Healthier Together

Improving health and care in Bristol, North Somerset and South Gloucestershire

Overview of BNSSG's Community Mental Health Target Operating Model and Implementation Process

1. Overview and Principles

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.

This approach aligns with the Government's White Paper 'Integration and innovation: working together to improve health and social care for all' (published in February 2021) which 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. The organisations who will deliver care at a local level will be called Integrated Care Partnerships (ICPs). These organisations are currently in shadow form in BNSSG.

This paper provides an overview of:

- BNSSG's Community Mental Health Target Operating Model.
- The process for implementation and delivery of the Service from 1st April 2022.
- Existing contracts associated with the Target Operating Model.

1.1 Principles underpinning the model

The Service will:

- Have a whole system, 'one team' approach with a collaborative culture: it will break the traditional divide between primary care, community services, social care, mental health services, hospitals and VCSE provision with partners responsible for all outcomes 24/7, with extensive co-production throughout.

- Deliver value for individuals: it will be driven by outcomes that matter to the people we serve, as defined by people with lived experience and our communities, with high levels of transparency around performance and improvement.

- Be personalised, preventative, proactive and trauma-informed in delivering support: it will be tailored to someone's individual needs, responsive to them and co-designed with them, ensuring their carer or support network is actively supported and engaged.

- Provide a model of care based on inclusivity, particularly for people with coexisting needs, with the highest levels of complexity and who experience marginalisation. The Advancing Mental Health Equalities Strategy will be delivered in full to tackle inequalities in access, experience and outcomes.

- Create a system and culture which enables professionals to collect and report outcome measures routinely, and a system-wide Mental Health and Wellbeing Outcomes Framework and dashboard. The service will embed quality improvement to sustain and build upon effective approaches.

- Be supported by a system leadership and cultural change programme to enable collaborative and effective working across BNSSG.

2. A Population Health Management approach

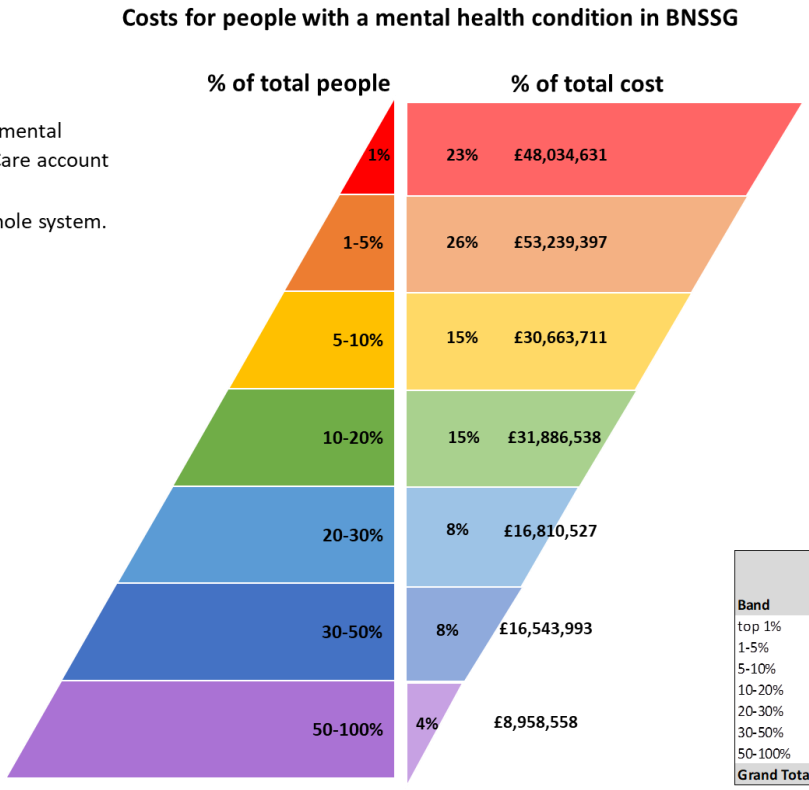
The Service will take a Population Health Management Approach. This means:

- 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 experiences and outcomes that matter to people and making the best use of resources (value).

This will involve using robust data to understand the needs of our local population. For example, Figure 1 below illustrates that 1% of the population (1,342 people) with a mental health condition accounts for 23% (£348 million per annum) of the cost across the health system. Using a Population Health Management approach will strengthen our understanding of the characteristics and needs of different individuals and groups. This will help us to design services that will more effectively meet needs and offer opportunities to prevent illness in the future.

