COMMISSIONER DISCUSSION REPORT

From fragmented services to connected community care



Norfolk mental health, wellbeing and inclusive hackathon: participant evidence, tested approaches and a practical commissioning roadmap

4 November 2026 • Evidence-informed working report

Prepared from the inclusive hackathon data, creative group outputs and coded notebook observations, supplemented by published research and national guidance. The report is intended to support discussion, co-validation, and pilot design. It is not an independently evaluated impact study.

Executive summary

The hackathon generated a consistent message: people want coordinated services that are easy to enter, but they do not want care to become impersonal. Creative prototypes imagined a welcoming 24/7 community hub, a Medwell medication support centre, connected local hubs, peer-led community spaces, a “Balloon People” approach to person-centred coordination and a Norfolk Deaf Community Covenant. Participants also identified concrete failures in transitions, medication access, information sharing, interpreters, housing-related exclusion, staff turnover, and fragmented funding.

The strongest commissioning opportunity is to connect and adapt existing provision before creating new services. The proposed programme combines (1) named navigators and integrated outreach; (2) safe medication and discharge coordination; (3) accessible community and crisis support; and (4) funded participation and Deaf leadership. A 12-month pilot should test quality, equity and total public-sector costs rather than assume that prevention automatically creates cash savings.

Six recommendations for commissioners

- Commission a 90-day joint pathway review with people with lived experience, housing, NHS, social care, probation and the voluntary sector.
- Pilot a named community connector / care navigator with warm handovers and a no-wrong-door access route.
- Strengthen prison, hospital and temporary-accommodation transition arrangements, including prescribing continuity and follow-up.
- Co-design an accessible, non-clinical wellbeing hub and extended-hours crisis alternative using existing estates and services wherever feasible.
- Adopt a Norfolk Deaf Community Covenant with funded BSL access, Deaf co-leadership and measurable accountability.
- Pool a modest evaluation and innovation budget; establish a credible baseline and monitor costs across organisational boundaries.

1 | Purpose, scope and evidence

This report asks: what difficulties did participants identify, what did they design at the hackathon, which ideas resemble interventions trialled elsewhere, and what can Norfolk commissioners practically do to improve outcomes and steward public funds?

Analysis is organised into six provisional themes: T1 coordination and fragmentation, T2 access and inclusion, T3 local integrated provision, T4 continuity and recovery, T5 trust and relationships, and T6 participation and empowerment. The analytical distinction between problems, solutions and values is retained throughout

2 | The scale of need and why the issues matter

Indicator	What the published evidence says	Interpretation / caution
Mental health, England	22.6% of people aged 16–64 had a common mental health condition in 2023/24 (up from 18.9% in 2014). [1]	A national prevalence estimate, not a measured Norfolk rate.
Norfolk mental wellbeing	22% reported high anxiety in 2022/23; Norfolk JSNA estimated ~93,000 residents aged 16–64 with common mental disorders using an older 17% national rate. [2]	The local estimate is based on older prevalence assumptions. Do not mix it with the 2023/24 national rate as if comparable.
Self-harm emergency admissions	1155 Norfolk emergency admissions for intentional self-harm in 2023/24. Standardised rate about 130 per 100,000 versus 117 for England. [2]	Admissions are not the same as unique people or total community self-harm.
Local housing pressure	North Norfolk recorded 1,204 homelessness approaches in 2024/25, up from 779 in 2021/22. [3]	One Norfolk district only, not a county total.
Deaf healthcare access, UK	The BSL Advisory Board reports 67% of deaf respondents had no accessible way to contact their GP and 81% had experienced an appointment with unmet communication needs. [4]	These are findings from reported research, not Norfolk-specific prevalence.

