



Mental Health Forum 2021 Report





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Introduction

John Wright joined the Board of Healthwatch Bedford Borough as a Director in February 2020, taking over as Chair in the summer of that year. With so much stress and distress brought about by the pandemic on top of the strains and struggles of modern daily life, John believes that there has rarely been a more important time for all of us to focus on our mental health.

John opened the Forum by reflecting on the attention that has always been given to physical health compared with mental health, perhaps indicative of the stigma that is still attached to mental illness despite several high-profile awareness raising campaigns.

He highlighted the extent to which those with more serious and profound mental health difficulties still struggle. Commentators in the media report on people waiting for or being unable to access treatment for a whole range of conditions, all of which make dealing with daily life unduly stressful and a worrying or puzzling prospect. Even receiving an acknowledgement or diagnosis that they may be experiencing mental ill health can at times be difficult for some.

John drew attention to the unprecedented demands that young people face today. The pressures of, for example, social media can make life and relationships far more complicated. He asked whether we, as a society, are putting sufficient resources into Children and Adult Mental Health Services (CAMHS) and into providing professional support in schools, colleges and universities, so that young people can navigate their way safely through the transition of childhood and adolescence into a successful and fulfilling adulthood.

John went on to set the scene for the Forum by posing a series of questions to be considered:



- 1. What more do we need to do?**
- 2. Have we got the balance of investment between physical and mental health right?**
- 3. Are we putting sufficient resource into enabling as many of us as possible to feel part of and engaged in the community?**
- 4. Is the support and advice available, so we can all live our lives to the fullest extent possible?**

Methodology

Objective

Mental health care is changing. By 2023 there will be an extra £1 billion per year investment and the government is hoping this will completely revolutionise care. The intention being that access to psychological therapies, improved physical health care, employment support, trauma informed care, and support for self-harm will mean mental health care is delivered in a completely different and more localised way.

Healthwatch Bedford Borough held an online Mental Health Forum to investigate how mental health services will deliver this program of work. We brought together members of the public, health professionals and people with lived experience of using mental health services across multiple teams to share their views and feelings about this transformation.

Our approach

Healthwatch Bedford Borough's Mental Health Forum was held in partnership with Bedford Borough Council, East London Foundation Trust (ELFT), Mind BLMK and BLMK Clinical Commissioning Group (BLMK CCG). The daytime event was open to anyone living or working in Bedford Borough and held online due to COVID-19 restrictions prohibiting face-to-face engagement. It was actively promoted through the Healthwatch Bedford Borough website and social media platforms, and through stakeholders including NHS and local authority Commissioners, service providers, faith and community leaders, community groups, the charity sector and members of the public, all of whom encouraged participation.

The Forum was chaired by Healthwatch Bedford Borough Director Ashok Khandelwal. Attendees included Mohammad Yasin MP and Cllr Louise Jackson, portfolio holder for Health & Wellbeing for Bedford Borough - as well as service users and members of the public.

Dave Hodgson, Mayor of Bedford Borough, chaired a question-and-answer (Q&A) session in which participants put their questions to a panel of experts. Participants responded to four poll questions and were also encouraged to use the chat function to post comments throughout. To gauge reactions, we recorded the Forum including the Q&A session, chat and the result of polls which we held during the event.

Methodology

A qualitative analysis approach was used to organise and analyse the data from the chat and Q&A sessions. Comments made were wide-ranging and covered a number of services. A member of staff assigned codes to represent strands or themes within the data. From this, four themes emerged regarding the patient journey and attitudes to the current mental health transformation. These codes were then used to unearth issues within each theme.

Healthwatch Bedford Borough values individuals' experiences with, and feelings about, health services. Our aim using this methodology is to reflect those experiences without bias.

Results

The results from the analysis of comments and views expressed during the Forum are presented under the four themes that were identified from the data:

- **Seeking help**
- **Awaiting assessment and treatment**
- **Empathic care and continuity**
- **Making improvements**

Results from the four poll questions are also presented (pages 20-21):

- **What is most important to you?**
- **To what extent has COVID-19 affected your mental wellbeing?**
- **How should services change?**
- **What is most important in improving services?**

Speakers

Presentations from speakers have been written-up and are included in Part 2 of this report:

- Andrew McCulloch – Committee Member, Healthwatch England (HWE)
- Olivia – Mental health service user
- Michelle Bradley - Director for Bedfordshire and Luton Mental Health Services, ELFT
- Dr Roshan Jayalath – BLMK CGG
- Caroline Lewis – CEO, MIND BLMK
- Simran Khinder – Recovery Service Operational Manager, ELFT Recovery College
- Sally Wilkin – People Participation Lead, Bedfordshire and Luton Recovery College, ELFT

Findings

Dr Jayalath in his presentation acknowledged that mental health is not within the formal training of a GP. At the same time, Time to Change which is led by Mind and Rethink Mental Illness, report that 9 out of 10 people with mental health problems are seen within primary care. Clearly primary care has a huge role in providing acceptance and understanding when people take the first step in asking for help. Receptionists are usually the first person that people speak to when they find the courage to ask for help or report an episode of poor mental health. How Receptionists speak to people with mental health problems was touched on by both Olivia and Dr Jayalath in their presentations and it is something that Healthwatch receives feedback on regularly.

People from the Deaf community report **problems in accessing services**. Key issues for them are ensuring appointments have an Interpreter; lack of understanding of the mental health needs of deaf people; and administrative and I.T. systems which don't fit their needs. They feel the services are not following legislation on disability and sensory loss – they are not given the communication support they need to access mental health support.

The Recovery College is valued but the booking system works on the basis that the majority of service users need to book in the very short-term to avoid Do Not Attends. Opening up this conversation to service users may suggest a need to review this.

E-forms were mentioned as another option for communicating with GP practices, but other people were not aware of them as an option.

Poor communication was a key theme. When a service user asked, 'who is accountable?' this was answered in terms of which Head of Service is ultimately accountable. Instead, service users wish to know who they can turn to when they find themselves lost in the system with no clear pathway. One participant said, 'need better communication between Crisis team, wellbeing service, community mental health team and GP's, all very poor'.

The **need for empathic care** was emphasised in Olivia's presentation and then echoed in the Forum chat. As one participant described what 'An integrated service would look like - Listen, with no repeated unnecessary assessments.'

Mental health is not within the formal training of a GP

BUT

9 out of 10 people with MH problems are seen within primary care

Michelle Bradley described how people are working in silos and need to dovetail their work so that people's needs are met. In her words, the transformation plans aim to improve care for adults with the highest levels of complexity and severity and to make sure that people do not fall through the cracks. Dr Jayalath described **the lack of pathways for people with complex needs**. He said that quite often there have been two or more health conditions and social factors as well.

One of the challenges for GPs within the system is getting people to the right environment, the right setting, and at the right time. Dr Jayalath himself said that he can't always get a person with complex needs to the right service within the current system. He feels that this is one of the challenges within the current system for GPs. Dr Jayalath also stressed that the psychology of the people with long term conditions is an area that has not been looked at.

These structural difficulties were acknowledged by people using the service in terms of frustration and fatigue regarding transformations and service changes. **Lack of communication between professionals** was cited as an issue blocking integrated care: 'Psychiatrists within multidisciplinary psychiatric teams (MDTs) at ELFT refuse to have two-way communications with (others). They work in SILO's and use GDPR as the reason for not sharing information.' 'I was promised about 4years ago that things would improve but nothing has.' One health professional described why he felt issues were being lost. Transitions from Child and Adolescent Mental Health to Adult Mental Health was also raised by a representative from the Bedford Borough Parent Carer Forum.

In moving away from current systems with a care program approach and Care Coordinators, there is a recognition that this is scary and doesn't feel safe for people. However, this may be because of poor administration in the past, a failure to admit when major errors are made in notes or referrals lost and the feeling that there is little information about how differently the new system will operate. People need to know how close new services will be, whether they will be open 24 hours a day or 9 to 5 and what kind of staff will be available.

There was a feeling that with such a wide gap between the aims of the service and how it is experienced on the ground, co-production cannot be effective without acceptance of hard truths about the current system. Participants felt that current co-production did not recognise them fully as equals 're co-production – we are ignored.' 'we can cope with questions if services are willing to listen to the answers.'



One of the challenges.. is getting people to the right environment, the right setting, and at the right time.

