Report to:	**STRATEGIC COMMISSIONING BOARD**
Date:	28 November 2018
Reporting Member /Officer of Strategic Commissioning Board	Dr Vinny Khunger, CCG Governing Body GP Lead Jessica Williams, Interim Director of Commissioning
Subject:	**101 DAYS FOR MENTAL HEALTH PROJECT: MENTAL HEALTH IN THE NEIGHBOURHOODS BUSINESS CASE**

Report Summary:

People with multi-faceted needs are falling between commissioned services in Tameside and Glossop. Although there are a number of options to support people diagnosed with mental health needs in primary and secondary care many people fall between the thresholds for these services and often present to their GP, A&E and other settings looking for help. Sadly there have been a number of people within this group who have taken their own life.

In January 2018 the Strategic Commissioning Board (SCB) agreed to commit to improving the mental health of the Tameside and Glossop population by agreeing to prioritise investment in mental health to improve parity of esteem. Investment to support establishing a new model of mental health support in the neighbourhoods and improving support to people with ADHD and autism were included.

Following an analysis of options by a multi-agency working group SCB agreed investment to establish the 101 Days for Mental Health Project in May 2018. This included investing in the support of an experienced consultancy partner, the Innovation Unit[1] to support bringing together a wide range of partners and people with lived experience to collaboratively co-produce a new model of care for mental health in the neighbourhoods.

The Project has concluded in this proposal to establish an innovative new model of mental health support in the Neighbourhoods, starting with a prototype in one neighbourhood prior to incrementally reaching the whole of Tameside and Glossop.

This business case describes the new model and requests that c.£931,513 of existing resources are redesigned and £1,048,831 additional funding is committed recurrently for this development as follows

Provider	Investment	Vehicle
Pennine Care FT	£346,284	Contract Variation
PCFT/Integrated Care FT	£183,227	Contract Variation
TMBC Employment Support	£60,990	Contract Variation
Voluntary Community	£408,330	Tender

[1] The Innovation Unit is a social enterprise that brings innovative solutions to the public services https://www.innovationunit.org/

Sector		
Estates Estimate	£50,000	
Total	£1,048,831	

As the model will be phased in over the coming months the funding required will be phased as the team expands. An estimate of funding required each year is as follows:

2018/19	**2019/20**	**2020/21**	**Recurrent**
£152,000	£526,000	£1,048,831	£1,048,831

Recommendations:

It is recommended that SCB recognise the benefits that this new model will bring and agree that the Business Case should be funded.

Financial Implications:

(Authorised by the statutory Section 151 Officer & Chief Finance Officer)

Budget Allocation (if Investment Decision)	£1,049m
CCG or TMBC Budget Allocation	CCG: £0.988m TMBC: £0.061m
Integrated Commissioning Fund Section – S75, Aligned, In-Collaboration	S75 (Pooled)
Decision Body – SCB, Executive Cabinet, CCG Governing Body	SCB
Value For Money Implications – e.g. Savings Deliverable, Expenditure Avoidance, Benchmark Comparisons	Evidence underpinning proposals demonstrate VFM when implemented in other locations.

Additional Comments

The investment outlined in this proposal is congruent with both national and local MH Strategy and recurrent budgets are incorporated in financial plans including the recurrent consequences of GM Transformation funding included in this business case. It is important that the model is delivered within the budgets identified and performance is closely monitored to ensure the outcomes are in line with both qualitative and quantitative expectations.

A degree of caution must be exercised regarding the planned timeline for implementation as difficulties in recruitment and retention could impede pace of development and resources must be flexed accordingly to allow for this whilst continuing pursuing the wider development of neighbourhood mental health support.

Legal Implications:
(Authorised by the Borough Solicitor)

There needs to be a very clear case for investing in this approach to address demand and improve outcomes and reduce the overall cost to the economy especially as this in the main is discretionary early help and the most expensive interventions are mandatory. Arrangements must be put in to monitor performance, which must be based on evidence of clear outcomes and reduced expenditure

How do proposals align with Health & Wellbeing Strategy?	The proposal aligns with the Developing Well, Living Well and Working Well programmes.
How do proposals align with Locality Plan?	This proposal supports the achievement of: • Healthy Lives (early intervention and prevention) • Community development: this will strengthen and sustain community groups and voluntary sector organisations to provide the necessary support in the community. • Enabling self-care: improving skills, knowledge and confidence of people with long-term conditions or with on-going support needs to self-care and self-manage. • Locality based services; for people who need regular access to health and social services, these will be fully integrated in localities, offering services close to, or in, people's homes.
How do proposals align with the Commissioning Strategy?	This supports the 'Care Together Commissioning for Reform Strategy 2016-2020' commissioning priorities for improving population health particularly; • Supporting the wider determinants of health and wellbeing, giving children the best start in life and helping people to stay in and return to work, thereby improving their own prosperity. • Early intervention and prevention across the life course to encourage healthy lifestyles and promote, improve and sustain population health. • Creating the right care model so that people with long term conditions are better supported and equipped with the right skills to look after themselves and manage their conditions more effectively, reducing dependency on the health and social care system by promoting independence. • Supporting positive mental health in all that we do.
Recommendations / views of the Health and Care Advisory Group:	The Health and Care Advisory Group (HCAG) strongly supports the recommendations. HCAG noted that the ongoing support from the Innovation Unit will be vital to ensure that the vision of transformed services is achieved and they were reassured to note that robust monitoring of outcomes is integral to the plan.
Public and Patient Implications:	This neighbourhood mental health development has been co-produced with input from patients and the public with lived experience of mental health needs.
Quality Implications:	If the investment is released to implement the new model of care for mental health quality of care available for patients will be improved.
How do the proposals help to reduce health inequalities?	This new development directly relates to a cohort of individuals who have struggled to access or receive any mental health support within the existing provision, due to not meeting current thresholds of services. Therefore, this development provides a new provision to support this cohort.

What are the Equality and Diversity implications?	There are no equality and diversity implications associated with this report.
What are the safeguarding implications?	There are no safeguarding implications associated with this report.
What are the Information Governance implications?	There are no information governance implications associated with this report.
Has a privacy impact assessment been conducted?	Not applicable.
Risk Management:	Risks will be identified and managed by the implementation team.
Access to Information :	The background papers relating to this report can be inspected by contacting Pat McKelvey, Head of Mental Health and Learning Disabilities, CCG Commissioning Directorate.  Telephone: 07792 060411  e-mail: pat.mckelvey@nhs.net

1 BACKGROUND/INTRODUCTION

1.1 In January 2018 the Strategic Commissioning Board agreed to:

a) Commit to improving the mental health of the Tameside and Glossop population by agreeing to prioritise increasing investment to improve parity of esteem.

b) Commit to prioritise investment in mental health services until 2021 and that this would be done on a phased basis in order to support the following objectives:-
- Affordability;
- Development of robust business cases for each scheme;
- Phased approach to building complex services;
- Recognition of the time lag in recruitment to mental health posts.

