Live It Well

(Draft)

A strategy for improving the mental health and wellbeing of people in Kent and Medway

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Vision statement

"With our partners we will co-create a mental health system that makes mental health everybody's business. The system will address the varied needs of the people living in Kent and Medway. It will deliver a range of activities to promote positive mental health and wellbeing in the community, it will lessen the prevalence of common mental health problems, and it will lessen stigma and discrimination. We will ensure that prevention is targeted at those at higher risk. Service responses will intervene early when people develop problems, and will enhance the inclusion, physical health and optimal functioning of people who have severe mental health problems. Service providers will deliver a personalised service for all service users. Wherever possible, services will be community-based. They will work in equal partnership with service users and their families, and will facilitate recovery and reintegration through the provision not only of best practice care but of accessible, supportive and empowering relationships."

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Foreword

Who might we get to write this?
e.g. a combined statement from the two DPHs? A local 'celebrity'? A comment from Re-Think?

Executive Summary

1. Overview

Now is a very opportune time to develop a vision and a strategy for improving the mental health and wellbeing of people living in Kent and Medway.

Firstly, because of recent consultation and listening exercises locally and with the development of our joint strategic needs assessment (JSNA) (1.), we have never been better informed about the mental health needs of the population of Kent and Medway. Secondly, the 10 year *National Service Framework for Mental Health* (2.) and its implementation have come to an end. The NSF very largely set the direction for commissioning mental health services locally but now we need to move forward and consider what further improvements we need and how best to commission for them, and to use world-class commissioning approaches to achieve that.

With good timing the Department of Health has recently launched its consultation document *New Horizons: A shared vision for mental health* (3.), with a clear vision over the next ten years. It states with much ambition that by 2020 we will raise the importance of mental wellbeing to the same priority as physical health, we will deliver more prevention, we will improve the quality and outcomes of care, we will deliver more personalised services, we will address inequality in access and experience of care, we will reduce stigma, and we will improve the physical health of those with significant mental health problems.

New Horizons captures some clear shifts in thinking that we have to make locally - both about the importance of mental health and wellbeing for a population and about how mental health is delivered in any population. In our vision and strategy we have to consider many challenges - how we shift much more towards public health approaches to promote, achieve and sustain people's mental health, how we support individuals to make lifestyle choices that will improve their mental wellbeing as well as their physical health, how we engage the widest coalition of resources to

improve mental health and wellbeing, and how we deliver services in the most innovative ways.

Lastly we must note some contextual issues. Even without a recession the Government has set some markers for improvement across Government services – higher quality, more innovation, greater productivity, more prevention (often referred to as the QIPP agenda). The global financial crisis will mean that the funding environment in Kent and Medway for health and social care will be much more challenging over the next five years than it has been over the last five. Recovery from recession is predicted to be hesitant, and high unemployment will impact on the mental health of Kent and Medway residents.

(see Appendix 1 for financial summary)

So, just delivering more of the same types of services cannot and will not be our agenda. Our vision, from now until 2015, is shaped by what we have heard from those who use services and by our clear understanding of need, but also by recognition of some fundamental shifts needed, and by focused thinking on a few absolute priorities. We will deliver improved service quality by continued development of Commissioning for Quality Incentives (CQUINs), and encouraging quality in primary care via the Quality and Outcomes Framework (QOF scheme). We will also deliver improved quality and efficiency by a specific focus on the 10 High Impact Changes for Mental Health (4.)

(see Appendix 2 for the key performance indicators, or KPIs, that will be used to monitor the implementation of this strategy)

(see Appendix 3 for full list of 10 High Impact Changes for Mental Health.)

It is important to note that there are separate strategies for dementia care and services, for child and adolescent mental health services, and for drug and alcohol services, and therefore these are not covered here.

2. What service users and carers say services should be like

Local

- they should fit in with where we live
- in the community as far as possible, rather than health locations
- in places where everyone else also uses resources to get on with life

Personalised

- a single point of contact for service users
- alternatives to medication, increased access to talking treatments
- better signposting to resources and services so we can arrange support for ourselves with a personal budget

Timely

- services should be when we want them (which is usually early on)
- better out of hours support with 24 hour support for people in crisis
- a proper procedure when police detain people with mental health problems

Non stigmatising

- service users should be empowered, not disempowered, by mental health services
- challenge stigma, not identifying service users as separate from the rest of society
- personalised relationships with people we know

*sources include
Canterbury and District Mental Health Forum August 2009
West Kent PCT Listening Exercise 2008
Four specific workshops to develop the vision held across Kent and Medway in June 2009

3. What we know about local needs

The **prevalence** and **impact** of mental health problems on society is poorly appreciated:

- The proportion of the population surveyed in England meeting the criteria for one common mental disorder (such as anxiety or depression) rose from 15.5% in 1993 to 17.6% in 2007 (5.). A quarter (24%) of people with a common mental disorder were receiving treatment for an emotional or mental health problem, mostly in the form of medication (5.)

- Nearly one third of those going to GPs have a mental health problem (6.)

- The wider cost of mental health problems to the country (estimated at £77billion in 2005/06) exceeds Treasury spending on the NHS as a whole at £76 billion (6.)

- Mental health problems are estimated to be the commonest cause of premature death and years of life lost with a disability – 23 per cent of the burden of disease in high income countries and 40 per cent of years lived with a disability (quoting World Health Organisation reports) (6.). The average life expectancy of people with schizophrenia is 10 to 12 years less than those without, due to increased physical health problems and a higher suicide rate.

- One third of people think that people with mental health problems should not have the same rights to a job as everyone else (5.).

The **Mental Health Joint Strategic Needs Assessment** for Kent and Medway (1.) estimates that there are:

- 163,00 to 190,000 people with common mental health problem(s) at any one time, of whom 25% need treatment
- More than 60,000 people are estimated to have severe mental illness, and around 12,000 people are estimated to have severe and enduring mental illness

Mid 2008 estimates put the **population** of Kent and Medway combined at 1.66 million. The population of Kent is expected to increase by 10% (138,000) between 2006 and 2021, and in Medway by just over 2% (5,800 people). Across Kent and

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Medway the population over 65 is expected to increase by about 15% between 2008 to 2013, and by about 40% over the period 2008 to 2023. This growth will be more marked in Eastern and Coastal Kent. There will be a consequent increase of and strain upon informal carers.

Significant **determinants** of mental ill health are:

- Deprivation is strongly correlated with mental ill health – and is concentrated in the coastal towns. This would encompass poverty, low income, debt, unemployment, poor housing, and poor physical health. It has recently been suggested that debt is a stronger risk factor for mental ill health than low income (7.)

- Social capital – the strength that individuals draw from their interactions with others - is weaker in some parts of Kent than others. This is more the case where deprivation is greatest, and for specific groups such as carers and older adults

- Healthy lifestyles – exercise and healthy eating can reduce risks of depression. Alcohol dependence in particular is more common among people with mental health problems than the rest of the population.

4. Our Commitments

Our vision for improving the mental health and wellbeing of people in Kent and Medway is crafted from the analysis we have made from all the sources described above. Given this analysis our efforts will be targeted in 10 discrete areas – which we have set down below as our commitments.

