Community Mental Health Transformation Roadmap and Annexes

Last updated: 31 May 2023

Contents

CMH transformation is a complex programme with lots to deliver across the LTP duration

Purpose:

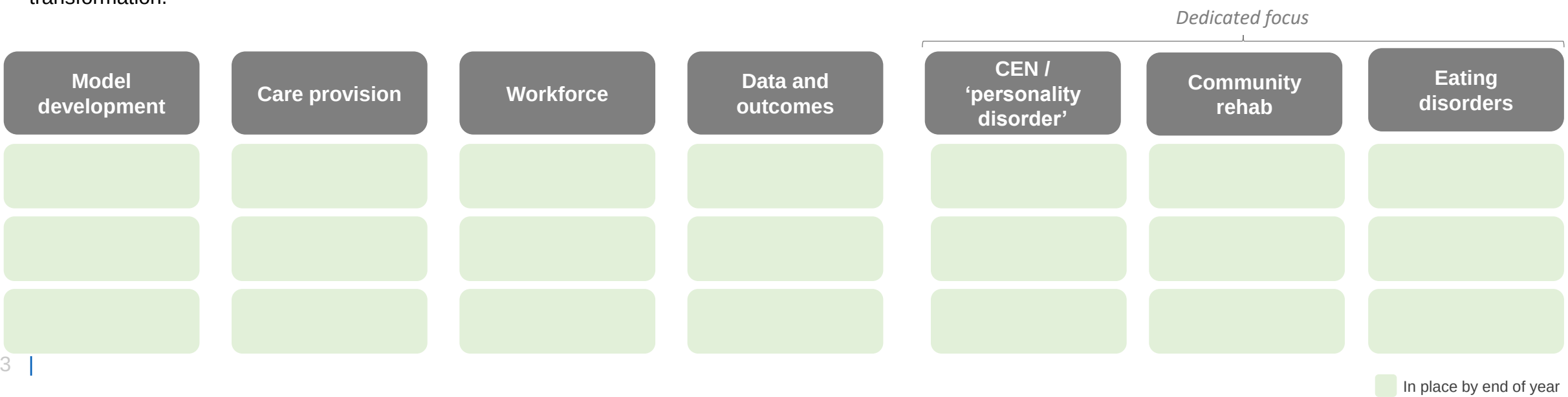
- This document is designed to support systems in the delivery of community mental health transformation.
- It is intended to set out the different elements which will make up the delivery of LTP commitments on community mental health transformation.
- It will also provide a simple and visual way of understanding system progress across the breadth of deliverables required for transformation.

How to use:

- The 'roadmap' sets out the key milestones and deliverables that underpin the transformation of community mental health as set out in the Community Mental Health Framework.
- Whilst the roadmap sets out the expected progress, we recognise that not all systems will be starting from the same point, nor will all systems progress at the same speed. The roadmap should be used as a guide for systems as to what needs to be delivered by the end of 2023/24 and can be tailored according to your systems plans.
- It should be read in conjunction with the 'criteria for data flow' which sets out the minimum criteria that must be met in order for a system to contribute towards the LTP access target – that section describes an interim point, whereas the roadmap is the route towards and beyond that point.

Versions :

- Version 1: Draft version of annexes including model development, care provision and workforce.
- Version 2: Finalised version including model development, care provision, workforce, data & outcomes, and eating disorders.



By 2023/24 - Priorities for Community Mental Health transformation

Note: Please click on each deliverable to link to detailed annex slide

Model development	Care provision	Workforce	Data & outcomes	*Dedicated focus[6]* CEN / 'personality disorder'	*Dedicated focus[6]* Community rehab	*Dedicated focus[6]* Eating disorders
Joint governance with ICB oversight[1]	"Must have" services[3] commissioned at PCN level tailored for SMI[7]	Recruitment in line with indicative 23/24 MH workforce profile	Interoperable standards for personalised and co-produced care planning	Dedicated function linked to core model: increased access to dedicated function and consultation, support, supervision and training to core model		
Model design coproduced with service users, carers & communities	"Additional" services[4] commissioned at PCN level tailored for SMI[7]	Expand MHP ARRS roles in primary care	Routine collection of PROMs using nationally recommended tools	Embed experts by experience in service development and delivery		
Integration with primary care with access to the model at PCN level[2]	Improved access to evidence-based psychological therapies	Staff accessing national training to deliver psychological therapies	Waiting time measured for CMH services (core & dedicated focus areas)	Co-produced model of care in place to support a diverse group of users	Ensure a strong MDT approach[5]	No barriers to access e.g. BMI or weight thresholds
Commissioning and partnership working with range of VCSE services	No wrong door approach means no rejected referrals recorded	Multi-disciplinary place-based model[5] in place	Interoperability for activity from primary, secondary and VCSE services		Clear milestones are in place to reduce reliance on inpatient provision	Early intervention model (e.g. FREED) embedded
Integration with Local Authority services	Tailored offer for young adults and older adults	Staff retention and well-being initiatives	Impact on advancing equalities monitored in routine data collection		Co-produced care and support planning is undertaken	Clear arrangements in place with primary care for medical monitoring
Expanding PCN coverage for transformed model	Principles for advancing equalities embedded in care provision	Dedicated resource to support full range of lived experience input			Supported housing strategy delivered in partnership with LAs	Support across spectrum of severity and type of ED diagnoses
Shift away from CPA towards personalised care	Support for co-occurring physical needs & substance use	Staff-caseload ratios to deliver high quality care				Joint working with CYP ED services including transitions
Alignment of model with NHS Talking Therapies, CYP & perinatal	Trauma-informed & personalised care approaches	Place-based co-location approaches				Accept self-referrals, VCS referrals and Primary Care referrals.

1. Governance to include commissioners, primary care (inc. PCN leadership), mental and physical health services, local authorities, VCSE, service users and carers
2. "PCN level" defined as a footprint of typically 30,000 and 50,000 people (this can also be thought of as "sub-place", "localities", or "clusters of wards"). More targeted, intensive and longer-term input for people with more complex needs can be provided at the wider community or "place" level of around 250,000–500,000 people (this can also be thought of as a "PCN-cluster")
3. Must-have: physical health checks, EIP, employment support, psychological therapies, social prescribing, personalised care planning, care coordination, peer support, outreach for inequalities
4. Additional: advocacy services, carer support, community assets, culturally competent services, financial advice, housing, social care, support groups, volunteering & education
5. Should include clinical psychologists; MH nurses; MH pharmacists; occupational therapists; primary care staff; psychiatrists; psychological therapists; social workers; community connectors; paid peer support workers
6. Systems should have commenced work on 2 of 3 dedicated focus areas in 2021/22, meeting relevant expectations. Where appropriate, aspects of core transformation model should be applied to dedicated focus areas
7. In this context 'SMI' covers a range of needs and diagnoses, including but not limited to; psychosis, bipolar disorder, 'personality disorder' diagnosis, eating disorders, severe depression and mental health rehabilitation needs – some of which may be co-existing with other conditions such as frailty, cognitive impairment, neurodevelopmental conditions or substance use

In place by end of year

Table of acronyms

Term	Definition	Term	Definition
CMH	Community Mental Health	LTP	Long Term Plan
CEN	Complex Emotional Needs	ICB	Integrated Care Board
PCN	Primary Care Network	SMI	Severe Mental Illness
VCSE	Voluntary, Community and Social Enterprise	ARRS	Additional Roles Reimbursement Scheme
CPA	Care Programme Approach	PRSB	Professional Records Standards Body
ARMS	At-Risk Mental State	IPS	Individual Placement and Support
NICE	National Institute for Health and Care Excellence	EIP	Early Intervention in Psychosis
HEE	Health Education England	PT – SMHP	Psychological Therapies for Severe Mental Health Problems
OPMH	Older Peoples Mental Health	CYP	Children and Young People
MDT	Multidisciplinary team	MHP	Mental Health Practitioner
PROMs	Patient Reported Outcome Measures	MHSDS	Mental Health Services Data Set

Breakdown of the annexes

Getting started

The 'getting started' box outlines the steps a system should consider before mobilising that particular aspect of transformation

Success

The 'success' box outlines some of the key markers of what successful transformation could look like (not an exhaustive list)

Resources and guidance

The 'resources and guidance' box includes references to existing resources and documentation that are relevant to implementing that particular aspect of transformation.

Many resources can be found on the NHS Futures Colloboration Platform. Please follow this link to join the NHSE Adult Mental Health page.

Service User Voice/Expectations

The 'service user voice/expectations' ~~will~~ outlines how this aspect of the roadmap will lead to a different and better experience for service users

This box includes quotes from the AMH advisory network, as well as quotes from case studies & resources.

Relies upon delivery of:

Different aspects of transformation are interlinked, which means different 'boxes' in the roadmap need to happen in conjunction for successful transformation.

The 'relies upon delivery of' box shares the other aspects of the roadmap that need to be in place for this section to be transformed.

Model development

Joint governance with ICB oversight

Getting started

1. CMH transformation leaders should be experienced clinicians, commissioners, practitioners, managers and people who have used and have experience of services, who can work effectively across organisational and professional boundaries.
2. Agree a robust Terms of Reference to ensure all partners have clarity on their roles and responsibilities.