1.2 The development of a new neighbourhood mental health model was included in the investment plan in order to meet the needs of people multi-faceted needs, who currently fall between secondary care mental health services and the psychological therapy service.

1.3 The Public Health Development Fund business case was also agreed. This included a commitment to invest in mental health employment and peer support.

1.4 A multi-agency working group was established to consider options to meet the needs of people in the group. This group identified the Lambeth Living Well Hub as a model of good practice and was chosen for further exploration. In May 2018 the Strategic Commissioning Board agreed investment to establish the 101 Days for Mental Health Project, bringing in the Innovation Unit to support the collaborative co-production of a new model of care for mental health in the neighbourhoods through a ground up collaboration between all partners, including people with lived experience.

1.5 The 101 Days for Mental Health Project has run from Mid-August to October with a variety of workshops bringing together a collaboration of stakeholders from a wide range of services, both service providers and individuals with lived experience. A small Design Team has taken forward work between much larger workshops with a Collaborative Team. Working together a model for meeting mental health needs of people who are currently not receiving a service in the neighbourhoods has been co-designed. Almost 100 stakeholders and individuals with lived experience have contributed to the development overall.

2 CASE FOR CHANGE

2.1 One in four adults will be affected by a mental health problem in their lifetime. 50% of all lifetime mental illness will be established by age 14, and 75% by the time a person reaches their mid-twenties. The cost of mental ill health to the economy, NHS and society is over £100bn every year. For too long, people with mental health needs have struggled to get the support they need.

2.2 The 2016 Five Year Forward View (FYFV) for Mental Health sets ambitious targets for mental health and recommends significantly investing to improve care: crisis care, psychological therapies, liaison services in acute hospitals, perinatal and children's services and suicide prevention.

2.3 Currently in Tameside and Glossop there are number of options to support people suffering with poor mental health; these include Healthy Minds for people with mild to moderate mental health needs, secondary care services such as the Access Team (which can provide short-term interventions), Community Mental Health Teams for people with severe and enduring mental health conditions who require longer term case management and

Home Treatment services for people in acute mental health crisis who are at risk of an inpatient admission. The locality is also fortunate to have the Anthony Seddon Centre, Tameside Oldham and Glossop Mind and Age UK that provide support for those experiencing mental health difficulties.

2.4 However some individuals with multifaceted needs fall between the thresholds for these services and struggle to cope. Particularly for those experiencing mental distress or crisis that isn't related to a specific diagnosis. These individuals are often referred to various commissioned services but not accepted onto the caseloads. Therefore they have no other option but to present to their GP, A&E or other community services. Sadly a number of people in this cohort have taken their own lives in recent years.

3 THE NEIGHBOURHOOD MENTAL HEALTH DEVELOPMENT

3.1 The work undertaken by the 101 Days for Mental Health Project Collaborative and Design team has highlighted the complexity of the challenge facing the local mental health system. It highlighted the nature of the challenge as:

- Not having one clearly defined problem
- Not being able to be solved simply by applying current expertise easily available within the local system
- Not being able to be resolved in a short amount of time
- Not being able to be solved and sustained if existing relationships authority and power are maintained
- That change will likely face significant resistance from people, practitioners and organisations if they are not actively involved in the design and delivery of the solution.

3.2 It is clear from the analysis collectively undertaken by this cross agency and partner group, that effectively addressing gaps in provision and better meeting the needs of our under-served cohorts, requires an approach to development and implementation that has the following characteristics:

- learning focused; where insight and understanding about both the nature of the problem, and the nature of the solution evolves over time through
- shifting the authority and responsibility to the people who are actually affected
- combining both new models of delivery, alongside investment in key systematic issues
- long-term and strategic - recognising that changes will take time
- ongoing deep levels of collaboration and cooperation across all levels of our system
- active experimentation and iteration of ideas and models

3.3 This approach reflects existing theory, research and evidence from system change projects in areas of health and mental health, including the work by R. Heifitz on adaptive leadership and system change[2].

3.4 To meet the challenges of development & implementation outlined and to ensure that form enables function, the Collaborative and Design team identified the need to take a stepped and iterative approach to delivery and scale. To enable this, it is proposed that initial delivery and implementation will apply a prototyping-led methodology and start delivery in one Neighbourhood. Hyde has been chosen as a time commitment from psychiatry is available.

3.5 A small team will be brought together in Hyde to prototype the new model - a process of concurrent delivery and development, where participants are supported to run small, focused and targeted learning experiments in order to dynamically iterate a model of

