to improve nutritional screening by increasing understanding and recording of an appropriate nutritional screening tool;
- Develop nutritional pathways that provide helpful advice and signpost to dietetic services when a high nutritional need is identified (under or over nutrition);
- Have a culture that supports everybody who is trying to lose weight/prevent weight gain and identify good role model champions amongst staff and service users;
- Aim to improve the quality of food served, and reduce the rigidity of meal times, in order to reduce the likelihood of service users seeking unhealthy alternatives such as takeaways, especially late at night;
- Ensure dietary advice is accessible to all, available in a variety of formats, including easy read;
- Provide opportunities to engage in the recommended levels of physical activity each week (150 minutes) by promoting it as a treatment intervention;
- Ensure that leisure services in the community proactively support those of us with a lived experience of mental health conditions and/or learning disability to engage in physical activity;
- Offer physical activity alongside medications which are known to cause weight gain
- Ensure exercise prescription within hospital settings is evidence based and provided by appropriately qualified staff to be able to develop specific, individual care plans through shared decision making;
- Improve links and referral pathways with community providers;
- Work with the dedicated physical activity clinical champions funded by PHE as part of their work on ‘Everybody Active Everyday Framework’;
- Change the culture around antipsychotic prescribing so that clinicians are trained to consider the impact of weight as part of prescribing. This includes discussing options with service users, side effects of their medication (including antipsychotics) in order to come to a collective decision about future care plans;
- Provide accessible information and guidance for staff, patients and carers on the impact of medication on weight gain;
- Develop a prescriber decision-aid tool;
- Ensure we have a compassionate understanding of why we eat and move as we do
- Provide psychological support for service users and staff in managing their own excess weight;
- Develop a model for the use of psychological approaches which includes all elements from brief advice to packages of psychological therapy;
- Ensure that psychologists and therapists have the ability to confidently include eating and activity in psychological assessments, formulations and treatment plans in partnership with service users;
- Increase the availability of education resources and training on weight management for staff including Making Every Contact Count, brief advice and more specialist training
- Work with Health Education England and the relevant training providers to ensure that physical and mental health is equally incorporated into undergraduate and postgraduate training for health professionals;

- Work with Health Education England and training providers to deliver more bespoke weight management training for staff working in Mental Health/Learning Disability services;
- Provide training to peer support workers so that they can deliver healthy lifestyles education to their peers;
- Use a whole family approach to increase family and carers' (including young carers) knowledge and skills of healthy eating and physical activity so that they are able to support the physical health needs alongside the mental health needs of the person they care for;
- Ensure those who use services are fully involved in decision making, and empowered to take action;
- Work with the Local Authorities to map existing community based weight management and physical activity offers; ensuring information about what is available is accessible
- Ensure community-based specialist weight management, physical activity services (where they exist) and wider leisure offers are accessible and/or have referral pathways in place, providing training where appropriate and challenging stigma when services are seen to exclude individuals with lived experience of a mental health condition or a learning disability;
- Work with primary care to develop clear referral pathways;
- Ensure that Local Authorities and NHS commissioners consider the needs of people with lived experience of a mental health condition and/or learning disabilities within any weight management and/or physical activity and commissioning intentions;
- Work with families on weight related issues of all family members and to emphasise a family approach to healthy lifestyle;
- Continue to incorporate daily physical activity into care planning to the recommended levels (60mins daily for 5-18year olds);
- Reduce consumption of high calorie/fat or sugary foods available for C&YP by increasing the availability of healthy food/snacks;
- Ensure training to staff and support for families working with C&YP includes education on diet and physical activity;
- Ensure that all C&YP accessing our service are offered the opportunity have their BMI checked on a regular basis;

Recovery

Recovery in this context equates to personal recovery and is a different concept to clinical recovery, which is focused on the absence of symptoms and 'returning to normal'. Personal recovery is considered to be individually defined and is about living a satisfying and meaningful life, with or without symptoms.

A recent review of the recovery literature identified five components that have a significant role in most people's recovery, namely:

1. Connectedness (relationships)
2. Hope
3. Identity (beyond a diagnosis or service user)
4. Meaning and purpose to life
5. Empowerment

These five factors are known collectively as the CHIME framework.

Services that are recovery orientated focus on the individual goals of individuals, recognising and building on their personal strengths, foster self-management and offer a range of opportunities for individuals to find meaning in their lives.

Co-production, learning from and working with people with lived experience of mental health to develop and deliver services should be at the heart of genuine recovery focused approach.

Recovery challenges conventional approaches to treating mental ill health. It is consistent with the government's vision and takes a more holistic approach to mental wellbeing and health improvement, rather than addressing mental illness in isolation from other important factors in people's lives.

It is recognised that current and former service users can help to support people who experience problems with their mental health. Peer Support is one way of helping people recover from mental distress and its impact on their lives. It enables people to provide knowledge, experience, and emotional, social or practical help to each other.

Peer support relies on the assets, skills and knowledge in the community, and the recognition that local people can offer help in ways that are sometimes more effective than professional help.

A data review of CCG commissioned recovery services has revealed that all recovery college programmes are performing well against targets. The Partnership is committed to reviewing the whole patient journey pathway across Tees and Durham to identify whether the current approach is the right approach.

Suicide Prevention

Tees has an established suicide prevention task force. This is supported by a joint funded post of Suicide Prevention Coordinator who has been responsible for undertaking an audit of all recorded suicides over the last three years. The finding from this audit have identified high risk groups and key themes of:

- Financial issues
- Relationship issues/breakdown
- Mental Health conditions diagnosed, but not well managed.
- Adverse Childhood Experiences
- Work related (e.g. changes to work – redundancy, retirement)
- Recent contact with the criminal justice system
- Persistent physical conditions .

Development of 6 stage Teesside Suicide Prevention Plan:

1. Reduce the risk of suicide in key high-risk groups
2. Tailor approaches to improve mental health in specific groups
3. Reduce access to the means of suicide
4. Provide better information and support to those bereaved or affected by suicide
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour
6. Support research, data collection and monitoring.

STP Funding allocation is to be used to build upon the work already being undertaken including increased capacity for the Tees Training Hub. Also a community fund for local groups to bid for between £1000 & £5000 to work with groups identified a high risk. Some funding is being spent on developing an algorithm to focus on early warning identification particularly considering the self-harm A&E pathway.

Mental Health in Stockton

The current mental health strategy aims to reduce health inequalities and improve health and wellbeing for all, building on Stockton's Local Strategic Partnership (LSP) aspiration of "Promoting Achievement and Tackling Disadvantage".

This was based upon a strategy and delivery plan that encompassed all of the drivers for change and offered a framework for delivery across the short, medium and long term.

The Health and Wellbeing structures aimed to improve and protect Stockton-on-Tees' health and to improve the health of the poorest fastest.

The Borough of Stockton-on-Tees has a significantly higher incidence and prevalence of depression than both the regional and national averages.

Stockton has a higher than national average admissions for mental and behavioural disorders but a lower than national average number of adults in concurrent contacts with mental health services and alcohol misuse services.

IAPT treatment programme: The England average is continuing to improve and Stockton has moved from being above the national average to below the national average since quarter one of 2017/18.

Premature mortality: The rate for 2013-15 and 2014-16 is higher than the national average. For the period 2014-16, Stockton-on-Tees had the 9th highest rate when compared against the England authorities.

Stockton-on-Tees has higher than the national average admission episodes for mental and behavioural disorders due to use of alcohol. However, the percentage of people in concurrent contact with mental health services and substance misuse services for alcohol is below both the regional and national average.

Stockton's multi-agency strategy outlines the plans for improving the mental health and emotional wellbeing of the residents in the Borough. It highlights an ambition to work collaboratively and in partnerships across a range of communities, settings and services to ensure better outcomes for all.

The strategy also considers existing local works, including the CCG mental health work plan, the Tees-wide Suicide Prevention Plan, NHS Long Term Plan and the Future in Mind priorities.

