Target Operating Model for Bristol, North Somerset and South Gloucestershire's Integrated Adults Community Mental Health Service

Vision

We want everyone across Bristol, North Somerset and South Gloucestershire to have happier, healthier and more fulfilled lives. In developing BNSSG's Integrated Community Mental Health Service we are sparking the beginning of a radically different approach to drive better outcomes. It is a new model of proactive, personalised and preventive mental health care that brings people, communities and organisations together to offer the right support, at the right time, in the right place.

Mental illness is our largest cause of disability and for far too long people with mental health problems have been stigmatised, have experienced care that treats their minds and bodies separately, and have failed to consistently receive the support they needed – sometimes with tragic consequences.

It is imperative that we improve outcomes and offer people what they need to recover and thrive. To do this we must provide co-designed support tailored to people's needs – be that clinical, practical, social and financial. This requires a different model of care that leaves behind the historic boundaries between services. We are seeking new, local partnerships to be developed for care to be integrated and provided closer to home, enabling people to benefit from the assets and support within their neighbourhoods and communities.

Our ambition includes developing a new workforce with lived experience to strengthen local teams, with all staff members providing support that is accessible, trauma-informed and culturally inclusive. We need a new style of partnership through a 'one team' approach – with primary, secondary, voluntary and community sector partners supporting people, together. The different, complementary expertise each brings will be recognised and valued, providing a model of care that that sees a whole person – recognising their emotional, physical, social and spiritual needs, and their aspirations in life.

Crucially, BNSSG will be a great place to work. Staff will have the skills and resources to deliver high-quality, evidence-based services in a kind and compassionate environment. Each day teams will see the positive impact their work has on people's lives.

Our Integrated Community Mental Health Service is a key part of BNSSG's mental health improvement journey, with a focus on continuous progress and measurable impact. As a priority, we seek the fastest improvements in those with the poorest outcomes and will tackle the entrenched mental health inequalities people experience. We will be transparent and accountable throughout.

We have a huge opportunity to improve the mental health of our population. We all have a responsibility to make the most of it and ensure that people can access the right support, at the right time, in the right place – able to thrive in, and with, their communities.

Target Operating Model

Author and purpose of document	▪ This Target Operating Model has been developed by BNSSG Clinical Commissioning Group. ▪ It seeks to provide a vision for BNSSG's Integrated Community Mental Health Service for adults. ▪ This model will be developed further by all localities (including NHS, Local Authority, Voluntary, Community and Social Enterprise and Lived Experience partners) over May – September 2021. This document should guide this process, but there is significant opportunity for localities individually or in collaboration to propose innovation and alternatives.
Service	▪ Integrated Community Mental Health Service
Period	▪ Ten years
Further Information	▪ A glossary is provided to clarify key terms (Appendix 9).

1. Population Needs

National and local context and evidence base

The Bristol, North Somerset and South Gloucestershire (BNSSG) Integrated Community Mental Health Service will fundamentally change the way people experience mental health support. It will deliver a new model of proactive, personalised and preventive mental health care, aligned with the national Community Mental Health Framework published in September 2019[1] and the Government White Paper 'Integration and innovation: working together to improve health and social care for all' published in February 2021[2]. It will provide a mixed medical and social model, offering people and their carers the right interventions, at the right time, in the right place. This includes clinical, practical, social, financial and physical health support, to prevent mental health crisis and help people live to their full potential. The Service will continually evolve and improve, informed by the latest research and evidence.

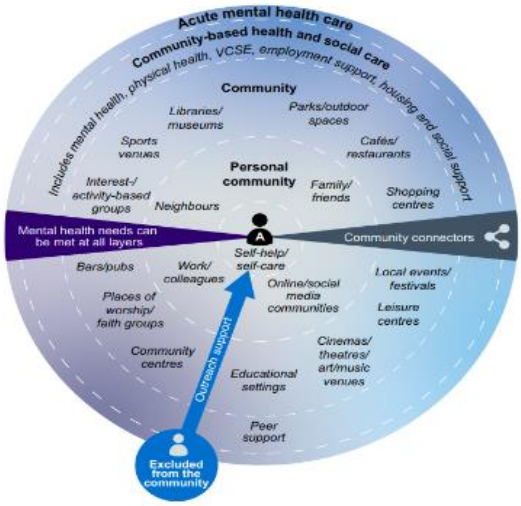
National context

Mental ill health is the largest cause of disability in the UK, closely connected with other issues, including poor physical health, education and work prospects. The national Community Mental Health Framework set out a transformational move away from secondary mental health care delivered exclusively by NHS Trusts across large geographies. Instead, it is now expected that mental health support will be delivered at a locality level through partnerships of providers. Traditional divisions, such as those between primary and secondary care, will no longer exist. Support is expected to be fundamentally preventative and tailored to an individual's needs, as and when they need it. Figure 1 below summarises a person's links to a typical community, showing the services that might be available to help them stay well.

[1] www.england.nhs.uk/publication/the-community-mental-health-framework-for-adults-and-older-adults/

[2] www.gov.uk/government/publications/working-together-to-improve-health-and-social-care-for-all/integration-and-innovation-working-together-to-improve-health-and-social-care-for-all-html-version a summary of which can be found here: https://www.kingsfund.org.uk/publications/health-social-care-white-paper-explained

Figure 1: National vision for community mental health services[1]



The Government's White Paper 'Integration and innovation: working together to improve health and social care for all' (published in February 2021)' seeks to:

- Establish Integrated Care Systems (ICSs) across England to develop greater integration between the NHS and social care.
- Reduce the requirement for competitive procurements within the health system.
- Increase the focus on commissioning at a smaller population level (than CCGs have traditionally served) and give partners within those populations greater agency to decide what services are needed for their populations.

Local context

The overall ambitions of BNSSG's emergent Integrated Care System are to:

- Build an integrated health and care system where the community becomes the default setting of care, 24 hours a day, 7 days a week, and where high quality hospital based services are only used when needed.
- Support people to maximise their health, independence and be active participants in their own wellbeing.
- Increase the number of years people in BNSSG live in good health.
- Reduce inequality in health outcomes between social groups.
- Create communities that are healthy, safe and positive places to live.

Supporting mental health and wellbeing in the community is integral to achieving these ambitions. A Value-Based approach is at the heart of our vision, as set out in Appendix 1.

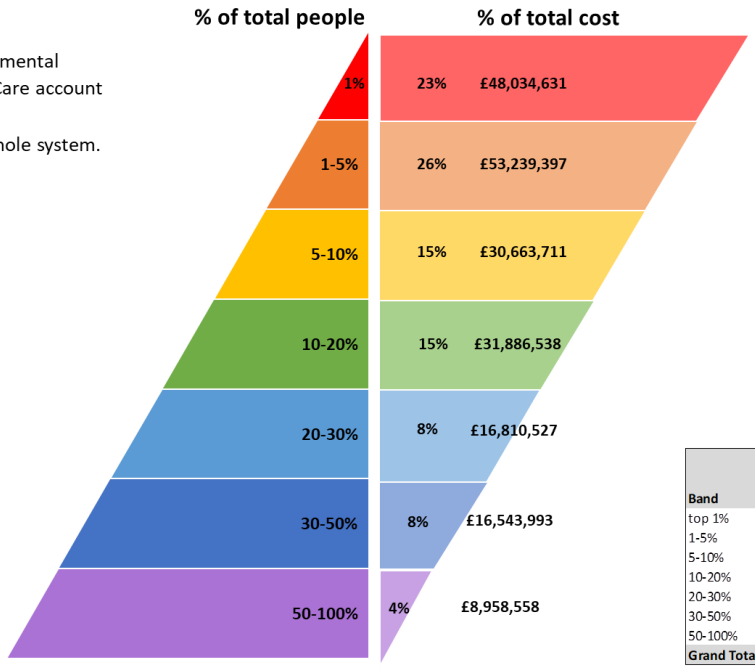
Local mental health needs

An Initial Mental Health Data Set which analyses mental health data from across BNSSSG is provided in Appendix 5. Further to this, localities will be offered Population Health Management support to strengthen their understanding of local mental health needs and model demand to inform their integrated community mental health response. This next iteration will also be aggregated to a Local Authority and system level to support consideration of the elements of care that could appropriately be considered at those levels.

As an example, the diagram below illustrates the different health costs associated with supporting people with a mental health condition within BNSSG. A breakdown of this diagram is available for each locality area within Appendix 5 to support consideration of tailored approaches to improve care and outcomes.

Costs for people with a mental health condition in BNSSG

- **1%** of the BNSSG population with a mental health condition flagged in Primary Care account for
- **23%** of the total costs across the whole system.
- For BNSSG this is **1342** people
- Costing **£48m**
- An average of **£35,793** per person



Band	Number of people	Average cost per person
top 1%	1342	£35,793
1-5%	5372	£9,911
5-10%	6715	£4,566
10-20%	13430	£2,374
20-30%	13430	£1,252
30-50%	26860	£616
50-100%	67151	£133
Grand Total	**134300**	**£1,535**

Cost include admissions and attendances across primary, secondary and community care as well as prescribing - (1 year average). Some costs are PBR, some are indicative. Maternity inpatient activity is included because it cannot be separated from outpatients using the system wide dataset

Mental health needs are not always well defined and people can experience stigma and barriers to accessing mental health support. Given this, there is a risk of under reporting of prevalence and unmet need in relation to mental health service access rates. In addition, the COVID-19 pandemic has led to a rise in stressors linked to mental ill health, such as complex bereavement and economic instability, and it is common for reaction to traumatic events to be delayed. The Service will be expected to use Population Health Management to model and respond to demand.

A broad summary of BNSSG's mental health and wellbeing needs as at 2019/20 is noted below:

- According to Public Health England profiles, the estimated prevalence of common mental disorders aged 16 and over in England is 16.9% of the population[3]. In BNSSG this includes 18.7% in Bristol, 14.2% in North Somerset and 13.6% in South Gloucestershire.
- According to the Quality and Outcomes Framework reporting by General Practices, in BNSSG the prevalence of depression for people aged 18+ is 12.6% / 105,500 people, and mental health (defined by QOF as schizophrenia, bipolar affective disorder, and other psychoses – effectively Serious Mental Illness) is 0.8% / 8,400 people[4].
- There were 93.7 (Bristol) per 100,000, 60.7 per 100,000 South Gloucestershire and 59.3 per 100,000 North Somerset admission episodes for mental and behavioural disorders due to the use of alcohol (narrow). The England average is 69.2.
- The prevalence of mental health problems disproportionately affects people living in the most deprived areas.
- In parts of BNSSG, hospital admissions for self-harm are 40% above the England average.
- People living with severe and enduring mental illness experience a reduced life expectancy of up to 20 years, predominantly due to unmet physical health needs.
- 53% of all admissions via A&E are linked to drug, alcohol or mental ill health.
- Bed occupancy in our mental health trust often exceeds 100% compared with a more

[3] 2017 Public Health England fingertips tool https://fingertips.phe.org.uk/profile-group/mental-health

[4] QOF Definition: The Quality and Outcomes Framework (QOF) is a voluntary scheme within the General Medical Services (GMS) contract. It aims to support contractors to deliver good quality care. The objective of the Quality and Outcomes Framework (QOF) is to improve the quality of care patients are given by rewarding practices for the quality of care they provide, based on a number of indicators across clinical care and public health. There are 4 areas which relate to mental health; Depression, Dementia, Learning Disabilities and Mental Health (SMI). Data from the QOF provides prevalence, achievement and personalised care adjustments for each clinical care or public health area at a national to practice level. QOF 2019-20 Interactive QOF Data Further detail and maps of this data are included in Appendix 5.

appropriate occupancy of 85%. This results in high use of expensive 'out of area' admissions, adversely impacting on the person, their family and carers.
- BNSSG has one of the highest mental health nurse vacancy rates in England.
- Poor mental health impacts upon wider society and is estimated to carry an economic and social cost of £105 billion a year in England, including £1.9 billion in BNSSG.

Appendix 5 contains further information about our population's needs and includes information on how this breaks down by locality.

Current community mental health services

Currently we have the following services supporting mental health in the community:

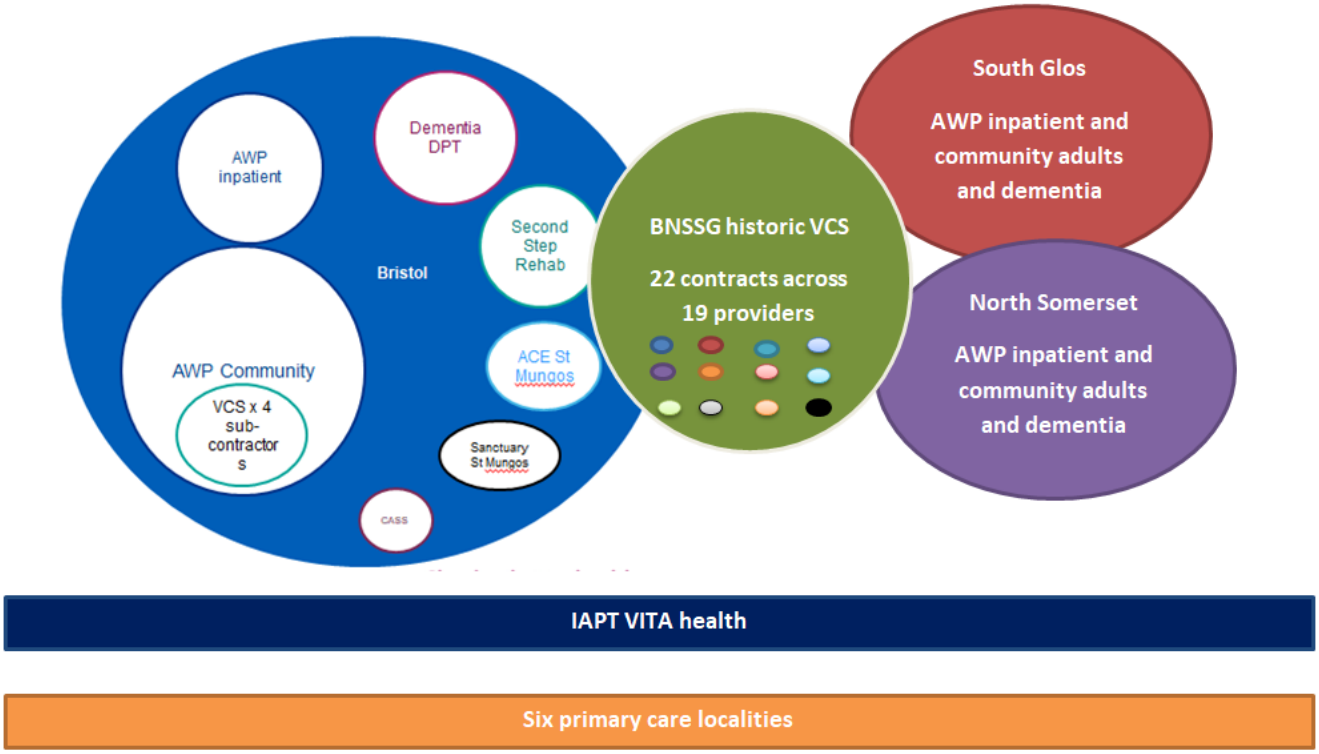
There are 78 general practices across BNSSG, arranged in six localities:
- Bristol has three localities: Bristol North and West; Bristol South; Bristol Inner City and East.
- South Gloucestershire is one locality.
- North Somerset has two localities: Woodspring and Weston, Worle and Villages.

Each Primary Care Network has a Board consisting of GPs, nurses and practice managers. BNSSG has 19 Primary Care Networks, covering 30,000-50,000 patients within localities. Above this level each primary care locality has a GP Membership Forum which is currently run by the CCG to provide an opportunity to feedback on current and future projects. Integrated Partnership Boards have also formed for each locality bringing together wider locality partners including the Local Authority and VCSE which it is anticipated will develop into Integrated Care Partnerships.

The BNSSG population has one secondary care mental health provider, Avon and Wiltshire Mental Health Partnership NHS Trust (AWP). Our Improving Access to Psychological Therapies (IAPT) provider is Vita Health. BNSSG also commissions a range of Voluntary, Community and Social Enterprise (VCSE) providers to deliver secondary mental health care in close partnership with AWP.

The system also has three Local Authorities with differing populations and urban, suburban and rural geographies. Each Local Authority has differing arrangements for mental health social care and a different offer in terms of services commissioned to provide universal, targeted or specialist support that could be accessed by people living with mental illness.

The current Mental Health provider landscape is broadly summarised by the following diagram. It should be noted that this diagram is for illustrative purposes only. The size of the circles and boxes do not represent the relative size of services. For example, we know that a huge amount of mental health care happens within a primary care setting:



Need for local transformation

BNSSG's Integrated Community Mental Health Service ambitions have been developed through extensive engagement with people with lived experience of mental ill health, their families and health and care professionals, alongside undertaking reviews of our current mental health services. This evidence has highlighted the need to fundamentally redesign services:

- People have shared stories about having to be on the verge of crisis before they get the help they need. The frustration and anxiety of trying to get support has escalated symptoms, for some to a point of crisis. People feel that they are treated like they are a burden being 'bounced' between services, confused as to why they are too ill to be supported by one service and not serious enough to be eligible for support by another.

- When people with mental health problems require physical health support, providers, (including acute trusts), are not consistently able to meet their needs. Physical health staff can lack the training, knowledge and skills required to recognise and support people, detrimentally affecting their physical and mental health outcomes.

- People feel unclear about where to go to find help as care can be fragmented. This is particularly true where people have additional complexity and require a strong, integrated response from services, such as a co-morbidity of problematic substance use.

- Transitions are difficult: a proportion of young people moving into adult mental health services are 'lost' in the transition and may then present to adult services later in their life with more complex needs. Older people, and people whose care is transferred from drug and alcohol misuse services to community mental health services, can also experience discontinuities in their care.

- Mental ill health is not experienced equally and some groups are at a higher risk than others[5].
    - Poverty increases the risk of mental health problems and children from the poorest 20% of households are four times as likely to have serious mental health difficulties by the age of 11 as those from the wealthiest 20%[6].
    - People from Black and minority ethnic groups are at increased risk of poor mental health and inequalities exist in access to mental health treatment, experiences of care and outcomes. For example, Black adults are more likely than adults in other ethnic groups to have been detained under the Mental Health Act[7].
    - Women are ten times as likely as men to have experienced extensive physical and sexual abuse during their lives: of those who have, 36% have attempted suicide, 22% have self-harmed and 21% have been homeless[8].
    - The prevalence of mental ill health is also higher amongst other marginalised groups, such as LGBTQ+ people, people who are disabled and care leavers[9].

- Our clinical staff feel overburdened by the weight of too many assessments and trying to find services for people only to have referrals rejected. Staff say that they feel frustrated and overwhelmed by the responsibility of a caseload without the resources to provide the high quality support they know is needed. In redesigning our system, we must make it easier for staff to work productively together as 'One Team' valuing each other's contributions, and developing a healthy and fulfilled workforce.

- As a system we have some of the highest nurse vacancy rates in the NHS. We have high occupancy rates in Psychiatric Intensive Care (PICU) and are often still left with no option but to use Out of Area Placements for people as a last resort. When someone is placed Out of Area it means they are far from the support networks of family, friends and local professionals and it generally leads to poorer outcomes and longer lengths of stay.

What is important to local people?

This Target Operating Model has been co-developed with people with lived experience of mental health care in the community, including family members and carers, and people providing care. We expect Service delivery partner(s) to continue and build on this approach so that our communities and those with lived experience are directing and deciding on service delivery to most effectively meet local needs.

We have co-produced a set of 'I Statements' to show what 'good' looks and feels like to local people (overleaf). We have developed the local Outcomes Measures and key performance indicators for this Service in line with these statements (see Appendix 2).

[5] Commission for Equality in Mental Health (2020), Mental health for all?, Centre for Mental Health

6 Morrison Gutman, L. Children of the new century. London: Centre for Mental Health and University College London ; 2015.

[7] HM Government . Detentions under the Mental Health Act. [Online]. Available from: https://www.ethnicity-facts-figures.service.gov.uk/health/mental-health/detentions-under-the-mental-health-act [Accessed 20 April 2021].

8 Scott, S. & McManus, S. (2016) Hidden Hurt: Violence, abuse and disadvantage in the lives of women. Agenda

9 NHS Digital (2018) The mental health of children and young people, 2017, www.gov.uk/government/statistics/mental-health-of-children-and-young-people-in-england-2017-pas

Experts by Experience

- I want to be listened to, be seen and respected, and have choice.
- I want to be assessed 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.
- I want to access care when I need it and expect waiting times kept to a minimum.

