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# BNSSG Community Mental Health Programme

# NHS England Submission

# Our Approach

Our Community Mental Health Programme will deliver a new model of proactive, personalised and preventive mental health care for people living with moderate to severe mental illness and complex needs. It will provide a mixed medical and social model, offering people and their carers the right interventions, at the right time. This includes clinical, practical, social, financial and physical health support, to prevent mental health crisis and help people live to their full potential. It will tackle entrenched stigma and discrimination, enabling people to be active members of their communities.

Achieving this requires a new approach to support at place (Primary Care Network), locality (Integrated Care Partnership) and system (secondary care) levels. Tailored interventions will focus on diagnosing and supporting people with common and severe mental illnesses. Multi-disciplinary, pan-organisational community teams will wrap around service users in primary care, in our new community mental health hubs and in our redesigned specialist mental health teams, utilising everyone’s skills and capacity.

The following underpin our developments:

* New Integrated Care Partnerships between health, social care, VCSE and lived experience will oversee a comprehensive model of early intervention and treatment for people with severe mental health needs.
* Mental health clinicians working alongside peer support workers, providing personalised care and treatment, making the best use of our communities’ skills and expertise.
* With improved technology, implement a model of trusted assessment and warm transfers and allow professionals to understand a patient’s care journey in real-time, minimising needless story-repetition.
* We will be outcomes-focused, sharing qualitative and quantitative information to understand impact.
* Sustain changes through more efficient and effective support, reducing crisis admissions through improved access and earlier treatment.

These will be delivered through:

* A new Integrated Response Hub providing a range of trauma informed clinical and social interventions delivered by culturally competent multi-disciplinary teams (NHS, Local Authority, VCSE and Peer Workers). These hubs will bridge the gap between primary and secondary mental health provision, providing holistic support and evidence-based treatment (including specialist interventions).
* Increasing non-medical support for service users and carers, appointing new peer support roles and recovery navigators, enabling personalised care, choice and access to the right support, first time.
* Establishing a VCSE Alliance with responsibility for coordinating, strengthening and embedding wider support in our communities (including housing, debt and employment), building on, and complementary to, social prescribing link workers.
* Digital investment to support a new trusted assessment model, warm transfers and integrated outcomes data collection Tackling entrenched disparities in access, experience and outcomes, seeking the fastest improvements in those with the poorest outcomes.
* Inclusive and transparent ways of working. This programme is being co-produced by people with lived experience and professionals (our ‘Discovery Phase’ involved over 40 engagement events with over 1,000 participants). Our co-designed ‘I Statements’ (Appendix 1) will guide this programme.

By 23/24, our population can expect to access Locality and PCN based holistic, person-centred care which supports their Mental Health and wider social needs.

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# Governance: BNSSG’s Community Mental Health Programme Board

**Leadership**

* Chair: Director of Transformation, BNSSG CCG
* Co-Sponsors: Chief Executives of Mental Health Trust / Local Authority

**Board Membership (See Appendix 3)**

* Directors from CCG, 3 Local Authorities (DPH / DASS); MH Trust; IAPT; Lived Experience; VCSE providers and Equalities leads

**Role (see Appendix 2 for Governance Structure)**

* Strategic direction, financial planning, cross-sector mental health leadership and oversight of delivery. It provides constructive scrutiny, facilitates solutions to inter-organisational challenges and enables a system-led approach. Meets at least monthly.

**Reporting:**

* To ICS Mental Health Steering Group and Health and Wellbeing Boards

**Community Mental Health Steering Groups (Appendix 4)**

* Thematic Steering Groups to drive improvement.
* Each Co-Chaired by clinical and lived experience leads.
* System-led: all include NHS, local authority, VCSE and Lived Experience leaders.
* ‘Engine room’ for transformation: needs and gap analysis; improvement plan (including pathway design); implementation; evaluation.

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| **Indicative Timeframe 2021 – 2024** | |
| **2021 /**  **2022** | Design and Reconfigure   * Co-design a core community mental health model through ICPs * Reconfigure workforce * Eating Disorders - Parity of provision: bolster Steps and CEDS model, Peers * Rehabilitation – Discharge to Assess approach; reduction in OAPs. * ‘PD’ - Develop whole system approach; modelling. * Physical Health SMI – New workforce, approach, roll out interventions. * YP transitions – Additional workforce. * OP transitions – Older Adult Clinical Lead. * VCSE - Develop VCSE Alliance; health inequalities (e.g. Black Thrive). * Peer Support – Increase provision / develop BNSSG Peer Framework. * Outcomes and Digital Infrastructure – Develop Outcomes Framework / Dashboard * Organisational Development: System leadership programme * Joint commissioning: NHS / LAs * Locality Joint Strategic Strengths Assessments |
| **2022 / 2023** | **Expand and Refine**   * New Community Mental Health model commences via ICPs (April 2022)   + Integrated Response Hubs and MDTs   + Workforce, including Recovery Navigators; Peer Workforce   + Continue to roll out specialist services offer. |
| **2023 / 2024** | * Expand and refine new community mental health model based on learning from Year 1 and Year 2. * Align specialised services into community model. |

Delivery Risks and Mitigations (Appendix 5)

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# Younger and Older Adults Transitions