Success

1. Representation should include as a minimum: ICBs, mental health services, primary care (including PCN reps), service users/carers, local authorities (social services, drug and alcohol services, housing), employment services, VCSE representatives, public health.
2. CMH governance structures should report into overall ICB governance boards.
3. Data flows to ICB to demonstrate performance against core LTP ambitions for access, and against quality markers including outcome measures and wait times.

Resources and guidance

- Local Government Association and NHS Clinical Commissioners Integrated Commissioning Guidance
- NHS England Large Scale Change – A Practical Guide
- NICE guideline on Shared Decision Making
- Lived Experience Leadership – Mapping the Lived Experience Landscape in Mental Health

Service User Voice/Expectations

For lived experience & patient leadership to be on par with clinical leadership.

For committees to be co-chaired with someone with lived experience and for all organisation to consider appointing a patient director as according to the NICE guidelines on Shared Decision Making.

Relies upon delivery of:

- Model design coproduced with service users, carers & communities
- Commissioning and partnership working with range of VCSE services
- Integration with primary care with access to the model at PCN level[2]
- Integration with Local Authority services

Model designed and co-produced with service users, carers & communities

Getting started

1. Service users, carers and families are represented on formal governance structures and operational groups.
2. Local systems identify community groups to develop long term relationships to inform new integrated models and to form part of the ongoing service user involvement, including representation from groups currently under-represented in services.
3. Local areas and systems make appropriate and sustained financial investment into the remuneration and co-ordination of experts by experience to participate at all levels of the transformation agenda.

Success

1. Adheres to the six key principles of co-produced commissioning.
2. Dedicated resources to support co-production have been developed which may include designated services/roles to facilitate co-production locally.
3. Strategies are in place to demonstrate how co-production will be used to continuously evaluate the community mental health transformation. There is a diversity of lived experience represented to help to address inequalities within services.

Resources and guidance

- Working Well Together – Evidence and tools to enable co-production in mental health commissioning
- NHS England Patient and Public Participation Policy
- NHS England and NHS Improvement and Coalition for Personalised Care model of Co-production
- The Ladder of Co-production
- The Patient Leadership Triangle

Service User Voice/Expectations

We're involved from the beginning in a meaningful way, beyond traditional methods of engagement.

More than just having our voices heard, we are included in the decision making and that where people want to they can be involved with the ongoing delivery, evaluation and continual improvement of the services.

Relies upon delivery of:

Commissioning and partnership working with range of VCSE services

Dedicated resource to support full range of lived experience input

Embed experts by experience in service development and delivery of dedicated focus areas

Integration with primary care with access at a PCN level

Getting started

1. Establish lead GPs in each practice/PCN to provide strategic leadership on mental health and maintain strategic relationships with mental health providers.
2. Consideration should be given to the types of interventions provided locally and to what extent these are wholly, partially or virtually aligned to PCNs depending on the size, speciality and remit of the team.
3. Ensure access to mental health services is provided at PCN-level by ensuring service users are able to easily request and access support within primary care settings.

Success

1. Integrated meetings for case/care coordination are taking place across primary care, secondary care, VCSE orgs, local authorities and any other appropriate local mental health providers to enable joint approaches to delivering care and support.
2. Mental health practitioner roles have been recruited in each PCN and are delivering brief interventions where appropriate, working with other PCN-based roles to help address the holistic needs of people with complex mental health problems and facilitating onward access to mental and physical health and biopsychosocial interventions.
3. Non-mental health primary care workforce is able to easily access advice/support/guidance from mental health colleagues to provide support for service users.
4. Primary care services are able to flow clinical data across different IT systems and to the MHSDS. There is not manual duplicate data entry across different IT systems.

Resources and guidance

- Additional Roles Reimbursement Scheme (ARRS)- Mental Health Practitioner resources
- Fuller stocktake report
- Other ARRS roles including personalised care roles
- CORE20PLUS5 (NHSE approach to action on inequalities)

Service User Voice/Expectations

Care should wrap around me and I should receive more or less care depending on how unwell or well I am rather than being shifted from my GP to a Trust and from team to team constantly having to retell my whole history and risk falling between the gaps or becoming frustrated and actively avoiding services.

Relies upon delivery of:

- "Must have" services[3] commissioned at PCN level tailored for SMI[7]
- "Additional" services[4] commissioned at PCN level tailored for SMI[7]
- Every ICB to have a new model fully in place
- Record access data from new model (inc. primary, secondary and VCS orgs)
- Expand MHP ARRS roles in primary care
- Interoperability for activity from primary, secondary and VCSE services

Commissioning and partnership working with range of VCSE services

Getting started

1. Understand the local landscape of existing VCSE provision and undertake gap analysis for underserved populations.
2. Agree plans between ICBs/providers and the VCSE as to how the VCSE organisations will be recognised as equal partners and that engagement with the sector translates into appropriate representation in formal governance structures.
3. Ringfence a proportion of transformation funding to invest in contracting with the VCSE with consideration given to how to best transfer information for direct care purposes.
4. Develop contracting models to provide sustainable funding to VCSE organisations e.g. alliance models and multi-year contracting.

Success

1. Local commissioners support VCSE organisations of all sizes to access longer term funding of 3+ year contracts.
2. VCSE alliance is established which brings together the breadth of provision in a local area – facilitating collaboration between organisations and ensuring smaller grassroots, local community/faith and user-led organisations are supported.
3. Specific roles (e.g. Community Connectors, peer support workers) are hosted in VCSE organisations and are a part of the PCN-level MDT.
4. VCSE services are seen as an equal delivery partner in a transformed model.

Resources and guidance

- Rethink's Keep Thinking Differently Guide
- Building Communities that Care
- King's Fund – Building resilience and sustainability

Service User Voice/Expectations

I am supported to access services which best meet my needs

My care is holistic and I am able to access help for things which may be adding to my distress, e.g. my housing or financial situation

Relies upon delivery of:

- Development of trauma-specific support, drawing on VCSE provision
- Interoperability for activity from primary, secondary and VCSE services
- Multi-disciplinary place-based model[5] in place
- Principles for advancing equalities embedded in care provision

Integration with Local Authority services

Getting started

1. Ensure there are named senior local authority figures included in governance and operational groups, including Directors of Adult Social Care, Directors of Public Health and housing leads.
2. Agree a joint approach to workforce, including embedding mental health social work and the principles of strengths / asset-based approaches within the new models.
3. Ensure local authority expertise is routinely sought and embedded within the new models – including drug and alcohol services and housing.

Success

1. An integrated approach to commissioning is established between NHS and local authority partners – ensuring the full breadth of mental health and local authority services are reflected within commissioning processes. This may include a co-produced mental health delivery plan which accounts for how health and social care will work together.
2. There is a trusted assessor / single assessment process to reduce the number of assessments needed for people to get access to the right services wherever they may present.
3. Have a shared understanding of community assets available within the local area and how these can be leveraged to support delivery of community mental health services for people with SMI.

Resources and guidance

- Rethink - Local authorities and Community Mental Health Framework – Making Partnership Real
- Local Gov: Must Know: Is your council doing all it can to improve mental health?
- Getting started with Integrated Personal Health Budgets

Service User Voice/Expectations

Help to find decent safe housing so I can focus on getting better and not be constantly worried about where I'm living or not feel safe in my flat.

Better supported housing so I can get better after being in hospital and not end up back in again.

I can access peer support groups close to home, and not have to travel far distances to access support

Relies upon delivery of:

- No wrong door approach means no rejected referrals recorded
- Multi-disciplinary place-based model[5] in place
- Shift away from CPA towards personalised care
- Support for co-occurring physical needs & substance use
- Interoperable standards for personalised and co-produced care planning

Expanding PCN coverage for transformed model

Getting started

1. Agree between primary and secondary care which geography of PCNs will be transformed in each year to expand coverage by 23/24 so all stakeholders are aware of potential changes to service delivery ahead of time. Models are built around existing GP practices, neighbourhoods and community hubs.
2. Appraise local CMHT caseloads and map these against each constituent Primary Care Network. Areas are expected to explore local opportunities to wholly or partially align caseloads and teams to these networks. Time should be given to caseload holders to develop strong links with their PCN colleagues.

Success

1. Over the course of the LTP programme, the ICS transform PCNs and expands coverage of transformed models across the ICS.
2. Each PCN within an ICS footprint has access to an integrated primary and community mental health team, which considers the wider determinants of health in unison with assessing mental health needs.

Resources and guidance

- Community Mental Health Framework
- Criteria for data flow
- National webinar – measuring the impact of transformation
- Good practice case studies

Service User Voice/Expectations

I am able to access a transformed model of care, support and treatment close to home

I am able to join groups and access support provided by VCSE and local authorities close to home

My mental health and physical health needs are met together in unison

Relies upon delivery of:

- Joint governance with ICB oversight[1]
- Commissioning and partnership working with range of VCSE services
- Model design coproduced with service users, carers & communities
- Integration with Local Authority services
- Integration with primary care with access to the model at PCN level[2]
- Recruitment in line with indicative 23/24 MH workforce profile

Shift away from CPA towards personalised care and support planning

Getting started

1. Engage with lived experience advisors to understand the existing good elements of care planning which can be built upon.
2. Review existing caseload and agree plan to ensure all service users on/off the CPA are phased into the new approach.
3. Bring together all partners involved in delivering care to agree the development of joint approaches, including case management, risk management, training/supervision and interoperability.
4. Set out a clear communication and engagement plan to bring staff and service users/carers/families on the journey.