Carers

- I want to know that help is available if / when I need it
- I want to be heard, respected and valued as an equal partner in supporting the person.

Workforce

- I want to be effective
- I want to be kind
- 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 (no more "wrong doors"; primary/secondary gaps; "referral cliff edges")
- 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.

This Target Operating Model sets out:

- What we want to achieve from the Integrated Community Mental Health Service to help address local needs (Section 2 and 3.1)
- Who the Service is for (Section 3.2)
- What the Service will include (Section 3.2)
- How we will measure the value of the Service (Section 5)

2. Outcomes

2.1 NHS Outcomes Framework Domains and Indicators

The Integrated Community Mental Health Service will help to achieve the following domains. These are subject to change following the national annual review.

Domain 1	Preventing people from dying prematurely	**X**
Domain 2	Enhancing quality of life for people with long-term conditions	**X**
Domain 3	Helping people to recover from episodes of ill-health or following injury	**X**
Domain 4	Ensuring people have a positive experience of care	**X**
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	**X**

2.2 Locally defined outcomes

The Integrated Community Mental Health Service will help to achieve the BNSSG-wide Mental Health and Wellbeing Outcomes Framework, summarising the system's collective ambition for improvement. This Outcomes Framework is under development. Appendix 2 provides an indication of its content.

The Integrated Community Mental Health Service's delivery partners are not expected to achieve all of the indicators in the Framework alone. This is a system-wide Framework and will be part of the key performance indicators used to monitor the Integrated Community Mental Health Service. The Outcomes Framework includes quality measures and will be considered alongside the quality requirements of the service set out in Section 5.

The Mental Health and Wellbeing Outcomes Framework will include process measures, outcomes and impacts:

- Developed and agreed upon locally from standard sets, or where necessary, bespoke measures.
- Common to the BNSSG's Integrated Care Outcomes Framework (e.g. measures of integration).
- Common to the Integrated Care System Outcomes Framework (e.g. reductions in health inequalities and as per the value framework).
- Nationally directed (NHS, Public Health, social care).

We expect to publish the performance of all BNSSG system partners against this Framework at least annually, with improvement supported through a regularly updated dashboard. This includes partners involved in the Integrated Community Mental Health Service and those that are not.

3. Scope

3.1 Aims and objectives of service

Overarching aims

The BNSSG Integrated Community Mental Health Service aims to put people and communities at the centre of mental health and wellbeing support, providing integrated services tailored around the needs of people and their families.

It will use a place-based approach, enabling people to benefit from the assets and support within their neighbourhoods and communities.

It will bring services closer together as 'one team' of equal partners across physical and mental health, community, social care, housing, primary and secondary care, community pharmacy, drug and alcohol services, and fully involving voluntary and community sector partners. The different, complementary expertise each brings will be recognised and valued.

It will offer personalised, proactive and preventative care. People's emotional, physical, social and spiritual needs, and their aspirations in life, will be recognised and supported, helping people to live to their full potential and prevent mental health crisis. This is a fundamental shift from reactive to proactive and preventive care.

It will help people to live lives free from stigma and discrimination.

It will develop a new workforce with lived experience to strengthen local teams, with all staff providing support that is accessible, trauma-informed and culturally inclusive. Staff will have the skills and resources to deliver high-quality, evidence informed services in a kind and compassionate environment.

It will deliver consistent outcomes across BNSSG, whilst reflecting the different needs of communities. It will tackle significant health inequalities, seeking the fastest improvement in those with the poorest outcomes, and will be transparent and accountable for the progress made.

Objectives

The Service will:

- Ensure patients, their families and carers have a **high quality experience** of place-based care, while demonstrating measurable improved outcomes.
- Enable patients and carers to **easily access** and navigate the care they require ensuring parity of esteem with physical healthcare.
- **Eradicate duplication**, fragmentation and confusion by providing a 'front door' for mental healthcare, with staff working as "One Team" across all service delivery partners and ensuring comprehensive, integrated, person centred health and social care support is delivered.
- Focus on **prevention** and proactive care, through improving access to community assets and implementing the Making Every Contact Count (MECC)[10] approach, preventing the escalation of mental illness.
- Help people to **recover** from mental illness, achieve their recovery goals, maximise independence, have a good quality of life and sustain their wellbeing. For example, through support to engage in employment or developing a social support network.
- Eliminate Out of Area placements and reduce growth of aftercare spend, including S117.
- Manage **resources** efficiently to deliver an excellent standard of service within the financial envelope available, and support the system to achieve financial balance for mental health.
- Continually **review and improve** the model of care and service delivery.

3.2 Service description/care pathway

Population covered

The Integrated Community Mental Health Service will be accessible to the population aged 18 and over registered with a GP practice in Bristol, North Somerset and South Gloucestershire CCG, with provision of transitional care for those aged 16-18 as detailed within this target operating model. There will be no barriers to vulnerable patients accessing services e.g. homeless patients who may not be registered with a GP, but should still be offered services according to their needs. Providers will adhere to the NHS Choice Framework.

There may be cases where it is clinically appropriate for adult services to provide treatment to those under the age of 16. This provision should be appraised on a case-by-case basis in conjunction with Child and Adolescent Mental Health Services and relevant paediatric services. The Service delivery partner(s) should deliver care where it is safe and clinically appropriate for an adult service clinician to do so.

Unregistered patients living in the Bristol, North Somerset and South Gloucestershire area including those who are homeless or vulnerably housed will also have equitable access to services and should be encouraged and facilitated to register with a GP. Referrals for patients registered with a GP practice in another CCG should be directed to the equivalent commissioned service in that local area.

It should be noted that Local Authority responsibility is defined by 'ordinary residence' which has different legal definition to that of health, meaning that local authorities and health partners will have a small cohort of patients where legal responsibility does not coincide. Localities will need to work across Local Authority boundaries to provide support where that is the case.

The Integrated Community Mental Health Service will support people with mental illness, their carers and families. It will support people with mental health problems, whatever their origin,

10 https://www.makingeverycontactcount.co.uk/

severity or complexity - irrespective of diagnosis.

It includes people with the following specific needs:

- Common mental health needs, such as anxiety or depression.
- Complex mental health difficulties associated with a diagnosis of “personality disorder” / personality difficulties and complex trauma; people who use alcohol and other drugs, and other addiction needs, including gambling problems.
- Severe mental illnesses such as psychosis, schizophrenia or bipolar disorder.
- Eating disorders.
- Coexisting frailty (likely in older adults).
- Coexisting neurodevelopmental conditions.
- Complex lives, including people who do not wish or are unable to engage with mental health services
- Self-harm
- At risk of suicide
- Carers
- People who have experienced developmental trauma, including adverse childhood experiences.

It will also include groups experiencing higher levels of discrimination and marginalisation and therefore needing specific, tailored approaches to meet their needs:

- People from minority ethnic groups
- The Gypsy, Roma and Traveller community
- Refugees and asylum seekers
- People with a learning disability
- Disabled People
- LGBTQ+ people
- People who are at high risk of mental health problems, including:
    - People affected by domestic and sexual abuse; trauma; torture.
    - People misusing substances.
    - People with life threatening illnesses.
    - People who have been bereaved.
    - People leaving the criminal justice system; people with multiple vulnerabilities or frequently in contact with the police.
    - People who are homelessness, including people who sleep rough.
    - Socially excluded people.
    - People with economic insecurity; in debt
    - People not in employment/workless (newly or long term)
    - People leaving the armed forces (may have experienced trauma, struggling to find work, a suitable home or forming new relationships)
    - Students away from home for first time - feeling disconnected from family (particular foreign students); living in a new town/country; stress of study.
    - Young people leaving care

The Service must ensure equity of access to services for their whole population.

The Service must provide information in an accessible way, and where appropriate in a range of languages and formats that are easily used and understood by the intended audience. This will include:

- Providing reasonable adjustments and changes to service delivery to ensure that the service is inclusive and accessible to the population, including people with learning disabilities and autism; people with co-morbidities, e.g. substance misuse; and people from marginalised groups.
- Meeting the Accessible Information Standard (AIS) to support people with a disability, impairment or sensory loss.
- Complying with the Learning Disability Standard (NHS Trusts) and Autism Strategy.
- Providing support for people who have limited or no English; who have limited literacy; or who have a condition which limits their ability to communicate.
- Demonstrating cultural competence, and building trust and strengthened partnerships with local community groups, ensuring services are designed around population characteristics.
- Providing regularly updated information about the breadth of local mental health support in a central place (for the public and professionals).
- Addressing psychological barriers – including demonstrating implementation of key approaches, e.g. Trauma Informed Practice; Psychological Informed Environments.
- Demonstrating how equality and diversity data is being used to inform service improvements and improve access.
- Ensuring interventions are in locations most appropriate to a person's needs.

The Service will use a flexible structure for the delivery of services, accommodating people's changing needs over time. As outlined in the Royal College of Psychiatrists' Community Mental Health guidance[11], the term 'complexity' is used to capture the different requirements for services that people with mental health problems may have, ranging from 'less complex' to 'complex' and to 'more complex': The levels of complexity will be overlapping and there will not be gaps in provision between them. For example, it will not be possible for people to fall between services such as when people are deemed too complex for their GP but not suitable for IAPT or too complex for IAPT but not complex enough for secondary care.

'Less complex needs'

- For a significant number of people with less complex needs, these will be met by time-limited, brief interventions often involving one practitioner. These could be, for example, a brief consultation with a GP, involvement in a community support group or treatment in the IAPT (Improving Access to Psychological Therapies) programme.

'Complex needs'

- Many people with complex needs, including those with psychosis, bipolar disorder, severe depression, complex post-traumatic stress disorder or people with complex mental health difficulties who are diagnosed with a personality disorder, can be well cared for in the community, with the support of an integrated mutli-disciplinary mental health service in which care is shared with primary care staff and community mental health staff. Such staff will be based in the community service that also provides care for less complex needs. As well as the direct provision of care, it will also involve care coordination for some people with complex needs.

'More complex needs'

- For those with more complex needs, a specialist multidisciplinary team will be required,

[11] Royal College of Psychiatrists / National Collaborating Centre for Mental Health (2021). The Framework for Community Mental Health for Adults and Older Adults: Support, Care and Treatment.

which will involve the staff mentioned above, as well as further input from specialist mental health staff. This team can function in a wider geographical area than services for those with less complex needs.

Underpinning principles

The Integrated Community Mental Health Service will be person-centred and provide and coordinate a high quality, holistic response to an individual's care needs, whatever mental health needs they may have. People will be enabled to use their own skills and assets to keep them well or to support the achievement of their recovery goals and milestones.

The BNSSG Integrated Care System incorporates the goals set out in NHS England's Community Mental Health Framework, which include mental health support being delivered at a locality level to enable care to be integrated and wrap around the person.

The Service will provide early intervention, but also respond quickly, proactively and holistically when an individual's needs increase. Through effective care planning, the Service will deliver continuity of care to support a person to stay healthy, well and independent in the community. The Service will be ambitious for achieving recovery goals, working with someone to reduce support and maximise independence as and when they are ready. It will work as one, meeting the breadth of people's needs and creating a joined-up experience of care for people in their locality.

The Integrated Community Mental Health Service will be based on these founding principles:

- **Whole system approach:** The Service will be a key part of BNSSG's approach to improving mental health and wellbeing. It will consider the whole population's needs, not individual service silos, to provide proactive and effective support and system leadership.

- **Collaborative culture:** The Service will succeed or fail on the basis of its relationships – both relationships between people using and providing services, and between different organisations providing support. Breaking the traditional divide between primary care, community services including pharmacy, social care, mental health services, hospitals and VCSE provision, requires leaders (including Lived Experience leaders) to play a key role and for all those involved to be treated as equal partners. The Service will support the creation of open and collaborative ways of working.

- **'One team' approach to consistent support** will be embedded to ensure that people never "fall between the gaps" of care. This will remove service boundaries and thresholds. It will reduce the reliance on referral and discharge and the transactional, linear model that previously underpinned the links between organisations. It will include trusted single assessment models[12], new approaches to 'accountable multidisciplinary team' working (through new Mental Health Integrated and Personalised Care Teams) where resources are pooled, and caseloads and outcomes are jointly owned by teams. There will be parity between service delivery partner(s). All will be respected for their expertise and have a responsibility for offering integrated care, and embedding support within communities (including housing, debt and employment), building on, and complementary to, social prescribing link workers.

- **Coproduction:** This Target Operating Model has been developed in partnership with local people with lived experience of mental illness, their families and carers and service delivery partners. When services are co-designed they are more effective for the people

[12] A trusted assessment involves a trusted assessor carrying out an assessment of health and/or social care needs in a variety of health or social care settings. It aims to speed up assessment processes so the person being assessed waits no longer than necessary before moving on to the next stage of their care.

using them. The Service needs to embed a robust and inclusive model of coproduction and co-design, led with communities and people with lived experience.

- **Delivering value for individuals:** The Service will be designed according to our Integrated Care System Value Based Health and Care approach (detailed below) and driven by outcomes that matter to the people we serve, as defined by people with lived experience and our communities including the wider determinants of health.

- **Community asset based support**: The Service will increase people's access to community assets. These assets promote health and maintain wellness within the community, and may provide a preventive function as well providing support. This may include health and social care services; local facilities and services (including parks, libraries and peer support groups); personal interests (including creative groups, workplaces and employers and places of worship), and personal relationships with family, carers, friends and neighbours. Everyone involved in a person's care has a potential role to play in facilitating their connection with community resources.

- **Evidence-based and informed support:** The Service will offer evidence-based psychological and/or pharmacological approaches that:
    - Build on strengths and support choice.
    - Are underpinned by a single care plan, accessible to all involved in the person's care.
    - Focus on prevention.
    - Improve quality of life, including supporting individuals to contribute to and participate in their communities as fully as possible and connect with meaningful activities.
    - Create or fulfil hopes and aspirations in line with their individual wishes.

- **Care is wrapped around the person,** tailored to their individual needs, responsive to them and co-designed with them. The Service will ensure that care will be convenient and responsive, there when needed, and consistent. It will be provided by people who know and understand them to meet the breadth of their needs: clinical, practical, social, housing, financial and physical health support.

- **A mixture of clinical and non-clinical workforce**: The Service will increase the provision of non-medical support for service users and carers, appointing new peer support roles and Link Workers, enabling personalised care, choice and access to the right support, first time.

- **Continuity of care**: making sure the person experiences an ongoing relationship with a team member and care is coordinated and progresses smoothly as they move between different parts of the health and care system. This team member must be recognised and able to work across organisations.

- **Access:** everyone with a mental health need will have been connected with or offered some level of support within 24 hours. The Service will work towards a same day access principle for all services and ensure that local mental health support is fully accessible.

- **A model of care based on inclusivity** will be provided, particularly for people with coexisting needs, with the highest levels of complexity and who experience marginalisation. Support will be trauma informed and culturally inclusive and an approach of equality, diversity and inclusion will be embedded. The *Principles and Knowledge and Skills Framework* developed by the BNSSG Trauma Subgroup will inform the service approach. The Service must implement NHS England's Advancing

Mental Health Equalities strategy[13] in full – through co-production with community partners. The Service will be accountable for reducing inequalities in access, experience and outcomes. No one will be turned away on the basis of complexity, but will be helped to access the right support for them.

- **A data-driven model focusing on outcomes**, with high levels of transparency around performance and improvement. This will involve investment in digital infrastructure and the shared care record to support a new trusted assessment model, warm transfers, and integrated outcomes data collection. This will allow professionals to understand a person's care journey in real-time, and allow the person to feel the professional knows them and understands their story without having to fully repeat it.

- A model that **embeds quality improvement** to sustain and build upon effective approaches.

Value Based Health and Care Approach

Partners will be required to take a Value Based Health and Care approach. This means:

- Meeting the goals of Population Health: improving physical and mental health outcomes, promoting wellbeing and reducing health inequalities, for a whole population and not just those who present to services.
- Focusing on achieving the outcomes that matter to people and making the best use of resources (value).

The service will take part in the Population Health Management (PHM) development programme which pulls data from across the system to understand people's risk of becoming unwell, the needs of groups of the population and how they use services, and use this information to shape services accordingly. Further details are provided in Appendix 1.

Expected Service delivery structure

BNSSG's new model of care will predominantly be place-based. Unless noted, the service requirements in this target operating model are to be provided at locality level.

Services which need to be provided at BNSSG level could be delivered by a collaboration of the service delivery partner/s to deliver at scale. We will expect the following services to be at BNSSG or Local authority level:

- The BNSSG Open Door (Integrated Response Line) Service: service delivery partner (s) will need to provide a Service that is integrated with each locality, for example, to connect people to local community support.

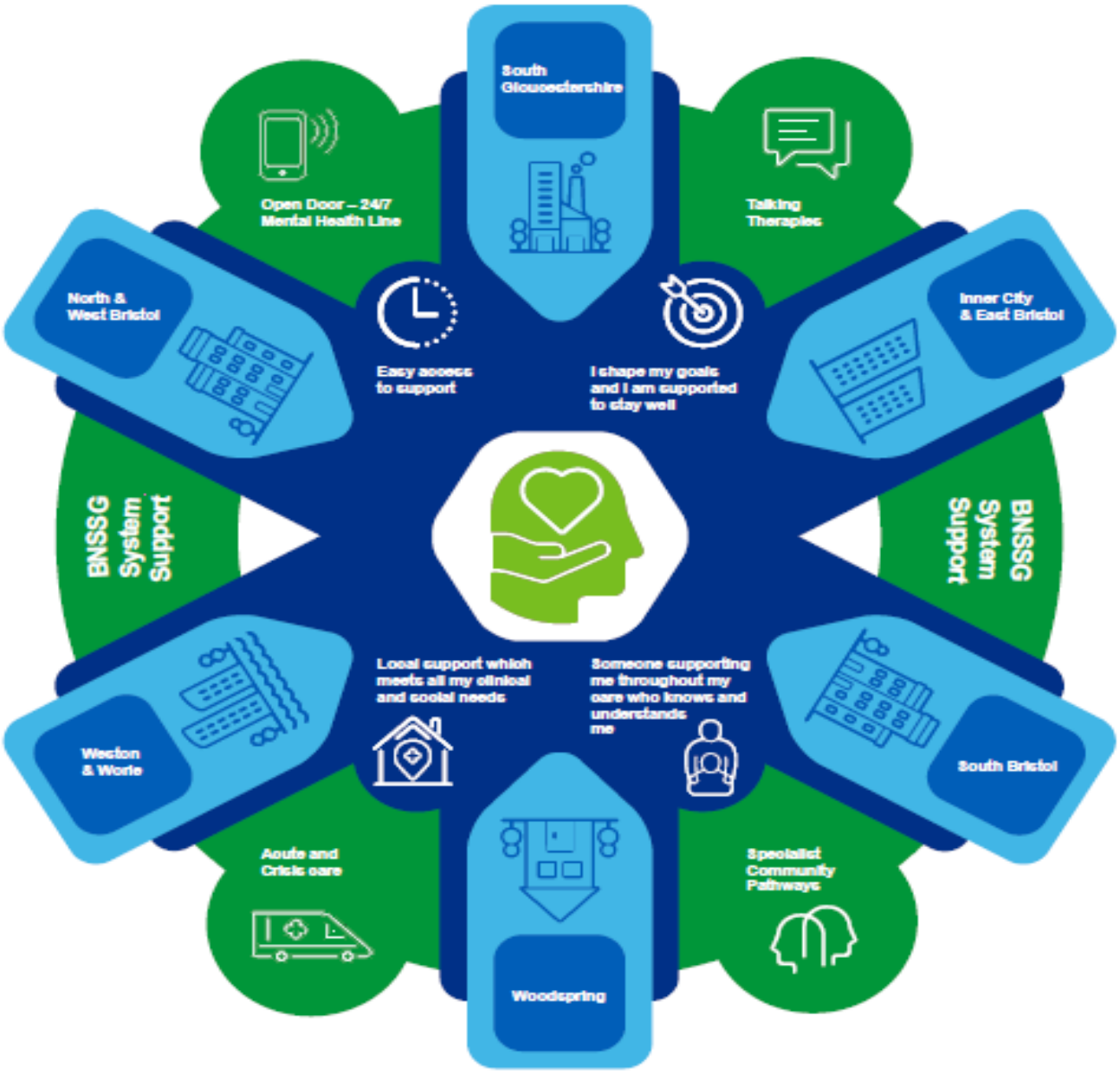
- Specialist pathways: service delivery partner(s) will need to provide a Service that is integrated with each locality. There will be a system- led approach to developing care pathways for people with specific additional needs, so that there is a smooth transition between the Service and specialist pathways.
    - Personality Difficulties and Complex Trauma
    - Eating Disorders
    - Community Rehabilitation
    - ADHD
    - Autism
    - Dementia
    - Perinatal

[13] NHS England (2020) 'Advancing Mental Health Equalities' www.england.nhs.uk/wp-content/uploads/2020/10/00159-advancing-mental-health-equalities-strategy.pdf

Overview of specific elements of the Service

The diagram below offers an overview of BNSSG's Integrated Community Mental Health Service. Our Six BNSSG localities will provide a locality based integrated community health service offer drawing in BNSSG system support to assist delivery.

