Sussex & East Surrey

Sustainability & Transformation Partnership

Mental health in Sussex and East Surrey: strategic framework and delivery roadmap

September 2017 v3

Executive summary

This strategic framework sets out the opportunities we have to improve the lives of adults and young people with mental health conditions in Sussex and East Surrey. It benefits the whole care system. This builds on the four areas in our case for change to improve services for common mental health conditions, psychosis, dementia and youth services (aged 14-25). It addresses the need to improve crisis services and to integrate physical and mental health. This document is linked to priorities identified in the Sussex and East Surrey STP programme, including delivery of place based plans. It also sets out our delivery roadmap to 2020/21.

We created 12 opportunity areas using national policy (including the five year forward view for mental health), local data and knowledge plus best practice evidence. These aim to promote independence, support resilience and provide care in the least intensive setting required. Each opportunity area has an associated evidence base drawing on case studies and local clinical opinion. Place based plans for dementia have been linked with relevant opportunity areas in this framework. Improvements for people who will use proposed services have been described. Enablers for these opportunities are linked to enabling STP workstreams (workforce; information and digital; accountable care; commissioning).

We assessed each opportunity for its overall health and wellbeing impact. Three opportunities have the greatest expected impact for people using services. These are integrated physical and mental health care, crisis support with improved out of hours access and housing/employment support. All 12 of our opportunities will be implemented.

There will be a £23.6m mental health financial gap in our STP by 2020/21 without implementing these 12 opportunities,. This is due to an underfunded start position of £7.6m compared with the national average and pressures from demand, inflation and five year forward view investment.

Our opportunities benefit the whole care system. We will invest in the opportunity areas to eliminate the 2020/21 mental health financial gap. We will also make savings associated with reduced A&E activity (£11.7m) and reduced system variation (£9.0m). This scenario results in fewer mental health inpatient admissions, social care support and mental health A&E attendances. It also results in increased community contacts.

Implementation of opportunities are set out in a delivery roadmap, beginning with early implementation in 2017/18 for integrated physical and mental health and specialist placement reductions followed by crisis support, recovery care and suicide prevention. Other opportunity areas will be implemented between 2018/19 and 2020/21. The mental health steering group will work closely with the STP places to support dementia care delivery. We will work alongside national bodies to access support to implement our opportunities and support the transforming care agenda.

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Introduction – our strategic framework links to STP priorities and our case for change (1/2)

- The sustainability and transformation partnership (STP) in Sussex and East Surrey covers a population of 1.8 million, and involves four local authorities, 8 clinical commissioning groups, 9 NHS trusts, 213 GP practices and third sector organisations. It is one of the most financially challenged STPs in England, and has a number of performance challenges.
- Earlier this year the STP agreed 13 priorities for Sussex and East Surrey, one of which one was mental health. Samantha Allen and Wendy Carberry have overseen a mental health steering group consisting of STP mental health providers, commissioners and the third sector. We have produced a strategic framework for adult and youth services. We will review children's services separately.
- Our work cannot happen in isolation to the rest of the STP. It will link with local care plans to deliver change required, including place based work to improve dementia services. STP enablers for information and digital, workforce, accountable care and commissioning reform will support our improvements to mental health care.
- Our case for change presents local challenges in mental health for common disorders, psychosis, dementia and youth services:
- Almost 10% of our population access mental health services while 15% are already over the age of 70
- Access to psychological therapies must increase to 25% by 2020/21 and support for more complex service users is lacking
- Life expectancy for those with severe mental illness is twenty years' worse than the general population
- Incidence of dementia and cognitive impairment is currently high and will increase ~10% by 2020/21 while the current care model is reactive
- Young people are using mental health services less than they should despite high mental health needs
- Support for crisis planning falls well below the national average and crisis services should be offered 24/7
- Physical and mental health are often co-morbid, and hence more holistic approaches are needed
- Spend per head is lower than peer groups and costs vary widely, while local authority budgets have reduced
- This document lays out the strategic framework and delivery roadmap for mental health, incorporating opportunities for improvement. It includes opportunity impacts on health/ wellbeing and finance.
- It builds on, refines and further develops the care model for those with dementia outlined in the place based plans.
- If we implement this framework we will benefit our whole population and the organisations that deliver their care.

Introduction – the five year forward view for mental health provides a clear direction for minimum service improvement (2/2)

Crisis	• All areas will provide crisis resolution and home treatment teams (CRHTTs) delivering a 24/7 service
Acute	• All acute hospitals will have all-age mental health liaison teams in place, and at least 50% of these will meet the 'Core 24' service standard as a minimum
IAPT	• 75% of people are able to access treatment within 6 weeks, 95% within 18 weeks; and at least 50% achieve recovery across the adult age group, with a focus on people living with long-term physical health conditions • 25% of people with common mental health conditions are able to access psychological therapies
EIP	• At least 60% of people with first episode psychosis starting treatment with a NICE-recommended package of care with a specialist early intervention in psychosis (EIP) service within 2 weeks of referral
Primary Care	• New mental health therapists will be co-located in primary care
Integration	• More people with a severe mental illness receiving a full annual physical health check • People with long term conditions will receive mental health support
IPS	• A doubling in access to individual placement and support (IPS), enabling SMI patients to find and retain employment
ECRs	• Out of area placements will be eliminated for acute mental health care
Suicide	• Reduced suicidal rate by 10% supported by local multi-agency suicide prevention plans

Source: Mental Health Five Year Forward View, Carnall Farrar analysis

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We developed mental health opportunities guided by national policy and local expert views

Our case for change used national policy, local data and workshops to identify four mental health improvement areas. These are common mental health conditions; psychosis; dementia and cognitive impairment; youth services. It indicates crisis services and integrated physical mental health as two cross cutting themes for development.

The mental health five year forward view requires us to implement several changes to IAPT, early intervention in psychosis, Core 24 crisis services and crisis resolution and home treatment teams. These requirements are the basis of opportunities developed to meet the case for change. A clinical and professional working group agreed 12 opportunities derived from the five year forward view, best practice evidence and local workshops.

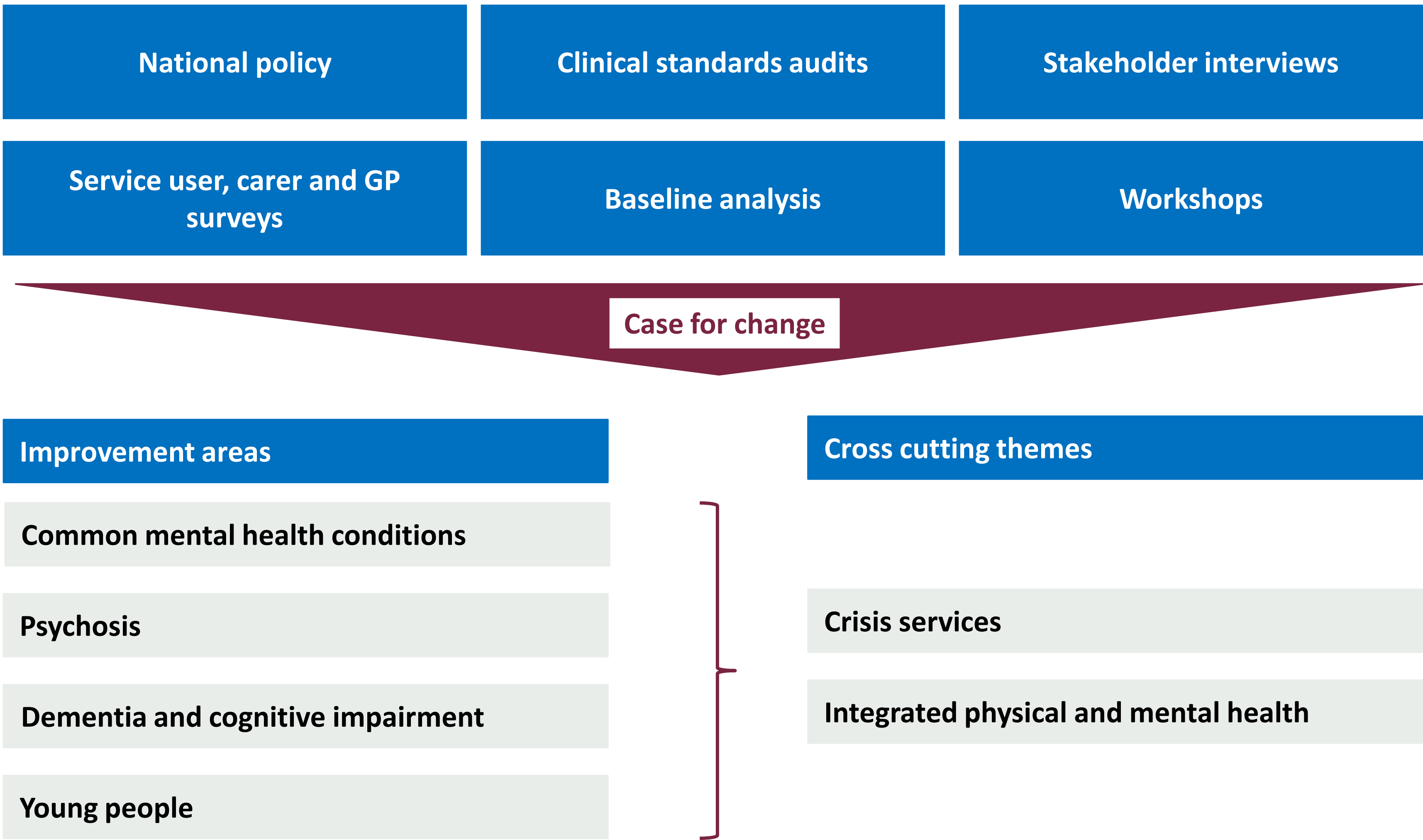
These 12 opportunity areas will meet the case for change with four enablers (workforce, information and digital, accountable care delivery models and STP strategic commissioning). For dementia, opportunities will be linked to place based plans with additive impact from early identification and intervention, housing and employment and recovery/carer support.