Themes

1



Seeking help

2



Awaiting assessment and treatment

3

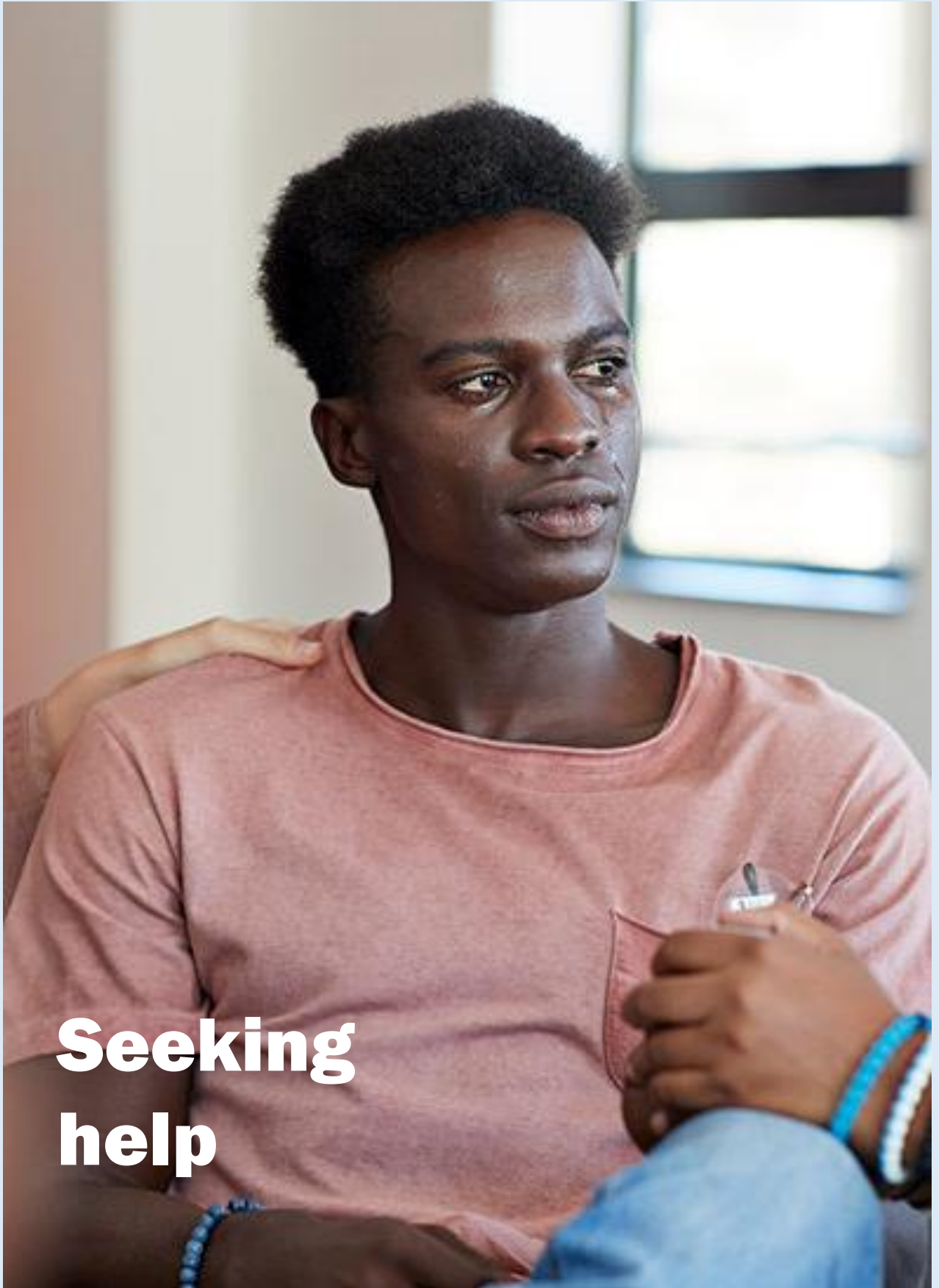


Empathic care and continuity

4



Making improvements




**Seeking
help**

Seeking help

The first theme concentrates on people's experiences of trying to find help. This could be someone either experiencing mental illness difficulties for the first time or those encountering a sharp deterioration in their ill mental health.

For some, the stigma surrounding mental health means that they avoid seeking help. A report from the Mental Health Foundation in October 2021 describes this: 'Stigma and discrimination can also make someone's mental health problems worse, and delay or stop them getting help.' Social isolation, poor housing, unemployment and poverty are all linked to mental ill health. So, stigma and discrimination can trap people in a cycle of illness.



For some, the stigma surrounding mental health means that they avoid seeking help

Where to turn

Some participants were uncertain of where to turn for help. Primary Care has a huge role in providing acceptance and understanding when people take the first step in asking for help. Receptionists are often the first point of contact when people find the courage to reach out or to report an episode of poor mental health, but participants spoke of feeling blocked or not listened to. How Receptionists speak to people with mental health problems was touched on by both Olivia and Dr Jayalath in their presentations and is something that Healthwatch Bedford Borough regularly receive negative feedback on.

Several ways of trying to access services were mentioned:

- e-Consult forms were mentioned as a way of contacting a GP to make a telephone appointment, but others were not aware of this option. It was unclear from the comments received whether these forms were used as a method of first choice or because the alternative of staying for an hour on hold was impractical.
- one person described her experience of trying to use the Recovery College, saying that 'sometimes the prospectuses go out to people too late, then courses fill up quickly'.

Another person asked about Multi-Disciplinary Teams (MDT) within Primary Care Networks, saying that 'few practices in Bedford have these'. They should, but don't in practice.' This suggested an acceptance of MDTs in primary care as helpful to patients but that the person concerned had seen little evidence of this happening to improve their care in reality.

Access to services

It was acknowledged that the current system is based on thresholds, leading to conversations based around getting information to match service criteria. This can feel alienating, especially to people new to the system who are seeking help for the first time.

A Forum participant told us they had heard of people referred into mental health services, who are being signposted to the Samaritans because they do not reach service thresholds. Whilst we can not comment on speculation, this does point to gaps in the system.

Others spoke of not being able to access specialist services, mirroring Dr Jayalath's examples of situations in which people do not fit clear referral pathways because of the complexity of their needs. From his experience, Dr Jayalath said that GPs are not always able to get their patients to the right services within the current system. Effectively, the current service acts as its own gatekeeper. Having a GP as a single point of contact is valued by patients but GPs find themselves caring for people with mental health problems when they have had little training in this area of specialism. Mental health services acknowledge that change can cause anxiety. However, patients felt that an emphasis on how services work internally rather than how they can access them contributes to their anxiety and sense of frustration.

The Deaf community

People from the Deaf community pointed out that services do not conform to legislation on disability and sensory impairment. Consequently, they are not given the communication support they need to access mental health care and treatment. Problems can begin before they even talk to a doctor or nurse. When trying to book an appointment, they come across administration and technical challenges which don't meet their needs. One Forum participant said they 'would like doctors and surgeries to stop phoning when it clearly says on the document that the patient is Deaf'. Another asked for services to stop asking families to interpret for them.

The Accessible Information Standard (DCB1605), published under section 250 of the Health and Social Care Act 2012, has recommendations on how services can be accessed. An important element of this is that communication needs are defined by the individual themselves and any plan for meeting those communication needs should be co-produced with the individual.

There was a definite feeling that both the practical and mental health needs of Deaf people are little understood. Hearing impairment by itself brings a certain amount of isolation from the wider community. The lack of proper infrastructure consequently places even more pressure on this community.

Awaiting assessment and treatment



Awaiting assessment and treatment

When a mental health difficulty has been identified and referral accepted, a person will typically have to wait for an assessment from a mental health professional. This can either take the form of a formal diagnosis or triage assessment to best understand how acutely unwell the person is feeling at that point in time. This can mean a long wait for diagnosis, especially when a referral is made from a county to a specialist centre. This can also incur a long wait for treatment.

From pillar to post

Self-referral has been welcomed by many people, but this has not resolved all the problems. There remains 'repeated hoops' in the system which people feel they must jump through, with some people having to describe what they need repeatedly. 'You self-refer, then get assessed, then get referred, then wait some more, then get assessed again' and 'You have to keep repeating yourself over and over to each department.'

Particular services refer on and signpost again, with one participant described being referred on by the Bedfordshire Wellbeing Service after waiting for months. Others spoke of feeling lost in the system. 'I requested an issue be taken back to the service and haven't heard, 14 months later.' Participants described constantly having to ask when their treatment would begin. Another participant echoed this frustration, saying 'You shouldn't have to complain to get a response or support. Or treatment.'

