Bath & North East Somerset Council

NHS
Bath and North East Somerset
Clinical Commissioning Group

MEETING	**HEALTH AND CARE BOARD**
DATE	**06/03/19**
TYPE	**An open public item**

Report summary table	
Report title	Mental Health Review – RULE 15
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Summary	This document sets out the case for Bath and North East Somerset Clinical Commissioning Group (the CCG) and Bath & North East Somerset Council (the Council) to implement a new model of Mental Health provision.
Recommendations	The Board is asked to agree that the CCG and Council work with existing system leaders to deliver the new Thrive model of Mental Health provision in B&NES.
Rationale for recommendations	The CCG and the Council recognise that the creation of a new model of mental health provision is a bold and transformational step. However, services cannot continue to be delivered in the same way because in the long term this is unaffordable, unsustainable and, most importantly, will not deliver the preventative, collaborative and personalised service that local people and professionals have asked for. There are many strengths in existing community mental health services locally with strong examples of innovation and partnership working across system leaders and third sector organisations. Under the preferred proposal, the Thrive model of care would be commissioned to start 19/20. Thrive supports the provision of mental health services using a whole-system, population-based approach which focuses on the mental health and mental illness needs of different groups of people as well as the needs of individuals. It enables integration across health, education, social care and voluntary sector, with a central focus on delivering improved outcomes for people. The implementation of the Thrive model will also allow for more effective links to place initiatives such as GP Primary Care Networks and will ensure mental health is embedded across all sectors of provision. The decision is being made in accordance with Rule 15 of the Council's constitution. It would generally to be an ordinary

	Health and Care Board decision though due to the need to make the decision before end of March 2019 due to contract expiry it is necessary to use the Council's urgency procedure.
Resource implications	The following funding assumptions will continue to apply to future contracting arrangements. • Funding may need to be adjusted from the 2019/20 baseline to align with the Council and CCG planning assumptions in health and care funding arising from both organisations' financial planning and annual budget-setting processes and National Guidance. • The new commissioning and provider delivery models will need to identify areas and timescales for cash-releasing efficiency savings or improving value which can be realigned to sustain the role out of Thrive model across the wider mental health economy. • Demographic change pressures will need to be managed within available resources. • New investment requests to support delivery of our priorities will be reviewed on an individual basis and require sound quantitative and qualitative evidence of system benefits. • Commissioners and providers will continue to work in partnership to jointly identify areas of opportunity efficiencies.
Statutory considerations	Community mental health and care services play a vital role in meeting the statutory responsibilities of the Council and CCG. For the Council, these included those in the Care Act (2014); Mental Capacity Act (2005); Mental Health Act/Deprivation of Liberty Safeguards (2007); Children Acts (1989 and 2004) and SEND (Special Educational Needs and Disabilities) reform. Public Health responsibilities include a duty to promote the health & wellbeing of the inhabitants of its area and to reduce inequalities amongst its population. The review also supports the delivery of local strategic priorities, including those set out in the Health & Wellbeing Strategy, Better Care Plan, NHS Long Term Plan, % Year Forward View, Council vision and priorities, and CCG 5-Year Strategy. An Impact Assessment (EIA) has been undertaken and is attached as an appendix to the Report. The EIA will be regularly reviewed and updated throughout the implementation phase of the Programme.

Consultation	Details of all parties consulted in preparing this report (including compulsory sign off from the CCG Finance Officer, Section 151 Officer and Monitoring Officer of the Council)
Risk management	A risk assessment related to the issue and recommendations has been undertaken, in compliance with the Council's decision making risk management guidance.
List of attachments	Appendix 1: Consultation Report Appendix 2: Community Mental Health Services Appendix 3: You Said We Are Doing Appendix 4: Collaborative Framework Appendix 5: Impact Assessment
Background papers	Not Applicable

Bath and North East Somerset

Mental Health Review

Full Business Case

March 2019

Appendices

Appendix 1: Consultation Report
Appendix 2: Community Mental Health Services
Appendix 3: You Said We Are Doing
Appendix 4: Collaborative Framework
Appendix 5: Impact Assessment

1. Executive summary

This document sets out the case for Bath and North East Somerset Clinical Commissioning Group (the CCG) and Bath & North East Somerset Council (the Council) to implement a new model of Mental Health provision.

In January 2015, the (CCG) and the Council in Bath and North East Somerset (B&NES) began a joint review of all community health and social care services, this was delivered under the 'Your Care, Your Way' Programme. On conclusion of this review the majority of community health and social care services within B&NES were contracted to Virgin Care, as prime provider on 1st April 2017.

Following the appointment of Virgin Care, Commissioners undertook a more detailed review of community mental health services including those provided by Avon and Wiltshire Mental Health Partnership NHS Trust (AWP). This built on the Your Care Your Way recommendations, in order to achieve a truly transformational and long term change in mental health and wellbeing provision for the benefit of its target population people in B&NES.

Section 2 summarises the extensive programme of engagement and consultation that has taken place with local people and professionals since the review of community mental health services began in May 2017. Following a series of over 20 different engagement events, a formal public consultation was held in February 2019 to seek feedback on the proposed model for community services and the results of this engagement and consultation were then used to finalise the transformation priorities.

Section 3 explains how services will be developed to support the new model of provision. It begins by summarising the drivers for change including the changing needs of the local population. This section also includes further detail on how we will address the priorities identified throughout our engagement and public consultation.

Section 4 provides an explanation of how we will mobilise the new model of provision. It sets out the outcome-based accountability approach that will be used to measure the performance of local organisations who provide mental health services, ensuring that they deliver improved mental health and wellbeing outcomes for the whole population as well as achieving performance targets for each of the services they are responsible for.

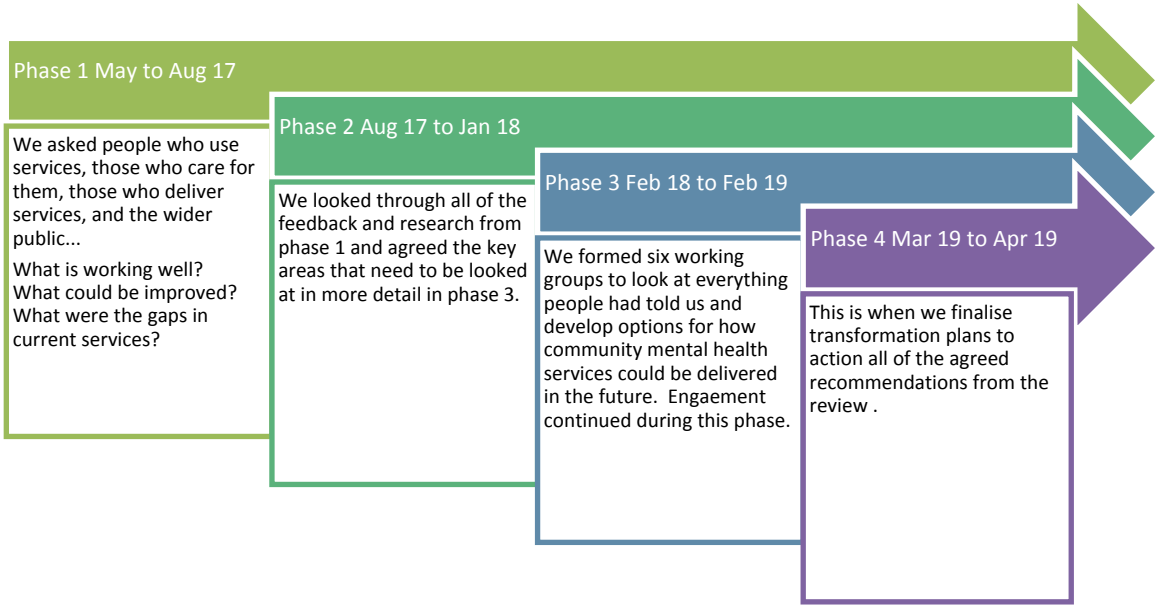
Section 5 contains detail on how mental health funding is currently allocated across our community mental health services. This section also contains details of additional investments that are being sought to support delivery of our priorities.

2. Listening to the community

2.1 Our Engagement Approach

The mental health review has been delivered in four key phases between May 2017 and February 2019. For the duration of the review, the CCG and the Council carried out ongoing engagement with our population in order to hear about people's experiences and ideas. This feedback has been utilised to help shape the future model of provision.