By 2015 we will have:

i. ***Built coalitions between all elements of public services, the voluntary sector, and the independent sector that focus on collaborative endeavour and shared enterprise to improve mental health and wellbeing***

ii. ***Lessened the stigma, discrimination and unhelpful labelling attached to mental ill health and those using mental health services***

iii. ***Reduced the occurrence and severity of common mental health problems, particularly by targeted actions to improve wellbeing for more of those people at higher risk – those in more deprived communities, those in black and minority ethnic communities, and those who are seldom heard***

iv. ***Demonstrably improved the life expectancy and the physical health of those with severe mental illness, and demonstrably improved the recognition of mental health needs in the treatment of all those with physical conditions***

v. ***Reduced the number of suicides***

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vi.	***Ensured that all people with a significant mental health concern, or their carers, can access a crisis response service at any time and an urgent response within 24 hrs - and that service contact points are more local***
vii.	***Ensured that all people using services are offered a personalised service, giving them more choice and control over the shape of support they receive wherever the care setting is***
viii.	***Delivered better recovery outcomes for more people using services, and in the most appropriate setting for them***
ix.	***Ensured that more people with both mental health needs and drug and/or alcohol dependency (dual diagnosis) are receiving an effective service***
x.	***Delivered effective mental health services in prisons in ways that ensure the safety of more offenders with mental health problems***

In pursuing these commitments we will be guided by four key principles – to deliver improved health outcomes, to improve all aspects of quality, to seek innovative improvements to service and system performance, and to deliver value for money.

5. Our Commitments:

- **why have we chosen these**
- **where we are now with each commitment**
- **the actions we are going to take to meet each commitment**

In this section we will explain why we have chosen these commitments, give an outline of where we are now (the JSNA may have more detail), and list the actions we will take to meet each commitment in a prioritised order.

i. We will build coalitions between all elements of public services, the voluntary sector, and the independent sector that focus on collaborative endeavour and shared enterprise to improve mental health and wellbeing.

The NHS has a core responsibility for providing a comprehensive service, based on need, for anyone presenting with a mental health problem. However, if we are to lessen the occurrence of mental health problems among the people of Kent and Medway, we will have to engage all relevant agencies in that endeavour. The significant determinants of poor mental health have much in common with those of poor physical health – deprivation, unemployment, debt, stress, poor physical health, poor housing, lack of social networks, and so on. The work to raise awareness of these issues, to recognise people at risk, to signpost people to support or services, to offer 'first aid' support, to enable people to develop more resilience, to reduce stigma, to make mental health everybody's business, cannot be just 'government' work. In particular, it cannot be the work of government agencies working in silos.

We believe it can only be planned and initiated if we collaborate across all stakeholder agencies and develop innovative and enterprising ways to alleviate some of these problems.

Currently we have a Strategic Commissioning Board for Mental Health, covering all of Kent and Medway, and three Joint Commissioning Boards (JCBs) for Mental Health, one each for Eastern and Coastal Kent, for Medway and for West Kent. There is Primary Care Trust and Local Authority Social Services representation on all of these, and there are mechanisms in place to ensure JCBs have service user and carer views. Our strategy addresses how we will widen engagement.

In the autumn of 2009 the terms of reference for the three JCBs were significantly revised, and they adopted a much strengthened stance on commissioning.

Comments from the four stakeholder workshops held in June 2009 included:

- wellbeing also had a community dimension – strong, safe and sustainable communities promoted mental wellbeing, while a sense of community was felt to be good for an individual's wellbeing.

- the voluntary sector has a large role to play, particularly in working with people from BME communities;

- schools need education around mental health. Mental health promotion and prevention work is important to raise public awareness of the need to look after our mental health and wellbeing, and to be aware of the early signs that something is wrong;

- link in with some of the Regeneration projects that are taking place in certain areas of Kent? SEEDA would be the agency here. Projects mostly happen at district level, e.g. around old coal fields, and various housing initiatives, "Community Cohesion" sites.

What we will do or initiate *as a priority* in 2010-11 is.....

- We will consistently ensure over the next five years that the importance of improving mental health and wellbeing and that the importance of all agencies collaborating on this goal together are widely accepted – by using such channels as influencing Local Strategic Partnerships and their Health and Wellbeing subgroups, by influencing Crime and Disorder Reduction Partnerships, and by strengthening Local Planning and Management Groups (LPMGs). We will ensure the widest circulation of the Joint Strategic Needs Assessment in support of this commitment. We will encourage all three PCTs to achieve collaboration on this goal by fully exercising their World Class Commissioning leadership competence on the mental health and wellbeing agenda.

- We will engage all mental health service providers with the broader vision for mental health and wellbeing development and encourage them to develop initiatives to raise awareness and to collaborate together in such initiatives.

- We will instigate the development of a Kent and Medway-wide mental health

promotion network. Among other objectives the network will develop training strategies aimed at both non-health professionals – i.e. those that could recognise people at risk in the workplace – and for health professionals; both strategies will be aimed at raising awareness, identifying risk, offering initial support, and signposting people to more comprehensive support.

And, *over the next five years:*

- We will ensure that key agencies are as aware of the economic and social return benefits of a mental health and wellbeing strategy and initiatives as they are of the benefits to individuals.
- We will continue to develop the commissioning strengths and influence of the Strategic Commissioning Board for Mental Health across Kent and Medway, and of the three constituent Joint Commissioning Boards.
- We will continue to encourage user and carer engagement and develop more effective user and carer engagement processes.
- We will improve advice and signposting about mental health and wellbeing support at council gateway sites.
- We will be open to all proposals from any source, including potential providers as well as existing providers, which will enhance our success on delivering this agenda.
- We will support and encourage new partnerships at the local level within towns, villages, streets and any other relevant locality where such collaboration will increase our ability to deliver this mental health and wellbeing agenda.

*HIC refers to High Impact Changes for Mental Health (4.) – see Appendix 3.

ii. We will lessen the stigma, discrimination and unhelpful labelling attached to mental ill health and those using mental health services

Stigma is an unnecessary burden carried by mental health service users, and it also deters people from seeking help in the first place. Almost nine out of ten people with mental health problems (87%) reported the negative impact of stigma and discrimination on their lives in the Stigma Shout survey (5.). The fear of stigma and discrimination may deter relatives or friends seeking help for others too. Further, 69% of service users said they had been treated differently (in a negative way) because of their mental health problem, and 71% said stigma and discrimination had stopped them doing the things they want to do.

In the Stigma Shout survey employers were the second highest-scoring group from which those with mental health problems personally experienced most stigma and discrimination (35%), with only their immediate family higher (36%). The ability to work, and to derive both income and self-esteem from that, is of profound importance in many people's lives.

Offenders, too, do not want to be labelled with a mental health diagnosis because of the stigma and discrimination this brings with it.

Time to Change has identified that movies are the main source of information that reinforces negative stereotypes of mental illness above and beyond any other form of media.

This commitment matches one of the pledges made by the South East Coast SHA pledges in 'Healthy People, Excellent Care' (8.) – to campaign to overcome discrimination against people with mental health problems. A further pledge made by the South East Coast SHA pledges in 'Healthy People, Excellent Care' is to work with employers to maintain employment for those with mental health problems.

Comments from the four stakeholder workshops held in June included:

- early recognition of symptoms was important so that people could take time off rather than struggle to manage and become more ill – the stigma surrounding mental illness needed to be addressed and removed;

- help with mental health issues should be provided in 'ordinary settings' without being labelled 'mental health' and where a range of appropriate help and support is provided for several different issues so the setting is anonymous;

- Resource centre in community for social activity and activities of normal living, creative workshops, cooking, walking, health centre, swimming;

- the Third Sector will be essential to provide a real mixed economy of help and support with a wide variety of possible access routes in discrete locations not labelled 'MENTAL HEALTH'.

What we will do or initiate *as a priority* in 2010-11 is.....

- We will encourage employers to pay at least as much attention to mental health discrimination as any other form. We will persuade more employers to sign up to the 'Mindful Employer' initiative, and persuade more to commit to the national 'Time to Change' initiative. . We will achieve this through the commissioning of employment services.