Communication

Poor communication was a recurring theme. When one service user asked, 'who is accountable?', this was answered in relation to which Head of Service was ultimately accountable. Instead, the service user wished to know who they could turn to when finding themselves lost in the system, with no clear pathway. Another participant commented on a need for 'better communication between the Crisis Team, Wellbeing Service, Community Mental Health Team and GPs, all very poor'.

Where there are gaps in the system, service users experience these as having to constantly fight for treatment. This has been a cause of additional anxiety and poor mental health. The transformation needs to recognise the impact of poor communication and take steps to address this.

Transitions and other conditions

Participants described the current system as particularly challenging to navigate when there was a transition from one service to another, or another complex condition was present. 'Transitioning from children to adult services is very difficult' '[It is important that] staff have understanding of neuro-diversity and the impact on mental health.' People felt that 'medically unexplained symptoms were used as an excuse', describing how some organisations rejected referrals when there was a complex condition. For example, people said that:

'Mental Health and learning difficulties [need to be] understood and learning difficulties not used to water down mental health concerns'

Treatment

When treatment was agreed, participants said that they or their communities still faced challenges. In the Q&A session, a local faith leader questioned how inequalities and disparities that impact ethnic minorities are being faced. A teacher asked what was being done to address communication issues with the Deaf community. He described how huge access issues for this community were impacting and described how little understanding many health professionals have. Another service user described the impact of constantly chasing when funding for a certain treatment was withdrawn. 'There's a lot of blaming others and shrugging shoulders. Who is accountable?' Another participant described how they felt their treatment was not by mutual agreement, going on to say that she was not permitted to be part of multi-disciplinary team meeting about her care.

Situations are left unresolved if staff do not have a rounded view of people's needs. Multi-disciplinary team meetings can help to address this, but limited resources mean that appropriate staff members are not always available for these. Increased resourcing may address this, but it is important that this is done within the context of an outward-facing organisation. 'I was promised about 4 years ago that things would improve but nothing has.' Another participant expressed a concern 'things are said to patients and then not passed over to the next department. Then you are passed from one to the other'. Another participant echoed the frustration saying 'You shouldn't have to complain to get a response or support. Or treatment'.

In the Q&A session, a question was asked about the length of time it took for mental health crisis triage. The participant explained that this can mean waiting for hours with police officers who are not trained in mental health. The participant asked for more triage teams to cover Bedford and Bedfordshire.





**Empathic
care and
continuity**

Empathic care and continuity

Empathic Care

The need for empathic care was emphasised by Olivia in her presentation and then echoed in the Forum chat. She described travelling to a hospital during a period of poor mental health. During the journey, her Support Worker telephoned her and shouted at her for not ringing her first. Another participant felt this was not an isolated incident 'Just wow. That support worker. This is so common'.

There was a feeling that services do not always understand the people they support. 'Understand the pressure on families' and 'Know your patient' were some of the comments made. Sometimes adjustments were not made which would have been important to the person involved, an example given related to allowing an advocate or family member in to support them during appointments. One participant felt that empathy and listening was key to a better service, 'An integrated service would look like - Listen, with no repeated unnecessary assessments.'

Clinical decision making clearly needs to be undertaken by Clinicians in partnership with patients and service users to ensure a relationship of trust is formed.

Continuity

Fears of moving within the system and a lack of continuity was another recurring theme. Transitioning from children to adults' mental health provision was mentioned as problematic. Moving around within the system is clearly far from easy 'We know what integration is, we don't have it'. A participant described asking for more information regarding discussions about her care. 'Psychiatrists within multi-disciplinary teams refuse to have two-way communications with others. They work in SILOs and refuse to share information using GDPR data regulation'.

A positive response was given in the chat to a speaker who gave an example of good care 'So there was consistency – that's vital.

'Know your patient'

Making improvements

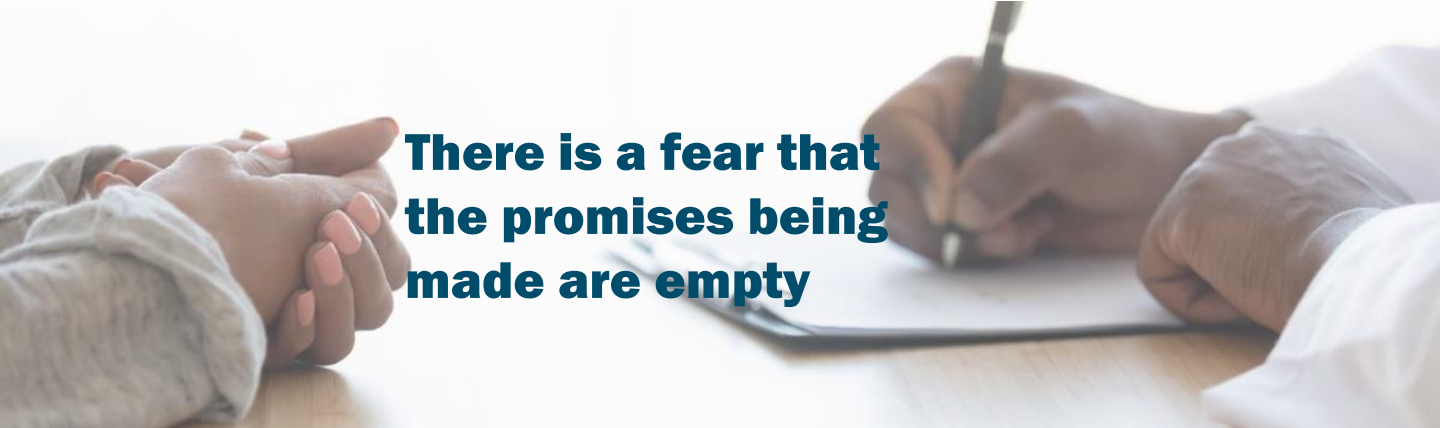


Making improvements

After previous transformations and restructuring during the past five years, there is a fear that the promises being made are empty, 'these are just wish lists' and 'I was promised 4 years ago that things would improve but nothing has'.

Closing perceived gaps and the delivery of a more caring service were called for to ensure people don't feel missed or lost in the system.

In moving away from current systems with a care program approach and Care Coordinators, there is a recognition that this is scary and doesn't feel safe for people. However, this may partly be based on people's experiences of poor management and communication in the past, leading to the frustration and fatigue expressed by service users regarding transformations and service changes. Services were asked to 'admit when errors are made in notes and referrals lost'. The feeling is that there is little information about how differently the new system will operate.



There is a fear that the promises being made are empty

Co-production

Whilst the People Participation Leads have improved participation in Bedfordshire, there is a distinct feeling of lack of ownership and accountability, with one participant reporting 'they ignore us.' One health professional described why he felt issues were being lost, 'mental health representatives are few and far between. This means that these issues raised are continually being passed from meeting to meeting'.

A wide gap is perceived between the aims of the service and how it is experienced on the ground. Consequently, some people feel that co-production has become tokenistic and not accepting of hard truths about the current system. For example, participants felt that ELFT's current co-production did not recognise them fully as equals. 're. co-production – we are ignored'. 'listen and read Coroners reports and what the CQC says'. With one participant writing 'we can cope with questions if services are willing to listen to the answers.'

What is most important to you?

1. Hope – **38%**
2. Control – **25%**
3. Chance to do things you like – **38%**



To what extent has COVID-19 affected your mental wellbeing?

1. A lot – **20%**
2. Quite a lot – **24%**
3. A little – **43%**
4. Not at all – **13%**

How should services change?

1. **More choice in terms of support and treatments** – 23%
2. **Shorter waiting times for services** – 23%
3. **Better coordination of services** – 54%



What is most important in improving services?

1. **Improving mental health for everyone** – 50%
2. **Reducing avoidable harm** – 14%
3. **Improving people's experiences of services** – 36%



Andrew McCulloch

Committee Member,
Healthwatch England

Dr Andrew McCulloch from Healthwatch England was the first speaker. Andrew has been a national committee member of Healthwatch England for over 3 years. He is also a Board member of Social Work England and regularly consults to the World Health Organisation (WHO). Andrew has a lifelong interest in mental health and patient experience, having served formerly as the Chief Executive Officer of the Mental Health Foundation and has held mental health policy roles at other prestigious institutions. He has a research background with a doctorate in Psychology from Southampton University.

Andrew McCulloch

Andrew began by saying that he had suffered from a mental illness but has come through it, as many others do. He described how mental health and wellbeing are fundamental to our existence. Without mental health there is no health. Without mental health we cannot enjoy life, participate, support our family and friends and do all the things we need to do. That is not to say that people with a mental illness cannot do some or all of these things – mental health is a different dimension, it is the positive that enables us to live.