Fig 1: Phases of the Mental Health Review



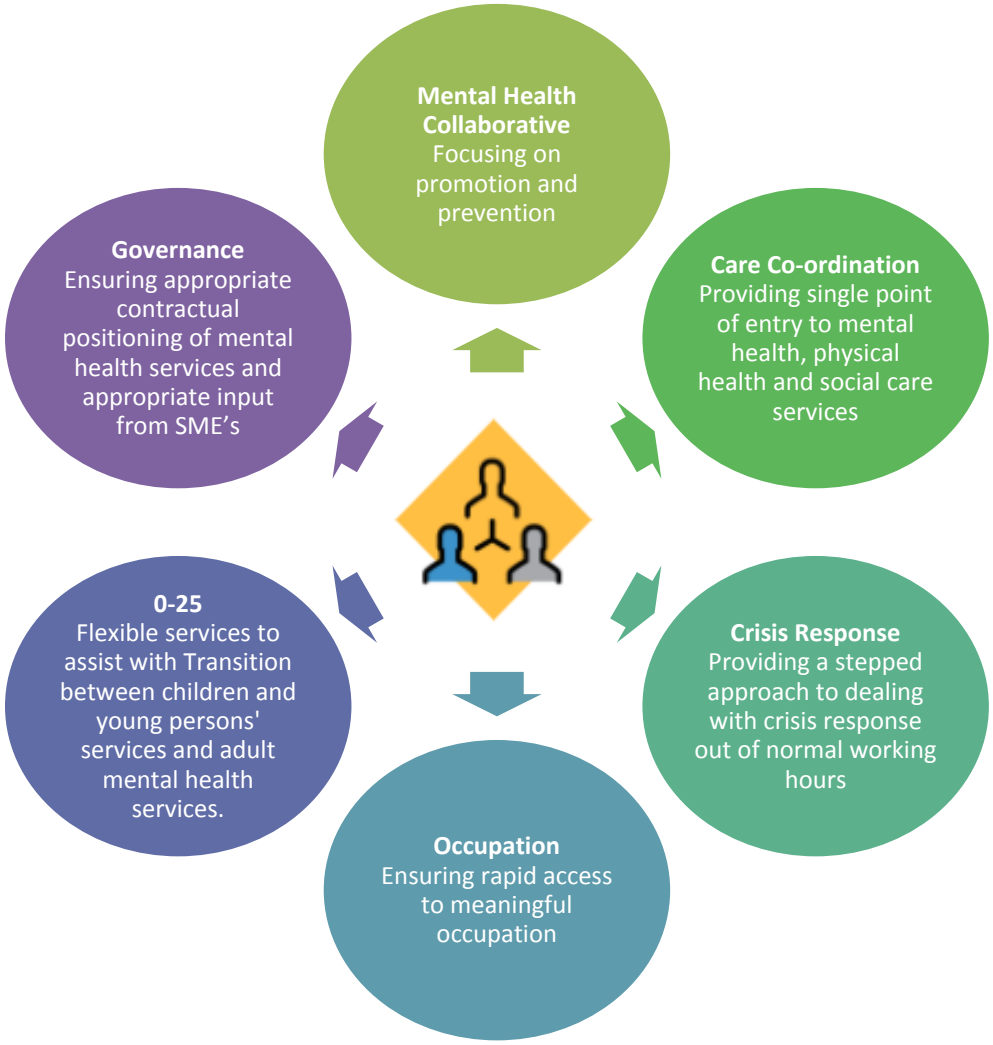
The review was informed by hundreds of face-to-face conversations with local people and professionals and over 20 engagement events were held to hear about their experiences and ideas. Proactive outreach (including 1:1 and group discussions) was delivered to engage seldom heard groups, including young people, carers and people who are homeless.

During our first phase of engagement (May-August 2017), we asked people who use services, those who care for them, those who deliver services, and the wider public: what is working well in community mental health services? What could be improved? What are the gaps and overlaps in current services? We met with 120 people who use services and those who care for them via a range of organisations, including voluntary sector organisations and carers groups.

In February 2018, we formed six workstreams to look at everything people had told us and to develop detailed options for how community mental health services could be delivered in the future. Each workstream had membership from people across the Council, CCG, key providers, voluntary sector representatives and Community Champions (who represent the public, those who use services and carers). Eight Community Champions (one of whom is a young person) have been involved and helped us to co-produce the service model(s) as the review has progressed. In

September 2018 these workstreams were combined into one group to ensure the interdependencies and overlaps in each area were fully considered.

Fig 2: Mental Health Review Workstreams



In June 2018, we organised a series of workshops and drop-in event, inviting people who use services, those who care for them, those who deliver services, and the wider public, to come together to do some detailed planning on how we can improve how community mental health services are delivered.

Approximately 20 people who use services and those who care for them attended (including four young people). 70+ providers/professionals also attended, many of whom had personal, as well as professional, experiences to share.

From September-November 2018, we delivered further targeted face-to-face engagement with specific groups and communities, to ensure that a diverse range of views inform the changes we are planning make to services. We met with 167 people during this time, including students, young carers, Black and Minority Ethnic (BME) Groups, the LGBTQ+ community, people who are homeless and people living in

deprivation. We also held one phone interview and received written feedback from five young people.

In total, so far, we have engaged with almost 450 members of the public, people who use services and those who care for and support them, and 200+ professionals.

Fig 3: Summary of Engagement

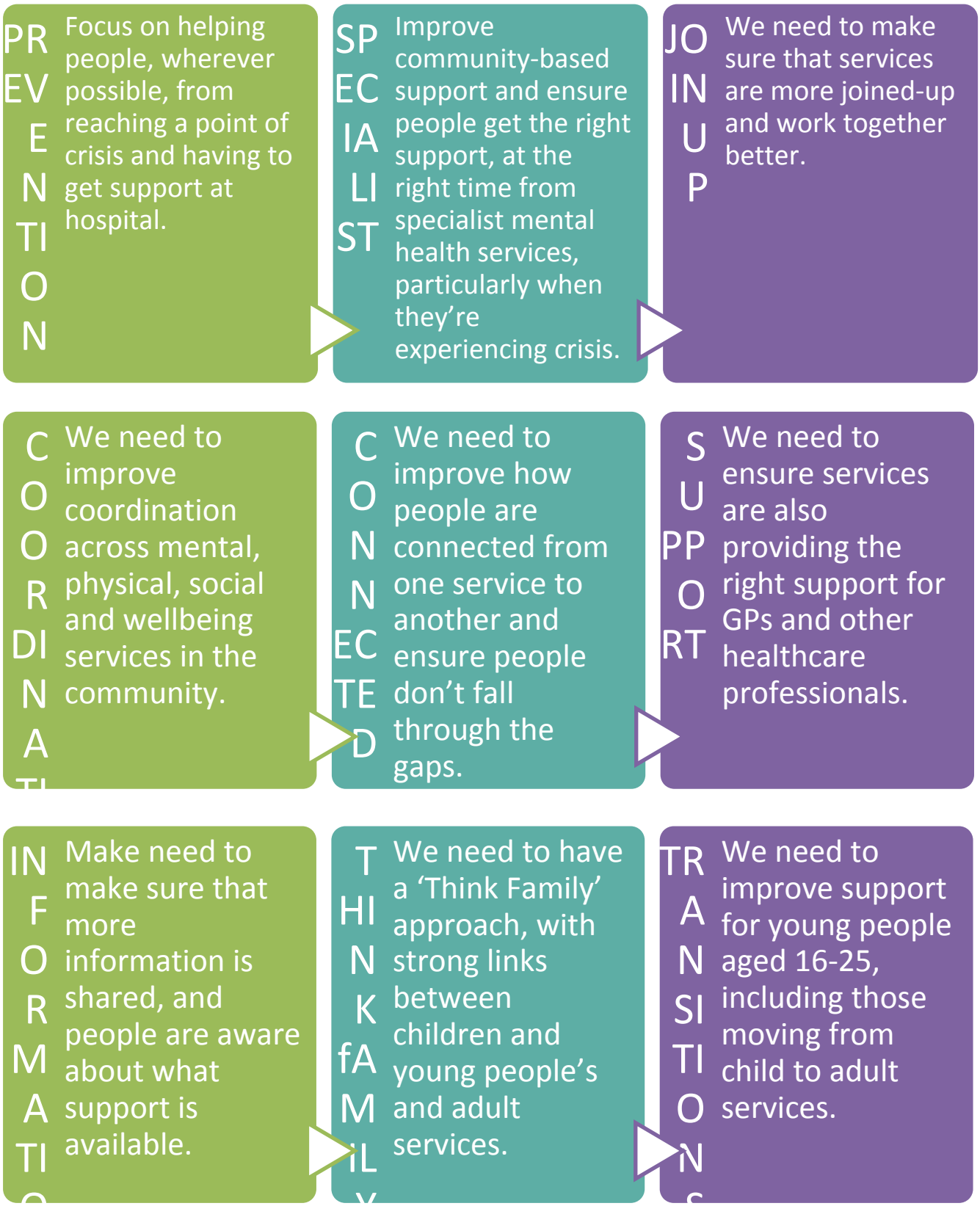
Formal public consultation was carried out in February 2019, which focused on the new model of provision for community mental health services and the key initiatives that would support delivery of the priorities identified as part of the review. People across B&NES were asked to share their views via a survey (available both online and in paper form), which was shared on social media and via services and a range of community and third sector organisations. The proposals were also shared and discussed with the CCG's patient engagement group Your Health Your Voice on 7 February.

Full details regarding the formal consultation approach and its findings can be found in Appendix 1 of this report.

2.2 Identifying our Community Priorities

This Full Business Case, is the culmination of almost two years of discussion and debate with a wide range of local people and professionals to understand their priorities for community mental health services. These priorities subsequently became the guiding principles for the construction of the new model of provision and key deliverables set out in Section 3 of this report.

Fig 4: Key priorities



3. Feeling the Difference

3.1 Drivers for change

Community based mental health and social care services are those that take place in people's homes and local care settings, a summary of the types of services that support people with mental health needs is found in Appendix 2. There is a local, national and international focus on prevention, early intervention, self-management, pro-active care, recovery, the adoption of strengths based approach and the integration of health, physical and social care in mental health.

In the future, community services will need to adapt in order to thrive in the face of the significant challenges ahead. Health and social care services across the country are facing a period of unprecedented challenge. The demand for health and social care services is rising relentlessly as people are living longer with multiple complex conditions and we must be able to continue to improve the quality of care and support balanced against financial constraints. Community based services will need to become a driving force for the important shift in emphasis towards improved health and wellbeing and the delivery of new models of care and support at or close to home.

In addition, following the appointment of Virgin Care as Prime Provider and the development of integrated pathways of care, the organisations that provide mental health services will need to adapt to work together better within one single clear pathway, become more responsive to the needs of people, and link effectively with other related services, particularly the Wellness Services, in taking a holistic, preventative approach to supporting people's wellbeing.

