HEALTH AND WELLBEING SCRUTINY COMMITTEE **28 FEBRUARY 2023**

ADULT MENTAL HEALTH STRATEGY UPDATE

REPORT OF THE DIRECTOR OF PLACE (SUNDERLAND) – NORTH EAST AND NORTH CUMBRIA INTEGRATED CARE BOARD

1. PURPOSE OF THE REPORT

1.1 To provide the Health and Wellbeing Scrutiny Committee with an update on the work that has taken place to implement the Adult Mental Health Strategy for Sunderland which was approved for publication in June 2021.

2. BACKGROUND

2.1 As presented to the Health and Wellbeing Scrutiny Committee in November 2020, the former Sunderland CCG had committed to developing an Adult Mental Health Strategy for the city.

2.2 This report will provide a summary of the work undertaken to develop and publish the strategy, as well as progress made around implementation of the three key principles of the strategy.

2.3 The development of the strategy took place in four phases:

Phase one – engagement of the scope
We invited a wide range of stakeholders to provide feedback on the intended scope of the strategy. This included clinical leaders within the CCG, All Together Better Programmes, Together for Children, Councillors, representatives from GP Practices, providers, CAMHS Strategic Partnership and Sunderland City Council. This feedback confirmed that the scope was appropriate and that whilst children's services was out of scope it was important to reference transition between children's and adult's services.

Phase two – involving people
A large-scale engagement exercise took place between November 2020 and January 2021. This consisted of gathering intelligence via a suite of questionnaires aimed at the public, service users and carers, larger employees and staff involved in the delivery of services. Alongside this, one-to-one interviews were conducted with various providers, LA colleagues, primary care and All Together Better (ATB). Focus groups were held with various groups with some asset-based focus groups covering (but not limited to) African Women's Voices, Becoming Visible, and True Colours.

Phase three – review of findings
To validate the research captured, a draft engagement report was shared for comments and feedback. This consultation included sharing the report with stakeholders, various meetings, and specific focus groups.

In addition to the substantial engagement work, we worked with Public Health colleagues to refresh the 2019 Mental Health and Wellbeing Joint Strategic Needs Assessment (JSNA). The intelligence gathered from the Health Needs Assessment also supported the development of the vision and content of the strategy.

Phase four - present and publish the strategy
Using the analysis generated from the engagement phase and the JSNA the Vision and three key priorities were generated:

Everyone's Mental Health Matters: Empowering people by supporting individuals, families, and communities to improve and maintain mental and physical health, so they can lead fulfilling and healthy lives.

Priority One: An ounce of prevention is better than a pound of care: Strengthening and promoting lifelong mental health and wellbeing with a focus on prevention.

Priority Two: Right Response, Right Time, Right Place: Ensuring there is appropriate and timely access to flexible and inclusive mental health care services for all, focussing on the whole person.

Priority Three: Working with you on what matters to you: Delivering care designed around the individual, without barriers across teams, services, and organisations.

The strength and validity of the vision and priorities were tested with key stakeholders including the Sunderland CCG Governing Body, 'Programme 2' of All Together Better, the Community Mental Health Transformation Group, internal groups with Sunderland City Council (SCC) and focus groups of people with protected characteristic. The feedback generated from these discussions provided an opportunity to adjust and clarify the final vision and strategy.

3. CURRENT POSITION – PRIORITY ONE

3.1 Our strategy pledged four important commitments to deliver priority one – 'an ounce of prevention is better than a pound of care'. A short summary of progress against each commitment is noted as follows:

Our Commitment	Our Progress
We will promote mental health awareness to address wider determinants of health and strengthen coping strategies with a focus on the greatest areas, of communities in need.	A Community Connector programme is underway in Sunderland to develop a support network to help raise knowledge and awareness of community activities and services that are available to support residents across the city with their mental health and wellbeing. This project is an extension of the Connectedness Plan which involved a series of locality events and training workshops, training up over 100 local volunteers and the final citywide celebration event was held in December 2022. The connectors are people who use a peer support model to link others in their local community with activities and services that can help improve their quality of life. Through local knowledge and awareness this sharing of information can support organisations directly on connecting people with their communities.