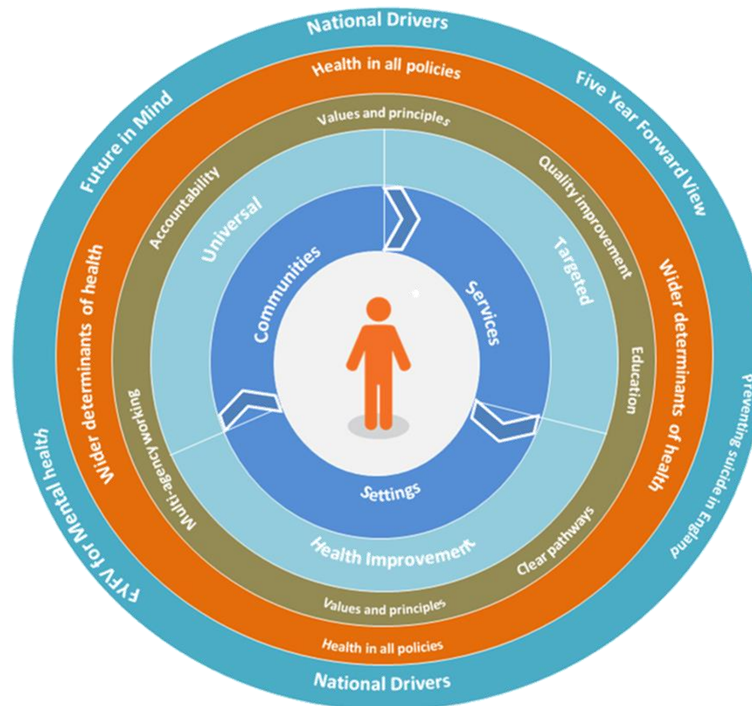
Opportunities to align commissioning and procurement processes have also been considered alongside utilisation of contract levers to enhance service provision not limited to mental health services E.G; improving pathways between substance use and mental health services or embedding workforce training in commissioned services.

The priorities are:

- To promote mental health & wellbeing across the lifecourse for the whole population, supporting mentally healthy communities and places, to prevent ill health by addressing the wider determinants of health.
- To take a targeted approach for groups at risk of poor mental health and wellbeing, including those during the transition period, older people and new mums. To improve

early identification, access and intervention to prevent the progression of poor mental health

- To support those with mental health problems to promote recovery and wellbeing including their physical health. To prevent recurrence or reduce risk of recurrence for those with established conditions, ensuring the right care at the right place at the right time.



Underpinning the effective delivery and implementation of the integrated strategic action plan are a set of core values and principles agreed by partners which should be implemented to form the basis for all future work to be built on.

The Strategy Group reports into the Health and Wellbeing Board and the plan covers the following areas of work:

Depression and anxiety

- Bereavement services – Cruse Bereavement Services is a charity dedicated to supporting bereaved people through one to one, groups or telephone support.
- Stockton Service Navigator Project - handholding support to access social prescribing services or Public Health commissioned services. The Navigator can help find an activity such as a walking group, creative arts group, exercise class or social group to support health and wellbeing. We can also signpost and support you to access other services such as the Citizens Advice Bureau, education providers, volunteering and job clubs.
- Stigma and discrimination – pilot with Middlesbrough and Stockton Mind
- IAPT (Provision of Psychological Therapy)
- Recovery college – Hartlepool and East Durham Mind
- Out patients – TEWV
- Intensive Home Treatment team – TEWV

- Social isolation and loneliness scoping document produced
- Integrated Mental Health Steering Group – with dedicated action plan to address many of the issues identified within the needs assessment and raised by the parties involved across the borough.
- Crisis and prevention concordat
- Voluntary and community sector organisations that support a range of individuals to improve their emotional wellbeing and mental health.
- Close 2 Home Reablement project - Middlesbrough and Stockton Mind
- Active Minds mental health sports project - Middlesbrough and Stockton Mind
- Energise women's mental health sports project - Middlesbrough and Stockton Mind
- Step Forward Tees Valley, supports local people to overcome the complex reasons preventing them from finding work - wider programme managed by Northern Inclusion Consortium, Health Link Work for Stockton, which focuses on helping people with health related barriers, provided by Middlesbrough and Stockton Mind.

Dual diagnosis

CGL (Change, Grow, Live) Drug and Alcohol services are the commissioned provider in the Stockton area to support adults and young people to understand the risks their drug or alcohol use pose to their health and wellbeing, and support them to reduce or stop their use safely.

CGL integrated services address the needs of the whole person and encompass housing, education, training and employment as well as psycho-social, counselling and clinical substance misuse treatment. Once stability or abstinence has been achieved, we provide aftercare to help maintain recovery and reduce the likelihood of relapse. CGL provide specialist support for alcohol, all illegal drugs, New Psychoactive Substance (NPS), prescription and over the counter (OTC) medication and steroids

CGL work with the families and friends of people affected by drug or alcohol use to help develop and maintain strong, loving and stable relationships critical to successful recovery. CGL also prioritise the safeguarding of children and vulnerable family members affected by the substance use of a family member.

CGL also have in reach teams based throughout GP surgeries in Stockton and within the University Hospital of North Tees.

CGL Stockton Young person's service provide Tier 3 psychosocial drug and alcohol treatment to young people aged up to 18 years, exceptions for age 18 years plus can be granted for young people identified with an additional needs and vulnerability such as learning difficulty or disability. The treatment encompasses a holistic identification of the young person's needs, issues and concerns that are affected by or impacted as a result of their substance use, for example physical and emotional health and wellbeing, family breakdown, offending behaviour and sexual exploitation.

They work with a varied range of people involved in a young person's care such as parents/carers and professionals. Service delivery is flexible to meet the needs of the young person and to minimise any barriers to positive engagement, these can be offered and provided at a suitably agreed venue, including home visits, education establishments or community based settings such as youth services.

The service also aims to enhance a wider awareness and prevention of young people's substance use by providing advice, information and support on current trends and themes and associated signs and symptoms.

Children and Young People

Children's Services are currently reviewing smarter ways of working. Moving away from the current traditional approach to Children's Services, toward a child centred whole system approach (family focused) with a view to offering a universal offer, a school offer and a personal offer to families and CYP.

HaST CCG commission TEWV to provide Child and Adolescent Mental Health Service (CAMHS), this service is open access and can support children up to the age of 18. A review of the CAMHS service, to ensure it is meeting the needs of younger people, is underway.

Future in Mind. The focus in has been on upskilling schools to identify needs and support children rather than to refer everyone to TEWV. The role of schools is of importance in the transformation of children's mental health services.

Services impacting on all or multiples above

- Tees Training Hub delivering free mental health training courses for frontline practitioners and line managers working in public, private and voluntary sector. A range of training is offered, including:
    - Mental Health First Aid (adult and youth);
    - Mental Health First Aid Lite;
    - a Life Worth Living; and
    - Applied Suicide Intervention Skills Training.
- IAPT
- Teesside Samaritans
- Job Centre Plus
- Citizens Advice
- Stockton Information Directory
- Stockton Welfare Advice Network
- Middlesbrough and Stockton Mind

These are further explored in this report.

STRATEGY GROUP WORK PROGRAMMES

IAPT Service Review 2018

The Improving Access to Psychological Therapies (IAPT) programme began in 2008 and has transformed treatment of adult anxiety disorders and depression in England. Over 900,000 people now access IAPT services each year, and the Five Year Forward View for Mental Health committed to expanding services further, alongside improving quality.

IAPT services provide evidence based treatments for people with anxiety and depression (implementing NICE guidelines).

IAPT services are characterised by three things:

1. Evidenced based psychological therapies: with the therapy delivered by fully trained and accredited practitioners, matched to the mental health problem and its intensity and duration designed to optimize outcomes. From April 2018 all clinical commissioning groups were required to offer IAPT services integrated with physical healthcare pathways. The IAPT Pathway for People with Long-term Physical Health Conditions and Medically Unexplained Symptoms guidance is intended to help with implementation and sets out the ideal pathway for IAPT services.

2. Routine outcome monitoring: so that the person having therapy and the clinician offering it have up-to-date information on an individual's progress. This supports the development of a positive and shared approach to the goals of therapy and as this data is anonymized and published this promotes transparency in service performance encouraging improvement.

3. Regular and outcomes focused supervision so practitioners are supported to continuously improve and deliver high quality care.

The priorities for service development are:

- Expanding services so that at least 1.5m adults access care each year by 2020/21. This means that IAPT services nationally will move from seeing around 15% of all people with anxiety and depression each year to 25%, and all areas will have more IAPT services.

- Focusing on people with long term conditions. Two thirds of people with a common mental health problem also have a long term physical health problem, greatly increasing the cost of their care by an average of 45% more than those without a mental health problem. By integrating IAPT services with physical health services the NHS can provide better support to this group of people and achieve better outcomes.

- Supporting people to find or stay in work. Good work contributes to good mental health, and IAPT services can better contribute to improved employment outcomes.

- Improving quality and people's experience of services. Improving the numbers of people who recover, reducing geographic variation between services, and reducing inequalities in access and outcomes for particular population groups are all important aspects of the development of IAPT services.