  'Lack of mental well being in the workplace is costing the UK £25.9billion per annum in terms of sickness absence, presenteeism and turnover, and an additional nearly £5b in terms of incapacity benefits. It is not only economically costly but also costly to the health and wellbeing of individuals and their families. Initiatives like MINDFUL EMPLOYER energize employers to do something about the wellbeing of their employees and is of vital importance to the health of the nation.'
  Cary L Cooper CBE, Distinguished Professor of Organizational Psychology and Health, Lancaster University

  (www.mindfulemployer.net)

- We will encourage NHS employer organisations to become exemplar

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employers in managing staff wellbeing, as recommended in the NHS Health and Wellbeing Independent Report by Professor Boorman (9.).

- We will commission for community mental health services to be available in more community settings and support providers to achieve this, and to change signs and signposting to be less labelling of service users.

And, *over the next five years:*

- We will sustain a positive communication plan about mental health and raise awareness of the harm caused by stigmatising and unhelpful labelling of those people with mental health issues. We will speak out about negative or inaccurate media portrayal of mental health issues and the use of perjorative terms to describe those with mental ill health.

- We will ensure more employers are aware of the NICE guidance 'Promoting mental wellbeing through productive and healthy working conditions: guidance for employers' (10.) launched in November 2009 which advises employers:

    - to adopt a business-wide and integrated approach to improving mental health management. This should take into account the nature of the work, the workforce and the culture of the organisation

    - to implement robust systems for assessing and monitoring mental wellbeing in order to flag areas for improvement and address any risks.

    - to offer flexible working arrangements

    - to strengthen the role of line managers in promoting mental health in the workplace.

- We will explore how PCTs together with occupational health (OH) professionals and others involved in mental health initiatives can collaborate with small and medium size enterprises (SMEs) to offer advice, support and better access to OH services.

- We will encourage the development of more holistic 'wellbeing' strategies, with a sensible mind-body balance, and holistic occupational health responses

- We will ensure this commitment remains a high priority among the community development work we undertake.

iii. We will reduce the occurrence and severity of common mental health problems, particularly by targeted actions to improve wellbeing for more of those people at higher risk – those in more deprived communities, those in black and minority ethnic

communities, and those who are seldom heard

The Joint Strategic Needs Assessment makes the case for specific targeting of support towards more deprived communities, BME communities, carers, and older people. Other groups more prone to common mental health problems are those with long-term physical conditions, the homeless, those with physical or sensory impairments, and offenders.

Black and minority ethnic groups (BME) are overrepresented in mental health services. People from BME groups are also more likely to be detained under the Mental Health Act. 23% of mental health inpatients in 2008 were from a BME group (4.).

Summary of range of current targeted initiatives in place:

Arts on prescription Books on prescription Healthy walks Community choirs, etc. This table to be revised

This commitment supports one of the pledges made by the South East Coast SHA pledges in 'Healthy People, Excellent Care' (8.) to ensure that access to psychological therapies in primary and secondary care is in line with best practice.

Comments from the four stakeholder workshops held in June included:

- the fundamental issues surrounding wellbeing are the same for all human beings regardless of race or culture;
- current service provision was piecemeal and there was no holistic assessment – wellbeing is multi-faceted and would require the whole person to be considered and not just their mental health;
- providing more support to GPs and Primary Care in general so that the surgeries are more able to deal with mental health as well as the physical healthcare of their patients (eg - access to CPNs);
- some targeting of resources would be useful to address some of the inequalities within Kent – it was cited that the life expectancy in Dartford is 14 years lower than in the more affluent parts of Kent and Medway.

What we will do or initiate *as a priority* in 2010-11 is.....

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- We will strengthen our commissioning and support of schemes and initiatives that are targeted towards 'at risk' people or communities, which build their protective factors against mental health problems and provide more social capital. We will link this strongly to needs identified in the Joint Strategic Needs Assessment, such as those of the growing elderly population and of carers. We will identify a variety of avenues to achieve more support, such as using Healthy Living Centres and other 'contact points' such as Gateways and drop-ins, working with voluntary organisations and volunteers to develop buddying schemes, working with social enterprise groups, and with faith communities. We will make judgements on what we support based on social return on investment principles (11.). We will work alongside enhanced primary care schemes in deprived areas, such as the Triple Aim scheme in Thanet.

- We will invest in and deliver psychological wellbeing programmes to help people to build emotional resilience. The programmes will be targeted towards people at higher risk, especially those whose needs have increased following the impact of the economic downturn. We will monitor the outcomes of these interventions and develop tools to measure whether we are improving the psychological wellbeing of target groups.

- Primary Care Psychological Therapy services continue to be rolled out across Kent and Medway, delivered by three different service providers. Psychological therapy provides treatment to people with 'common' mental health problems (anxiety and depression). We will ensure there is wider uptake of these therapies and that people know that they can self-refer for an assessment. We will also ensure that those whose first language is not English can access and benefit from these services. We will evaluate the outcomes of these services regularly and ensure they optimally deliver positive benefits to users. We will also ensure that service providers have networks in place to provide service users with other avenues of support.

- We will take advantage of technology, particularly the developing range of on-line support initiatives, to help people access a wide range of support for mental health and wellbeing. We will continue to invest in the development of the local Live Life Well initiative – an information and resource site (www.liveitwell.co.uk). We will direct people to other resources that provide mental health support such as Signpost Kent (www.signpostuk.org) and the "The Big White Wall" (www.bigwhitewall.com). This is a social networking site that offers support networks for people in emotional distress where they can remain anonymous. The Big White Wall is run in partnership between the Tavistock and the Portman NHS Foundation Trust, and was winner of the 2009 MediaGuardian Award for Innovation in Community Engagement.

- We will ensure there is widespread knowledge of the Mental Health Matters telephone helpline (0800 107 0160), and the NHS credit crunch stress telephone line (0300 123 2000).

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- We will actively market these support initiatives with a sustained communications campaign across Kent and Medway.

And, *over the next five years:*

- We will widely circulate and encourage use of the wellbeing equivalent of 'five fruit and vegetables a day' – as developed by the Foresight Mental Capital and Wellbeing Project (7.). These are a list of suggestions for individual action, based on an extensive review of the evidence:

1. **Connect…** With the people around you. With family, friends, colleagues and neighbours. At home, work, school or in your local community. Think of these as the cornerstones of your life and invest time in developing them. Building these connections will support and enrich you every day.
2. **Be active…** Go for a walk or run. Step outside. Cycle. Play a game. Garden. Dance. Exercising makes you feel good. Most importantly, discover a physical activity you enjoy and that suits your level of mobility and fitness.
3. **Take notice…** Be curious. Catch sight of the beautiful. Remark on the unusual. Notice the changing seasons. Savour the moment, whether you are walking to work, eating lunch or talking to friends. Be aware of the world around you and what you are feeling. Reflecting on your experiences will help you appreciate what matters to you.
4. **Keep learning…** Try something new. Rediscover an old interest. Sign up for that course. Take on a different responsibility at work. Fix a bike. Learn to play an instrument or how to cook your favourite food. Set a challenge you enjoy achieving. :earning new things will make you more confident as well as being fun.
5. **Give…** Do something nice for a friend, or a stranger.

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Thank someone. Smile. Volunteer your time. Join a community group. Look out, as well as in. Seeing yourself, and your happiness, as linked to the wider community can be incredibly rewarding and creates connections with the people around you.

- We will explore the merits or translating these 'five a day' principles into other languages for different ethnic groups.
- We will encourage and support present and past service users to tell their stories and give support to others who may benefit.

iv. We will demonstrably improve the life expectancy and the physical health of those with severe mental illness, and demonstrably improve the recognition of mental health needs in the treatment of all those with physical conditions.