The implications extend beyond specialist mental health. Delayed engagement can manifest in housing crisis, repeated appointments, loss of medication, avoidable emergency contacts, worsening physical health and social isolation. Public expenditure is then split between NHS, councils, housing and criminal justice. NICE explicitly recommends integrated, long-term, and co-designed care for people experiencing homelessness. [5]

3 | What participants told us: problems, solutions and values

Theme	Problem expressed	Proposal / underlying value
T1 Coordination	Different providers, changing paperwork and uncertainty about interagency sharing (IMG_7719; notebook p.10).	Joint protocols; connected records; a single named contact. Value: no repeated storytelling.
T2 Accessibility	Waiting, digital barriers, BSL interpreting needs, rural transport and unclear eligibility (IMG_5843, IMG_5844; notebook p.17).	Multiple access points, outreach, communication support. Value: equitable access.
T3 Community services	Clinical pathways are hard to navigate and some spaces feel unwelcoming (IMG_5835, IMG_5839; notebook p.15).	Hubitis, Our Hub, campfire/peer space and outreach. Value: belonging.
T4 Continuity	Short projects, transfers, discharge and interrupted prescriptions (IMG_5842; notebook pp.11–12).	Medwell centre, health passports and warm handovers. Value: stability.
T5 Trust	Fear, stigma, not being heard and lack of personal contact (IMG_5836, IMG_5839; notebook p.13).	Better listening, advocacy cafe, human contact in crisis. Value: dignity and safety.
T6 Participation	Communities lack influence over budgets and service decisions (IMG_5834, IMG_5844; notebook p.15).	Participatory budgets and Deaf Community Covenant. Value: shared power.

These themes interact. A person can have several nominal routes into care yet experience no successful handover. Conversely, a single coordinated system can still exclude someone if access relies on digital forms, spoken English or fixed appointments. The design principle suggested by participants is: “one connected system behind the scenes, multiple welcoming doors in front.”

4 | Hackathon concepts worth developing

A. “Our Hub” / “Hubitis” / community campfire

Participant vision. A friendly, inclusive place with arts, nature, peers, practical support and a promise that people are not simply turned away. The models include “WE NEVER CLOSE” and 24/7 aspirations.

Commissionable test. Prototype extended hours and an out-of-hours connection pathway first and do not assume a fully staffed 24/7 physical hub is financially or operationally warranted.

B. “MedWell Centre”

Participant vision. A single place to obtain medication advice, understand prescriptions, resolve transitions, and access emergency guidance.

Commissionable test. Trial a pharmacist-led medication continuity pathway linked to GP, prison discharge, mental health teams and community pharmacies. Clinical prescribing and dispensing remain with authorised professionals.

C. “Balloon People” / human connector

Participant vision. A recognisable person who can connect services and help someone identify the right support, including psychiatry, housing and community provision.

Commissionable test. Give each high-need participant a named navigator, with clear accountability for completing referrals and maintaining contact.

D. Norfolk Deaf Community Covenant

Participant vision. A pledge for Deaf people to participate in all relevant service decisions, co-produce new services and identify partnership/funding routes.

Commissionable test. Create a Deaf-led governance group, funded interpreting capacity and annual access audit; distinguish BSL users' language needs from hearing-loss adjustments.

E. "Beyond the label" peer community spaces

Participant vision. Rebrand or redesign community places to be welcoming and person-centred rather than diagnosis-defined.

Commissionable test. Commission peer involvement and accessible co-design of existing neighbourhood venues, with supervision and safeguarding.

F. Connected information / wiki / health passport

Participant vision. An accessible, person-owned way of showing preferences, needs, contacts and plans so the person does not repeat their story.

Commissionable test. Test consent-led personal summaries and interoperability with the existing Norfolk and Waveney Shared Care Record rather than duplicating clinical records.

5 | Have similar problems been addressed elsewhere?