# Young People’s Transitions

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| **Current need** |
| We have high levels of socio-economic deprivation which increase risks to young people’s mental health:  **Bristol:**   * 41 areas in the most deprived 10% in England, 3 in most deprived 1%. * Over 9,300 (2-17 years) have a diagnosable mental health problem. * Higher than average rates of violent crime; homelessness and under-18s admitted to hospital because of alcohol.   **North Somerset:**   * Third highest inequality in England; 9 areas amongst most deprived in England.   **South Gloucestershire:**   * Around 4,800 children and young people aged 5-19 may have a mental health problem. |
| **Our vision for the new service** |
| We will build on our national exemplar work in South Gloucestershire to deliver a consistent transitions service for young people, offering accessible, flexible support based on need that is co-designed and implemented in partnership with people with lived experience and wider health, social care and VCSE colleagues. |
| **How we will deliver our new model** |
| Our model will be co-produced with young people, health and care partners. Implementation will focus on increasing our existing complement of Clinical Transitions Support Workers and VCSE staff (Off the Record) in line with population health needs. Coupled with new peer support roles, staff will provide age and culturally appropriate support (16-25 age range). Our multi-disciplinary team will enable young people to access services, working alongside them and wider agencies, including VCSE partners in housing, employment and the criminal justice system. Staff will work into our new locality hubs, ensuring that their expertise is aligned with wider community mental health services.  As young people formally transfer to Adult Mental Health services, we will provide warm transfers and introductions to adult services, avoiding ‘cliff edges’ where young adults become ‘lost’ within the system. This will reduce deterioration, crisis presentations and admissions. |
| **Timescale for delivery** |
| **Phase 1:** Levelling up existing provision through increasing our Band 7 Clinical Transitions Workers, establishing new peer workers roles across BNSSG and undertaking detailed workforce modelling in partnership with VCSE; development of our Mental Health Transitions Improvement Plan using population health management insights to inform our clinical model, targeted at those our communities with greatest need (e.g. care leavers, young offenders, people with autism, minority ethnic groups).  **Phase 2:** Implementation of our Improvement Plan, including new governance and oversight from CAMHS, adult mental health services, primary care, VCSE, social care and criminal justice colleagues. Through the implementation of our Connecting Care platform, we will ensure that information is visible to all professionals working with young adults. |

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# Older People’s Transitions

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| **Current service provision / need** |
| By 2025 in BNSSG there will be:   * 31% increase in the number of over 75’s * 31% increase in over 75’s living in a care home * 29% increase in over 75’s living alone * 28% increase in over 75’s unable to manage self-care   Old age-related mental health disorders account for 23% of emergency hospital admissions in BNSSG. This reflects increasing rates of organic mental illness (e.g. dementia) and increasing numbers of older adults with functional SMI (including PD, psychosis and bipolar conditions). |
| **Our vision for the new service** |
| Our integrated older adult service will provide treatment and psychosocial interventions, enabling people to continue successful self-management. Where older adults require specific clinical interventions, we will provide integrated physical, mental health and social care support through our locality hubs. |
| **How we will deliver our new model** |
| The diverse needs of this population require specialist leadership. We will appoint a BNSSG Clinical Lead for Older Adults. In partnership with service users, carers, physical health and social care colleagues, they will complete detailed scoping of population health needs and associated resource requirements.  Using the outputs of BNSSG’s Joint Strategic Strengths Assessments (already underway) in each of our localities, we will develop an integrated model of service provision, aligned with integrated frailty services. These will work alongside our community hubs, with service users and carers supported to transition to older adult services through warm transfers and trusted assessment by the multi-disciplinary team. Records will be integrated, with clinical information shared between teams on our Connecting Care platform, allowing holistic care to be delivered by the wider multi-disciplinary team.  We recognise the impact of social isolation and digital exclusion – which has been exacerbated by the COVID-19 pandemic. In partnership VCSE organisations, we will develop a complementary psychosocial offer that enables service users to remain at home with the correct support for their needs. Through this, we anticipate a reduction in older adult admissions and long term care costs.  Noting the anticipated increase in older adults across BNSSG, we will upskill professionals (health, social care and VCSE) through utilising HEE’s OPMH competency framework to develop education packages which will support professionals with specialist consultation in primary care, locality hubs and across secondary services. Education, training and respite for carers will also be developed. |
| **Timescale for delivery** |
| **Phase 1:** Appointment of an Older Adult Programme Clinical Lead to develop the scope and integrated workforce requirements.  **Phase 2:** Implementation of programme, aligned with wider integrated care developments and partnerships with physical health care. |

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# Partnership Working

During 2021/22 we will establish Integrated Care Partnerships (ICPs) to develop a comprehensive model of early intervention and treatment for people with severe mental health needs, tailoring provision to their local needs.

Our Locality Boards are the forerunner to ICPs, bringing together the community of experts from physical health, mental health, social care, VCSE and Lived Experience. Working together, led by Primary Care, each Board has developed a transformation plan that includes mental health and reflects local population needs gathered through population health management approach.

Each Locality Board has implemented a programme of organisational development, including the development of a joint ‘collaborative agreement’ that sets out the principles by which all members of the board will work together. By April 2022 this will evolve to a contractually binding arrangement, underpinned by a shared set of values and behaviours.

ICPs will deliver our Community Mental Health transformation programme, and are working together to develop their detailed delivery plan. New roles will be established, aligned with those appointed through the ARRS and existing community mental health teams. These staff will support new locality hubs, which will reflect local population needs whilst also maintaining fidelity to our core mental health service model.

**Primary Care**

* BNSSG’s Primary Care Commissioning Committee is overseeing this programme
* Mental Health leads are in each PCN and Locality
* BNSSG supported by GP Mental Health Clinical Leads
* Strong Primary Care involvement in each Community Mental Health Steering Group (e.g. PD, Eating Disorders; Physical Health).

**Local Authority**

* Involvement from Directors of Adult and Children Social Care, Public Health and housing, in each Local Authority.
* Building Healthier Communities Programme supporting asset-based approaches for people with SMI and social determinants support.
* Development of Joint Commissioning plans between Local Authorities and NHS.

**VCSE**

* Invest resources to support the development of a VCSE Mental Health Alliance. This will enable shared leadership and representation, and provide a stronger voice for VCSE organisations across BNSSG, regardless of size. This model will build on the established model for community based physical health services.

We support employers, schools and universities to improve mental health and wellbeing (e.g. MHFA / Zero Suicide training); have established community-led approaches to support diverse needs (e.g. Thrive Bristol’s Somali Mental Health project); and have been selected as a national ‘test and learn’ site to bring green social prescribing to our most underserved groups – with environment partners.