This commitment matches one of the pledges made by the South East Coast SHA pledges in 'Healthy People, Excellent Care' (8.), and is fully supported by this strategy because of the wealth of evidence that shows that those people with severe mental health problems have, on average, a significantly shorter life expectancy.

Comments from the four stakeholder workshops held in June included:

- Physical, mental and emotional wellbeing are linked together. To some this means a holistic approach. Some would add 'spritual' to the list;
- Current service provision was piecemeal and there was no holistic assessment – wellbeing is multi-faceted and would require the whole person to be considered and not just their mental health;
- Provide accessible, acceptable and appropriate services in neutral settings without labelling;
- Focus more mental health and welfare help and support in Primary Care.

What we will do or initiate *as a priority* in 2010-11 is…..

To improve the life expectancy and physical health of those with severe mental illness we will:

- As part of our communications campaign we will ensure there is wider awareness of the physical health risks for those with severe mental health problems, that mental health service users are not discriminated against in seeking general health care, and that support mechanisms are more widely

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known.

- Ensure our mental health service providers assess the physical health needs of service users, with particular focus on high-risk groups such as those on Care Programme Approach (CPA), dual diagnosis clients, offenders with mental health problems and on all admitted patients (including forensic services), and liaise with the GPs of service users where risks or needs are identified.

- Work with primary care commissioning at each PCT to:

    - ensure the numbers of patients on practice mental health registers (with schizophrenia, bipolar disease and other psychoses) and on depression registers represent local prevalence as fully as possible
    - analyse practice variation on management of these (i.e. for mental health the annual review rates achieved, and follow-up achieved) and to address variation in the degree of exception reporting
    - identify the range of specialist support needed to make improvements in primary mental health care and address inequality

To improve the recognition of mental health needs in the treatment of all those presenting with physical health conditions or problems we will:

- Work with primary care commissioning in PCTs to ensure the continued improvement of recognition of mental health problems among all those with long term conditions – focusing more widely than just on the quality indicator for case-finding for depression among patients on a practice diabetes register and /or the CHD register.

- Improve the specification, delivery and monitoring of outcomes of liaison psychiatry services in both A&E departments and in acute hospital in-patient settings at all District General Hospitals in Kent and Medway.

And, *over the next five years:*

- We will ensure that the specialist community services for patients with long-term conditions (e.g. diabetes, stroke, heart failure, COPD, community matrons or integrated teams) are competent at identifying common mental health problems among patients on their caseloads, use appropriate assessment tools, and can make referrals via appropriate referral pathways.

- We will support the health and social care implementation of 'Your Health, Your Way' and information prescriptions in long-term condition care (which focus on improving self- care and self-management) and ensure people with long-term mental health problems are included in these initiatives.

- We will ensure that cancer services also are competent at identifying common mental health problems among patients they manage, use appropriate assessment tools, and can make referrals for mental health support via appropriate referral pathways.

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v. *We will reduce the number of suicides*

Suicide is a major public health issue. On average, there are approximately 140 deaths from suicide annually in Kent and Medway. Deaths from suicides are in a younger age group than most diseases and therefore account for a much larger number of years of life lost than would be expected for similar numbers of deaths in other disease areas. The National Suicide Prevention Strategy states that many suicides are preventable which gives an added impetus for action.

Reducing the death rate from suicide is a government priority. The National Suicide Prevention Strategy which was published in 2002 reinforced the White Paper Saving Lives, Our Healthier Nation 1999 (OHN), target of a reduction in the death rate from suicide by at least 20% by 2010. It set out the national strategic priorities and actions for how this was to be achieved. In 2007 and 2008 national progress reports were produced giving updates and reinforcing the national commitment. Standard 7 of the National Service Framework for Mental Health 1999 also reinforced the importance of suicide prevention and gave a framework for action

Comments from the four stakeholder workshops held in June included:

- higher than national average level of suicide attempts in some parts of Kent and Medway;
- having a responsive attitude to people seeking help in a crisis – it was noted that the Police are the first port of call for someone contemplating suicide – the NHS needs to be responsive and positive and not to appear determined not to get involved.

What we will do or initiate *as a priority* in 2010-11 is…..

Local research indicates that only 35% of people who commit suicide had been in contact with mental health services. (Lawrence and Bean 2008) This is similar to the national findings. This means that the majority of suicides are not known to mental health services at the time of their death. As a result no one agency can be responsible for suicide prevention. Indeed, in order to be effective a strategy must involve a wide range of agencies who may have an impact on the behaviour of both high risk groups and the wider population.

Consequently in November 2009 a Kent and Medway wide multi-agency suicide prevention steering group was formed with the remit of ensuring that a Kent and Medway suicide prevention strategy was developed and implemented. This includes representation from PCTs, the acute trusts, KMPT, Kent Police and the voluntary sector.

Looking at the national priorities and the epidemiology of suicide in Kent and Medway local priorities will be likely to be:

- To reduce risk of suicide in known key high risk groups including
    - those in contact with mental health services,

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- those who have self harmed,
- prisoners and young-middle-aged men particularly men in routine and manual occupations.

- To promote wellbeing in the wider population particularly focusing on additional groups who are of concern including those who misuse substances.
- To reduce the availability and lethality of suicide methods. The suicide methods which are most used in Kent and Medway are hanging and self poisoning followed by jumping from a high place and railway suicides. Reducing these will be a priority for action
- To improve reporting of suicidal behaviour in the media. There is good evidence that irresponsible reporting in the media can lead to copycat suicides. A national resource for journalists has been produced to help improve reporting and this needs to be disseminated to all Kent and Medway media.
- To monitor suicide statistics and progress towards national targets and ensure appropriate audit.

Key actions to facilitate these priorities

Overall as part of the action plan in all risk groups appropriate actions need to be outlined for all agencies who are in contact with them. People who contemplate suicide, or take their own life if they are not in contact with mental health services, will fall into one of three groups, each requiring a different service response.

- Those in contact with primary care
- Those in contact with other services
- Those not in contact with any services

Other services will include ambulance services, accident and emergency departments, the police, drug and alcohol services, housing and voluntary sector agencies.

Appropriate service interventions are likely to include appropriate identification, management and referral for depression in primary care, awareness training, appropriate training in referral, signposting and management of suicide risk for other agencies.

For those who are not in contact with any services suicide prevention interventions would include mental health promotion activities, improving self referral opportunities for counselling and support.

In addition, in collaboration with Kent Police and other agencies, suicide hotspots will be identified and appropriate management action taken. This could include the display of signage and contact numbers for the Samaritans or the construction of physical barriers if appropriate.

And, *over the next five years:*

Continue as above.

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vi. We will ensure that all people with a significant mental health concern, or their carers, can access a crisis response service at any time and an urgent response within 24 hrs - and that service contact points are more local

The delays experienced by people with critical or urgent mental health needs add unacceptable additional stress and anxiety to them and their carers. The 'If only we could get more immediate help' comment is commonly fed back from service users.

Delayed specialist support has other risks, for example that people present at Accident and Emergency departments where staff less experienced with mental health emergencies may not be able to offer the most appropriate support or interventions, or that people begin to despair or lose awareness and suicide risk increases.

Further, a clear critical and urgent care pathway would help general practice to appropriately refer people to the right service.

This commitment matches one of the pledges made by the South East Coast SHA pledges in 'Healthy People, Excellent Care' (8.).

Comments from the four stakeholder workshops held in June included:

- providing quality services and ensuring continuity of care – working at the pace of the client and always being ready to offer support when the client felt they needed it without having to be re-assessed and having to start from scratch each time they suffered a relapse (timely access to services);

- single access points for health are needed and they should have more flexible hours, perhaps 8-8 and open at weekends;

- reaching out to the population like "street doctors", moving away from the institution.