Approach / place	Evidence and lessons	Transferability
NICE integrated homelessness care (England)	NG214 recommends multidisciplinary teams, peer support, one-stop shops, assertive outreach, named practitioners and coordinated transitions. [5]	Strong guidance fit; commissioning should adapt to local population and service map.
Crisis cafés (England)	A national observational study found crisis café availability associated with 7.8% lower psychiatric admission rates. Association does not establish that cafés caused the reduction. [6]	Test locally with matched comparisons, crisis risk protocols and suitable operating hours.
Housing First pilots (Greater Manchester, Liverpool, West Midlands)	National evaluation includes outcomes, implementation and formal cost-benefit studies published in 2024. [7]	Relevant to people facing homelessness and complex needs. Fidelity, housing supply and cross-agency costs matter.
Specialist homeless discharge services (England)	Economic evaluation of 354 people found promising cost-effectiveness for step-down models compared with usual care, with results varying by model. [8]	Prioritise safe discharge and short-term step-down support where local need warrants.
BSL-accessible services (UK)	BSL Advisory Board and SignHealth document exclusion and argue for accessible contacts, interpreting and culturally competent mental health services. [4,9]	Direct fit for Norfolk Deaf Covenant. Requires commissioning rather than goodwill alone.
Social prescribing / connectors	Recent systematic review of 18 economic studies says robust cost-effectiveness evidence remains limited. [10]	Potential value for access and social connection. Don't book assumed cash savings.

An important local point: Norfolk and Waveney already has a Shared Care Record that allows authorised professionals to view relevant information across organisations. [11] NSFT also describes plans to introduce a new electronic patient record in 2027. [12] A hackathon digital proposal should therefore test usability, consent, the practical limits of sharing and people's understanding of the system, rather than assume no infrastructure exists.

6 | Proposed commissioning package

Workstream	Minimum viable pilot	Accountability / safeguards
1. No wrong door	Two local access sites plus outreach, named navigator, and documented referrals.	Joint NHS–council–VCSE lead; safeguarding, escalation, accessible communications.
2. Transition & medicines	Discharge checklist, medicines reconciliation, pharmacy contact and 48–72h follow-up for eligible participants.	NHS clinical and pharmacy leadership; custody links; data-sharing review.
3. Wellbeing & crisis alternative	Use an existing community venue for peer support, evening access and clinician-supported crisis pathways.	Crisis service clinical protocols; emergency escalation; independent feedback.
4. Deaf inclusion	Funded Deaf co-production panel, BSL access audit, interpreter availability and accessible appointment routes.	Deaf community co-chair; NHS and local government accountable owners.
5. Person-controlled information	Accessible portable personal summary/health passport connected to established records where lawful.	Privacy impact assessment, role-based access, alternatives to digital.
6. Evaluation & procurement	Shared outcomes dashboard and cross-sector cost evaluation before expansion.	Independent evaluation; baseline and comparison strategy.

7 | How to improve quality and save money responsibly

Potential efficiencies should be treated as hypotheses, not booked savings. A better referral may initially increase appropriate treatment, contact, and total recorded expenditure. Savings can arise later, be offset by demand, or accrue to a different organisation from the funder. The pilot should identify both cost avoidance and any genuinely cash-releasing changes.

Cost pressure	Mechanism worth testing	Measurement
Repeated assessment and administration	Shared plans, named navigator and completed handovers.	Staff minutes per referral; duplicate assessments; failed contacts.
Emergency admissions and crisis escalation	Earlier engagement and structured alternatives to crisis.	Risk-adjusted A&E, crisis team use, admissions and bed-days.
Medicine interruption	Reconciliation, timely supply, and clear responsible prescriber.	Missed doses, urgent prescriptions, medicine-related contacts.
Housing instability / discharge	Housing and health coordination at admission and discharge.	Delayed discharges, returns to hospital, housing stability.
Communication failures	BSL access, plain English, face-to-face options, supported contact.	Missed appointments linked to access barriers; rebooking; complaints.

Short funding cycles	Multi-year contracting with measurable outcomes and workforce continuity.	Tender/admin costs, vacancy and turnover, continuity of support.

Illustrative economic evaluation framework

For each participant, compare total cost over 12 months: intervention staff and venue costs + NHS acute and community utilisation + council/housing expenditure + relevant criminal justice contacts. Analyse separately by organisation and then as a whole-system total. Use locally agreed unit costs and, where feasible, a matched comparator or staggered rollout. Include health-related quality of life, lived-experience outcomes and equity measures, not just service use.