	Organisations who have signed up to the programme are provided with; support, information and resources by our Peer Community Coordinators. Our partnerships with education continue to grow and has seen an increased amount of education and awareness raising around mental health issues and support in the University of Sunderland and this is also being embedded into the curriculum. Since the implementation of our Primary Care Practitioners team, we are seeing an increased amount of people who would not usually access mental health services, as this is a less formal level of intervention with less stigma attached to it. These patients are people being supported and signposted to appropriate services to meet their needs. Home Group are providing a programme across the city to support discharges and are providing patients with education, tools and techniques to help them maintain healthy living in the community once discharged which will also have a positive impact on the number of hospital readmissions. Dedicated Mental Health Link Workers are in place via Sunderland Counselling Service to provide additional emotional and practical support to wrap around existing mental health services, to support people to engage in or be retained in treatment, prevent deterioration, maximising treatment outcomes and supporting independence.
We will work in partnership with communities to identify priorities, understand barriers to access, and co-produce solutions in relation to mental health and wellbeing.	A dedicated project is underway hosted by Washington Mind to take a collaborative approach, linking with our local community assets, making use of the developed relationships with the community voice. This project is generating valuable intelligence from our community to understand what the perceived barriers to access are and how we can best overcome these barriers. Autism in Mind are currently working with the Mental Health Crisis team to reduce any barriers that autistic people may encounter whilst seeking crisis support.
We will develop and implement a prevention system to strengthen public mental health delivery.	Led by the Public Health team, plans are in place to implement a Prevention Concordat for Better Mental Health. This concordat will be an opportunity to join a community of practice working towards creating resilient communities and building the case for a shift to support prevention activity. The aim is to prevent mental health problems and promote good mental health.
We will promote and encourage the uptake of annual health checks for patients with serious mental illness to support their mental wellbeing and prevent physical ill health.	We are continuing to support both primary and secondary care to ensure that patients with a severe mental illness (SMI) in Sunderland have an annual health check. We have significantly improved our achievement over the last year and can report that at the end of the financial year 2021/22, 56.4% of patients on the SMI register in Sunderland received an annual health check. Whilst this is positive, we recognise that further work is required to improve this to ensure that all SMI patients benefit from the

	healthcheck process. Mobile equipment is now available to undertake the elements of the check in the community and a pilot is about to commence in one PCN area. This pilot will provide an outreach service for patients identified as harder to engage with to ensure they are supported fully to receive a physical health check.

4.0 CURRENT POSITION – PRIORITY TWO

4.1 Our strategy pledged four important commitments to deliver priority two – 'right response, right time, right place'. A short summary of progress again each commitment is noted as follows:

Our Commitment	Our Progress
We will Improve accessibility of mental health care and support by working in partnership to co-produce and improve services.	We have a strong ethos to support co-production in Sunderland and call upon the expertise of those with both past and current 'lived experience'. We rely heavily on this valuable resource to ensure that our service delivery meets the needs of our population. As we work across the city to implement new and improve existing services, we will continue to draw upon the added intelligence that co-production delivers so that we can be confident that service provision reflects the patient's perspective. We have utilised the knowledge and experience of our service users as we design and implement changes to pathways and provision to support our Community Mental Health Transformation Programme. Our 'experts by experience' have reinforced the benefits of peer support and this is reflected in our peer support programme of work, recognising that within some mental health pathways this would work well, whilst not so well in others. A good example of where this insight adds real value is within the eating disorders pathway, where our experts by experience told us that peer support for patients would not be welcomed. Our lived experience service users tell us they perceive this to be a 'competitive disease' and would feel in competition around the acuteness of their circumstances with their peer. As we continue with our transformation programme, we are developing mental health hubs, initially in three of our six PCN areas, with a view to expansion once we have a fully established and mature operating model. The mental health hubs will operate an open-door approach to encourage engagement and trust amongst the local population, as well as provide a venue for low level support in terms of peers networking, coffee and chatting to reduce social isolation, and provide access to helpful materials and online resources etc.
We will work with specific groups of people who	We need to ensure that our services are equally