Success

1. Patient Reported Outcome Measures such as DIALOG and Goals Based Outcomes are used to identify the service user's own personal needs and goals and these are addressed within co-produced and intervention-based care plans.
2. All service users have a named key worker who identifies staff from across professions and partners to jointly deliver a recovery and needs-led led approach for service users and their carers.
3. Delivery of care recognises the unique contributions of the members of the multi-disciplinary team and staff are supported to use their individual skills and knowledge.

Resources and guidance

- PRSB care standards
- PRSB Toolkit to support transition
- CPA Position Statement
- Personalised Care – Future NHS page
- DAPB4022: Personalised Care and Support Plan - NHS Digital
- Getting started with Integrated Personal Budgets

Service User Voice/Expectations

People see me as a person not a risk entity

I'm involved in deciding my care and support. My personalised care and support plan is regularly reviewed and updated, with my input.

All of my support needs are captured across mental health, physical health, social care and VCSE needs

Relies upon delivery of:

- Integration with primary care with access to the model at PCN level[2]
- Interoperable standards for personalised and co-produced care planning
- Commissioning and partnership working with range of VCSE services
- Routine collection of PROMs using nationally recommended tools
- Integration with Local Authority services
- Staff-caseload ratios to deliver high quality care

CMHT alignment of model with NHS Talking Therapies for anxiety & depression

NHS England

Getting started

1. Ensure primary care are aware of breadth of local mental health service offer to make sure individuals are referred to most appropriate services.
2. Identify opportunities (e.g. through regular MDT meetings) for NHS Talking Therapies staff and CMH staff to jointly identify appropriate treatments and pathways for individuals seeking support.
3. Explore locally-led approaches and models that support seamless pathways between Talking Therapies and CMH (e.g. trusted assessor scheme).
4. Identify and invest in gaps in provision, including investment in psychological therapies for a range of treatments outside of Talking Therapies (e.g. eating disorders, psychosis, bi-polar disorder).

Success

1. Community mental health services and Talking Therapies work collaboratively, to ensure people seeking support in Talking Therapies who require support from community mental health services are supported to access help.
2. Patients that need to access Talking Therapies and/or CMH services are supported to find the right service for their needs in a timely manner without being bounced between services.
3. Staff in both Talking Therapies and community mental health services have an understanding of provision across both services, meaning people seeking support are not sent to the wrong service.
4. Where an individual requires a different team, the individual is supported throughout the process and identified wider determinants of health continue to be met within PCN-based team.
5. Utilising the nationally available supervision funding to expand supervisor capacity and support the delivery of the national PT-SMHP training programmes.

Resources and guidance

- IAPT Manual IAPT Manual (england.nhs.uk)
- IAPT LTC Guidance IAPT-LTC Full Implementation Guidance (rcpsych.ac.uk)
- Increasing Access to Psychological Therapies for Severe Mental Health Problems - Implementation Guidance

Service User Voice/Expectations

I go to one place, which is in my local area, to receive my mental and physical care. I prefer this as it makes my care more accessible.

All my needs as a person are assessed and taken into account. This means that I and the staff caring for me arrive at a better and faster understanding of my mental and physical health problems.

Relies upon delivery of:

Improved access to evidence-based psychological therapies

Staff accessing national training to deliver psychological therapies

Routine collection of PROMs using nationally recommended tools

Alignment of model with Perinatal Mental Health (PMH) services

Getting started

1. Identify a lead who takes responsibility for ensuring alignment between community mental health (CMH) services and perinatal mental health (PMH) services.
2. Ensure local communications are clear around the PMH services offer and who is appropriate vs other services within the CMH system.
3. Explore locally-led approaches that support seamless pathways and transitions for individuals to and from CMH and PMH services.
4. Consider the needs of partners who may be in touch with CMH services and/or are supporting partners receiving support from PMH services. *(Partners of those accessing specialist community PMH services are able to receive evidence-based assessment for their mental health and signposting as appropriate*).

Success

1. Staff in both CMH and PMH services have a good understanding of provision across both services, meaning people are not sent to the wrong service.
2. Community mental health (CMH) and perinatal mental health (PMH) services work collaboratively to make decisions about the types and timings of treatments and ensure people who require support from either service can access clinically appropriate treatment.
3. Individuals that need to transition to and/or from PMH services to CMH services can do so seamlessly, without having to repeat their story.
4. Improved awareness of the needs of partners and family members of those receiving support in PMH services.

Resources and guidance

- Long-Term plan commitments for Perinatal mental health
- Perinatal Mental Health dashboard (NHS Futures)
- Perinatal Mental Health resource library (NHS Futures)
- CCQI standards for community perinatal mental health services
- CCQI standards for inpatient perinatal mental health services

Service User Voice/Expectations

"Switching from CMH to Perinatal and back to CMH can be distressing with no one to bridge the gap. Services should be much more joined up – I want to be treated like a whole person".

"Continuity of carer is critical. When I'm seen by a new doctor it's so important that they have read my notes. Having to repeat my story every six months made me very anxious."

Relies upon delivery of:

- Model design coproduced with service users, carers & communities
- No wrong door approach means no rejected referrals recorded
- Principles for advancing equalities embedded in care provision
- Alignment of model with NHS Talking Therapies for Anxiety and Depression, CYP & perinatal

Alignment with CYP is captured on slide 24

Care provision

Physical Health Care services commissioned at PCN-level

Getting started

1. Partnership with the VCSE sector to commission specific outreach services, co-produced with people with SMI, to increase the uptake of physical health checks – with a focus on underserved communities, e.g. healthy eating support, team sports, gym memberships, home exercises.
2. Commission dedicated services to deliver SMI physical health checks and ensure access to follow-up interventions.
3. Joint approaches with the VCSE sector to commission holistic health and wellbeing services for people with SMI e.g. healthy eating support, team sports, gym memberships, home exercises.
4. Work with PCNs and primary care to ensure GP SMI registers are up to date.

Success

1. People with SMI are offered a comprehensive physical health check every year, with an increasing number taking up the offer (the core check being incentivised through QOF) and are able to access support for physical health needs as part of a holistic offer of care.
2. Physical and mental health services are aligned and working jointly to support people with SMI, e.g. linking up with specialist MH tobacco dependency services for people with SMI.
3. Local recording of SMI physical health checks demonstrate the outcome of the check (e.g. number of individuals identified with high blood pressure who were supported to access a GP appointment).
4. SNOMED and Read Codes are aligned across primary and secondary care to enable accurate reporting.

Resources and guidance

- Improving physical healthcare for people living with severe mental illness (SMI) in primary care: Guidance for CCGs
- Personal Health Budgets (PHBs) for mental health
- CORE20PLUS5 (NHSE approach to action on inequalities)
- Rethink physical health check toolkit
- Equally well guide on Covid-19 vaccinations

Service User Voice/Expectations

Physical health checks are holistic and include conversations about my mental health as well as my physical health

I am supported to access follow-up interventions after my physical health check

Relies upon delivery of:

- Commissioning and partnership working with range of VCSE services
- Record access data from new model (inc. primary, secondary and VCS orgs)
- Support for co-occurring physical needs & substance use
- Interoperability for activity from primary, secondary and VCSE services

Individual Placement and Support services commissioned at PCN-level

Getting started

1. To achieve LTP access targets, allocate appropriate investment to services from CMH baseline funding. Awarding contracts on a multi-year basis can help with recruitment of IPS workforce.
2. Ensure referrals to IPS can be accepted from the range of partners involved in delivering CMH services, as well as allowing for referrals from primary care / self-referral.
3. Promote IPS as a solution for NHS organisations to fulfil their local employer responsibilities as anchor institutions. Collaborating with local communities to improve local social, economic, and environmental conditions can help support the health and prosperity of people and communities.
4. Ensure accurate performance and data reporting through MHSDS, along with accompanying robust governance structures.

Success

1. All IPS services follow an evidence-based model and use fidelity reviews as a means of driving quality improvement. Fidelity reviews are delivered by IPS Grow and assess services against a number of factors that are proven to improve outcomes for people with SMI including the degree to which IPS is integrated within clinical teams and MDTs.
2. CMH-recommended outcomes measures (incl. DIALOG) are adopted as a means of measuring outcomes and assessing employment aspirations.
3. All IPS providers are supported to expand access and are set up to receive referrals from all appropriate sources.
4. New IPS services achieve min. 30-40% of clients into new / retain existing employment; mature services achieve job outcome rates of min. 40-50%.