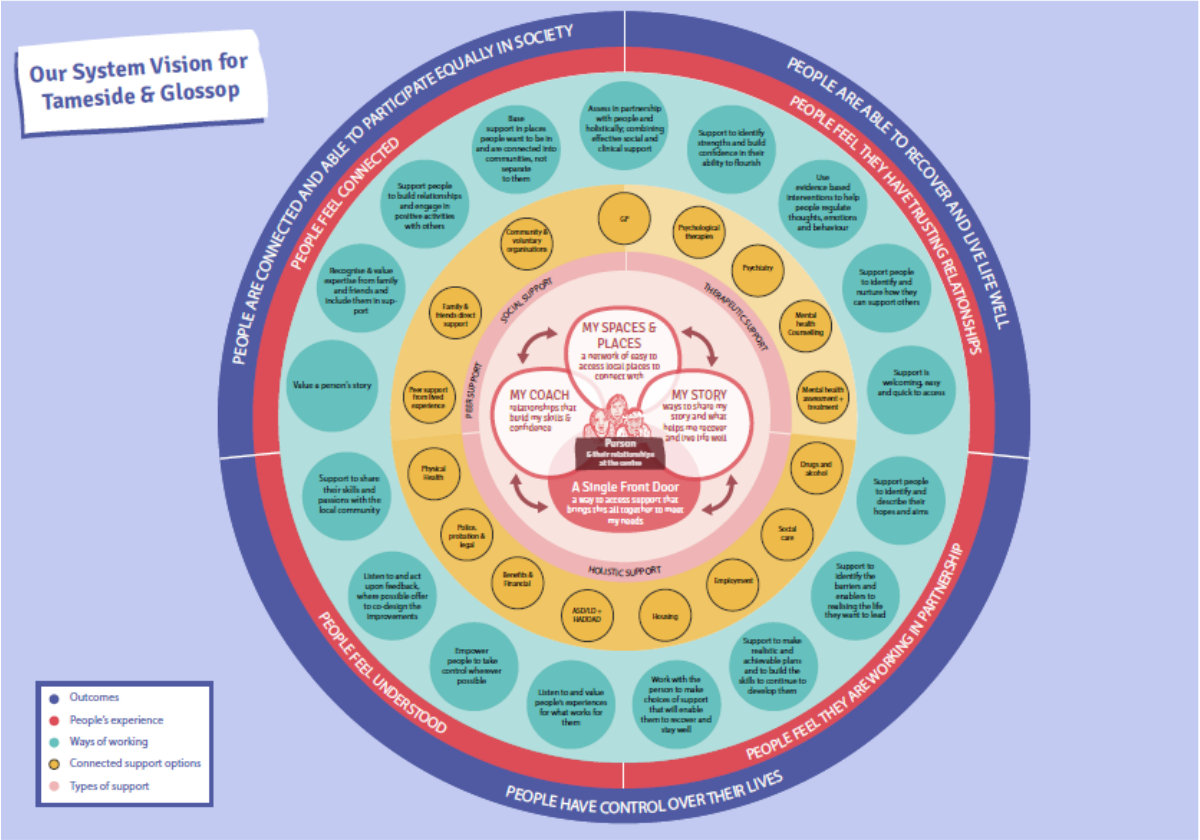
[2] The Practice of Adaptive Leadership: Tools and Tactics for Changing Your Organization and the World, Ronald A Heifetz (2009)

practice or delivery and generate evidence of desirability, feasibility and viability. As one of the Living Well UK programme sites the teams will benefit from ongoing support from the Innovation Unit.

3.6 From Hyde the model will be incrementally rolled out to two more neighbourhoods at a time, with the aim of full coverage 12 months from the start.

3.7 It is proposed that the development is be funded through a combination of existing TMBC, Pennine Care and VCS resources plus new investment as per the financial plan agreed at SCB in January.

4 THE NEIGHBOURHOOD MENTAL HEALTH DEVELOPMENT



4.1 This diagram outlines the key elements of the new model, developed to deliver three big outcomes. These are

- People are able to recover and live life well
- People are connected and able to participate equally in society
- People have control over their lives

4.2 To deliver these outcomes the new neighbourhood mental health system has three main elements. These are

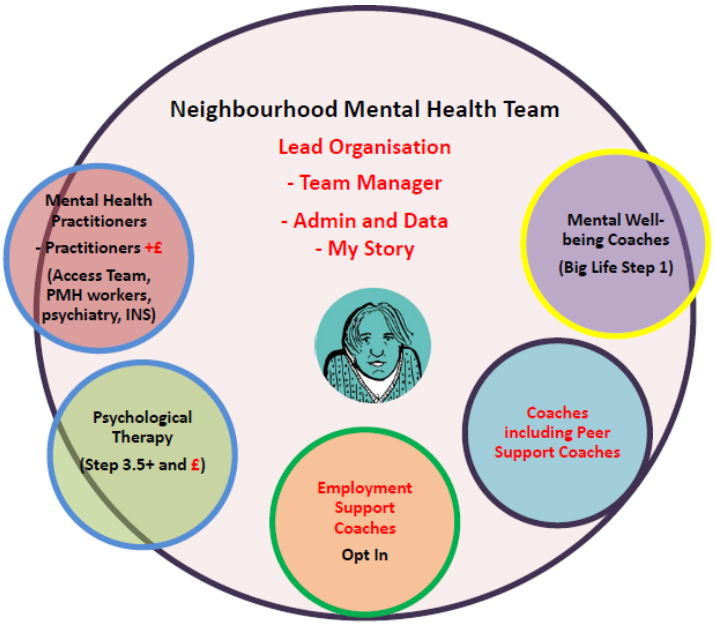
a) Mental Health Support 'Front Door' - Straightforward entry into a broad offer through a referral or via a drop-in in welcoming community places and spaces in each of the five neighbourhoods. Once fully established this virtual front door will be the route into all adult mental health services so there will no longer be any confusion about which service to refer to or for referrals to be rejected. Further details can be found in **Appendix 2**.

b) My Coach - the neighbourhood mental health team will be made up of mental health coaching experts from a range of backgrounds including employment, peer mentoring, clinical, medical and psychological therapy, this team will work with people with multi-faceted needs to design a plan, *My Story*, to improve their mental health. People being supported will be provided with up to 12 weeks of coaching to take their plan forward – taking control of their own mental health. This team will work in close partnership with a wide range of other services, sharing expertise and enabling coordinated co-terminal care where required. Once team is established it is hoped to expand the coaching offer to include wider partners eg Active Tameside, Be Well, social prescribers, housing officers etc. Further details can be found in **Appendix 3**.

c) *My Story* – people seeking support will be guided to develop their own plan, capturing the essence of themselves, people around them who matter and experiences that are significant for them. People will be supported to plan and set their own goals, that they can track and share with others through an online platform. Further details can be found in **Appendix 4**.

d) My Places and Spaces - the recommendation that mental health support is offered to people in 'places where people want to be' came out strongly in the Project. It is therefore proposed that the team has one main office and support base in the community, with extended opening hours. This would be well sited within the Health and Wellbeing Hub proposed for Denton, or perhaps Hyde. Regular sessions will be available at a community location in each neighbourhood, as well as flexibly in settings chosen by people wanting support. This will require support from all partners to work with the team to establish a robust offer in appropriate accommodation. Further details can be found in **Appendix 5**.

4.3 At the Centre of the Model will be a new Neighbourhood Mental Health Team. This team will be established through a combination of redesigning existing resources and additional posts, as illustrated by the diagram below. To support integrated working the team will have designated staff for each Neighbourhood but, unless capacity is extended in the future, will remain a single specialist team.



Existing Resources are Black; New resources are Red

Blue outline = PCFT; Green Outline = TMBC; Purple = New element; Yellow = Big Life

4.4 Over time the Team will build coaching capacity in each Neighbourhood within key partners, with a particular focus will be on effectively reaching men.