Figure 1: 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



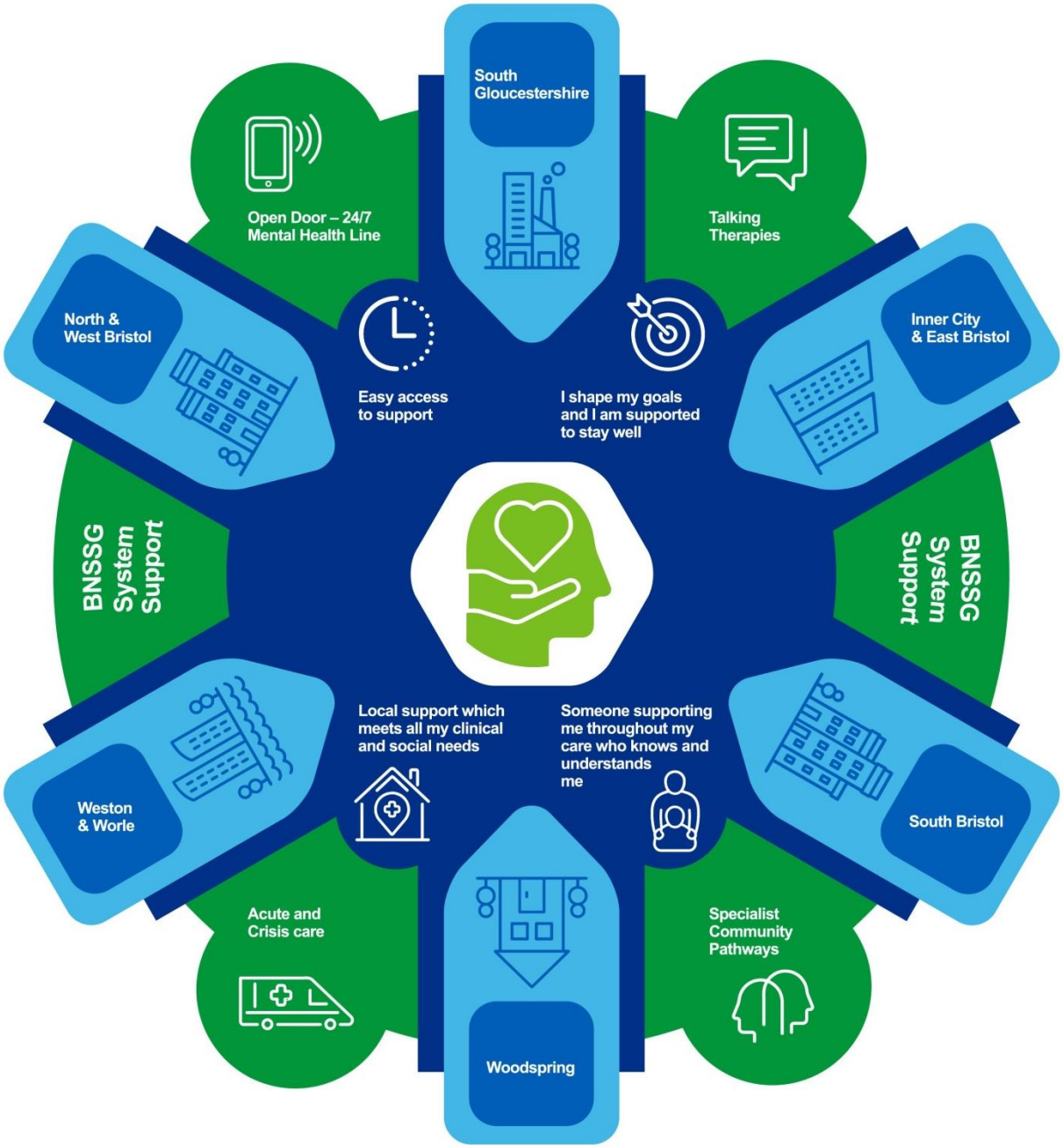
Band	Number of people	Average cost per person
top 1%	1342	£35,793
1-5%	5372	£9,911
5-10%	6715	£4,566
10-20%	13430	£2,374
20-30%	13430	£1,252
30-50%	26860	£616
50-100%	67151	£133
Grand Total	**134300**	**£1,535**