IAPT services across Durham and Tees are in the process of recommissioning IAPT services in 2019/20.

Mental Health Conveyance Service

In 2018, NHS North Durham, NHS Durham Dales, Easington and Sedgefield (DDES), NHS Darlington, NHS Hartlepool and Stockton-On-Tees (HAST) and NHS South Tees Clinical Commissioning Groups (CCGs) combined funding to procure a service which commenced in March 2018.

The Mental Health Act 1983 and associated Code of Practice 2015 require patients detained (generally under S135 Mental Health Act 1986 (MHA)) for assessment or treatment to be transported to hospital by ambulance.

Previous arrangements with NEAS as the sole provider did not deliver a satisfactory service, resulting in long delays for patients who needed transport to a mental health hospital.

It is also recognised that general ambulances are not necessarily appropriate transport for people in mental health crisis.

Across the region the CCG's have developed and piloted service models with a specialist ambulance provider delivering reduced waiting times and improved patient experience, supported by positive feedback from professionals involved in patient care.

All Durham and Tees area CCGs agreed to formally procure a two year service. In December 2018 the winning bidder, ERS Medical, was announced.

The service is operating from Bowburn, County Durham and with response times given as a maximum of 1 hour, which may be raised at peak traffic times..

Crisis and Home Treatment Team Services Reviews

The CCGs have worked with the review leads, South Tees CCG for the Tees-wide review and North Durham CCG for County Durham area to examine all crisis services and activity.

Reports have been completed in 2018 and reported into the respective CCG Executives and the Partnership Commissioning Group.

As a result of the reviews, the Partnership is working with Tees Esk and Wear Valleys NHS Trust (TEWV) to review findings and identify opportunities for service development in the 2019-20 financial year.

The Crisis Care and Prevention Concordat group is overseeing wider partner requirements.

This includes Street Triage programmes, Police Force Control Room Mental Health support, Crisis Houses and Safe Havens.

Suicide Prevention

Strategy Group members are actively involved in the local Suicide Prevention Task Force which has it's own suicide prevention plan.

In addition, the Sustainable Transformation Programme (STP) area of Durham, Darlington, Tees, Hambleton, Richhmondshire and Whitby was successful in securing £500,000 NHSE funding for suicide prevention work in 2018-2020.

This is being used to support key project areas of:

- **Local data analysis, audit and real time data surveillance**

  There is the expectation in the National Suicide Prevention Strategy HM Government 2017, Suicide Prevention Guidance (PHE 2016) that all Local Authority areas have partnership plans that have been informed by robust health needs assessment based upon regular audit, data analysis and real time reporting, inclusive of NHS data, information and intelligence.

  Finance is being allocated to enable all of the Local Authority areas on the STP footprint to have updated their present audits and achieved a consistency of approach and effective analysis for the targeting of vulnerable groups and unmet need.

- **Work force development initiative**

  The ambition is to achieve a shared public mental health and suicide prevention training hub operating across the STP footprint as a trial for delivery across the wider North East STP footprint based upon the existing Tees Valley training hub model. This is intended to provide greater value for money, increased delivery, ensuring consistency and avoiding duplication whilst providing an opportunity for quality assurance and evaluation to demonstrate behavioural change in practice.

- **Grass Roots project funding allocation process**

  To strengthen existing procedural structures for the dissemination of small grants to community groups specifically engaged with building resilience and targeting vulnerable groups (based un suicide audit findings) and extend across the STP footprint. This will involve expanding the reach of existing arrangements to target those at risk of suicide through the North Yorkshire “stronger” model and the County Durham Foundation and the establishment of similar arrangements across all STP footprint areas. It will continue to build the evidence base whilst facilitating flexible, innovative and creative ways of working to meet need for example; peer/ mentor support. The allocation process will avoid heavy governance requirements and will enable small grant funding to reach grass roots organisations quickly and subsequently provide a direct timely support to the target group.

- **Primary care database development**

  Areas of the North West have been working to develop a primary care data base algorithm on the EMIS system that enables the flagging of patients who are presenting with early risk signs of the potential for suicidal behaviours. The funding is to pilot this in a number of GP practices within the STP footprint and to further develop links with IAPT development in primary care for early help. This would enable GPs and practice staff to more effectively target those potentially at risk and provide an early intervention and effective risk management.

- **Team Talk – suicide prevention though football**

  Team Talk is a successful, established project which will be extended across the foot print of the STP area. It aims to use football fan culture as the medium through which to engage men about their emotional health, promoting healthy conversations and early help seeking behaviours. An established partnership group including Local Authorities, universities, 2 premier league Football Foundations and specialised voluntary sector

organisations are taking forward a BLF bid in 2018/19. This additional NHS funding and visible support for the initiative is likely to secure the bid and an additional £496k in to the areas for suicide prevention targeted at middle aged men.

- **A review of the existing clinical pathways for the management of deliberate self-harm in A/E departments**

  Funding is to map existing pathways across the Acute Hospital Trusts in the STP footprint and recommendations for improvement, to include for example:

  - Bench marking against NICE guidance: Self-Harm Quality Standard (QS 34))
  - Data collection and reporting
  - Analysis of presenting need
  - Evaluation of effectiveness
  - Staff training and development
  - Patient experience
  - Identification of best practice
  - Shared learning event

  This will contribute to the zero suicide ambition work within NHS settings.

Mental Health Liaison Service

TEWV NHS Trust provide mental health liaison services, also known as liaison psychiatry, commissioned by the CCGs.

It is recognised that physical and mental health are inextricably intertwined and long-term conditions (LTCs), such as diabetes, are associated with high rates of mental illness. Some 70% of NHS spend goes on the treatment of LTCs, generally involving treatment in acute hospitals.

Psychological stress is often expressed as physical symptoms, which are an example of medically unexplained symptoms (MUS). Furthermore, the mental health needs of a patient in a physical health care setting often remain undiagnosed and therefore untreated. To optimise the physical health care of patients, Liason Services aim to ensure that their mental health and wellbeing are addressed at the same time.

Liaison services are currently provided throughout the acute hospital, including in A&E departments to help meet the needs of patients with a mental disorder secondary to their physical disorder, or a physical disorder alongside their mental disorder, and for patients (particularly those with medically unexplained symptoms) where it is impossible to separate the two.

The Liaison Service is an integral part of the services provided by acute hospital trusts – trusts that have incorporated a liaison service have demonstrated much better costeffectiveness.

Current performance demonstrates that Liaison Teams in Hartlepool and Stockton-on-Tees CCG areas are exceeding the 90% targets in relation to the percentage of assesments in A&E which are undertaken within 1 hour of referral and the percentage of assesments undertaken on wards within 24 hours of referral.

On average, performance across the CCG area is around 95%.

People Placed Out of Area for Treatment

The Government has set a national ambition to eliminate inappropriate Out of Area Placements (OAPs) in mental health services for adults in acute inpatient care by 2020-21. NHS Digital introduced a collection of OAPs in order to understand whether progress is being made on the ambition and to understand where and why OAPs are happening.

An Out of Area Placement (OAP) for acute mental health in-patient care is defined as happening when:

A person with assessed acute mental health needs who requires adult mental health acute inpatient care, is admitted to a unit that does not form part of their usual local network of services.

This means an inpatient unit that does not usually admit people living in the catchment of the person's local community mental health service, and where the person cannot be visited regularly by their care co-ordinator to ensure continuity of care and effective discharge planning.

For example, an OAP is a placement of a patient to any other provider that is not the patient's home provider, including:

- Any other NHS unit, regardless of distance travelled.
- Any Independent Service Provider (ISP), regardless of distance travelled.

Findings were published in Deceember 2018. NHS Digital describe this as an interim data collection in the Clinical Audit Platform (CAP) until the data becomes aligned and available from the Mental Health Services Dataset (MHSDS). The MHSDS is the chosen mechanism for the long-term collection of this data.

The report demonstrated that there were five inappropriate OAPs active at period end for Hartlepool and Stockton-on-Tees CCG. It should be caveated that these have not yet been individually audited and TEWV NHS Trust are actively examining all cases. Oversight is with the Partnership Board.