What we will do or initiate *as a priority* in 2010-11 is…..

- We will commission a single urgent care pathway currently covered by the functions of the intake and crisis response and home treatment services. We will ensure the pathway improves the working arrangements between key agencies involved in crisis and urgent response – primary care, OOH services, emergency services (particularly police and ambulance services), A&E departments, and Crisis Response and Home Treatment teams. We will specifically improve the emergency arrangements for patients who fall under Section 136 of the Mental Health Act. (HICs 2,4,5,9)

- For patients known to the local mental health services, or their carers, and trying to contact in crisis or for an urgent need we will ensure they have a known point of contact (a named care worker) in the service. We will ensure that they or their GP can access this urgently.

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- We will ensure that urgent care face-to-face responses are local and that support includes home based care (HIC 1).

And, *over the next five years:*

- We will ensure that response times to crises are consistent across Kent and Medway and meet a minimum acceptable standard (HIC 4).

- We will ensure that crisis responses are protocol-driven to minimise risk in patient management. These protocols will include how to manage risks for patients who frequently contact or attend emergency services and who need frequent emotional support.

- For patients not known to local mental health services we will ensure there is access to an out-of-hours telephone helpline service and, depending on the risk assessed, that the service can offer the most appropriate support or referral either immediately or on the next working day.

- We will ensure that primary care out of hours (OOH) services have the competence and capacity to manage or refer mental health crises to appropriate support.

vii. We will ensure that all people using services are offered a personalised service, giving them more choice and control over the shape of support they receive wherever the care setting is

'*Social work is committed to enabling every child and adult to fulfil their potential, achieve and maintain independence and self-direction, make choices, take control of their own lives and support arrangements, and exercise their civil and human rights. Its approaches and working methods aim to promote empowerment and creativity.*' (12.).

This position is enshrined in *Putting People First* which "promotes choice and control for all, pushes councils to do more preventive work, explicitly values the 'social capital' that individuals and communities bring with them to the table and is serious - perhaps for the first time - about the need for 'universal services' to be made available to all. At the heart of the Putting People First policy - indeed at the heart of what has come to be known as 'personalisation agenda' - is the individual citizen, each with their own idiosyncrasies, gifts, weaknesses, hopes, worries, dreams and nightmares" (13.).

Our joint commissioning stance is fully in support of implementing more self-directed support and the personalisation agenda.

Comments from the four stakeholder workshops held in June included:

- It was felt that the level of engagement depended on the menu of services available. Personalisation relied on having an assessment of what was required and then making sure that the appropriate response to help and

assist the service user was available. Not a menu but a response to what would really make a difference to the individual;

- "Personal narratives" were felt to be key to helping the personalisation agenda happen, i.e. they need to see examples of success to really believe it can happen;

- "Diversity" is key to personalisation. Personalisation needs to be "outcomes focused", i.e. what is it we want to achieve from this in terms of people's lives. What are the outcomes people want? People have diverse needs. The method of how you achieve the outcomes therefore is less important;

- The individual should be at the centre of care, but it must not be assumed that they know best or that they know how things work. The response therefore needs to be tailored to the individual and to empower them to manage their own care.

What we will do or initiate *as a priority* in 2010-11 is…..

- We will procure more independent brokerage services, develop more widespread use of the 'Kent Card' to enable service users to chose a wider range of services, and ensure brokerage is better regulated.

- We will monitor frequently the reported patient experience of those using contracted mental health services, identifying issues such as the degree to which the service user felt they were consulted or given choice on their treatment and their care plan, and on perceptions of carer attitude.

- We will ensure that all people with severe mental health problems are given the opportunity to use advance directives, statements, agreements and crisis cards to express their wishes about their care when they are well.

And, *over the next five years:*

- We will ensure that providers use a validated assessment tool that enables service users to take a lead in their assessments and the directing of their care.

- We will ensure that every service user has an estimated social care budget, and we will pilot personal mental health care budgets in all localities.

- We will ensure that, wherever possible, service users in in-patient settings have access to the same services and opportunities that people can access in the community, e.g. wifi access, access to exercise.

- We will ensure that waiting lists for access to personalised services are minimal.

- We will enable service users to express a choice over the location of the community mental health services they use across Kent and Medway.

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viii. We will deliver better recovery outcomes for more people using services, and in the most appropriate setting for them

People with severe mental health problems have the same wants and needs as anyone else. The trajectory of mental illness is not one of persistent deterioration and people need to be supported to lead meaningful lives and exercise choices. Outcomes for people with severe mental health problems improve when care and treatment supports people's fundamental human needs – for autonomy and self-determination, for confidence, and for relatedness – which are at the heart of a recovery approach.

Comments from the four stakeholder workshops held in June included:

- Therapeutic optimism may be a better term. Service users may be concerned about giving up their access to support, possibly because they have had a hard road to get access in the first place and do not want to go through that again;

- Recovery is multi-faceted and needs to be determined by the individual – staff should be optimistic about what their service users can achieve and encourage them;

- When undertaking an assessment the individual should have one which focuses on the positives rather than accentuating the negatives, and makes full use of Primary Care, Improving Access to Psychological Therapies (IAPT) and other community services;

- Services should focus on providing a series of steps back to recovery following an episode of illness. Emphasis on the positives and helping people regain control of their lives.

What we will do or initiate *as a priority* in 2010-11 is…..

- We will ensure that providers deliver effective and personalised care planning for recovery – and that best theoretical practice becomes mainstream practice. We will ensure that services are organised around the recovery-oriented principles expressed in the Recovery-Oriented Practices Index (ROPI) (14.) and that service users are supported to recovery with goal-setting, tools to measure change, building on their strengths, engagement of their support network in recovery planning, and building social networks and support to remain in employment or with job-seeking.

- Within psychological therapy services we are embedding evidence-based measurement of 'moving to recovery' with use of pre- and post-intervention scales and scoring tools. We will develop the use of these across a wider range of services, using both HoNOS and patient-recorded outcome measures

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(PROMs) (HIC 7). The Recovery Star would be one very useful PROM.

- We will ensure that GPs are better supported to take back the management of appropriate patients from secondary care services.

And, *over the next five years:*

- We will ensure that service users receive the support and care planning they need particularly prior to and over discharge from hospital care and, equally at that time, that support networks are increased (HIC 3).
- We will ensure, as much as is possible for individual service users, that home based care is the norm as part of supporting recovery (HIC 1).
- We will monitor frequently the reported service user experience and provider response in this area (HIC 6).
- We will compare prescribing differences across major therapeutic drug groups to explore reasons for prescribing anomalies and ensure people are receiving the most beneficial medication that they need.

ix. We will ensure that more people with both mental health needs and drug and/or alcohol dependency (dual diagnosis) are receiving an effective service

Our Joint Strategic Needs Assessment identified lack of information about dual diagnosis prevalence as a problem for us. Many people who present to drug and alcohol services have varying degrees of mental health problems, and many of those who present with mental health problems also have some drug and / or alcohol problems. Some of these people also present with problems that are challenging for primary care management. Historic problems exist with 'silo' management of services for one or the other need, but with little integrated care delivery between services.

During 2009-10 we have been assessing the scale of need with our main providers.

Our commissioning approach will address those with less severe mental health problems plus substance misuse as well as only those with severe mental illness.

Comments from the four stakeholder workshops held in June included:

- Overall between 30% to 50% of people with severe mental health problems may have current drug or alcohol issues. Between 20% and 45% of inpatients in acute psychiatric wards have problematic drug or alcohol use. In high secure psychiatric units between 60% and 80% of patients have a history of substance misuse prior to admission. It is possible that as many as two-thirds of those who come into contact with drug or alcohol treatment services may also have some kind of mental health problem;

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- A radical change in staff attitudes to enable people to achieve their ambition and to make a contribution to society;
- Employing staff experienced in helping people gain confidence in work and employment through training and education, volunteering, supported work and actual employment.