4.5 The Team is commissioned to work with people with multi-faceted needs such as

- The effects of childhood abuse
- Emotional instability
- Dual diagnosis (substance misuse, LD and autism)
- Young adults transitioning from CAMHS
- People with complex psychological needs
- Medically unexplained symptoms
- People frequently asking for help, including GP, A&E
- People under the care of tertiary services e.g. with eating disorders

4.6 It is also proposed to invest additional resources to support ADHD & Autism diagnosis and provide mental health support through the neighbourhood team.

4.7 The pathway into the team is either through self-presentation or through an introduction from another service.

5 COMMISSIONING THE NEIGHBOURHOOD MENTAL HEALTH TEAM

5.1 It is proposed to build the team by redesigning existing services and investing in additional capacity.

5.2 Existing Resources – it is proposed that the following resources, over time, move into the Neighbourhood Team.

Provide	**Element**	**Existing resources***
PCFT	Mental Health staff	£522,873
TMBC	Opt In	£48,640
Big Life	Step 1 IAPT (ICFT Contract)	£360,000
	Total	£931,513

* estimated

5.3 Additional Resources – it is proposed to invest £1,048,831 recurrently to establish a viable team with additional capacity in the health services, the Council services and the Voluntary Community Sector. Financial details are included in Section 12.

5.4 A phased approach is proposed as follows:

Phase	**Timescale**	**Neighbourhood team**
1. Prototype in Hyde 2. Tender for lead organisation and coaches 3. Contract variations for PCFT, ICFT and Council expansion and recruitment to new posts	Jan to June 2019	Initial team established through secondments of a Team leader from the Collaborative and other key staff to create an embryonic team to develop and prototype new model. New posts join team as recruited. People in Hyde receive a service.
4. Roll out to 2 more neighbourhoods and integration of existing provision	July to Oct 2019	Expansion of team and further refinement of the model. Integration of PCFT Access Team, Opt In and Psychological Therapies. People in three neighbourhoods receive a service

Phase	Timescale	Neighbourhood team
5. Roll out to 2 more neighbourhoods	Nov 2019 to Jan 2020	People in all five neighbourhoods receive a service

5.5 The development of the new model will be guided and supported by the multi-agency Design Team, supported by the Collaborative.

6 LINKS TO THE STRATEGIC COMMISSION STRATEGIC PLANS

6.1 We anticipate that the new model will, as well as reducing problems or eliminating symptoms, focus on supporting people to get and keep well through; improving people's personal sense of meaning, close interpersonal relationship and social integration.

6.2 This supports the "Care Together Commissioning for Reform Strategy 2016-2020" commissioning priorities for improving population health particularly;

- Supporting the wider determinants of health and wellbeing, giving children the best start in life and helping people to stay in and return to work, thereby improving their own prosperity.
- Early intervention and prevention across the life course to encourage healthy lifestyles and promote, improve and sustain population health.
- Creating the right care model so that people with long term conditions are better supported and equipped with the right skills to look after themselves and manage their conditions more effectively, reducing dependency on the health and social care system by promoting independence.
- Supporting positive mental health in all that we do.

6.3. In line with Tameside and Derbyshire's sustainable communities' strategies this new model of care also supports ambitions to have;

- Happy, healthy people and families with solid networks of support, who feel safe and in control of their personal circumstances and aspirations.
- Resilient and thriving communities where local people work together, in new and dynamic ways with public services.
- A strong, prosperous economy which makes the most of Tameside and Glossop's rich assets, supporting people to gain new skills or find meaningful employment opportunities.

6.4 By focusing on these areas we believe we can significantly reduce our legacy of poor health outcomes and avoidable deaths.

7 SUPPORT FOR THE STRATEGIC COMMISSION'S QUALITY, INNOVATION, PRODUCTIVITY, AND PREVENTION (QIPP) AGENDA

7.1 **Quality**

- Better service user and carer experience
- Better integrated health and social care approach
- A range of provisions that meet NICE Quality Standards
- Better developed and trained workforce
- Better staff reported satisfaction
- Increased access to timely packages of support

7.2 **Innovation**

- Integration of primary and secondary care, health and social care and physical and mental health care
- Working together to radically rethink our approach to the role of public investment in promoting great mental health outcomes
- Reduction in unnecessary admissions, administration
- Incorporates best evidence to support a whole-system change
- Increase independence and self-management;
- Provides opportunity for peer support & volunteering
- Help to identify groups, organisations and opportunities in the community that can support people in building social networks and develop coping skills to prevent mental health crises in the future- linking those met in crisis with other health & wellbeing services
- Working in new and dynamic ways to provide appropriate and timely support, notably, new approaches to commissioning, supporting wider determinants of health, prevention and investment in the voluntary and community sector
- Collaboratively build partnerships and models of working, especially with organisations outside of health and care

7.3. **Productivity**

- Reduced demand for acute inpatient provision
- Reduced demand for specialist mental health inpatient provision
- Reduced A&E attendances RAID assessments
- Increased numbers of people receiving the right support required
- More treatment provided in the community and home settings
- Development of high quality, place based services used optimally and understood by the population
- Increased capacity and capability across economy to drive innovative models of care

7.4. **Prevention of**

- Inappropriate hospital admissions
- People having to lose their independence
- Crises through good monitoring and early intervention in the community
- Prevent escalation of mental health problems to avoid a mental health distress & crisis
- Prevent unnecessary referrals to secondary mental health services, A&E departments and other emergency out of hours services
- Pressures on GPs
- Pressures on ambulance services
- Pressure on family members and /or carers
- Pressure of staff within existing provision

8 KEY PARTNERS / STAKEHOLDERS INVOLVED

8.1 This neighbourhood mental health development has been established with input from almost 100 stakeholders from a variety of different organisations across the borough through a range of discussions and workshops. Organisations include; The Anthony Seddon Fund, Pennine Care Foundation Trust, Tameside and Glossop Integrated Care Foundation Trust, The Big Life Group.

8.2 It was extremely important to gain insight into people's experiences of trying to access mental health support from a range of people with lived experience including; individuals struggling with their mental health, parents bereaved by suicide and carers of individuals

who are struggling to cope. Some of the comments mentioned within the workshops outline the need for better support

> *"Referrals keep being done and keep being told all I need is therapy, when done it, was advised no more therapy, also say don't meet criteria"* **Individual with lived experience Healthwatch feedback**

> ***"**Mental Health care seems very impersonal and far from caring so far. I am finding it increasingly difficult to believe I can get help and continuing support, as someone with complex needs, and feel worse whenever I try to get help, only to be ignored, or put on a list again for a very long wait, and only able to access CBT with no other options offered"* **Individual with lived experience**

> *"I want to feel people listen, empathise and care about me. I want to feel wanted and not a burden."* **Individual with lived experience**

8.3 It was also extremely important to engage all partners as ongoing system wide collaboration is crucial for implementation of the neighbourhood mental health model.