Resources and guidance

- Guidance for ICBs – February 2023
- Case studies highlighting aspects of good practice
- IPS Resource Pack May 2021
- Resources available to model the workforce required to achieve the local LTP targets
- HEE recruitment vignettes
- MHSDS dashboard, data quality workshops and data resources and guidance
- Collection of stories of individuals who have accessed IPS
- IPS Employment Recovery Stories
- Information for potential clients

Service User Voice/Expectations

"Work has had a big impact on the speed of my recovery. IPS has given me the confidence to pick myself up and realise that I can find work and move forward with my life without feeling pressured or inadequate. It has enabled me to function and get back to my normality and I have been really enjoying contributing to society. I don't think I would have been able to find a job without my ES, and due to the work and their support I have been stable and have not had a relapse since starting".

Relies upon delivery of:

- Recruitment in line with indicative 23/24 MH workforce profile
- Record access data from new model (inc. primary, secondary and VCS orgs)
- Commissioning and partnership working with range of VCSE services
- Routine collection of PROMs using nationally recommended tools
- "Must have" services[3] commissioned at PCN level tailored for SMI[7]

Early Intervention in Psychosis services commissioned at PCN-level

NHS England

Getting started

1. To ensure sufficient recruitment of workforce and service provision, allocate appropriate investment from CMH baseline funding.
2. Provide access to a full range of NICE-approved interventions, increase service provision to include people aged over 35, and introduce appropriate pathways and services for at-risk mental state (ARMS) patients.
3. Ensure EIP services remain a key part of the rapidly transforming mental health offer within transformed CMH services.
4. Routinely capture outcomes and access data in line with latest EIP guidance.

Success

1. People with a suspected first episode of psychosis are able to start treatment within 2 weeks of referral (At least 60% of people is the current LTP commitment).
2. Everyone accessing EIP services receives high quality care and treatment via a NICE-approved care package. (A target of at least 95% of services is the current LTP commitment).
3. All people aged 14 – 65 years can access services, as well as provision and effective pathways for people with an at-risk mental state (ARMS).
4. Outcomes (and analysis of available equalities data) are regularly measured (conducted) and reviewed, and used to drive improvements of the services provided.

Resources and guidance

- EIP Triangulation Tool
- NCAP Audit 2020/21 Report
- Implementing the EIP Access and Waiting Time Standard: Guidance – December 2022 update (awaiting publication approval)
- Guidance on recording and reporting on NICE-recommended interventions using SNOMED CT codes – November 2022 update
- Improving NICE-concordance for EIP teams Support pack for regions – August 2018

Service User Voice/Expectations

I was so wary of help and advice from others, that when I was referred into EIP, I felt I could relax in a way that I hadn't been able to in so long…With the continued support of EIP across three years I feel like "me" again.

Relies upon delivery of:

- Recruitment in line with indicative 23/24 MH workforce profile
- "Must have" services[3] commissioned at PCN level tailored for SMI[7]
- Routine collection of PROMs using nationally recommended tools

All other must-have and additional services are available at PCN-level

Getting started

1. Understand your local population's mental health and physical health needs, including identifying health inequalities, map the existing community assets available, and determine where there are gaps in provision.
2. Establish partnership working with local authorities and VCSE organisations. Joint governance structures should be established that include local authorities, VCSE and lived experience advisors.

Success

1. Every service user can access the support services they need at a PCN-level as a holistic approach to their care, including VCSE, employment support, housing support etc.
2. Where an individual may not be able to access an evidence-based psychological intervention, their needs will still be assessed and they will be offered support to access wider social need support (debt, housing, befriending etc) until they are able to access psychological support.
3. Mental health staff are embedded within PCNs and work effectively with the wider PCN workforce as part of an integrated team.

Resources and guidance

- Community Mental Health Framework
- NCCMH Community Mental Health Framework Long Guide
- Community Mental Health Animation

Service User Voice/Expectations

I want access to advocacy support when I can't do these things for myself, so I can get the right support for me

I want to know what is in my community, and be able to do something without needing a referral

Relies upon delivery of:

- Joint governance with ICB oversight[1]
- Commissioning and partnership working with range of VCSE services
- Integration with Local Authority services

Improved access to evidence-based psychological therapies/Staff accessing national training to delivery psychological therapies

Getting started

1. Local systems should develop a specific local strategy for implementing increased access to NICE-recommended psychological therapies for psychosis, 'personality disorder', eating disorders and bipolar disorder.
2. Recruit additional psychological professionals with the required specific psychological therapy competencies and accreditations, utilising recruit-to-train funding where available. These professionals should also be supported to access training to supervise trainees.
3. Ensure therapists have sufficient time in their job plan for training on and delivery of psychological therapies. This can be supported by creating other roles e.g. Mental health and Wellbeing Practitioners to take on work around care planning and co-ordination.

Success

1. Every service user should be able to access suitable evidence-based psychological therapies, although not all will choose to take up the offer.
2. All psychological therapies should be offered according to the principles and protocols set out by NICE.
3. Therapists must be competent to deliver the therapies as set out in nationally-agreed competence frameworks for their delivery.
4. Utilising the newly developed national dashboard to understand access to evidence-based therapy.

Resources and guidance

- NHSE PT-SMHP resources
- PT-SMHP Implementation Guidance
- HEE training offer for PT-SMHP
- UCL Competence Frameworks

Service User Voice/Expectations

My clinicians are aware of the different therapies available

I am given a choice of the psychological therapies which would benefit me and understand what they are

Relies upon delivery of:

- "Must have" services[3] commissioned at PCN level tailored for SMI[7]
- Interoperable standards for personalised and co-produced care planning
- Staff accessing national training to deliver psychological therapies
- Waiting time measured for CMH services (core & dedicated focus areas)
- Multi-disciplinary place-based model[5] in place
- Alignment of model with IAPT, CYP & perinatal

No wrong door approach means no rejected referrals recorded

Getting started

1. Ensure access to mental health services is provided at PCN-level by ensuring service users are able to easily request and access support within primary care settings.
2. Ensure a mechanism (e.g. via existing governance structures or integrated PCN meetings) is in place for joint discussions between all partners to agree appropriate alternative services for any need which cannot be met within the new model.
3. Ensure assessment processes include consideration of social and mental health needs and service users are supported to access the breadth of services offered according to their needs.

Success

1. All referrals or requests for service are provided with support from the new model or are transferred via a supported handover to alternative services/self-help where their needs cannot be met within the new model.
2. Where social needs are identified which can be met through VCSE or similar partnership arrangements, the individual is supported to meet these needs as soon as they are identified.
3. Service users requesting support are kept informed throughout the process in a timely way.
4. Activity is recorded in MHSDS in line with waiting time standards for community mental health.

Resources and guidance

- Community Mental Health Framework
- Community Mental Health animation
- Measuring waiting times in non-urgent CMH services guidance

Service User Voice/Expectations

Whoever sees me asks me what they can do to help me today

My options and next steps are explained to me at every step in the process

The care I receive is holistic and flexible to my needs

Relies upon delivery of:

- "Must have" services[3] commissioned at PCN level tailored for SMI[7]
- Recruitment in line with indicative 23/24 MH workforce profile
- "Additional" services[4] commissioned at PCN level tailored for SMI[7]
- Multi-disciplinary place-based model[5] in place
- Alignment of model with IAPT, CYP & perinatal

Tailored offer for young adults, ensuring alignment with CYP

Getting started

1. Ensure young adults (and their families) are represented in design, delivery and evaluation of services and governance arrangements.
2. As part of model development, ensure joint working arrangements are in place between CYP and adult services to support transitions, and that appropriate partners in the VCSE sector and local authorities are also part of the working arrangements.
3. Consider groups of young adults who may have a higher rate of mental health difficulties and/or face more barriers to accessing services. For example, ensuring there are places in place to support care leavers and students.

Success

1. There are clear pathways between CYP and Adult services that ensure there are no rigid age-based thresholds that automatic transitions when a young person turns 18 and arrangements for transitions are in line with NICE guidelines.
2. The proportion of young people who successfully transition into adult services is reviewed at regular intervals between ICB's, CYP and AMH providers.
3. Existing services have been adapted to be developmentally appropriate for young adults.
4. The workforce has the appropriate skills, competencies and knowledge to effectively engage and work with young adults.

Resources and guidance

- Meeting the needs of young adults within models of mental health care (NCCMH)
- Transitions from children's to adults' services for young people using health or social care services (NICE)
- Learning from Literature: Young adult models of mental health care toolkit (NHS Futures page)

Service User Voice/Expectations

"We need age boundaries to be flexible and person-centred because nothing changes overnight on our 18th birthday, and for many, it is a time of so many other transitions in life that it is already under significant pressure. We need more availability of options for therapies and support with joined-up, holistic between services, and more availability of advocacy for the many who may have to be relying less on family in a way they haven't before."

Relies upon delivery of:

- Model design coproduced with service users, carers & communities
- Alignment of model with IAPT, CYP & perinatal
- Commissioning and partnership working with range of VCSE services
- Principles for advancing equalities embedded in care provision
- No wrong door approach means no rejected referrals recorded
- Waiting time measured for CMH services (core & dedicated focus areas)

Tailored offer for older adults

Getting started

1. Ensure there is at least one named ICB-wide lead for improving older people's mental health (OPMH) (e.g. a MH provider clinical director to work across ICB Mental Health and Ageing Well programmes).
2. Integrate with other partners, including PCNs, acute and community providers to address the physical health co-morbidities of older adults with SMI, and multimorbidity, and to ensure that mental health needs are considered alongside ongoing physical health needs.
3. Recruit OPMH-specific staff to work in the new models, including older adult peer support workers (or equivalent) and OPMH new roles e.g. OPMH advanced clinical practitioners.