It should be noted that, whilst the CCGs acknowledge that out of area placements are to be avoided where possible, particularly when deemed inappropriate, these figures are low for the CCGs. The national position is as below:

Table 1: OAP activity (all and inappropriate) over the period: by Region

England, 1 to 30 September 2018

Area	OAPs active at period end	Inappropriate OAPs active at period end
England	*690*	*660*
London	165	160
Midlands and East	185	175
North	145	130
South East	85	80
South West	105	100
Unknown	10	10

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Commissioning for Quality and Innovation (CQUIN)

NHS England 2017-2019 Commissioning for Quality and Innovation (CQUIN) scheme is intended to deliver clinical quality improvements and drive transformational change. The scheme was updated to reflect the ambitions of the Five Year Forward View Next Steps, the NHS Mandate and the Planning Guidance.

Depending on provider performance, the CQUIN scheme is worth a maximum of 2.5%, payable in addition to the Actual Annual Value (AAV). The AAV is the aggregate of all payments made to the provider for services delivered under the specific contract during the contract year, not including CQUIN and other incentive payments, and after any deductions or withholdings), subject to certain exclusions.

The 2.5% payable depending on performance is split as follows:

- Up to 1.5% of the scheme is assigned to the clinical and transformational indicators. Each national indicator has a minimum weighting of 0.25%.
- Up to 1.25% of the scheme is assigned to support local areas.

There are two parts to the scheme:

1. Clinical quality and transformational indicators - 13 indicators have been defined which aim to improve quality and outcomes for patients including reducing health inequalities, encourage collaboration across different providers and improve the working lives of NHS staff.

2. Supporting local areas - a proportion of the CQUIN funding has been earmarked to support the development of Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs) – reinforcing the critical role local partners have to deliver system wide objectives.

The 13 indicators of part one are:

Indicator	Goal
1. Improving staff health and wellbeing	**Goal:** Improve the support available to NHS Staff to help promote their health and wellbeing in order for them to remain healthy and well
2. Reducing the impact of serious infections	**Goal:** Timely identification and treatment for sepsis and a reduction of clinically inappropriate antibiotic prescription and consumption
3. Improving physical healthcare to reduce premature mortality in people with serious mental illness (SMI)	**Goal:** Assessment and early interventions offered on lifestyle factors for people admitted with severe mental illness (SMI)
4. Improving services for people with mental health needs who present to A&E	**Goal:** Ensuring that people presenting at A&E with mental health needs have these met more effectively through an improved, integrated service, reducing future A&E attendances
5. Transitions out of Children and Young People's Mental Health Services	**Goal:** To improve the experience and outcomes for young people as they transition out of Children and Young People's Mental Health Services
6. Offering Advice and Guidance	**Goal:** Improve GP access to consultant advice prior to referring patients to secondary care
7. e-Referrals	**Goal:** All providers publish their services and make all first outpatient appointment slots available on e-Referral service by 31 March 2018
8. Supporting proactive and safe discharge	**Goal:** Improving experience of patients discharged from hospital to care home and facilitating use of technology
9. Preventing ill health by risky behaviours – alcohol and tobacco	**Goal:** To support people to change their behaviour to reduce the risk to their health from alcohol and tobacco
10. Improving the assessment of wounds	**Goal:** To increase the number of full wound assessments for wounds which have failed to heal after 4 weeks
11. Personalised care and support planning	**Goal:** To identify the groups of patients who would benefit most from the delivery of personalised care and support planning and provide this support to them
12. Ambulance conveyance	**Goal:** To support the ambulance service in becoming a community-based provider of mobile urgent and emergency healthcare
13. NHS 111 referrals	**Goal:** To increase the proportion of NHS 111 referrals to services other than to the ambulance service or A&E

For mental health commissioned services these are monitored across Durham & Darlington, Tees, North Yorkshire & York, delivered by TEWV NHS Trust.

Programmes of work which will remain in place through to end of March 2019 consist of:

- **NHS Staff health and wellbeing**
  - Introduction of health and wellbeing initiatives
  - Healthy food for NHS staff, visitors and patients
  - Improving the uptake of flu vaccinations for front line staff within Providers

- **Improving physical healthcare to reduce premature mortality in people with severe mental illness (PSMI)**
  - Improving Physical healthcare to reduce premature mortality in people with SMI: Cardio Metabolic Assessment and treatment for Patients with Psychoses
  - Communication with General Practitioners

- **Improving services for people with mental health needs who present to A&E**
  - Reduce by 20% the number of attendances to A&E for those within a selected cohort of frequent attenders who would benefit from mental health and psychosocial interventions, and establish improved services to ensure this reduction is sustainable.

- **CAMHS to AMH Transitions**
  - Transitions out of Children and Young People's Mental Health Services (CYPMHS)

- **Preventing ill health by risky behaviours – Alcohol & Tobacco**
  - Tobacco screening
  - Tobacco Brief Advice
  - Tobacco referral & medication
  - Alcohol Screening
  - Alcohol brief advice & referral

- **Virtual Recovery College**
  - Development of an online publicly available information resource and online learning platform for residents of TEWV localities with a focus on personal recovery and self-management

Most areas across the programme are reporting as on track and work continues to promote flu vaccination and on achieving a 5 percentage point improvement in two of the three NHS annual staff survey questions on health and wellbeing, muscularskeletal (MSK) problems and stress.

Early Intervention in Psychosis (EIP)

EIP teams are specialist community mental health teams that treat individuals with a first episode of psychosis. Access and waiting time standards were introduced in April 2016. To receive NICE concordant care, patients need access to two types of psychological therapies, CBT for psychosis and Family Intervention.

Early Intervention in Psychosis (EIP) Teams are in place across TEWV NHS Trust and are meeting targets in line with the Access Standard supported by CCG investment.

These services have not been subject to review in the current CCG plan but will continue to be performance managed within the Partnership Commissioning process.

Individual Placement and Support (IPS)

Individual Placement and Support (IPS) is described by NHS England as an employment support service integrated within community mental health teams for people who experience severe mental health conditions.

Rates of employment are lower for people with mental health problems than for any other group of health conditions and IPS is an evidence-based programme that aims to help people find and retain employment. For the service user the benefits of being in employment include an income and a greater sense of purpose and wellbeing, while for the health system there is an overall reduction in the use of primary and secondary mental health services, leading to improved efficiency and savings.

This approach to providing employment support for people experiencing severe mental health problems is shown to be twice as effective as vocational rehabilitation and associated with reduced use of other services including inpatient admissions. In 2016/17, IPS services in England achieved approximately 2,300 job outcomes.

NHS England has committed to doubling access to Individual Placement and Support (IPS) services nationally by 2020/21, enabling approximately 20,000 people who experience a severe mental illness (SMI) to find and retain employment.

In 2018, NHS England launched transformation funding to support the national expansion of IPS services. The Cumbria and North East STP/ICS Individual Placement Support bid was successful and announced in March 2019. Work will commence in the 2019-20 financial year.

Serious Mental Illness (SMI) Health Equality

People with a serious mental illness (SMI) are at risk of dying prematurely, in some cases 20 years earlier than the general population. Many of these deaths are preventable if conditions like high blood pressure, diabetes and cardiovascular problems are identified and treated early.

The CCG is currently reviewing, with Tees Esk and Wear Valleys NHS Trust and South Tees CCG, adoption of the Bradford Mental Health Physical Health Review template in primary and secondary care to help address this issue.

The Mental Health Physical Health Review template was originally designed, piloted and implemented by a team from Bradford District Care NHS Foundation Trust (BDCFT) in collaboration with the area's primary care organisations.

It is a short, electronic physical health assessment template for healthcare professionals in primary care responsible for carrying out annual health checks for patients with serious mental illness. The template has been adapted for use on SystmOne and EMIS and is available nationally. It can also be used on secondary care systems with adaptation.

People with serious mental health problems are at a significantly higher risk of developing preventable chronic conditions such as diabetes and cardiovascular disease. Evidence shows that people with SMI die up to 20 years younger than the average population. Preventable cardiovascular disease (CVD) is the major cause of death.

Untreated physical illness in people with mental health problems also places a major burden on health systems by increasing use of unplanned and urgent health care.

The CCG has began work on the Mental Health Physical Health programme which supports delivery of the Five Year Forward View for Mental Health objective that, from 2018/19 onwards, at least 60 per cent of people on the SMI register should receive a comprehensive annual physical health assessment and follow up care.

The National Institute for Health and Clinical Excellence (NICE) recommends annual physical health checks for people with serious mental illness. To date all practices in Hartlepool and Stockton CCG area have agreed to share data to support the programme.

Initial data shows a wide variance across England and the region, however this may be in part due to the data not having the full range of practices reporting.