The UK is sadly one of the most mentally unhealthy societies in the world and this is thought to be in part due to inequality and fragmentation in our society. Which is why Andrew then went on to describe the key determinants of mental health.

In terms of the individual, our genetic makeup does give us some predispositions but this is not the major cause of the vast majority of mental health problems, neither does it stop us experiencing good mental health. Early learning, lifestyle and environmental factors are the main issues. How we think, how we live and the social stresses on us will be the biggest determinants of mental health.

Unemployment is a major cause of mental ill health but it works in many ways, reducing social interaction, exercise, financial resources and self-esteem. Physical health interacts very closely with mental health. This is not just because physical illness brings us down but because of a relationship between mental health and many physical illnesses such as diabetes and heart disease.



Services help but good health and social care perhaps only contribute about 20% towards health outcomes. The rest is due to environmental factors e.g., employment, housing, work and diet. And of course, all these factors interact. It is easier for some than others to gain employment, someone with a steady income is more likely to have a good diet, and so on.

‘Without mental health, there is no health.’

What can local Healthwatch do? The answer is a lot. Healthwatch is in a unique position to access health and social care decision making and it is there for all, across the piece. Healthwatch will know what is happening to people using mental health services, including primary care and social care. Healthwatch understand what effects people's lives and what the blocks are locally. Local knowledge and local voices are key to understanding which factors will have the biggest impact and where the gaps are.

Hearing people's voices is key, and key information about mental health will come from everywhere, not just service users, vital though their voice is. It will come from seldom-heard groups, schools, residential care, the police – anywhere. Putting the picture together is key. Neither are there standard seldom heard groups which every Healthwatch needs to focus on. This needs to be assessed locally.

Andrew McCulloch has worked with a range of groups over the years including children and young people, young black men, lonely older men and so on. He said Healthwatch is valued and their evidence is listened to because it is based on patient and public voices. With mental health services, it is possible to turn lives around especially when the approach is practically focused and accessible. Ideally this would be achieved by working with local people to co-produce the strategy.

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Olivia

Service user

Olivia is 28 and has an interest in crafts and making jewellery. She plays guitar and has eclectic taste in music. She listens to all types of genres and has tried to play most of them. She is rarely bored. She has a determined attitude. Before she experienced problems with her mental health, she used to work in a Hospital Histopathology Department as a Medical Laboratory Assistant. She says this was ideal. In the study of human tissue, she was learning something new everyday. She developed an interest in biology and increased her self-confidence, growing happier in stating her point.

Olivia is concerned that recovery currently means fighting your corner and pushing for the treatment that's right for you. She feels she was lucky to have supportive friends and family but not everyone has that. She says 'the support should be based around the person, rather than around the system. It is difficult to find your way, and I'm hoping that the new system will recognise that.'

Olivia is currently focusing on recovery and treatment. She aspires to her own business in crafting and making jewellery.

Olivia's story

Olivia began by describing her experiences of using mental health services for the past 12 years. She said that these had varied along her mental health journey and hoped that by sharing them with the Forum she may be able to show some insight into what she has found helpful, and what she has not.

The first area she explored was with her GP, which Olivia described as being fantastic. What was helpful for her was that her GP had been incredible at listening, and reported that he went the extra mile, even remembering her story as well as the names of people who came along on the way. This was so useful for her. Starting from scratch, having to go back over past conversations Olivia found difficult. Even worse, she said, this can be traumatic.

At her lowest, Olivia was hospitalised. She saw many consultants and struggled to find the right medication that helped to calm her down. She stressed the importance of her GP at this point, describing how he took it upon himself to dig deep and find a medication that really did work for her when she was in crisis. Similarly, he found an antidepressant that suited her.

Olivia said that she then went on to do an intensive course of Dialectical Behaviour Therapy, and her GP listened to the help she was receiving and supported her to come off medication. This level of support continued. Whenever there was a dip in her mental health, he would encourage her progress, speaking in a way that mirrored the work she did with her DBT Therapist. Care that made her feel valued, which she describes as crucial to her recovery.



‘It is very difficult to make that first step in picking up the phone to ask for help’

Olivia raised the issue of Receptionists receiving mental health training, saying it would be helpful. She said it is very difficult to make that first step in picking up the phone to ask for help. With Receptionists tending to be first point of contact it could be beneficial for both parties if they were trained for such eventualities. Olivia remembered occasions when she was feeling dysregulated and would only call to speak to her own GP. She would ring to ask if he was free, accepting that he may not be available, in which case she would turn to other services. However, the possibility of talking to her preferred Clinician meant that Olivia was not always put in the position of having to continually repeat herself. This mainly occurred if it was not understood why she could not speak to another GP, who could read through her notes, and why it was her personal preference to work with her own GP who knew her story.

In her experience, Olivia found that other GPs who didn't know her were quick to offer medication. This had not helped her specific needs. Olivia described having moved onto the crisis team. She expressed her mixed feelings about this, recognising that if it wasn't for them, she would not have had the therapy she needed and may not be making the progress she is today. She said that she was very lucky one day, whilst in pain that she thought would never end, that she had managed to get over to the crisis team. She was met by a Therapist who fast tracked her onto a group Dialectical Behaviour Therapy course, which she believes saved her life. Olivia still uses the skills she acquired there every single day. It has meant she could come off medication and has not had any further acute hospital admissions. She shared her disappointment that the funding for this course was cut. She described feeling devastated and reported that others in her group felt the same. It had given everyone hope. The course had created so much enthusiasm and people had worked hard. The group wrote letters, relatives became involved, but they were not successful in their plight to have this specific therapy course reinstated. Olivia felt very strongly that people living with a mental illness should not have to fight for the right to get better – they should be supported by services. She ended up taking out a loan to pay privately to continue the treatment, which is not an option for some people. This is something that she finds deeply upsetting.

Olivia went on to describe her experience with the Community Mental Health Team (CMHT) as not being positive.

‘people living with a mental illness should not have to fight for the right to get better – they should be supported by services’

She experienced disorganisation. She was promised treatments which she didn't receive* and was left chasing up her own appointments. She was told she was entitled to funded treatment, but only if she wrote a letter explaining this. When she did, she ended up chasing the treatment for a year. She said nobody ever knew where the letter was or what to do with it. Olivia said that she never saw that doctor again. Every time she had an appointment there it was with someone new, and she had to explain everything continually from the beginning. Every time she stepped foot in the CMHT building she had to take a parent along, as she would end up needing someone to help care for her afterwards.

*This comment relates to past experiences rather than the care that Olivia is currently receiving.



Olivia believed that the Community Mental Health Team made her unwell due to the disorganisation and lack of communication. She said the team kept trying to give her medication, or therapy that she had been advised by her Dialectical Behaviour Therapy specialist was contrary to her best wishes, as it might interfere with her current treatment. She also had a Support Worker who, whilst she was on the way to hospital, shouted at her for not ringing her first. After this incident, her Support Worker kept changing. Once again, Olivia experienced a lack of continuity of care. She did not feel listened to. For instance, after disclosing personal trauma she received Doctor's reports which were inaccurate. Olivia described how upsetting it was to read these. She found the experience all so exhausting that she realised she was better without the CMHT.

Olivia concluded her presentation by saying that she hoped describing her experiences was helpful today, she understood that everybody has had a different journey.