What we will do or initiate *as a priority* in 2010-11 is…..

- We will ensure that drug and alcohol needs assessments capture dual diagnosis needs and that data is robust enough to inform future service planning. We will ensure that the full picture is informed by data held by a range of different agencies – such as police, probation, health providers, and social care.
- We will ensure that care for those with dual diagnosis is mainstreamed within mental health service providers, and that they receive integrated support.
- We will negotiate protocols with service providers that specify the circumstances in which mental health services provide support to drug and alcohol services for complex patients, and vice versa.

And, *over the next five years:*

- We will include dual diagnosis needs as an integrated part of the annual commissioning treatment plan.
- We will secure full integration between Drug Intervention Programmes and the Police Custody Suite Diversion Schemes to achieve better outcomes for those identified with dual diagnosis in the criminal justice system.
- With mental health service providers we will:
    - Reflect in contracts that joint working around dual diagnosis is part of their core business
    - Ensure staff in both mental health services and in drug and alcohol services are adequately trained to identify dual diagnosis patients using a structured assessment, and can implement and coordinate care planning to the level of national occupational standards
    - Expect prevention and reduction of substance misuse among those with severe and enduring mental illness and those on in-patient wards, and elsewhere in the local mental health services
    - Develop and monitor patient outcomes
    - Ensure that dual diagnosis patients can access talking therapy services
    - Ensure that those with drug and/or alcohol problems and complex mental health problems receive an assertive service if needed.

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x. We will deliver effective mental health services in prisons in ways that ensure the safety of more offenders with mental health problems

There are 9 adult prisons across Kent and Medway holding more than 5,000 prisoners at any one time. Rochester has the only Young Offenders Institution in the county. Health among prisoners is not as good as the general population. In 2009 the Prison Reform Trust identified that 72% of male and 70% of female prisoners suffer from two or more mental disorders (1.). Substance misuse problems are also very high amongst offenders. Further, around 60% of released prisoners are not registered with a GP. Re-offending within 3 years of release is as high as 80%.

In 2007 a mental health needs assessment across the Kent and Medway Prison estate found significantly higher prevalence of mental illness amongst the prison population than in community populations. Notably, young offenders at HMYOI Rochester had a very high prevalence of Obsessive Compulsive Disorder. There were five self-inflicted deaths of prisoners with mental health problems across Kent and Medway prisons during 2007 – 2008.

Current prison mental health services in Kent and Medway are not as effective and as high quality as they could be, and are a high priority for improvement and lessening risk. In response to this the MH Commissioning Directorate successfully re-tendered (during autumn 2009) the existing Kent and Medway Adult Prison Mental Health Service to procure a better-specified, safe, high quality and value-for-money service. Further investment is being sought to provide 'end to end', comprehensive mental health services for the prison population. In the interim some additional resources have been received from the National Offender Management Service for HMYOI Rochester to provide bespoke mental health services across the spectrum of need (i.e. primary and secondary care, and a daytime resource centre providing mental health and learning disability services).

We are also implementing recommendations required by the Bradley Review (15.). This clearly sets out the policy mandate for the diversion of offenders with mental health problems and or learning disabilities, where appropriate, away from custody. We are piloting a Police Custody Suite Diversion Scheme across the 6 suites in Eastern and Coastal Kent PCT and the one suite in Medway PCT. The pilot is for eight months and its primary aim is to provide Kent Police and Magistrates with information from the mental health and / or learning disability assessment of people detained in custody. The scheme will provide opportunities for the diversion of offenders with mental health problems and / or learning disability away from custody where appropriate. An evaluation report will be available in May 2010 and a Business Case for recurrent funding will be made should the pilot prove to be effective. This scheme already exists in West Kent PCT.

Comments from the four stakeholder workshops held in June included:

- 50% of offenders seen now have a significant alcohol problem and 20% have a serious drug problem. High levels of obsessive-compulsive disorder and personality disorder at 80%;

- Support would need to be multi agency, the practical side of things like housing, income support, employment, training, education, literacy training, health education etc;

- CPA needs to permeate the prison walls in both directions;

- Help with re-entry to society needed, "Sunlight type centres" coffee shop model mentioned.

What we will do or initiate *as a priority* in 2010-11 is.....

- We will continue to develop safe, 'end to end', equitable mental health services for those in the criminal justice system (HIC4).

- We will establish Police Custody Suite Diversion Schemes across Kent and Medway so that the service is universally accessible (HIC5).

- We will improve access to community forensic mental health services (HIC1).

- We will adopt a blueprint Service Level Agreement and Service Specification for the provision of Psychiatric Court Reports to both Magistrates and Crown Courts (a further Bradley Review recommendation). This will prevent the remanding into custody of offenders in the interim of receipt of a psychiatric report (HIC5).

And, *over the next five years:*

- Following an analysis of the impact assessment of the Police Custody Suite Scheme across Kent and Medway we will review the need for a Court Diversion Mental Health Service. The results of this gap analysis will shape Kent and Medway's future requirement for a Court Diversion Scheme (HIC5).

- We will incentivise innovation among providers by targeting CQUIN incentives towards them. All contracts will have an annual quality improvement plan led by providers in partnership with users of services.

- We will ensure that assertive outreach is made available to those who are or have been in the criminal justice system and would benefit from it.