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

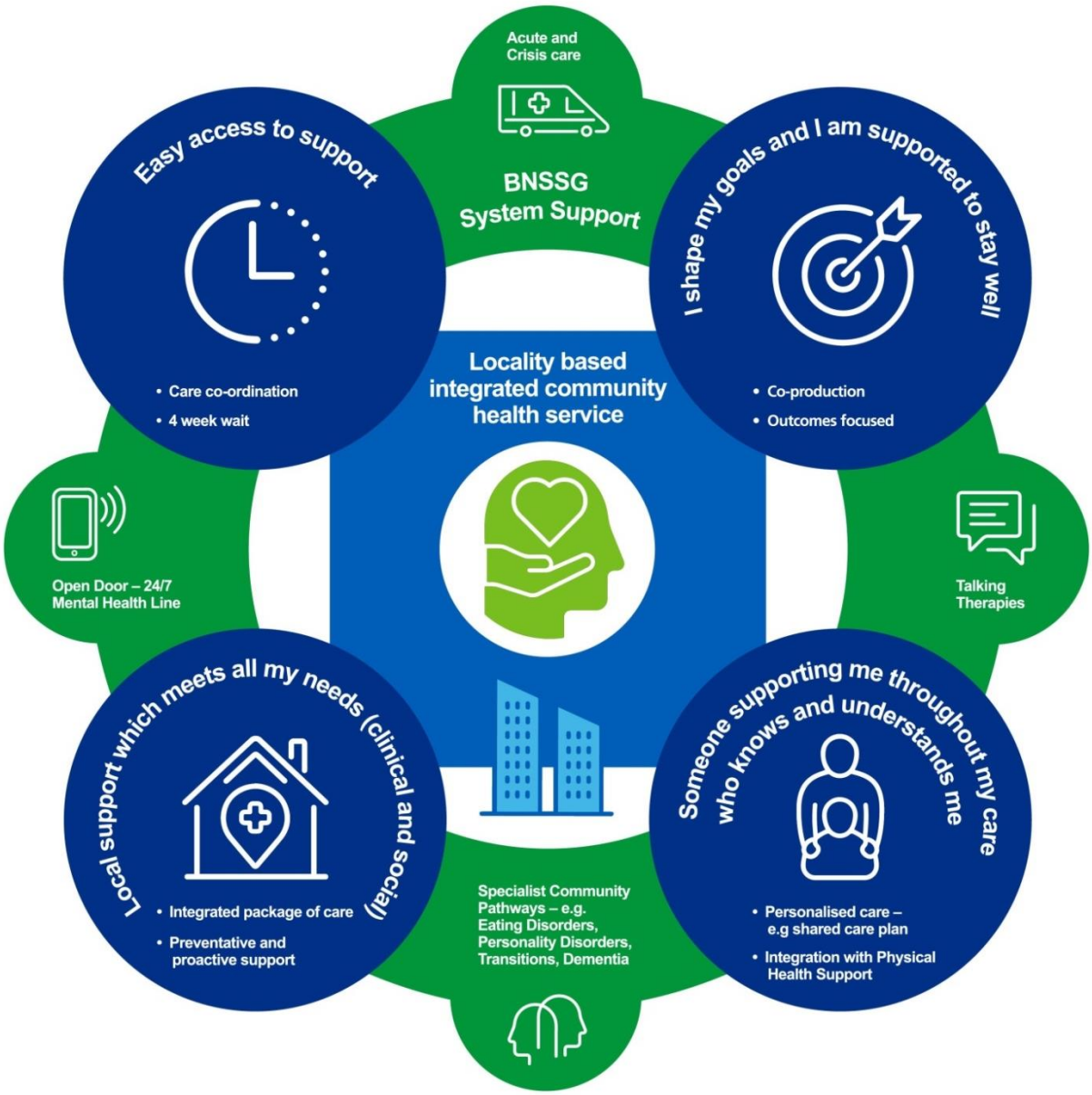
3. Summary of the model

BNSSG's Integrated Community Mental Health Service's Target Operating Model has been co-designed with a wide range of partners. It focuses on what matters most to people, their carers' and our staff. The following diagram summarises the Integrated Community Mental Health Service's approach:

- **Figure 2: Whole BNSSG System**



- **Figure 3: Example of the model at a locality or ICP level**



Further details on the core aspects of the model of care are outlined below:

3.1 Access

- Easy access to support is a core part of the model. The model suggests that people can access help either directly through their locality OR via the 'Open Door' 24/7 mental health line if they are unsure of what support they need. Locality health partners will develop a response that ensures accessible care for all (e.g. considering the needs of people who find it hard to access support via telephone) that will effectively meet local needs and demand.
- In line with this there will be ambitious accessibility targets:
  - A 24 hour response period from initial point of contact with the Mental Health System (either via locality or the 'Open Door'). The level of response will relate to presenting need.
  - A '4 week wait' from initial point of contact to the commencement of treatment, in line with national ambition.