Health Check Achievement 2018-19 (Quarter 2) Goal for 18/19 (50% for all CCGs)	**ACTUAL %**
England	16.7%
North	16.7%
NHS ENGLAND NORTH (CUMBRIA AND NORTH EAST)	16.7%
NHS Darlington CCG	39.5%
NHS Durham Dales, Easington and Sedgefield CCG	30.0%
NHS Hartlepool and Stockton-on-Tees CCG	9.0%
NHS South Tees CCG	19.1%
NHS Newcastle Gateshead CCG	3.7%
NHS North Durham CCG	28.6%
NHS North Tyneside CCG	8.9%
NHS Northumberland CCG	5.4%
NHS South Tyneside CCG	12.8%
NHS Sunderland CCG	23.0%
NHS North Cumbria CCG	22.8%

This remains a prioity for the CCG and the Strategy Group.

Macmillan has funded a brand new research project in Middlesbrough and Stockton aiming to improve the experiences for people living with mental health problems who are also affected by cancer. This is being led through Middlesbrough and Stockton Mind.

Social Prescribing

Social Prescribing is a means of enabling GPs and other frontline healthcare professionals to refer patients to a link worker, to co-design a non-clinical social prescription to improve their health and wellbeing.

The model provides patients with a face-to-face conversation during which they can learn about opportunities to improve their health and wellbeing.

There are usually three key components:

1. a referral from a healthcare professional
2. a consultation with a link worker and,
3. an agreed referral to a local VCSE (Voluntary, Community and Social Enterprise) organisation

People with social, emotional or practical needs are empowered to find and design their own personal solutions, i.e. “co-produce” their “social prescription”.

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Social Prescribing is one of six key elements of the wider “personalisation” movement in health and social care and links with other CCG initiatives such as Integrated Personal Commissioning, Personal Health Budgets and shared decision making.

Personalised care means empowering people to have greater choice and control over the way their health and care is delivered. It is fundamental to the changes the NHS is seeking to make over the next few years. The result is better health and wellbeing for individuals, better quality and experience of care that is integrated and tailored around what really matters to them and more sustainable NHS services.

The CCG funds Catalyst – a voluntary development agency for the Borough of Stockton-on-Tees which acts as the leading voice for the VCSE (Voluntary, Community & Social Enterprise) sector - to annually deliver against agreed health outcomes.

The main focus of Catalyst’s delivery to date has been to commission projects from the voluntary sector’s existing offers that contribute towards health outcomes which have been carried out across the Stockton and Hartlepool localities under the “Health Initiatives” brand.

It has been recommended that for 2019/20 there should be a re-design of the Catalyst offer so that it is more clearly aligned to a social prescribing model; so that health gains can be easier to assess and evaluate. Any new model must continue to map to CCG priorities and objectives.

The proposed model for social prescribing reflects a direction of travel that Catalyst and the CCG have wished to see develop locally for some time. It is anticipated that this new model will better reflect need and drive resources to those organisations that are delivering effectively. The new model should also be a more sustainable model as it focuses on the sectors “core offer” rather than seeking innovation and/or scalability on an annual basis.

For any social prescribing initiative to be successful it is important to be clear about:

- The targeted condition, population and eligibility
- The strategic fit with the CCG’s plans and those of other partners
- Referral criteria including pathways, handover, monitoring and closing cases and,
- Stakeholder engagement/good fit with existing services and effective partnerships to deliver

Catalyst, via a grant agreement for the project, will be funded to:

- Assess a range of VCSE providers and their plans for services/pathways against the outcomes required of this model.
- Accept suitable providers onto a framework for delivery of “Healthy Links” VCSE delivered services.
- Implement a contact and assessment process for clinical staff/patients so they have a single point of contact (for their locality) to be assessed against a range of VCSE providers and directed to the correct provider/pathway suitable for their needs. This will be delivered by the Stockton Service Navigation Project (SSNP).
- Undertake a regular review of all services to ensure they are meeting patient need and delivering high quality outcomes.
- Assess the range of services on offer as part of this project on a regular basis and open up the “window” for further assessment should a gap in need be identified.
- Monitor funding across all providers against the available budget.
- Act as the lead across the collaborative project.
- Assess outcomes to cover primary and acute service utilisation.

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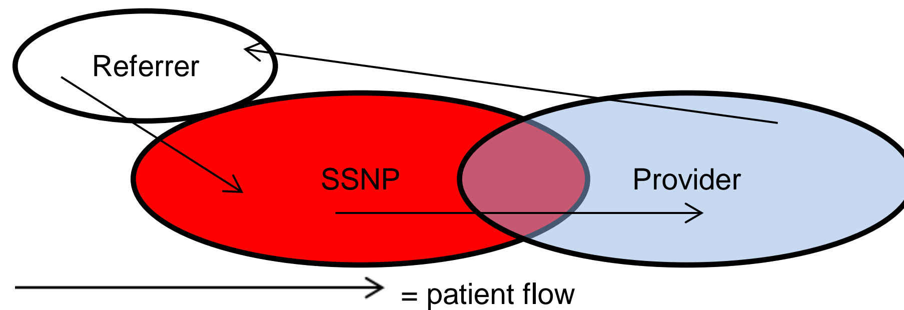
SSNP will provide a face to face or telephone review of need and link those individuals to the correct voluntary sector provider. This will be an active process between SSNP and the provider so that people are not only sign-posted, but actually supported to access the service provided as per the diagram below where the central lighter red area represents the social prescribing link in action.



In reality this might mean that a patient is accompanied by a volunteer to the provider service as well as supported to engage with the activities on offer. Catalyst and SSNP have held preliminary discussions to identify a Hartlepool facing provider/host as an extension to the existing SSNP service offer

The aim of the service is to provide personalised assessment, action planning, signposting, information and support to clients (16+) in Stockton-on-Tees. The service supports clients to make informed choices and access appropriate services which will benefit their health and well-being. The service encourages clients to take responsibility for their own health and well-being but the SSNP also provides practical support with accessing services and advocacy.

There are clear benefits to utilising this existing service due to its experience and knowledge in the referral management process and the communication needed to support patients and referring agencies, as people progress along their chosen pathway.

It is possible that some of our targeted population are already accessing services via SSNP but the Healthy Links model will fund new additional capacity (1.0 wte.) within SSNP that will specialise in supporting people with SMIs as well as a dedicated Hartlepool facing service.

This additional capacity will be block funded by Catalyst with an anticipated throughput of 250 new referrals and 90 re-referrals; processes will be put in place to ensure that activity recorded and collated is particular to this project.

VCSE providers will have responded to a bid opportunity circulated by Catalyst. This model assumes that the VCSE sector will be putting forward existing core service offers rather than having to develop annual innovation under the old scheme.

As the service offer is core, Catalyst believe that this will be more sustainable under a pay-by-referral model that should the project end, can continue to be part funded by user contributions or funding from other agencies as is the norm in the VCSE sector.

The mix of services will be reviewed on a regular basis and should monitoring by Catalyst identify a gap in service, new VCSE providers will be invited to the list of Healthy Links model projects following assessment, should they meet the expected service levels and corporate governance arrangements in the initial bid process.

Persistent Physical Symptoms

Persistent physical symptoms, sometimes known as "medically unexplained symptoms" (MUS) or “medically unexplained physical symptoms (MUPS).

Symptoms are not considered to be faked or imagined – they are real and can affect a person’s ability to function properly. Being unable to understand the cause can make them even more distressing and difficult to cope with.

When mystery symptoms seem to be caused by problems in the nervous system but there is no identified neurological condition, they may be referred to as a ‘functional neurological disorder’.

Examples of such symptoms include:

- tingling in the hands or feet
- a tremor in one or both arms
- headaches or migraines
- changes in eyesight, like blurred vision or seeing flashing lights

NHS England state that medically unexplained symptoms are common, accounting for up to 45% of all GP appointments and half of all new visits to hospital clinics in the UK.

Many people with medically unexplained symptoms, such as tiredness, pain and heart palpitations, also have depression or anxiety. Treating an associated psychological problem can often relieve the physical symptoms.

For others, the symptoms may be part of a syndrome, such as:

- chronic fatigue syndrome (CFS) – also known as ME
- irritable bowel syndrome (IBS)
- fibromyalgia

Persistent physical symptoms are common and include those symptoms that last at least three months and are insufficiently explained by a medical condition after adequate examination and investigation. Examples include unexplained abdominal pain, musculoskeletal pains, fatigue, headache and dizziness.

These symptoms are often associated with functional impairment and psychological distress among patients, and increase healthcare costs.

Observational studies in primary care report that women, especially those aged 35-45 years, more commonly present with these symptoms.