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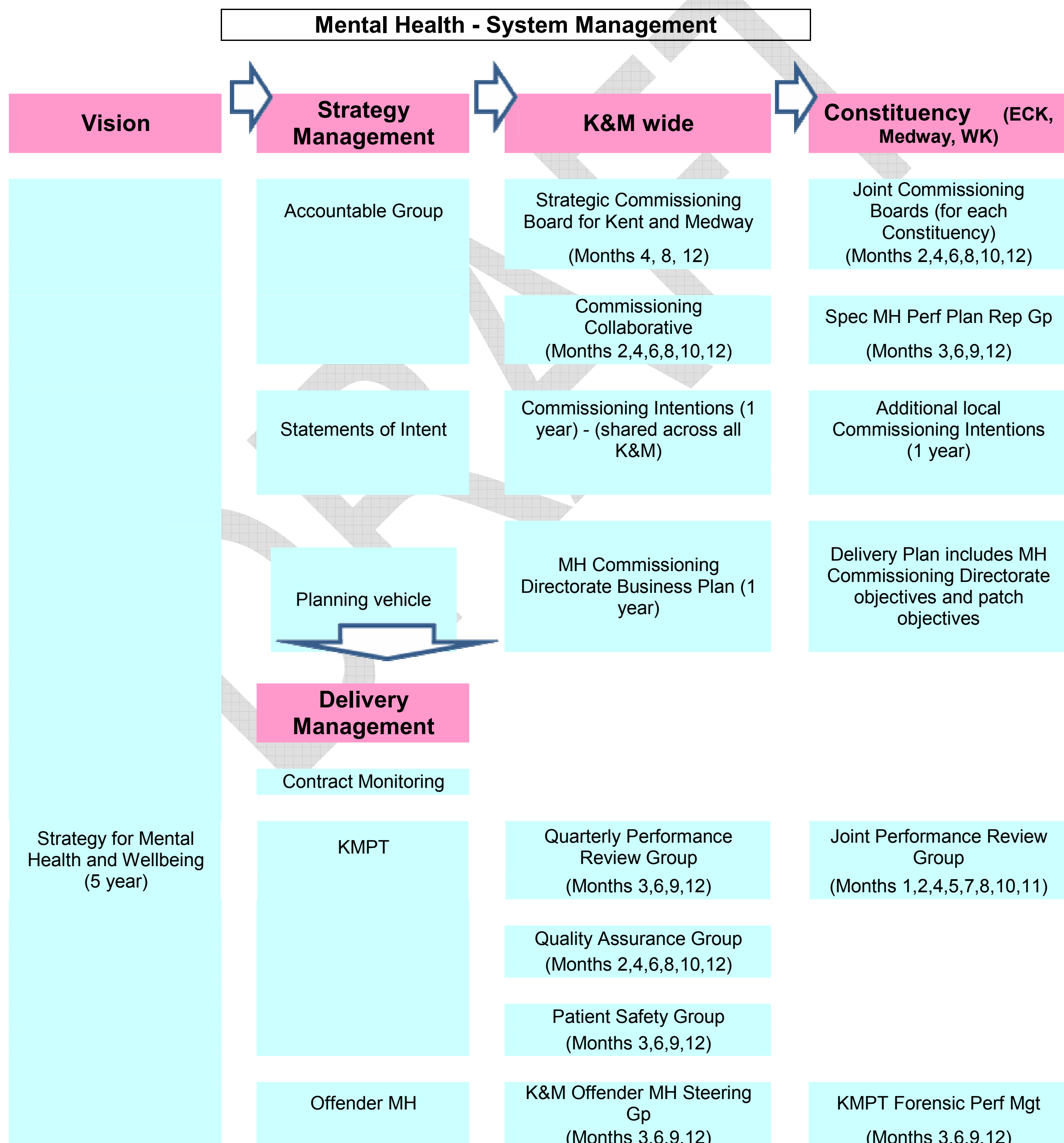
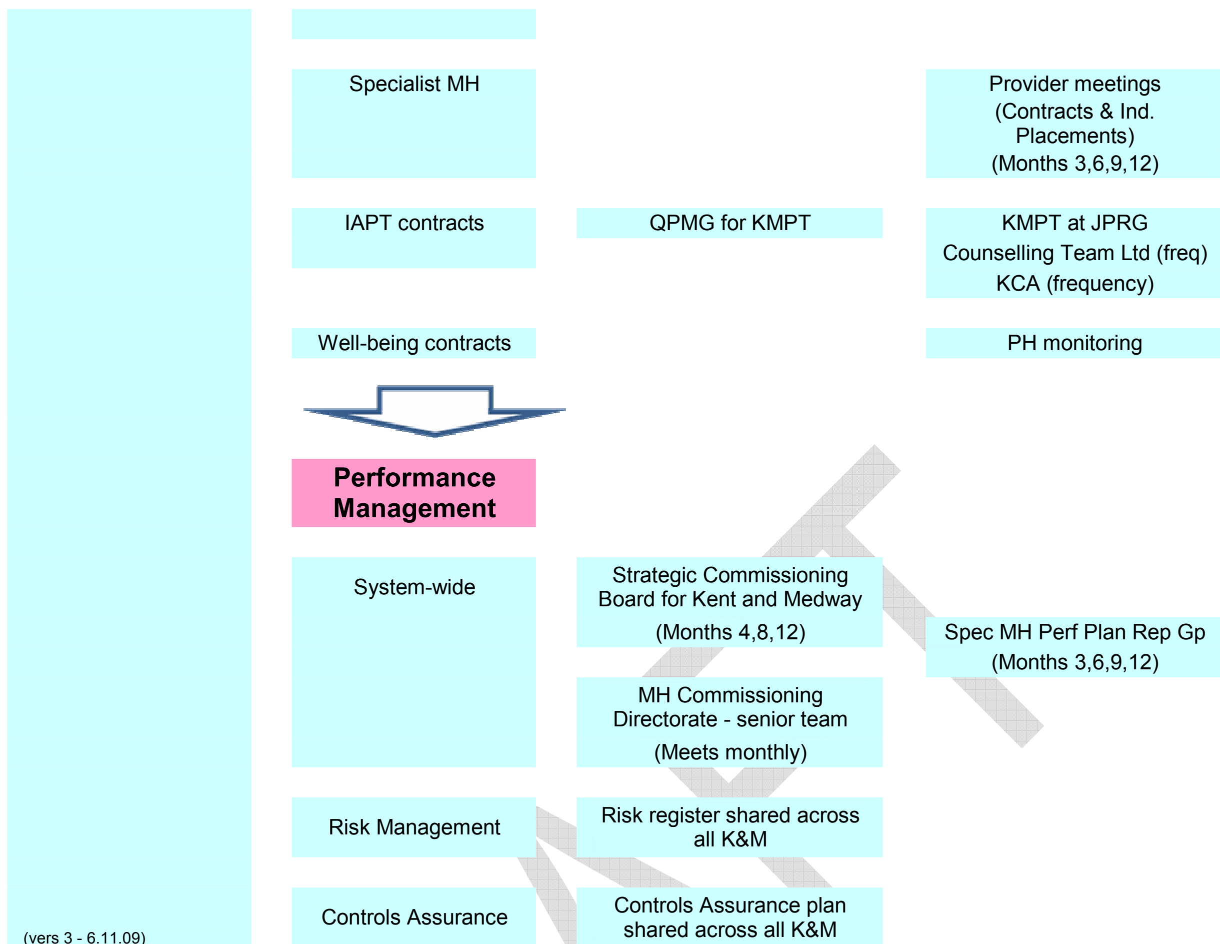
6. How will we monitor our progress?

Throughout this strategy we have made clear our vision, the 10 commitments we will deliver on over the five year period, the actions we will pursue to deliver those commitments and have identified the priority actions that we will implement or initiate within the first year.

We already have in place sound governance and performance management arrangements within Mental Health Commissioning, and strengthened these during 2009-10. These are best seen with reference to a 'system management map' we developed in 2009 to illustrate them (shown below). This shows all the main groups involved for strategy development and commissioning, and for contract review, and the frequency with which they meet during an annual cycle.





In addition, for all our contracts we have an arrangement of Key Performance Indicators and Quality Indicators that we measure progress on throughout the year. Those contracts also specify a range of mechanisms and frequencies to secure feedback from users and carers on their experience of aspects of services. Also in our contracts with KMPT and the larger forensic contracts we have introduced the the use of CQUINs in 2009-10, and will further develop these over the next five years.

For the explicit purposes of monitoring the delivery of the strategy we will begin in a number of ways; we will incorporate all the actions against the commitments into our directorate annual business plan and ensure these are reflected in the objectives and action plans of all locality and specialist commissioners, and we will monitor progress against a set of key performance indicators (KPIs) outlined in Appendix 2. We are building a baseline position against all these currently.

We have routinely identified the risks to service delivery and quality as part of governance processes, and developed controls assurance processes, all shared with the three PCTs, and this will continue.

In addition to the regular monitoring shown in the table above we will formally report progress to the three PCT Boards and to the two Local Authorities formally on an annual basis.

7. References

1. Kent and Medway Joint Strategic Needs Assessment – Mental Health, Mental Health Strategies, April 2009.

2. National Service Framework for Mental Health. DH 1999.

3. New Horizons: Towards a shared vision for mental health. DH 2009.

4. 10 High Impact Changes to Mental Health Services. CSIP / NIMHE 2006.

5. Key facts and trends in mental health. NHS Confederation August 2009

6. Mental Health and Wellbeing. South East PHO 2006.

7. Mental Capital through Life: Future Challenges – Foresight Project of the Government Office for Science. 2008.

8. Healthy People, Excellent Care - South East Coast SHA pledges ihttp://www.southeastcoast.nhs.uk/hpec/Pledges.asp

9. NHS Health and Wellbeing independent report. Professor S Boorman. Nov 2009.

10. Promoting mental wellbeing through productive and healthy working conditions: guidance for employers' NICE guidance. Nov 2009.