Olivia experienced a lack of continuity of care

She did not feel listened to

She found the experience all so exhausting



Michelle Bradley

29

Director for Bedfordshire and Luton Mental Health and Wellbeing Services



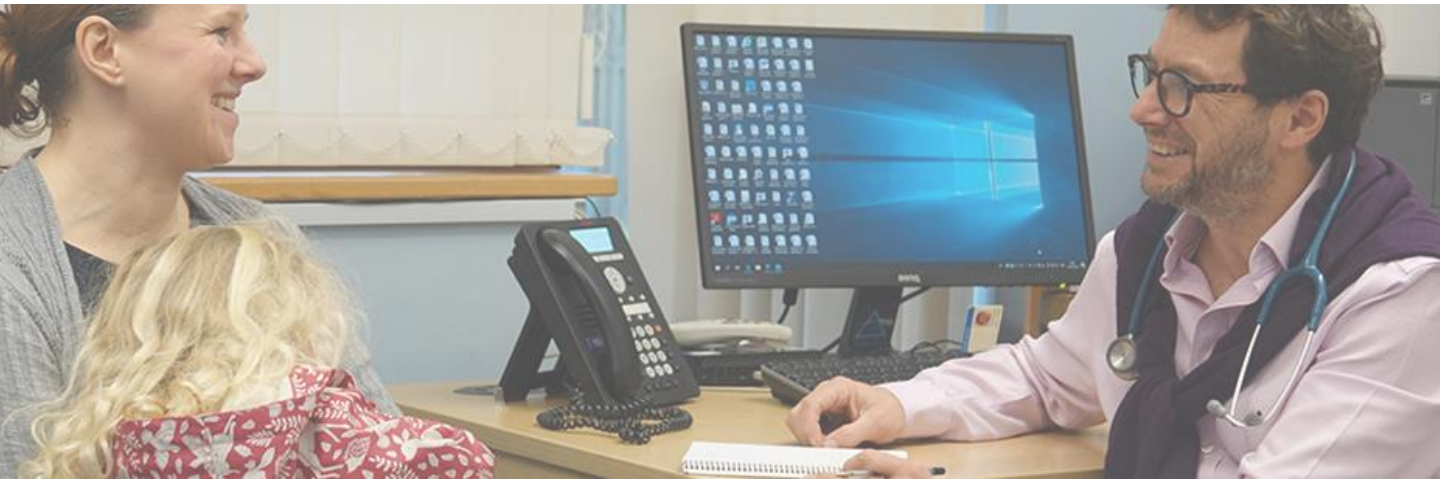
Michelle is a registered Nurse (for people with mental health and learning disabilities) and has worked within Bedfordshire health services for over 30 years, including working as a Commissioner for both mental health and learning disability services.

She lives in Bedfordshire and has been the Director of Mental Health Services for ELFT over the last 5 years. She is committed to improving health care services and during this time, has been part of the local journey in shaping local support for people.

Part of her role is to work within the wider system, supporting hospitals, primary care, social care and our voluntary sector to ensure they use resources in the most effective way to support people living in Bedford Borough.

It is an exciting time in mental health services, with significant investment and a new national framework to transform community mental health support and so it is timely and a great opportunity to hear from the people of Bedford Borough about what matters to you.

Michelle Bradley



Michelle began by describing the National Transformation Framework as a five-year programme, with a significant investment in terms of mental health services across the country. The purpose of the programme is to change where and how resources are used to enable people to access care, wherever and when they need it. The goal is to support people with their own recovery and to manage their own conditions. For this to be done effectively, an objective is to work with community organisations. The framework talks about joining mental health, physical health and social care together, and providing coordinated care. Across all services people are working in silos. The challenge for the system is to dovetail mental health with other services to work in a much more integrated way.

Primary Care Networks

Secondary care is where the Community Mental Health Teams and services tend to sit now. This transformation recognises the need to bring primary and secondary care together in a different way. The core transformation model increases support in primary care. This is not just for mental health but also physical health.

It involves addressing the inequalities for people with severe, enduring mental illness, in terms of access and health checks. It also talks about more integration with local community services.

Michelle explained that, currently, multi-disciplinary teams have an Occupational Therapist, a Psychologist, and a Doctor or a Nurse. In the new model this will be expanding to include, for example, Pharmacists and Peer Support Workers, reaching out into the community through social prescribers and community connectors and working in partnership with the voluntary sector.

The Transformation Framework relies on a sound understanding of local community assets and what these offer to people, such as where to go for housing support or advice around debt and finances, and how to support carers adequately.



Michelle offered an example of adults with eating disorders to suggest that small services in each of the Primary Care Networks (PCNs) wouldn't be needed as it was more efficient to provide these across the whole population. This could apply to other services like early intervention psychosis, the Crisis Care Team, people with rehab needs, plus people with complex difficulties associated with the diagnosis of personality disorder, linking these services around primary care. Money is being made available for issues such as problem gambling and supporting people when they leave the criminal justice system, suggesting that these could also be wrapped around the PCN's with other services such as drug and alcohol support.

The framework also sets some key outcomes for the wellbeing of adults and older adults. This requires the Trust to adopt a 'whole person' approach by thinking about each individual and their holistic support needs, alongside that of a 'whole population' approach to address health inequality across the Borough. The transformation brings a shift towards PCNs who will feel and look very different. Community Mental Health Teams as we know them, will be redesigned as primary and secondary care becomes integrated and the relationships between health and community groups and local authorities is strengthened.

With new investment going into the voluntary sector, this will encourage different ways of thinking about supporting people, Michelle explained. For example, she mentioned lunching clubs or walking clubs that are provided by a range of voluntary sector partners in Bedford Borough.

She said the aim of this transformation is to enable people with a full range of mental health challenges to access support when they need it, and to see that no-one falls through the cracks. Michelle remarked that this was about challenging thresholds. At the moment, she said, people might go to a well-being service, then they go to a Community Mental Health Team, but some are told that they do not meet the criteria. There is, therefore, a gap which people sit in, in which their needs are not being met.

ELFT recognises that they need to improve care for adults and older adults with the highest levels of complexity and severity by thinking about how teams can work more intensively and by reaching out to people in a way that Community Mental Health Teams are not currently.

'The aim of this transformation is to enable people.. to access support when they need it, and to see that no-one falls through the cracks.'

In Bedford Borough, a group have already started developing the model to transform services locally. They are looking at how people make contact and gain access to services, moving beyond the language of referrals and discharges to how this will work with the GPs. They have identified the Caritas Group as the first PCN to engage with on this piece of work, moving to the De Parys Group as the second.



The ELFT Transformation Team has already been identified and they are now starting to think differently about their offer to people who come through the front door. In terms of new goals, a Carers Link Worker and Community Connectors have already been employed on production and will start to work with mental health services this year.

Specialist support

Michelle said that the framework identifies some specific areas in which they need to focus on in order to improving care; these being:

- **adults with complex needs associated with diagnosis of personality disorder**
- **adults with eating disorders and**
- **improving care for older people**

For young adults (18 to 25 years of age) they are working with the Child and Adolescent Mental Health Services (CAMHS) on the transition from CAMHS to adult services. Many young people find this experience extremely difficult as adult services can feel quite different to what they are used to.

Some services are out of scope with this transformation in terms of investment, but Michelle said this will not stop ELFT from looking at these. Firstly, people with common mental health problems that are treatable with improving access to psychological therapy services. Secondly, conditions such as dementia that coexist with severe mental health problems. Dementia is being looked at in terms of a pathway, but not as part of the National Transformation Framework.

Commissioners have, however, taken a different approach to people with neuro developmental conditions, including ADHD and Autism, who are living with a coexisting severe mental health problem. So, rather than treating this group of people as outside of the scope, ELFT have been asked to include them in the terms of this transformation.

Roshan

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Jayalath

**MBBS, MRCP,
MSc(Psychiatry), DMHP,
DFSRH**

Having initially trained and worked in Psychiatry, Dr Jayalath qualified as a GP and has been working at King Street Surgery, a thriving training practice in Kempston, Bedford, as a partner for the past 11 years. Being the lead GP for mental health at the practice, he instigated the Bedford Substance Misuse and Mental Health Liaison groups 10 years ago and has forged links between primary care and these services, delivering a joint vision of improving mental health through collective and collaborative leadership.

As a local GP, he is committed to improving health care services in the community and would like to ensure equality, fairness, and collective leadership. He believes in working collaboratively and has worked very closely with Healthwatch Bedford Borough over the past few years. Dr Jayalath believes they have given a powerful voice to local people in getting the best out of local health and social care services.

He says that 'through organising this Forum, Healthwatch Bedford Borough have provided a platform for local people to have a stronger voice and influence the delivery and design of services, especially at a time where we are looking at reforming local mental health provision.'

Dr Jayalath began by describing the impact that COVID-19 has had on the NHS. General practice has not been immune, with a 25% increase in demand on their services compared to pre-pandemic times. This means there is now 25% extra demand on the same workforce and limited physical space, dealing with the same estates and facilities without extra provision. This, he said, is the reality of the current situation.

He then moved on to talk about mental health. He indicated that everyone knows something about general practice from their own experience, and the truth is that it is not geared up enough to provide care for mental health issues. At the end of the day, this doesn't serve the interests of the community, services or the individuals themselves. That is why this needs to change.

Before identifying gaps, he wished to describe the current service. Directly accessible services within Bedford Borough include the crisis service which is a self-referral service, people do not need to wait for a GP appointment.

The current service includes GPs who can contact a Mental Health Link Worker. This is usually a Nurse or Practitioner working alongside them. There is also the Mental Health Practitioner role and the Social Prescriber, both able to put people in touch

with social elements that they may not have been aware of. This shows how we need to make contact with the person as a whole.