Success

1. There is equity of access to psychological therapies for older adults, including for older adults with specific needs (for e.g., those with complex emotional needs or 'personality disorder', those in need of community Rehabilitation or Eating Disorder services etc.)
2. Tailored approaches are taken to ensure the needs of older adults are being met in the delivery of interventions and measurement of outcomes, and older adults are not being referred to services that don't meet their needs.
3. Approaches to reducing digital exclusion are undertaken specific to older adults.
4. HEE's OPMH Competency Framework is implemented across all staff working in the new models.

Resources and guidance

- Older People's Mental Health Competency Framework
- The Framework for Enhanced Health in Care Homes
- Faculty of Old Age Psychiatry resources

Service User Voice/Expectations

I have equal and appropriate access to services which meet my needs.

Services are joined up and holistic, with a range of options available which enable older people to have a meaningful life.

Relies upon delivery of:

- Principles for advancing equalities embedded in care provision
- Model design coproduced with service users, carers & communities
- Recruitment in line with indicative 21/22 MH workforce profile
- Multi-disciplinary place-based model[5] in place
- Commissioning and partnership working with range of VCSE services

Principles for advancing equalities embedded in care provision

Getting started

1. Undertake population needs mapping at a community/PCN level, using data and local community engagement, to identify under-served groups. Undertake a gap analysis of VCSE service provision, and ringfence funding to help address MH inequalities.
2. Build partnerships or alliances with local organisations (e.g. VCSE providers) that can help reach these under-served groups and come together to deliver existing and new support offers.
3. Recruit lived experience roles from groups identified as experiencing inequalities, ensuring they are appropriately supported.
4. Consider recruitment and training strategies for the development of a representative workforce to help advance equalities in care.
5. Review requirements of PCREF, and ensure all MH Trusts in the system have plans to embed the organisational competencies

Success

1. Each PCN has a population health profile which considers all inequalities important to the local area.
2. A clear local equalities action plan for improving access, outcomes and experience is in place and regularly monitored, including transitional needs of young people (18-25) and older adults.
3. Lived experience input is embedded at all levels to help shape priorities.
4. Strong partnerships or alliances are in place with local organisations that help with outreach and delivering services to underserved groups, with increasing sustainable investment into VCSE organisations.
5. Plans are in place for a more diverse, representative workforce, with good standards of cultural competence and skills to meet the needs of the local population.
6. The PCREF has been fully embedded in all MH Trusts in the system.
7. Improvements in addressing inequalities are evidenced through routine data collection (see slide 39)

Resources and guidance

- NHS Advancing Mental Health Equalities Strategy
- CORE20PLUS5 (NHSE approach to action on inequalities)
- PCREF workspace on NHS Futures
- (NCCMH) Steps and guidance on commissioning and delivering equality in mental health care
- Centre for Mental Health – Briefings on equalities in mental health
- Network Contract DES – tackling neighbourhood health inequalities guidance for 2023/24

Service User Voice/Expectations

Services help me to live a longer, recovery focused life where I am empowered to make decisions about my care

Organisations work together to address inequalities and support me in a holistic way, including my wider socio-economic needs

To see service users represented and embedded within systems

Relies upon delivery of:

- Model design coproduced with service users, carers & communities
- Dedicated resource to support full range of lived experience input
- Commissioning and partnership working with range of VCSE services
- Shift away from CPA towards personalised care
- Tailored offer for young adults and older adults
- No wrong door approach means no rejected referrals recorded
- Support for co-occurring physical needs & substance use
- Impact on advancing equalities monitored in routine data collection

Support for co-occurring physical needs and substance use

Getting started

1. Joint approaches with VCSE sector to commission holistic health and wellbeing services which support people with co-occurring physical health needs and substance use who may have previously fallen through gaps, including for those with hearing impairments, visual impairments and other physical disabilities.
2. Establish joint working relationships between mental health and drug and alcohol services. There is consideration around data sharing agreements and shared care plans.
3. Review existing inclusion/exclusion criteria to ensure co-occurring substance use needs can be met via the new models, including personalised and tailored approaches where needed. Individual assessments are undertaken to ascertain what support can be provided.
4. Service users are involved in the development and delivery of service, and are embedded across the system.

Success

1. Service users are able to access support for physical health needs as part of a holistic offer of care.
2. Access to mental health support is available for people with a co-occurring substance use need.
3. Where an individual may not be able to access an evidence-based psychological intervention, their needs will still be assessed and they will be offered support to access wider social need support (debt, housing, befriending etc) until they are stable and able to access psychological support.
4. Services accurately record and flow access data and patient outcomes. There are data sharing agreements and shared care plans in place.

Resources and guidance

- Better care for people with co-occurring mental health and alcohol/drug-use conditions – guidance for commissioners and service providers
- Review of drugs part two: prevention, treatment, and recovery - GOV.UK (www.gov.uk)
- GOV UK - 'From harm to hope'
- NICE guidance - coexisting SMI and substance misuse
- Community mental health framework

Service User Voice/Expectations

I am able to access support for my mental health when I need it and am not excluded from services if I have substance use needs

Services are accessible and flexible to my needs, for example, accessing morning appointments rather than late appointments

Relies upon delivery of:

- Commissioning and partnership working with range of VCSE services
- No wrong door approach means no rejected referrals recorded
- Integration with Local Authority services

Trauma-informed and personalised care approaches

Getting started

1. Work across the system (including VCSE, local authority and lived experience partners) to establish an organisational approach to trauma informed and personalised care.
2. Develop system understanding of the 4 key assumptions for trauma informed care:
    1. Realising what trauma is and how it affects us
    2. Recognising traumatic events and their effects
    3. Responding to traumatic events and their consequences
    4. Resisting re-traumatisation
3. Service users are involved in the development and delivery of service, and are embedded across the system. They are recognised as part of formal governance structures.

Success

1. Care is person-centred, and responsive to the changing needs of the service user. Organisations take a personalised approach to care, offering choice to accommodate the wide range of individual needs.
2. Service users are seen as equal partners and involved in the delivery of their care; they are empowered to make decisions and services recognise the value of trusting relationships in delivering care.
3. Staff and service users feel physically and psychologically safe.
4. Peer support is integral to service delivery and is understood as a key vehicle to building trust, establishing safety and empowerment.

Resources and guidance

- Working definition of trauma-informed practice - GOV.UK (www.gov.uk)
- CNWL Trauma Informed Approaches
- PRSB Toolkit to support transition to personalised care

Service User Voice/Expectations

I want an assessment to be about understanding me and my needs, where I don't have to repeat myself if I don't need to. Services are emotionally intelligent, trauma informed and psychologically informed.

I have the right to feel and be safe. I want to trust that services will provide the right care if I ever feel vulnerable, and will make sure I'm safe

I receive a personalised care plan which is reviewed at regular intervals.

Relies upon delivery of:

- "Must have" services[3] commissioned at PCN level tailored for SMI[7]
- Shift away from CPA towards personalised care
- Model design coproduced with service users, carers & communities
- Dedicated resource to support full range of lived experience input
- Improved access to evidence-based psychological therapies

Workforce

Recruitment in line with indicative 23/24 workforce profile

Getting started

1. Agree a workforce plan with relevant partners and undertake integrated approaches to recruitment with local authorities and the VCSE.
2. Ensure the workforce plan includes appropriate skill-mix to deliver the breadth of transformation ambitions and a mix of clinical and non-clinical roles.
3. Develop tailored strategies for rapid and inclusive recruitment processes, with mitigations for risks and delays.
4. Explore use of new roles / alternative models to address recruitment challenges.

Success

1. All transformation-funded roles are recruited to in line with submitted transformation plans, including new roles (Mental Health and Wellbeing Practitioners and peer support workers).
2. Innovative approaches to workforce configurations are being taken and ongoing recruitment decisions are informed by previous recruitment challenges and successes.
3. Consideration is given to the most appropriate employing organisation and all new staff are supported to work as one team even if employing organisations are different.

Resources and guidance

- LTP Analytical Tool
- Health Education England resources on new roles in mental health

Service User Voice/Expectations

I am able to access a peer support worker, and advocacy support as part of my care

The workforce configuration is monitored to ensure it is working for the local population needs

Lived experience advisors are embedded at all levels, and are included in recruitment processes

Relies upon delivery of:

- Integration with primary care with access to the model at PCN level[2]
- Expand MHP ARRS roles in primary care
- Commissioning and partnership working with range of VCSE services
- Staff retention and well-being initiatives
- Integration with Local Authority services

Expand Mental Health Practitioner ARRS roles in primary care

Getting started

1. Build relationship between the MH provider and PCNs and ensure the MHP role addresses local population health needs.
2. Ensure investment for all planned roles is accounted for in the funding envelope available for community mental health services, taking into consideration 50% funding comes from the ARRS programme.
3. Embed the MHP roles in accordance with the PCN DES contract specification, taking care to ensure the role is not isolated and has sufficient support, to mitigate against future retention issues.
4. Consider how MHPs could sit alongside other PCN-based roles that can support mental health needs, including ARRS roles like social prescribing link workers

Success

1. All PCNs have recruited MHPs in line with available entitlements for the year.
2. Clear pathways and joint operational management plans are in place to ensure MHPs can seamlessly integrate into both primary and secondary care teams.
3. MHPs are meeting the needs of service users with complex mental heath needs – ensuring people with SMI can be seen, assessed and treated from a locally-based team.
4. A range of clinical and non-clinical roles are considered, and wider socio-economic needs of services users are met.
5. MHPs can support and upskill broader PCN MDT to increase competence in supporting people with complex mental health needs

Resources and guidance

- NHS England – PCN DES Contract (see page 111 for mental health roles)
- NHS Futures page for ARRS roles

Service User Voice/Expectations

For the first time I feel like I've been really listened to and taken seriously

I was seen so quickly and didn't have to wait months to talk to somebody. That's so important when you're feeling really low.