11. Social Return on Investment – an introduction. Cabinet Office, Office of the Third Sector. September 2009.

12. A Statement of Social Work Roles and Tasks for the 21st Century. GSCC, 2008.

13. Social Work and Government Policy: Easy Targets or Things to Celebrate? by Andrew Tyson on September 16, 2009.http://www.communitycare.co.uk/blogs/progress-on-personalisation/2009/09/social-work-and-government-policy-easy-targets-or-things-to-celebrate.html

14. Recovery Oriented Practice Indices www.scotland.gov.uk/Resource/Doc/924/0040412.pdf

15. The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system. DH.April 2009 .

8. Other Reading, Links, etc.

Sinking and Swimming; Understanding Britain's Unmet Needs. The Young Foundation. 2009. (www.youngfoundation.org)

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Appendix 1

1.1. Investments in Public Health

	Eastern and Coastal Kent	Medway	West Kent
Current investments in Public Health (2009-10)			

1.2. Investments in contracted services

2009-10	Eastern and Coastal Kent	Medway	West Kent
KMPT – Contract excluding CQUINs			
KMPT- CQUINs			
SW London and St Georges MH Trust			
South London & Maudsley FT			
NHS Non Contract Activity (other NHS)			
IAPT – Trainee Funding (from SHA)			
IAPT – Locally provided			
Mental Health Placements			

2010-11	Eastern and Coastal Kent	Medway	West Kent
KMPT – Contract excluding CQUINs			
KMPT- CQUINs			
SW London and St Georges MH Trust			

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South London & Maudsley FT			
NHS Non Contract Activity (other NHS)			
IAPT – Trainee Funding (from SHA)			
IAPT – Locally provided			
Mental Health Placements			

1.3. Primary Care expenditure – Quality and Outcome Framework (QOF)

	Eastern and Coastal Kent	**Medway**	**West Kent**
Primary care expenditure – QOF (Mental Health Indicators) (2008-09)			
Primary care expenditure – QOF (Depression indicators) (2008-09)			

1.4. Primary Care expenditure - Prescribing

Primary care expenditure – prescribing (2008-09)			
Antipsychotic group			
Cost/1000 registered patients			
Antimanic group			
Cost/1000 registered patients			
Antidepressants – costs per 1000 Star PU			

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1.5. Current / planned business cases

Business cases awaiting decision or in development

Eastern and Coastal Kent	Medway	West Kent	Offender / Specialist

Business cases planned

Eastern and Coastal Kent	Medway	West Kent	Offender / Specialist

1.6. CQUINs

Commissioning for Quality and Innovation (CQUINs) is a new national scheme that allows for commissioners to make available a financial incentive as part of the contract for quality improvements and innovative service change. CQUINs were used with all major contracts in 2009-10 and will continue to be used. The CQUINs value was 0.5% of the contract in 2009-10 and is rising to 1.5% in 2010-11.

1.7. Payment by Results / Tariff development

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Appendix 2 – Key Performance Indicators by commitment

By 2015 we will have:

		Baseline	Target
i.	Built coalitions between all elements of public services, the voluntary sector, and the independent sector that focus on collaborative endeavour and shared enterprise to improve mental health and wellbeing		
	• Put in place at least three strategic schemes or campaigns over the life of the strategy that require significant collaboration across all stakeholders		
ii.	Lessened the stigma, discrimination and unhelpful labelling attached to mental ill health and those using mental health services		
	• Increase the numbers of employers signed up to the Mindful Employer initiative in Kent and Medway by (xx%), or from XX to YY • Increase the number of organisations pledged to Time to Change		
iii.	Reduced the occurrence and severity of common mental health problems, particularly by targeted actions to improve wellbeing for more of those people at higher risk – those in more deprived communities, those in black and minority ethnic communities, and those who		

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are seldom heard

- Psychological therapies – increase the number of referrals / self-referrals to psychological therapies
- Psychological Therapies – the number of people who completed treatment who moved to recovery
- Psychological Therapies – people with a black or minority ethnic code are accessing IAPT services at same rate as those coded 1 British

iv. Demonstrably improved the life expectancy and the physical health of those with severe mental illness, and demonstrably improved the recognition of mental health needs in the treatment of all those with physical conditions.

- Increase the number of high risk people who have assessments of their physical health, such as those on Care Programme Approach (CPA), dual diagnosis clients, offenders with mental health problems and on all admitted clients (including forensic services)

- Increase the number of general practices who have undertaken a review of >90% of registered patients with schizophrenia, bipolar affective disorder and other psychoses in the preceding 15 months. (QOF – Indicator MH9)

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- Reduce the degree of exception-reporting on indicator MH9 among practices with above-average levels, and lower the PCT average level of exception-reporting

- Increase the number of people supported by liaison psychiatry services in both A&E departments and in acute hospital in-patient settings at all District General Hospitals in Kent and Medway

- Increase the number of people with a long term condition receiving some form of psychological support, such as psychological therapy

v.	Reduced the number of suicides
vi.	Ensured that all people with a significant mental health concern, or their carers, can access a crisis response service at any time and an urgent response within 24 hrs – and that service contact points are more local
	• Reduce the number of presentations of clients in crisis to A&E services • Reduce the number of major breakdowns of clients in recovery

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vii.	Ensured that all people using services are offered a personalised service, giving them more choice and control over the shape of support they receive wherever the care setting is	
	• Increase number of people using mental health services who have a personal budget	
viii.	Delivered better recovery outcomes for more people using services, and in the most appropriate setting for them	
	• Move a proportion of interventions (appointments) currently taking place in secondary care settings to primary care settings • Reduced the number of readmissions of people who have been discharged in the previous 3 years • Increase the % of those with serious mental health problems maintained in employment • Increase the % of those with serious mental health problems assisted back into employment	
ix.	Ensured that more people with both mental health needs and drug and/or alcohol dependency (dual diagnosis) are receiving an effective service	
	• Increase the number of people cared for by	

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mental health or drug and alcohol services who are identified as having dual diagnosis

- Increase the number of people cared for by mental health or drug and alcohol services who are identified as having dual diagnosis and are having shared or integrated care under a protocol

- Eradicate instances of where dual diagnosis clients report or feel they are being bounced between services

- Reduce the number of attendances at A&E for alcohol or substance misuse-related accidents

- Increase the number of secure tenancies for dual diagnosis patients receiving enhanced care

x. Delivered effective mental health services in prisons in ways that ensure the safety of more offenders with mental health problems

- Increase the number of mentally ill people diverted away from custody, where appropriate, following implementation of Police Custody Suite Diversion Schemes across Kent and Medway

- Reduce the number of people in prison requiring secondary mental health services and transfer to hospital under the Mental Health Act 2007

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reduces

- Reduction in re-offending rate of people with mental illness
- Reduction in self-inflicted deaths of people in prison

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Appendix 3 - 10 High Impact Changes to Mental Health Services (4.)

1. Treat home based care and support as the norm for delivery of mental health services.
2. Improve flow of service users and carers across health and social care by improving access to screening and assessment.
3. Manage variation in service user discharge processes.
4. Manage variation in access to all mental health services.
5. Avoid unnecessary contact for service users and provide necessary contact in the right care setting.
6. Increase the reliability of interventions by designing care based on what is known to work and that service users and carers inform and influence.
7. Apply a systematic approach to enable the recovery of people with long-term conditions.
8. Improve service user flow by removing queues.
9. Optimise service user and carer flow through an integrated care pathway approach.
10. Redesign and extend roles in line with efficient service user and carer pathways to attract and retain an effective workforce

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