All 12 opportunities have a positive impact on the case for change improvement areas with some having greater overall impact than others. Each opportunity description includes high level activities, expected impact and an evidence basis.

The impact of opportunities for people using services has been described for each of the four improvement areas in the case for change.

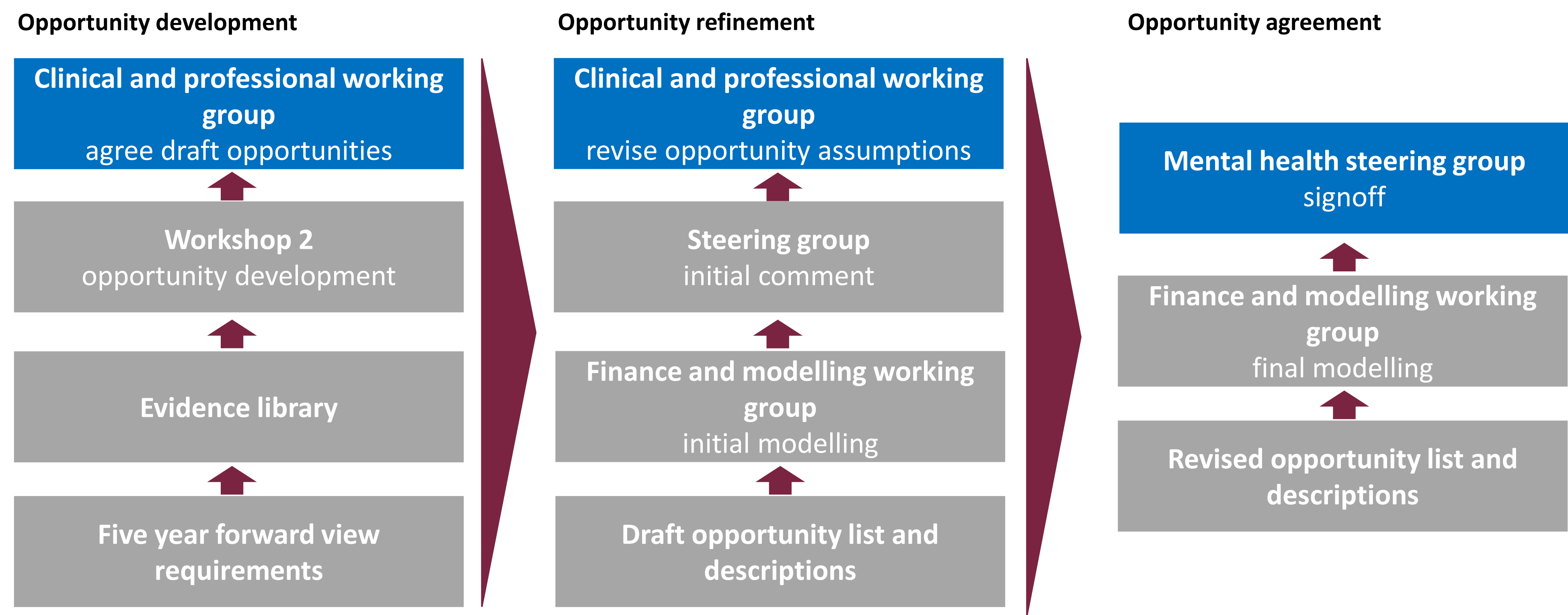
Source: Carnall Farrar analysis

Our case for change includes four improvement areas and two cross cutting themes built from multiple sources



Source: Carnall Farrar analysis

We developed opportunities via a clinical and professional working group, signed off by our steering group



Source: Carnall Farrar analysis

Twelve opportunities with four enablers will address our case for change

Opportunities

1. Primary prevention and resilience
2. Suicide prevention
3. Early identification and intervention
4. Proactive care coordination, planning and support
5. Access to whole pathway psychological therapy
6. Single point of access
7. Integrated physical and mental health care
8. Crisis support with improved out of hours access
9. Housing and employment
10. Recovery care model
11. Eliminate out of area acute placements
12. Reduce out of area specialist placements

Enablers

- Workforce
- Information and digital
- Accountable care delivery models
- Strategic commissioning

Source: Carnall Farrar analysis

For dementia, several opportunity areas are linked to place based plans

#	Mental health opportunities	Link to place based
1	Primary prevention and resilience	
2	Suicide prevention	
3	Early identification and intervention	*Place based*
4	Proactive care coordination, planning and support	*Place based*
5	Access to whole pathway psychological therapy	
6	Single point of access	*Place based*
7	Integrated physical and mental health care	*Place based*
8	Crisis support with improved out of hours access	*Place based*
9	Housing and employment	*Additive to place based*
10	Recovery care model	*Additive to place based*
11	Eliminate out of area acute placements	
12	Reduce out of area specialist placements	

#	Place based dementia interventions
1	Build knowledge and change behaviours
2	Bring integrated health and social care into the home
3	Rapid response
4	Falls prevention
5	Reablement
6	Single point of access
7	Care coordination, planning and management
8	Timely diagnostics
9	Access to expert opinion
10	Facilitation of transitions of care incl. discharge planning
11	Mental health liaison

Note: further detail on place based interventions in appendix

Source: Sussex and East Surrey STP place based planning

All opportunities have a positive impact on improvement areas identified in the case for change

Key: Significant impact; Some impact; Little impact; No impact

	Opportunity	Common mental health conditions	Psychosis	Dementia and cognitive impairment	Young people
1	Primary prevention and resilience	Significant impact	Little impact	Little impact	Significant impact
2	Suicide prevention	Significant impact	Some impact	Little impact	Some impact
3	Early identification and intervention	Some impact	Little impact	Some impact	Significant impact
4	Proactive care coordination, planning and support	Little impact	Some impact	Significant impact	Little impact
5	Access to whole pathway psychological therapy	Significant impact	Some impact	Little impact	Some impact
6	Single point of access	Little impact	Significant impact	Significant impact	Some impact
7	Integrated physical and mental health care	Significant impact	Significant impact	Significant impact	Significant impact
8	Crisis support with improved out of hours access	Some impact	Significant impact	Little impact	Little impact
9	Housing and employment	Little impact	Significant impact	Some impact	Some impact
10	Recovery care model	Significant impact	Significant impact	Significant impact	Significant impact
11	Eliminate out of area acute placements	Little impact	Some impact	Little impact	Some impact
12	Reduce out of area specialist placements	No impact	Little impact	Little impact	Little impact
13	Place based plans	No impact	No impact	Significant impact	No impact

Source: Mental health clinical and professional working group; Carnall Farrar evidence library, Carnall Farrar analysis

Opportunity descriptions (1/8)

Opportunity	Description	Impact	Case study/evidence
1 Primary prevention and resilience	• Identify groups most at risk of developing common mental health problems/dementia (e.g., those with social isolation, including lonely elderly; parenting; risk of housing loss, etc.) • Institute/ expand targeted services to build resilience for these groups (befriending services, parenting and specialist support; healthy walks; debt and welfare service) • Build on broader preventative/ public health activities where these are associated with reducing prevalence of mental health problems (e.g., exercise, smoking cessation) • Work with schools/ workplaces to embed preventative activities (anti-bullying, social and emotional learning; stress management) • Support with a common set of standards and objectives that can be shared across public health, social care, healthcare and commissioning	• Reduce prevalence of mental health conditions • Reduce A&E and inpatient activity • Reduce secondary and community contacts	• SCFT Chathealth text service in Sussex schools • Befriending services • Smoking prevention • Parenting and specialist support • Family intervention projects
2 Suicide prevention	• Deliver existing suicide prevention plans led by local authorities • Increase awareness of suicide by local media campaigns • Train local gatekeepers, such as teachers and police officers and training for workers in physical health to embed suicide prevention activity • Target support for high-risk people in the community • Train and support professionals in primary care settings to identify and refer risk	• Reduce suicide/self harm rate by 10% (FYFV) • Reduce inpatient activity • Increase community contact • Improve people's resilience to life challenges	• Suicide Safer Communities work in Brighton and Hove • StayAlive app • Headspace in Australia • European Alliance Against Depression 4-Level Approach