BNSSG overview of Integrated Community Mental Health Services



The Integrated Community Mental Health Service will provide a Locality-based service offer. This will include locality partners coming together to offer a more intensive level of support when needed, as well as preventative and proactive wraparound support. Localities will be able to draw in support from specialist community, inpatient and crisis mental health teams and BNSSG's talking therapy provider, to ensure a fully integrated model of care.

The Integrated Community Mental Health Service will be supported by an open door integrated response line to help direct people into the right support who might otherwise be 'lost' within the system or struggle to find the right access.

Locality Based Integrated Community Mental Health Service

Part A) Accessing the Service and linking with others

Upon initial contact with the Service, a person, their carer or supporting professionals, including GPs, will be able to directly access support regardless of their level of need. The open access support will be:

- The BNSSG Open Door (Integrated Response Line) will provide advice, guidance, brief interventions and an introduction to the Community Mental Health Service Offer. This element of the service is not the only route in as people will be able to access support through many routes e.g. primary care, VCSE. It is, however, expected to direct people into the right support who might otherwise be 'lost' within the system or struggle to access the care they need. It will also need to link with any social care front doors or Single Points of Access in place in each of the Local Authority areas.
- Their Link Worker (who could be, for example, a primary care worker, mental health specialist, peer support VCSE worker), if the person is already receiving help from a service.

The Integrated Community Mental Health Service will include Integrated and Personalised Care Teams (Mental Health Multi-Disciplinary Teams) which will offer a more intensive level of support when that is needed, as well as preventative and proactive wraparound support (such as social prescribing, debt or housing advice) to anyone across the mental health system that would benefit from that.

The central functions of the integrated team will be to effectively treat, care for and support people with the full range of mental health needs in the community setting. This will involve:

- Assessment and advice or brief interventions, support and treatments
- Specific Bio-psychosocial and pharmacological interventions, collaborative care planning and coordination
- Support to access community assets as part of a stepped or integrated package of care

Where needed, care navigation led by Link Workers will be available to support someone to move through the system and access appropriate help. If someone has complex needs they may also have a Care Co-ordinator who is a clinical or social care professional such as a mental health nurse, social worker, occupational therapist, psychiatrist etc.

Given the fluctuating nature of mental health throughout people's lives, support will need to be flexible and have the ability to be quickly adapted in order to meet someone's needs.

The following sections of the target operating model describe individual components of the Service.

Open Door (Integrated Response Line)

A new Open Door (Integrated Response Line, which could include a digital element) will be required as part of the Integrated Community Mental Health Service. The 'front door' will need to recognise and address the barriers people face, including confidence, technology, poverty and stigma.

The core functions of Open Door are to:

- Help people, their carers' and other supporting professionals to get a quick response to connect them with the immediate and most appropriate support for their mental health needs. This will include quick access to:
    - Preventative support in people's communities – linking with VCSE lead organisations (e.g. Social Prescribing; debt; housing; physical activity support)

- Community Mental Health Support – including Mental Health Integrated and Personalised Care Teams.
- Specialist community pathways.
- Community based crisis care.
- IAPT (Improving Access to Psychological Therapies).

- Use the existing infrastructure of NHS 111 and the developments of 111 First, helping to avoid unnecessary attendances at high acuity services.

- Get people to the right place based on their need. This includes developing support for people who may have accessibility needs.

- Keep professionals informed when a patient or carer accesses the Open Door (Integrated Response Line) directly.

The Service will need to have a single connection point for all mental health enquiries. The approach being that when someone phones 111 they will be offered an option to be immediately put through to this service if they require mental health support.

Linking with other mental health specialist services aligned to people's needs

Most people with mental health issues will have their needs met by the Integrated Community Mental Health Service, but for people with more complex needs specialist support may be required. For example, the provision of specialist therapies for personality disorders.

The Service needs to provide care and planning beyond linear pathways, and have an agreed approach to draw in support from specialist services in a way that maintains the principles of person centred, proactive integrated care.

Partners that may need to be drawn in to support a response from the Community Mental Health Service are likely to include:

- Specialist community mental health teams, which will provide support, care and treatment for people with the most complex needs, in particular for people with psychosis or people with a diagnosis of personality difficulties, and complex trauma.

- Rehabilitation teams for people with long-term complex needs who may need additional support with activities of daily living. This support includes the provision of, care coordination, and additional support and planning tailored to meet specific rehabilitation needs.

- Crisis resolution and home treatment services and inpatient care for people in crisis who need urgent and emergency high-intensity support, care and treatment.

- Specialist inpatient treatment services for people whose needs cannot be effectively met by core community mental health services, for example perinatal mental health services, eating disorder services or community forensic mental health services.

- Support for those who may be at risk of exclusion from their community, including socially excluded people, people who sleep rough, people leaving the criminal justice system or people with multiple vulnerabilities frequently in contact with the police.

Flexing people's support, care and treatment to draw in specialist care should be simple, supported by dedicated Link Workers assigned to the person.

Specialist support will be integral to the 'one team' approach at a locality level (outlined below) and will have a core role in providing advice, guidance and clinical supervision to services provided at a locality level.

Part B) Mental Health Integrated and Personalised Care Teams functions and roles

The Service will establish Mental Health Integrated and Personalised Care Teams (IPCTs) to support the coordination of care for people with varying levels of need, including those with longer term and complex requirements. This will support people who may not traditionally meet the diagnostic thresholds for services, through a model that focuses on complexity, encompassing physical health and wider social needs. It is expected that each locality will have an IPCT, but this could be part of a broader existing MDT approach.

The IPCT will take a community asset based multi-disciplinary approach, working as 'One Team ' across service delivery partners. Multidisciplinary professionals (from different organisations) will build a culture of trust, openness, and compassion, and support the development of a bio-psychosocial model. The different, complementary expertise each brings will be recognised and valued, providing a holistic model of care. Many people will live with mental ill health throughout their life, experiencing periods of wellness and periods where they are unwell. At different points people may need support from a range of different people, many of whom may not be mental health specialists. The IPCT will ensure that care is provided in a flexible manner. Interventions offered to people will be tailored according to their needs. As needs change so can the interventions, without multiple referrals and repeated assessments.

This 'One Team' approach will be an ethos across all care and interventions and will not be confined to formal multi-disciplinary meetings. It will ensure a better experience for patients, meaning they are not 'bounced between different agencies, that they experience care that empowers them and addresses all of their needs. This will align with wider approaches across the health and care system, e.g. High Intensity User programmes, social care programmes etc.

Each IPCT will:

- Ensure people are treated as people first and ensure all care is personalised, not the sum of their needs or conditions. This will require having a trauma informed and culturally sensitive approach that involves training staff to work relationally and holistically.
- Provide a collaborative shared Care Plan for every person which takes a holistic, asset based and person centred approach to meet the individual's needs and complexity whilst making the most of their strengths.
- Deliver care co-ordination across all agencies involved in care and support. This will be delivered by a named Link Worker or Care Coordinator whose skills will be appropriate to an individual's level of need.
- Ensure care records are accessible to all relevant agencies where consent has been granted.
- Ensure people are able to access their Link Worker or Care Coordinator flexibly when they need support.
- Ensure records are complete and shared so that people do not need to repeatedly tell their story.
- Provide evidence-informed, holistic interventions and treatment to support the achievement of recovery goals and milestones. Minimum expected interventions are described under part C) and treatment and interventions below, but this is not an exhaustive list as the service will be innovative in testing new interventions.
- Have a multi-disciplinary team with appropriate skill mix, clinical supervision and

reflective practice to support varying levels of need, including but not limited to peers, recovery and wellbeing workers, clinicians, social care professionals, community pharmacy, drug and alcohol workers, employment advisors and volunteers.

- Have paid peer support roles within the model with appropriate training, support and guidance.
- Ensure that where someone needs more or less support, they are introduced to the person ororganisation that will help them next, whether that is a crisis service or, for example, a social prescribing offer (including green social prescribing) or access to another agency, such as Citizen's Advice.
- Ensure someone who doesn't currently need intensive support from the IPCT support has a wellbeing plan based on the individuals' assets and achievements through their recovery journey. This plan will be held both by the person, their carer and on the person's shared clinical record. It will include the wrap around support that the individual will continue to access; what previous triggers have caused illness and how the individual and their network can monitor and respond to these. It will also explicitly contain how the person can re-access IPCT support should this be required. In co-designing these plans the Locality Based Integrated Service should utilise technological solutions such as pre-existing NHSE authorised or reviewed apps available nationally.
- Ensure carers are supported to access care assessments and other support.
- Take a Making Every Contact Count Approach to addressing needs, e.g. physical health.

The Mental Health Primary Care Additional Roles Reimbursement Scheme (ARRS) roles will become part of the Integrated and Personalised Care Teams.

Coproducing care plans

The IPCT will undertake assessment and care planning in collaboration with the person and their families, carers and support network (where the person requests this). There will be a shared approach to decision making within care planning.

The Service need to include collaborative care planning for people using services and carers, partners or a family member who the person may rely on. Whilst the care plan is owned by the person, a carers' consideration section or a separate support plan for carers should also be included.

It is particularly important for people who have more complex needs to have a well-constructed care plan that is developed collaboratively at the outset and reviewed frequently to ensure it supports the achievement of recovery goals and milestones and gives the right level of support. All care plans need to be co-produced and owned by the person, taking into account all of their needs, preferences and what is important to them, as well as their rights under the Care Act, and Section 117 of the Mental Health Act when required.

People will be able to hold their own copy of their care plan. The person will receive a comprehensive evidence-informed assessment and plan which views them as a person first. The plan will include:

- Their aspirations, ambitions and goals for their recovery and wellbeing.
- Their mental health
- Their physical and mental health medication
- Psychosocial and psychological needs
- A plan for when someone's needs increase
- Strengths and areas for development
- A Care Act assessment, where appropriate
- Social determinants of health, such as housing and any co-morbid substance misuse

- Physical health checks and interventions

This method for coordinating and planning care will replace the Care Programme Approach (CPA). The CPA's key elements are a needs assessment, a care plan, regular review and care coordination. This target operating model sits on top of those aspects of the CPA, including care planning and care coordination, and reframes them in a system that will work for everyone. This will focus on improved outcomes and will deliver place based integrated mental health care to people whatever their level of need.

Providing Trusted Core Assessments

The Service will develop and implement a model of 'Trusted Core Assessments' co-designed with people with lived experience. This will offer a core assessment that is consistent across patient care, recognised and built upon by different professionals and partners. Trusted Core Assessments will be carried out by a trusted assessor who is authorised by the Service and all affiliated organisations to carry out a Trusted Assessment on behalf of others. Feedback from people going through the process should be regularly collected to review and improve it.

The Trusted Core Assessment would be built upon by partners to ensure that people do not have to repeat their story, but also to allow additional information to be added to give the most holistic view of someone's strengths and needs. This approach will also support professionals in meeting their relevant professional regulatory requirements.

The Trusted Core Assessment is not intended to act as a single and final assessment and people using services will have the agency to jointly consider with their supporting professionals when a revised assessment may be helpful.

Link Workers (name to be chosen by locality partners)

The IPCT will include Link Workers. The Service will ensure that anyone who needs mental health support in their locality will have a named 'Link Worker' to help them access quality care and treatment Depending on someone's needs a Link Worker could be a member of the primary care team, peer supporter, a key worker, psychiatric nurse, psychiatrist or other health and social care professional. This is not a prescriptive list as each locality will develop its own workforce approach, including innovation around new roles. It is provided to illustrate the need to tailor the Link Worker appropriately to an individual's needs. Alongside helping to get the right support, at the right time, they will support a wide range of needs.[14] This may include accessing mental health support; help with finances; and signposting to a range of statutory and voluntary sector services (working closely with social prescribing networks).

For people who experience inequalities in access to support, care and treatment, the Link Worker will also facilitate access to the assets and resources that meet their individual needs, thus contributing to a reduction in health inequality.

People should be actively supported to access all the services that are relevant to them. This includes identifying resources, facilitating introductions to services and supporting ongoing engagement (which includes supporting access back into mental health services with ease and flexibility if the person requires long-term but less frequent care).

In some circumstances, the care coordinator might also have the role of the Link Worker, especially if the person has more complex needs. This is in line with the NHS England and NHS Improvement publication, Advancing Mental Health Equalities Strategy[15].

[14] Health Education England (2016), 'Care Navigation: A Competency Framework'

[15] NHS England (2020) 'Advancing Mental Health Equalities' www.england.nhs.uk/wp-content/uploads/2020/10/00159-advancing-mental-health-equalities-strategy.pdf

Risk management

Providers are responsible for agreeing a shared approach to managing risk and positive risk taking across local partnerships. This will be at the core of care co-ordination through the IPCT. This will ensure that recovery goals are ambitious and people can live as independently as possible. This will include but not be limited to:

- Ensuring current risks are not a barrier to achieving recovery goals and that a risk assessment includes the benefits and challenges of taking a risk. For example, if someone with self-harm behaviours could step down to lower support, risk consideration will include the risk of stasis, hopelessness or institutionalisation and dependency from not doing so.
- Ensuring a system response to risk which offers people consistency across agencies and ensures risk is held appropriately by individuals and organisations as presenting risk changes.
- An approach to risk which considers, but is not overly weighted on, historic events and historic risk.
- Ensuring that length of interaction with mental health services across someone's life does not limit ambition around recovery goals.
- Supporting other system partners/agencies to understand risk and be positive e.g. supporting a housing partner to accept someone outside their standard risk ceiling.
- Having a learning culture around risk assessment which assures and empowers the professionals working in the system.

Review

IPCTs will offer interventions to meet specific recovery goals. Progress against those goals will be regularly monitored with alternative interventions offered where an intervention is identified as not helping someone meet their recovery goals.

Reviews will be recorded within an individual's care record. The IPCT will complete aggregate analysis of reviews to ensure the reviews are happening regularly.

The Service will have clear processes in place to follow up service users who do not attend appointments, and risk assessments and risk management plans are updated in accordance with national standards.

Engagement with Services

The Service will take an assertive approach to engagement. It will not cease to engage with people solely for the reason that they have not attended a specific number of appointments or responded to a letter or phone call. Approaches to engagement will be personalised and where an individual may be struggling to engage with support, partners will collectively consider which professionals and strategies would be most effective in achieving engagement with the service. The service will still need to plan to meet accessibility targets for people who find it harder to engage.

Part C) Treatment and interventions

The Service will offer interventions incorporating a focus on the social determinants of health. Interventions will be designed around an individual's own asset base and that of the community that they are living within. It will also consider the asset base available where people may also identify with communities of interest, such as people who are LGBTQ+.

The Integrated Community Mental Health Service will provide a variety of opportunities for people to receive effective therapeutic interventions to support the achievement of recovery goals and milestones. The list below is not exhaustive as the Service will also be expected to test innovative interventions. Minimum expected interventions include:

- Assessment, advice and consultation for mental health needs.
- Evidence-based interventions for mental health needs, including psychological support and pharmacological treatments, and NICE-recommended psychological therapies for people with Severe Mental Illnesses. Therapies will include but not be limited to; individual and group clinical psychology interventions, Arts Psychotherapies, Cognitive Behavioural Therapy, Cognitive Analytic Therapy, Dialectical Behavioural Therapy, Mentalisation Based Therapy, Eye Movement Desensitisation and Reprocessing, family and couple therapy, Psychodynamic Psychotherapy and Group Therapy.
- Specific support groups (such as older adult groups, hearing voices groups, or problem-specific support groups, for example for diabetes or depression, support for people who self-harm or are at risk of suicide).
- Peer Support.
- Social prescribing.
- Talking therapies including specialist counselling if appropriate.
- Psycho educational courses
- Community assets (for example, libraries, leisure and social activities, employers and workplaces and faith groups).
- Coordination and delivery of care.
- Domestic abuse and sexual violence services.
- Effective support, care and treatment for co-occurring drug and alcohol-use disorders.
- Employment, education, volunteering and training services.
- Help and advice on finances (including benefits).
- High-quality, co-produced, personalised care and support planning.
- Housing and social care services.
- Links with Community Pharmacies as part of a making Every Contact Count approach

- Services enabling access to mental health information and online resources.
- Services supporting people affected by self-harm and suicide.
- Support that takes into account frailty, mobility issues and sensory impairments, and helps people live independently.

SNOMED intervention codes will be used against all clinical interventions and any applicable non clinical interventions. Where SNOMED codes do not exist for interventions the system will need to agree a common set of codes to be used as an alternative. This coding will allow the system to understand what interventions are offered to which groups, in what timeframe and eventually linked to which outcomes. This will allow the system to better understand which interventions offer the most value to individuals and the health system. The Service will be responsible for ensuring all people providing care and support interventions are completing SNOMED data entry. The code set will need to be clearly defined and clinical templates developed for practitioners to ensure the consistent use of codes, to ensure that reports are accurate and meaningful.

Acute and crisis mental health services

Many people experience mental ill health as a relapsing and remitting condition where throughout their lives they will have periods of wellness and other periods where they can become very unwell. Whilst the ambition for the Integrated Community Mental Health Service is to be as proactive and preventative as possible there will clearly be a need for people to access intensive crisis support when they are experiencing acute or deteriorating mental ill health**.**

This Integrated Community Mental Health Service must deliver;

- Timely and proactive support to people known to services who are showing deterioration in their mental health and need urgent support to prevent a crisis
- Clear approaches to rapidly offering intensive crisis support to keep people in the

community and rehabilitation care to help them rejoin the community which demonstrably contributes to BNSSG achieving zero out of area placements.

- Approaches to crisis plans which will be held by the person and their carer as well as on a shared electronic record for the wider system. These will be reviewed both as part of core care planning and subsequent to an episode of crisis care
- Analysis of common themes arising from people escalating to crisis which is regularly reviewed by the system. Development and ownership of a rolling action plan to work with partners to address common themes and shape and strengthen services in response
- For people receiving rehabilitation support the Service will ensure a timely and proactive plan is in place for people moving to lower support accommodation or lower support packages of care that maximise peoples' independence.

Medication

The Service will provide advice on medication, prescribe medication, monitor people 'responses and undertake specific medication monitoring in line with NICE guidance, the medication's Summary of Product Characteristics and the local BNSSG Formulary (adult and paediatric). The service will ensure they work to good medicines governance.

Individuals and their carers will be given clear information on the benefits of potential medications and their side effects to enable shared decision making. Information will be provided to patients at the point of prescribing to facilitate them to take their medication optimally, ensuring they are supported to best manage their medication. Patient support will be ongoing with regular medication reviews taking place in line with local and national guidance. The Service should ensure they implement a person-centred collaborative approach to ensure the best value from medicines.

The Service will include a mechanism to trigger a co-produced multi-disciplinary care review if an individual has chosen to cease their medication or it is believed that this may be the case. The aim of this review will be to understand the reasons for ceasing medication and work with an individual to co-produce a revised medication plan and proactively avoid the deterioration in mental health that can accompany ceasing medication.

The cost and volumes of prescribing for mental health drugs by the Service will be monitored to support the understanding of needs and also to drive early intervention and non-clinical approaches where applicable.

The Service will embed an Every Contact Counts approach by working with local community pharmacies where appropriate, to support patient outcomes by ensuring that any issues with medication compliance are highlighted early to the community mental health team.

Risk stratification should be used to identify patients who would benefit most from Structured Medication Reviews (SMRs) within general practice, supported by PCN pharmacists, to help patients to engage with and optimise their medication. This could include those patients with complex and problematic polypharmacy or those who have had recent hospital admissions.

Physical health

Nationally, people with serious mental illness are known to die 15-20 years early as a result of avoidable physical health conditions. The Integrated Community Mental Health Service will treat people holistically and use a Making Every Contact Count[16] approach. The Service will therefore need to work closely with partners delivering person-centred physical health care, in particular for conditions which are known to have a common co-morbidity with mental health such as diabetes,

[16] https://www.makingeverycontactcount.co.uk/media/27613/mecc-resources-fact-sheet-v9-20180601.pdf

COPD, heart disease, and conditions related to obesity and.

