



In Good Mental Health

Feedback from public event at Kings Lynn Town Hall

10am-12.30pm on Wednesday 14 November

As part of a review of Mental Health services in Norfolk and Waveney a number of public events were held to give stakeholders the chance to:

- hear about the review
- give their views about where Mental Health support is and is not working
- influence the development of a 10 year Mental Health strategy

Three events were arranged and widely publicised through the media and social media, through primary care, the hospitals, the voluntary sector and the CCGs in the area. For the Kings Lynn event, 42 people pre-booked through the eventbrite page for the event and on the day we had 42 people in attendance. The presentations were from;

- David Edwards OBE, Chair, Healthwatch Norfolk
- Jonathan Clemo, Chief Executive, Community Action Norfolk
- Amanda Green who gave a personal perspective on mental health support

Table discussions were held and feedback was gathered against the following questions:

Workshop One: Your experiences of local Mental Health support and services:

What is working? What needs to change? What are the current issues or barriers?

Workshop Two: What does future Mental Health support look like? How would these changes make a difference to you?

All feedback is to be independently reviewed and used to inform the draft Mental Health strategy. This draft will again be presented for further public and stakeholder feedback. Feedback from all events has been recorded against the following themes:

1. Complex, slow and hard to navigate processes
2. Poor integration of care
3. Issues with quality and consistency
4. Concentration on treatment rather than prevention
5. Community care not fully utilised
6. Other points made

Please note: The following are views expressed by individuals who attended this event which we have recorded verbatim. Where the written feedback was, in isolation, not clear we have included context by adding <notes>. However this was not possible for all the feedback and so, where we have not been able to add context, the written comments have been recorded here verbatim.



1. Complex, slow and hard to navigate processes

Services can feel overly complicated and difficult to move through for service users and carers, as well as for health and care professionals.

1. Future support needs to be local. Local in patient and community provision.
2. There needs to be a central number like 111 for triaging symptoms and directing on to other services. 24/7 support for mental health.
3. Lack of clarity/incorrect information about what services can offer
4. GP is first port of call – interaction between primary care/secondary care MH. What do you do/where do you go in a crisis? Unknown. Go to A&E?
5. People should only have to tell their story once between UCS support and formal health services
6. <There should be> short admissions to de-escalate people in crisis <and> support for people being discharged from hospital.
7. MH patient in crisis at A&E should be triaged and then seen by MSFT psychiatric nurse of a coordinated response.
8. Crisis hub – MIND/NSFT – support for people in receipt of NSFT services
9. Assessment process needs to change. Walk-in assessment centre is needed rather than A&E. Need more staff generally.
10. There are too many waiting lists and delays in getting treatment
11. There is an expectation to attend A&E when in crisis – this could be a ¾ hour wait
12. Need to improve awareness of who can help/link to services (specialist/practitioners don't need to know all services)



2. Poor integration of care

Patients/service users & families find care to be disjointed, fragmented & confusing, with a lack of cohesion and communication between services, resulting in individuals 'falling between cracks'.

1. Support needs to be throughout the system. This needs to be cohesive.
2. Issues with patients with mental health issues ending up in prison system. There needs to be better communication between NHS, prison system and wider health services. More resource is needed.
3. Boundary between child and adult mental health services – need clarity about where patients get support at age 17-18 it is difficult to make adjustments
4. There need to be clear referral pathways with information for the public
5. There needs to be more education for A&E staff and police in mental health
6. <There should be> mental health screening alongside physical health screening.
7. Recognise and <better> utilise social/voluntary/community resources
8. Primary care/first points of contact need more information/training on identifying problems and where to access resources
9. Closing the 'gap' between those too unwell for wellbeing and not unwell enough for specialist services. Needs to be improved community resource for those who fall in gap
10. Transition not robust enough (e.g. moving to area)
11. <There needs to be> support for co-dependency situations
12. Needs to be improved work between social care and MH services – coordination and communication
13. Need more collaboration between professionals and peer support. Need to wraparound support alongside the MH intervention to enable you to carry on/change beyond that intervention.