Relies upon delivery of:

- Integration with primary care with access to the model at PCN level[2]
- Multi-disciplinary place-based model[5] in place
- Improved access to evidence-based psychological therapies
- Interoperable standards for personalised and co-produced care planning
- Recruitment in line with indicative 23/24 MH workforce profile
- Interoperability for activity from primary, secondary and VCSE services

Multi-disciplinary place-based model in place / Place based co-location approaches

Getting started

1. Draw on innovative workforce configurations and expand existing MDT approaches across clinical and non-clinical roles.
2. Ensure the breadth of disciplines for delivery of transformed service is reflected in MDTs – including but not limited to psychological professions, occupational therapists, mental health pharmacists, mental health social workers, substance use expertise, advanced MH clinical practitioners and the paid employment of peer support workers / senior lived experience practitioner / expert by experience roles.

Success

1. Expertise from all members (clinical and non-clinical) of the MDT is available and easily accessible to ensure timely care and support offered to service users.
2. VCSE and local authority staff are part of the MDT.
3. Consideration has been given across the MDT as to the most appropriate level staff should operate at (e.g. MHPs will be working at PCN-level whereas an OPMH clinician may operate across multiple PCNs).

Resources and guidance

- Multidisciplinary Team (MDT) Toolkit | Health Education England (hee.nhs.uk)
- HEE Roles Explorer - FutureNHS Collaboration Platform
- Health Education England resources on new roles in mental health

Service User Voice/Expectations

I expect that the people involved in my care will listen to me, talk to me and to each other, and work together. I don't want to repeat myself if I don't have to

Relies upon delivery of:

- Integration with primary care with access to the model at PCN level[2]
- Recruitment in line with indicative 23/24 MH workforce profile
- Commissioning and partnership working with range of VCSE services
- Expand MHP ARRS roles in primary care
- Integration with Local Authority services

Staff retention and well-being initiatives

Getting started

1. Staff across ICS are engaged and involved from the beginning design and delivery phases of the transformation, to create a shared ownership and vision.
2. Consider how the different cultures of primary, secondary care, VCSE and local authorities will operate in terms of how work is arranged and how collective decisions are made in relation to service provision.
3. Undertake organisational development / cultural development work to support the new team to define joint values, behaviours and working practices.
4. Community and PCN level multidisciplinary teams are developed to link into existing PCN structures to maximise the potential for joint working.

Success

1. The collective workforce understands their role, remit and feels part of the local community/PCN team.
2. Staff across ICS feel valued and take pride in their work.
3. The collective workforce has a shared vision, where needs-led care is at the heart of delivery of support and care.
4. A local health and wellbeing strategy is in place for your workforce, and it's impact is regularly evaluated. There are open channels of communication in place for staff, including implementation of exit interviews.

Resources and guidance

NHS England » NHS health and wellbeing framework

Supporting your workforce webinar

Service User Voice/Expectations

Lived experience advisors should be embedded in systems, and are treated as an equal partner. My views are validated, acknowledged and supported.

Workforce has a shared vision, where my care is needs-led.

Relies upon delivery of:

- Integration with primary care with access to the model at PCN level[2]
- Recruitment in line with indicative 23/24 MH workforce profile
- Commissioning and partnership working with range of VCSE services
- Integration with Local Authority services

Dedicated resource to support full range of lived experience input

Getting started

1. Ensure there is a wide range of lived experience input into the programme – at all levels of the programme and at varying degrees of seniority.
2. Ensure people with lived experience are supported appropriately and tailored approaches are taken to providing support depending on the type of involvement/engagement.
3. Develop peer support roles to support the delivery of care which supported by appropriate training and supervision.

Success

1. Specific roles have been developed or services commissioned to support lived experience input which includes providing appropriate training, supervision and ongoing support.
2. There is sustainable funding to provide ongoing support for people with lived experience and they are seen as part of transformation teams.
3. A wide range of peer support roles are available in local communities.

Resources and guidance

- The SUN Network Co-production and Involvement guidance
- Rethink – Thinking Differently Guide and Keep Thinking Different Guide

Service User Voice/Expectations

The contribution of service users and carers is valued equally to those of professionals

Lived experience advisors are embedded throughout the system at all levels of seniority.

I am empowered and enabled to contribute a lived experience perspective. Involvement opportunities for lived experience advisors are transparent, open and widely communicated.

Relies upon delivery of:

Recruitment in line with indicative 23/24 MH workforce profile

Model design coproduced with service users, carers & communities

Staff retention and well-being initiatives

Staff-caseload ratios to deliver high quality care

Getting started

1. Undertake population needs mapping at a local level and develop a workforce plan in accordance with local need. Consider provision of resource to enable delivery of high quality care including face to face contact with service users.
2. Ensure the workforce plan includes appropriate skill-mix to deliver the breadth of transformation ambitions and a mix of clinical and non-clinical roles.
3. Appropriate plans are put into place to enable staff to access supervision and training. Establish team meetings and team working to offer professional discussion and reflective practice.

Success

1. Staff across the MDT have time to deliver high quality and equitable care to all service users, including seeing patients face to face where appropriate.
2. Staff are supported to access appropriate training to enable them to deliver high quality care to service users. Staff also have appropriate supervision arrangements in place to support them to deliver safe practice.
3. Service users have timely access to the appropriate, high-quality, personalised care which meets their needs.
4. Outcome measures are used to improve understanding of service users' needs, shared decision making between practitioners and services and awareness of impact of interventions.

Resources and guidance

- Psychological Professions Workforce Plan for England – HEE

Service User Voice/Expectations

I would like the staff member to not feel rushed to get work done with me, like they need to be elsewhere and don't give me focus, or seem tired, or lack interest. I also want the process to be consistent if a staff member is off work, so I don't need to repeat my story or start all over again.

I would expect my professionals to have a geographical area that is management and allows them to travel from client to client, on time.

Relies upon delivery of:

- Recruitment in line with indicative 23/24 MH workforce profile
- Dedicated resource to support full range of lived experience input
- Staff retention and well-being initiatives

Data and outcomes

Interoperable standards for personalised and co-produced care planning

Getting started

1. Ensure new local care planning guidance is congruent with the PRSB guidance and develop local guidance to ensure a consistent approach to logging and storing information within personalised care plans.
2. Ensure ICB Digital leads are engaged with primary/secondary care and the local authority to map out the local interoperability requirements to transfer and cross populate care plans across providers.
3. Consider how to develop IT solutions to enable VCSE services to easily be notified over new referrals and a light touch approach to reporting back service user engagement.

Success

1. Care and support plans are consistently recorded and data is entered by the workforce in a standardised approach and shared in real time with all appropriate providers.
2. Care plans are standardised across services to allow smooth transfer of information between primary/secondary care and local authority IT systems.
3. Bespoke solutions are in place (e.g. web portals) to support patients to access commissioned VCSE services, and for these services to have a proportionate process to report ongoing involvement.

Resources and guidance

- PRSB care standards
- PRSB Toolkit to support transition to personalised care
- CPA Position Statement

Service User Voice/Expectations

I do not need to tell my story more than once. My personalised care and support plan is an accurate record and is shared with those who I consent to sharing it with.

Relies upon delivery of:

- Interoperability for activity from primary, secondary and VCSE services
- Shift away from CPA towards personalised care
- Trauma-informed & personalised care approaches

Routine collection of PROMs using nationally recommended tools

Getting started

1. Consider the 3 recommended tools and how they can be used as a suite of complementary measures to benefit service users:
    - **Goal Based Outcomes (GBO)** – focuses on what people want from their care
    - **ReQoL-10 –** provides a better understanding of, and measures the factors contributing to personal mental health recovery
    - **DIALOG –** measures quality of life and ensures practitioners focus on meeting a person's wider social needs. Can facilitate holistic care planning
2. Work with service leads and service users to agree implementation plans for the 3 tools, including timelines, how they will be administered, how data will be used, how service users will be informed of their benefits and usage, and any training or IT solutions required.