Source: Mental Health Five Year Forward View, 2016; Sussex and East Surrey mental health stakeholder interviews and system wide workshops, 2017; Carnall Farrar evidence library; Sussex and East Surrey case studies for mental health services, 2017

Opportunity descriptions (2/8)

Opportunity	Description	Impact	Case study/evidence
3 Early identification and intervention	• Develop and target interventions for particular cohorts (especially for youth); For areas of variation and/or inequality, interventions will be targeted to improve support for those groups. • Draw on connections with the third sector to improve proactive engagement with hard to reach groups • Support primary care (including IAPT and GP support) to reduce stigma and identify at risk cohorts, using co-commissioned services for early intervention and integrated approaches for working with approved mental health professionals (AMHPs) • Maintain (at least) current levels of at least 60% of people with first episode psychosis starting treatment with a NICE-recommended package of care with a specialist early intervention in psychosis (EIP) service (FYFV)	• Reduce inpatient admission/ institutionalisation rate • Reduce A&E and inpatient activity • Reduce contacts for more complex conditions • Reduce stigma	• SPFT i-Rock • Jigsaw in Ireland • Headspace in Australia • Early intervention in psychosis (EIP)
4 Proactive coordination of care and support, planning and management	• Develop care plans covering physical and mental heath needs and social needs at first presentation for all service users to include holistic (employment, social care and physical health care needs) plus medication assessments and medication recovery planning, starting from those with dementia and co-morbidities • Build on place based work to institute multi disciplinary teams to coordinate care • Include LA and third party services to support these patients in their own homes • Develop and institute proactive discharge planning for those people who are medically optimised for discharge, no longer requiring an inpatient bed, but still needing some level of care and/ or support to facilitate reablement and/ or prevent their health from deteriorating • Create robust safeguarding initiatives for vulnerable adults	• Increase the number of patients dying in their usual place of residence • Reduce A&E and inpatient activity • Reduce care home admission/placement • Increase care closer to home • Assist service users and carers to navigate in the system	• Dementia golden ticket • Oxleas Advanced Dementia Service • Midhurst Macmillan Palliative Care Service • Older Peoples Service, South West Yorkshire Mental Health NHS Trust • Greenwich Coordinated Care

Source: Mental Health Five Year Forward View, 2016; Sussex and East Surrey mental health stakeholder interviews and system wide workshops, 2017; Carnall Farrar evidence library; Sussex and East Surrey case studies for mental health services, 2017

Opportunity descriptions (3/8)

Opportunity	Description	Impact	Case study/evidence
5 Access to whole pathway psychological therapy	• Expand access or provide alternative area of support for people whose needs are too complex for current IAPT services but are not severe enough to meet current thresholds for secondary care therapies (e.g. people with mild-moderate eating disorders, patients with a more complex trauma histories , and those between the ages of 18 and 25 who may benefit from a different approach to engagement and therapy.) • Deliver psychological therapies to in contact with secondary care services where recommended by NICE guidance • Enlist support of, and build support in, the third sector to assist with co-ordination of care and enabling interventions • Expand digital delivery of cognitive behavioural therapy, e.g,. online access to a therapist, with instant messaging in which client and therapist communicate in real time with typewritten responses • Train up health care professionals to assess patient motivation to self-manage physical health and to identify those who may need more support	• Reduce section 3 detentions • Increase number of people accessing to psychological therapy • Increase number of patients in recovery stage • Reduce inpatient activity	• IAPT • Therapist-delivered internet psychotherapy for depression • City and Hackney Primary Care Psychotherapy Consultation Service

Source: Mental Health Five Year Forward View, 2016; Sussex and East Surrey mental health stakeholder interviews and system wide workshops, 2017; Carnall Farrar evidence library; Sussex and East Surrey case studies for mental health services, 2017

Opportunity descriptions (4/8)

Opportunity	Description	Impact	Case study/evidence
6 Single point of access	• Provide a "no wrong front door" approach covering secondary health services, integrated physical and mental health services and assessments without replacing the current access route to IAPT or crisis line services • Assess the feasibility and risk of different options including multiple access points and a single telephone number • The person, the GP, community services and acute staff can seek help to support people with their care by gaining more efficient, coordinated access to services • Triage will be used to signpost people to appropriate local services and advice	• Improve access to appropriate services • Reduce inappropriate A&E and inpatient activity • Reduce the need to repeat in explaining patients' conditions • Increase community contacts	• New York Care Coordination Program • Birmingham RAID model • SPFT i-Rock • Mindsight CAMHS: One stop

Note: *plus see slide 25 for an example of access for users, carers and professionals
Source: Sussex and East Surrey mental health stakeholder interviews and system wide workshops, 2017; Carnall Farrar analysis

Opportunity descriptions (5/8)

Opportunity	Description	Impact	Case study/evidence

7 Integrated physical and mental health care	• Identify/ stratify at risk groups for mental health issues cohorts through identifying stressors associated with physical health (e.g., diagnosis with long term condition, stroke, cancer) and proactively target support/ CBT at this cohort to reduce depression and anxiety (e.g the Patient Activation measure in physical care settings)
	• Provide mental health assessment and treatment for people presenting to acute care and require a mental health assessment/intervention
	• As an example, Time to Talk Health (West Sussex) and Diabetes Care For You (Brighton and Hove) incorporates new, integrated pathways designed jointly and offered jointly by those working within mental and physical health, including social workers
	• Co-locate new mental health therapists in primary care (FYFV) to support delivery to at risk groups and help primary care offer mental health support
	• For those with severe conditions/ psychosis:
	  • Provide full annual physical health check (FYFV)
	  • Target physical preventative measures (e.g., smoking cessation)
	  • Expand CPA to cover physical health needs
	  • Explore making one organisation accountable for physical and mental health care for severe and enduring mental illness
	• Provide support for care homes to proactively manage conditions and avoid unnecessary emergency hospitalisation
	• Establish transformative systems to allow appropriate data sharing (flow freely) between mental and physical health settings, including social care, and better decision making
	• Support with a common set of standards and objectives that can be shared across public health, social care, healthcare and commissioning
		• Reduce premature mortality of people living with severe mental illness (FYFV)
		• Reduce psychological distress
		• Reduce length of stay
		• Reduce delayed transfer of care
		• Reduce unnecessary/ repeated contacts
		• Service users will be treated holistically
			• Time To Talk Health
			• Health in Mind
			• Time to Talk Proactive Care Psychological Therapies Project
			• Diabetes Care for you
			• Alcohol care teams in the Royal Bolton Hospital
			• Three dimensions of care for diabetes at King's College Hospital

Source: Mental Health Five Year Forward View, 2016; Sussex and East Surrey mental health stakeholder interviews and system wide workshops, 2017; Carnall Farrar evidence library; Sussex and East Surrey case studies for mental health services, 2017

Opportunity descriptions (6/8)

Opportunity	Description	Impact	Case study/evidence
8 Crisis support with improved out of hours access	• Identify high risk groups and design and reach agreement on a crisis plan between the service user and clinical team through negotiation and consensus building, facilitated by a third party • Design joint crisis plan to mitigate the negative consequences of relapse, including admission to hospital, use of the Mental Health Act for those in crisis, and associated costs • Ensure a MDT is in place to help people in crisis to get appropriate psychological treatment and care; and to help carers to get sufficient support in the community • Equity of access will be offered across Sussex and East Surrey for those in crisis • Provide out of hours help to people and their carers who are experiencing a mental health crisis or emotional distress • Act as an alternative to A&E and/or hospital admission • All areas will provide crisis resolution and home treatment teams (CRHTTs) delivering a 24/7 service (FYFV) • All acute hospitals will have all-age mental health liaison teams in place, and at least 50% of these will meet the 'Core 24' service standard as a minimum (FYFV)	• Reduce section 2 and 3 detentions under the mental health act • Reduce rate of s136 detention/ s136 suite use • Reduce A&E and inpatient activity • Improve out of hours support for service users and carers • Increase care closer to home	• Safe havens • Street Triage • North East London Foundation Trust's Integrated Adult Care Pathway

Source: Mental Health Five Year Forward View, 2016; Sussex and East Surrey mental health stakeholder interviews and system wide workshops, 2017; Carnall Farrar evidence library; Sussex and East Surrey case studies for mental health services, 2017

Opportunity descriptions (7/8)