3.1.1 Policy Drivers

Health and social care organisations across B&NES, Swindon and Wiltshire have begun working together in a new way to meet the many challenges facing the health and care system and improve the quality of services.

As part of our Sustainability and Transformation Partnership (STP) we are developing new ways of working and a structure of governance. An STP Mental Health Transformation Programme Board has been established, which is tasked with the co-creation, with partners, of a B&NES, Swindon and Wiltshire (BSW) Mental Health strategy and vision which will improve the mental health and wellbeing of people of all ages, with a focus on those with the greatest needs. Its scope extends from plans to improve the whole population's mental wellbeing, to early interventions and specialist treatments for people experiencing mental health crisis.

All STP partners recognise that significant engagement, collaboration and planning work has already taken place across B&NES and the Mental Health Transformation Programme Board will look to build on the work that has already taken place, rather than start again from the beginning. Early indications are that there is a preference to adopt the Thrive model, which is central to the B&NES approach, across all of BSW.

There are also discussions underway between the Executive Committees of the three CCGs in recognition of the changing NHS context, which includes the move to planning, commissioning and delivering services at a strategic (i.e. STP wide), place-

based (i.e. Council footprint) and neighbourhood (i.e. Primary Care Network) level. These discussions are at an early stage and it is acknowledged that any changes to mental health commissioning arrangements will need to balance the opportunities to deliver economies of scale and the benefits of improved consistency and quality of outcomes with the requirement to maintain appropriate local clinical decision making.

Mental health remains a key priority for the STP both in its own right and as a theme that runs through other programmes of work including areas such as prevention and self-care, planned and urgent and emergency care.

Refreshed Planning Guidance Refreshing NHS Plans for 2018/19 includes the requirement on CCGs to actively encourage every practice to be part of a local primary care network, so that there is complete geographically contiguous population coverage of Primary Care Networks as far as possible by the end of 2018/19. This will entails clusters of GP practices organising primary and community services around patient populations serving populations of at least 30,000 to 50,000. Any proposed new model of provision must be aligned to these emerging networks.

The Five Year Forward View for Mental Health (2016) is also a key driver and describes the following priorities as areas for action:

a) A 7 day NHS-right care, right time, right quality
b) An integrated mental health and physical health approach
c) Promoting good mental health and preventing poor mental health – helping people lead better lives as equal citizens

The NHS Long Term Plan (2019) sets out requirements to improve responsiveness of community health crisis response services. People identified as having the greatest risks and need will be offered targeted support for both their physical and mental health needs. The plan also set out ambitions to embed a single multidisciplinary Clinical Assessment Service (CAS) across the different organisations that provide services. The NHS Long Term Plan also commits to a major expansion in the community mental health workforce and integration between physical and mental health. Building on the co-location of IAPT workers in primary care, a significant proportion of community mental health staff will become aligned with Primary Care Networks. This will particularly help older people with mental health problems, dementia and co-morbid frailty, as well as the primary care workforce.

Other key policies that have been considered in defining the new model of mental health provision include;

- The Care Act 2014
- B&NES Council Joint Strategic Needs Assessment
- Adult Mental Health and Social Care Commissioning Strategy 2015-2020

3.1.2 Local Drivers

The health and social care system in B&NES is facing a challenging time. The

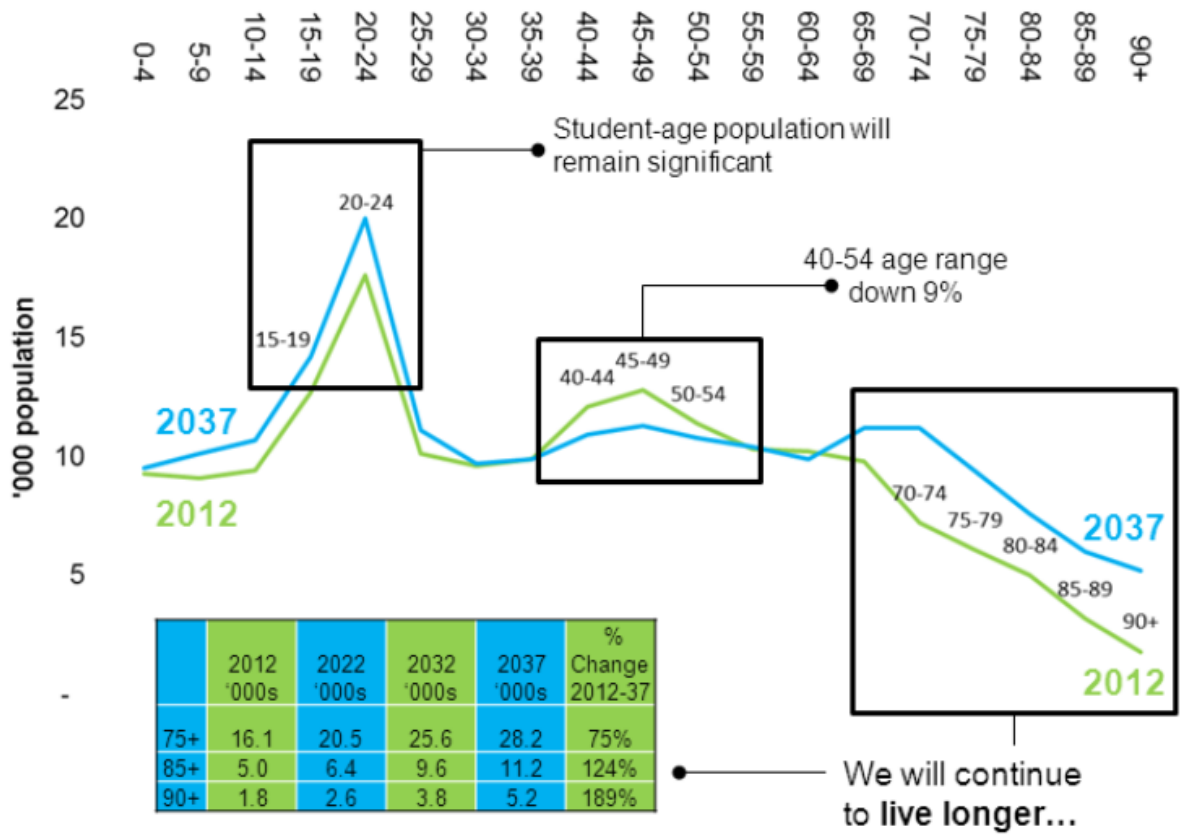
population is ageing, the prevalence of long term conditions is increasing and the demand for health and social care services is growing. At the same time the aspirations and needs of the community are also changing as people expect more personalised services and more choice and control over how their individual needs are met.

The current financial climate also places a greater imperative on the CCG and the Council to develop models of care within available resources that are both robust and sufficiently flexible to be responsive to changing needs, aspirations and technological advances over the next decade and beyond.

The needs of our population

As defined in Figure 5 below the Joint Strategic Needs Assessment (JSNA) indicates that there will be a 12% rise in the population to 199,100 by 2037 with the number of over 75 year olds set to increase by 75%.

Fig 5: B&NES Population Projections



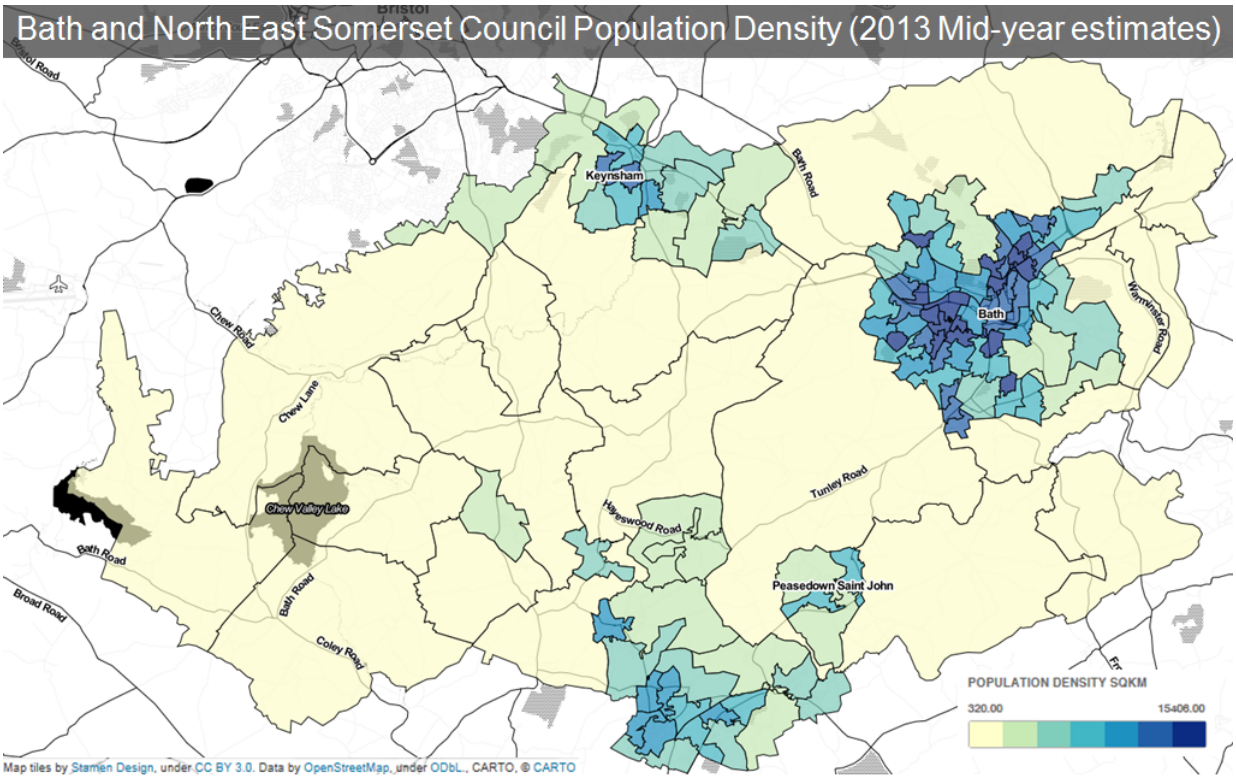
	2012 '000s	2022 '000s	2032 '000s	2037 '000s	% Change 2012-37
75+	16.1	20.5	25.6	28.2	75%
85+	5.0	6.4	9.6	11.2	124%
90+	1.8	2.6	3.8	5.2	189%

The dependency ratio of those aged 0 to 15 and 65+ when compared agsinst the working age populations is also set to increase, from a current ratio of 1:2 to 1:1 by 2037 as shown in Figure 6 below.