Success

1. All 3 tools have been embedded in services and are being used to help improve understanding of service users' needs, shared decision making between practitioners and services and awareness of impact of interventions.
2. IT solutions are in place to enable outcome data to be collected quickly and simply and both practitioners and service users can see changes in scores over time on a graph or similar visual aid. This should empower individuals and help shape personalised care.
3. Data from routine monitoring of outcome measures shapes local service offers and delivery. Services focus on interventions and improvements that data indicates lead to better outcomes for service users
4. Over time, the impact of transformation is reflected in improvements in local aggregated outcomes data

Resources and guidance

- NHSE Frequently Asked Questions (FAQ) document (NHS Futures page)
- DIALOG resources (East London Foundation Trust)
- Goals Based Outcomes (GBO) resources (Goals in Therapy)
- ReQoL-10 resources (University of Sheffield)
- *Full CMH PROMs guidance in development*

Service User Voice/Expectations

[Goal Based Outcomes] empowered me to have the freedom to set myself goals realistic and practically achievable to me

I felt ReQoL-10 helped the therapist, as well as myself, gain a snapshot of my moods and emotions within a recent period of time.

Relies upon delivery of:

Interoperability for activity from primary, secondary and VCSE services

Interoperable standards for personalised and co-produced care planning

Shift away from CPA towards personalised care

Waiting time measured for CMH services (core and dedicated focus areas)

Getting started

1. Review the guidance (link below) and ensure the waiting time standard definition and the phased approach to implementation is understood.
2. Develop a plan in collaboration with system partners for reporting the key data points to be measured as part of the waiting time definition, with all data flowing to MHSDS by end 23/24, and using the national definition to measure waiting times locally.
3. Use the CMH dashboard on NHS Futures to understand current waiting times at an ICS and provider level.
4. Identify bottlenecks and pathway changes which contribute to waiting times, and ways in which these can be streamlined to improve patient experience
5. Review patient pathways of the longest waiters to identify mitigations.
6. Consider support offer for service users while they wait for services, to minimise risk and improve people's experience at the start of their journey with CMH services

Success

1. Systems have a clear picture of how long people are waiting to start receiving care, in line with the national definition, and this is reported at a national level.
2. Plans are in place locally to start improving waiting times for all service users – systems are starting to identify bottlenecks in their processes and working with service users to improve patient journeys and reduce waits.
3. Longest waits are significantly reducing, and 'waiting well' initiatives are in place to support those still waiting for the care they need.

Resources and guidance

NHSE guidance on measuring waiting times in non-urgent CMH services

CMH dashboard ('waiting times' tab)

SNOMED guidance to be published by end Q2 2023/24

Guide to submitting data on MHSDS

Service User Voice/Expectations

"If waiting times were reduced, I could have had access to help sooner, avoiding reaching crisis point and spending [time] in hospital"

[Patient respondent to CRS consultation]

Relies upon delivery of:

- Interoperability for activity from primary, secondary and VCSE services
- Routine collection of PROMs using nationally recommended tools
- Record access data from new model (inc. primary, secondary and VCS orgs)
- Integration with primary care with access to the model at PCN level[2]

Interoperability for recording activity from primary, secondary and VCSE services

Getting started

1. Consider how interoperability across primary and secondary care IT systems will be undertaken to create integrated mental and physical healthcare records (subject to informed patient consent).
2. Explore if existing IT systems have the ability to integrate through NHS Digital workstreams (see resources) without the need for bespoke developments.
3. Have conversations with VCSE at the point of commissioning to understand their capabilities and work collaboratively to find solutions that enable activity being delivered is able to be flowed via MHSDS.
4. Ensure that the ICB has a Digital Lead in place to develop and implement plans to support local systems to achieve local interoperability.

Success

1. Primary and secondary care services are able to flow clinical data across different IT systems in real time, and there is not manual duplicate data entry across different IT systems.
2. Primary care, VCSE organisations and local authorities are supported to contribute to the delivery of care, support and treatment by being able to access the right information at the right time.
3. Where appropriate, the use of honorary contracts will be considered to commissioned VCSE organisations hosting mental health roles wholly dedicated to transformed models.

Resources and guidance

NHS Digital – GP Connect

NHS Digital – Message Exchange for Social Care and Health (MESH)

Supplier Led Interoperability Programme (SLIP)

Service User Voice/Expectations

Those involved in my care are able to access my records and understand my background so that I don't need to repeat my story.

I can decide what information and how much information is shared with those involved in my care. My opt-in and opt-out options are clearly communicated to me.

Relies upon delivery of:

- Interoperable standards for personalised and co-produced care planning
- Record access data from new model (inc. primary, secondary and VCS orgs)
- Integration with primary care with access to the model at PCN level[2]
- Commissioning and partnership working with range of VCSE services
- Shift away from CPA towards personalised care
- "Must have" services[3] commissioned at PCN level tailored for SMI[7]

Mental health inequalities monitored in routine data collection

NHS England

Getting started

1. Map out availability of existing local population data, including detailed demographics, service usage, and broader factors which could impact upon mental health (e.g. disability, housing).
2. Consider how to improve recording of protected characteristic data.
3. Identify most significant areas of inequalities through engagement with local services and communities (see 'Principles for advancing equalities embedded in care provision' slide for more detail).
4. Consider infrastructure, governance, and other local enablers and barriers to routine collection of demographic data and data completeness.
5. Use metrics on CMH dashboard (under development) to understand MH inequalities at an ICS and provider level.
6. Triangulate data from multiple sources to ensure accuracy.

Success

1. Demographic information and outcome measures data is routinely collected and used to help identify and inform action on reducing inequalities for local under-served groups, as well as flowing to MHSDS.
2. Clearly defined metrics are helping systems understand the impact of local action on advancing equalities and are being regularly monitored.
3. Qualitative feedback is being captured alongside quantitative data, to capture people's experience of accessing MH services.
4. Data is widely accessible and presented in a user-friendly format so systems and local services can use insights to inform their actions and priorities.
5. Data, combined with service user input, is being used to drive change and advance equality of access, experience, and outcomes.

Resources and guidance

- Community Mental Health dashboard (NHS Futures)
- MHSDS Mental Health Data Hub
- (OHID) Fingertips for Severe Mental Illness
- NHS Digital MH inequalities dashboard

Service User Voice/Expectations

Data is used to understand and address local health inequalities within a wider population, and support is targeted based on findings.

Wider socio-economic factors which impact my mental health are understood and addressed.

Relies upon delivery of:

- Principles for advancing equalities embedded in care provision
- Interoperability for activity from primary, secondary and VCSE services
- Record access data from new model (inc. primary, secondary and VCS orgs)
- Routine collection of PROMs using nationally recommended tools
- Waiting time measured for CMH services (core & dedicated focus areas)

Please note: this section is being developed with a focus on joining up pathways across community and in-patient. This section will be released in line with ongoing work to review the guidance.

NHS England

Services for people who have been given a a diagnosis of Personality Disorder*

*Some people given a diagnosis of personality disorder do not recognise or identify with it; some consider the diagnosis to have been actively harmful. It is therefore important that systems develop a service offer that is responsive to an individuals own understanding of their needs, irrespective of a formal diagnosis.

Please note: this section is being developed with a focus on joining up pathways across community and in-patient. This section will be released in line with ongoing work to review the guidance.

Community mental health rehabilitation

Adult eating disorders

Improved access to dedicated function linked to core model: increased access to dedicated function and consultation, support, supervision and training to core model

NHS England

Getting started

1. Based on the assessment of local need and demand, commissioners and providers, along with service users should determine current eating disorder service provision, identify any gaps, and create a plan to improve delivery of services.
2. Co-production from the very early stages of model development are essential, embedding paid lived experience roles as part of service design and delivery.
3. Utilise the experience, perspective and reach of VCSE organisations to understand the needs of communities and service users and how they can support services.
4. Link with AED Provider Collaboratives jointly working to transform the whole pathway of care for individuals.
5. Focus on early intervention by implementing a model such as FREED.

Success

1. A dedicated, multidisciplinary community eating disorder (CED) service with care delivered in the community, supported by intensive day patient or inpatient treatment for people with a high level of physical or psychiatric risk that cannot be managed safely in the community.
2. A CED service should ideally serve a wider geographical area (recommended 1 million or greater all-age population), with the skills and competences to provide care to a range of people, including those presenting for the first time, with long-term and enduring problems, with comorbid conditions (physical and mental health as well as drug and alcohol use), young people transitioning from children and young people (CYP)-CED services, older people and minority groups.
3. Introducing wait list support (resources/initiatives); supporting people as they wait for evidence based, NICE concordant interventions.

Resources and guidance

- Adult Eating Disorders: Community, Inpatient and Intensive Day Patient Care: Guidance for commissioners and providers (england.nhs.uk)
- Adult Eating Disorders - FutureNHS Collaboration Platform

Service User Voice/Expectations

"This will help people with experience of an eating disorder to receive comprehensive, consistent, and integrated pathway of care where previously there had been a wide range of specialist eating disorders services and, in some places, none at all."

Relies upon delivery of:

- Model design coproduced with service users, carers & communities
- Commissioning and partnership working with range of VCSE services
- Integration with primary care with access to the model at PCN level[2]
- Staff accessing national training to deliver psychological therapies

Embed experts by experience in service development and delivery

Getting started

1. Service users, carers and families are represented on formal governance structures and operational groups.
2. Local systems identify community groups to develop long term relationships to inform service improvements and to form part of the ongoing service user involvement, including representation from groups currently under-represented in services.
3. Local areas and systems make appropriate and sustained financial investment into the remuneration and co-ordination of experts by experience to participate at all levels of the transformation agenda.
4. Understand your local population by engaging a diverse range of service users; to support the design and delivery of local pathways, to prevent barriers to access and reduce health inequalities.