> *"We need to be empowering people to solve their own problems wherever possible… this means fluid and flexible relationships between people and professionals around how decision making happens"* **Dr Simon Darvill Consultant Psychiatrist**

8.4 The value of having an established and sustained collaborative forum for the local mental health system is clear, participants reported a range of significant values from this level of collaborative activity including:

- Increasing awareness of provision available locally
- Deeper knowledge of inter and intra organisational processes
- Shared understanding of the significant challenges faced by the local system and a shared sense of what requires prioritisation
- a deeper understanding of the experiences of people using and delivering local mental health services
- Opportunity to understand issues from a systemic perspective
- Increasing the ability to generate solutions that are systematic and not in silo
- The value of a non-hierarchical way of working that enables people from traditionally different levels of the system to participate in the analysis of the problems and generating new solutions
- Greater opportunities to foster and engender relationships of trust, openness and transparency

9 OUTCOMES AND BENEFITS

9.1 **Patient Outcomes**	**Impact/ benefits**
Increased capacity to actively manage own mental health and prevent crises from happening	The model will encourage individuals to become active participants in their care talking control and increasing capacity to self-manage to support ; • improved mental health • reduced mental distress • sense of control • increased confidence • improved ability to recover and stay well reducing demand for health and social care services

Increased employment opportunities less absenteeism	Employment support coaches are integral to this model. Empowering individuals to self-manage their mental health and well-being to stay well in work. Supporting people back into employment after absence and guiding people to gain new skills or find meaningful employment opportunities.
Improved Service User Experience	This development directly relates to individuals who have struggled to access or receive any mental health support within the existing provision. Therefore the new model will allow access to appropriate provision, offer more choice and control over the support they need to improve and better manage their mental health. Contributing to improved experiences.
Increased access to life changing support and interventions	Increased capacity will ensure access to a range of timely treatment and support options in the community. Again this will offer more choice and control to the individual allowing ability to self-manage.
9.2 **System Outcomes**	**Impact/ Benefits**
Reducing MH A&E attendances	Having appropriate access to a range of treatment and support options available in the community will provide an alternative option to attendance at A&E.
Reducing no. of admissions to MH ward	It is anticipated that having more robust options of support in the community will reduce the need for number of people who require a short stay admission as their needs will be pro-actively met outside of secondary care.
Reduced usage of secondary care mental health services-usage and referrals	The new model will directly support reductions in inappropriate referrals to secondary care services as the single front door will assess the referral and have the appropriate service to refer too. Overtime it is anticipated that the new neighborhood MH development will support step down from CMHT caseloads therefore reducing pressures within these teams.
Reducing demand in Primary Care	Having open access to a range of venues in the community and support and treatment options will reduce the demand in GP appointments for this cohort of individuals.
Reduced number of individual funding requests to out of area providers	The local offer of psychological therapies will be expended to reduce the need for referrals to specialist out of area therapies.
Reduced prescribing costs in Primary Care	Primary care clinicians will have an alternative treatment option than medication to support patients.
Reduction in waiting times to access psychological therapies	Increased capacity of psychological therapies and a range of other provisions will reduce waiting times for this treatment option.

10 EVIDENCE BASE

10.1 The Lambeth Living Well programme [3] was identified as a model of good practice through research into the 'gap' in our current provision.

10.2 In June 2010, Lambeth Clinical Commissioning Group (CCG) established the Living Well Collaborative ('the Collaborative') with users of services, carers, statutory organisations across secondary care, primary care and commissioning, voluntary sector agencies and public health. This was a shared platform to begin a journey towards meaningful and sustainable whole system transformation of mental health services that would radically improve the recovery outcomes of those with mental health needs in Lambeth. The three outcomes Lambeth work towards are;

- Recover and stay well, and experience improved quality of life and physical and mental health
- Make their own choices to achieve their personal goals and experience self-determination and autonomy
- Participate on an equal footing in daily life

10.3 Three innovations lie in the heart of Lambeth's system;

(i) The Living Well Hub- the 'front door' to mental health services delivered by a multi-disciplinary team of from primary and secondary care and the voluntary sector. The Hub is an open access offer, with no thresholds or eligibility criteria, to help people who are experiencing difficulties.

(ii) The Living Well Network- a community of providers, support agencies, statutory organisations and people who help citizens of Lambeth live well by resolving problems that trigger mental ill health, including housing, employment, debt, benefits and isolation.

(iii) The Integrated Personalised Support Alliance – an alliance contracting model that has helped 200 people with complex mental health needs move out of rehabilitation wards into community settings. The IPSA is recovery focused and supports people to improve physical and mental health and work towards goals in education, employment and training.

10.4 The Lambeth Model[4] has been evidenced to;

- Reduce referrals to the Assessment and Liaison service by 31%
- Reduce referrals to secondary care services by 25%
- Reduced of caseloads of long term care co-ordination by 27%
- Support the reduction in waiting times in community mental health teams. This was achieved by offering rapid clinical assessment and screening in the Hub and by only referring those who need specialist intervention to secondary care, thereby creating capacity in secondary care teams to see people more quickly.
- In total, the Hub offered support to over 5000 people with evidence starting to show improvements in people's well-being via validated measures.
- The average (mean) cost per person introduced to the Hub was £103 (as analysed between 1st march and 30th June 2017). When compared to national reference costs, this suggests that for many people the Hub is likely to provide a comparatively low cost (and high volume) means of freeing up resources in the local secondary care Assessment and Liaison services.
- 91% of Hub staff agree that the service has moved away from a traditional model of mental health and as a result of this mental health care is more integrated within the

[3] http://lambethcollaborative.org.uk/

[4] http://lambethcollaborative.org.uk/wp-content/uploads/2018/03/LWN-Hub-Year-Two-Evaluation-Report-December-2017_04.01.18.pdf

local community. The same percentage felt empowered to be part of service development.

10.5 As envisaged in the original Collaborative aim, a wide range of clinical and social care support is offered by the Hub and in turn people are making introductions for a broad range of social and clinical reasons

10.6 Key to Lambeth's development journey was working to this principle of form enabling of function. Decisions around the structures, policies and procedures followed collective and collaborative work to first identify the optimal relationships, values and identities required to realise their local vision. From this work significant structural change was carried out to ensure the enabling and conducive conditions where developed. This including significant changes to contracting arrangement, service organisation, key procedures and policies.