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# Dedicated Focus Groups: Eating Disorders

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| **Current service provision** |
| Our current Eating Disorders service model varies across BNSSG, with differences in provision across our community and primary care services in Bristol, North Somerset and South Gloucestershire. |
| **Our vision for the new service** |
| Our new Community Eating Disorders Service will provide a compassionate, responsive, evidence-based, trauma-informed, sustainable, effective, equitable, and community-centred service to all individuals living with any type of eating disorder across BNSSG. |
| **How we will deliver our new model** |
| We will provide a stepped care model (Appendix 6), accepting all presentations, delivering evidence-based care and treatment with individuals moving seamlessly between steps in the pathway, dependent on needs. Investment will initially be targeted at developing Specialist Eating Disorder triage workers, psychologist posts and peer workers.  Our investment will enable high intensity psychological therapy and specialist clinical management, as well as less intensive therapy (e.g. computerised CBT and CBT-N for Bulimia Nervosa and Binge Eating Disorders) to be implemented and sustained.  Investment in a FREED service model (18-25 year olds), embedded with both CAMHS and Adult Services, will enable young adults to access evidence-based treatments quickly, delivering better long term outcomes. This is particularly important when we consider the diverse needs of our student population and the prevalence of eating disorders.  Our specialist provision will be aligned with our Community Hubs, working closely with core community mental health provision and primary care to enable shared care where clinically appropriate, supporting people with long term eating disorders.  Treatment will be personalised according to clinical needs and presentations, particularly for those who experience severe and/or enduring eating disorders (SEED). We will design a new process of clinical risk management to ensure that service users are treated in the least restrictive environment and clinical pathway.  We will harness the capacity and capability of VCSE organisations alongside the development of our new clinical model, using their expertise to improve support for service users, their families and carers, enabling earlier access to wider support and groups to enable sustained recovery. Peer support workers will also be a feature of our new service model, working alongside service users to support guided self-help work in 1:1 and group sessions. |
| **Timescale for delivery** |
| **Phase 1:**   * Provide parity of provision across BNSSG, bolstering Steps 2 and 3 of the Community Eating Disorders Service; bringing together the Community Eating Disorders Service with the existing Primary Care Eating Disorders Service * Deliver Guided Self Help (1:1 and group sessions) * Embed VCSE in each step * Develop a shared care agreement for physical health monitoring and intervention for service users at high medical risk * Undertake needs analysis for specialised eating disorders, e.g. Binge Eating Disorders and Avoidant restrictive food intake disorder   **Phases 2 and Year 3:**   * Embed the FREED model across all steps of the service * Provide a highly specialised MDT-led service provision at step 4 linked with primary care, community mental health and physical health services, aimed at severe/high risk, enduring long term, complex and co-dependent presentations * Implement a shared care agreement for physical health monitoring and intervention for service users at high medical risk. |

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# ‘Personality Disorder’ and Complex Trauma

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| **Current service provision** |
| Almost 60% of our mental health secondary care recovery caseload has a primary or secondary diagnosis of ‘Personality Disorder’. Services are fragmented and inconsistent across BNSSG, with demand outstripping capacity. As a result, high numbers of this service user group present in crisis. |
| **Our vision for the new service** |
| Our new model will provide holistic care across all levels of need. Support will be relational and trauma informed, created jointly with service users, with an emphasis on understanding their needs and goals. Service users report feeling highly marginalised and isolated when they enter services, and we will address this through involving them in decision-making, democratic processes and social and occupational activities. Our clinical model will be co-produced with people with lived experience and we will appoint new peer support workers to support service users on all levels.  We will tackle stigma and attitudes towards this service user group across the wider health care system through raising awareness, increasing understanding and providing suitable levels of training, including deploying KUF. This will provide the right training, supervision and reflective practice in order that all staff have the right skills and competencies in supporting people with complex emotional needs.  We will develop an evidence based stepped care, goal focused model, which provides the right interventions and support early on, including a variety of psychosocial intervention, to enable and empower people with PD/complex trauma. It will ensure that higher intensity treatments are only offered when needed, including highly specialist services. Failure to engage or respond to treatment should be met with efforts from the service to respond creatively and with a greater emphasis. |
| **How we will deliver our new model** |
| We have established BNSSG’s new Personality Difficulties and Complex Trauma Steering Group. This leadership group will be co-chaired by a clinician and by an individual with lived experience of a ‘PD’ diagnosis; with support from national ‘Personality Disorders’ advisor / KUF South West project manager. We are also establishing a Clinical Reference Group to inform and guide these developments. |
| **Timescale for delivery** |
| **Phase 1:**   * Agree baseline for future service, appointing Clinical Associate Psychologists and a new Band 7 Lived Experience Expert (funding secured) * Implement Structured Clinical Management to provide a common BNSSG approach * Train/Develop care co-ordinators and wider staff teams in KUF, SCM, MBT and DBT * Develop/enhance lived experience roles across BNSSG * Support Steering Group and Clinical Reference Group to oversee development of our system-led strategy and clinical model (including conducting a gap analysis). * ‘Change for Good’ Programme alignment to identify how we best tailor services for people with multiple disadvantage.   **Phase 2:**   * Expand Peer Support worker roles across BNSSG. * Expand KUF beyond PD service into wider mental health provision * Increase provision of psychosocial and therapeutic interventions, in collaboration with GPs and community partners * Development of therapeutic day service model as a specific intervention to help people remain well in their community   **Phase 3:**   * Expand and develop the service and range of evidence based interventions provided * Further workforce expansion according to population needs |