The CCGs have been working with NHS England on a programme to assess and respond by supporting practices in identifying potential PPS/MUPS patients within their clinical systems. Pilot sites are in place at Kingsway Medical Practice, Billingham and Denmark St, Darlington.

The criteria is:

- Patients 18 and over with >15 appointments in the last financial year (01/04/2016 – 31/03/2017).
- Excluding patients who are on a QOF register, housebound and pregnant women.

- The exclusion QOF registers are Atrial Fibrillation, CHD, Asthma, Cancer, CKD, Diabetes, Epilepsy, Heart Failure, PAD, Rheumatoid Arthritis, Palliative Care, Osteoporosis and COPD.

Based on the above criteria practices are identifying patients with potential PPS/MUPS to clinically review.

Once the clinician has reviewed the patient and if they feel that the symptoms/high number of appointments can be explained then the patient will be removed from the list. Once all the patients have been reviewed the patients left in the PPS/MUPS Patients list is the definitive list who have multiple unexplained physical symptoms.

Those patients who remain on the list may be offered appropriate advice, support and guidance using a patient questionaire.

The outcome of the pilots will be utilised in service planning for 2019-20.

Children and Young People

Positive Approaches and Parental Support

SBC Children's Services are working with Public Health, Harrogate and District Foundation Trust, North Tees and Hartlepool Foundation Trust and Family Action to develop a strengths based approach to parenting support. This approach will provide a clear offer to families from universal through to specialist level and will map out provision from the ante-natal period until the teenage years. Work was completed in October 2018 with roll out now taking place.

The Growing Healthy Service ensure that health visitors are trained to undertake perinatal mental health screening and a clear perinatal mental health pathway has been introduced. All staff within the Growing Healthy Service are to be trained in Health, Education, Nutrition in the Really Young (HENRY)

There are developments within the 0-19 Service around Vulnerable Parent Pathway. STEPS seek to identify risk factors and indicators relating to vulnerable parenting with a view ot offering support enhanced visits by the 0-5 service and Family Action focussin gon parenting and attachment. The Vulnerable Parent Pathway is due to launch august 2019. The universal offer already offers at least 1 additional visit than is the required offer. Work is ongoing in the daisy chain family support programme.

The ASD (Autism Spectrum Disorder) pathway is being improved to address needs as they are identified. This includes support available through universal services, targeted and joint commissioning a Family Support service (CCG/SBC) which commenced in October.

The Future in Mind programme in schools is ongoing to support low level mental health needs.

Specialist Addictions Midwife and Doctor weekly appointments have been introduced within CGL via the family group conferencing team (direct links to social services for referrals or concerns). Feedback is very positive from clients and staff. The Safeuarding Lead for CGL is also on site for any referrals, making joint referrals effective.

The substance misuse service Change Grow Live (CGL) have based two roles within Family Group Conferencing Team from March 2019 with a focus on identification or drug/alcohol

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use, brief advice, support into specialist services and hidden harm. Much of this work will be delivered in the home setting or community venues.

This work will promote wider programmes for families affected by drug or alcohol use including parent factor and MPACT.

CGL are also working with a Family Hub in Billingham to deliver clinical provision for alcohol services in a family setting.

A pilot is being undertaken between Early Help (Youth) and 5-19 team within the 0-19 Service. The pilot will work with two secondary schools, one located in an area of deprivation and the other in an area of affluance. The pilot will use the 'This is me' tool to look at physical, social and emotional health of the year 9 cohort. The pilot will be structured around delivering in small groups, with all questionaires completed on the same day. The pilot should identify any immediate concerns, the need for further 1:1 work, opportunities for small group work and to identify any population health needs.

The Family Information Directory is working to provide online self help in realtion to mental and emotional health. The community offers for the 0-19 service are all promoted via the directory.

Parental Mental Health

The newly commissioned 0-19 service is working with TEWV perinatal mental health service and NTHFT midwifery service to ensure a robust perinatal mental health pathway is in place alongside a clear notification pathway.

As part of the new 0-19 service delivery model, HDFT has recruited an emotional resilience nurse to lead on the upskilling of the 0-19 workforce to support early identification and intervention with children, young people and families affected by mental health issues. This post commenced in July 2018 and is prioritising links with providers of relevant emotional health and wellbeing services including IAPT.

Early Help in Social Care

Mental health and wellbeing are key factors in the developing models for early help in adults services. Initial work includes the refining of the social prescribing model and synergy between providers for differing levels of need.

Future in Mind

The Future in Mind pilot project undertaken in 2017/18 helped participating secondary schools develop a whole system's approach to support children's emotional health & well-being.

The learning from this pilot work with secondary schools across Stockton is now being offered to primary schools. In order to help their pupils succeed, schools have a key role to play in supporting them to be resilient and mentally healthy. There are a variety of things that schools can do, for all their pupils and for those with particular problems, to offer that support in an effective way.

Schools can provide a positive and protective influence for mental health and creating resilience, providing the child or young person with the inner resources to cope, buffer negative stressors and thrive.

A ‘whole system’ approach is being taken forward with 37 Primary schools in Stockton on Tees during 2018/19. Each school has identified a “school champion” who will receive module base learning delivered from experts across those services specialising in mental health & well-being; their own skills will also be developed further through learning sets where schools can share good practice. Schools will work with the project team to develop an action plan using the resources and evidence made available to help position the schools to develop and spread further knowledge across the classrooms, with staff, children and their parents/carers.”

The first training modules training commenced in June 2018 followed by learning sets for the school champions in July. The training modules have been evidenced based, developed and delivered through joint working between a number of organisations including Stockton Borough Council, Tees, Esk & Wear Valley NHS FT, Hartlepool Education Psychology services and Alliance Psychological Services Limited.

Primary School Questionnaire

Kidscreen-52 is an evidenced based Health Related Questionnaire that is being used within a number of primary schools taking part in the project above. to measure emotional wellbeing.

The purpose of the survey is to collect data about the attitudes, health needs and risk behaviours of our children. Consistent, reliable and comparable data will enable us to identify priority risk areas and to design, implement and evaluate supportive programs targeting those areas.

The KIDSCREEN-52 survey assesses children’s and adolescents’ subjective health and well-being. It asks questions on physical activities and health; feelings; general mood; about themselves; free time; family & home life; money matters; friends; school & learning and bullying.

In August 2018 data was returned for 29 schools and 1094 completed questionnaires. The data was analysed and reports produced and shared initially at the Education Matters meeting to be held in September.

Many schools have now completed their returns and some are at the stage of having received their initial feedback reports (each school receives a tailored report).

Transition

A Transition from primary to secondary school initiative has involved a multi agency assess and meet needs working group in Stockton as part of SEND Work stream as well as a PFA group.

Special Educational Needs and Disabilities

Key lines of enquiry (KLOEs) in Stockton have examined how life course and transitions are managed and can identify that in the main communication pathways amongst professionals exist but that development is required to formalise these (often relying on existing networks and relationships between individuals and services).

It is the intention that the development areas from the SEF KLOEs will be used by the SEND Development Group to map across into the Working Group areas.

Wider welfare determinants of health

It has been acknowledged by the steering group that wider welfare issues have an impact on mental health within our community.

The strategy group has been working on a programme with Stockton Welfare Advice Network (SWAN) to help close this gap and improve a response based upon a greater awareness of need and capacity in teams to support people with mental health issues to address their wider needs.

Making Every Contact Count

The Making Every Contact Count (MECC) programme has been adopted in Stockton. This recognises that staff across health, local authority and voluntary sectors, have thousands of contacts every day with individuals and are ideally placed to promote health and healthy lifestyles, including good mental health.

For organisations, MECC means providing their staff with the leadership, environment, training and information that they need to deliver the MECC approach.

For staff, MECC means having the competence and confidence to deliver healthy lifestyle messages, to help encourage people to change their behaviour and to direct them to local services that can support them.

For individuals, MECC means seeking support and taking action to improve their own lifestyle by eating well, maintaining a healthy weight, drinking alcohol sensibly, exercising regularly, not smoking and looking after their wellbeing and mental health.
MECC focuses on the lifestyle issues that, when addressed, can make the greatest improvement to an individual's health:

- Stopping smoking
- Drinking alcohol only within the recommended limits
- Healthy eating
- Being physically active
- Keeping to a healthy weight
- Improving mental health and wellbeing.

A training plan in place and training has commenced across the Borough and the CCG has produced a supporting document which is to be piloted in Stockton in 2019-20. The first of the north east Train the Trainer development sessions has been completed, with further dates across the north east in 2019.