11 IMPACT ASSESSMENT

11.1 Equality and Diversity

Equality Impact Assessment (EIA) Form is attached as **Appendix 1**.

11.2 Geographic Implications

The intention is to take a stepped and iterative approach to the delivery and scale of this model, therefore it will not be available across all neighbourhoods in the first instance, but will be expanded incrementally to all neighbourhoods by January 2020.

11.3 Partner Organisations and Wider Health Economy

The process of collaborating with a variety of partner organisations to develop the new model has already supported innovative new ways of working and communicating. The approach to collaboratively commission a variety of providers to deliver this model is expected to achieve better integration across the mental health system in Tameside and Glossop. As described in section 8 it is anticipated that the development will lead to a range of system outcomes that will have a positive impact on primary and secondary care services and the wider health economy.

11.4 Supports the Patient Choice policy

This proposal will expand and broaden the remit of support options available across a variety of organisations and settings allowing patients more choice over their care and treatment.

11.5 Affect Access

This proposal directly relates to individuals who have struggled to access or receive any mental health support within the existing provision. The development will directly increase opportunities for access to healthcare for these individuals.

12 FINANCIAL CONSIDERATIONS

12.1 Additional Resources - In addition to the existing resources outlined in Section 5.2 above it is proposed to commit £1,048,831 recurrently to establish a viable team to reach across all five neighbourhoods, working into the five Integrated Neighbourhood Teams.

Provider	Element	Investment	Vehicle
Pennine Care FT	Mental health practitioners and psychological therapists	£346,284	Contract Variation
PCFT/Integrated Care FT	ADHD, Autism and Learning Disability staff	£183,227	Contract Variation
TMBC	Employment Support Coaches	£60,990	Contract Variation
Voluntary Community Sector	Lead provider – manager, admin, data Mental Wellbeing Coaches Peer Support Coaches	£408,330	Tender
Estates Estimate		£50,000	
	Total	**£1,048,831**	

12.2 The funding will be invested incrementally, in line with the plan to prototype the model in one neighbourhood initially, prior to extending to two more at a time until all five are covered. Further work is underway to ascertain the phasing of the budget but it is estimated as follows:

2018/19	2019/20	2020/21	Recurrent
£152,000	£526,000	£1,048,831	£1,048,831

12.3 Procurement of the Model - The model has been developed through the collaboration of many partners and it is proposed to take this approach forward into it is proposed to build the model through two routes:-

a) Contract Variations in existing contracts to provide the additional capacity within the model as follows
   - Mental health practitioners and therapists – Pennine Care Foundation Trust
   - MH Employment Support Coaches – TMBC Employment Support Team
   - Neurodevelopmental practitioners – Integrated Care Foundation Trust

b) Tender for Lead Provider, peer support coaches and mental health and wellbeing coaches.

13 KEY RISKS

13.1 Risks will be managed through implementation by the Implementation and Design Teams.

13.2 Some of the risks that have identified to date are outlined below and will be expanded on fully and managed as part of the mobilisation process:

- Workforce implications – recruitment and retention in mental health services is challenging, not least due to the growth across GM. This may impact on the ability to second experienced clinical staff into the new development and backfill vacancies.
- Information Governance requirements will need to fulfilled
- Timescale to establish the new team may slip, notably due to requirement to tender for the Lead Provider
- Capacity and demand – robust monitoring will be in place to monitor demand and develop a creative model to meet the needs
- Training for all services involved – re appropriate referrals
- Managing complex change across organisations is required to deliver the aspirations of this development
- Estates & facilitates identification and management

A Risk Register will be developed to manage all identified risks.

14 PERFORMANCE AND OUTCOME MONITORING

14.1 As one of the four sites chosen become a partner in the Innovation Unit Living Well UK programme our local performance and outcome monitoring framework will be developed with the tailored support from the mental health team at Innovation Unit and the independent academic programme evaluator.

14.2 Proposed need, performance and outcome data to be collected:

14.3 Outcome

	Potential Measures
Needs of people looking for support	• Presenting factor/s – reason for referral/introduction • Demographic data • Referral/introduction source e.g. self-referral, RAID GP etc.
Ensure swift and easy access to life changing support and interventions Have no gap between services Have no wrong door, no silo working	• Total activity • Activity by element of service accessed • Waiting times to access support • Reduction in referrals rejected from 'front door' • Number of individual funding requests to out of area therapies • Retention rates of service users • Referrals to other organisations e.g. third sector VCS.
Patient centred outcomes to demonstrate the impact on; - Improved mental health - Reduced mental distress - Improved self-management - Sense of control - Increased confidence - Recovery rates - Service user experience & satisfaction	Through standardised outcome reporting tools/ validated measures (to be agreed) e.g. PROMs/CROMS, WEMWEBS, WASAS Quality assurance monitoring through service users experience feedback - stories/case studies etc.
Impact on wider service use	• Reduced A&E attendances - RAID referrals and Assessments • Reduced usage of secondary care mental health services- reduced referrals, waiting times and usage. • Reduced number of short stay admissions • Reduction in occupied bed days • Spend per service user per year • Unit cost per service user • Drug costs total and per service user • Rehab (IPSA) bed cost • Increased staff reported satisfaction

APPENDIX 1

EQUALITY IMPACT ASSESSMENT

Subject / Title	101 Days for Mental Health Project: Mental Health in the Neighbourhoods Business Case

Team	**Department**	**Directorate**
Commissioning	Commissioning	Commissioning

Start Date	**Completion Date**
24.10.18	24.10.18

Project Lead Officer	Pat McKelvey
Contract / Commissioning Manager	Pat McKelvey
Assistant Director/ Director	Jessica Williams

EIA Group (lead contact first)	**Job title**	**Service**
Pat McKelvey	Head of Mental Health and Learning Disabilities	Commissioning Directorate
Arrianne Garton	Commissioning Project Manager – Adult Mental Health and Learning Disabilities	Commissioning Directorate

PART 1 – INITIAL SCREENING

1a.	**What is the project, proposal or service / contract change?**	Neighbourhood Mental Health Development The proposal is to implement an innovative new model of mental health support in the neighbourhood. Starting with a prototype in one neighbourhood, prior to incrementally reaching the whole of Tameside and Glossop.
1b.	**What are the main aims of the project, proposal or service / contract change?**	The new model will support individuals with multi-faceted needs that currently fall between the thresholds for commissioned services in Tameside and Glossop and therefore struggle to access any support for their mental health. This often results in presentations to GP's, A&E and other settings looking for help. Sadly a number of these individuals go on to take their own life. The new model will provide increased access to life changing support and interventions with the aim to; - Improve mental health and wellbeing - Reduce mental distress - Prevent escalation of mental health problems to avoid a mental health crisis - Prevent unnecessary referrals to secondary mental health services, A&E departments and other emergency out of hours services Increase interdependence and self-management - Increase peoples sense of control - Increase confidence - Support recovery - Service user experience & satisfaction - Reduce isolation - Help to identify groups, organisations and opportunities in the community that can support people in building social networks and develop coping skills to prevent poor mental health & crises in the future

1c. Will the project, proposal or service / contract change have either a direct or indirect impact on any groups of people with protected equality characteristics?