Opportunity	Description	Impact	Case study/evidence
9 Housing and employment	• Engage with district councils, borough councils and housing providers • Build on existing work and strategies to develop a housing and employment strategy across Sussex/ across Surrey for those that require support • Double access to individual placement and support (IPS), enabling SMI patients to find and retain employment (FYFV) • Recognise the need for systemic support for housing and accommodation • Develop holistic support coordination for education, employment, housing, drug and alcohol issues, community involvement etc. • Promote a recovery ethos e.g. leadership support and mental health training for housing officers and employers	• Increase employment rate • Reduce homelessness rate • Reduce inpatient activity • Increase support in the community • Increase number of service users in a fulfilling life	• Individual Placement and Support • Supportive housing
10 Recovery care model	• Adopt the recovery and discovery college model with the involvement of peers, carers and family to support patient in their recovery journey and include dementia support • Provide educational courses for recovery that are designed to increase knowledge and skills to promote solution focused activity • Promote self-management by helping service users to control and become an expert in their own wellbeing and recovery and enjoy life despite mental health challenges • For carers, improve quality of services by meeting the needs of carers (such as respite and reducing stigma) and improve partnership working with carers as a part of a person's treatment • Involve carers more actively involved in the wider team that provides treatment and observation • For peers, secure greater involvement of peer and peer support within services and pathways to support a recovery model approach acknowledging the value of expertise by experience • Involve people with mental health conditions, family and carers in care planning • Provide family support/buddy system to support patient through the journey	• Reduce frequency of relapse • Increase number of patients returning to social life, in full employment or studies • Reduce A&E and inpatient activity • Improve resilience of service users and carers	• Sussex Recovery and Discovery Colleges • Surrey Recovery College • Lighthouse Recovery Support • Open Dialogue

Source: Mental Health Five Year Forward View, 2016; Sussex and East Surrey mental health stakeholder interviews and system wide workshops, 2017; Carnall Farrar evidence library; Sussex and East Surrey case studies for mental health services, 2017

Opportunity descriptions (8/8)

Opportunity	Description	Impact	Case study/evidence

11 Reduce out of area/ specialist placements	• Reduce out of area placements for locally commissioned acute mental health care where it can be provided locally, by
	  • Determining an appropriate bed base to meet demand within the footprint of the STP and rehabilitation support solutions
	  • Bringing people into suitable and more local care settings, linked to strategic accommodation and care co-ordination planning
	  • Making best use of local inpatient and rehabilitation facilities
		• Reduce out of area placement
		• Avoid the need of travelling a long distance for carers
		• Allow service users to be closer to home
			• North East London Foundation Trust's Integrated Adult Care Pathway
			• Sheffield Health and Social Care Foundation Trust

12 Reduce out of area/ specialist placements	• Where services are not available locally, consider developing local provision where a suitable volume of patients exists (e.g., autism spectrum disorder)	• Reduce out of area placement • Avoid the need of travelling a long distance for carers • Allow service users to be closer to home	• North East London Foundation Trust's Integrated Adult Care Pathway • Sheffield Health and Social Care Foundation Trust

Source: Mental Health Five Year Forward View, 2016; Sussex and East Surrey mental health stakeholder interviews and system wide workshops, 2017; Carnall Farrar evidence library; Sussex and East Surrey case studies for mental health services, 2017

For common mental health conditions – people will recover faster and improve their confidence

Impact for people using services:

- More people will:
  - recover faster from their conditions
  - have improved confidence and resilience
  - have meaningful activities in their life
  - have good social networks with family and friends
  - experience less discrimination
  - have better physical health

Opportunities with greatest impact

Primary prevention and resilience

Suicide prevention

Access to whole pathway psychological therapy

Recovery care model

How this impact will be felt:

- People will be able to access support in their community no matter how complex their condition is thanks to whole pathway psychological therapy
- When someone needs support in the middle of the night, they will know who to call or where to go to find help due to out of hours help and 24/7 crisis support
- When someone has a physical condition and has to see their GP or go to hospital, they will be asked about how they are feeling and what to do to improve their mental wellbeing
- Support for debt advice, employment opportunities, relationship support and other lifestyle factors will be offered together with medical interventions from primary prevention services
- People will only have to tell their story once to get the support or advice they need to improve their condition due to integrated physical and mental health services
- When people leave care settings they will know what to do to continue to improve their wellbeing and confidence due to recovery support
- People will feel supported by others who have experienced their condition thanks to peer support and co-produced services

Source: Carnall Farrar analysis

For psychosis - people will live longer with more meaningful lives

Impact for people using services:

- More people will:
  - live longer than they do today
  - find activities that make them feel better about themselves
  - believe their life has meaning
  - form social bonds with neighbours and family
  - live in places where they feel comfortable

Opportunities with greatest impact

- **Single point of access**
- **Integrated physical and mental health care**
- **Crisis support with improved out of hours access**
- **Housing and employment**
- **Eliminate out of area acute placements**

How this impact will be felt:

- Those who live in deprived areas will get support they need for accommodation, employment or training to help them improve their mental wellbeing thanks to systemic housing and holistic support
- Families and carers will feel supported together instead of just the individual(s) with psychotic conditions as carers will be part of treatment teams
- People will be given medical therapies that they need in time to make a positive difference to their lives
- When people receive medication they will know why it is the best option, what to do if they experience side effects and what other support they can access
- People will not be in hospital for longer than they need to be as proactive care plans will exist in advance
- People will only have to tell their story once to get the support or advice they need to improve their condition due to integrated physical and mental health care
- When people leave care settings they will know what to do to continue to improve their wellbeing thanks to planned care support and advice
- People who would have previously been detained under the mental health act are able to receive more comprehensive care in the community

Source: Carnall Farrar analysis

For dementia and cognitive impairment – people will stay independent for longer and socialise in their community

Impact for people using services:

- More people will:
  - feel independent where they live for longer
  - be able to socialise in their community
  - have independent daily activities
  - maintain meaningful relationships

Opportunities with greatest impact

Place based dementia plans

Proactive care co-ordination, planning and support

Single point of access

Recovery care model

How this impact will be felt:

- People with dementia will receive more care in their place of residence and their local community due to proactive care planning supported by multidisciplinary teams
- Carers will feel more supported to look after themselves and those under their care as they will be part of the care team and will receive their own support
- People in early stages of dementia will receive advice for employment and family support as part of resilience support services
- When people have a physical health problem, they will be treated as a whole person and given appropriate support for their dementia needs thanks to integrated physical and mental health services
- People or their carers will only have to tell their story once to get the support or advice they need to improve their condition
- People will only be in hospital when that is the best place for them. When it is time to leave they will wait less to do so and will understand where they are going thanks to proactive care planning
- People (and their carers) will already know what type of care they will need as their condition progresses due to resilience and care plan support
- People will know what palliative care needs they will have in the future and will be able to prepare themselves, their carers and families

Source: Carnall Farrar analysis

For young people – people will have a positive future outlook and be able to cope with the challenges of adulthood

Impact for people using services:

- More young people will:
  - feel connected with people like themselves
  - have a positive outlook of their future
  - Feel more able to cope with moving into adult life
  - improve their confidence and independence