Fig 6: Dependency Ratio

B&NES also has a significantly higher proportion of residents (10%) aged 20-24 than nationally (7%), this can be attributed to the high student population. There are also substantial variations in population density within the B&NES area. Figure 7 demonstrates the distribution across the area.

Figure 7: Population Density



Rural communities have experienced significant social change over the last couple of decades and 14% of the local population live in dispersed rural areas or villages, this compares to 10% for England as a whole and 20% for the South West. Very often villages do not offer adequate services for the local community to access, which forces people to travel out of their community to access services such as doctor's surgeries, schools, shops and post offices. Analysis of some of the lowest-income households in B&NES suggests that between 8% (Chew Valley South) and 18% (Bathavon West) of residents in wards outside the city of Bath and the market towns are in receipt of income-related support or tax credits.

For children and young people evidence suggests that 12% of children in B&NES live in poverty, with 34% in Twerton, 25% in Southdown and 21% in Radstock.

The prevalence of mental illness in B&NES is generally below or similar to the national average, with the exception of depression, where prevalence is higher. Protecting Adult Needs and Services Information system (PANSI) estimates 18,570 people in B&NES aged 16-64 have a common mental illness 2010/11 (16% of working age population).

3.2 New service model

There are many strengths, and excellent work, in existing community mental health services locally, including examples of innovation and partnership working. This

includes an established model in B&NES of integrated mental health teams, where local authority employed social workers and social care staff work alongside their health counterparts. Consistent feedback from service users, carers and supporters highlights the value of this way of working in delivering high quality outcomes across the health and social care system.

There are a range of services in place ranging from what can be described as wellness services, to more specialist community mental health services. Virgin Care, as Prime Provider now has responsibility for directly delivering some, and for managing all sub-contracts other than those commissioned from AWP.

However, as the existing provision is largely carried over from pre April 2017, the services are commissioned (or sub-contracted) separately, on the basis that the individual specifications detail what each service will achieve (mainly) in isolation. The main driving force for each service will therefore be in meeting its own targets and performance indicators, as it is this which determines the continuation of funding, and is the format in which monitoring takes place. Commissioners and Virgin Care may have a sense of the 'whole picture' but the specifications are not 'Pathway' based, taking into account a person's journey and holistic needs. A key output of this review will be to better coordinate pathways between services and providers.

We are proposing a new approach for how we deliver community mental health services in B&NES, to make sure that people get the right support, in the right place, at the right time.

Our current approach for providing mental health services focuses on experts organised around specific community service functions who work with people at different stages of their need. People have told us that it can be difficult to access the advice, support or care that best meets their needs quickly and easily. At the same time, it is not always easy for providers of services to know which other partner organisations might be most appropriate to offer additional support to an individual, their carer(s) or families. This means that people may not get signposted to other services e.g. employment and education advice or may be treated longer in an inpatient setting when there are actually services in the community that could support them.

Fig 8: Current Service Provision

TIER 1 Self-directed help and health and wellbeing services	TIER 2 Primary Care Talking Therapies	TIER 3 Specialist community mental health services	TIER 4 Highly specialist condition-specific mental health services	TIER 5 High intensity mental health services
Support usually involves responding to stress and mild emotional difficulties and may be resolved through making lifestyle adjustments and adopting new problem solving and coping strategies.	Support usually involves responding to mental health and emotional difficulties such as anxiety and depression. Support may involve talking therapies and lifestyle advice. This approach may also support people who have a range of long-term health conditions.	Responding to mental health problems that are adversely affecting the quality of personal, daily and/or family, occupational life. Recovery focused treatment may include psychological and / or drug therapies.	Providing care in response to complex/ specific mental health needs. Includes specialist programmes of recovery focused support.	Supporting those in full mental health crisis. Involves intensive recovery and focused support and treatment at home or in a hospital.

Traditionally people experiencing difficulties that could be related to their mental health have their first contact with tier 1 services, for example by their GP or the Primary Care Liaison Team. They may then be referred onto more specialist community services (tier 2 and 3) whilst step 4 and 5 services provide highly specialised, intensive care. It should be noted that support from social care services often provide valuable input alongside health services.

3.2.1 The Thrive Model

We have identified the Thrive approach as the preferred model of mental health provision in B&NES. This approach has recently been adopted to support children and young people locally and builds on a needs based, whole system approach to supporting people's mental health. The Thrive approach replaces the current 'tier' pathway or model of care with 'clusters' or 'groups.' These groups are:

- STAYING WELL – Signposting people to services and equipping them with the skills to self-manage or control mental ill health.
- GETTING HELP – Supporting people to create a goals-based treatment plan, specialist counselling or medical advice, helping them build resilience through support networks.
- CRISIS – Rapid and intensive evidence-based intervention, extensive treatment, risk management and crisis response.

Thrive recognises that people may access services across all of these groups or just one and will need to be supported appropriately whatever their level of need.

Fig 9: Thrive Model

Thrive supports the provision of mental health services using a whole-system, population-based approach which focuses on promoting mental health across the whole community, including groups who may be at risk of, or have, mental illness.

A population-based approach looks at the mental health and mental illness needs of different groups of people rather than just the needs of individuals. It enables integration across health, education, social care and voluntary sector, with a central focus on delivering improved outcomes for people.

3.2.2 Implementing the Thrive model

Implementation of the Thrive model will require strong provider collaboration across both system leaders; Virgin Care and AWP (including the Council in its role as provider of social care, embedded within AWP), as well as third sector organisations.

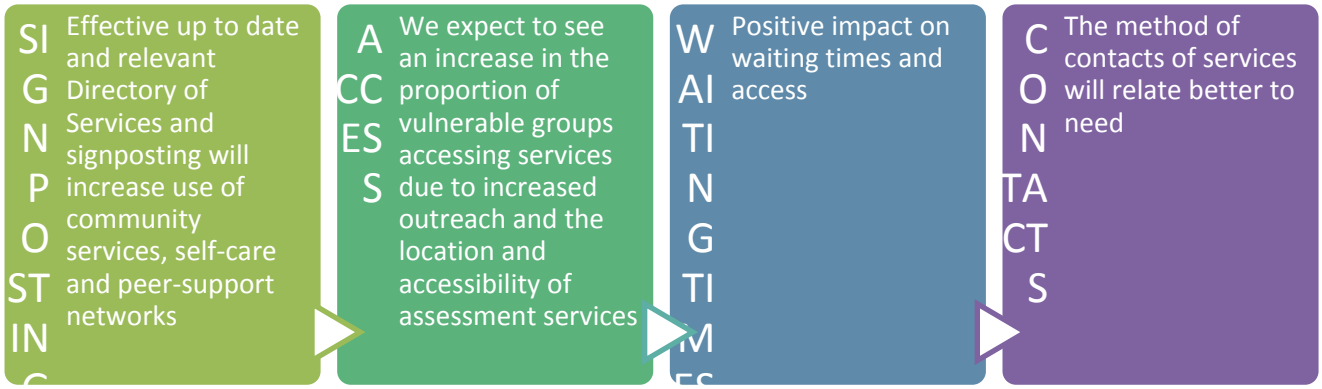
Implementation will take place between April 2019 and March 2020 and includes the following key deliverables:

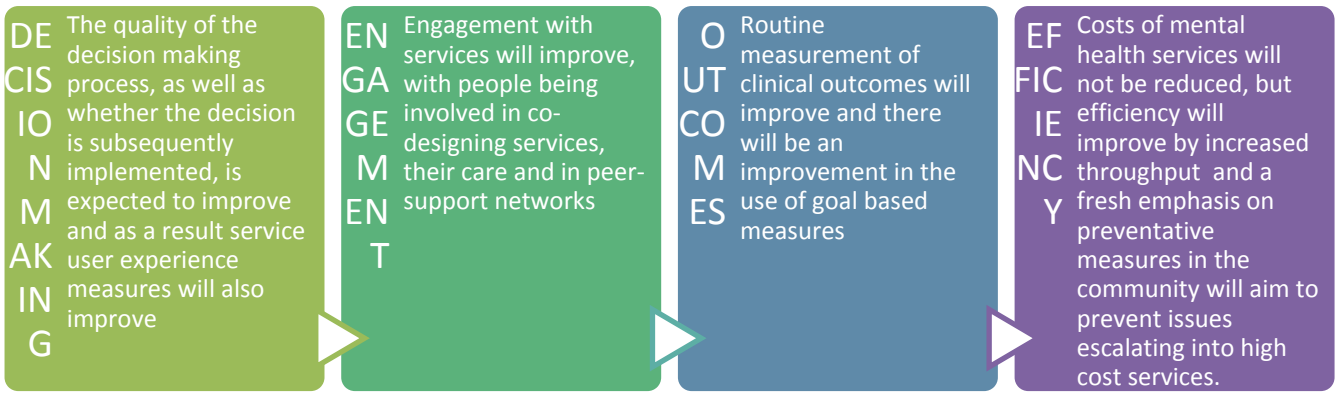
Fig 10: Thrive Deliverables

3.2.3 Benefits of the Thrive Model

The Thrive model was developed by a collaboration of authors from the Anna Freud National Centre for Children and Families and the Tavistock and Portman NHS Foundation Trust. There are nine Thrive accelerator sites across England who have been working to implement Thrive as part of their mental health transformation plans since October 2015. This work is funded through the NHS Innovation Accelerator programme. Alongside these accelerator sites there is a Community of Practice which includes over 70 organisations that have implemented (or are currently implementing) the Thrive framework. Learnings from these sites is shared widely and key benefits that are expected to be realised through its implementation in B&NES include;