Smoking Cessation

Public Health is currently working with Middlesbrough and Stockton MIND to provide the stop smoking support for their Stockton service users. The staff are now be able to prescribe NRT to any smokers within their services. TEWV mental health trust has fully implemented the NICE Guidance PH48: Smoking: acute, maternity and mental health services and has a good referral information to be given to patient when discharge.

Smoking is included in the CCG Health Equality work programme for 2019-20 and work is already included in secondary care services and ongoing.

Staff within CGL have been trained to provide NRT vouchers via local pharmacy scheme.

Financial Welfare

Work is ongoing in Stockton to ensure effective working arrangements between mental health providers and welfare advice services to provide integrated support to those who are affected by financial and welfare exclusion

Welfare advice training/awareness has been delivered to primary and secondary mental health staff

Stockton Service Navigator Project

The contract for Stockton Service Navigator Project has been extended until 2021.

Social Isolation

“First Steps” three year funding has been secured to expand work with people with Autism, people with Aspergers and older people funded by Stockton on Tees Borough Council Public Health.

The service amims to connect people to each other and services to address social isolation and befriending. Patients can be referred and self-refer. Support delivered through 1 to 1 and group sessions. The Warwick/Edinburgh scale is used to make initial assessment and measure progress.

Working with a range of referrers and seen 2000 plus since 2012.

Public Health Resource Library

The Public Health Resource Library has been updated to ensure that appropriate information and guidance is available, including in Health Visitor packs in relation to the transition to parenthood.

Better Health at Work

The North East Better Health at Work award is a partnership between the Northern Trades Union Congress (TUC), all 12 North East councils and their Directors of Public Health.

The award is aimed at improving the health of workers, their families and local communities and more than 400 businesses in the region are already taking part.

Stockton Local Authority and business in the area are signed up to the award and outcomes are reported at www.betterhealthatworkne.org.

Five Ways to Wellbeing

Catalyst held a VCSE Health & Wellbeing Forum on 17th September focussed on Mental Health with updates/handouts on the 5 Ways to Wellbeing; Time to Change Campaign; Social Isolation & Loneliness; Suicide Prevention strategy; World Mental Health Day campaign; Promotion of Tees Wide Mental Health training and Future involvement/communication with VCSE around Mental Health. 35 people/organisations attended with positive engagement and feedback.

Catalyst also held a Stockton Volunteers Partnership on 17th October themed ‘Does volunteering improve Mental Health?’ including the positive impact of volunteering and better ways to support the mental health of volunteers – with updates/handouts on the 5 Ways to Wellbeing; advice and best practice from Middlesbrough and Stockton MIND; lived experience talk (M&S MIND Volunteer) themed group discussions and promotion of Tees Wide Mental Health training. 25 people/organisations attended.

Middlesbrough and Stockton Mind have been successful with an application to Lottery Reaching Communities and will be starting a new project called Community Minded in June 2019. The project will run for 3 years supporting people with mental health problems to volunteer with the aim of improving their mental health by linking into the 5 Ways to

Wellbeing. Middlesbrough and Stockton Mind will work with Catalyst and the voluntary sector in Stockton to achieve this.

CGL are currently delivering peer mentoring diploma training to 8 individuals. The service currently has peer mentors on placement from local community and on day release from HMP Kirklevington.

Reducing Stigma

Training to increase awareness of mental wellbeing, targeted at the voluntary sector, were delivered between September 2018- Feb 2019. Further work will continue in 2019-20.

Dual Diagnosis and Co-existing Conditions

It is recognised that effective approaches and pathways for those who are affected by co-existing mental health and substance misuse problems should be in place.

From the RPIW event it was agreed that CGL and Stockton Mental Health Services would work closely together to improve the care patients receive from both services and ensure that they are getting all the support they need. This includes having joint appointments with the patient and named workers. In addition named staff involved meet separately every 4 weeks to update each other on progress/issues and concerns. CGL are also now invited to attend formulation meetings at Roseberry Park and Stockton Mental Health Services are also using CGL buildings for their own 1:1's and initial assessments when requested by the patient.

Also following on from the event it was agreed to set up a Co-existing Mental Health and Substance Use quarterly Network Group, as it was identified that multiple agencies would benefit from sharing knowledge and skills relating to Co-existing Mental Health and Substance Use issues.

The Network objectives are to:

- Implement and monitor the improvements from the RPIW workshop
- Identify training needs for staff different agencies
- Share knowledge, skills and good practice ideas
- To review evidence based guidance for coexisting mental health and substance use conditions for both children, young people & adults and to work with partners as required in order to establish pathways where gaps in service are identified.
- To allow multiagency Update on current issues from both service user perspective and organisational perspective

The CCG has committed to ensure providers consider engaging with substance misuse services within the new IAPT model to support low level mental health problems and substance misuse problems.

Substance Misuse and Mental Health Teams

The substance misuse service in Stockton is provided by CGL who are now attending TEWV discharge meetings and joint case meetings. This followed an improvement event held and improvements are already noted. Teams having regular huddle meetings.

Welfare and Substance Misuse

Effective approaches and pathways have been developed in Stockton for those who have welfare issues that impact on their mental health and substance misuse problems through Stockton Welfare Advice Network (SWAN).

Dual diagnosis will be a key consideration in the review of drug and alcohol services commissioned by Public Health

Bereavement Services

Stockton Public Health jointly commission CRUSE with Middlesbrough Council and Redcar & Cleveland Council to provide bereavement support services. A pathway review has been conducted and monitoring will be ongoing.

An improvement programme, in terms of referral times and performance, has been created and new performance targets initiated, although it is recognised that the service provision is of a high standard.

Hearing People's Voices

As part of the IAPT services public engagement process, Catalyst directly contacted 31 groups across Hartlepool & Stockton-on-Tees in April 2018. Although the timescales were limiting for most, 10 focus groups were held and others supported completion/distribution of the survey which had 61 responses from service users. A separate session was held with Catalyst/CCG's Community Health Ambassadors who also promoted the survey/model. A thank you letter and final engagement report was shared with all participants – who were happy to be involved in future engagement opportunities.

Next Steps for the Strategy: Towards 2021

The Strategy Group has considered the priorities of the Joint Strategic Needs Assessment and revised the priorities for the 2019-20 programme with the aim of ensuring that an holistic approach to the promotion of good mental health is taken, equality for people with serious mental health issues is achieved and that all welfare, wellbeing and support services in Stockton are able to respond positively to ensuring that people who are struggling with debt, addiction and inequality can be supported with any associated mental health conditions.

Where appropriate, priorities that were addressed in 2018-19 will continue to be monitored by the Strategy Group, but the focus will be on the key issues identified in the JSNA.

These are:

Issue number	Strategic issue?	What needs to be done?
1	The percentage of school age children with social, emotional and mental health needs is significantly higher than the national average. It is therefore essential that resilience is developed in Children and young people (CYP) to protect their emotional wellbeing across the life course. CYP should be supported and be given the tools to enable them to forge meaningful and appropriate relationships, to have respect for themselves and others and to respond appropriately and recover from the challenges that occur over the life course.	A whole system approach should be developed and implemented with the child's needs at the centre. This means providing high quality maternal and perinatal care to help families build strong attachments and positive emotional health and wellbeing. This will ensure that all of our services consider the family as a whole, their strengths and their needs, and work together to develop solutions. Services should work proactively to identify CYP at risk of Adverse Childhood Experience (ACE). It is important that CYP exposed to ACE are given appropriate support in a timely manner. The work around resilience should continue to be supported in schools and colleges via the Future in Mind project, in conjunction with specialist support from other agencies as needed.
2	The Borough of Stockton-on-Tees has a significantly higher incidence and prevalence of depression than both the regional and national averages.	A whole systems approach is required to prevent/minimise the development of depression in the residents of Stockton. A single point of access model, with integrated services should be developed with patients at the centre. This would ensure that patients receive the correct care and support at the right time, in the right place. This should have regard to the wider determinants of health and seek to ensure effective working across all agencies. We need to understand the relationship between social isolation/loneliness and the prevalence of depression and anxiety across the life course within the borough. Further investigation is required to establish the reasons for high levels of depression and anxiety, having regard to diagnosis, treatment and prevention.