Opportunities with greatest impact

Primary prevention and resilience

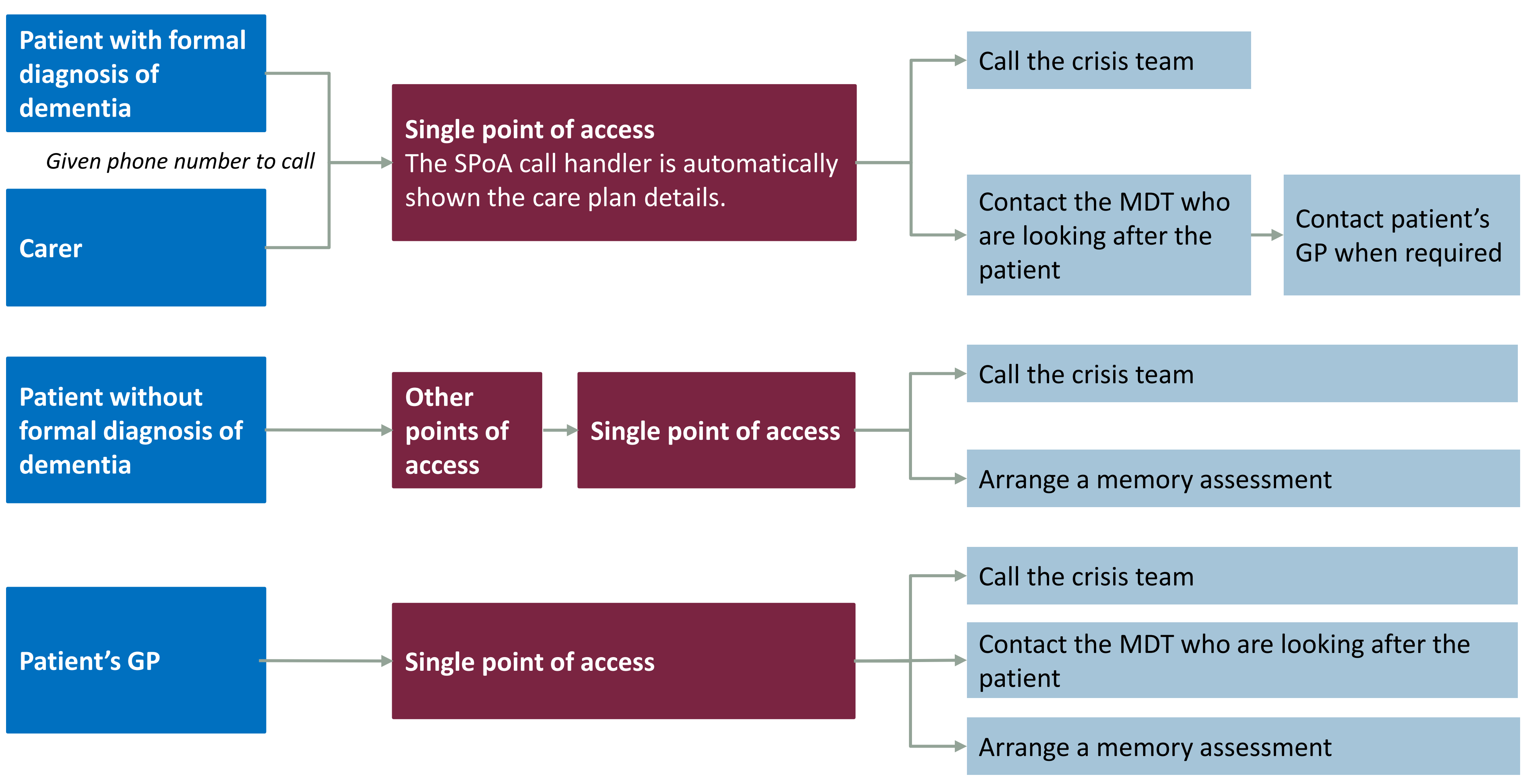
Early identification and prevention

How this impact will be felt:

- More young people will receive support for their mental health conditions thanks to an expanded youth service offering resilience and preventative activities
- Young people will not be turned away from services they need thanks to whole pathway support offers
- Young people will know they can get help for the biggest challenges in their lives, not just medical support, as part of broader preventative and holistic support offers
- Young people will want to go back and finish support and advice courses that they start thanks to co-produced services
- Peer support will help young people get help that makes sense to them
- Young people will feel more confident to deal with the challenges they face and know what to do when they have a mental health need due to increased resilience advice and support
- When young people have physical health problems, they will also know how to maintain their mental wellbeing due to integrated physical and mental health care
- Families of young people will feel supported too and know how they can help young people with their recovery as they will be part of the care system

Source: Carnall Farrar analysis

Example: Service users with dementia will be supported to access the correct team via the access route they choose



Enabler: our workforce needs support to deliver care in new ways with new people

1

Workforce

Co-production, lived experience and peer working

- Support people with mental health conditions and lived experience in the early stages of care model design to ensure services are person centred and deliver best possible outcomes
- Ensure that lived experience support is a component of new service model delivery, integrated with traditional staff roles
- Involve peer workers, carer and family in care and treatment to support early identification, recovery and reduce deterioration across opportunities

Workforce planning

- Understand outcomes and skills required from a new workforce before determining roles required to deliver them
- Develop new roles with existing workforce so STP workforce plans reflect what the future workforce will deliver
- Link with higher education institutions to support workforce delivery requirements
- Provide mental health training to primary and community care colleagues regarding identification of crisis and approach to signpost patients to the right services

Skills for workforce resilience

- Create a specific training agenda around creating truly integrated physical and mental health care services
- Provide mental health training and support to multidisciplinary teams
- Provide emotional support to staff and develop the resilience of the workforce

Quality improvement programme

- Define common outcomes and objectives for physical and mental health, including consistent assessment of outcomes that all organisations will strive to deliver
- Create a programme of work that can be used by commissioners and providers to improve quality with shared measures of success for mental health (including training, experiential learning, audits, waste reduction and evidence-based best practice change)
- Deliver a quality improvement programme that meets the common outcomes and objectives set for the STP, integrated with existing improvement programmes for providers and commissioners

Source: Carnall Farrar analysis

Enabler: information sharing will support business process and cultural change to ensure opportunity delivery

2

Information and digital

Communicate
- Engage patients and service users about the need to share information
- Communicate improvements to data and information with delivery staff

Create information sharing environment
- Use of apps and online self management and information tools
- Ensure mental health data is included in an STP-wide patient level data set with appropriate information governance
- Move to single IT systems for accountable care delivery
- Ensure clinical system interoperability

Link data
- Create linked patient data for identification across care settings
- Provide access to linked patient data for all professionals
- Create integrated patient records
- Provide access to integrated records for call handlers in single point of access and members of MDTs

Monitor and review
- Perform continual review of data metrics to monitor progress of mental health opportunities
- Create reporting for decision making by opportunity area

Source: Carnall Farrar analysis

Enabler: accountable care is one way of promoting care coordination and independence for cohorts of patients

3

Accountable care delivery models

Issues

Outcomes

- Fifteen to twenty years difference in life expectancy for people with/ without serious mental health condition, largely as their physical health is poorer
- People present in the wrong places, resulting in suboptimal outcomes (and expense)

Fragmentation

- Mental health care is currently highly fragmented, with service users and GPs finding it difficult to navigate
- Often poorly integrated with physical health care (e.g., dementia patients spending too long in acute beds)
- Social care (housing and employment) important for good outcomes, but status not systematically recorded

Commissioning

- Each CCG has different service specifications (and hence different services)
- Limited resource available in CCGs to commission

Accountable care

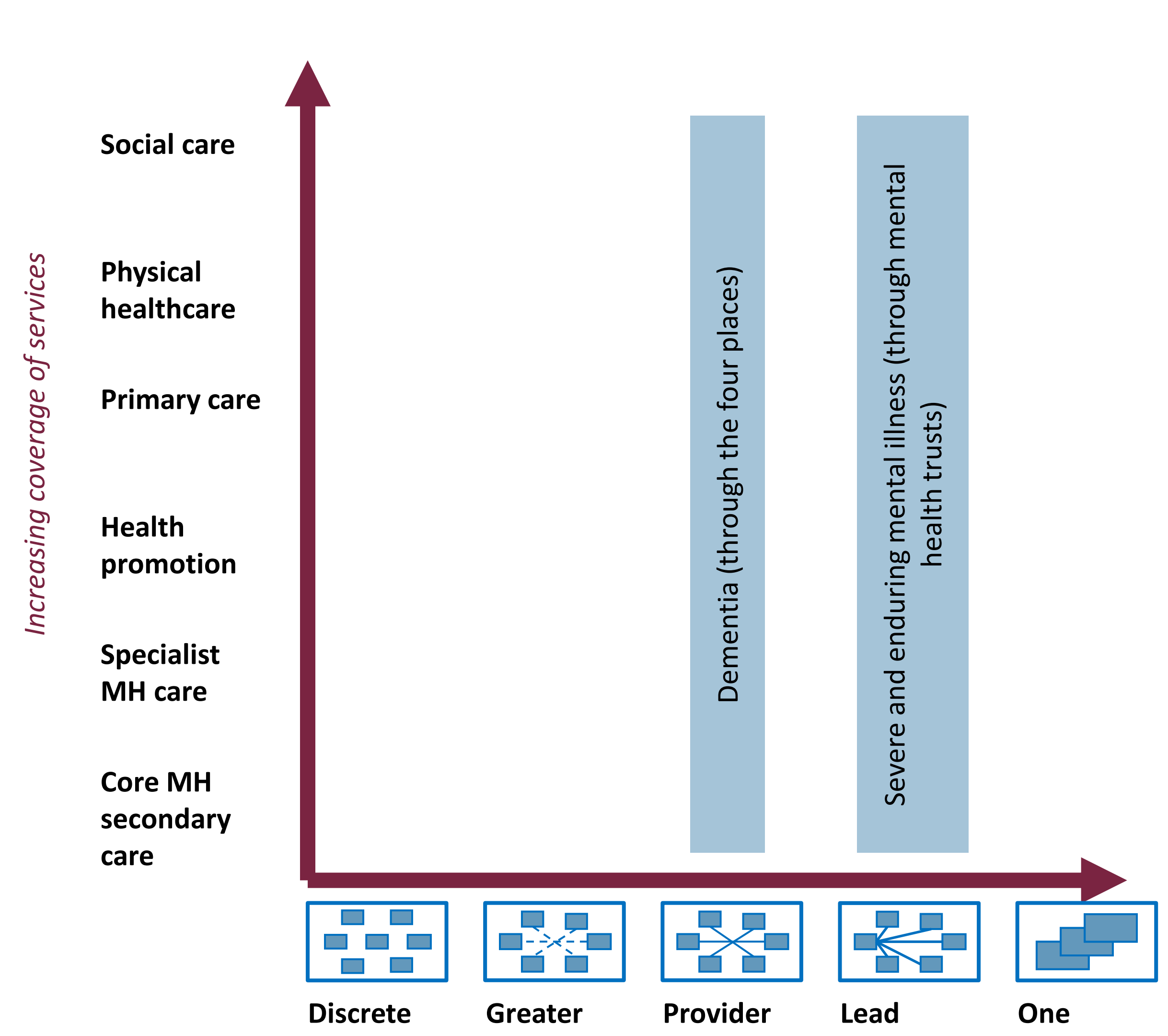
- These issues could be overcome if a single organisation were to be given accountability for all (or most) care needs of a particular cohort of service users
  - *Accountability* means holds the budget, fashions the care model (in cooperation with others) and assesses, for each service user, which interventions to make
  - *Accountability* does not mean the organisation delivers all the interventions (though it may deliver some)
- Accountable care works best where
  - There is a defined population cohort with a similar care need
  - A baseline cost for the population can be calculated
  - There is a need to coordinate services
  - The service users are likely to have a long (> 1 year) interaction with the health service
  - Services of differing intensity need to be coordinated and offered appropriately
- This suggests an accountable care arrangement could work for:
  - Those with severe and enduring mental illness (psychosis, severe non-psychosis and some specialist disorders)
  - Those with dementia
- Next, need to decide which services will be included for each cohort, and the form of the organisation