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# Community Rehabilitation

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| **Community Rehab** |
| In 2019 BNSSG co-produced (with people with lived experience) a multi-agency review of rehabilitation provision. From this we know we need to:   * Support people to be treated out of hospital * Focus on individual assets, self-management and holistic approaches * Increase peer workforce * Ensure easy access in/out of services |
| **Our vision for the new service** |
| Our ambition is to significantly reduce the number of people in locked rehabilitation and in out-of-area placements and to have a consistent community rehabilitation offer across BNSSG, with clear person-centred pathways that support people to stay well in their community.  We want an integrated approach aligning with ICPs/ PCNs, enabling people with SMI greater equality and citizenship, housing, social connection, employment and participation, alongside holistic mental health support. |
| **How we will deliver our new model** |
| **Person-centred:**   * Building on existing ethos: coproduction, peer, recovery and trauma-informed and psychologically informed approach * Embed outcome-focussed approach (IROC/DIALOG+) * Culturally, the service understands complex equality and intersectionality * The service promotes self-management, safety, positive risk-taking and tailors support to ensure each intervention enables recovery * Strengthening links with IPS and wellbeing support * Co-production in all planning and service development. * Follow NICE guidance e.g adults with complex psychosis * Close links with local communities to strengthen equality of access.   **Workforce:**   * Strong leadership to ensure people are on the correct pathway, receive the most appropriate interventions and are stepped down from out of area locked rehab * Multi-disciplinary team (MDT) collaboration with skills/expertise embedded from VCSE, clinical, social care, drug and alcohol, housing and community. * Focus on wrap-around support; developing roles that support people through their whole rehab journey. * Increased number of peer workforce   **Pathway priorities:**   * Enabling the system to end out-of-area placements * Scoping local team requirements and strengthening/coproducing integration of the whole rehabilitation pathway * Enabling timely transitions between inpatient and community rehabilitation, including strong MDT leadership to facilitate return from out-of-area. * Embed learning from other areas that have a range of components including high dependency inpatient rehabilitation. * Work to assess ongoing needs and provide interventions in the least restrictive environment (discharge to assess). * Invest in high quality independent and supported housing pathways; co-designed with local authorities, VCSE & housing providers. Encouraging flexible and multiple housing opportunities. * Building on best practice from Bristol Community Rehabilitation. |
| **Timescale for delivery** |
| **Year 1:**   * Complete scoping exercise to inform pathway * Appoint leadership. * Define ‘Discharge to Assess’ model for rehabilitation. * Develop model for people with highest level of complexity (currently Out of Area) to be supported in the community.(including relationships/networks with NHSE, VCSE, lived experience and local authorities) * Audit people Out of Area and begin to step down from locked rehab. * Joint Commissioning model with LA for enhanced local provision. * Gain accredited AIMs standard * Develop non-medical wrap around support throughout the whole pathway   **Year 2 and Year 3:**   * Refine and expand model * Develop and integrate Recovery model * Continuous improvement & review * Measure savings and reinvest into local solutions. |

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# Integrating Physical Health

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| **Our vision for the new service** |
| We seek to increase the quality of life and life expectancy of people with severe mental illness through coordinated and effective physical health support from primary, secondary, VCSE and social care partners. |
| **How we will deliver our new model** |
| Using baseline funding in 2021/22, establish a BNSSG-wide physical health improvement model that delivers health checks, follow-ups and health inmprovement interventions to at least 60% of people on ‘SMI registers’, involving:   * **Governance:** SystemSteering Group with primary, secondary, commissioning and lived experience membership, and social care, VCS and Public Health links. * **Shared ethos and culture:** framing work through a health inequality lens, with physical health checks as precursors to treatments and improvement interventions. * **Co-production** with people with lived experience throughout.   **Phase 1:**  In co-designing our new community mental health model through ICPs we seek to:   * Introduce ‘Physical Health and Wellbeing Workers’ across ICPs (Band 4 nurses, trained in key skills, e.g. Motivational Interviewing). * Develop protocols/shared care agreements outlining roles and responsibilities. * Develop a template for checks to be recorded and data shared through Connecting Care; gain access to all GP practices’ SMI EMIS records; test digital approaches. * Establish BNSSG Community Physical Health and Wellbeing Peer Group to share best practice. * Through pilots, test QI methodologies to:   + Improve communication between primary and secondary care and VCSE partners to work collaboratively to improve physical health.   + Improve access to, and links with, specialist secondary care services – e.g. Diabetes Mellitus specialist nurses, diabetes clinics, Consultant Physicians   + Increase knowledge within wider workforce.   + Target outreach to underserved groups, e.g. minority ethnic communities; co-produce new BNSSG standard invitation letter.   + Develop user-led approaches.   + Commission a structure of peer support. * Workforce: ARRS alignment; Joint roles (e.g. 50/50 roles within mental health and primary care/acute). * Develop a shared approach with social prescribing (including green social prescribing), public health and VCSE partners to strengthen physical health and wellbeing offers e.g. sports and wellbeing activities via Wesport.   **Phase 2**   * Appoint consultant geriatrician, working between acute services and mental health services to deliver physical healthcare across inpatient and community services. * Develop a range of other Physical Health roles, e.g. physicians assistants, ANPs, AHPS and support physical health staff who might have joint roles between mental health and other services, such as primary care and acute. * Develop links, and help commission services such as mental health endocrine services for diabetes and cardio-metabolic syndrome. |