14. Needs to be more engagement with voluntary services and knowledge about what they can offer
15. Systems (e.g. patient records) are not connected
16. System is too delineated between physical/MH/social
17. There needs to be a link between assessment beds and in home - there needs to be support for MH conditions (not dementia)
18. Expand to 'unknown services' – support groups/crisis lines for people not know to fit NSFT, triaged by 111?
19. Substance abuse – link to ASB/police involvement/Volunteer special constable – still has gaps in spite of fantastic reach work
20. Communications between mental health provider, acute trusts and GPs needs to improve. Continuity of care needs to improve. Lessons do not seem to be learned The same stories are often highlighted in the press and are missed opportunities and failures in the system.
21. Housing services don't recognise mental health issues
22. There need to be more home visits and support workers
23. GP issues – they don't always listen to outside agencies. They need more training to spot the signs. They prescribe antidepressants without ensuring support is in place
24. Services are fragmented – missed opportunities
25. Clinicians not engaging enough with families.
26. Need to improve communication between organisations
27. "If services were better connected I'd get better more quickly" <written as a direct quote from a service user>
28. Better integration of services would mean less people falling through the gap in the net, i.e. mental health support delivered in job centres/schools



29. Need to improve awareness of who can help/link to services
(specialists/practitioners don't need to know all services)
30. Key workers: in housing, social care, health – this is continuity. Perhaps not realistic to have key workers per organisation, but key workers across organisations be possible. Similar to Lead Professional in children's services.
31. There are organisational barriers to integration/working across systems



3. Issues with quality and consistency

Service users expressed concerns over inconsistent, slow and poor quality care across Mental Healthcare services in Norfolk & Waveney.

1. Mental health map of Norfolk needed – with funding allocated appropriately. Funding need to be distributed fairly.
2. Need to look at individual needs as needs may be complex. Need for crisis care, well-being etc.
3. <there needs to be> accurate and timely diagnosis
4. The right service needs to be available at the right time with services which can address the physical and mental health and social difficulties in a joined up way
5. <There needs to be> less out of area placements – explore new ways of treating Mental Health
6. <There needs to be> speedier access to support. Too much medical treatment (anti-depressants) and not enough talking therapy.
7. <There needs to be> improved services (not medical) for severe mental illness (e.g. schizophrenia)
8. Access thresholds between assessment and treatment
9. <there are a> lack of services for complex/co-morbid people (don't 'fit the box')
10. Lack of holistic care "don't connect the dots" between physical, MH and social
11. Professionals don't have time/skills/capacity to explore root causes/overlapping issues
12. Need to management expectations of patients re: self-management
13. Need to de-medicalise normal adjustments issues/reactions (e.g. bereavement, relationship breakup, ordinary life events)
14. Help to manage demand/services for those who need them



15. Exclude/sign post those care eligible to appropriate services
16. There is a lack of assessment beds
17. NHS/social care should invest in care home beds and coordination of in-home care
18. Dom Care providers need basic training in mental health and a link with social groups/voluntary sector –relate to carer/cared for
19. Crisis system must meet local needs. Should take same approach as Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) with a triage crisis line via 111
20. Demand on MH in increasing and quality/access not meeting demand
21. Eating disorder patients <have to> travel out of area
22. Specialisms – some services don't exist locally
23. There is a difficulty in recruitment for acute psychiatrists.
24. Recruitment issues across all sectors. Lack of staff leads to quality/capacity issues
25. Need to work out where problems are and invest in those services
26. Need to invest in younger staff as older staff retire. More feet on the ground.
27. Need to focus on staff retention.
28. Is sufficient funding going to be made available?
29. Services are not funded adequately
30. Overall feel services are not good enough. Community psychiatric nurse (CPN) support at home has gone. Admiral nurses have gone.
31. Too much bureaucracy
32. Need more training for professionals in listening skills.



33. There is an assumption that the medical model is best. Need to change this approach. Shouldn't be expected to fit into a specialist job.

34. Over reliance on medication



4. Concentration on treatment rather than prevention

View that there is a lack of services focusing on preventative measures, with current focus heavily weighted in downstream treatment

1. Mental health services are separate from physical services. Can more be done to align them?
2. There is a disparity between physical and mental health
3. Support must start young – build skills, emotional voices and self-recognition. Validation. Recognise and provide for difference without separating people.
4. More training for professionals – awareness, identification, support and treatment
5. <There should be> children's peer-to-peer support
6. <There should be> more open discussions
7. Education with health and well-being at the core, and support for people who speak out.
8. Exploration needs of biotypes of depression to impact treatment
9. More mental health awareness in school with support for families – more on the impact of ADHD/AS Diagnosis in families with early intervention which is vital as long term service use is damaging
10. Less medical intervention without social integration - both in balance
11. Recovery focused – living with conditions and resilience of long term conditions both mental and physical
12. Need earlier intervention. More peer-to-peer work. More people in non-mental health organisations to be given support to help their service users. More integrated support.
13. More low level support to prevent need for crisis services in the community. More prevention work.
14. Need to do more to bridge the gap to stop people needing crisis service.