The physical health support provided by the Service must align with national best practice. It must deliver:

- The Long Term Plan target (for 60% of patients on the Serious Mental Illness register to receive all 6 annual Physical Health Checks). This includes;
  - Developing a template for health checks to be recorded and data shared through Connecting Care using a data set across the system.
  - Gaining access to all GP practices' Severe Mental Illness EMIS records, for example through Connecting Care.
  - Testing digital approaches to health checks.
  - Embedding a robust approach to ensuring that the physical health needs identified are quickly and effectively addressed. The health check should be a gateway to tailored support.
- Extended lifestyle support through partnerships with Public Health and wider local partners.
- Medicine reviews, including consideration of physical and mental health medication interactions.
- Protocols/shared care agreements outlining roles and responsibilities.
- Approaches to share and embed best practice (e.g. BNSSG Community Physical Health and Wellbeing Peer Group; training for wider workforce).
- Partners delivering the Service will ensure physical healthcare is fully integrated, knowing where expertise and responsibility lies across partners and being able to draw upon strengths, skills and trusted relationships. For example, strong coordination will be in place with specialist secondary care services – e.g. diabetes clinics, Consultant Physicians.
- Targeted outreach to underserved groups (e.g. minority ethnic communities).
- A proactive approach to successfully managing common co-morbidities such as COPD, diabetes and high blood pressure when they occur
- Support provided at the pace of the individual service user, ensuring that they retain their choices in the process.

Personal Health Budgets

The Service must actively offer patient choice and alternative forms of service provision, including the delivery of personal health budgets.

Tele health and online support

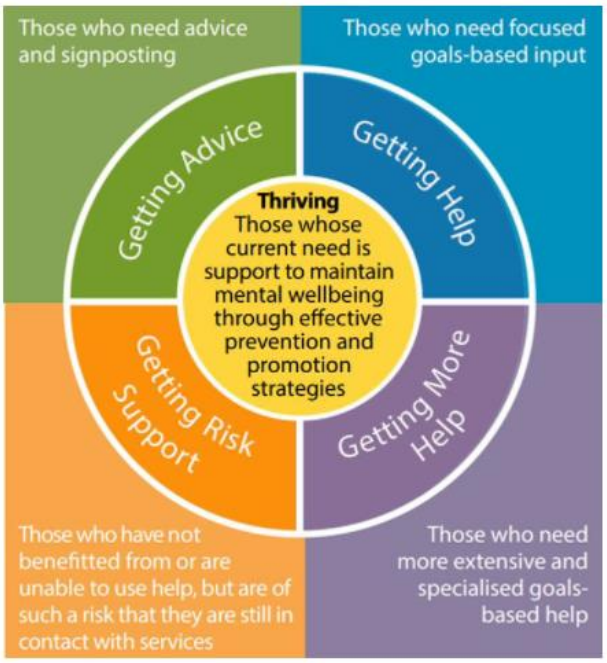
The Integrated Community Mental Health Service will engage fully with the development of new technology for the improvement of efficiency and patient outcomes. The Service should utilise new technology and telehealth to:

- Maximise efficiency, enabling health care professionals to care for a larger caseload remotely and reducing wasted time and resources.
- Provide access to remote advice, monitoring and treatment providing the most timely care possible.
- Provide tele health coaching.
- Facilitate access to remote advice from other health care professionals and specialists to support the provision of high quality care.
- Empower people to manage their own health and wellbeing without delaying access to health and care services as the need arises.
- Manage the balance of digital based contacts with patients vs face-to-face contacts with a particular focus on digital inclusion.

Support for young people

Support for young people aged 16-25 must have prevention at its core, particularly as we know that Adverse Childhood Experiences are key determinants for future mental health need. Care must enable young people to achieve their recovery goals in a timely way so that, for example, a mental health crisis at 19 does not lead to a lifelong relationship with mental health services. Instead, the Service will give young people the skills to proactively manage their mental health whilst being able to access support as and when they need it.

The Service will seek to ensure the i-Thrive model for children and young people's mental health and wellbeing is embedded within the approach for those aged 25 and under:



The THRIVE Framework is for:

- all children and young people aged 0–25 within a specified locality;
- all families and carers of children and young people aged 0–25 within a specified locality, and;
- any professionals who seek to promote mental health awareness and help or support children and young people with mental health and wellbeing needs, including those at risk of mental health difficulties (whether staff in educational settings, social care, voluntary or health sectors or others).

Whilst formal transitions between Child and Adolescent Mental Health Services (CAMHS) and the Service will need to be in place for the most complex young people, the Service must recognise that many young people may not go through a formal transitions process because:

- They have never had contact with CAMHS.
- They have had a successful discharge from CAMHS previously.
- They have disengaged from CAMHS prior to their 18th Birthday.
- They were receiving lower level support which ended when they left school,
- They were receiving mental health support from a voluntary sector provider.
- They have moved to BNSSG to study. This may include young people who have chosen not to disclose previous use of mental health support.
- A mental health need has arisen after an individual has turned 18.

It is vital that the Service has a targeted approach for young people who have not gone through a formal transitions process. This approach will include targeted wrap around support for young people based within their local community, such as social prescribing, peer support or access to other Voluntary, Community and Social Enterprise (VCSE) initiatives.

The Service must recognise the impact of adverse childhood experiences and be able to offer trauma informed approaches as part of the service model.

Support for young people will also need to have an equalities focus, considering how the service will need to adapt to the needs of young people with protected characteristics in order to deliver equity of access to and outcomes from mental health support. Specific thought should be given to supporting young people of diverse ethnicities, sexualities and gender identities. This should include reaching out to any groups underrepresented by current provision and proactively seek to address inequalities.

The Service will have strong links with local services for Children and Young People, build local partnerships and engage with relevant working groups across Healthier Together Integrated Care System to ensure awareness of emerging population trends, and ensure specific young people who need support, receive it.

Some young people disengage from CAMHS at some point before their 18th birthday or lose support upon leaving school and subsequently present to adults services after their 18th birthday without having been through any process of formal transition. CAMHS and the Service transitions workers will meet regularly to consider these cases and look at missed opportunities and system learning to strengthen future approaches to support young people.

The Service will need to support and input into Education, Health and Care Plans for young people where they are in place.

Formal Transitions from CAMHS to the Service

The Integrated Community Mental Health Service will deliver transitions support alongside Clinical Transitions Support Workers from CAMHS, VCSE staff and new peer support roles for young people aged 16-25. Integrated Community Mental Health Service transitions workers will have a network across BNSSG for supervision, peer support, training and potentially cross cover where appropriate.

The Service will work with specialised pathways to have clear plans in plans for bringing home young people who have been placed out of area and will work with Child and Adolescent Mental Health Services to avoid such placements being made, wherever possible.

As young people formally transfer to the care of Adult Mental Health services, the transitions support must 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. Warm transfers will include meetings between current and future professionals, the young person and their family or support network to introduce the young person to their new team and agree how onward support will work. This should include a handover of care and a seamless transfer of responsibility and governance for prescribing if indicated.

Support for families and children

Whilst mental health support for children is outside the scope of the Service, taking a holistic and person centred approach will mean that the Service will need to think about the whole family. This will require the Service to:

- Be fluent in understanding the impact of adult behaviours on children as well as the additional challenges children in families with mental ill health may face, such as bullying or impacted learning
- Take a contextual safeguarding approach considering the family / community context
- Actively take responsibility for family (not just individual) needs and impacts, working closely with relevant support services for families, including schools, early help and GP support, for example.

Support for older adults

Older adults may have differing types of needs, such as frailty alongside a lifelong chronic mental health condition or a new diagnosis such a dementia having previously been mentally well, or a combination of these presentations. They may therefore require support in different ways to meet these needs. Services providing care need to meet the person's complexity of need, taking into account any impact from the person's age and whether specialist older adult expertise is required for both themselves and their carers and families. This expertise might exist within the core community mental health team, or specialist older adult support might be sought from another service.

The Integrated Community Mental Health Service will deliver integrated older adult's support including care home liaison. This will provide treatment and psychosocial support, enabling people to continue successful self-care. Where older adults require more specific clinical interventions, integrated physical, mental health and social care support will be provided through joint working with physical health services where needed. Records will be integrated, with clinical information shared between teams on Connecting Care, allowing holistic care to be delivered by the wider multi-disciplinary team.

In partnership with wider Voluntary, Community and Social Enterprise organisations, the integrated older adult support will develop a complementary psychosocial offer that enables service users to remain at home with the right level of support for their needs. This will also tackle digital exclusion for older adults allowing them to benefit from new technologies but also access support via non digital methods if needed. Through this, we anticipate a reduction in older adult admissions and long term care costs.

The Service will have ambitious recovery goals to support maintenance of independence for people who have experienced lifelong chronic mental ill health and who are now becoming physically frail.

Noting the anticipated increase in older adults across BNSSG, the Service will access Health Education England's Older Peoples Mental Health Training Framework to upskill professionals (health, social care and Voluntary, Community and Social Enterprise) in IPCTs.,. Education and training for carers will also be developed.

The Service needs to have an agreed approach to draw in support from dementia services in a way that maintains the principles of person centred, proactive integrated care. In addition, dementia services will need to be integral to the IPCT approach at a locality level (outlined below) and will have a core role in providing advice and guidance and clinical supervision to services provided at a locality level.

Support for people with comorbidities

Below outlines the support that should be provided for the most common co-morbidities with mental health:

i) Substance misuse
ii) Learning disability
iii) Neurodevelopmental Disorders – ADHD and Autism

i) Substance misuse

The Integrated Community Mental Health Service will be available to people with substance use and mental health needs.

- The Service will develop a strong place-based partnership with the local drug and alcohol service provider / substance use partnership.
- The Service will provide shared care mental health support to clients with drug and alcohol problems, aligned with NICE and Public Health England guidance[17].
- All staff will be trained in the recognition and shared management of clients with drug and alcohol problems, including brief interventions.
- All staff recognise that everyone with a substance use problem will have social, psychological / mental health needs – and be confident in trauma informed practice.
- Service will be familiar with local authority arrangements for supporting complexity, homelessness and criminal justice pathways.
- The Service will develop data sharing access with drug and alcohol providers.
- The Service (involving specialist mental health and local authority partners) will support system transformation around substance use and mental health, working closely with acute health providers.
- People will not be required to be engaging with Drug and Alcohol services in order to access mental health support and no one will be turned away on the basis of complexity.
- Professionals within the service will be trained around discrimination and stigma to create a culture of empathy around drug and alcohol dependency.
- The Service will have a protocol for engaging and supporting individuals who present whilst intoxicated. They should work in partnership with drug and alcohol services to ensure the completion of joint care planning with an MDT style approach to an individual's care. Throughout a patient's care pathway open and continued communications occur between stakeholders.

ii) Learning disability

The Integrated Community Mental Health Service will be available and accessible to people with a co-morbidity of mental health needs and learning disability. Reasonable adjustments will be required across all services to ensure they meet the needs for people with learning disabilities including ensuring the Accessible Information Standard is met.

Information should also be presented in a way that is accessible and understood by those with a learning disability. The service delivery partner(s) should be in a position to implement the Accessible Information specification and implementation guidance and ensure they take the necessary steps to ensure they remain compliant.

The Service will liaise with Community Learning Disability Teams (including those out of area), Young People's Learning Disability Transitions Teams and other agencies working with people who may be below threshold for those teams.

The Service will need to ensure those supporting people with learning disabilities are trained in and using the Positive Behaviour Support model and contribute to the Dynamic Support Register as appropriate to help people to maintain homes and placements within BNSSG.

The Service will use the Green Light Tool Kit and the Learning Disability Improvement Standards to audit and improve how services support people with a co-morbid learning disability.

iii) Neurodevelopmental Disorders – ADHD and Autism

The Integrated Community Mental Health Service will be available to people with a dual diagnosis of mental health needs and neurodevelopmental disorder (NDD).The Service will work closely with partners delivering NDD services including appropriate information sharing and joint treatment planning.

[17] - https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/625809/Co-occurring_mental_health_and_alcohol_drug_use_conditions.pdf

The Integrated Community Mental Health Service will develop an approach to supporting people with suspected NDD if they are waiting for a diagnostic assessment and confirmed NDD if they are waiting for treatment or medication prescription and titration.

Carer engagement and support

The families, carers and support networks of people using services may also require support. The Service will ensure there are adequate structures and processes in place to meet their needs. This may include psychosocial education, carers' assessments, and support for young carers and carers of older age.

Under the Care Act, all carers are legally entitled to an assessment of their needs. A carer's assessment may be completed by the local authority to consider the person's mental health, physical health and social support needs, as well as their resources and ability to support the person in care. All services should work together in a whole system approach to support carers to access assessments and /or support services in a timely manner.

The 'Triangle of Care'[18] is a therapeutic alliance between service user, staff member and carer that promotes safety, supports the achievement of recovery goals and milestones and sustains wellbeing. The Service should work to ensure that carers are included as an equal partner in the support of the person.

Accessible support for people with protected characteristics

As described above, delivering the Advancing Mental Health Equalities Strategy will be a core requirement of the Service and localities will need to have robust plans to monitor and address inequalities of access, experience and outcomes for marginalised groups within their communities.

Localities will need to ensure that services reflect the diverse communities that they serve and are considerate of the issues affecting different marginalised groups within communities such as people of different ethnicities, gender identifies or people who are LQTBQ+. Examples of how this could be achieved are as follows:

- Ensuring training is co-produced and co-delivered by people with lived experience and reflecting the relevant protected characteristic.
- Ensuring that such training is designed to support a culture shift away from where there may be historic perceptions around for example mental health need and being LGBTQ+.
- Considering where protected characteristics may intersect to compound inequalities of access and outcomes.
- Considering guidance around choice of mental health provider where people may not feel comfortable accessing local services as a result of their protected characteristic.
- Revising forms and care records to ensure they allow people to accurately reflect their gender identity or ethnicity.
- Revising equalities monitoring in line with the above and in order to maximise the opportunity to understand needs within groups where historically there has been limited data, e.g. people who are LGBTQ+.

Hours of operation

- The Service will be responsible and accountable for the population 24/7/365.
- The Service will be available for people at times that are convenient to them**.** The Service will analyse demand for mental health services outside of standard working hours and shape hours of access in response.

Response times

The Service will have:

18 Carers Trust (2013) The Triangle of Care, Carers Included: A Guide to Best Practice in Mental Health Care in England. Second Edition

- A 24 hour response to connect the person to initial support, regardless of whether the first point of contact is the Open Door or the Integrated Community Mental Health Service. This initial contact may be from a peer support worker or Link Worker where the person already has a named contact. This may take the form of text, email or phone call depending on the preference of the person. The purpose is to ensure that no one is left in distress waiting for a response and where appropriate to connect people to support that might help them whilst they are waiting for appointments
- A maximum 4 week wait from the point of initial contact with the Service through to an evidence-informed intervention being provided (e.g. the creation of a comprehensive, integrated and co-produced personalised care and support plan; someone with bipolar disorder beginning a course of NICE-recommended psychological therapy).

3.3 Digital

Personalised, preventative, proactive care and early intervention is supported by increasing digital maturity across the service and this is clearly described throughout this target operating model. Through deployment and use of digital technologies, this service will provide an environment for collaborative working able to support services where they are most needed and making the most of limited resources, particularly staff time – optimising utilisation of digital assets and embedding digital into clinical practice.

An Outcomes and Digital Infrastructure Steering Group has been initiated, with representative membership from all BNSSG mental health partners. Engagement with this group has informed this section. The group will continue during the next stages to this programme, to inform and lead delivery of the digital aspirations set out

The digital principles which underpin this target operating model include:

Where possible, we will do things once: We need a common set of underpinning information systems to support patient administration, clinical and operational processes. The foundation infrastructure and support of these also needs to be consistent for staff who may work across organisation and locality boundaries. Common systems will simplify integration, interoperability and development work, and to ensure economies of scale and value for money are maximised. Currently there are multiple information systems in use, supporting different models of care, across statutory mental health providers (including RiO, IAPTUS and EMIS) and wider partners may have their own local or no systems. Getting to an integrated system is not a simple task and ICPs will need to think about phasing integration onto fewer systems and how patient data flows (for both clinical and reporting) will be managed in the meantime. Consideration may need to be given to who will act as lead provider for shared systems or digital services. To support this alignment, ICPs should use a consistent digital requirements management approach to enable system-wide providers to consistently prioritise and respond to their digital needs.

Digital will also need to support **shared/common standards** across the system, for coding, formatting and common processes. Place based services will still require system wide commonality in some areas such as assessment, complexity/risk stratification, PHM and reporting. This improves safety for patients and ensures comparable outcome measures. Additionally to also provide consistent patient and staff experience, as well as improving efficiency and value for money. Locality based services will need to work together to ensure these are established and used in the same way across the system.

Patient records will be recorded electronically in all cases. Shared and trusted assessments, care plans and wellbeing plans will be available electronically to any team

member involved in delivering care. Patient information should follow the patient, for transfers of care in and out of the system; from child to adult services, and between different elements of the service This should enable the patient to tell their story once and not be concerned that they have to keep everyone up to date or have to make repeated requests for services. Patients want to be assured that they can be seen safely by everyone who is caring for them, and the team delivering the care to have all the information they need to make the right decisions with and for them.

Consideration should be given to what **information is digitally accessible to patients**, and what patients can share with the service through digital access to empower them to become partners in their care. This may be through wider use of patient access modules linked to GP systems, through new planned innovations such as the planned mental health shared care plan, through validated apps (available through the NHS Library or through ORCHA) or other innovations. Patients may want online/digital access to their records, and to test results, medication, outpatient letters, their care and wellbeing plans. They will want to be able to manage appointments, request repeat/ changes to medication and connect easily with their link workers through digital routes. They will want tools to be able to help themselves and manage their own conditions.

Empowering patients as partners in care to feel more in control of their own health and personalised care is also likely to include self-management tools/apps, accurate and up to date information online to support self-care, and signposting information including tools such as MIDOS. Online Information should be in single version of the truth, up to date, accurate, accessible (meeting accessibility standards) and easy to navigate. Information should be available online in accessible formats, including Easy Read, and in languages other than English. User Led Design practices will be used to ensure services better meet the needs of their population.

Due **consideration will need to be given to the digitally excluded** and how this will be managed in an increasingly digital world. ICPs will have a detailed understanding of which parts of their communities are digitally excluded and will provide a range of ways to access services. ICPs will proactively engage users to ensure they design services to be accessible for all, while promoting schemes that tackle data poverty and increase the digital skills and confidence of their users.

Keeping patients /service users safe is the guiding principle of all staff across the system. People must to be confident that **staff across the system have the right information at the right time** about them, their diagnoses, medications, preferences, risk and other relevant information, regardless of location. To ensure accuracy and completeness of the record across the system information will be recorded as contemporaneous notes directly into the clinical record at the point of care. Making contemporaneous notes that can be shared immediately across the system increases safety and reduces duplication of effort, saving staff time.

Safety should be supported by digital systems so that wrap around care is effectively supported, caseloads are managed to avoid people falling out of view, escalating risk is flagged and escalation is avoided. Care planners and practitioners will use and share PHM systems and BI to enable them to proactively respond to operational incidents in real-time.

Access to records at the point of care requires **appropriate digital infrastructure and equipment**, including digital support for remote working, for virtual collaboration, as well as record access to be available to all staff delivering care. Consideration needs to be given to the digital tools and network access and controls (smart cards / tokens etc.) that staff need to do

their jobs effectively and well. While some underpinning digital infrastructure will be provided and managed at ICS level, the cost of providing digital tools and equipment for staff, and support for that equipment must be factored in to the service/contracting costs.

All information will be **SNOMED** coded wherever possible, using the contemporary nationally mandated data sets and record standards, including PRSB and Minimum Viable Record standards as described in the reporting sections and mandated in the NHS standards contracts. All activity must be reflected in the Mental Health Minimum Data set.

All staff will be trained appropriately and regularly to make the best use of digital technologies and record systems. Training must be explicitly linked to data quality and getting it right first time: training ensures that that records are coded, accurate and complete, and data quality is maintained across both primary and secondary data uses.

To ensure **data quality** data entry templates may be required to ensure reliable and consistent data entry is recorded at the point of care. Staff should not be expected or required to enter data into multiple systems. Staff should be confident that the information they create can be used to both support safe and appropriate direct care and contribute to management of services, planning and commissioning services, policy and research; avoiding collection or manipulation of data specifically for such purposes.

Drive efficiency using systems to produce management information from clinical information to manage services rather than clinicians spending time producing local reports e.g. on case lists, waiting lists etc. Use digital, online and/or automated transactional processes where possible to drive efficiency.