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# Workforce

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| **Our vision** |
| BNSSG to be the best place to work, to attract and retain the most talented and committed workforce. |
| **How we will deliver our new model** |
| We will recruit a Mental Health System Workforce Planner to provide expertise and leadership to deliver BNSSG’s Workforce Strategy (see draft - appendix 9), focusing on existing and new workforce.  This will include:   * Additional mental health workforce requirements (set out in the NHS mental health implementation plan) and investment in our workforce pipeline and new roles e.g. Nurse Practitioners; Apprenticeships; Recovery Navigators and Peer Workforce; Additional Reimbursement Roles. * Expand MDT approaches across clinical and non-clinical roles, aligned with ICPs (e.g. psychological professions, social workers, substance use expertise, advanced Mental Health clinical practitioners; GP Mental Health leads, peer support workers; VCSE and Lived Experience). * BNSSG system OD programme to support shared inclusive culture (“One-Team Approach”). * System approach to learning through BNSSG’s Learning Academy and universities so all staff are trained to the same standards and common competences. * Continued professional development, introducing new capabilities through CPD training opportunities, e.g. trauma informed approaches, biopsychosocial approach to assessment, KUF for Personality Disorder and specialist HEE funded programmes. * Promote inclusivity and diversity, for our workforce to reflect and support our diverse local communities (e.g. Addressing Equalities). * Provide leadership to address delays in recruitment/vacancy rates * Develop career frameworks for professions other than nursing and medicine (medicalised and non-medicalised). * Focused support for social care workforce. * Strengthen workforce wellbeing and resilience, including flexible working |
| **Timescale for delivery** |
| **Year 1:**   * Recruit MH System Workforce Planner. * Further develop and implement BNSSG’s MH Workforce Strategy * Ensure Workforce needs embedded within system outcomes framework and dashboard. * Agree new community mental health model (delivered through ICPs) and reconfigure workforce.   **Year 2:**   * Majority of additional workforce recruited in 2022/23 (in line with the mobilisation of the community mental health specification). |

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# Measuring and Monitoring Change

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| **Our vision for the new service** |
| BNSSG’s Community Mental Health ‘I Statements’ require partners to collaborate for *“care to be joined up and accessible”;* to ensure that people “*only tell their story once”* and for staff to have “*IT systems that enable them to do their job*”.  BNSSG’s Mental Health Outcomes and Digital Infrastructure Steering Group will:   * Develop a system-wide Mental Health and Wellbeing Outcomes Framework and dashboard, and lead how our programme uses population management data. By combining data from across the health and care system (national, local and wider determinant metrics, and linked patient level data from acute, primary, social, mental health, community and continuing health care), our tools will enable us to identify and effectively target resources to improve patient outcomes. This analysis will enable:   + Development of our whole-person pathways and support opportunities to improve care quality (e.g. find and address duplication, gaps in care, failure events) * Streamline data collection to reduce clinical burden, while also improving clinicians’ access to key information and empowering people who use the services to self-monitor. This will ensure that all providers:   + Submit high quality data to MHSDS   + Have access to shared care records via Connecting Care to allow multi-agency use of care plans * Ensure Information Governance standards met.   **Phase 1:**   * + Service Specification to ensure delivery of the above by all providers (e.g. activity and outcomes reporting and full submission to MHSDS)   + Develop and embed our Outcomes Framework and Dashboard to systematically collect and analyse user and carer experience data   + Develop digital transformation plans to drive interoperability between different IT systems; ensure shared care records (which integrate high-quality, personalised and co-produced care and support plans for people with severe MH problems)   **Phases 2 and Year 3:**  Embed new systems using quality improvement methodologies to best effect. |

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# Addressing Inequalities and Advancing Equalities

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| BNSSG has some of the most deprived wards in England, with stark health inequalities and around one in ten people living in a deprived location. We have an ethnically diverse population and are committed to ensuring support is tailored to people’s needs – including being culturally responsive.  We know that people with serious mental illness continue to experience significant and ongoing stigma and discrimination, and we are building upon our local ‘Time to Change’ programmes to tackle this and enable people to have the best quality of life as active members of their communities.  Supported by national leads we are developing BNSSG’s Advancing Mental Health Equalities programme to address inequalities in access, experience and outcomes of mental healthcare. For example, this will include:   * Full implementation of NHS England’s Advancing Mental Health Equalities Strategy, including embedding the Patient and Carers Race Equality Framework. * Monitoring our impact in narrowing health inequalities through BNSSG’s Mental Health Outcomes Framework and Dashboard. * Addressing gaps in data and mental health support, e.g. LGBTQ+ community. * Strengthening community-led approaches to improving mental health, including:   + Developing BNSSG model of ‘Black Thrive’, including new Black Mental Health Practitioner Network, and a programme to ensure a culturally competent mental health system (including training, development and recruitment).   + Evaluate impact of BNSSG’s new Children and Young People Mental Health Development Workers pilot (Somali Community)   We will use our learning from initiatives such as ‘Golden Key’ and ‘Change for Good’ to identify how we can best tailor services for people with multiple disadvantage. This will include   * Identifying how we can recruit and develop peer support and engagement workers to help bridge the gap between service users and services. * Consider how we may provide women-only services to ensure that we address the often intersecting factors of domestic abuse, sexual violence and mental health.   Working with our VCSE Alliance, we will ensure that resources are provided to a range of large and smaller-scale organisations to support community-led approaches.  Our community hubs will include VCSE partners from housing, debt, employment. They will work with, and alongside, health professionals to ensure that determinants of mental health are proactively identified and addressed.  We will review and consolidate training and support for all staff working across our mental health system ensuring that we equip our workforce with the skills to engage and support service users from across our diverse communities. |

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# Co-Production

BNSSG’s Programme has been established through strong co-production with people with lived experience and carers. It has built upon extensive co-design undertaken over recent years to support areas such as BNSSG’s Mental Health Strategy; crisis care and our extensive mental health response to COVID-19.

* **Co-Production in Discovery Phase**

Alongside people with lived experience and carers being part of our Boards and Steering Groups, a coproduction plan is being implemented. Through this, over 40 engagement discussions with people with lived experience and professional colleagues were held between November 2020 and January 2021. This included focused engagement with population groups currently underserved, e.g. Somali community groups; our Deaf community, our LGBTQ+ Steering Group.

From this, we co-produced ‘I Statements’ (Appendix 1) which provide the guiding principles for this work.

