

Bath and NE Somerset

Mental Health Services

Collaborative Framework

January 2019

Collaboration

This framework is about 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.

Collaboration focuses on placing the person at the centre of a range of timely support which meets their individual and varying needs:

- People and services will work together to build a unique package of support which promotes recovery and maintains wellbeing and so reducing 'pillar to post' signposting ; individuals are able to recognise the whole picture and how it reflects their lives.
- It recognises that people have mental and physical health needs which affect their present and future wellbeing
- It 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
- It acknowledges 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
- Organisations and people work together holistically 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. It aims to avoid people feeling they are in a 'revolving door' once they have been discharged from a service, and longer term progression is planned and managed more effectively
- It provides a shared and consistent approach within a quality framework and ensures continuity of support whereby a person only has to tell their story once
- Timely and appropriate interventions are available when an individual requires them

Measuring Achievements

Organisations will provide a brief annual report on how they have met the objectives and the challenges they have encountered.

1. Share training and resources on a reciprocal basis
2. Involvement/attendance at a pathway wide steering group / forum. Provide regular updates on service developments and new business which could be accessible to/beneficial for other organisations, increasing capacity
3. Accessing the shared support plan across the collaborative – the Integrated Care Records
4. Utilise an online database of shared resources across the pathway, such as meeting / activity rooms, best practice, toolkits etc.
5. Link in with the Volunteer Pass scheme to make the best use of volunteers and to broaden their experience and knowledge
6. Respond to a shared outcome framework and appropriate quality indicators
7. Promote the value of collaborative working with non-commissioned as well as commissioned services, on an equal basis, to deliver a comprehensive community-wide pathway of support
8. Access and utilise the Directory of Services, ensuring your services are entered correctly, kept up to date
9. Develop a forward plan for managing every individuals' mental and physical health, even if they don't meet CPA criteria
10. Share business planning, especially around external funding which complements the B&NES pathway, to ensure the pathway works as a whole, avoiding unnecessary duplication, and conflicting systems in operation
11. Agree to and sign up to a toolkit for implementation of the Mental Health and Wellbeing and Carers' Charters within services and establish a system for peer reviews