Success

1. Services reflect the needs of service users, carers and families and are responsive to need for further changes.
2. Adhere to the six key principles of co-produced commissioning.
3. Dedicated resources to support co-production have been developed which may include designated services/roles to facilitate co-production locally.
4. Peer Support Workers and Lived Experience Practitioners are a key part of the workforce delivering care and support, with their expertise valued.

Resources and guidance

New tools to tackle inequalities in mental health care by involving patients in service design (rcpsych.ac.uk)

Service User Voice/Expectations

"Embedding experts by experience is integral to eating disorder service development and delivery model via engagement of our service-user and carer voices."

Relies upon delivery of:

Dedicated function linked to core model: increased access to dedicated function and consultation, support, supervision and training to core model

Model design coproduced with service users, carers & communities

No barriers to access

Getting started

1. The Community Eating Disorder service should aim to maximise access and minimise waits and they may wish to look at work done in Children and Young People's Community Eating Disorder teams where services are tracking access and waiting times.
2. While a person is waiting for treatment, services should consider whether to involve or signpost to VCSE organisations or draw on online resources, local groups or telephone helplines for additional support.

Success

1. Decisions on accepting referrals and discharge are never made based solely on a person's BMI, weight, frequency of bingeing and purging episodes, or comorbid conditions.
2. People should receive treatment, care and support as soon as possible, regardless of whether presenting for the first time or with a long-term condition.
3. If a person is moving to another area and requires ongoing care, then CED service should proactively contact the CED service in that area to ensure continuity of care.
4. Care provided in most appropriate setting to meet person's needs
5. Take a holistic, integrated approach to care, including collaborating with other services to provide care on comorbidities.

Resources and guidance

Adult Eating Disorders: Community, Inpatient and Intensive Day Patient Care: Guidance for commissioners and providers (england.nhs.uk) p.12

Framework for Supporting Individuals Waiting for Support from Adult Eating Disorder Services

Service User Voice/Expectations

"Tackling severe malnutrition is still important for understanding the extent of immediate risk to eating disorder lives. By removing barriers to accessing eating disorder treatment for people who may not be underweight, BMI and any other weight criteria for accessing help will be eradicated."

Relies upon delivery of:

Dedicated function linked to core model: increased access to dedicated function and consultation, support, supervision and training to core model

Integration with primary care with access to the model at PCN level[2]

Impact on advancing equalities monitored in routine data collection

Early intervention model embedded

Getting started

1. Understand the capacity and effectiveness of current services to deliver early intervention.
2. If not already established develop early intervention model such as FREED.
3. Establish links with Primary Care and VCSE sector to raise awareness and promote early intervention.

Success

1. Improved awareness of the service in the community, the importance of early identification and reduce the stigma around eating disorders to increase help-seeking in the local population.
2. Imbedded early implementation model – recognised as key part of the model with adequate resourcing to meet needs and prevent individuals becoming more unwell / supporting earlier recovery.
3. Every person that presents to the CED should receive a written care plan following assessment. Care plans should be developing in line with the eating disorders NICE guideline, with a recognition that early intervention demonstrates effective outcomes

Resources and guidance

Appendices and Helpful Resources for (england.nhs.uk) (FREED case study)

First Episode Rapid Early Intervention for Eating Disorders | FREED (freedfromed.co.uk)

Service User Voice/Expectations

"FREED ensures rapid and timely assessment and evidence-based treatment for people aged between 18 & 25 with a suspected eating disorder. This is so crucial to making sure better treatment outcomes can have a positive experience for young people with eating disorder, their families, and carer's."

Relies upon delivery of:

Dedicated function linked to core model: increased access to dedicated function and consultation, support, supervision and training to core model

Clear arrangements in place with primary care for medical monitoring

Getting started

1. The ability to comprehensively monitor and manage the physical health of all people with an eating disorder is an essential function of a CED service.
2. A CED service must be equipped to conduct a full medical assessment, including blood tests and ECGs, and receive same-day results to facilitate same-day clinical decision-making.
3. Medical monitoring needs to be based on local medical monitoring agreements clearly established across the CED service and primary care network, with one consistent protocol agreed on by local commissioners.

Success

1. Joint working with primary care around referrals and follow-up.
2. Protocol should be developed by CED in collaboration with primary care services, clearly outlining the responsibilities for each service.
3. Remain accessible to provide specialist consultation on interpretation of medical monitoring results / support staff development etc.
4. Follow Medical emergencies in eating disorders (MEED) principles to manage risk.

Resources and guidance

- Adult Eating Disorders: Community, Inpatient and Intensive Day Patient Care: Guidance for commissioners and providers (england.nhs.uk) (p.15)
- Adult Eating Disorders - FutureNHS Collaboration Platform – examples of medical monitoring protocols etc

Service User Voice/Expectations

"The ability for services to comprehensively monitor and manage the physical health of all people with an eating disorder is essential in keeping people safe."

Relies upon delivery of:

Dedicated function linked to core model: increased access to dedicated function and consultation, support, supervision and training to core model

Support across spectrum of severity and type of ED diagnoses

Getting started

1. Based on the assessment of local need and demand, commissioners and providers should determine current eating disorder service provision, identify any gaps, and create a plan to improve delivery of services.
2. Plan to provide evidence-based treatment, care and support for the full range of eating disorder diagnoses, including binge eating disorder and OSFED.
3. Engage experts by experience in service design and improvement for range of diagnoses.

Success

1. Comprehensive offer in place to provide evidence-based treatment, care and support for the full range of eating disorder diagnoses, including binge eating disorder and other conditions (e.g. ARFID).
2. To be able to support individuals whether this is their first experience of an eating disorder or have a long term condition.

Resources and guidance

- Adult Eating Disorders: Community, Inpatient and Intensive Day Patient Care: Guidance for commissioners and providers (england.nhs.uk)
- Adult Eating Disorders - FutureNHS Collaboration Platform

Service User Voice/Expectations

"Individuals will be seen by the service who understand and can support each person's eating disorder, no matter how it presents."

Relies upon delivery of:

Dedicated function linked to core model: increased access to dedicated function and consultation, support, supervision and training to core model

Joint working with CYP ED services including transitions

Getting started

1. For age-based transitions, the CED service should work with the CYP-CED service for a minimum of 6 months before the planned transition to ensure a seamless care pathway.
2. The parents or carers should be provided with information and advice around the young person's transition, given the change in their rights and role when a young person enters adult services.

Success

1. Provide coordinated care working with other services to reduce and prevent gaps in care during service transitions (age-related, geographical or community to inpatient transitions); develop communication between services to embed clear protocols and joint working agreements.
2. Adult Eating disorder services should provide a seamless pathway for young adults supporting a positive experience of transitioning from children and young people (CYP)-CED services where needed and avoiding unhelpful 'cliff edges in care'.
3. Care plans, which have been co-produced by the person, their family, partner or carer, should outline how transitions will be managed.

Resources and guidance

Access and Waiting Time Standard for Children and Young People with an Eating Disorder: Commissioning Guide

Adult Eating Disorders: Community, Inpatient and Intensive Day Patient Care: Guidance for commissioners and providers (england.nhs.uk) (p.17)

Transitions - NHS England National Adult and Older Adult Mental Health Programme - FutureNHS Collaboration Platform

Service User Voice/Expectations

"By strengthening the offer to children and young people (CYP) with eating disorders who need transition to adult services, a more robust coordinated care approach can be provided, reducing and prevent gaps in care during service transitions."

Relies upon delivery of:

Dedicated function linked to core model: increased access to dedicated function and consultation, support, supervision and training to core model

Accept self-referrals, VCS referrals and primary care referrals

Getting started

1. Review current referrals models and opportunities to remove barriers / ease referrals
2. Explore use of VCSE to refer and support potential additional demand.
3. Engage with Primary Care and look at referrals data to see how this can be improved.
4. Commissioners should also note that increasing awareness of available services and the removal of barriers to accessing care can lead to an increase in demand for services, which may then require adjustments to local prevalence estimates.

Success

1. Facilitated acceptance of referrals from VCSE, Primary Care and self-referrals.
2. Relationships, support and systems in place with Primary Care and VCSE to support them on referrals.

OR

3. Facilitated acceptance of referrals from VCSE, Primary Care with longer term plans in place to accept self-referrals.

Resources and guidance

Primary Care Resources - NHS England National Adult and Older Adult Mental Health Programme - FutureNHS Collaboration Platform

Beat self-referral-final.pdf (contentfiles.net)

Service User Voice/Expectations

"Enabling quick and direct access to adult community eating disorder treatment through self-referral and from primary care services will ultimately improve access and reduction in waiting times for any type of eating disorder assessment, diagnoses and treatment."

Relies upon delivery of:

Dedicated function linked to core model: increased access to dedicated function and consultation, support, supervision and training to core model