There is also the voluntary sector, the Recovery College, Bedfordshire Wellbeing Service and NHS 111 option 2, which people can reach without going through their Doctor. Patients can also go directly to a mental health Crisis Cafe in the Bedford Health Village where patients can speak to one of the Practitioners.

Dr Jayalath then offered his own thoughts, based on his experience of working in primary care, on the gaps that he had identified. What has been apparent for a number of years is the number of people who do not fit a clear referral pathway because of the complexity of their needs. This is often because they have a number of conditions, known amongst health professionals as multi-morbidities. Quite often there are two or more health conditions, coupled with additional social factors. He knows, as a GP, that he cannot always get a patient to the right service within the current system. He pointed out that health services need to correct this by working together to support these services, doing this is an integrated way.



He knows, as a GP, that he cannot always get a patient to the right service within the current system

He then moved on to the reception that people receive from primary care services in terms of mental health. Another presenter had mentioned how Receptionists at surgeries responded to people with mental health problems and said that they need training. Dr Jayalath agreed with this point, saying that mental health is not within the formal training of GPs, and that primary care, as a whole, is working with psychiatric colleagues to address training gaps.

Dr Jayalath then touched upon child and adolescent mental health needs. As a GP he reported that he personally knew how many children with mental health problems had come to his surgery, stating that this was an issue that he felt deeply. A child's mental health has a huge impact on the adults around them. And with adults who may have lost their jobs, and are financially struggling, possibly losing their homes, then the interconnection means that both the adult(s) and child(ren) struggle.



Dr Jayalath went on to speak about older people's care. Sometimes older people come to GPs surgeries with different symptoms, such as cognitive impairments, anxiety and physical health issues. These can mask mental health issues. Sometimes, however, it is mental health issues which are foremost, masking other conditions. Again, this presents an additional training and development need for GPs.

The doctor gave his opinion that people with long term mental health conditions who have been discharged from mental health services often face difficulties in getting the right care. He felt that GPs do not have enough knowledge to manage these patients within the practice. The problem often being how GPs can get the support of the mental health specialists, working alongside them to ensure these patients are cared for effectively within primary care.

People with physical symptoms which are medically unexplained can also get some-what lost within the system. These people may go through several physical investigations, but often there is no clear course of action for them. This is another gap.

Dr Jayalath also stressed that the psychology of people living with long term conditions is an area that has not been sufficiently examined. Although individual GPs work hard to help their patients with diabetes, COPD or other life altering diseases, there has not been a systemic look at how to meet their mental health needs.

‘People with physical symptoms which are medically unexplained can also get some-what lost within the system.’

The evidence suggests that if you live with a number of conditions, you **are two to three times more likely** to have a mental health issue, yet we do not have enough support for people facing such challenges.

The doctor then explored the issue of physical health for people with severe mental illness. It is known that people living with the most severe and complex mental health conditions often have premature mortality rates. This means there is a reduction in their life expectancy, often meaning they die younger than the rest of the general population. Clearly, we need to look after their physical health as well.

Dr Jayalath looked at the issue of people at risk of suicide. It is known that many people who attempt to take their own life have had contact with their GP in the weeks before. That is where a focus on lessons learned can help GPs learn about what they can do differently moving forward. He then looked at what transformation can bring to general practice and stressed that what everybody wants is maximum benefits for patients.

What is needed is for people to be treated in the right environment, in the right setting, and at the right time.



This is where primary care comes into the picture. Patients come to their GP because they want a non-stigmatising environment close to home. That is considered by many to be the best place. The aim is to improve GP care by working alongside Psychiatrists to provide support. It is called bridging the gap so that we no longer need to look at this as primary and secondary care. Instead, we will aim to be one team looking after the patient.

He highlighted the need for two-way communications. In general practice, GPs often need advice or to refer a patient. The referral takes time because an assessment needs to be undertaken by the psychiatry service. This often involves the need to contact the Consultant and other issues. What is needed is better communication, supporting shared learning between professions.



Dr Jayalath considered that, by working alongside the Psychiatrist, skills are improved for both parties. For GPs it went some way to increasing their expertise. Local resources are vital, as it is often economic and social disadvantages, housing, and financial issues which have led to poor mental health in the first place. The Doctor felt that the Social Prescriber comes into the picture here, working closely with the local voluntary sector and local authorities to bring the kind of integrated approach that he felt will be needed.

Dr Jayalath drew attention to early intervention. For some people who are struggling, this can be seen by increased smoking, alcohol and drug use. The question is 'how can we help them before this escalates into a mental health issue?'

'how can we help them before this escalates into a mental health issue?'

His final point was rapid access back into secondary care. He said it is important that we have a mental health system that reacts when a GP feels that a patient is deteriorating. The NHS should be able to get that rapid access back to the mental health services, rather than waiting and carrying on treating within general practice for too long because that may prevent a crisis occurring.



Caroline Lewis

Chief Executive – Mind BLMK

Caroline Lewis

Caroline was asked to explain what effect COVID-19 had had on people in Bedford. She started by explaining how the general public had, at large, been remarkably resilient during the pandemic. However, many people had experienced worsening mental health.

After initial difficulties in adjusting, people used their protective factors to bounce back. By protective factors she meant things like family, friends, hobbies, work and volunteering. People who experienced problems with their emotional wellbeing for the first time recovered relatively quickly. She said that these coping strategies and protective factors had really made a difference to us all. Of course, the other side of the coin is that some people, for example those living on their own and/or not in regular employment, lacked this protection. They may have felt the effects of lockdown much more strongly and, consequently, found it much harder to manage.

Caroline described what had happened to people with mental health needs, who approach MIND for help. They observed situations in which the people who reached out to them had both social and clinical needs. Often, their presenting social needs were greater. MIND saw an increase in people experiencing loneliness and isolation, but they also saw an increase in the use of drug and alcohol. Caroline acknowledged that during this period there was so much more severity and complexity.

Moving forward, Caroline felt there would be a wide range of pandemic-related emerging issues. MIND have received calls about greater financial hardship, loss of employment, and bereavement, with some people losing their significant other. In addition, the impact on personal relationships, familial pressures and people being confined in the same home environment for a long period of time due to the lockdowns. For some households this has resulted in interpersonal violence and abuse. Domestic abuse organisations and the police have reported an increase in domestic abuse during this time. MIND have also seen an increase in anxiety and social phobias, which have manifested as increased fears and worry.



MIND saw an increase in people experiencing **loneliness** and **isolation** and in the use of **drugs and alcohol**

An important phenomenon is that two thirds of people with existing mental health problems said their mental health has got worse since the first lockdown. There was a general picture of people who were new to feeling such impact on their mental health and it is felt that the effects of the COVID-19 pandemic will be felt for a long time on the population. For those with an existing condition, two thirds said that their condition had got worse since the first lockdown. This is linked to the lack of protective factors but also people have not been able to access appointments and GPs as they had previously.

Caroline identified the pre-pandemic trend of increasing problems in young people which, she said, is continuing. She pointed to a big rise in the percentage of young people experiencing mental health problems. In 2017 it was 10% of the population, this has since risen to 16%. Two thirds of young people said their mental health problems got worse during the first lockdown. Also, 32% of young people reported self-harmed in the past year due to the challenges of the pandemic, showing a continuing trend that needs to be addressed.

An important message from Caroline was that the pandemic obviously means that there is now a much stronger case for change. There has been intense pressure on the workforce and frontline workers during this period. This has been the case within the voluntary sector, primary care and the mental health Trust.

32% of young people reported self-harmed in the last year

+ **INCREASE in domestic abuse**

+ **INCREASE in anxiety and social phobias**

Two thirds of people said their mental health got worse since the first lockdown

Four out of five people report dramatic improvements in their mental health since restrictions have been lifted

She stressed that the provision of mental health support does not always meet the range of needs that exist, and gaps have become more apparent. It was previously clear that pre-pandemic services had a capacity and demand deficit. With the transformation agenda, Caroline stated that we have a real opportunity to address these gaps moving forward, by making sure that local transformation addresses emerging and evolving needs from the pandemic.

People have experienced life through the pandemic and the impact is not expected to stop now. She emphasised that the picture is not completely negative. Four out of five people report dramatic improvements in their mental health since restrictions have been lifted. Caroline finished her presentation on a note of hope, saying that during the pandemic we, as a society, have become more open about mental health and have spoken about it much more. These conversations are much more free-flowing and if people are discussing their needs more openly it gives services the chance to get support to them much quicker.