Source: Carnall Farrar analysis

Dementia accountable care systems, led by the places, should coordinate all services; SEMI should start from mental health services

3

Accountable care delivery models



- For each cohort, the aim is to promote greatest independence feasible and hence to be managed in the lowest intensity care setting appropriate
- Will require clear criteria for which service users/ patients are managed by whom, and how they are regularly reviewed and referred
- Where different cohorts require similar service, the service specification should be as similar as feasible

Source: Carnall Farrar

Dementia would start from a provider alliance in each place; severe and enduring mental illness should span Sussex

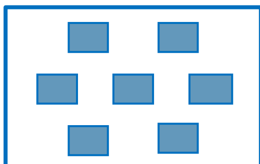
3

Accountable care delivery models

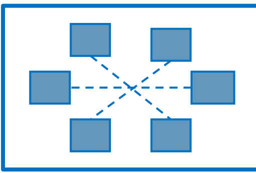
Common mental health conditions straddle primary and secondary care, moving from cooperation towards an alliance model

Dementia would be located in the places, which will initially be alliances

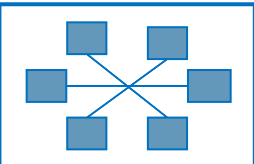
Severe and enduring mental illness could be carved out under a lead provider to coordinate different care settings



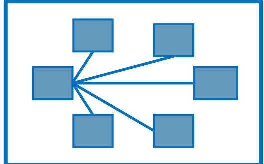
Discrete providers
- Rudimentary agreement on coordination of care
- Providers have own incentives, limited attempt to align
- Ad hoc information sharing
- Occasional shared pathways



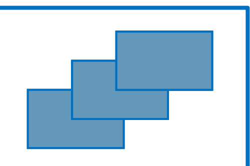
Greater cooperation
- Limited agreement on how providers coordinate care
- Providers have own incentives, that may/ may not align
- Better information sharing + protocols
- Some shared pathways



Provider alliance
- Explicit agreements about how providers coordinate care for members of cohort
- All providers share incentive pot based on shared goals
- Common information on cohort



Lead organisation
- One organisation coordinates care for all of cohort
- Holds budget for all of cohort
- Common information on cohort, coordinated by lead organisation
- Pathways led by lead organisation



One organisation
- All care provided by one organisation
- Holds budget for all of cohort
- Hold information records
- Sets pathways

Cohorts

Dementia
- 18,000 people in Sussex and East Surrey (diagnosed)

Common mental health conditions
- 200,000 people in Sussex and East Surrey

Severe and enduring mental illness
- 25,000 people in Sussex and East Surrey

Source: Carnall Farrar analysis

Enabler: strategic commissioning will allow consistent outcomes to be achieved whilst supporting local delivery models

4

Strategic commissioning

Setup
- Create memorandum of understanding to create a strategic commissioning function for specific areas of mental health across the STP using specialist expertise from local clinicians
- Determine potential areas for strategic commissioning based on national guidance and best practice
- Agree opportunity areas that require strategic commissioning
- Determine accountable care requirements for mental health and support commissioning and setup of a mental health accountable care organisation for relevant opportunity areas, led by mental health trusts
- Support commissioning and setup of accountable care for dementia, led by the four places

Create commissioning aims and objectives
- Create person-centred outcomes for commissioning STP-wide mental health activity
- Define specifications for success, including standards and a common offer that can be applied across the STP

Enable delivery and support accountable care
- Support place based and locality delivery functions to create pathway-based models of care against consistent commissioning requirements
- Encourage local delivery of care to take advantage of existing networks and local engagement activities to achieve desired outcomes
- Link commissioning to accountable care delivery (e.g. commission a lead provider to deliver care for severe and enduring mental illness)

Review
- Complete ongoing monitoring of delivery against commissioning requirements
- Revisit areas that require strategic commissioning and determine if more can be added

Source: Carnall Farrar analysis

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Health and wellbeing impact assessments suggest three of the opportunity areas will have greatest impact – crisis, integration and housing support

An evidence base has been created for each of the 12 opportunity areas developed by the clinical working group with impact examples presented in this section (and see appendix document for full range of impact areas).

Five criteria have been developed to assess the overall health and wellbeing impact by opportunity area (access; quality; service user experience; carer support; equality and inequality). Each of these has associated statements to assess opportunity impact.

Against these five criteria, each opportunity has been given an overall health and wellbeing impact rating. The highest rated opportunities are integrated physical and mental health care, crisis support with improved out of hours access and housing/employment support.

Three other opportunities received the second highest rating score, being early identification and intervention, proactive care co-ordination/management and recovery/carer support.

Source: Carnall Farrar analysis

Each opportunity has significant impact on the health outcomes, supported by local best practice and a literature review

#	Opportunity	Measure of greatest impact	Reference
1	Primary prevention and resilience	Incidence of depression: reduced by 11.2-19.5%	*Clarke et al., 2001*
2	Suicide prevention	Suicide rate: reduced by 56.1-60.1%	*European Alliance Against Depression*
3	Early identification and intervention	Increased access: Increase youth access by 40%	*I-Rock*
4	Proactive care coordination, planning and support	Acute medical admissions: reduced by 25%	*Dementia golden ticket*
5	Access to whole pathway psychological therapy	Recovery rate: increased by 11.9%	*Time to Talk, IAPT services*
6	Single point of access	Length of stay for mental health patients: reduced by 6.25%	*Birmingham RAID model*
7	Integrated physical and mental health care	Recovery rate (mental health): 55%	*Parsonage et al., 2014*
8	Crisis support with improved out of hours access	Acute psychiatric admissions: reduced by 33%	*Safe havens*
9	Housing and employment	Employment 12 months sustained rate: 21-35%	*Individual Placement Support*
10	Recovery care model	Length of stay: reduced by 75%	*Sussex recovery college*
11	Eliminate out of area acute placements	Number of patient transferred out of its area: reduced to 0%	*North East London Foundation Trust's Integrated Adult Care Pathway, 2016*
12	Reduce out of area specialist placements		

Source: Carnall Farrar evidence library, Carnall Farrar analysis

The opportunities have been assessed for positive health and wellbeing impact against five criteria

Access

- Address issues for access to services so more people with mental health needs would be able to be identified, treated and supported earlier and faster in the right place
- Ensure referrals are made appropriately by designing clear patient pathways and providing sufficient information and assistance to service users, carers and health professionals, especially GPs and social workers

Quality

- Maintain a high quality of care by measuring services against clinical standards across people's journey of care
- Measure clinical outcomes to understand the effectiveness and efficiency of services to improve mental health and wellbeing of people with mental health conditions
- Take wider determinants of health (e.g. housing and employment) into account to ensure the people are supported to live a fulfilling life and reduce the risk of worsening the mental health conditions due to social conditions

Service user experience

- Involve service users in care planning and decision making to ensure their needs are addressed effectively
- Support service users from the start of their journey and ensure they are well supported in the recovery phrase
- Respect people's choice in care and treatment and assist them to gain confidence in self care and live a fulfilling life

Carer support

- Provide sufficient information and assistance to support carers to take care of people with mental health conditions
- Involve carers in tailoring care plans to better manage people with mental health conditions in the community
- Provide appropriate support services (e.g. respite care) to improve carer wellbeing