don't typically access services and are at greatest risk of mental health to ensure fair and equitable access.	accessible to all; to do so we must continue to engage with cohorts of patients who we know are less likely to ask for help. The engagement work undertaken in the development of the strategy and further engagement via the Alternatives to Crisis Community Connector Programme will be utilised so that we can understand the barriers which may prevent access and put measures in place to address this. This will be incorporated into service design and reviews as standard practice and will also be part of our continued engagement work across the community in existing programmes. The mobilisation of warm hubs across the community, including voluntary and community sector organisations (VCSO) mental health premises, is seeing an increased footfall of residents who would not normally engage or interact with mental health support. The opportunity is therefore being taken to raise awareness and education around what is available to support mental health and wellbeing. Washington Mind have worked with all warm space hubs to introduce 'Ray's Corner' which is a suicide prevention initiative. The Corner provides a suite of information detailing how and where to access mental health and wellbeing support. Alongside this a QR code has been developed which provides direct online access to a wealth of information; to date over 600 people have accessed information via this route. This initiative has recently been awarded as a national innovation and will be rolled out to other Mind organisations across England and Wales. We have identified a Mental Health Champion in each GP Practice who can support the practice in raising awareness and education around Mental Health, as well as support with signposting to available support. The majority of the champions are in administrative roles and are not intended to replace clinical expertise but instead scaffold existing infrastructure. In lots of cases, they are front of house facing and most likely to be the first point of contact in practice.
We will promote the help and support available to all communities to prevent mental ill-health and improve mental health and wellbeing.	Work is progressing to establish a central Directory of Services (DoS) across the City. Key partners are working together to provide details of the mental health information and other support available so that it can be incorporated into the city's emerging DoS. Alongside this, we are confident that the Community Connector Programme will encourage patients and residents to access support as appropriate, to help manage and improve their mental health and wellbeing. The programme can also offer support and resources to organisations across the city including networking opportunities, training, and access to Peer Community Coordinator's.
We will work with service providers to deliver equality in mental health care (access, experience, and outcomes) so no-one is left	We are working with partners across the city to address the barriers identified in our engagement work some of these are new and emerging as new

behind by implementing the Advancing Mental Health Equality Framework.	challenges for communities present themselves. We recognise that there are groups of patients who do not routinely ask for help to improve their mental health, particularly males, peoples with disabilities and black, Asian and other ethnically diverse communities. We are therefore looking to further understand these barriers, basing our work on the Advancing Mental Health Equality Framework to ensure our service delivery models are open and accessible to all, with equity as a standard. Our links to informal support groups across the voluntary sector will provide a valuable gateway into reaching out to these vulnerable groups of patients.

5.0 CURRENT POSITION – PRIORITY THREE

5.1 Our strategy pledged five important commitments to deliver priority three – 'working with you on what matters to you'. A short summary of progress against each commitment is noted as follows:

Our Commitment	Our Progress
We will identify and increase ways to involve people with lived experience of mental ill health, and their carers, to co-produce, quality assure, and improve services.	We are committed to drawing on the expertise of people with lived experience as we know the benefits that this can bring to service design. We work closely with the University's Patient Carer and Public Involvement Team. Our Community Mental Health Transformation Programme has had vital representation from this team to help shape future developments. Alongside this we believe that as we develop our peer support and community connector programmes, this will continue to provide valuable feedback relating to barriers and areas of improvement and this will play a significant role in co-production across the city.
We will ensure services work together, promote inclusive access to care and treatment to avoid people 'slipping through the gaps' or being caught in competing thresholds and access criteria.	A six-month pilot has been developed locally to introduce a Mental Health multi-disciplinary team (MDT). Initially this will be in two PCN areas and learning from this will support a wider rollout across all PCNs. The MDT aims to • Develop multi-disciplinary working that includes multiple professionals. • Deliver proactive, patient centred care to those with the most complex mental health needs. • Provide timely services at Neighbourhood level. • Promote a patient centred culture. • Facilitate appropriate information sharing to coordinate care.
We will explore new approaches to ensure services wrap around people and are proactive with them, including methods of delivery to support all services users, such as peer support, telephone advice and guidance, communication methods.	We recognise the importance of peer support, and this has been a strong theme from all engagement and service development work. As a result, we are developing a Peer Support Network. The network would have a pool of peer support workers which can be drawn upon for patients across Sunderland. We envisage this resource will:

	• Ensure patients are linked to the correct healthcare service • Help and support patients to attend crucial health appointments when they do not feel that they are well enough to attend alone • Connect patients with services outside of healthcare • Provide transport to health or other necessary appointments • Be someone that they can talk to • Take them to events that prevent social isolation The Mental Health Link Workers within Sunderland Counselling Service act as a wrap around provision for people accessing or struggling to engage with primary or secondary service. They will link with the patient to see what additional support they may need, build relationships with them and thus be able to intervene early should their mental health worsen. Building this type of relationship allows a person-centred understanding of that individual's support needs, what their triggers may be and what support plan needs to be put into place, enabling the patient to access support and understand how they can self-manage where appropriate. Mental Health practitioners are working across our PCN areas to ensure that all patients referred into the team have a wrap plan upon discharge so that they know how to manage symptoms and seek support at the right time to avoid escalation of problems.
We will ensure patients feel enabled, empowered and confident to self-manage conditions.	We recognise that by empowering patients, they are likely to be able to improve their mental health and well-being and seek the support they need at the most appropriate time. More work is needed to ensure that when patients do reach out for help, they are provided with education and tools and techniques to self-manage their condition and to know when to seek further support from their clinical team. With the provision of a peer support network, we hope that this will nurture a culture of confidence in our patients to engage with lower-level community support services which will provide them with the assistance they need to keep well. Significant work has been undertaken to promote awareness and self-help techniques for women experiencing menopausal symptoms which has been extremely well received. Further education work is taking place across the city to ensure that appropriate help is available to support women. A pilot is in place with Sunderland Counselling Service for parents and carers of children who are receiving community Children and Adolescent Mental Health Service (CAMHS) and who themselves may need short-term social, emotional, and practical support. This project will develop awareness and foster engagement with services by connecting and signposting with an aim to empower patients to access the support they need for themselves, and their

	families. The team can provide direct emotional support, provision of self-help materials, a "check in" system, packages of support and onward referrals where necessary.
We will ensure there is effective transition • From child and young peoples to adult mental health services • From service to service/organisation to organisation • Following discharge from services	We are working with our main provider to improve the discharge process and ensure that documentation, focuses on informing primary care what information is needed and why. For example, where a diagnosis has not been made, explaining what would be beneficial to general practice e.g. patient thinks X but we disagree and explain why. Correspondence will be clear on what can be done to ensure the patient can be supported and managed in a community environment. Whilst initially this work focussed on the discharge process the project team are reviewing all processes, e.g., general letters, discharge summaries, medication etc. One of the key themes identified in our engagement work was around the transition process from childrens to adults' mental health services. Our Mental Health Clinical Network recently considered this and recommended that guidelines be developed to take into account the referral process when a patient is reaching the threshold for referral into adults' services. This will be reviewed at a provider level and taken forward as appropriate. Consideration is being given to the transition of patients who are receiving support and are moving from children to adults to ensure a smooth transition process with no disruption to care. Our adult teams plan to work with the Children and Adolescent Mental Health Service (CAMHS) Partnership Group in the City to drive forward this work. Whilst not a direct outcome, we believe the work planned to implement the iTHRIVE model in Sunderland will also shape future transition processes. The Home Group hospital discharge programme supports patient to live independently following discharge. The type of support offered is broken down into three main groups: advocacy and advice, practical support and emotional support. This offers: • Help finding alternative accommodation or accessing benefits • Support with long term tenancy or financial management • Support in accessing appropriate services relating to mental or physical health • Developing domestic or life skills, as well as social skills or behaviour management • Emotional support and advice • Risk assessment to help in establishing personal safety and security • Increasing social engagement and reducing isolation

6.0 DEVELOPMENT OF A MENTAL HEALTH DASHBOARD

6.1 A dashboard to track the delivery of the strategy is being developed, which includes several key outcomes and associated indicators linked to the areas set out in the strategy.

6.2 The dashboard is still in draft form due to the unavailability of data for some outcomes and indicators. Work has commenced by lead agencies on the development of the indicators which require new collections and/or require further work.

6.3 The dashboard will focus on six key outcomes which will measure success of the strategy. The outcomes are:

- More people with better mental health
- Fewer people who suffer from avoidable harm
- Increased recovery for more people with mental health problems
- A positive experience of care and support
- Fewer people who experience stigma and discrimination
- Better physical health in those people with mental health problems.

6.4 Whilst a draft is available now, it is anticipated that the dashboard will be implemented in quarter four of 2022/23 once development has concluded across the workstreams.

7.0 RECOMMENDATION

7.1 Members are asked to note the content of this report and note the progress that is being made towards the delivery of the Adults Mental Health Strategy outcomes in Sunderland.

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