The service will take up **ICS wide digital innovation** to improve clinical effectiveness across the Healthier Together partnership particularly for management of complex patients. This may include digital solutions to enable practitioner to practitioner across organisations conversations to support advice & guidance, decision-making and referrals. Innovation costs are often funded as a project at the start - business cases should be clear about how project and ongoing costs will be met e.g. improved efficiencies.

Systems must be deployed safely and require robust clinical safety assessments and DPIA to be considered before implementation for new systems, or new uses of existing systems. Procurement and choice of new digital systems should be considered at ICS level to ensure economies of scale and resource use, integration and interoperability, consistency of patient experience, and comparable outcome measures.

The **single shared record across physical and mental healt**h is currently Connecting Care health. At the moment Connecting Care is largely read only, but provides a view of health and social care records. Information that is shared with the local shared record must be timely, accessible and complete to inform personalised care.
The data set to be shared from any clinical system should include the following where recorded:

- Problems (current and past)
- Diagnoses (current and past)
- Medication (current, past and issues)
- Risk and warnings
- Procedures
- Investigations
- Examinations
- Dates of encounters, admissions and referrals and assessments including specialist assessments

- Patient demographics
- Documents attached to the record to include
  - Specialist assessments e.g. perinatal
  - All care plans including specialist care plans
  - All physical health checks

New interface specifications should be costed into the service.

- **Patients want to be confident that their data is protected and to understand how it is used**, and that their consent will sought and recorded when appropriate. People receiving health or care will share their information with confidence if they feel like there are safeguards in place, and that those entrusted with their data will keep it safe. Consideration should be given as to how consent will be managed digitally across the system so that patients understand the consent model and so it works consistently across systems, in line with Caldicott principles and the duty to share for individual care (Section 251B of the Health and Social Care Act 2012). Caldicott Principles 7 and 8 are particularly relevant to this service:

  - *Principle 7: The duty to share information for individual care is as important as the duty to protect patient confidentiality. Health and social care professionals should have the confidence to share confidential information in the best interests of patients and service users within the framework set out by these principles. They should be supported by the policies of their employers, regulators and professional bodies.*
  - *Principle 8: Inform patients and service users about how their confidential information is used. A range of steps should be taken to ensure no surprises for patients and service users, so they can have clear expectations about how and why their confidential information is used, and what choices they have about this. These steps will vary depending on the use: as a minimum, this should include providing accessible, relevant and appropriate information - in some cases, greater engagement will be required.*

These principles are in addition to the standards and conditions specified in the national contract (see https://www.england.nhs.uk/wp-content/uploads/2021/03/4-FL-GCs-2122.pdf).

National Data and Reporting Requirements

National reporting requirements must be met:

- The provision of the Mental Health Minimum Dataset is mandatory for all NHS funded services.
- Need to consider whether if flowing of activity within the General Practice Appointment Dataset applies, or only Mental Health Minimum Dataset.
- The Mental Health Data Quality Maturity Index standards and monitoring will apply.
- Recording and monitoring against all applicable Operational Plan and Long Term Plan performance measures is necessary.
- All statutory returns (performance, workforce, finance, quality, estates etc.) are required.

Local Data and Reporting Requirements

The Mental Health Minimum Dataset will flow into the System Wide Dataset to enable analysis to support Population Health Management and address inequalities

Information systems must enable monitoring of the outcomes framework as well as providing local demand, capacity, activity and performance insight required to effectively manage and continue to develop the offer.

3.4 Workforce requirements

The Service will be delivered by a well-motivated, engaged and skilled workforce. The Service will engage the workforce fully in identifying solutions to population needs and system challenges and will support the development of:

- A large growth in non-clinical roles, including Link Workers and peer support workers.
- A shift away from centralised mental health services covering large areas into smaller locality based services of integrated teams, including health, social care and VCSE professionals.
- A new pipeline for all types of staff to address workforce shortages.
- Extensive training and workforce development (e.g. in trauma informed and culturally responsive care[19]).

The Service will implement BNSSG's strategic workforce priorities. These are as follows:

- **Make health and care in BNSSG the best place to work**: valuing, supporting, developing and investing in our people, ensuring that the service can attract, develop and retain staff will require the service to address the following requirements:
  - Demonstrate **equity of access to employment opportunities**, aiming for a diverse workforce representative of the population served, providing a living wage and stable employment.
  - Value **staff health and well-being**, providing good working conditions and promoting the health and wellbeing of all staff, including provision of access to mental health support when appropriate.
  - Provide **development opportunities** so that staff have the skills required to deliver their role, and enhance their skills to support service and career development.
  - Consider **career opportunities** by working across partners to provide opportunities for shadowing, coaching, mentoring and rotations along with creating career pathways to help retain and develop staff.
  - Provide pathways to enable **volunteers** with appropriate experience to move into paid roles with training and support.
  - Establish clear **training frameworks** for non-clinical roles to ensure staff have the appropriate competences, and support.

Some of this work will be best undertaken collaboratively across partners and there will be some specific support with staff development available from the Community and Primary Care Training Hub.

- **Prioritise urgent action on workforce shortages:** attracting new people into care
  - The Service should, where possible, include **employability programmes** that provide training and support to help those with lived experience and from the local community acquire the skills needed to work in mental health and care, and work with community partners and voluntary organisations to support residents who might otherwise face barriers to work.
  - Partners will recognise their **anchor institution** role and will work to advance the welfare of the populations they serve and the way in which they can support local community wealth and development, through the provision of employment opportunities. This will include specific targeting and marketing of opportunities at the local community, and at those with lived experience.
  - Given national shortages of nursing and medical roles in mental health, it will be important that the Service providers employing these staff groups work with system partners to develop **sustainable pipelines**, through joined up approaches to workforce planning and development. For example, providing placements for trainees. Like the

[19] www.centreformentalhealth.org.uk/sites/default/files/2019-04/CentreforMH_EngagingWithComplexity.pdf

wider system, there should be opportunities to access **apprenticeship programmes,** and other training routes, which assist in providing employment for the local community and support the creation of the workforce of the future.

- **Develop a workforce to deliver 21st century care:** a transformed workforce with new types of roles and different ways of working
    - The Service will create **new and innovative** workforce models, with a blend of clinical and non-clinical roles – including peer support roles, Link Workers, social prescribers and mental health practitioners – working together to provide personalised care. Utilising a blended skills workforce model, based on the competences required to deliver care, rather than established roles, is important both for patients and for staff, as it provides new supply routes, attracting a more diverse workforce into the service.
    - Time will need to be invested in engaging existing staff in the development of new workforce models at an early stage so that they can support the design, training and implementation to make these roles successful.

    - **Develop a new operating model for workforce:** addressing governance and cultural differences to deliver a truly integrated workforce

    - **Develop our leadership culture**: positive, compassionate and improvement focused leadership that delivers better outcomes.

In order to ensure that there is an integrated workforce that supports seamless service provision and minimises handovers between individuals and organisations, staff will need to be supported to work across organisational boundaries. This will include streamlined systems, processes and policies, agreed approaches to risk management, statutory and mandatory training passporting and governance arrangements which allow staff to work seamlessly across organisational boundaries. Mental health clinicians will need to work alongside peer support workers, social care and the voluntary sector, providing personalised care and treatment and working collaboratively as equal partners.

Culture and identity will need to be nurtured so that there is a sense of belonging to both an organisation and to the Locality Partnership. Working together will require a culture of trust, openness and compassion. This culture will need to be fostered both at the level of leaders, and through deliberate efforts to enable staff to build working relationships at all levels. Activities such as shadowing, rotations, joint roles, coaching, reflective practice, team building and joint, cross organisational training and development events can all help to build the identity of the Locality Partnership and enable staff to work across boundaries.

Whilst some staff will regard new approaches as an opportunity for new and better approaches, others may feel worried about what the change will mean for them and their roles. It will be important that there is a clear engagement and communication plan to ensure a smooth transition, so that staff understand what the changes will mean and how they can become involved with the process.

3.5 Estates requirements

The Service must:

- Be geographically accessible within locality footprints including consideration of public transport routes and the availability of local community transport services.
- Be non-stigmatising, including considering the experiences and perspectives of different communities.
- Be Co-located with a non-mental health services.
- Include Psychologically Informed Environments.

- Consider the post COVID-19 demand for online or tele support.
- Flexible use of estates across delivery partners and wider system partners.
- The provider should provide premises that comply with NHS standards including the relevant Health Building Notes (HBNs) and Health Technical Memoranda (HTMs). Any derogations away from these standards should be presented to the commissioner for review and agreement along with a mitigation plan.

3.6 Other requirements

The Service is required to have systems and processes in place to ensure that people are given the opportunity to take part in high quality research studies. Examples of such systems and processes could include:

- Adopt an 'opt-out 'policy in which people with mental health needs and family/carers are informed that research is a routine part of the philosophy of the BNSSG Mental Health Model and that they may be contacted about opportunities to join research unless they explicitly request not to be contacted.
- Have a system in place such as a 'consent for approach register 'to keep a record of people who are willing to be offered research opportunities, together with relevant demographic details and their diagnosis
- Have job descriptions and plans that make reference to the Service delivery partner(s) 's commitment to promoting people's recruitment in to research studies and the view that it is a positive intervention
- Inform existing and new employees at induction of the Service delivery partner(s) commitment to contributing to the evidence base, a culture of innovation and improvement, and how employees can contribute
- Ensure access to appropriate research-relevant training
- Facilitate opportunities for people with mental health needs and family/carers to inform and participate in the research portfolio. For example, research opportunities for people with mental health needs and family/carers should be clearly presented in clinical areas using posters and leaflets or other media, and in Service delivery partner(s) communication strategies

The Service should demonstrate that research does not only concern medical trials, but should include social and non-pharmacological interventions, and that facilitating service user involvement in the design, implementation and dissemination of studies can lead to improved outcomes and better value.

The Service will make a statement on research activities undertaken in the annual Quality Account and should include a statement of the number of people recruited and the number of studies they host.

3.7 Out of scope

This section of the target operating model identifies areas of mental health care that are currently out of the scope of what the Integrated Community Mental health Service will be expected to deliver. Some of these areas of care may become part of a future locality based model of mental health care in time.

- All mental health services currently commissioned by NHS England Specialised Commissioning or commissioned by the CCG specifically on behalf of NHSE will continue to be delivered by NHSE commissioned providers. The Integrated Community Mental Health Service will be expected to work closely with these services to support shared care and any transitions. Future changes to commissioning arrangements for

NHSE commissioned services could allow flexibility for these services to be included in future phases of the Community Mental Health Programme.

- Child and Adolescent Mental Health Services

These specialist pathways are expected to be provided once, across BNSSG, not on a locality basis. However, the Service will need to ensure that these pathways are closely integrated so that key support (e.g. from primary care or VCSE partners) is included.

These specialist pathways will support the Integrated Community Mental Health Service by providing:

- Advice, guidance and training around early intervention and prevention.
- Case consultation and supervision.
- Diagnostic assessment and formulation relating to that support (e.g. PD and eating disorders)
- The provision of specialist treatment and interventions.
- Ensuring a seamless transition for a person where they may no longer need specialist support and well-designed process to support people within their community if possible.
- Connection with Link Worker to ensure they are part of the 'one team' around the person whilst they are receiving specialist support.

3.8 Interdependence with other services/partners

The Service will work collaboratively across organisational boundaries and disciplines to secure improvements that are tailored to local needs and assets, in turn increasing sustainability and the effective use of limited resources.

The Service is expected where possible to consider co-location of integrated staff teams supporting the provision of community mental health services both to foster strong collaborative working practices but also to make the connection with the person more joined up.

The principles of a single team will require investment in time and development, to avoid many of the challenges that are often reported as barriers to integrated working. Respecting and understanding the skill set and contribution of all professionals and a joint commitment around the needs of the person.

Record keeping and collaborative care planning are expected to build on existing standards of good practice, given that currently the approaches will be diverse across different professional groups and organisations each Locality based integrated community mental health service will be required to consider the design locally and contribute to elements that we be developed at a system level.

As part of collaborative system working the Service will have a training offer for system partners.

Social care

The Integrated Community Mental Health Service will include social care as a key and equal delivery partner.

The arrangements for mental health social care across BNSSG are as follows:

- In Bristol social workers who work across adults and older adults mental health are based with the Council and are part of generic (non-mental health specialist) adult social care teams.

- In North Somerset social workers work across adults and older adults mental health are co-located with Avon and Wiltshire Partnership recovery teams.
- In South Gloucestershire social workers for adults are integrated into the Avon and Wiltshire Partnership recovery teams, giving AWP full management responsibilities. Social workers for older adults are based with the Council and are part of generic (non-mental health specialist) older adult social care teams.

The BNSSG system will explore and work towards opportunities for aligned and ultimately full joint commissioning with Local Authority partners. This approach will support the Integrated Community Mental Health Service in achieving integrated care and improved outcomes for people, for example, through the strategic joint commissioning and shared ownership potentially including budgets for Aftercare arrangements including for people subject to S117.

The Service will also consider with Local Authorities as partners the flexible use of workforce. For example, creating opportunities to develop a wider pool of Approved Mental Health Practitioners which will support improved outcomes for the whole system

Physical Health Services

The Integrated Community Mental Health Service will be part of a locality approach to delivering health services and will be fully integrated with physical health support delivered by Primary Care, Sirona CIC and partners. The locality approach will have a holistic, asset based and Making Every Contact Count approach to supporting people to stay physically and mentally well.

Making Every Contact Count (MECC) focuses on the lifestyle issues that, when addressed, can make the greatest improvement to an individual's health:

- Stop smoking
- Alcohol intake and staying within the recommended limits
- Healthy eating
- Physical activity
- Keeping a healthy weight
- Improving health and wellbeing

The Integrated Community Health Service will include VCSE organisations within each locality to co-ordinate the local VCSE assets available to support individuals. This approach includes interventions such as link workers, social prescribing and staff trained in Mental Health First Aid.

Improving Access to Psychological Therapies (IAPT)

The Improving Access to Psychological Therapies Service (IAPT) will form part of the Integrated Community Mental Health Service and the provider Vita Minds will be a partner in this approach. People receiving therapy through the IAPT programme will be able to access the wrap around support such as social prescribing and peer support as it is key to sustaining the outcomes achieved from a course of IAPT therapy. People who require more support than can be offered through IAPT or who are still unwell at the end of their course of therapy will be supported to access further interventions.

Information about the use of IAPT will be included in population health management analysis to help the Integrated Community Mental Health Service build intelligence about existing and emerging needs across the population and design appropriate service responses

The Open Door (Integrated Response Line) is also likely to support some people to use IAPT where appropriate but it will be expected that many people will continue to directly access IAPT.

Office of the Police and Crime Commissioner and Avon and Somerset Constabulary

The Service will work closely with Avon and Somerset Constabulary An area of particularly

relevance to the Community Mental Health Service will be the need to work jointly with the police around people who are frequently in contact with the police either by telephone or through face to face interactions with the police including but not limited to via Section 136.

The Service will consider all opportunities to jointly commission or deliver services in conjunction with the Office of the Police and Crime Commissioner and Avon and Somerset Constabulary.

4. Applicable Service Standards

4.1 Applicable national standards

The CCG requires the Service delivery partner(s) to keep up to date with local and national policies and quality requirements. The list (Appendix 6) outlines examples of documents the CCG expects the Service delivery partner(s) to follow. The Service delivery partner(s) are required to incorporate the most up to date versions of these and similar policies and practice when delivering the model of care.

4.2 Applicable local standards

- CQC standards and regulations - www.cqc.org.uk/guidance-providers/regulations-enforcement/regulations-service-providers-managers

Medicines management

Clinicians providing NHS commissioned care within the Services should:

- Prescribe for adults in accordance with the BNSSG Joint Formulary and other relevant local prescribing guidance. https://www.bnssgformulary.nhs.uk/
- Prescribe for children in accordance with the paediatric updates in the BNSSG Joint Formulary, or the BNSSG Paediatric Joint Formulary https://www.bnssgpaediatricformulary.nhs.uk/
- It should be ensured that patients have continuity of medicines across the healthcare system, with all clinicians ensuring clear communication processes in relation to patient medication and if /when digitally possible using a single medication record
- Where relevant ensure shared care protocols are in place and adhered to
- Practice antibiotic stewardship in line with national and local guidance
- All clinicians should follow the process outlined in the BNSSG Formulary for new drug requests and shared care protocols that can be found on the formulary website
- A prescribing budget for certain areas will be included in the Service delivery partner(s) contract (see individual service details) and the provider will manage spend within that budget
- The Service delivery partner(s) are responsible for the production and updates of any necessary Patient Group Directions for their services, in line with the BNSSG Patient Group Directions Policy
- All dressings will be supplied or prescribed in line with the Pan Avon Dressings Formulary
- The Service delivery partner(s) services will work with Integrated Care Systems to minimise the impact of medicines waste
- Specialist clinicians will engage with the Integrated Care Systems and other Service delivery partner(s) in the development of pathways and guidelines involving medicines
- All medication incidents should be recorded on Datix
- Medicine Incidents themes should be shared with the CCG Medicine Optimisation team via agreed route
- A Controlled Drug lead should be nominated for the service and all CD incidents should be reported to the NHS England Controlled Drug Accountable Officer, as well as the relevant CCG link person for the service
- A senior pharmacist or healthcare professional is required to represent the organisation at

system Medicine Optimisation groups such as the Area Prescribing Medicines Optimisation Committee (APMOC).

The prescriber is responsible for ensuring that appropriate clinical monitoring arrangements are in place for the medicines that they prescribe and that the patient and other healthcare professionals involved understand them.

Prescribing Process and Governance

The Service is expected to ensure robust governance of all prescribing activity, including the use of policies and procedures relating to prescribing activity to support high quality, safe and appropriate prescribing and may periodically be asked to demonstrate this is the case.
The Service should have a nominated lead for controlled drugs or equivalent senior officer responsible for oversight of all prescription usage by the service including audit and raising appropriate concerns around controlled drug management.

All prescribing should be undertaken via existing prescribing systems such as EMIS and Rio initially which may develop into a shared solution as the service progresses. It is anticipated that the service will prescribe via the electronic prescription service (EPS)

The Service is responsible for funding all prescribing activity undertaken on FP10 prescription pads. This will include the initial prescription and any repeat prescriptions required thereafter where appropriate. The service will be expected to prescribe within their devolved budget. The Service delivery partner(s) will periodically be expected to provide data on the medication prescribed on FP10 prescription pads from the epact system.

The Service should ensure it is fully compliant with the NHS Counter Fraud Authority guidance on Management and control of prescription forms, including prescription pad destruction as part of contract termination. For clarity BNSSG CCG will not be liable for any costs of inappropriately used prescriptions.

The following link provides NHS Service delivery partner(s) with the information needed to obtain and maintain prescribing codes for your organisation and prescribers, order prescription forms (FP10), reconcile invoices, access data about your prescribers and services. Service delivery partner(s) s should liaise with BNSSG CCG's Medicines Optimisation Team who contains the necessary CCG signatories to complete the process.
https://www.nhsbsa.nhs.uk/sites/default/files/2017-02/Local_Authority_and_Provider_Welcome_Pack_v1.5.pdf

During contract termination the prescription services department of NHS Business Services Authority (NHS BSA) must be informed the Service delivery partner(s) 's Organisational Data

Safeguarding Children and Adults at Risk

At the commencement of the Service it is not expected that the partners collaborating to deliver locality based services will have formal legal status as a partnership or single organisation. Consequently, partners within the Service will continue to have their own safeguarding policies and procedures in place. Where appropriate, partnership agreements that outline how safeguarding will work within collaborative arrangements, such as Integrated Personalised Care Teams, will be developed.

As development of the ICS and locality health partnerships take place and legislation changes, the service will need to be protective, adaptable and reactive to change and ensure safeguarding arrangements are updated accordingly. In this section, where 'the Service' is referred to it means there is expected to be one arrangement, process or policy across partners. Where 'each partner organisation' is referred to it is expected that each partner will need to have their own

arrangement, process or policy until such time as locality partners have a legal entity.

Young people transitioning to adult services
Safeguarding means protecting people's health, wellbeing and human rights. It's fundamental to high-quality health and social care and is about keeping everyone safe and taking care of their wellbeing.

All safeguarding adults work is underpinned by the Making Safeguarding Personal guidance and the Safeguarding Principles as laid out in The Care Act 2014. Making safeguarding personal means it should be person-led and outcome focused. It engages the person in a conversation about how best to respond to their safeguarding situation in a way that enhances involvement, choice and control, as well as improving the quality of life, well-being and safety.