Break-even calculation: annual pilot delivery cost ÷ independently validated net cost avoided per participant = number of participants needed to break even. Do not insert an assumed saving per person before collecting data. Present low/base/high scenarios and distinguish financial cash release from social value and cost avoidance.

8 | A phased implementation roadmap

Timing	Actions	Decision / output
0–30 days	Convene cross-sector steering group; nominate lived-experience and Deaf co-chairs; verify hackathon extracts; map existing provision and contracts.	Agreed problem statements, service map, risks and governance.
31–90 days	Co-design two prototypes; conduct accessible journey mapping; baseline use and costs; data-sharing and clinical-safety assessment.	Pilot specification, logic model, evaluation protocol and budget.
Months 4–6	Launch small access/navigation and discharge/medicines pilots; introduce Deaf access measures; collect participant feedback monthly.	Early implementation and safety review; refine based on evidence.
Months 7–12	Test community hub access hours and peer support; audit referral completions, wait times, crisis contacts, satisfaction, costs and unequal outcomes.	Independent 12-month evaluation and scale/adapt/stop decision.
Year 2 decision	Expand only components that demonstrate acceptability, safe delivery, improved outcomes, and plausible value.	Commissioning case with costs and implementation requirements.

9 | Outcomes commissioners should ask to see

- Access: time from request to first meaningful contact; proportion receiving a completed warm handover; proportion able to contact services in their preferred format.
- Continuity: medication interruptions, post-discharge contact within 72 hours, repeat assessments and service disengagement after transitions.
- Experience: feeling listened to, knowing who to contact, trust in services, reported discrimination and perceived ability to influence decisions.
- Equity: stratify outcomes by housing insecurity, Deaf/BSL access, disability, age and neighbourhood where safe, meaningful and lawful.
- Clinical and social outcomes: crisis presentations, admissions, housing stability, wellbeing measures and sustained community participation.

- Value: marginal delivery cost, whole-system cost, avoided contacts where defensible, opportunity costs, and whether any savings are actually realisable.

10 | Ethical and practical conditions for success

The programme should be co-designed with people at risk of homelessness, people with learning disabilities, Deaf/BSL users, unpaid carers, and others who experienced exclusion. Involvement should be paid where appropriate, with accessible formats and communication support. Participation must not depend on written or digital literacy. Clinical decisions must remain under appropriately qualified supervision, and crisis support must have safeguarding and escalation arrangements. Person-held records or wiki-style summaries require consent choices, data minimisation, robust access controls, and clear responsibility for updates. The existence of a Shared Care Record does not mean that all partners can lawfully view or contribute to every field.

There are potential unintended consequences: a hub may divert staff from existing provision; short projects may increase dependency and then close; referral schemes may overload underfunded charities; and sharing can undermine trust if people do not understand who can see their information. These risks should be tracked explicitly.

11 | Priority decisions for the next commissioning meeting

1. Agree one jointly owned problem definition and identify two pilot geographies from service and need data, not anecdote alone.
2. Confirm whether to commission one integrated navigation pathway rather than several overlapping new platforms.
3. Ask NHS medicines, prison health and council housing teams to co-produce a transition safety protocol.
4. Commission a Deaf-led access and co-production exercise and establish who is accountable for interpreter provision.
5. Allocate a protected budget for lived-experience participation, independent evaluation and implementation learning.
6. Request a 12-month business case using validated local baseline costs, with explicit stop/adapt/scale criteria.

12 | Conclusion

The outcomes from the hackathon suggest a practical future: a connected system with many accessible entry points, trusted relationships, and meaningful shared power. Many of the proposals are consistent with existing NICE and NHS policy, so the commissioning challenge is not inventing a wholly new model but making recognised approaches function reliably across organisational boundaries. The strongest next step is a carefully co-produced, measurable pilot combining coordinated navigation, safe transitions, accessible community support and accountability to people who use services. Better outcomes and better use of public funds should be demonstrated together, not assumed.

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