Equality and Inequality

- Reduce inequalities across social, economic and demographic groups regardless of where people live, their age or where/if they work
- Maintain and improve equality for groups with protected characteristics

Source: Carnall Farrar analysis

- - Confidential draft: work in progress - -

Integrated physical and mental health, crisis support and housing and employment are likely to have the greatest positive impact

	Opportunity	Access	Quality	Service user support	Carer support	Equality and inequality	Overall impact
1	Primary prevention and resilience	Moderate	Very high	Moderate	Minimal	Very high	High
2	Suicide prevention	Minimal	High	Moderate	Minimal	High	Minor
3	Early identification and intervention	High	Very high	Moderate	Minor	High	High
4	Proactive care coordination, planning and management	Minor	Moderate	Very high	Very high	Moderate	High
5	Access to whole pathway psychological therapy	Very high	High	Very high	Minor	Moderate	Moderate
6	Single point of access	Very high	Moderate	High	High	Very high	Moderate
7	Integrated physical and mental health care	Moderate	Very high	Very high	Moderate	Very high	Very high
8	Crisis support with improved out of hours access	Very high	Very high	Very high	Very high	High	Very high
9	Housing and employment	Minimal	Very high	Very high	Minimal	Very high	Very high
10	Recovery care model	Minimal	Very high	Very high	Very high	Minor	High
11	Eliminate out of area acute placements	Minimal	High	Very high	High	Minor	Minor
12	Reduce out of area specialist placements	Minimal	High	Very high	High	Minor	Minor

Source: Carnall Farrar analysis

Key: Very high impact; High impact; Moderate impact; Minor impact; Minimal impact

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The "do something" scenario includes system activities required to achieve financial surplus by 2020/21

Do nothing

- Modelling explicitly covers CCG and local authority commissioned services for mental health
- Do nothing:
  - Increases activity in line with demographics
  - Adjusts for Five Year Forward View must dos, inflation and efficiency requirements

2020/21 financial challenge

Do something

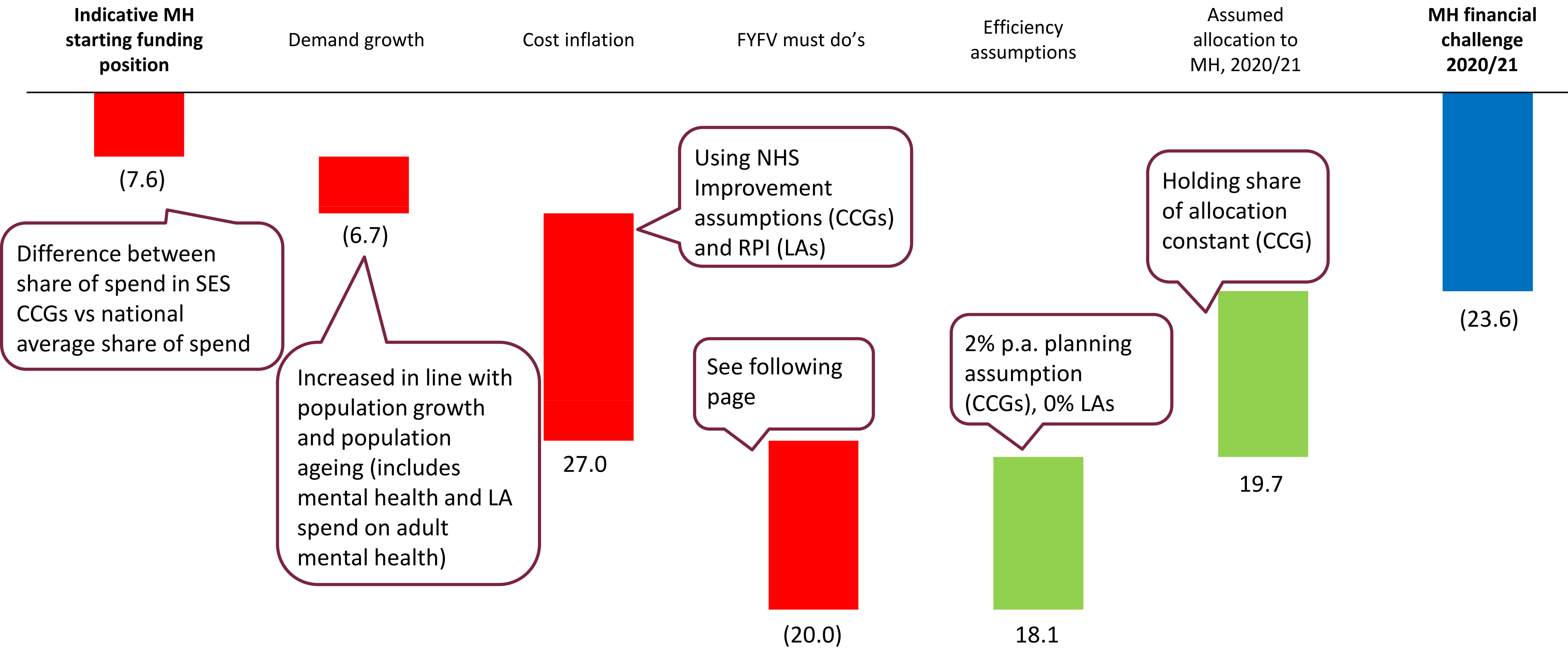
- Do something adds the effects of the twelve opportunities
- Revenue effects estimated with the clinical and financial groups
- Investment estimated locally and triangulated with experience elsewhere
- The model estimates further gain from reducing system variation not included in the opportunities
- It estimates the effects of the opportunities on acute (physical) hospitals and primary care

2020/21 financial surplus

- Model structure tested and validated with finance and modelling group
- Do nothing assumptions tested and validated with finance and modelling group
- Activity assumptions from opportunities sourced from literature/ local experience, then tested and validated with clinical and professional group
- Financial effects of opportunities tested and validated with finance and modelling group

Source: Carnall Farrar analysis

The “do nothing” bridge predicts a £23.6m financial challenge by 2020/21



Included in the bridge are:

- All spend outside the block contract by CCGs on mental health care and block contract spend on CAMHS and specialist services
- The cost to the trusts of providing adult mental health services within the block contract
- Local authorities adult mental health spend

Source: CCG data returns, provider data returns, Carnall Farrar analysis

We estimate that implementing the Five Year Forward View for mental health would cost £20m

Area	Target	Cost basis	Cost
Crisis	• All areas will provide crisis resolution and home treatment teams (CRHTTs) delivering a 24/7 service	• Expanding current costs	£2.4m
Acute	• All acute hospitals will have all-age mental health liaison teams in place, and at least 50% of these will meet the 'Core 24' service standard as a minimum	• Expanding teams from 10 hour cover	£3.2m
IAPT	• 75% of people are able to access treatment within 6 weeks, 95% within 18 weeks; and at least 50% achieve recovery across the adult age group • 25% of people with common mental health conditions are able to access psychological therapies	• Increase in appointments at 80% marginal cost	£9.1m
EIP	• At least 60% of people with first episode psychosis starting treatment with a NICE-recommended package of care with a specialist early intervention in psychosis (EIP) service within 2 weeks of referral	• Minimal – target being met now	£60k
Primary Care	• New mental health therapists will be co-located in primary care	• NHS England funded	0k
Integration	• More people with a severe mental illness receiving a full annual physical health check	• £300/ per person	£1.6m
IPS	• A doubling in access to individual placement and support (IPS), enabling SMI patients to find and retain employment	• £2,700 per person	£3.7m
ECRs	• Out of area placements will be eliminated for acute mental health care	• Assumed within current bed base	£0m
Suicide	• Reduced suicidal rate by 10% supported by local multi-agency suicide prevention plans	• Investment allocated already	uncosted

Source: Mental Health Five Year Forward View 2016

This framework offers an opportunity to achieve significant financial benefit in a "do something" scenario with investment paid back by 2020/21

- A recurrent investment of £7.3m in the 12 interventions will deliver £17.5m pa of gross savings for CCGs alone
- These savings flow from significant reductions in the requirement for inpatient beds, crisis contacts and A&E liaison contacts
- In turn these interventions will reduce the cost of services provided by the local authorities by £6.7m
- As part of the development of this financial strategy, CCG and STP place finance and commissioning leaders have agreed in principle that they will all pay the same unit charge for the same unit of service
- This standardisation allows providers to rationalise delivery models to achieve efficiency improvement, over and above that expected by the NHS annual contracting process. The impact of this is an annual saving of £9m pa across the provider system
- Combined, these impacts lead to the elimination of the 'Do Nothing' deficit by 2020/21
- Further benefits also flow to the acute sector through the reduction in the numbers of people attending A&E, requiring a bed in the acute hospital and requiring treatment in the acute setting for their dementia. This is an additional benefit to the acute sector of £11.7m pa.
- This assessment does not include the potential benefits of prevention. These will be longer term benefits that will also flow from this strategic framework and add to the positive impact