The Service will adopt the following Safeguarding Principles:

- Empowerment – people being supported and encouraged to make their own decisions and informed consent
- Preventions – it's better to take action before harm occurs
- Proportionality – the least intrusive response appropriate to the risk presented
- Protection - support and representation for those in greatest need
- Partnership - local solutions through services working with their communities who have a part to play in preventing, detecting and reporting neglect and abuse
- Accountability – accountability and transparency in delivering safeguarding

The Service will be expected to provide robust governance in meeting the safeguarding functions to demonstrate how these statutory duties are being met.

The Service will need to cooperate and work in partnership within the ICS to seek common solutions in responding effectively to the evolving safeguarding legislative changes.

Workforce safeguarding approaches
Each partner organisation within the Service will have a robust Safer Recruitment and Retention policy in place to fulfil its legal obligations. This will include Disclosure and Barring Service (DBS) Independent Safeguarding Authority (ISA), Data Protection Impact Assessment (DPIA).

Each partner organisation within the Service shall evidence that it has published contact information for the following, which will be shared with the Integrated Care System on request:

- Named Safeguarding Adult Lead.
- Named Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) Lead(s).
- Named Prevent lead

The Service will ensure that up-to-date policies and procedures for safeguarding children, young people and adults at risk of abuse and neglect are in place for each partner organisation. These will adhere to all relevant legislation identified in the Care Act (2014). Additionally, for those young people in pathways to adult services who are in contact with the service when under the age of 18, or for any other children who come into contact with the service through family contact or similar, the Service should have arrangements in place to raise any identified safeguarding concerns under the relevant children's legislation and local processes. Each partner organisation should also have specific guidance and policies in relation to the Mental Capacity Act 2005 and DoLS, Prevent, Modern Slavery, and Domestic Abuse.

Each partner organisation will ensure that the safeguarding policy addresses the risk of harm of abuse, to eliminate discrimination, harassment and victimisation, to advance equality of opportunity. This will foster good relations between people who are known to be of greater risk and are identified under the protected characteristics cited in the Equality Act (2010).

The Service will have a partnership agreement outlining how partners within the locality based health service will work together to keep people safe. This collaborative approach, and how it fits within individual organisations' policies, must be effectively communicated to all those working in the locality based health and care service, including trustees, volunteers and beneficiaries who will have specific roles in relation to safeguarding. The Service will ensure that support is in place, with lines of accountability and responsibility for responding to safeguarding concerns, within a transparent culture. This will include Raising Concerns, Speaking Out, and where appropriate including allegations against staff where people are in a position of trust.

The Service shall have a written policy of confidentiality that is compliant with the General Data Protection Regulation (GDPR) 2016 and Data Protection Act 2018 (Data Protection Legislation). Where appropriate, confidential information will only be disclosed with the consent of the patient concerned, though there are circumstances where consent should not be sought or is only sought under the common law duty of confidentiality. Examples include circumstances where disclosure is required by law or to safeguard children or adults at risk of harm. The Service delivery partner(s) shall also ensure that all employees are trained in line with caldicott principles and understand the importance of patient confidentiality.

This is a service provision for Young People transitions and Adults and the concept of Think Family needs to be considered throughout all polices and practice.

Training
Each partner organisation within the Service will also ensure that all staff in contact with patients and the public have been appropriately trained in local safeguarding procedures and regularly maintain these competencies. Competencies and training must be aligned to the intercollegiate guidance relevant to their role:

- Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff (Royal College of Paediatrics and Child Health, 2014)
- Adult Safeguarding: Roles and Competencies for Health Care Staff (Royal College of Nursing 2018)
- Looked after Children Roles and Competencies for Health Care Staff (Royal College of Nursing 2020).

Effective working practices to prevent abuse and neglect, and to protect individuals.
The service will fulfil its statutory duties and responsibilities in relation to Safeguarding Children, Young People and Adults. Partners within the locality service who are delivering statutory functions will participate in the delivery for the safeguarding arrangements across the three local authorities. This will include attendance at the safeguarding arrangements, Boards or subgroups. Mandatory participation in strategy meetings, safeguarding adults reviews (SARs), Child Safeguarding Practice Reviews case reviews (CSPRs), and Domestic Homicide Reviews (DHRs).

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements

Quality performance targets are included within the Outcomes Framework found at Appendix 2. Additional local quality indicators will be added.

Please note that Quality Assurances processes are expected to change with the establishment of Integrated Care Systems. National Guidance is currently pending. This section will be updated in line with any future published guidance.

The service will be required to have policies and processes in place in the following areas, and

report on compliance and progress within these areas:

- Patient Safety Incident Management – in line with the Serious Incident Framework prior to the Patient Safety Incident Response Framework (due to be published in Spring 2022).
- NHSI Learning Disability Improvement Standards for NHS trusts (2018).
- Complaints and patient experience.
- Freedom to Speak up.
- Accessible Information Standards
- NICE guidance compliance where appropriate.
- Workforce Race Equality Standards and the Equality Delivery Standards
- Infection prevention and control
- Green NHS and Sustainability.
- Risk Management
- Medicines Management (where appropriate)

The service will be expected to report on the following Quality requirements.

- Incident reporting and compliance against the Framework.
- Training including –
    - Learning Disability and Autism training.
    - Statutory and Mandatory training Compliance.
    - Service specific training requirements.
- Care planning and risk assessment compliance.
- Patient Experience metrics, including –
    - Complaints number and compliance
    - Friends and Family Test (where appropriate)
- Recovery outcomes.
- Carer identification and referrals.
- Physical health checks and appropriate actions.
- Staff appraisal and supervision rates.
- Sickness rates.
- Vacancy and Turnover rates.
- Seasonal flu vaccination uptake.
- Zero Suicide plan and progress.

Evaluation

The Service will agree with the Integrated Care System the level of service evaluation required to be undertaken. In most cases the Service will be required to perform at least one full evaluation of the service per locality within twelve months of operation, and thereafter at least every 18 months. Other monitoring and audit activities may be required more frequently in agreement with the Integrated Care System.

The full evaluation should use appropriate data to assess whether the service is delivering the objectives as set out in the service target operating model and is providing value for money, while also evaluating the processes involved in running the service. An evaluation plan should be developed in conjunction with the Service delivery partner(s) 's service delivery plan and clearly state the choice of process, performance and outcome measures that will be collected.

This plan should then be agreed with the Integrated Care System and be funded from the overall value of the contract. Where appropriate, the evaluation must be delivered in partnership with a suitably qualified external organisation, to ensure transparency. It is expected the plan will collect

a mixture of quantitative, qualitative and process data (where appropriate), and complies with guidance on patient and public involvement in evaluation, and with best practice in ethical service evaluation.

Typical data might include as a minimum:

- Service User satisfaction interviews, surveys, complaints and compliments
- Staff feedback sought via interviews, focus groups or surveys
- Reflective practice sessions with staff
- Measures appropriate for assessing clinical and cost effectiveness
- Surveys, interviews, focus groups and workshops with stakeholders
- Person reported outcome measures, Quality of Life measures
- Performance measures such as numbers of people accessing the service, referrals, waiting times, demographics, Did Not Attend
- Data captured through Quality Improvement Methodologies such as Plan, Do, Study, Act cycles or run charts.

Numbers are to be proportionate and representative of the specific service component.

6. Location of Provider Premises

The Service delivery partner(s)'s Premises are located at:
The exact location will be confirmed once Service delivery partner(s) (s) are commissioned.

Appendix 1: Value Based Health Care and Population Health Management

The provider of Integrated Community Mental Health Services will be required to take a Value Based Health and Care approach. This means:

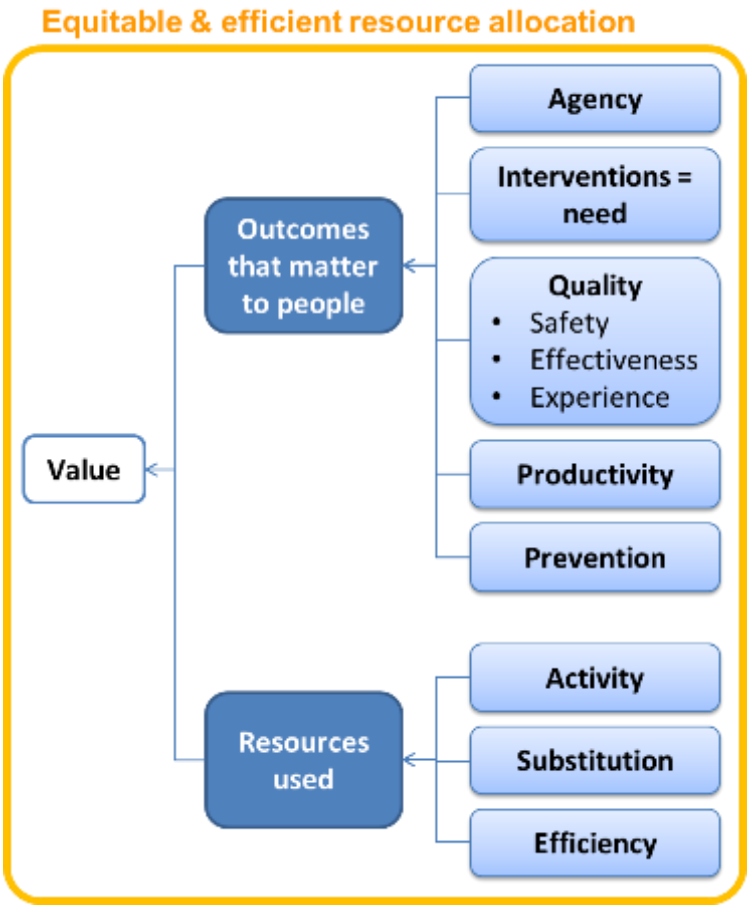
- Meeting the goals of Population Health: improving physical and mental health outcomes, promoting wellbeing and reducing health inequalities, for a whole population and not just those who present to services.
- Focusing on achieving the outcomes that matter to people and making best use of resources (value).

The Service will consider the relationship between mental and physical health.

NHS England NHS Improvement defines health inequalities as “unfair and avoidable differences in health across the population, and between different groups within society”. This may include, but is not limited to, deprivation, age, ethnicity, sex and gender.

The Integrated Community Mental Health Service needs to generate value to individuals and populations. The Healthier Together Value Framework sets out what we mean by value. This could be applied to think through a whole service or specific pathways.

Figure 2: Healthier Together Value Framework



This is what we mean by each element of the Value Framework:

1. **The wrapper**: decisions on where to use resources (including people, money) should be based on a balanced view of equity (what is fair) and allocative efficiency (what service mix will lead to the best overall outcomes for the resources available).
2. **Value**: value can be improved by focusing on outcomes that matter to people and/or reducing the resources needed to achieve those outcomes.
3. **Outcomes that matter to people** can be improved by:

    a.) Optimising individual agency, that is "the ability to take action or to choose what action to take" to achieve what matters to them. An important measure to consider here is the Patient Activation Measure (PAM) . Important interventions to consider are Care and Support Planning (CSP) and Shared Decision-Making (SDM).

    b.) Matching evidence-informed, cost-effective interventions to need is critical to improving outcomes at a population level. An important area to consider is current unmet need, which is that where someone would like to improve their health AND has the potential to benefit from something currently provided that they are not currently benefitting from.

    c.) Improving quality, which could be one or all three of the elements of quality; safety, effectiveness (whether the intervention does what it is supposed to) and experience.

    d.) Improving productivity means increasing the output/activity from a particular resource or set of resources, such as the number of severe mental illness health checks per GP per hour. Productivity should not pursued to the detriment of effectiveness and could have a negative effect on efficiency, although this may be considered worth the trade-off.

    e.) Prevention of poor health is generally one of the best ways to maintain health and promote wellbeing

4. **Resources used** can be improved by:

    a.) Reducing activity and ideally low value activity, which is activity that is either unwanted by a person (related to improving agency) or unwarranted, such as an intervention that has been shown to be of no benefit, e.g. using mirtazapine with other antidepressants for treatment-resistant depression. A significant reduction in activity could also be achieved by addressing failure demand, which is "demand caused by a failure to do something, or to do something right" for a service user", which results in the service user needing to make another demand on the service.

    b.) The substitution of services that are less resource intense but give similar benefit, such as non-medical interventions for mild-moderate depression.

    c.) Improving efficiency, which means when an output such as GP severe mental illness health checks is being achieved at the lowest possible average total costs.

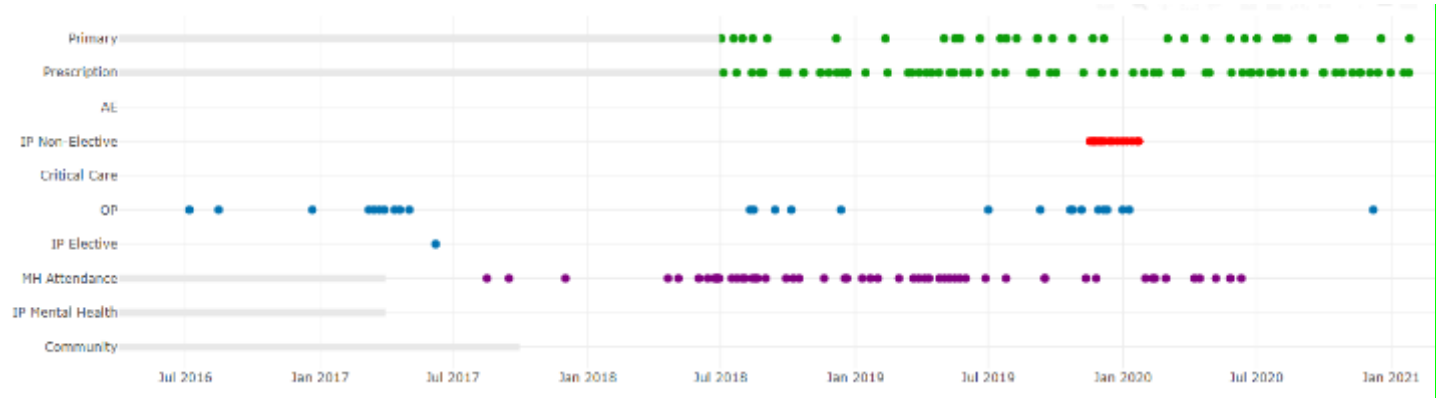
Population Health Management
Population Health Management is a critical enabler to the Value Based Health and Care approach.

The Integrated Community Mental Health Service will be required to take part in the BNSSG Population Health Management development programme to:

- Co-produce with the BNSSG team a set of analyses to support service design, which in addition to a traditional needs assessment will also include:
    - Risk stratification (quantifying and ranking risk) for certain groups or conditions
    - Segmentation (groups with similar needs or characteristics) of the population
    - Analyses of individuals' and segments' care over time and across services (see Figure 3 for example)
- Build the capability within the service team to use Population Health Management in the set-up, quality management, health and care provision, and evaluation of services.
- Develop the tools and supporting infrastructure to sustain the use of Population Health Management within the service.
- Agree to sharing data to the Population Health Management System Wide Dataset– a pseudonymised record level database involving multiple Healthier Together system partners.

The Service will not be asked to fund Population Health Management infrastructure but will need to account for staff roles including clinical and non-clinical Population Health Management data champions and Population Health Management data facilitators (people who are able to help the service make use of Population Health Management). Training, coaching and mentoring for these roles will be provided through the BNSSG development programme.

Figure 3 : Theograph of 5 years of care for a 29 year-old female



Note: A Theograph of 5 years of care for a 29 year-old female living in the second most deprived quintile on the severe mental illness register. The Theograph shows activity as coloured dots over time, by 'point of delivery', e.g. A&E, GP, mental health. Grey bars are missing data. These plots help us see the scale of the resources used for an individual across a partnership of organisations and over time. They prompt us to this about how we could be improving things for this person and how we could be making better use of all of the resources being invested. Live plots for use in clinical care are available in connecting care.

Appendix 2: Draft Mental Health and Wellbeing Outcomes Framework

BNSSG Integrated Care System is producing a system-wide Mental Health and Wellbeing Outcomes Framework, which outlines our collective ambition for improvement. The BNSSG system will annually publish performance against the outcomes framework.

Key principles that underpin this framework are:

- A reporting schedule will be created that sets out what information each organisation is responsible for providing, in what format and by when
- Where available, nationally reported information will be used to support / augment locally generated data
- Requirements will be reviewed regularly (at least annually) and adjustments made should national or local requirements change
- Where possible, existing outcomes frameworks will be utilized to define and monitor the service (this could include, NHS, mental health, social care and/or public health frameworks)
- In some cases, targets and baselines will need to be set in year one
- Common outcome measurement tools will be used across all services / partners to assess high level outcomes
- Service / pathway specific outcome measurement tools may also be used

Outcome	Output	Systems	Target
People will be able to access support early if they become unwell *'I want to access care when I need it and expect waiting times to be kept to a minimum'*	People will receive first contact from the 'open door' within 24 hours	TBC	95%
	People will have to wait a maximum of 4 weeks from initial contact to evidence informed treatment	TBC	95%
	People will access the right support first time: • % of people accessing advice & guidance (reducing referrals into secondary MH care) • Patient survey	Advice & guidance	TBC
	Supporting metrics: • How many people needed access to a service (i.e. total referrals)? • How long did their support last (i.e. length of treatment)? • How many people are still awaiting first contact (i.e. waiting list size for assessment)? • How many people are still awaiting start of their treatment (i.e. waiting list size for treatment)? • How many people are still receiving treatment (i.e. the active caseload)?	TBC	Baseline & monitor

Outcome	Output	Systems	Target
People will experience equal access to support *'I want care that is tailored to my needs'*	Programme of work to test equity of service for all, aiming to answer key questions: • Do rates of service request mirror those of the population being served? • Is a timely response for assessment and treatment provided equitably for all groups? • Is the range of treatment options offered the same for all groups? • Are the outcomes achieved the same for all groups?	TBC	N/A

Outcome	Output	Systems	Target
People will receive support aimed at preventing crisis episodes and avoidable harm	People will be supported by their community mental health team, reducing their use of other services • How many A&E attendances were there due to issues related to mental wellbeing? • How many admissions were there to Acute Hospital inpatient services due to issues related to mental wellbeing? • How many people were detained under s135 or s136? • How many people were admitted into a Health-based Place of Safety? • Evidence of appropriate drugs monitoring / medication review (incl. the impact on physical health)	TBC	Baseline & monitor

	People will be supported by their community mental health team, minimising their need for crisis / inpatient support
	
	• How many people required support from mental health intensive / crisis teams?
	• How many people were admitted to an acute mental health inpatient bed?
	  ○ Total admitted into an NHS or private bed in the region
	  ○ Total admitted into a non-NHS bed outside the region
	• How many people required s117 aftercare?
		TBC	Zero – Out of Area Placements
			
			Baseline & monitor other metrics

	People will be supported to prevent / avoid harm • E.g. total incidents of self-harm	TBC	TBC
	Supporting metrics: • Bed availability compared to national benchmark • Admission rate compared to national benchmark	TBC	N/A

Outcome	Output	Systems	Target
Patient and carer experience of service *'I want to know that help is available if / when I need it (carer)'* *'I want to be listened to (patient)'*	People have a positive experience of service and support; people do not experience stigma • Friends & Family Test (FFT) • Total responses to FFT • Service user survey	TBC	Baseline in year one, using national benchmarks
	Carers feel supported and central to the support offered to service users • Carer survey	TBC	Baseline in year one

Outcome	Output	Systems	Target
The service will help service users on their recovery journey '*I know who to call when I need support'* *'I want care to be joined up and accessible'*	People's care will be effectively coordinated • % of people with SMI / Complex needs with a link worker	TBC	75% (yr 1) 100% (yr 2)
	People will have improved physical health • Mortality gap for people with SMI reduced • Annual physical health check for people with SMI (LTP target)	TBC	TBC Trajectory to 100%
	Clinician Reported Outcome Measures (CROMs) • Mental Health Cluster Tool (requirement for statutory MH providers)	TBC	Baseline in year 1
	Patient Reported Outcome Measures (PROMs), used to understand outcomes for patients (some of which are noted below) – incl. holistic tools such as ICECAP / IROC • Tools to be agreed in year 1	TBC	Baseline in year 1
	People will be able to live more independent lives • Reduction in the number of people with SMI frequently attending their GP	TBC	Baseline in year 1
	People able to access education & training • The number of people in employment • Data from the IPS service	TBC	Baseline in year 1
	People have access to safe, warm home and a health standard of living • The number of people living in settled	TBC	Baseline in year 1

	accommodation		

Outcome	Output	Systems	Target
The workforce feels supported and effective at delivering the service *'I want to be effective'* *'I want to feel part of "one team"'* *'I want IT systems that allow me to do my job'*	Staff retention will be above the national average • Turnover rate • Vacancy rate	TBC	Baseline in year 1
	Survey results indicate that staff feel that they can make a difference AND that they are enabled by IT to do their jobs • Annual NHS staff survey results • Local staff survey	TBC	Baseline in year 1
	Supporting metrics: • Sickness rate (target to be in line with national average for MH services) • Supervision rate (target = 85%) • Appraisal rate (target = 90%) • Stat/man training rate (target = 90%) • Usage of bank / agency staff (baseline in year 1)	TBC	As noted
Outcome	**Output**	**Systems**	**Target**
Good quality data will be collected to support monitoring & oversight	The system will ensure timely and accurate MHSDS submissions • % of providers routinely submitting an MHSDS return (target = 100%) • DQMI score for each provider (target = 95%) • % patient interventions submitted to MHSDS with a valid SNOMED code assigned (target = 70%) • % patients with protected characteristics recorded (target = 95%	TBC	As noted

Helpful information to support the ongoing development of this framework has been offered during the feedback process. The Outcome and and Digital Infrastructure Steering Group ran three workshop sessions and as much as possible of that feedback has been incorporated. Feedback was received via the main process too and is summarised below. This will be reviewed and actioned by the Outcomes and Digital Infrastructure Steering Group, engaging appropriate partners, in line with the programme progress. Localities, VSCE and public health specifically have offered help with this.