Where a direct or indirect impact will occur as a result of the project, proposal or service / contract change please explain why and how that group of people will be affected.

Protected Characteristic	Direct Impact	Indirect Impact	Little / No Impact	Explanation
Age	✓			The service is for patients that are 18+, however by seeing vulnerable groups of patients and improving their quality of care this could have a positive effect for families and carers that could be under the age of 18.

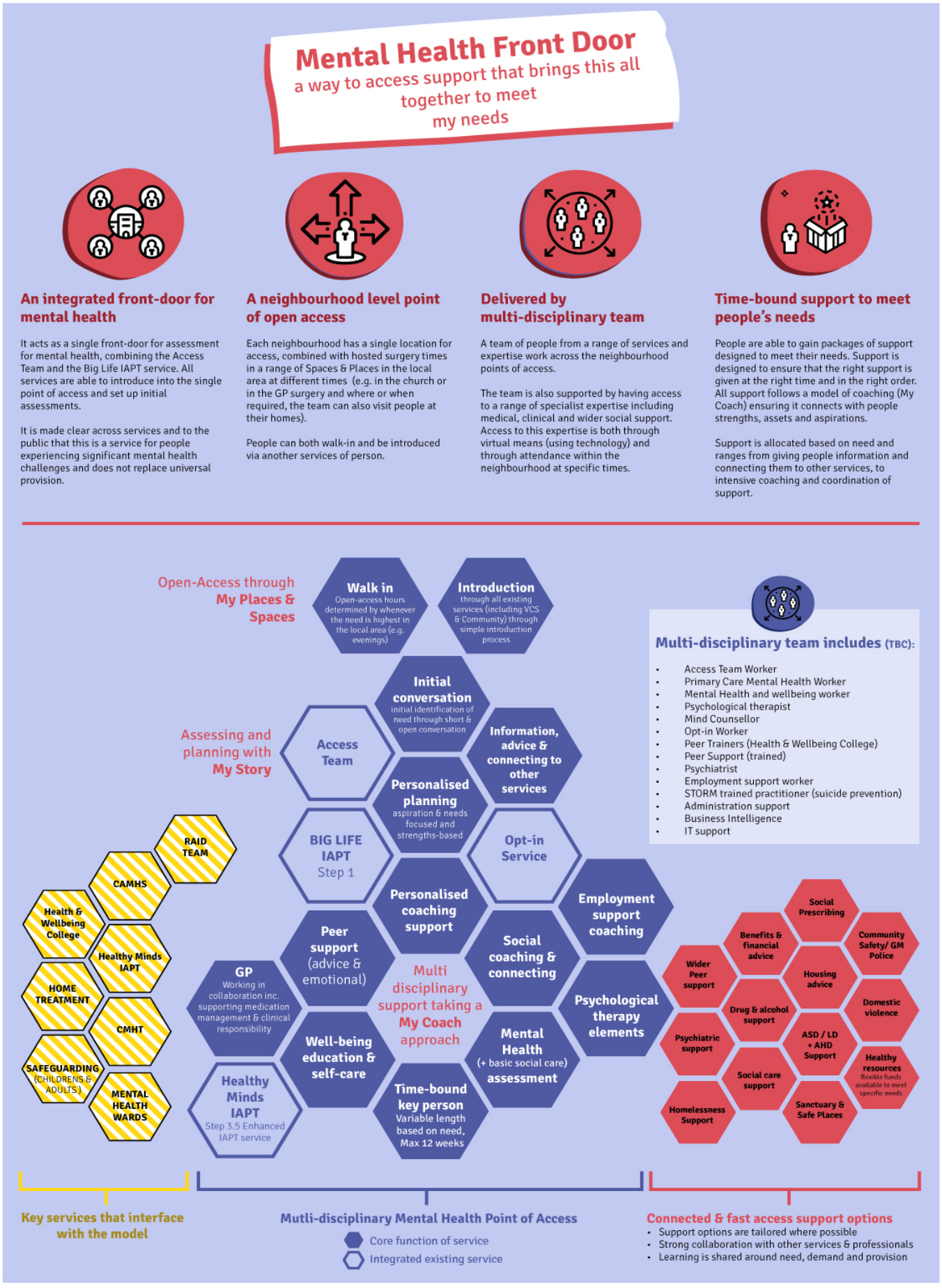
Disability	✓			The service is open to everyone who meets the criteria.
Ethnicity	✓			The service is open to everyone who meets the criteria.
Sex / Gender	✓			The service is open to everyone who meets the criteria.
Religion or Belief	✓			The service is open to everyone who meets the criteria.
Sexual Orientation	✓			The service is open to everyone who meets the criteria.
Gender Reassignment	✓			The service is open to everyone who meets the criteria.
Pregnancy & Maternity	✓			The service is open to everyone who meets the criteria.
Marriage & Civil Partnership	✓			The service is open to everyone who meets the criteria.
NHS Tameside & Glossop Clinical Commissioning Group locally determined protected groups?				
Mental Health	✓			The service directly relates to individuals requiring mental health support, who currently receive no support from commissioned services due to not meeting service criteria thresholds. The new development will provide access to a range of mental health support interventions for this group of individuals.
Carers	✓			Identified in the co-production of this model was the need to ensure carers have easy access to a range mental health support. The new development will support anyone who meets the criteria.
Military Veterans	✓			The service is open to everyone who meets the criteria.
Breast Feeding	✓			The service is open to everyone who meets the criteria.
Are there any other groups who you feel may be impacted, directly or indirectly, by this project, proposal or service / contract change? (*e.g. vulnerable residents, isolated residents, low income households)*				
Group (*please state)*	**Direct Impact**	**Indirect Impact**	**Little / No Impact**	**Explanation**
n/a				

Wherever a direct or indirect impact has been identified you should consider undertaking a full EIA or be able to adequately explain your reasoning for not doing so. Where little / no impact is anticipated, this can be explored in more detail when undertaking a full EIA.