Fig 11: Thrive Deliverables





3.3 Addressing the Communities Priorities

Appendix 3 of this report contains full details of the feedback we have received and what we are doing in response to what our engagement has told us, key themes are set out below;

- We have developed a Collaborative Framework that sets out how we expect all the organisations that provide mental health services in B&NES to work together and with individuals so people receive holistic care and support. It will require providers of adult and children and young people's services to work collaboratively in the interests of children and young people at all times, in addition to ensuring safe and effective transitions between services. A copy can be found in Appendix 4.
- Virgin Care is developing an overarching community navigation service to ensure consistent, up-to-date information and advice is readily available in a range of community settings.
- Across BaNES an Integrated Care record is being developed. This project is being led by Virgin Care. This will mean information relating to the direct care of an individual will be shared across some providers that were previously not able to access information about an individual. This will facilitate a reduction in needing to tell their story multiple times.
- Providers of mental health services will need to consider the needs of family members who are supporting an individual with mental health issues. All commissioned service contracts will feature a requirement to embrace a 'Think Family' approach.
- A new Mental Health and Wellbeing Charter has been developed to complement the Carers Charter, and which set out how people can expect to be treated and respected by community mental health teams, and by community organisations. This Charter will be adopted by all organisations that provide mental health services and activities in B&NES.
- Bath Mind and Virgin Care are working in collaboration to develop a proposal for an evening safe space, which is open every evening throughout the year, even on bank holidays, to provide a safe space for people at the point of crisis and will support them through this crisis to prevent their issues escalating. The provision of a forward plan will be a key element of this.
- To complement the work of Breathing Space, and to help prevent people entering crisis, Virgin Care are working with Curo determine the viability of extending the availability of the Wellbeing House to 7 days a week, and to increase the skill level of the staff so they are better able to manage people with higher level needs. This is in direct response to feedback from service users, services, Commissioners and AWP.
- The CCG, the Council and AWP are working together to improve the physical health of people with mental illness. There are schemes under way to improve the physical health checks undertaken both on AWP wards and in primary care. Further work to build on these initial developments will be progressed via the Collaborative Framework.
- AWP has worked with Oxford Healthcare to ensure closer collaboration and earlier involvement during the transition from childrens' and adolescent mental health (CAMHS) to adult services, developing shared protocols and establishing a transitions panel. This has also enabled the development of common transition standards to be adopted across all mental health providers working with young people aged 16-25.
- Commissioners are building on existing collaboration with schools and universities to ensure that services are better planned and joined up, to provide improved services to young people.

- The NHS Long Term Plan makes a renewed commitment that 'mental health services will grow faster than the overall NHS budget.' This will enable further service expansion (including enhanced counselling services) and faster access to community and crisis mental health services for both adults and particularly children and young people. These plans will be formalised as part of BaNES, Swindon and Wiltshire CCGs working closer together as a sustainability and transformation partnership.

4. Making it happen

4.1 Scope

The health and care system in B&NES is complex with a wide range of mental health services commissioned by the CCG and the Council to provide care and support for local people. Appendix 3 provides a summary of the type of dedicated services that are in place to support people with mental health needs in B&NES. Alongside these commissioned services it is recognised that there are a wide range of non-commissioned services provided through third sector networks that support people with mental health needs.

The Community Mental Health services provided by AWP were noted in the Your Care, Your Way Full Business Case as requiring further consideration in terms of their contract arrangements. The review has therefore given specific consideration to the following services;

a) **Early Intervention Team**; This service provides a multidisciplinary approach to help people in psychosis and provides support to them and their families as early as possible, giving them the best chance of preventing long term problems.

b) **Primary Care Mental Health Liaison Service (PCLS);** This service is the main integrated referral point into adult secondary mental health services and the team provides mental health support, brief interventions, advice and signposting for; service users and potential users of mental health services, their carers and relatives, GPs, Health and Social Care and third sector.

c) **Primary Care Talking Therapies;** This service offers support to people with common emotional, communication and mental health difficulties such as anxiety, depression and stress. Services range from self-help therapies, to psychoeducational courses and one-to-one support.

d) **Intensive Team;** This services provides assessment and home treatment for people aged over 16 years experiencing a mental health crisis, as an alternative to hospital admission. The team operates 24 hours a day 7 days a week.

e) Recovery Team; This is the main service to provide ongoing care, treatment and support for service users, their families, friends and supporters. The service will provide specific periods of interventions to service users requiring short or long term support to assist their recovery.

f) **Complex Intervention and Treatment Team (CITT);** This service is built around specialist teams that help meet the changing psychosocial and

environmental needs of an ageing population and to promote successful ageing.

Key Interdependencies

In determining the optimal contractual model for provision, there were a number of key interdependencies considered;

As the “front door” to secondary care mental health services, AWP B&NES Primary Care Liaison Service (PCLS) provides triage, assessment and early treatment that is close to home in partnership with Primary Care, the third sector and secondary mental health services.

Both IAPT and PCLS teams are responsive and work with individuals in primary care settings to support early treatment, close to home. With an in depth knowledge of secondary care mental health services, the teams also ensure that appropriate referrals are made to the right secondary team if required and according to individual service needs.

All brief interventions are delivered within the framework set by the Care Programme Approach and Risk Policy. All AWP secondary care teams accept PCLS assessments as “trusted assessments” avoiding duplication and repetition. There are clear pathways from PCLS to Intensive, Recovery, Complex Intervention and Treatment Team (CITT) and any other receiving team.

The BANES Talking Therapies Service (IAPT) delivers evidence-based Step 2, Step 3 and Long-Term Health Condition (LTHC) interventions within the definitions and to the standards set by the NHS national IAPT programme and NICE guidelines. The IAPT service offers a variety of routes into treatment, including self-referral. Practitioners work with individuals and groups and are co-located across a range of primary and community settings, having developed close working relationships with a range of partners including GPs, universities, the Pain Clinic at St Martins Hospital, the diabetes team at the RUH. The service works closely with a variety of local providers from the third sector, as well as other health and social care providers. Where possible they engage proactively with other health and social care teams to ensure proactive management of mental ill health within primary care.

Another key interdependency in secondary mental health provision across B&NES is that teams are made up of health staff employed by AWP and social care staff employed by the Council. These staff work in integrated teams and are able to provide an holistic Health and Social Care assessment for individuals experiencing severe and enduring mental health difficulties. All these teams have robust care pathways and networks with multi-disciplinary and multi-professional staffing. This enables good communication between teams and experts, enabling service users to reach the right team and support for their needs, first time.

Other key interdependencies are with: GPs, Primary Care practice staff, third sector information, advice, support and advocacy providers, housing services and employment services.

Contracting Options

The contracting options considered included;

1) Remain 'as is'

2) Subcontract AWP services to Virgin Care

3) Mixed subcontracting of AWP services and direct delivery by Virgin Care

4) Direct delivery by Virgin Care

These contractual models of provision were assessed as part of the review against a number of criteria, including;

Benefit to people who use the service and wider communities	Promoting the integration and joint delivery of health and care services	Alignment of services to the core functions and duties of Virgin Care as Prime Provider
Ability for the Prime Provider to deliver service transformation at population level	Interdependencies with other health and care services and pathways	Viability of existing providers of mental health services

As part of their assessment Commissioners have considered the optimal positioning of these services in-line with the criteria above and made an initial determination that AWP was the appropriate provider, all derive benefits due to their position within the wider Trust, including;

- access to professional guidance, clinical leadership and advice and support across the full range of mental health specialist services, both formally, via Trust-wide peer networks, learning and development support, quality support and other fora and informally.
- well embedded and robust clinical pathways into other secondary mental health teams.

- access to high quality statutory and mandatory training and supervision frameworks specifically tailored to the provision of specialist mental health and care services.
- access to specialist secondary care mental health and social care safeguarding support.
- access to Trustwide recruitment initiatives and AWP staff bank service
- close relationships with health and social care staff working across all sectors in B&NES.

Subsequent to this initial determination, assurance was sought from AWP on their capability to provide the services under a new model of provision, and this was evaluated by a group of CCG and Council subject matter experts.

It is acknowledged that whilst there are alternative providers of the services within the scope of the mental health review, it is critical to view the services provided by AWP as an holistic group of integrated services closely aligned to inpatient provision.

The outcome of this assessment is that these specialist mental health services will continue to be directly delivered by AWP and will be further developed through contract variation mechanisms within the joint (multi-lateral) contract led by Bristol, North Somerset and South Gloucestershire CCG in 2019/20.