A portrait of Simran Khinder, a woman with dark hair pulled back, smiling warmly at the camera. She is wearing a light-colored blazer over a patterned top. The background is a plain, light-colored wall.

Simran Khinder

Recovery Service Operational Manager, East London Foundation Trust (ELFT) Recovery College

Simran trained as a Social Worker at the University of Hertfordshire and worked in several senior roles in the public sector. Her experience covers local authorities, the third sector and NHS Trusts. As Operational Manager of the Recovery Services, which includes Employment Services, the Recovery College and the Diverse Cultures Community Support Team, her approach is to help individuals craft their own recovery.

In her career, she has aimed to provide culturally competent services, champion equality and improve access for people with mental health conditions. She feels this Mental Health Forum is important because of the huge positive impact the Mental Health Transformation Programme can provide.

There are a range of triggers such as homelessness, loneliness and financial insecurity that can cause a mental health crisis and we need to be more responsive to those circumstances for everyone.

Simran Khinder

Co-production

So, what does co-production mean? Simran answered this question by saying that co-production is about harnessing all the local resources available to services. It is really about working in partnership. Co-production goes well beyond user involvement, it promotes equal partnership between the Trust, their workforce and those users intended to benefit from their services. It does this by pooling different kinds of knowledge and skills and working together. This means going beyond 'service land' to designing and delivering public services with an equal and reciprocal relationship between professionals, other subject experts, communities, people with a range of different lived experience, their families, friends and neighbours. Where activities are co-produced in this way, both services and neighbourhoods become far more effective as agents of change. At the Recovery College, coproduction is not an 'on-off' exercise but an ongoing process involving peer trainers, subject experts, students and communities.

Transformation agenda

Simran gave examples of some of the opportunities offered by the transformation agenda.

These include:

- **Facilitating progression: Engagement with a wider range of place-based organisations and opportunities to enable people to move on and become a part of their communities**
- **Co-production, co-facilitation and co-learning: Access to a broader range of subject experts, access to a broader range of students, include community organisations (not simply those focusing on mental health)**
- **Better integration with communities and the ability to form a bridge between mental health services and communities – learning together breaks down barriers, erodes prejudice and discrimination**
- **Greater opportunities to be inclusive: serving different communities, people facing problems and emotional distress in communities as well as people with diagnosed mental health challenges**

Bedfordshire and Luton Recovery College

Bedfordshire & Luton Recovery College is part of the Bedfordshire Mental Health Academy, a formal partnership with East London NHS Foundation Trust (ELFT) and the University of Bedfordshire. Simran described a conversation she had in the planning stage with Michelle Bradley, in which she remembers Michelle saying that she wanted to create 'a service that that removed all barriers, so no criteria and no assessments. Something that is really open to people who don't actually have to jump through hoops to get the service that they need'.

So, what does the Recovery College do?

Simran said that they produce a range of educational workshops and courses, designed to improve health and wellbeing. These are delivered free of charge and are open to any adults who live or work in Bedfordshire. The aim is to help individuals increase their knowledge and skills and promote self-management. By doing so, people are empowered to make changes in their lives. The courses and workshops focus on mental health wellbeing and recovery and use an educational approach. They are co-produced and delivered either face to face or online by people with lived experience and professional experience. People who wish to use the Recovery College can self-enrol on courses and workshops.

Six defining features of a Recovery College (Perkins et.al 2018)

- **Coproduction, co-facilitation and co-learning lie at the heart of Recovery College: the bringing together lived/life expertise and professional/subject expertise on equal terms**
- **Being recovery-focused and strengths based in all aspects of the college**
- **Progressive – actively helping students to move forward in their lives**
- **Are integrated with our community and with mental health services and to form a bridge between the two**
- **Recovery College inclusive and open to all...people of different ages, cultures, faiths, genders, sexual orientation... as well as people who mental health (or other health) challenges, mental health workers, their relatives and people facing problems and emotional distress in communities**
- **Based on educational principles**

In the summer term of 2021, the Recovery College had over 100 different workshops in their prospectus. These change every term (three each year), and a new prospectus is produced every month.

Simran described how co-production is at the heart of what is offered within the prospectus. For them, it's all about co-facilitating and co-learning. They work in partnership with peer tutors and teachers who are individuals with lived experience. They come together to look at the subjects they want to cover, the skills that are needed, and what is needed by the community, working with up to 26 different third sector organisations to make sure they reflect and respond to the mental health needs of the locality. Simran also touched on openness. The Recovery College is free. It's for staff, for service users, and for the wider community. It's for me and you - it's open to anyone. The idea behind this is for a really holistic way of learning about people's experiences and learning needs. There is a really good mix of people within the sessions and the feedback the Trust receives is seen as the best way to improve.



co-production is at the heart of what is offered within the prospectus

The Recovery College is free. It's for staff, for service users, and for the wider community. It's for me and you.

Sally Wilkin

ELFT People Participation Lead



Sally is currently ELFT's People Participation Lead for the Bedfordshire and Luton Community Mental Health Transformation Programme.

Sally became involved with the Trust's People Participation Team as a service user in 2014. In 2018 she was successful in gaining employment within the Quality Assurance Team, as their Service User Lead. She describes her current role as 'getting the service user voice into the heart of everything that ELFT do'. She can make sure that the service user's voices, thoughts and opinions are at the heart of everything, right from the beginning. Her saying is 'nothing about us, without us.'

Sally understands the fear and uncertainty of being a patient with mental health services. She believes the Mental Health Transformation Programme has the potential to bring a much more holistic way of working with people in mental health distress and believes services need to find a way of working with the whole person, with their housing situation, their benefits, and their employment to promote individual recovery. This new way of working should recognise an individual's triggers for mental health distress and ask them what they need to get better.

Sally Wilkin

Sally began by describing her personal journey. This, she said, started on the sofa of despair. A life with no hope of getting back to her pre-breakdown self.

However, slowly she began her journey to recovery in 2015 by working with the People's Participation Lead. She depicted how she gradually regained her confidence. Her thoughts, opinions and suggestions were acted upon. She was able to influence improvement and change. She took part in a number of activities including speaking to new staff at inductions. She regained her appreciation of having responsibility and accountability, without pressure. It was fantastic for her to work alongside other people who completely understood her, her moods and abilities, and recognised her capabilities.

The experience was a reintroduction into a working environment, without worry of losing benefits or employment. She undertook a role as a Peer Tutor within the Recovery College, which increased her confidence.

After 3 years of working alongside the People's Participation Lead, she then decided she would take the next step into 'safe' employment. She worked alongside the ELFT employment specialists and was successful in gaining a 12 hour per week contract within the ELFT Quality Assurance Team. This new role was safe, as it was permitted work and the salary was extra to her benefits. For Sally, this meant that if it went wrong, she was still financially stable.

Sally said that she struggled at first but gradually, over the period of 4 years, she managed to make the jump off DWP benefits and increased her working hours to 18.75 (2 ½ days per week).



**'Recovery
is possible'**

Over time her confidence and abilities grew to the point where she is now in a part-time post within ELFT's People Participation Team as the People's Participation Lead for the Community Mental Health Transformation within Bedfordshire and Luton.