1d.	**Does the project, proposal or service / contract change require a full EIA?**	**Yes**	**No**
			✓
1e.	**What are your reasons for the decision made at 1d?**	This new development directly relates to individuals who have struggled to access or receive any mental health support within the existing provision, due to not meeting current thresholds of services. Therefore this new development will allow access to appropriate provision, offer more choice and control over the support they need to improve and better manage their mental health. Contributing to improved experiences. It is open to anyone who meets the criteria.	

APPENDIX 2

The Neighbourhood Mental Health Offer



APPENDIX 3

Key Components of the Neighbourhood Model: My Coach

My Coach
relationships that build my skills & confidence

A positive relationship of support

- Be a source of consistent support, believe in them and help them to believe in themselves
- Build the person's capacity to enhance the potential of their existing relationships and grow new relationships within their community
- Work with people to co-design a journey of support
- Help people grow and sustain responsibility for themselves, those around them and their communities
- Explore their aspirations and break them down into achievable steps
- Connect them to the support they need to create the conditions in their life to work towards their aspirations

Coaching when it's needed

People will receive the right amount of and intensity of coaching they need at any given time.

Formal coaching relationships should be time-bound and not last more than 12 weeks. Informal coaching may be longer-term.

Coaching from anywhere

Anybody in the system can play the role of a coach. They can be professionals working in specific services or volunteers in the community.

People in the system will be able to receive training and support to become a mental health specific coach and become an approved coach.

Choose your coach

People will be able to select the coach that best connects with different passions, skills and experiences.

Coaches could be within existing relationships they have or new relationships brokered by a service or through the single point of access.

Coaching is how we do things around here

A coaching-based approach that focuses on developing people's skills and confidence to recover and live life well shapes all forms of support.

Services across the system will be able to grow the ability to take a coaching approach – from employment support services to GPs.

How is it connected to the wider approach:

Mental Health Front Door
My Coach is a core element of the single point of access. People will be able to access different forms of coaching through the point of access, including intensive coaching when facing complex needs to coaching around aspirations and strengths.

My Story
Coaches will use My Story to help people to capture their story and develop a personalised recovery and support plan. My Story will also be a key way to identify and share strengths, assets and aspirations.

My Spaces & Places
Coaches may be hosted by or part of My Spaces and Places. The coaching way of working will be a key part of the mental health informed approach of all My Spaces and Places.

APPENDIX 4

Key Components of the Neighbourhood Model: My Spaces and Places

My Spaces & Places

a network of easy to access local places to connect with

A mental health informed network of local spaces & places

- Welcoming places where people can feel connected and grow their sense of belonging
- In the environments and locations where people want to be
- Places where people feel safe and comfortable
- Spaces to connect around shared interests and passions
- Easily recognisable as part of the network
- Forms a local mental-health informed network, where people are supported to make the best use of local assets and resources

Mental Health Informed network

My Spaces & Places are mental health informed, not mental health specific. They all have a shared understanding of the needs and challenges that people experience with poor mental health and are able to ensure that they recognises these in the design and delivery of support. This is to help reduce stigma and enable people to participate on an equal footing.

Becoming mental health informed will include training (including mental health first aid and My Coach approaches) and agreement to a wider set of principles & requirements.

Quick, easy and local access

People have access to a network of places and spaces in their community that are mental health informed. These can be voluntary and VCS organisations, faith organisations, community centres, restaurants, cafés, sports clubs etc.

Although localness is key to ensuring people have good access, geographical location will not limit people's opportunities to connect with support and positive relationships.

A membership model

Organisations and groups can subscribe to become a My Space & Place and be part of the mental health informed network. People will be able to clearly see who is part of the network through an online map and through seeing a mark/sticker to show their membership.

Membership will operate at different levels (like bronze, silver and gold) depending on their level of training and engagement with the wider network.

Working as part of a network

My Spaces & Places are supported to work as a network, ensuring that people have a joined-up and seamless experience. This includes working with individuals to use My Story to connect and share important information about needs and aspirations.

New My Spaces & Places are seeded (through grant funding linked to Social Prescribing) and nurtured where there are gaps in access and provision.

How is it connected to the wider approach:

Mental Health Front Door

My Spaces & Places connect with the single point of access in a number of ways. Firstly they act as ways into the point of access, where people can be introduced an initial conversations set up. Secondly, some My Spaces & Places host the single point of access at different times. Finally, the network acts a key integrated element of the support people receive as part of the new service.

My Coach

All My Spaces & Places have the opportunity to receive training and development to take a coaching based approach and can host coaches who have gone through training and approval processes.

My Story

My Story is the key resource used to help work with individuals to assess and plan with their needs, aspirations and strengths.

APPENDIX 5

Key Components of the Neighbourhood Model: My Story

My Story

ways to share my story and what helps me recover and live life well

Putting your story at the centre of assessment and planning

- An introduction to a person; their strengths, passions and challenges
- An overview of past experiences
- Describes the relationships of support people have around them and who their key people of support or carers are.
- Supports people to plan and set their own goals that they can track and share with others
- Support to identify possible solutions to problems people face
- Access to tools and approaches to support positive regulation on emotions and thoughts.
- Help people understand what options for support may be available

A way to share information

My Story is both a virtual and, where required, a printed recovery and support plan.

People can use this resource to share different kinds of information with the different people who support them. This includes their carers, families and friends.

The first page of any assessment

My Story will not aim to replace all existing information systems and assessments from different services.

My Story will become the first page of any assessment process, ensuring all services ask to connect with an individual's understanding of their story, strengths, passions and insight into what works for them.

Owned by the individual

My Story is owned by the person, so they have full ownership of their 'story' and therefore only share the information they choose with each different person they Meta meet. This includes both formal services and informal relationships.

Powerful technology

My Story is a connected tool that uses technology to ensure that it remains up-to –date and easily shareable in different ways and with different levels of information.

It connects with other information resources, helping people to be able to access information including; what services are available, to advice about self-management and education.

How is it connected to the wider approach:

Mental Health Front Door
My Story is a core element to the Single Point of Access. It is the key resource used for both assessments and planning with the person and it will be the way to (with permission) organise, monitor and review people's support during and after engaging with the service.

My Coach
It forms a central part of the support people receive from their coach. It is revisited regularly and evolves throughout a person's journey.

My Spaces & Places
All spaces & places within the mental health informed network will be aware of My Story and will seek to engage each person to review and develop it as part of any support and relationships they receive within the space or place.