Issue number	Strategic issue?	What needs to be done?
3	Premature mortality (including suicide). There are more premature deaths in adults with a serious mental health illness within the borough of Stockton-on-Tees than the national average (per 100,000).	Individuals with a serious mental health illness die prematurely, approximately 15 – 20 years earlier than the rest of the population. This is primarily due to preventable physical health conditions such as cardiovascular disease and cancer. A whole system approach is required to adequately address the needs of individuals with serious mental health needs. Every suicide is preventable. A whole system approach is required with local government, primary care, health and criminal justice services, voluntary organisations and local people all having a role to play. Therefore we should continue with the work of the Tees Suicide Prevention Taskforce working with a wide range of partner agencies. The impact of stigma and discrimination requires further investigation with regards to accessing physical and mental health services and welfare support.
4	Dual diagnosis. The Borough of Stockton-on-Tees has a higher than national average admissions for mental and behavioural disorders, but a lower than national average number of adults in concurrent contacts with mental health services and alcohol misuse services.	Provide a clear pathway for individual's with a mental health condition and issues relating to substance/alcohol misuse, to prevent individuals being bounced from one service to the other. Consider the co-location of services for alcohol/substance misuse, mental health and welfare support. Co-location/dual diagnosis co-ordination has been shown to increase the effectiveness of the interventions. The impact of effective services is likely to include a reduction in anti-social behaviour, a reduction in visible alcohol misuse and long term reduction in contacts with multiple agencies.

Protective Factors

The Strategy Group recognises the importance of protective factors that support good mental health in communities and will focus on identifying and suggesting improvements to community assets (community resources) which improve the health and the vibrancy of a community, they include physical assets such as public green space, play areas and community buildings, social assets such as volunteer and charity groups, social networks and the knowledge and experiences of local residents. These assets have potential to protect and increase community wellbeing and thus strengthen resilience.

When considering protective factors, these can be felt at a community level such as social networks, sense of local identify, levels of trust, reciprocity and civic engagement. The benefit of 'social capital' can be felt at an individual level (for example, through family support) or at a wider collective level (for example, through volunteering). Social capital is associated with values such as tolerance, solidarity or trust. These are said to be beneficial to society and are important for people to be able to cooperate.

Additional Risk Factors

The Strategy Group will work with partners to address related aspects of need in Stockton that directly and indirectly impact on people's mental health. These include:

• Loneliness - A significant risk factor for developing depression and increases premature mortality by 30% (PHE, February 2018)

• Social isolation may be a risk factor associated with self-harm, premature mortality and suicide.

• Exposure to an adverse childhood experience is a risk factor in developing depression and/or anxiety, suicide and dual diagnosis.

Children and young people are also affected by the factors listed above, plus an additional risk factor:

• CYP raised by a parent with a mental health problem. Whilst there is some evidence to support a hereditary factor with regards to mental health problems. It also important to understand the impact a mental health condition may have on parenting, with regards to style and consistency. There is also the impact that other behaviours relating to a mental health problems may have on parenting (such as self-medication and risk taking behaviours).

Ongoing Activity

Whilst it is recognised that leadership in reviewing provision for Children and Young People will be through the Children and Young People multiagency work programme, the Strategy Group will continue to work with partners to support the following ongoing programmes of work which aim to address the four priorities:

Children and Young People

Further work is required to identify the role of all agencies in the promotion of emotional wellbeing of CYP. It is not only the role, but the level of engagement with service that is difficult to establish. The services are currently fragmented across the 0-19 service, early year, the education system, CAMHS, GP's and TEWV.

There is a lack of information and data relating to the overall engagement of children and young people with the range of services offered in relation to emotional wellbeing. Further work is needed to identify all of the agencies involved in the promotion of the emotional wellbeing within CYP.

- Children's Services are currently reviewing smarter ways of working. Moving away from the current traditional approach to Children's Services, toward a child centred whole system approach (family focused). With a view to offering a universal offer, a school offer and a personal offer to families and CYP.
- HaST CCG commission TEWV to provide Child and Adolescent Mental Health Service (CAMHS), this service is open access and can support children up to the age of 18.
- Review of CAMHS service to ensure it is meeting the needs of younger people.
- Mental Health - Crisis/Intensive Home Treatment Service provides a 24/7 service for Children, young People and families who are experiencing an acute mental health or emotional crisis which without the involvement of the Teesside CAMHS Crisis Team

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may increase immediate risk and result in an acute hospital or inpatient admission. The service provides a rapid response, offers prompt assessment within a maximum of 4 hours of a referral being received (with a 1 hour target), and where appropriate, intensive time limited interventions.
- Future in Mind. The focus in has been on upskilling schools to identify needs and support children rather than to refer everyone to TEWV. The role of schools is of importance in the transformation of children's mental health services.
- Schools and colleges provide in-house support and may purchase additional support from providers such as Alliance.
- The commissioning of the 0-19 service delivered by Harrogate and District NHS Trust including the provision of Family Hubs and school nurses.
- Police Custody Appropriate Adult Service (Middlesbrough and Stockton MIND).

A strategic group has been established across partners to look at the issues facing Children and Young People across Stockton with regards to mental health and services. Three full day Children and Young People system workshops are being held to look at the system and the opportunities for improvement. A range of parteners are represented at the workshops including: Stockton BC (Public Health, Commisioning, Childrens Services), CCG, GP, Education, 0-19 Service, VCSE.

Depression and anxiety

There is a need to establish why Stockton has a high prevalence and incidence of depression within the borough. A range of factors are being considered including: diagnosis, treatment options, support, awareness of symptoms and access to services.

The links between socially isolation and loneliness are well documented. Further work is needed to identify the level of need within the borough, the impact this has on mental health, what services are currently available to support or are needed and identify appropriate interventions for prevention. This should be undertaken as a priority to minimise the impact of social isolation and loneliness across the life course.

Further work is to be undertaken within the borough to reduce the stigma and discrimination associated with the proactive accessing of support services and to understand the impact of stigma and discrimination on physical and mental health.

The most appropriate offer for Social Prescribing in relation to prevention of mental health problems is being explored. This includes the possibility of social prescribing prior to prescriptions for depression and anxiety in conjunction with IAPT support services.

Individuals exposed to an adverse childhood incident are more likely to develop a mental health problem. Work is to be undertaken to unpick the issues with a view to treating the cause of any mental health condition, as opposed treating the symptoms. This is particularly important for parents in order to end the cyclical nature of ACE and mental health problems

Premature Mortality (including Suicide)

Further engagement and consultation with individuals with a serious mental health condition and interested stakeholders is required to gather views on the issues relating to accessing physical and mental health services, with a view to identifying appropriate intervention to minimise early mortality.

Consideration is to be given to how services can be designed to maximise engagement of individuals with serious mental health illnesses to enable preventative interventions to take place. Some of the services that need to work as a whole system may include mental health, alcohol and substance misuse, smoking cessation, welfare support.

Tees have a Suicide taskforce including the funded post of Tees Suicide Prevention Coordinator. The Tees Suicide Prevention Coordinator has been responsible for undertaking an audit of all recorded suicides over the last three years. The finding from this audit have identified three high risk groups.

Work has been undertaken to develop the 6 stage Teesside Suicide Prevention Plan:

1. Reduce the risk of suicide in key high-risk group
2. Tailor approaches to improve mental health in specific groups
3. Reduce access to the means of suicide
4. Provide better information and support to those bereaved or affected by suicide
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour
6. Support research, data collection and monitoring.

STP Funding allocation is to be used to build upon the work already being undertaken including increased capacity for the Tees Training Hub. Also a community fund is in place for local groups to bid for between £500 & £5000 to work with groups identified a high risk. Some funding is to be spent on developing an algorithm to focus on early warning identification particularly considering the self-harm A&E pathway.

Dual diagnosis and co-existing conditions

Further engagement and consultation is required with individuals with a dual diagnosis and carers of individuals with a dual diagnosis. This is to be undertaken to establish the current issues with the service provision and to establish the best course of action to address this issue in order to maximise the treatment options.

A gap has also been identified with regards to training of professionals in relation to understanding the long term impact of trauma and adverse childhood experiences.

Current and ongoing work includes:

- Substance misuse – CGL commissioned service
- IAPT services for mental health
- More specific services for mental health conditions (Recovery College, Out Patients, Intensive home Treatment Team)
- Develop a single/integrated service for individuals with a mental health condition and an alcohol or substance misuse issue.
- Mental Health Liaison (collocated with Arrest Referral drug and alcohol team in police custody)
- In and out reach at Holme House Prison – Integrated Offender Management.
- CGL (Change Grow Live) are the commissioned provider for working with adults, aged 18 years and over, who need support around with alcohol and substance misuse within the borough. They offer advice, information, assessments, treatment options, care and support.
- TEWV and CGL are starting to work collaboratively. The early signs are promising with regards to patient engagement and progress.