3.2 Locality level:

- Each locality (blue within diagrams) will have an offer that is tailored to the needs of their local population, in line with a Population Health Management Approach.
- Integrated and Personalised Care Teams (IPCTs) will deliver support at a locality level considering someone's mental and physical health and social care needs. A number of partners within localities will work as 'one team' to provide support.
- Support will be delivered by a wider range of roles. For example, there will be a growth in peer support workers and the non-clinical workforce, in line with national expectations. Exact workforce arrangements will be designed by localities to meet their population's needs.
- People will receive a trusted core assessment. This means that, with their consent, relevant information will be shared across partners so that they do not have to tell their story multiple times. Partners can then build on the initial assessment so that there is a holistic and shared understanding of an individual's needs.
- Within localities people will have a 'link worker' (name TBC) who will be responsible for their care and will support someone through their journey. Dependent on someone's needs the link worker could be a primary care worker, mental health specialist, peer supporter or VCSE worker.
- Carers will be treated as equal partners with access to carers' assessments to understand and meet their support needs.
- Localities will be supported by Population Health analytics, enabling them to provide tailored approaches to care for different groups within their population. There will be specific focus on those at risk of poorer outcomes, whether due to an additional need (e.g. substance misuse), or because they are at greater likelihood of experiencing stigma and discrimination (e.g. due to their ethnicity or sexuality).
- Talking Therapies would be delivered by a system wide provider (Vita Health Group contracted until 2029). However, this would be experienced as part of someone's local care package with additional support to meet other needs being drawn in from the locality. For example, if someone was experiencing depression due to loneliness and problems with debt, they may be offered a course of talking therapies and support to access local community assets to address their isolation and debt. This holistic and integrated approach would help sustain any improvement in wellbeing delivered through talking therapies.

3.3 System level:

- Some care may need to be delivered at a system level (green within the diagrams), but only if this is the best way to improve patient outcomes. For example, NHS England has mandated that specialised pathways for eating disorders, personality disorders and rehabilitation are developed during 2021/22 using an evidence-based model across BNSSG. However, from a patient perspective, most care would still be experienced locally. For example, their locality team might be supported through clinical supervision or training to deliver early intervention support in these areas, or specialist therapy might be delivered from a base within their local area.
- Crisis care may be delivered at system level to ensure that out of hours support is rapidly available to those who need it. Patients will experience this as part of their local support offer.
- The 'Open Door' 24/7 mental health line may be provided at system level, although locality partners may propose alternative approaches.
- The Target Operating Model sets out the expectation that Integrated Care Partnerships will need to proactively develop a system-wide digital approach to delivering the Service.

4. Target Operating Model: Process for Design and Development Phase into Implementation and Delivery Phase

There are six shadow Integrated Care Partnerships in BNSSG. These are listed below:

- South Gloucestershire
- North and West Bristol
- Inner City and East Bristol
- South Bristol
- Woodspring
- Weston, Worle and Villages

These Shadow Integrated Care Partnerships will be invited to respond to the Target Operating Model with Integrated Delivery Plans. These plans will set out how the Target Operating Model's vision will be delivered in practice, to meet the needs of their communities. The plans will be developed through a supportive review and development based assurance process during the summer and early autumn of 2021.

4.1. Community Mental Health Steering Groups

System Steering Groups have been established to lead the development of specific areas of work. These focus on the areas specified by NHS England in the Community Mental Health Framework. The groups are as follows;

4.1.2. Infrastructure Steering Group Support

- **Outcomes and Digital** - An Outcomes and Digital Infrastructure Steering Group has been established to help deliver a system level response to these elements of the TOM. Emerging work packages include: Outcomes, Analytics (which will include Population Health Management, see below), Technical Infrastructure and Information Governance.

  As part of, and overseen by, this Steering Group, there will be a series of Population Health Management (PHM) workshops to support Shadow ICPs and improve understanding of the population characters and needs for each locality. The aim of these workshops will be to co-design PHM data packs with members of the Shadow ICP Boards and support teams to utilise this in their Community Mental Health Framework response.