* **Embedding Co-Production across the programme**

It is essential that this strong focus on coproduction is built upon and strengthened as this programme develops through service design into delivery by allocating funding to undertake a range of activities and to embedding lived experience across our governance structures with:

* + Lived Experience representatives on the Programme Board
  + People with relevant Lived Experience Co-Chairing each Steering Group and representation on each group (e.g, 110 people with Lived Experience applied to join [BNSSG’s Community Mental Health Steering Groups](https://www.imhn.org/work-with-imhn/opportunities/bnssg-mental-health-lived-experience-steering-group-6/))

In addition, the programme will continue to be supported by wider groups, including:

* Independent Mental Health Network (IMHN) Lived Experience Steering Group
* Carers
* Equality groups: Deaf Health Partnership, LGBTQ+ Mental Health Steering Group, BAME Mental Health Network, IF group
* BNSSG Healthwatch
* Existing patient engagement groups across adult and children’s services
* Local or community based groups, including faith groups

Throughout the programme we will use these groups to check and challenge our plans with a clear feedback loop to assess this. We will be open and transparent.

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# Improving Access and Waiting Times

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| **Include access data table** |
| **Our vision for the new service** |
| BNSSG’s model will significantly improve people’s access to timely, evidence-based and effective treatment – ensuring a maximum wait of four weeks. |
| **How we will deliver our new model** |
| It will be achieved through:   * Integrated Response Hubs will provide quick access to information about the help available; advice, guidance and brief interventions; warm introductions and links to community assets; medication support; triage and immediate needs assessment. This will enable people to quickly benefit from support (e.g. peer mentoring, online guided self-help, debt support). * MDTs ‘wrap’ tailored support around people from a range of providers (reduce hand-offs between professionals). * “Trusted Assessments” will offer consistent assessments across patient care, recognised by different professionals and organisations. * Recovery Navigators will provide interventions and support people to access care and overcome barriers, e.g. translation; venue familiarity. * Expansion of mental health workforce, including through increased peer workforce, will improve system’s capacity and increase choice. * Integrated systems, services and pathways and NICE compliant treatment. * BNSSG’s Outcomes and Digital Infrastructure Steering Group is focused:   + Improving data collection, reporting and assurance to monitor demand and capacity.   + Co-producing BNSSG Mental Health and Wellbeing Dashboard and Outcomes Framework to better understand and respond to needs.   + Undertaking focused work to improve reporting capability where this is currently weak (e.g. PD service). We will achieve this through the development and use of shared care records and Population Health Management approaches.   + Agreeing activity baselines for each pathway and treatment modalities. * This analysis and insight will inform quality improvement approaches to improve access to mental health services. This analysis will be supported by:   + Patient-Reported Experience Measures (PREMs)   + Patient-Reported Outcome Measures (PROMs)   + Clinician-Reported Outcome Measures (CROMs)   + Self-Assessment tools (e.g. Royal College’s Centre for Quality Improvement)   + Data on access (broken down by demographics)   + NHSE STP Progress dashboard   + Benchmarking performance to measure the impact of change. * In our COVID-19 response, prioritising patients with SMI over those with less urgent needs. * ICPs will understand and act upon barriers to people accessing mental health services. Different groups access services differently, with underrepresentation in some services and over representation in others (e.g. Black-British men being overrepresented in mental health secure care). ICPs will measure the impact of services, especially on protected characteristics and health inclusion groups, and undertake targeted work (co-produced with communities) to improve equity in access, experience and outcomes, * Out of Area placements will be eliminated. |

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# Improving Quality

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| **Our vision for the new service** |
| BNSSG’s new community mental health model seeks to improve the quality of care through an approach this is preventative, personalised, and proactive. |
| **How we will deliver our new model** |
| Quality of care will be improved through:   * ICPs bringing health, local authority, VCSE and Lived Experience partners together, creating tailored, seamless support for their communities (e.g. housing, debt and employment) and equity of provision. * Community Mental Health Steering Groups – chaired by Clinical and Lived Experience leaders – playing a key role in developing and overseeing implementation of quality, evidence-informed approaches. * Creating a Trauma and Adversity Informed and Responsive System, e.g. leaders embedding BNSSG’s principles and trauma knowledge and skills framework; undertaking and rolling out trauma and adversity leadership training; and including metrics linked to trauma and adversity in our system intelligence. There are also opportunities to contribute to reflect the growing evidence base around trauma informed practice through links with the ACE HIT. * BNSSG’s Mental Health and Wellbeing Dashboard (utilising SNOMED/MHSDS) will quickly identify the effectiveness of our interventions to enable changes to enable continual improvement. * QI methodologies, e.g. Appreciative Inquiry to support a shared vision for the future; Theory of Constraints to understand barriers to improvement; and PDSA cycles applied to all interventions. Priorities include working with existing community mental health teams and partners to consider priority areas for quality improvement e.g. considering patient flow to understand how this transformation could support improving access to a range of evidence-based psychological therapies for people with severe mental health problems. * Our model will include: * Staff supported to take up training to deliver evidence-based therapies (with protected time / supervision) – utilising HEE training programme where appropriate * Bringing drug and alcohol support, social care, housing, employment, education, and financial support, within Integrated Response Hubs and MDTs. * BNSSG’s IPS model across community mental health services, and alignment with [West of England’s ‘Thriving at Work’ programme](https://wearegrowth.co.uk/covid-19/thrive-at-work-west-of-england/). * Strengthening Suicide and Self Harm projects between VCSE and NHS partners. * Community-led preventative programmes, such as BNSSG’s Green Social Prescribing programme focusing on people with SMI. * Personalised care and support planning. Solutions will focus on shared decision making and patient choice, and we seek to utilise our digital social prescribing system, “Elemental”, to support the capturing of key ONS measures of wellbeing. The model will look to utilise personal health budgets, supported self-management, peer support, social prescribing and community assets as well as optimal medical pathways. |

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# Appendix 1: ‘I Statements’

Through our Discovery Phase we have co-designed a set of ‘I Statements’ with people with lived experience and professionals to capture what ‘good’ looks and feels like. These will guide this programme over the years ahead.