During 2019/2020 it is also anticipated that BSW and BNSSG STPs will look to develop separate, STP-wide commissioning and contracting arrangements with AWP, taking into account the national direction of travel towards the planning and commissioning of services at scale, at place and at neighbourhood level.

AWP and Virgin Care have signalled their commitment to working collaboratively with local partners through the STP and wider networks across the south west. Commissioners also fully acknowledge the critical role that Virgin Care has as Prime Provider in both the design and transformation of our community services and we expect that as key system leaders both Virgin Care and AWP are able to collectively influence the future model of community mental health provision not only across those services they directly provide or commissioning but also by development of a strong strategic relationships across the system.

4.2 Collaboration

There is a long and established history of strong and effective partnership working in B&NES with third sector providers across the area. Both AWP and Virgin Care hold a number of service level agreements and sub-contracting arrangements that ensure joint working with third sector organisations.

Providers in B&NES also have strong links with children's services provided by Oxford Health NHS Foundation Trust, the Royal United Hospitals Bath NHS Foundation Trust, the Police and local Safeguarding collaborations. These established relationships mean that system leaders are well-positioned to take forward the ambitions set out in the NHS Long Term Plan, the emerging STP Mental Health Strategy and the deliverable identified from this review.

The Mental Health Review has however provided an opportunity to strengthen these collaborative relationships and formalise them through a Collaborative Framework as described in Appendix 4.

Collaborative Framework

All providers involved in the mental health review support the development of a collaborative framework. The framework sets out the spirit of collaboration as well as the actions that will need to be taken to achieve a unique and high quality pathway for individuals with mental health needs. This framework will be embedded into all mental health service contracts in 19/20 and its effectiveness will be measured against a new outcomes based commissioning approach. We expect this framework will;

- Place the person at the centre of a range of timely support which meets their individual and varying needs
- Incentivise people and services to work together to build a unique package of support which promotes recovery and maintains wellbeing.
- Reduce 'pillar to post' signposting ; individuals are able to recognise the whole picture and how it reflects their lives
- Recognise that people have mental and physical health needs which affect their present and future wellbeing
- Recognises and takes into account the impact on families and carers, responds to the family's needs where appropriate, and ensures involvement throughout a person's recovery
- Acknowledge that a person's recovery path takes place across a range of services and interventions, and continues into the community, and that all services and interventions have an equally important role to play in supporting recovery and maintaining wellbeing
- Avoid people feeling they are 'falling off a cliff'(as described by service users) once they have been discharged from a service, and longer term progression is planned and managed more effectively
- Incentivise providers to work together on a holistic basis to prevent/reduce 'revolving door' scenarios, potential crisis interventions and expensive and distressing hospital re-admissions which may be not be local, and the resulting problems this causes families and carers
- Provide a shared and consistent approach within a quality framework and ensures continuity of support whereby a person only has to tell their story once
- Ensure timely and appropriate interventions are available when an individual requires them

The B&NES Mental Health Partnership Board will oversee progress of initiatives led by the Collaborative Framework and will monitor benefits that are being achieved. This group will also ensure joint working to progress delivery and manage any risks, challenges or barriers to delivery.

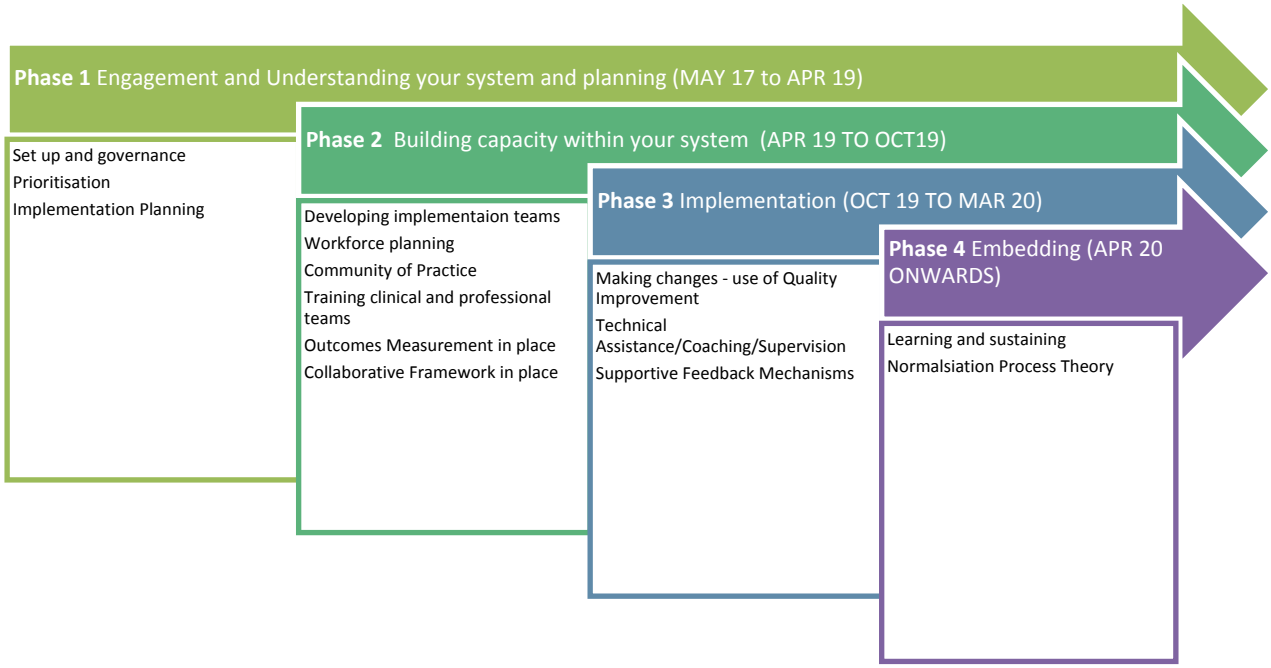
4.3 Implementation

The Thrive Model Framework provides an evidence based approach to implementation. Mobilisation tools have been developed by the Thrive programme and are focused around two key areas; the structure of implementation (a guiding framework) and the scope of implementation (the people and organisations involved).

4.3.1 The Structure of Mobilisation

The approach that Thrive takes to implementation is set out across four phases, shown below, which are considered crucial for successful implementation.

Fig 12: Implementation Structure



4.3.2 The Scope of Mobilisation

Thrive also recognises that delivering improved outcomes requires consideration of the role of implementation across the whole system of mental health services.

Moving towards the Thrive model requires engagement in change across the whole system. This includes traditional mental health services, Social Care, Council, education, key third sector services and other independent organisations that may contribute to supporting a person's mental health and well-being.

In addition to looking across the system, it is equally important to think about the different agencies, services and organisations within the system at the three different levels; the 'Macro', 'Meso' and 'Micro' levels. This is further explained in the diagram below;

Fig 13: Scope of Mobilisation

The speed at which the Thrive model is developed in B&NES must be balanced against our assurance that the new commissioning arrangements are appropriate and robust. Ultimately the Council and CCG remain accountable for meeting the relevant statutory responsibilities and achievement of the high level outcomes and priorities for our population.

The Council and CCG will oversee all mobilisation objectives and provide regular progress updates to all stakeholders including service users, providers and the wider public. A Commissioning Implementation Group will be established and will provide assurance to the Joint Commissioning Committee and Mental Health Partnership Board with regards to mobilisation progress.

4.3 Measuring success

The CCG and the Council are planning to use an Outcome-Based Accountability (OBA) approach to plan and measure the performance of community mental health services. This approach is a disciplined and practical framework for improving

outcomes for whole populations, and also for measuring the performance of services which focus on outcomes that the services are intended to achieve.

The system incentivises interventions that add most value for individuals, shifting resources to community services, a focus on keeping people healthy and in their own homes, and co-ordinated care and support across settings and regions. It also encourages a focus on the experience of people using the services, and achieving the outcomes that matter to them through more integrated and person-centred services.

The advantage of this approach is that it uses a clear and common language, which will help us work together as commissioners and providers on improving outcomes. They key definitions for this performance framework are:

- **Population outcome:** A condition of wellbeing we want for people with mental health needs, their families, communities and population.

- **Population output:** A measure that quantifies the result of the activity to support achievement of the outcome.

Moving to an OBA approach will necessitate changes to the commissioning arrangements of the Council and CCG to ensure that there are appropriate contract monitoring and performance management structures in place, both for those services to be delivered directly by Virgin Care and those that are to be delivered through sub-contracting arrangements with other providers.

The outcomes framework will further be developed through the implementation period with input from providers, service users and carers and will be built on the following key principles;

- Individuals with mental health needs are better able to manage their lives, are more resilient, and more engaged with their communities

- Individuals with mental health needs are engaged in meaningful activities

- Individuals with mental health needs feel safe and secure at home and in their community

- More people are aware of, and receive, their right and entitlements as individuals detailed under the Carer's and Mental Health & Wellbeing Charters

Quality Framework

Quality is the guiding principle for all of our work and is at the heart of any change within community services. Quality comes in many guises but for this programme it essentially means ensuring that the pace of change and the development of pathways are seamless and are demonstrated by the delivery of local, safe, effective and responsive services which provide real benefits to people in terms of their care.

As financial resources are constrained, we need to improve quality and outcomes through innovation in service design, efficiency, and a continued focus on prevention of ill-health alongside treatment and care. Our challenge is to deliver the highest quality care utilising resources in the most efficient way.