Outcome gaps to address:

- Primary care – e.g. reduction in repeat attenders
- Wider determinants of health / whole population measures
- Include some suggested medicines optimisation measures
- Measures relating to prevention interventions and services
- Self-reported measures and some way of showing the impact of VCSE and community work on patient flow through the system

- Distance travelled outcome measures
- Impact of non-clinical inputs on outcomes
- Make Every Contact Count (MECC) and physical health need
- Translate service description / pathway elements into outcomes
- A measure for system working / behaviours
- Considering the impact when someone is receiving a range of interventions
- Discrimination (or inequality?) associated with access or acuity level – ethnicity, hearing, LGBTQ+, LD, dependence on alcohol or drugs
- Staff well being
- Language re S117 / OAP measure

Outcome measurement tools:

Valuable detailed options provided by Jude Hancock from the Clinical Effectiveness Team.

IAPT use the following outcome measures:

- GAD 7
- PHQ 9
- Work and Social Adjustment Scale
- IAPT Phobia questions

Measures of personal (user) outcomes and impacts:

1. INSPIRE – a questionnaire for people to complete about their experience of how their worker supports their recovery, and their relationship with them. See attached
2. Goal Attainment Scaling (GAS) – a method of scoring the extent to which patients' individual goals are achieved in the course of interventions.
3. Questionnaire on the process of recovery (QPR) – a 15 item measure developed service users' account of recovery from psychosis. Asking people about aspects of recovery that are meaningful to hem. It is reliable and valid and is strongly associated with general psychological wellbeing, QOL and empowerment.
4. I.ROC (Individual Recovery Outcomes Counter) – a facilitated self-assessment questionnaire that seeks to measure recovery based on 12 indicators divided into four areas (home, opportunity, empowerment, people).
5. DIALOG / DIALOG+ -
   DIALOG is a scale of 11 questions. People rate their satisfaction with eight life domains and three treatment aspects on a 7-point scale. DIALOG provides a score for subjective quality of life and a score for treatment satisfaction. The scale is part of the DIALOG+ intervention but can also be used on its own.
   DIALOG+ is a full therapeutic intervention. It incorporates the DIALOG scale but goes far beyond administering a scale.

6. Dignity and respect – Thinking is that in the absence (so far as I can see) of measures of stigma within mental health services, a measure of dignity / respect, if we can find one, might be the most appropriate tool. Some work took place in 2012 between the local authority and the then PCT on the dignity and respect agenda but at the time, wasn't looking for a specific measure.

ONS wellbeing codes

Points and questions for consideration / answering as the framework develops:

- If this is an outcomes based contract, does it need a core data set for leverage / accountability?
- Suggestion of a core set of measures for VSCE sector
- Defining responsibility for delivery of measures across partners (individually and collectively)

- Clarity required around system governance / contract management processes
- Setting intended scale or direction of improvement required
- The link to financial framework and how we assess value
- Learning from Somerset
- Appraise key factors when considering the implementation of (an) outcome measurement tool(s):
    - Cost
    - Time taken to complete them
- Level of interest system or locality
- Phasing, based on data availability, and time for devolved development of thinking
- Being clear why we want to collect something, not things for the sake of it or because the data is readily available
- How do we bring in the qualitative balance to the data? Using peoples' stories. It's not one intervention that makes a difference to people, it's the collaboration between different organisations.
- Important to recognise the short, medium and longer term measures of success in meeting outcomes. The reduced mortality gap is a longer term measure that will have a number of component shorter/medium term measures to it – including the reduction in physical illnesses and maintenance of good health, involvement / participation / regular exercise / smoking reduction / etc. all framed in a person-centred context.

Information Schedule

To be developed

Requirement Basis • National • Local	Requirement	Frequency	Method	Data quality or reporting development required? Timescale?
National	The provision of the Mental Health Minimum Dataset is mandatory for all NHS funded services.	Monthly	Provider to NHSD to CSU to ICS	
	The provision of the Improving Access to Psychological Therapies (IAPT) Minimum Dataset is mandatory for relevant NHS funded services.	Monthly	Provider to NHSD to CSU to ICS	
	Need to consider whether if flowing of activity within the General Practice Appointment Dataset applies, or only Mental Health Minimum Dataset.	Monthly		
	The Mental Health Data Quality Maturity Index standards and monitoring will apply.	Monthly	NHSD reporting	
	Recording and monitoring against all applicable Operational Plan and Long Term Plan performance measures is necessary.	Quarterly		
	All statutory returns (performance, workforce, finance, quality, estates etc.) are required.			
Local	Outcomes Framework Reporting	Annually		
	BNSSG Mental Health and Wellbeing Dashboard to monitor activity; identify and effectively target resources to improve patient outcomes by joining together elements of the health and care system Demand, capacity, activity and performance measures tbc	Monthly	Provider / ICS	
	Service Evaluation	Annually	Provider to ICS	

Where possible we will use published standardised outcome sets. These may include capability measures, which are measures of wellbeing for use in economic evaluation. These are defined in terms of an individual's ability to 'do' and 'be' the things that are important in life. Appendix 3 contains an example. Other sources of standard sets include those suggested by the International Consortium for Health Outcomes Measurement, as illustrated using the example of depression and anxiety (Figure 4).

Figure 4. ICHOM standard outcomes set for depression and anxiety

Appendix 3: Example capability measure: ICECAP-A capability measure

The ICECAP-A (ICEpop CAPability measure for Adults) is a measure of capability for the general adult (18+) population for use in economic evaluation. Unlike most profile measures used in economic evaluations, the ICECAP-A focuses on wellbeing defined in a broader sense, rather than health. The measure covers attributes of wellbeing that were found to be important to adults in the UK.

ICECAP-A comprises five attributes (the lay terms are in brackets):

- Attachment (an ability to have love, friendship and support)
- Stability (an ability to feel settled and secure)
- Achievement (an ability to achieve and progress in life)
- Enjoyment (an ability to experience enjoyment and pleasure)
- Autonomy (an ability to be independent)

The ICECAP-A descriptive system was developed using qualitative methods. A set of UK index values for ICECAP-A have been estimated using a best-worst scaling. Qualitative and quantitative studies of the validity of the ICECAP-A have been conducted with general population and patient samples.

ICECAP-A is free to use, but the use of the measure must be registered with us first. More details on the registration, index values, validity and applications of the ICECAP-A can be found on this website.

Appendix 4: Examples of how people may experience the Service

We have outlined a series of case studies where we look at four people to illustrate how an integrated and place-based model of community mental health care would lead to more effective support, care and treatment and better outcomes for the people we serve

Louise (aged 18) Location Bristol Louise is living in university accommodation, having recently moved away from home to study. She was mugged and assaulted 10 months ago. Louise was diagnosed with PTSD and had a course of psychological treatment with a therapist (Ivor) in her home town over 200 miles away. This appeared to be effective and she started going to a ceramics class and a self-defence class with her friends and girlfriend at the time. They thought it might help to rebuild her confidence. She enjoyed this; however, since moving to a new city she is anxious about socialising. Louise has had minor hearing problems since the assault, for which she is seeing a GP in her university town. She has also talked a little about her anxiety and low mood. She feels isolated because she is nervous about going out, especially at night, so she does not socialise with university friends much and feels like a burden to her friends at home. She has not told her father about her low mood so as not to worry him. He is a widowed, single parent with three young children living at home

Louise's care under the new integrated CMH service

The majority of Louise's support, care and treatment can be provided at the local community level. Her journey starts with her GP (Fariha). Fariha is concerned about Louise's anxiety and avoidance, and with Louise's consent, makes contact with her therapist (Ivor), who works in a service in Louise's home town. Their conversation goes like this: Fariha contacts Louise and asks if she might like to talk to the local community connector. Louise seems uncertain about what to expect but agrees to try. After this conversation, Fariha speaks to the local community connector linked to the practice (Ellie):

Fariha arranges to see Louise again and together they develop a brief care plan, and Ellie meets Louise to discuss local groups she might be interested in joining: Note that Ellie has had to be quite proactive here, given Louise's current social isolation. The groups that Ellie is connecting her to may be located either in her university community or local community of Eastern. They aim to provide a space for Louise to take part in activities she enjoys, and possibly build friendships with local people who share similar interests, ideally within her community at university. She seems to feel more comfortable with online options at present and Ellie is able to recognise this, and provide her with signposting and support to access, but also acknowledges that in the future Louise may wish to look for an option that requires her to be present in person. Support, care and treatment Louise is still experiencing high levels of anxiety related to the assault, so may also benefit from a specific community support group for victims of crime. Fariha might also consider referring her to the local Improving Access to Psychological Therapies (IAPT) service for brief psychological therapy. Louise may also need specialised support to address the physical consequences of the assault related to her hearing, and the impact this will have on her ability to engage in her learning and meet her social needs. Ellie would be able to identify these groups if they exist or support Louise to access similar care elsewhere. Fariha may also provide advice about medication.

But Ellie would be the one who provides a consistent point of contact and support in a place where Louise currently feels disconnected and isolated. Implementing the framework in this way will help Louise to build connections with her new local community and support her mental health needs by reducing the current barriers to access and receiving care and treatment according to need, in a timely manner. Further support If Louise did not respond well to this support, care and treatment as indicated by routine outcome measurement (including her experience of care), the core community mental health Service will be able to provide advice to Fariha, Ellie and the IAPT (Improving Access to Psychological Therapies) service, and, if needed, further assessment, support, care and treatment could be provided.

Louise's care without Integrated Community Mental Health Service

It is likely that Louise would have been referred back to Ivor in her home town for further sessions of treatment for her PTSD. If Louise had been sent back during term time this would have interrupted her studies. If she had waited and returned after the term had ended, her symptoms might have worsened. Without a community connector, Louise would probably have become more isolated, and her confidence levels might have dropped further.

Ashik (aged 32) Location: Bristol
Born in Bangladesh, Ashik moved to the UK with his family aged 2. He was diagnosed with bipolar disorder 11 years ago, for which he takes medication, and is managing this well with support from specialist mental health services. Ashik works in the financial sector and was recently promoted, which has increased his workload. This is contributing to chronic and ongoing anxiety. Ashik sometimes manages his anxiety by drinking too much and sometimes taking cocaine. Ashik has an understanding partner and two primary schoolage children, whom he rarely sees on weekdays due to work. Ashik is happiest when he can spend time with his family at weekends. While he has a good relationship with his parents, Ashik has struggled to explain his current problems to them and worries that, as devout Muslims, they might disown him if they found out about his drinking and drug use. Ashik also worries that his parents will not understand his mental health problems. While he has a supportive GP, Ashik recognises that he needs some more help for his problems but does not know who else to talk to.

Ashik's care under the new Integrated Community Mental Health Service

At an appointment with his psychiatrist (Kim), Kim is aware that Ashik seems more anxious than usual and asks him questions from the GAD-2.b Here is an excerpt from their subsequent conversation: Support, care and treatment During his meeting with Kim, Ashik has a review of his medication to optimise treatment of his bipolar disorder and help with mood disturbance. He and Kim discuss other treatment options including psychoeducation (for the drug and alcohol use) and psychological therapy (for the anxiety), both of which he will be able to access locally. Kim asks Ashik whether it would be okay to speak with his GP about their discussion and he agrees. After this appointment, Kim contacts Ashik's GP, Reece (see conversation on the next page). Depending on the outcome of the psychoeducation, Ashik might need a more focused intervention for his drug and alcohol use and support from a community group such as Alcoholics Anonymous or Narcotics Anonymous, and long-term coordination of his support, care and treatment to retain employment.

Ashik's care without Integrated Community Mental Health Service

Without the framework, Ashik would probably not be able to access the psychological treatment he needs locally, and if he were able to he would probably be on a waiting list for 9 months. He would also in all likelihood be excluded from services for which he did not meet the criteria – for example, from an IAPT (Improving Access to Psychological Therapies) service because of his diagnosis of bipolar disorder, and from primary care because of his drug and alcohol use.

Diane Aged 82 Location Weston

Diane is a widow whose physically abusive husband died 8 years ago. She has four children and nine grandchildren, almost all of whom live nearby and have close relationships with her. Usually very independent, Diane's physical health has worsened over the last few years, with a recent diagnosis of chronic pulmonary obstructive disease. She had a mental health crisis aged 20 and was diagnosed with bipolar disorder and spent many years in and out of hospital, often detained under the Mental Health Act. Fluctuations in mood affect her relationship with her family, as she will either isolate herself or telephone them non-stop. She has had negative experiences as an inpatient and is wary of mental health services. She was prescribed lithium but stopped taking this by mistake during a hospital admission for her emphysema and, as a result, deteriorated. She is currently well, but is starting to forget things. Diane enjoys spending time with her family and friends and she has a dog, but she struggles to walk him as frequently as she used to.

Diane's care under the new Integrated Community Mental Health Service

The primary care nurse (Cheryl) at Diane's local GP surgery is giving Diane her flu jab, and during their conversation Cheryl becomes concerned that Diane seems confused, and that she is struggling to remember recent events. Cheryl speaks to Diane's GP (Tony) about her concerns, and with Diane's permission Tony phones Diane's daughter. As part of the conversation with her daughter Tony wonders if the problem might be related to Diane's medication, so calls her psychiatrist (Ignacio). Ignacio confirms that this is possible and arranges to see Diane for a lithium review. After this conversation Tony calls Diane to talk through options, and to arrange an appointment for a joint assessment involving both Tony and Ignacio. Tony is also concerned that Diane is becoming a little isolated again, and wonders whether the community connector, Rachel, might be able to help. Rachel then makes contact with Diane. After introductions, Rachel discusses possible activities with Diane

Even though Diane's physical and mental health history is quite complex, she has been able to lead a fairly independent life. She enjoys other people's company, so a dog walking group would be ideal for Diane as it would encourage her to remain physically active while opening up new social possibilities for her. Additionally, if Diane ever felt that she was unable to walk her dog, she would have built relationships within her community with people who she could ask to walk her dog for her. Tony and Ignacio will keep the memory loss under review, while Diane's lithium regimen is adjusted. If her memory problems persist, and other causes have been ruled out, Tony will refer Diane to the local memory clinic, and make sure Diane and the family are supported throughout the process.

Diane's care without the Integrated Community Mental Health Service

It is likely that Diane's care would be very fragmented. She has a complex set of needs, and it is possible that no one person would take responsibility for making sure that all of those needs are addressed.

Frank: Location: South Gloucestershire.

Frank has schizoaffective disorder. He also drinks alcohol and uses cannabis at times. His first episode of psychosis was following smoking cannabis aged 19 years old, when working in a garden centre. Frank has had several psychiatric hospital admissions due to the severity of his illness – he has tried to harm himself in the past and is vulnerable to being exploited financially, when unwell. As Frank's symptoms haven't responded to first and second-line antipsychotic medication, he is on clozapine, which means he must have blood tests and physical health checks once a month. Before being on clozapine, Frank was unwell for a long time. His symptoms, risks and difficulty with managing his daily activities, meant that he was unable to leave the hospital ward and needed a longer stay on an inpatient rehabilitation ward. Before being admitted he had been living with his mother in her home. However his mother is now elderly and frail and unable to support.

Frank's needs and how Integrated Community Mental Health Service will help

Frank is able to access inpatient rehabilitation care in his local area. This helps to stabilise and optimise his mental health and improve his functioning. After 10 months, his psychiatrist and community mental health team feel that he is ready to be discharged to the rehabilitation team. The care plan that was developed while Frank was still an inpatient is put into place and, before his transition out of inpatient services, he has already been supported to engage with his local community mental health rehabilitation team. They are a multidisciplinary team supporting everyone in Westside who has a long-term serious mental illness and those in 24-hour or 9–5 supported accommodation. They are located in a hospital rehabilitation placement, and have an in-reach service for people with rehabilitation needs in acute wards. This team has arranged a funded placement for Frank in accommodation with 24-hour staff support. Because Frank was given the opportunity to engage with the team before discharging from the rehabilitation ward, he feels that he has knowledge about what the next steps are for his care, who the team are and what to expect. The team work with Frank, his mother (Anne), the staff at the housing project, his GP and other relevant agencies, to ensure person-centred, personalised, recovery-focused working to support Frank to achieve his goals. On the right is part of a conversation between Frank, Anne and a member of the community mental health rehabilitation team (Paul), when Frank was still on the mental health rehabilitation ward.

Frank has regular support on a daily basis from the support staff in the housing project, to help with managing his daily self-care, managing finances, eating well and exercising, and also to attend his regular daytime activities. Frank was also diagnosed with diabetes mellitus, probably due to his being overweight, being sedentary when unwell and also due to his antipsychotic medication. With an integrated multidisciplinary team, Frank is able to receive care for his diabetes from his GP (who is being supported by a diabetes specialist). Previously, Frank did not like to spend much time in other people's company. However, he is now more sociable, has a couple of friends he sees regularly at the gardening club and also at the animal shelter. He also visits his mother once a week.

Frank is working towards moving into his own council flat with a permanent tenancy and a package of support. He is also going to start paid work two afternoons a week at the animal shelter.

Frank's care without Integrated Community Mental Health

Frank would most probably have been placed in a ward far away from his community, his mother and local care team, which would have had a negative effect on his health and likely have led to him to have to stay in inpatient care for longer. Without community connection, Frank would most likely have struggled to build on the progress he made while being supported by the community rehabilitation team and may have struggled with identifying transport options to help him access the resources in nearby towns. In an unintegrated team, Frank's diabetes care would not have been available in his local community, and he would have had to have travel to see a specialist. Frank's social care needs are met because his care coordinator, Paul, has the relevant skills, and being in an integrated team can draw on social care expertise when needed. However, without the framework, Frank would almost certainly have been referred to a social worker, which would have led to delays in receiving benefits and required Frank to have to repeat his story multiple times.

Appendix 5: Initial Mental Health Data Pack

Please see accompanying data pack. This could not be included within the document due to file size.