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| **Experts by Experience** | * I want to be listened to, be seen and respected, and have choice. * I want to tell my story once. * I want to know who to call when I need support & helped to access care. * I want care that is tailored to my needs – from both clinicians and my community. * I want care that is sensitive to my experiences and trauma, from people who understand. * I want care to be joined up and accessible across my different life stages. |
| **Carers** | * I want help. * I wanted to be heard, respected and valued. |
| **Workforce** | * I want people to be supported to be as well as possible. * I want to feel part of “one team” providing care that wraps around people when they need it. * I want to be kind, I want to be effective * I want us to move from talking about health inequalities to addressing them. * I want trusted relationships to proactively manage risk across organisations. * I want IT systems that will allow me to do my job. * I want to work in a service which provides appropriate training and development, and which supports my health and wellbeing |

# Appendix 2: Community Mental Health Governance Structure

# Appendix 3: BNSSG Community Mental Health Board Membership

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| **Name** | **Role / Organisation** |
| Jo Walker | CEO, North Somerset Council  Co-Chair, BNSSG Mental Health and Wellbeing Steering Group |
| Dominic Hardisty | CEO, Avon and Wiltshire Mental Health Partnership NHS Trust (AWP)  Co-Chair, BNSSG Mental Health and Wellbeing Steering Group |
| Deborah El-Sayed | Director of Transformation, BNSSG CCG  SRO for Mental Health, BNSSG |
| Lisa Manson | Director of Commissioning, BNSSG CCG |
| Hugh Evans | Director of Adult Social Care, Bristol City Council  SRO for Learning Disabilities, BNSSG |
| Liz Williams | Interim Director of Transformation, AWP  SRO for Autism, BNSSG |
| Christina Gray | Director of Public Health, Bristol City Council |
| Matt Lenny | Director of Public Health, North Somerset |
| Sara Blackmore | Director of Public Health, South Gloucestershire |
| Hayley Verrico | Director of Adult Social Care, North Somerset |
| Anne Clarke | Director of Adult Social Care, South Gloucestershire |
| Ann James | Director of Children and Families, Bristol |
| Carolann James | Director of Children and Families, North Somerset |
| Chris Sivers | Director of Children and Families, South Gloucestershire |
| Housing Leads | Local Authorities |
| Tom Renhard | CEO, Independent Mental Health Network, IMHN |
|  | Lived experience representative, Independent Futures (IF Group) |
| Jenny Theed | Director of Operations and Nursing, Sirona |
| Jean Smith | Chair, BNSSG BAME Mental Health Network / CEO, Nilaari |
| Elaine Flint | Chair, Bristol Equality Forum / Chair of Bristol Mental Health Equalities, Diversity and Inclusion Steering Group |
| Aileen Edwards | CEO, Second Step |
| Derrick Farrell | CEO, Vita Minds |
| Karen Black | CEO, Off the Record |
| Katrina Boutin | ICE - GP Locality Provider Lead |
| Indra da Costa | South Bristol - GP Locality Provider Lead |
| James Case | S. Gloucestershire - GP Locality Provider Lead |
| Mary Backhouse | GP Partner, Tyntesfield Medical Group |
| John Heather | Weston - GP Locality Provider Lead |
| Nicola McGuinness | N&W Bristol - GP Locality Provider Lead |
| Shruti Patel | Woodspring - GP Locality Provider Lead |
| Sarah Constantine | Medical Director, AWP |
| Simon Truelove | Finance Director, AWP |
| Mathew Page | COO, AWP |
| Eva Dietrich | BNSSG Clinical Director, AWP |
| Jane Rowland | Assistant Director, Strategy, AWP |
| Martin Jones | Medical Director |
| Alison Bolam | CCG Mental Health Clinical Lead |
| Maria Hamood | Adult Principal Social Worker, Bristol City Council |
| Sebastian Habibi | Programme Director, Healthier Together |
| Emma Moody | Co-Chair, Mental Health and Wellbeing Programme Board |
| Victoria Bleazard | Co-Chair, Mental Health, LD and Autism Programme Board |
| Nick Goff | Senior Contract Manager |
| Helena Fuller | Deputy Director of Commissioning |
| Jon Lund | Deputy Director of Finance |
| Padma Ramanan | Head of Finance – Mental Health |

BNSSG’s Community Mental Health Board reports to:

* Healthier Together’s Mental Health, Learning Disability and Autism Steering Group on a monthly basis to ensure the Community Mental Health Programme aligns with, and supports, wider mental health strategy and transformation. This is co-chaired by AWP Chief Executive and North Somerset Council Chief Executive.
* Healthier Together’s Mental Health, Learning Disability and Autism Finance Oversight Group, chaired by AWP’s Finance Director.
* Healthier Together’s Partnership Board as required (over the past quarter this has been on a monthly basis) to ensure alignment with wider system transformation programmes.
* BNSSG CCG’s Governing Body on a monthly basis to ensure transformation plans consider and incorporate wider commissioning and system needs. Any commissioning decisions are taken by BNSSG CCG’s Governing Body. This is chaired by BNSSG CCG’s Chief Executive.
* Bristol, North Somerset and South Gloucestershire’s Health and Wellbeing Boards.
* BNSSG’s Integrated Care Partnership Board.
* BNSSG Building Healthier Communities Board.
* Primary Care Commissioning Committee.

# Appendix 4: Community Mental Health Steering Groups

BNSSG Community Mental Health Steering Groups have been established to drive improvement. Each is comprised of a diverse group of leaders from across our system (including VCSE, primary, secondary, social care and people with lived experience), and is co-chaired by a clinical lead and a lived experience lead. Over 110 people with Lived Experience applied to join the Steering Groups through an open process managed by Independent Mental Health Network.

The Steering Groups are working together to:

* Identify national / international best practice
* Undertake a local gap analysis to identify key risks and areas for prioritisation (including a focus on addressing health inequalities)
* Develop a ‘whole system’ improvement plan, embedding Quality Improvement methodologies throughout – in close partnership with ICPs
* Oversee and support implementation of the plan – including offering critical challenge to support progress.