High quality care and support should be as safe and effective as possible with people being treated with compassion, dignity and respect. As well as clinical quality and safety, quality means care that is personal to each individual. This nationally recognised definition was first set out in 'High Quality Care for All' in 2008, following the NHS Next Stage Review led by Lord Darzi and is now the recognised definition of quality in the NHS. Within the CCG and the Council this is defined as:

- Safety: commissioning high quality care which is safe, prevents all avoidable harm and risks to the individual's safety; and having systems in place to protect people;
- Clinical Effectiveness: commissioning high quality care and support which is delivered according to the best evidence as to what is effective in improving an individual's health and care outcomes. Making sure care and treatments achieve their intended outcome;
- Experience: commissioning high quality care and support which aims to give the individual as positive an experience of receiving and recovering from the care as possible; including being treated according to what the individual wants or needs, with compassion, dignity and respect.

We also incorporate the Care Quality Commission's (CQC) approach which goes further to build on the three elements of Quality by adding two additional dimensions:

- Organisational Culture & Leadership: commissioning high quality care which is well-led;
- Responsiveness: commissioning high quality care which is responsive to the needs of patients.

We have set out objectives, responsibilities and governance arrangements for the monitoring and assurance of quality in the services we commission and what action we will take if there are concerns. This includes providing support, leadership and implementing quality improvement projects. Indeed, the measures of quality are not static. We know we need to raise the bar year on year to improve health outcomes, safety and the patient experience and to focus on areas where there is scope for improved reporting and monitoring i.e. social care outcomes in integrated specialist mental health teams

Impact Assessment

Care Quality Commission guidelines recommend that the CCG and the Council should carry out equality impact assessments as part of best practice in health and care provision. In addition there are legal requirements which place a duty on public services to promote equality in its policy making, service delivery, enforcement and employment. This includes three interdependent areas of responsibility:

- To eliminate discrimination
- To promote equality of opportunity

- To promote good community relations

The Equality Impact Assessment covers the following areas:

- Age
- Disability
- Gender reassignment
- Sex
- Marriage and civil partnership
- Pregnancy and maternity
- Race including nationality and ethnicity
- Religion or belief
- Sexual Orientation

As part of the development of this Full Business Case, we have conducted a stage 1 Impact Assessment informed by our extensive stakeholder engagement. A copy of the assessment can be found in Appendix 5. The CCG and the Council have concluded that the proposed transition will not negatively impact any of the protected Equality groups. The aim is to have a positive impact upon the provision of mental health services which will also benefit carers and families.

Following the appraisal of the Full Business Case and its approval, we will complete a Stage 2 Full Impact Assessment that will assess in detail the expected impact upon equality groups, the key risks to groups in the event of non-partial or delayed delivery and an action plan to address any newly identified challenges.

4.4 Managing risk

There are a number of key risks to the implementation of the new model of care in the proposed timescales, which are identified alongside the risk mitigation in Table 3 below.

Ref	Risk	Mitigation
1	**Funding** There is a risk that as a result of implementing the new model of provision there are that enhanced service provision cannot be funded within existing financial envelop.	Assurance of our providers ability to operate within the agreed financial envelopes and commissioner adequately specifying services and activity levels. Application again appropriate Mental Health Investment Standards and relevant Community Grants for key priority areas. The prompt identification of pressures through contractual mechanisms will need to be supported by Providers. Alignment across local B&NES as well as the BSW system to develop pathways

		and initiatives that will enable demand growth to be managed in the most appropriate fashion.
2	**Model Implementation and Continuity** There is a risk that it is not possible to mobilise the new model of provision within the proposed timescales.	Develop detailed implementation plan outlining key milestones and using a detailed risk and mitigation log. Establish the Commissioner led Implementation Group to govern the implementation process.
3	**Requirement for financial balance in year impacts upon delivery** Delays in implementation or benefits realisation will result in unplanned costs which will need to be met through reduction in planned investment. This could cause further delay in benefits realisation over the period.	Establish process through Implementation Group to progress transition in prioritised order and establish robust monitoring arrangements and where necessary considering the short term scope of services and performance measures to enable long term transformation to be achieved.
4	**Benefits Realisation** The new model does not deliver the expected impact on people's care experience and people's mental health.	Timely and ongoing evaluation of service delivery so that services can be adjusted if necessary.
5	**Stakeholder buy-in** Involvement is lacking during the mobilisation phase, causing delays to implementation and as a result the proposed benefits cannot be realised within timeframes.	Ensure all stakeholders are actively engaged with mobilisation, with sufficient opportunities for stakeholders to influence and feedback. Communicate progress regularly to all relevant stakeholders. Utilise appropriate contract levers such as Service Development Improvement Plans to set out expectations of providers.
6	**Culture Change** The level of culture change required for all providers and stakeholders to operate in a truly integrated way within the timescales is challenging	Timely and continuous engagement with key stakeholders and providers to foster understanding of the new model of care and embedding of collaborative framework. The CCG and the Council will need to facilitate collaboration and cooperation and wherever possible make provisions within existing and future contracts to mandate the requirement to work within the requirements set out in the collaborative framework.
7	**IT Landscape** Information Sharing	Successful mobilisation is predicated on stakeholders agreeing to share data and

	The current IT landscape across the whole of the health and care economy (system wide IT structures and information governance) is not yet sufficiently established to enable a single care record and care planning across provider or a joined-up approach.	engage with Virgin Care in the use of the ICR. The CCG and the Council will need to facilitate collaboration and cooperation and wherever possible make provisions within existing and future contracts to mandate the requirement to work with Virgin Care (and indeed any party the CCG and the Council wish to share data with in support of achieving enhanced outcomes, subject to appropriate information governance arrangements).
8	**Commissioning At Scale** STP priorities are not aligned to the local B&NES place based model of care.	Oversight through STP Mental Health Transformation Programme Board, which is tasked with the co-creation, with partners, of a B&NES, Swindon and Wiltshire (BSW) Mental Health strategy and vision which will improve the mental health and wellbeing of people of all ages, with a focus on those with the greatest needs. All STP partners recognise that significant engagement, collaboration and planning work has already taken place across B&NES and the Mental Health Transformation Programme Board will look to build on the work that has already taken place, rather than start again from the beginning. Early indications are that there is a preference to adopt the Thrive model, which is central to the B&NES approach, across all of BSW.
9	**Existing Contractual Arrangements** Provisions within the AWP bi-lateral agreement and current contractual provisions with Virgin Care contract do not allow sufficient flex to implement our priorities.	Delivery of priorities arising from the review will be manged via contract variation mechanisms during 19/20. Consideration is also given to current service specifications and Service Deliver Improvement Plans within existing contract negotiation processes.

5 Delivering value for money

Historically a large element of the resource to fund community mental health services has been allocated through block contracts through independent and joint commissioning arrangements across the CCG and Council.

In the future, funding needs to be more flexible and designed around outcomes. There are a range of new approaches – the Better Care Fund is a pooled fund for health and social care designed to promote integration; the Year of Care is a new pricing approach for long term conditions; and personal health and social care budgets are designed to give individuals more choice and control.

NHS England and NHS Improvement have also recently introduced specific local pricing rules for mental health services for working age adults and older people. The amended rule would make a blended payment the default approach for all mental health services for working age adults and older people, this approach can help support the ambition for our local mental health services, and the renewed commitment that mental health services will grow faster than the overall NHS budget. The approach aims to;

- ensure providers are appropriately reimbursed for the services they deliver to patients and to provide incentives for continuous improvements in quality, efficiency and expanding access

- ensure that payment for mental health services supports the delivery of evidence-based services that are aligned with population-level health needs and system-wide changes

- improve the reporting, recording and costing of mental health activity for working age adults and older people which supports financial transparency in data aligned with the Mental Health Investment Standard

- minimise transactional burdens and friction and to provide the space to transform services.

Although there is a strong drive to sustain community services as alternatives to hospital provision it must be recognised that the costs of care are rising; needs are increasingly complex and acute; and demand on services is growing. Added to that, the financial outlook for all commissioners and providers of health and care services in the medium term means they must continue to innovate and identify further efficiencies.

A key component of both the CCG and Council's financial strategy is to maximise the use of resources by ensuring costs incurred are those which deliver the most effective and safe care for people at the best obtainable value. The pie charts shown in Figure 14 and 15 below shows the outturn expenditure by organisation and type of care in 2017/18, this provides a starting point for understanding how mental health resources are used and identifying how we can use them differently to meet the challenges ahead.