- **Peer Support Workforce Steering Group** – This group is developing a Peer Support Framework to help localities understand and embed best practice. It is planned for a draft to be circulated with localities over July and early August for their input.

4.1.3. Models of Community Mental Health Care Steering Groups

- **Eating Disorders**, **Mental Health Rehabilitation**, **Personality Disorder and Complex Trauma** – These groups are developing whole-system pathways. They will seek support from Shadow ICP partners to develop and deliver these pathways, draft models to be agreed by September/ October.

- **Transitions (Young People and Older Adults)** (in development) - partners looking to agree scope and map existing support to help inform future best practice.
- **Improving the Physical Health of People with Severe and Enduring Mental Illness** – Focusing on addressing physical health needs of people with severe and enduring mental illness (including through health checks).

4.2. Resources and support for design and development phase

To support each Shadow ICP, a range of opportunities have been developed to help understand and connect key elements into the design process for Shadow ICPs:

- **Population Health Management workshops:** (See section 4.1 for further detail).
- **Understanding the estates profile across the Shadow ICP**
- **Learning Partnerships**: We have established links with a number of accountable care systems with international reputations for being at the forefront of integrated design delivery and development, to offer support and guidance.
- **Leadership and Organisational Development**: Some funding has been made available for Shadow ICPs to develop and progress their own choice of ICP OD priorities.
- **Supporting the ICP Model of Care design process:** Shadow ICPs have already embarked on the design of future integrated services and have in all six areas established community mental health sub groups. To support and enable the design process, each Shadow ICP will have access to an 18 week programme of learning and development with the Design Council.
- **Support from Mental Health Groups**, including Clinical Reference Group.
- **Digital and Data expertise**: System wide digital group of technical experts who will be able to advise Shadow ICPs on what existing digital infrastructure is available and its functionality.

Healthier Together and Locality Partnerships will jointly agree plans to deliver the Target Operating Model and assure that each Shadow ICP has a robust and credible plan for delivery of services from April 2022, including any phased delivery and development.

From autumn 2021 to the end of March 2022, the Service will begin to be implemented before it commences on the 1st April 2022.

5. Contracting Approach for Existing Contracts

As part of the delivery of the Target Operating Model, a decision is required on existing mental health contracts. These mental health contracts currently expire in March 2022, having been granted up to 1 year extensions by BNSSG in January 2021. The contracts vary in footprint with some matching local authority boundaries and some commissioned to a BNSSG footprint. The contracts include contracts from historic grant arrangements, as well as commissioned contracts, such as those resulting from the Bristol Mental Health procurement.

As part of the development and mobilisation of the Target Operating Model, the CCG will work in co-production with Shadow ICPs between June and August 2021 to develop a set of recommendations on the contracts due to expire in March 2022. In autumn 2021, the

CCG will seek to inform the existing providers of these contracts of the next steps in compliance with the 6 month notice period in contracts.

6. Contact Details

For queries relating to individual Shadow ICPs' development, please contact the following:

- Bristol Shadow ICPs (Inner City and East, North West and South Bristol)
  - bnssg.bristolareateam@nhs.net
- North Somerset Shadow ICPs (Weston and Woodspring)
  - bnssg.ns-area-team@nhs.net
- South Gloucestershire Shadow ICP
  - bnssg.sgloslocalitycalendar@nhs.net

For overarching Community Mental Health Programme queries – bnssg.mh.community@nhs.net

7. Timeline of activity

Month	activities
June 2021	• Community mental health working groups continue to provide expertise • Target Operating Model shared with Shadow ICPs and wider system • Support sessions for Shadow ICPs to begin developing response to Target Operating Model • Population Health Management workshops for Shadow ICPs begins • Work to consider existing mental health contracts begins
July 2021	• Population Health Management workshops conclude • Design Council programme to support Shadow ICP service design and innovation begins
August 2021	• Conclusion of work to consider existing mental health contracts
September 2021	• Draft delivery plans from Shadow ICPs due
October 2021	• Further work by Shadow ICPs to iterate draft delivery plans
November 2021	• Final delivery plans from shadow ICPs due • Mobilisation commences
December 2021 – March 2022	• Mobilisation ongoing
April 2022	• Services commence

* Please note some Shadow ICPs may wish to take early adoption approach and therefore work to accelerated timeframe