Steering Groups will report directly to the Community Mental Health Programme Board on a monthly basis. Steering Groups are currently structured as below:

* Personality Difficulties and Complex Trauma
* Eating Disorders
* Mental Health Rehabilitation
* Physical health of people with severe and enduring mental illness
* Younger People Transitions
* Older People Transitions
* Peer Support Framework
* Trauma Informed Practice
* VCSE Development
* Outcomes and Digital Infrastructure

Each working group has an agreed Terms of Reference outlining its aims, but also how it will embed our key principles around coproduction; advancing equality, diversity and inclusion; taking a preventative, trauma informed and whole population approach that is accessible and transparent in approach and outcomes. They will work closely with ICPs and wider partners.

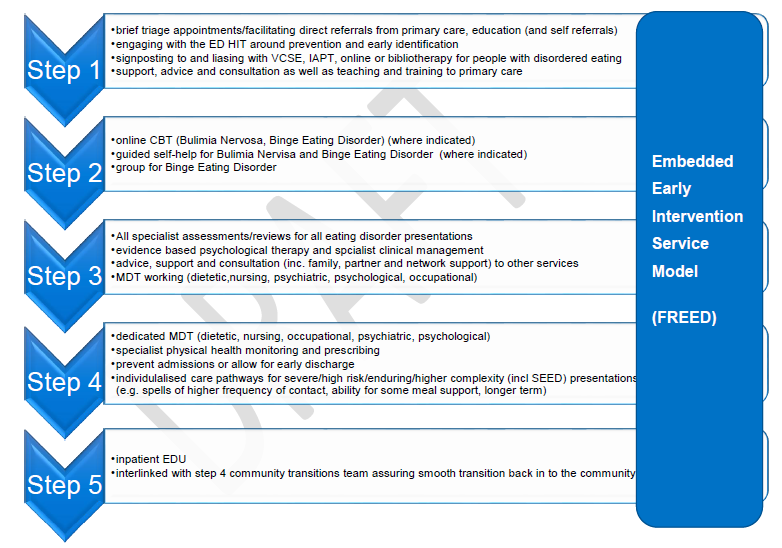
In addition to Steering Groups, the programme is shaped and supported by a range of groups, including:

* BNSSG’s Mental Health and Wellbeing Programme Board. This meets on a monthly basis and includes over 60 members from across the mental health and wellbeing sector within BNSSG (providers, commissioners, people with lived experience and advisors).
* BNSSG’s Learning Disability and Autism Programme Board
* BNSSG Mental Health Lived Experience Board (IMHN)
* LGBTQ+ Mental Health Lived Experience Board (IMHN)
* BNSSG BAME Network
* Equality, Inclusion and Diversity Steering Groups for each local authority.
* Change For Good: multi-agency partnership (sponsored by Bristol City Council, BNSSG CCG, Golden Key) aiming to address multiple disadvantage, initially focusing on complex needs and housing.

# Appendix 5: Delivery Risks and Mitigations

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| **No** | **Description of risk or issue** | **RAG \*** | **Mitigating action / response action** |
| **1** | **Pace of Delivery** - The NHSE submission is requiring a delivery detail to be described ahead of strategic agreement on future system transformation of ICPs. | 16 | 1. Extensive system engagement 2. Senior-level Programme Board 3. Close links with ICS/ICP leads 4. Regular NHSE dialogue |
| **2** | **Commissioning** - CCG commissioned Adult MH VCSE and Statutory Community contracts end 31/03/22. Decision on future solution needs to align with CMHP. | 9 | 1. Robust governance to oversee CMH programme and existing contracts. 2. Close links with ICS/ICP leads |
| **3** | **Inequalities** - Equity of access, experience and outcomes across BNSSG do not improve. | 6 | 1. Focus on advancing equalities and parity of provision in CMH specification. 2. PHM / local intelligence maps inequalities 3. Co-production to address barriers. 4. Outcome Framework / Dashboard to identify impact of interventions. |
| **4** | **ICT system interoperability** - Future provision lacks infrastructure to adhere to reporting (MHSDS). | 9 | 1. Outcomes and Digital Infrastructure Steering Group seek to address this. |
| **5** | **Finance** – System needs to address long-standing system deficit. | 16 | 1. System Finance Oversight Group established 2. Workforce strategy: sustainable workforce 3. Focus on reducing Out of Area placements / S117 for people to be supported locally |
| **6** | **COVID-19** position is leading to lack of workforce capacity to engage and fatigue. | 9 | 1. Programme Board oversight. 2. Whole system approach to assess risk and prioritise accordingly (BNSSG MH COVID-19 Business Case funding) 3. NHSE deadline extension 3rd March |
| **7** | **Recruitment delays** for Year 1 funding. | 6 | 1. Finance Oversight Group has prioritised addressing system workforce challenges 2. Workforce leads being recruited 3. New role development: e.g. Peer Workforce (and BNSSG Peer Framework); Additional re-imbursement roles. |
| **8** | **Finance** - ability to successfully spend allocated funding | 9 | 1. Workforce funding will be released on recruitment to support the tracking of spend. 2. Expenditure will be overseen by the Community Mental Health Programme Board and underspend will be reviewed to determine opportunities for alternate spend. This will be proactively reported to NHSE. |
| **9** | **Change Fatigue** - large transformational change amidst pandemic | 6 | 1. System leaders communicate programme’s impact. 2. Multi-organisation teams work together to develop plans / opportunities for improvement. 3. Co-production at every stage. 4. Large scale, system-wide development of model to support commitment. |
| **10** | **Lack of Co-production** | 3 | 1. Co-production with people and system partners is the golden thread to this model. A coproduction plan is being implemented (e.g. 40 engagement discussions with over 1,000 participants). |

# Appendix 6: Eating Disorders Model



# Appendix 7: BNSSG Mental Health Prevalence

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| The graphic below outlines the prevalence of mental health (QOF for 2019/20) by BNSSG Primary Care Network. |
| Table 1: Bristol Inner City prevalence = 1.3% |

# Appendix 8: Draft Model for Integrated Response Hubs