15. More prevention services in the community



5. Community care not fully utilised

Feeling that service users are signposted to secondary/formal care settings too easily, with a lack of offering of care in less formal, community support settings

1. STP is NHS dominated and needs more community investment (needed in transformation work). Community services are vital.
2. Needs to be a normalisation of mental health difficulties
3. Champions for MH issues need more resources to support implementing work (e.g. time, services)
4. Need responsive communities
5. Increasing patient role of responsibility – NHS can't fix all issues.
6. We need to create 'the village' <please note: this is a reference to Amanda Green's presentation 'Its takes a village'>
7. Review role of Personal Support Workers (PSW)
8. Need to stimulate independent sector to provide intermediate/advanced care for people with dementia
9. Invest in community and public health to keep people out of secondary care
10. For dementia – reminiscence/activities – social interventions – day care services. VITAL: there is a lack of support/domiciliary care for dementia at car homes
11. Social prescribing – link with resources that already exist
12. Keep people out of A&E – focus on community support keeping people supported.
13. Create courses which are beneficial – creative writing, sewing, painting
14. Not enough support in the community.
15. Voluntary sector can help connect people within the community



16. More community support would result in fewer tablets being prescribed

17. Needs to be more low level preventative services in the community

18. Social isolation – investment in Men Sheds (working well)



6. Other points made

1. Mental Health Act Review meeting is needed locally to reflect national MIND consultation (Liverpool)
2. What is working?
 - Self-Referral
 - People being identified
 - CBT – tools for life
 - Common MH services can work well e.g. for anxiety/depression
 - Champions for domestic abuse
 - Peer support/more impactful and influential
 - Services can be flexible i.e. didn't get on with doctor but able to access the nurse
 - Helpline is good (Norwich Mind) but waiting time isn't great
 - Vacancy wait has decreased considerably in WN NSFT services. Good retention rates.
 - Investment in purpose built inpatient unit
 - Pathways improved in CMHT – reduction in waits
 - Creative recruitment to meet needs
 - Crisis hub in WN
 - Focus on serious mental health and suicide prevention
 - Suicide prevention becoming a public health issue
3. Issues/Barrier:
 - NSFT special measures repeatedly and the impact on recruitment
 - Geography also impacts on recruitment, service accessibility and delivery
 - Expectations that service will make you better rather than it gives you the tools
 - Brexit – is there a medication impact?
 - Not enough research into MH causes and treatment
 - Waiting times are too long
 - Needs to be more early prevention
 - Not enough mental health promotion in schools
 - Need to better use the voluntary sector
 - Crisis team not great – don't turn up to appointments or turn up late and blame is put on service user
 - Referrals to MIND not followed through i.e. service user told they would be referred but didn't happen



- Support does not always meet needs
- Services not meeting needs so people are having to move locality to get a better service i.e. to bloody Norwich. POSTCODE LOTTERY.
- Opportunities better in Norwich than in the rest of the county.
- Wellbeing service is rubbish! Not listening. Services not listening. Communication is REALLY poor. GP services really inconsistent and based on giving medication.
- Crisis service is CRAP!
- Young person's service is failing
- There isn't any service available unless on the brink of suicide.
- Schools can't cope
- Need to fit into the box to get into a service
- Support isn't given early enough
- There is a sense that you need to reach rock bottom before you get support
- More dementia care home provision
- Resources need to match demand
- Expectations need to match reality and funding
- PR for NSFT and poor press coverage – lack of positive press
- Waiting times for psychological therapies
- Investment in CRHT so that we can “home treat” and support suicide prevention and admission avoidance
- Investment in MHLT – in order to support emergency assessment 24/7
- Focus on special measures and CQC reports rather than quality improvements and patient safety
- Lots of changes to Board/exec team on NSFT
- Lack of meaningful engagement with GPs
- Size of NSFT – focus on standardisation rather than locally developed

4. Change will:

- Improve wellbeing as a whole
- Would be better for local economy i.e. doing more training for the community
- Doing more in the community would resolve the stigma/discrimination and work things more possible
- Better services within the community
- Services would give people hope
- More peer support would give hope
- Stop the reliance on statutory services
- Less medical model – more social model



5. Society needs to equip people with skills to support health and wellbeing
6. Improve social inclusion and the reduce the dependence on services
7. Primary care – need to be careful of making inappropriate referrals – more training, link workers/MH practitioners
8. Dementia: GPs diagnose less at the moment as there is a lack of post-diagnostic support. Should work with Alzheimer's Society for support. Medication support particularly for vascular dementia
9. The value of admiral nurse in supporting carers – could this be made wider for mental health carers?
10. There needs to be a cultural change – what matters to you not what is the matter with you.
11. Beds out of county – no family support for distance/costs
12. Need more support for carers
13. Putting more money into crisis care is missing the point. It seems the system is failing. Don't need more money at the hospital - it needs to be in the community.