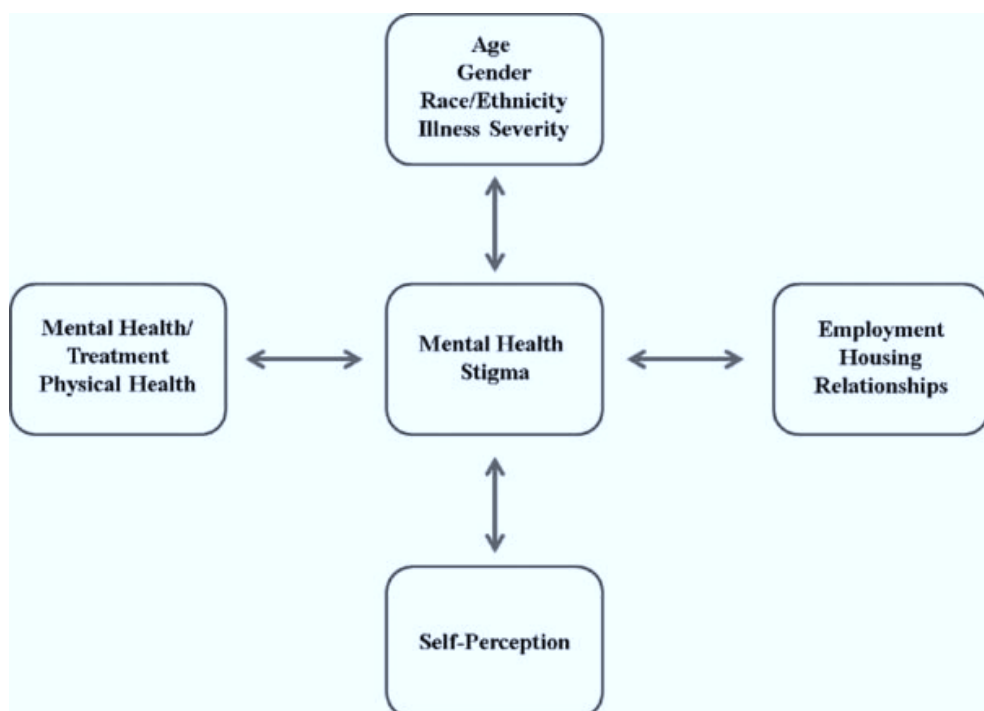
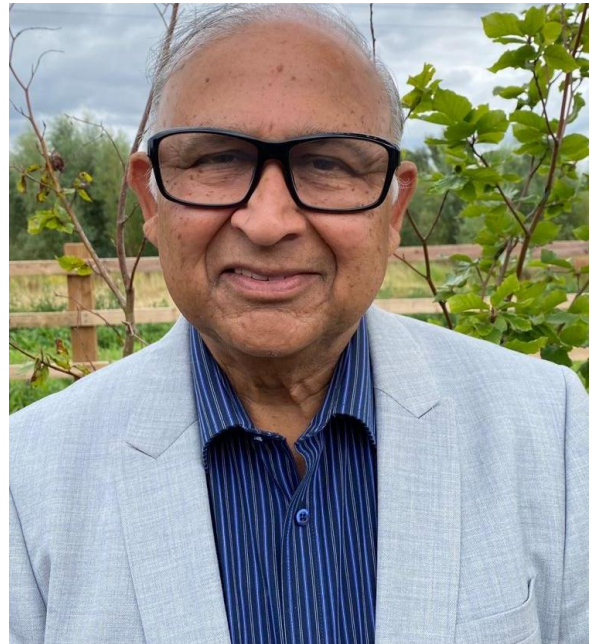
She stressed her experience of recovery as a journey, which goes forwards and backwards, forwards and backwards. Sally stated that recovery is individual to each person. It is a process that may offer small achievements, but the idea is small improvements day by day means progress. She expressed her belief that there really is hope. During previous episodes of poor emotional wellbeing, Sally described feeling so poorly that she could not see any hope. She felt like this back in 2014. Seven years later and she still has rough days. She now sees this as just life and comes back after a rough day with a better understanding of herself, and how to help herself manage a similar situation next time.

She urged anyone currently struggling to see her as an example of hope, that recovery is possible. She advised anyone in a similar situation to take any and all opportunities to improve their mental health, to give it a try, and, if there is a knock back, to take time, reflect, learn, stand up and start again.

Closing Remarks

Healthwatch Bedford Borough Director Ashok Khandelwal closed the Forum by thanking everyone for taking part in what he described as a ‘fascinating and different experience’. He commented on the enthusiasm generated by the sharing of knowledge, experiences and ideas and, in particular, the great deal of learning gained from service users who have ‘very important messages for us to hear’.

Ashok advised that Healthwatch Bedford Borough would capture and collate this vitally important feedback in a report and make recommendations that put the voices of service users and people from Bedford Borough at the heart of local services. He ended by reinforcing his own and Healthwatch Bedford Borough’s commitment to working together to make services better for now, and for the future.



Recommendations from Healthwatch Bedford Borough

1. Extended remit for East London Foundation Trust (ELFT) Working Together Group

The **ELFT Working Together Group** responds to the operational needs of the Trust, with limited strategic input. Healthwatch Bedford Borough is recommending that the remit of this group is extended to involve service users as strategic partners, with a stronger voice in the planning, commissioning, delivery, monitoring and review of services. This Group should have responsibility for setting its own agenda, with continuing support from the People Participation Lead, and report directly to the ELFT Board, thus fulfilling the Trust's QI pledge within its Co-Production Model to engage groups of people at the earliest stages of service design, development and evaluation.

To enable the Group to fulfil their extended remit, we recommend that they be given access to information, subject to the requirements of GDPR and patient confidentiality - including detailed, anonymised information about active complaints.

The Working Together Group will appoint Experts by Experience as part of the new co-production pathways and the Group will continue to perform a monitoring role (see recommendation 5).

These recommendations strengthen the practice of co-production by embedding its principles of equality and partnership.

The BLMK Integrated Care System describes co-production as a system in which service users have an '**equal share of the power, knowledge, resources and voice**' to influence the way that services are designed commissioned and delivered.

* NICE Quality Statement 3 states that service users should be involved in the planning, commissioning, delivery and monitoring and review of mental health services to guide improvements.

2. Compulsory Mental Health Awareness Training for GP practice Receptionists

Healthwatch Bedford Borough recommends that Primary Care Networks provide accredited mental health awareness training for all practice staff, including Receptionists. This training should be compulsory, refreshed/updated regularly and be incorporated into staff induction plans.

The aim of this training is to reduce the stigma around mental health and breakdown any barriers experienced by people seeking help with access to mental health services.

*NICE Quality Statement 3 states that people using mental health services should be treated with empathy, dignity, and respect.

5. Improved decision-making for service users

Healthwatch Bedford Borough recommends moving away from a criteria to a needs-based response/assessment, whilst recognising that this will be a continuing process as more preventative pathways are introduced. The Working Together Group will appoint Experts by Experience as part of co-production of new pathways and the Group, as a whole, will continue to provide a monitoring role.

*NICE Quality Statement 2 states that 'Supporting people to be at the centre of decisions about their own treatment and care, including people detained under the Mental Health Act, results in better quality decisions that are more appropriate to the person.'

6. Integrated care plans for people with complex needs and/or multiple chronic conditions, including named person as primary contact for the patient

People with complex needs and/or multiple chronic conditions need co-ordinated support to understand and manage their own conditions and healthcare needs. Crucial to this is the ability to navigate a system that reacts to individual symptoms or conditions rather than the person as a whole. Healthwatch Bedford Borough recommends that such patients have an integrated care plan, produced jointly by a multi-disciplinary team including all those directly involved in providing care. This plan should include contact details for all members of the MDT and identify a named person as the primary point of contact.

*NICE quality statement 4 states that 'people using mental health services understand the roles of the members of their multi-disciplinary team and know how to contact them about their ongoing healthcare needs'. The rationale for this is that mental health services are provided by different types of professionals in a range of settings, which can be confusing. Understanding the role of all those directly involved in a person's care and how to contact them can build trust and confidence, reduce concerns and help develop relationships. Maintaining a consistent team can provide familiarity and help improve relationships. This supports a person to more effectively manage their health and the effect it has on their life.

*The National Institute of Clinical Excellence (NICE) set out priority areas for quality improvement in health and social care by using Quality Standards. NICE have a set of Quality Statements for service user experience in adult mental health services (qs14).

***Please see next page for NICE Quality Standard**

NICE Quality Standard **Published 13 December 2011**

Service user experience in adult mental health services

www.nice.org.uk/guidance/qs14

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement. Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of 100% should be aspired to (or 0% if the quality statement states that something should not be done). However, this may not always be appropriate in practice. Taking account of safety, shared decision-making, choice and professional judgement, desired levels of achievement should be defined locally.

Quality statement 1: Empathy, dignity and respect

People using mental health services are treated with empathy, dignity and respect.

Quality statement 2: Decision making

People using mental health services are supported in shared decision making.

Quality statement 3: Involvement to improve services

People using mental health services are asked about their experiences and their feedback is used to improve services.

Quality statement 4: Contacts for ongoing care

People using mental health services understand the roles of the members of their multidisciplinary team and know how to contact them about their ongoing healthcare needs.

Quality statement 5: Access to services

People can access mental health services, including crisis support, when they need them.

Quality statement 6: Joint care planning

People using mental health services jointly agree a care plan with health and social care professionals, including a crisis plan if they may be at risk of crisis.

Quality statement 7: Inpatient contact with staff

People in hospital for mental health care have daily one-to-one contact with mental healthcare professionals known to them and regularly see other members of the multidisciplinary mental healthcare team.

Quality statement 8: Inpatient meaningful activities

People in hospital for mental health care can access meaningful and culturally appropriate activities 7 days a week, not restricted to 9am to 5pm.






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