Appendix 6: Key National Guidance and Quality Standards

NICE guidelines

- **Guidelines on mental health diagnoses and coexisting needs**

- Alcohol-use Disorders: Diagnosis, Assessment and Management of Harmful Drinking
- and Alcohol Dependence (CG115)
- Antisocial Personality Disorder: Prevention and Management (CG77)
- Attention Deficit Hyperactivity Disorder: Diagnosis and Management (NG87)
- Autism Spectrum Disorder in Adults: Diagnosis and Management (CG142)
- Bipolar Disorder: Assessment and Management (CG185)
- Borderline Personality Disorder: Recognition and Management (CG78)
- Care and Support of People Growing Older with Learning Disabilities (NG96)
- Challenging Behaviour and Learning Disabilities: Prevention and Interventions for
- People with Learning Disabilities Whose Behaviour Challenges (NG11)
- Coexisting Severe Mental Illness (Psychosis) and Substance Misuse: Assessment and
- Management in Healthcare Settings (CG120)
- Coexisting Severe Mental Illness and Substance Misuse: Community Health and Social
- Care Services (NG58)
- Common Mental Health Problems: Identification and Pathways to Care (CG123)
- Depression in Adults with a Chronic Physical Health Problem: Recognition and
- Management (CG91)
- Depression in Adults: Recognition and Management (CG90)
- Drug Misuse in Over 16s: Psychosocial Interventions (CG51)
- Drug Misuse Prevention: Targeted Interventions (NG64)
- Eating Disorders: Recognition and Treatment (NG69)
- Generalised Anxiety Disorder and Panic Disorder in Adults: Management (CG113)
- Learning Disabilities and Behaviour that Challenges: Service Design and Delivery
- (NG93)
- Mental Health Problems in People with Learning Disabilities: Prevention, Assessment
- and Management (NG54)
- Obsessive-compulsive Disorder and Body Dysmorphic Disorder: Treatment (CG31)
- Older People: Independence and Mental Wellbeing (NG32)
- Post-traumatic Stress Disorder (NG116)
- Preventing Suicide in Community and Custodial Settings (NG105)
- Psychosis and Schizophrenia in Adults: Prevention and Management (CG178)
- Self-harm in Over 8s: Long-term Management (CG133)
- Appendices 53
- Self-harm in Over 8s: Short-term Management and Prevention of Recurrence (CG16)
- Service User Experience in Adult Mental Health: Improving the Experience of Care for
- People using Adult NHS Mental Health Services (CG136)
- Social Anxiety Disorder: Recognition, Assessment and Treatment (CG159)

- **Guidelines included in other mental health care pathways**

- Antenatal and Postnatal Mental Health: Clinical Management and Service Guidance
- (CG192)
- Dementia: Assessment, Management and Support for People Living with Dementia and
- their Carers (NG97)
- Dementia, Disability and Frailty in Later Life – Mid-life Approaches to Delay or Prevent
- Onset (NG16)
- Mental Wellbeing at Work (PH22)

- **Other relevant guidelines**

- Behaviour Change: Digital and Mobile Health Interventions (NG183)
- Behaviour Change: General Approaches (PH6)
- Behaviour Change: Individual Approaches (PH49)
- Community Engagement: Improving Health and Wellbeing and Reducing Health
- Inequalities (NG44)
- Decision-making and Mental Capacity (NG108)
- Domestic Violence and Abuse: Multi-agency Working (PH50)
- Multimorbidity: Clinical Assessment and Management (NG56)
- Older People with Social Care Needs and Multiple Long-term Conditions (NG22)
- People's Experience in Adult Social Care Services: Improving the Experience of Care
- for People using Adult Social Care Services (NG86)
- Rehabilitation for Adults with Complex Psychosis (NG181)
- Smoking: Acute, Maternity and Mental Health Services (PH48)
- Supporting Adult Carers (NG150)
- Violence and Aggression: Short-term Management in Mental Health, Health and
- Community Settings (NG10)

- **Medication management**

- Community Pharmacies: Promoting Health and Wellbeing (NG102)
- Managing Medicines for Adults Receiving Social Care in the Community (NG67)
- Managing Medicines in Care Homes (SC1)
- Medicines Adherence: Involving Patients in Decisions about Prescribed Medicines and
- Supporting Adherence (CG76)
- Appendices 54
- Medicines Optimisation: the Safe and Effective Use of Medicines to Enable the Best
- Possible Outcomes (NG5)

- **Service transitions**

- Transition between Inpatient Hospital Settings and Community or Care Home Settings
- for Adults with Social Care Needs (NG27)
- Transition between Inpatient Mental Health Settings and Community or Care Home
- Settings (NG53)
- Transition from Children's to Adults' Services for Young People using Health or Social
- Care Services (NG43)

- **Guidelines in development at time of publication**

- Depression in Adults: Treatment and Management (GID-CGWAVE0725)
- Safeguarding Adults in Care Homes (GID-NG10107)

Quality standards

- **Quality standards relating to mental health diagnoses and coexisting needs**

- Alcohol-use Disorders: Diagnosis and Management (QS11)
- Anxiety Disorders (QS53)
- Attention Deficit Hyperactivity Disorder (QS39)
- Autism (QS51)
- Bipolar Disorder in Adults (QS95)
- Coexisting Severe Mental Illness and Substance Misuse (QS188)
- Depression in Adults (QS8)
- Drug Misuse Prevention (QS165)
- Drug Use Disorders in Adults (QS23)
- Eating Disorders (QS175)
- Learning Disability: Care and Support of People Growing Older (QS187)
- Learning Disabilities: Behaviour that Challenges (QS101)
- Learning Disabilities: Identifying and Managing Mental Health Problems (QS142)
- Mental Wellbeing and Independence for Older People (QS137)
- Mental Wellbeing of Older People in Care Homes (QS50)
- Multimorbidity (QS153)
- Personality Disorders: Borderline and Antisocial (QS88)
- Psychosis and Schizophrenia in Adults (QS80)
- Self-harm (QS34)
- Suicide Prevention (QS189)

- **Quality standards included in other mental health care pathways**

- Antenatal and Postnatal Mental Health (QS115)
- Dementia (QS184)

- **Other relevant quality standards**

- Community Engagement: Improving Health and Wellbeing (QS148)
- Domestic Violence and Abuse (QS116)
- Medicines Management for People Receiving Social Care in the Community (QS171)
- Medicines Management in Care Homes (QS85)
- Medicines Optimisation (QS120)
- People's Experience using Adult Social Care Services (QS182)
- Promoting Health and Preventing Premature Mortality in Black, Asian and Other
- Minority Ethnic Groups (QS167)
- Service User Experience in Adult Mental Health Services (QS14)
- Social Care for Older People with Multiple Long-term Conditions (QS132)
- Smoking: Supporting People to Stop (QS43)
- Transition between Inpatient Mental Health Settings and Community or Care Home
- Settings (QS159)
- Transition between Inpatient Hospital Settings and Community or Care Home Settings
- for Adults with Social Care Needs (QS136)
- Transition from Children's to Adults' Services (QS140)
- Violent and Aggressive Behaviours in People with Mental Health Problems (QS154)

To support BNSSG's local engagement and strategies, the Community Mental Health Service will be informed by the following national policies and evidence:

- NHS England's Community Mental Health Framework, NHS Long Term Plan and Advancing Mental Health Equalities Strategy
- Public Health England's Prevention Concordat for Better Mental Health, reviews outlining the disproportionate impact of COVID-19 and data tools
- Evidence-based guidance from NICE, Royal Colleges and the National Collaborating Centre for Mental Health.
- Key legislation, including the Care Act (2014); Equalities Act (2010) and Mental Health Act (1983 and revised draft 2021)
- Publications from the Centre for Mental Health, National Service User Network (NSUN) and Rethink Mental Illness.

Applicable standards

- Personal Health Budgets - https://www.england.nhs.uk/personal-health-budgets/
- Care Act 2014 - https://www.legislation.gov.uk/ukpga/2014/23/contents/enacted
- Serious Incident Framework - https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf
- Never event policy - https://www.england.nhs.uk/wp-content/uploads/2020/11/Revised-Never-Events-policy-and-framework-FINAL.pdf
- Advancing mental health equalities strategy
- Complaints Procedures - nhse-complaints-policy-june-2017.pdf (england.nhs.uk)
- Patient Experience - https://improvement.nhs.uk/resources/patient-experience-improvement-framework/
- The learning disability improvement standards for NHS trusts
- Mental Capacity Act - https://www.legislation.gov.uk/ukpga/2005/9/contents
- Relevant NICE Guidance and Quality Standards – the Service delivery partner(s) is expected to assess their position with regard to recommendations outlined within clinical guidelines issued by NICE to improve outcomes for people using the NHS and other public health and social care services. Specifically relevant are outlined in Appendix 5.

Appendix 7: Equality Impact Assessment

Please see separate document due to file size

Appendix 8: Quality Impact assessment

Please see separate document due to file size

Appendix 9: Glossary

Term	Definition
Accessible Information Standard	The Accessible Information Standard, formally known as DCB1605 Accessible Information, is made up of a Specification and Implementation Guidance - https://www.england.nhs.uk/ourwork/accessibleinfo/
Art Psychotherapies	Art therapy is a form of psychotherapy that uses art media as its primary mode of expression and communication. Within this context, art is not used as diagnostic tool but as a medium to address emotional issues which may be confusing and distressing.
Bio-Psychosocial Treatment Model	This model suggests that biological, psychological and social factors are all interlinked and important with regard to promoting health or causing disease. In other words, the mind and the body are not independent and separate things, but rather are connected and interdependent things.
Cinapsis SmartReferrals	Cinapsis is increasing the communication between. Primary care and secondary care and it are improving. Patient care, which is the heart of what existing changes. In technology are trying to achieve.
Co-design	Co-design in healthcare involves the equal partnership of individuals who work within the system (healthcare staff), individuals who have lived experience of using the system (patients and their families/carers) and the 'designers' of the new system.
Cognitive Analytic Therapy (CAT)	CAT stands for Cognitive Analytic Therapy; a collaborative programme for looking at the way a person thinks, feels and acts, and the events and relationships that underlie these experiences (often from childhood or earlier in life). As its name suggests, it brings together ideas and understanding from different therapies into one user-friendly and effective therapy.
Cognitive Behavioural Therapy (CBT)	CBT is talking therapies that can help you manage your problems by changing the way you think and behave.
Community Forensic	The Forensic Community Mental Health Team (FCMHT) provides specialist psychological and psychiatric interventions to assess treat and manage individuals who, as a consequence of mental illness or personality disorder, have offended, or, present a potential to offend and therefore pose a risk to themselves or others.
Connecting Care	Connecting Care is a digital care record system for sharing information in Bristol, North Somerset and South Gloucestershire. It allows instant, secure access to your health and social care records for the professionals involved in your care. Relevant information from your digital records is shared with people who look after you. This gives them up-to-date information making your care safer and more efficient
Continuity of Care	Making sure the person experiences an ongoing relationship with a team member and care is coordinated and progresses smoothly, as they move between different parts of the health and care system. Continuity

	of care is concerned with the quality of care over time
Co-production	Co-production is when an individual influences the support and services received, or when groups of people get together to influence the way that services are designed, commissioned and delivered. '
Dialectical Behavioural Therapy (DBT)	Dialectical behaviour therapy (DBT) is a type of talking therapy. It's based on cognitive behavioural therapy (CBT), but it's specially adapted for people who feel emotions very intensely. The aim of DBT is to help you: understand and accept your difficult feelings, learn skills to manage them and become able to make positive changes in your life.
Early Intervention	Early intervention is the process of providing specialist intervention and support to a person who is experiencing or demonstrating any of the early symptoms of mental illness.
EMIS	A digital clinical system supporting joined up working across all care settings.
ePACT	Electronic Prescribing Analysis and Cost Tool
Eye Movement Desensitisation and Reprocessing	EMDR (Eye Movement Desensitization and Reprocessing) is a psychotherapy that enables people to heal from the symptoms and emotional distress that are the result of disturbing life experiences
FP10	FP10 prescriptions are purchased by NHS organisations including Hospital Trusts, and are distributed free of charge to medical and non-medical prescribers.
Front door	Single or specific point of access.
High Acuity Services	Patients in need of immediate and intensive care.
Holistic Response	A holistic approach means to provide support that looks at the whole person, not just their mental health needs. The support should also consider their physical, emotional, social and spiritual wellbeing.
IAPT	The IAPT (Improving Access to Psychological Therapies) programme was developed to provide talking therapies for those with anxiety disorders and depression. It aims to better people's mental health by looking at methods of coping.
Integrated Care System	Integrated care systems (ICSs) are new partnerships between the organisations that meet health and care needs across an area, to coordinate services and to plan in a way that improves population health and reduces inequalities between different groups.
Integrated Community Mental Health	Care providers coming together to provide a collaborative person centric approach to meet the needs of the individual.
Integrated and Personalised Care Team (IPCT)	People who will work together from across the health, social care, voluntary and lived experience boundaries to deliver care in a locality setting.
Interoperability Platform	The ability of computer systems or software to exchange and make use of information.
Learning Disabilities Standard	The LD Improvement Standards state what people should expect from the NHS. They are designed to deliver improvements in quality & outcomes for people with a learning disability by ensuring NHS commissioned

	services listen, respond and learns to improving care for people with a learning disability.
Link Worker (name to be chosen by locality partners)	A member of staff to help an individual access quality care and treatment Depending on someone's needs a Link Worker could be a member of the primary care team, peer supporter, a key worker, psychiatric nurse, psychiatrist or other health and social care professional.
Linear Pathways	A rigid care pathway which could limit a patient centred approach to treatment.
Locality	An area within Bristol, North Somerset and South Gloucestershire (BNSSG). There are six localities within BNSSG
Lower-layer Super Output Areas (LSOA)	Small areas designed to be of a similar population size, with an average of approximately 1,500 residents or 650 households. They were produced by the Office for National Statistics for the reporting of small area statistics.
Mental Health	Mental health is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community
Mental Health Minimum Data Set	A set of data variables arranged across 62 data tables, designed by NHS Digital, that flows from providers of mental health services to NHS Digital and then out to commissioners. The dataset provides activity information for all services, including referrals, caseloads, community and inpatient activity. All providers of NHS funded services must provide this data under the NHS standard contract terms.
Mental Health data quality Maturity Index	A methodology for assessing the quality of the main data fields in the MHSDS. NHS Digital set targets about the expected quality and providers are benchmarked to show where data quality improvement is required. For example, improvements in ethnicity recording have been mandated through the 2020/21 and 2021/22 planning processes.
Mental Health Primary Care - Additional Roles Reimbursement Scheme	The Additional Roles Reimbursement Scheme (ARRS) is the most significant financial investment element within the Network Contract DES; it is designed to provide financial reimbursement for Primary Care Networks (PCNs) to build workforce capacity.
Mental Illness	Mental illnesses are health conditions involving changes in emotion, thinking or behaviour (or a combination of these). Mental illnesses are associated with distress and/or problems functioning in social, work or family activities
Mentalisation Based Therapy (MBT)	Mentalisation-based therapy (MBT) is a type of long-term psychotherapy. Mentalisation is the ability to think about thinking. It helps to make sense of our thoughts, beliefs, wishes and feelings and to link these to our actions and behaviours. MBT aims to improve a person's capacity to mentalise. We focus on what is going on in their mind and in the minds of other people and link this to

	understand and alleviate problematic behaviours.
Morbidity Gap	Refers to having a disease or a symptom of disease, or to the amount of disease within a population.
Multidisciplinary Team	Group of professionals from one or more clinical disciplines who together make decisions regarding recommended treatment of individual patients.
Neurodevelopment Conditions	Neurodevelopmental disorders are a group of disorders that affect the development of the nervous system, leading to abnormal brain function which may affect emotion, learning ability, self-control, and memory. The effects of neurodevelopmental disorders tend to last for a person's lifetime.
NICE	The National Institute for Health and Care Excellence
Peer Support Workers	Peer Support may be defined as the help and support that people with lived experience of a mental illness or a learning disability are able to give to one another.
Pharmacological approaches	Management of symptoms through the use of medication.
Place based approach	Place-based working is a person-centred, bottom-up approach used to meet the unique needs of people in one given location by working together to use the best available resources and collaborate to gain local knowledge and insight.
Place based care	Place-based care targets an entire community and aims to address issues that exist at the neighbourhood level, such as poor housing, social isolation, poor or fragmented service provision that leads to gaps or duplication of effort, and limited economic opportunities
PREVENT	The Prevent strategy, published by the Government in 2011, is part of the overall counter-terrorism strategy, CONTEST. The aim of the Prevent strategy is to reduce the threat to the UK from terrorism by stopping people becoming terrorists or supporting terrorism. In the Act this has simply been expressed as the need to “prevent people from being drawn into terrorism”.
Prevention	Often used to describe efforts to stop Mental Health problems before they emerge.
Primary Care	Healthcare provided in the community for people making an initial approach to a medical practitioner or clinic for advice or treatment.
Proactive Care	(Of a person or action) creating or controlling a situation rather than just responding to it after it has happened.
Psychodynamic psychotherapy	**Psychodynamic therapy** is the psychological interpretation of mental and emotional processes. Rooted in traditional psychoanalysis, it draws from object relations, ego psychology, and self-psychology. Psychodynamic therapy aims to address the foundation and formation of psychological processes. In this way, it seeks to reduce symptoms and improve people’s lives.
Psycho-Education	Psychoeducation (PE) is defined as an intervention with systematic, structured, and didactic knowledge transfer

	for an illness and its treatment, integrating emotional and motivational aspects to enable patients to cope with the illness and to improve its treatment adherence and efficacy.
Psychological Informed Environments	Psychologically informed environments are services where the day-to-day running has been designed to take the psychological and emotional needs of people with these experiences into account.
Psychosocial Education	Psychosocial education is used to support individuals and families with the aim of promoting awareness regarding unhealthy relationships and maladaptive behaviours.
Quality and Outcomes Framework (QOF)	The Quality and Outcomes Framework (QOF) is a voluntary scheme within the General Medical Services (GMS) contract. It aims to support contractors to deliver good quality care. The objective of the Quality and Outcomes Framework (QOF) is to improve the quality of care patients are given by rewarding practices for the quality of care they provide, based on a number of indicators across clinical care and public health. There are 4 areas which relate to mental health; Depression, Dementia, Learning Disabilities and Mental Health (SMI). Data from the QOF provides prevalence, achievement and personalised care adjustments for each clinical care or public health area at a national to practice level. QOF 2019-20 Interactive QOF Data Further detail and maps of this data are included in Appendix 5.
Qualitative	Relating to, measuring, or measured by the quality of something rather than its quantity.
Quantitative	Relating to, measuring, or measured by the quantity of something rather than its quality.
Quintile	Any of five equal groups into which a population can be divided according to the distribution of values of a particular variable.
S136	Section 136 allows the police to take you to (or keep you at) a place of safety. They can do this without a warrant if: you appear to have a mental disorder, AND you are in any place other than a house, flat or room where a person is living, or garden or garage that only one household has access to, AND you are "in need of immediate care or control" (meaning the police think it is necessary to keep you or others safe). Before using section 136 the police must consult a registered medical practitioner, a registered nurse, or an AMHP, occupational therapist or paramedic. The police can keep you at the place of safety for up to 24 hours, which can be extended for another 12 hours if it was not possible to assess you in that time. Legislation - https://www.legislation.gov.uk/ukpga/1983/20/section/136
Secondary Care	Secondary care refers to services provided

	by health professionals who generally do not have the first contact with a patient. Secondary care services are usually based in a hospital or clinic, though some services may be community based.
Secondary Mental Health Care	Secondary care generally needs a referral from a GP and cover both hospital and community care. Examples of secondary mental health services are hospitals, some psychological wellbeing services, community mental health teams (CMHTs), crisis resolution and home treatment teams (CRHTs), assertive outreach teams and early intervention teams.
Section 117	Section 117 aftercare is a legal duty that is placed on health and social services to provide after care services for individuals who have been detained under Section 3, Section 37, Section 47, Section 48 and Section 45A. It is the duty that comes in effect once the person has been discharged from the hospital. The aim of Section 117 aftercare is to provide services to prevent further admissions to a hospital.
Severe Mental Illness (SMI)	Within the Quality and Outcomes Framework (QOG – see above) The SMI indicator is defined as schizophrenia, bipolar affective disorder, and other psychoses. Within Secondary mental health care (see above) this is defined as mental health care clusters 10-17 which are the care clusters for psychotic disorders. This Target Operating Model deliberately refers to complexity in recognition of the fact that people may have a mental health condition not strictly categorised as an SMI alongside other additional needs which has a profound effect on their ability to live a full life.
SNOMED Intervention Codes	SNOMED is the clinical terminology mandated for capturing structured clinical content in electronic patient records within the NHS.
Social determinants of health	The social determinants of health (SDH) are the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems.
Social Prescribing Link workers	Social prescribing is a way for local agencies to refer people to a link worker. Link workers give people time, focusing on 'what matters to me' and taking a holistic approach to people's health and wellbeing. They connect people to community groups and statutory services for practical and emotional support.
System Wide Data Set	The Bristol, North Somerset and South Gloucestershire (BNSSG) system-wide dataset is a patient-level dataset that links together information across Primary Care, Secondary Care, Mental Health and Community Services for everyone in our region.
Trauma	Severe emotional shock and pain caused by

	an extremely upsetting experience
Trauma Informed	Trauma-Informed Practice is a strengths-based approach, grounded in an understanding of and responsiveness to the impact of trauma, that emphasises physical, psychological, and emotional safety for everyone, and that creates opportunities for survivors to rebuild a sense of control and empowerment.
Value – Based Approach	Equitable, sustainable and. transparent use of the available resources to achieve better outcomes and experiences of care for every person
VCSE	Voluntary, Community and Social Enterprise
Warm transfer	A transfer of care between two teams or providers of care, where the transfer occurs in front of the patient and family. This transparent transfer of care allows patients and families to hear what is said and engages patients and families in communication, giving them the opportunity to clarify or correct information or ask questions about their care.

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