Fig 14: CCG Budget 18/19

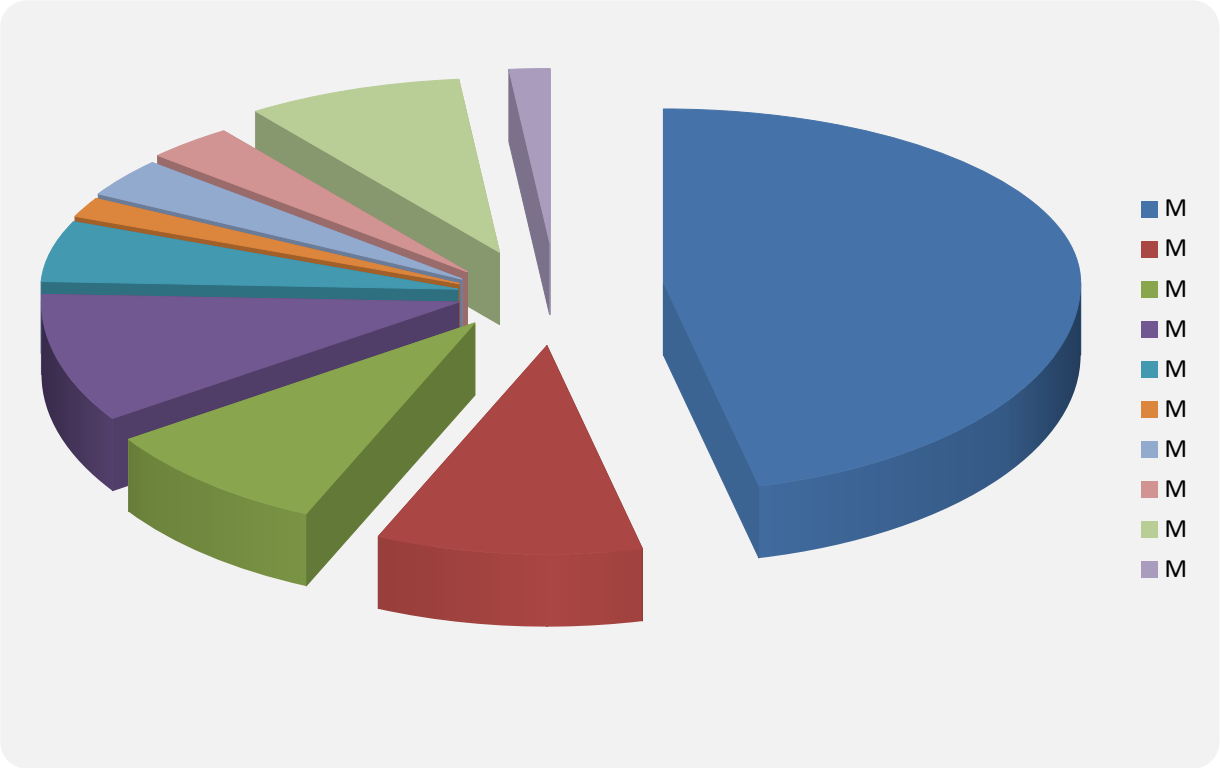
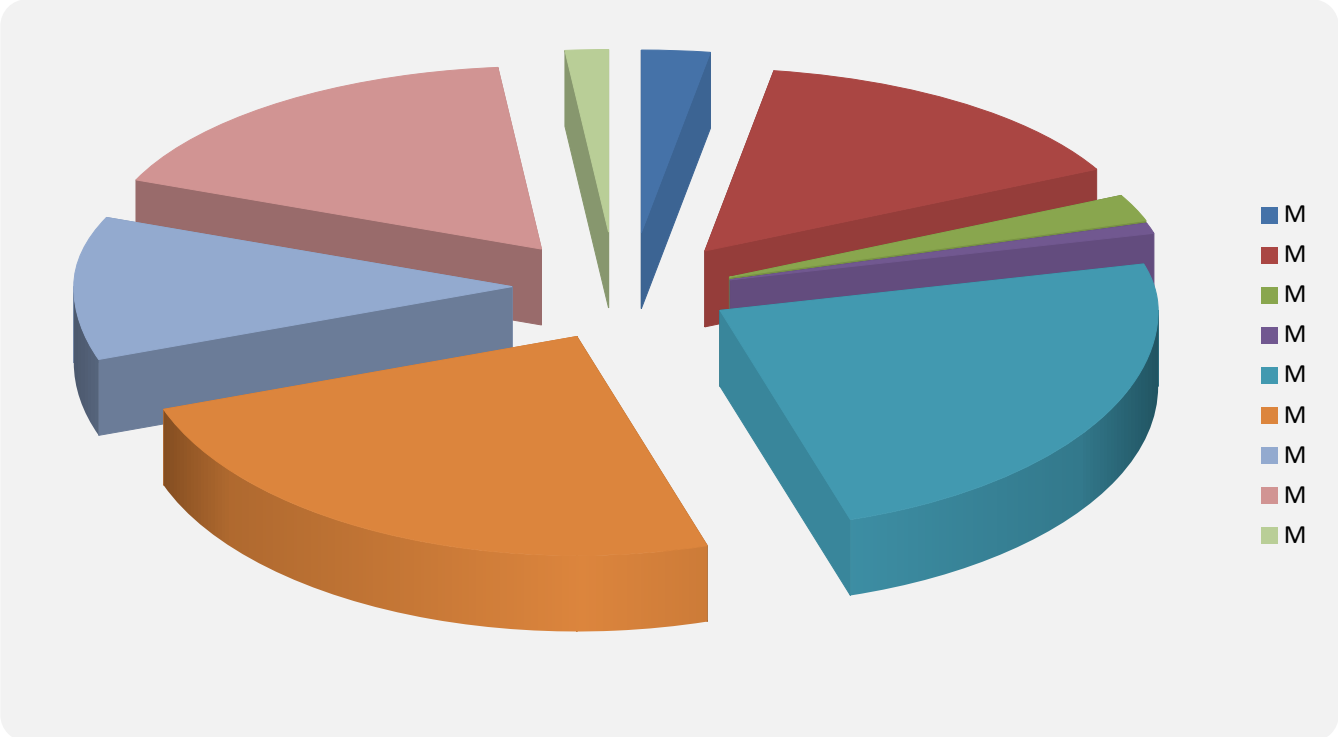


Fig 15: Council Adult Care, Health and Wellbeing Portfolio Budget 18/19



Planning ahead to achieve a mental health community delivery system that has a real impact on shifting care out of inpatient services and delivering quality and efficient services in the community is imperative to ensure we continue to improve outcomes for our population within the funding available.

If unaddressed, this will result in:

- More people, being treated in in-patient settings which do not necessarily result in the best wellbeing outcomes for them.
- Proportionately less money for community mental health services as more is necessarily spent in acute care. This increases the pressure on the in-patient system as less treatment is possible in the community setting.
- A system focused on responding to crisis rather than preventing crisis in the first place.

5.1 How services are funded

Commissioner Contract Funding

The current funding for all community mental health services in-scope is c£9.8 m across all current providers. Two key areas of additional investment have been identified to support delivery of priorities identified as part of the Mental Health Review;

Enhanced Crisis Provision

As part of the Mental Health Investment Standards, Commissioners have earmarked an additional £93,000 per annum investment towards enhanced Crisis provision in B&NES. The proposal currently is to develop a non-clinical intervention service where individuals in crisis or distress have access to a safe, calm, relaxing, and comfortable space. A full business case is currently being developed with support from the third-sector and is expected to be submitted to Commissioners in March 2019.

Enhanced Counselling for Young Adults

Commissioners have supported a third sector application for a grant from the national Health and Wellbeing Fund to provide community based listening support and counselling to 18-25 year olds. There are many students attending the local universities and colleges who struggle with the transition from school to higher education. By providing early help to distressed 18-25 year olds in the form of community support and counselling, the likelihood of them developing more serious mental health problems is reduced. The Commissioners endorsement of this application would allow potential additional Health and Wellbeing Fund monies of £164.9k (£97k in 19/20, £48.5k in 20/21 and £19.4k in 21/22) to be made available to enhance this provision.

Contract Funding Principles

The following funding assumptions will continue to apply to future contracting arrangements.

- Funding may need to be adjusted from the 2019/20 baseline to align with the Council and CCG planning assumptions in health and care funding arising from both organisations' financial planning and annual budget-setting processes and National Guidance.

- The new commissioning and provider delivery models will need to identify areas and timescales for cash-releasing efficiency savings or improving value which can be realigned to sustain the role out of Thrive model across the wider mental health economy.

- Demographic change pressures will need to be managed within available resources.

- New investment requests to support delivery of our priorities will be reviewed on an individual basis and require sound quantitative and qualitative evidence of system benefits.

- Commissioners and providers will continue to work in partnership to jointly identify areas of opportunity efficiencies.

Service Planning, Efficiencies and Transformation

Both the Council and CCG are developing their future year financial plans. In order to maintain high quality service provision against a backdrop of challenging government funding the plans need to identify areas that can improve financial efficiency to help meet demand and improve service delivery.

Areas of focus for both the Council and CCG are

- Value for Money – ensuring our approach to commissioning and contract management can demonstrate that services are performing well and are price efficient

- Practice Development – continually review and improve services to identify opportunities across health and care e.g. commissioning approach, service offering, reviews, support planning

- Provider Relationship – improving our systems and contracting methods to support a streamlined, well controlled and transparent approach in partnership with our providers.

6 Recommendation

The governing bodies of the CCG and the Council are asked to consider the following two options. Option 2 is the recommended option.

Option 1: Do nothing

The CCG and the Council recognise that the creation of a new model of mental health provision is a bold and transformational step. However, services cannot continue to be delivered in the same way because in the long term this is unaffordable, unsustainable and, most importantly, will not deliver the preventative, collaborative and personalised service that local people and professionals have asked for.

Option 2: Work with existing system leaders to deliver the new model of Mental Health provision

There are many strengths in existing community mental health services locally with strong examples of innovation and partnership working across system leaders and third sector organisations. These include services that have won awards and plaudits from patients, families, carers and communities.

Under this option, the Thrive model of care would be commissioned to start 19/20. Thrive supports the provision of mental health services using a whole-system, population-based approach which focuses on promoting mental health across the whole community, including groups who may be at risk of, or have, mental illness.

A population-based approach looks at the mental health and mental illness needs of different groups of people as well as the needs of individuals. It enables integration across health, education, social care and voluntary sector, with a central focus on delivering improved outcomes for people. The implementation of the Thrive model will also allow for more effective links to place initiatives such as GP Primary Care Networks and will ensure mental health is embedded across all sectors of provision.

Virgin Care and AWP as key system leaders have demonstrated commitment to work across the system collaboratively to ensure plans for transforming local services are realised.