Source: Carnall Farrar analysis

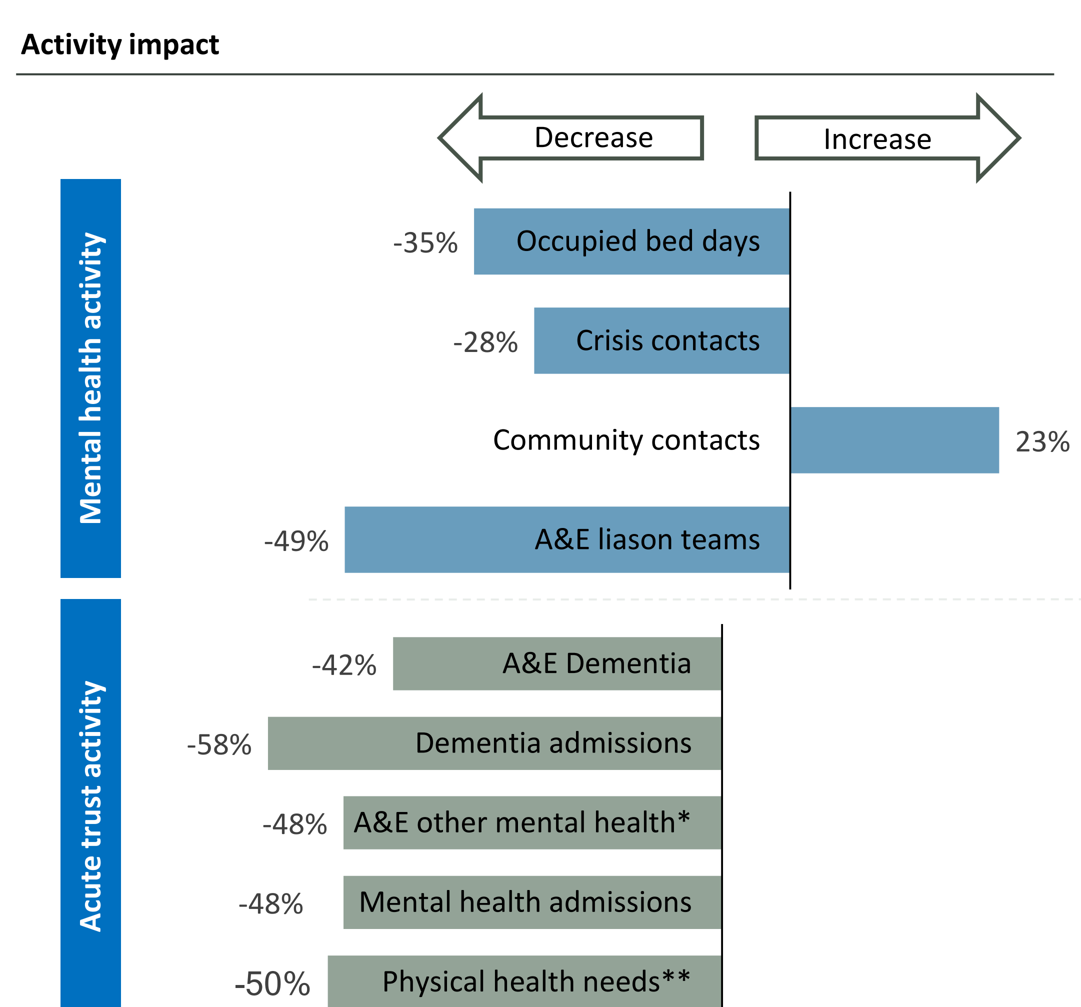
The 12 opportunities will provide a gross saving of £17.5m, investment of £7.3m and net savings of £10.2m for CCGs

	Financial Impact (£m)	Impact when considered alongside other opportunities	Gross financial impact (£m)	Investment (£m)	Net savings (£m)
1 Prevention	TBD	TBD	TBD	TBD	TBD
2 Suicide prevention	2.6	100%	2.6	0.3	(2.3)
3 Early identification	(0.8)	100%	(0.8)	0.3	0.5
4 Care coordination	(6.7)	100%	(6.7)	2.7	4.0
5 Access to psychological therapy	(3.0)	100%	(3.0)	1.1	2.0
6 Single point of access	(1.3)	100%	(1.3)	0.5	0.9
7 Integrated care	(2.1)	100%	(2.1)	0.7	1.4
8 Crisis	(3.1)	50%	(1.5)	0.7	0.9
9 Housing and employment	(1.0)	100%	(1.0)	0.2	0.7
10 Recovery care model	(2.3)	100%	(2.3)	0.8	1.5
11 Acute placements	(0.4)	100%	(0.4)	0.2	0.2
12 Specialist placements	£1.2	TBD	£1.2	TBD	1.2
Total	**(19.4)**		**(17.5)**	**7.3**	**(10.2)**

Note: Specialist placements are expected to have a saving of £1.2m in 2017/18, and potential additional savings in 2020/21

Source: Carnall Farrar analysis

Cumulatively, this equates to reductions in occupied bed days, A&E attendances and crisis contacts, allowing increased community contacts



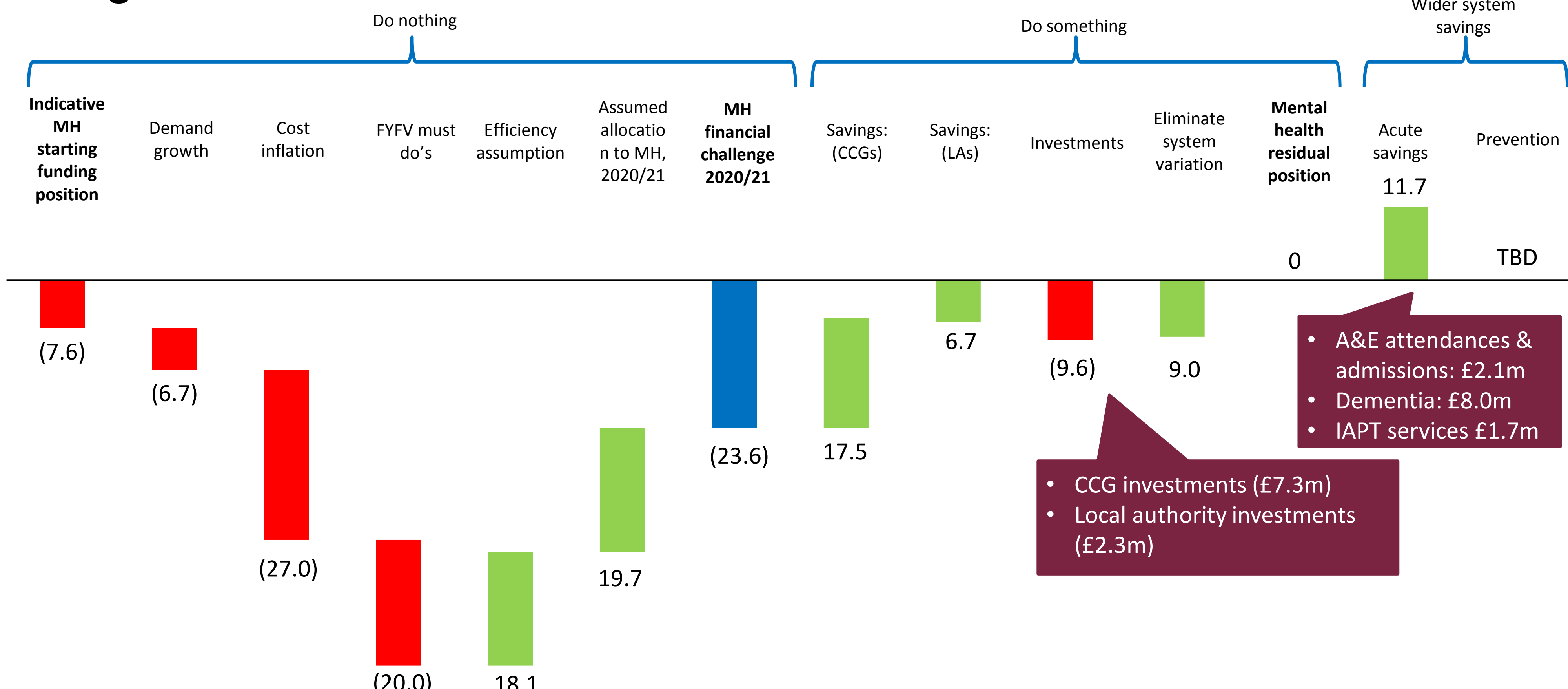
- For mental health trusts implementing opportunities there will be:
  - A decrease in the number of occupied bed days in mental health trusts
  - A reduction in crisis contacts
  - An increase in community contacts
  - A reduction in patients seen by A&E liaison teams

- For physical health care settings implementing opportunities there will be:
  - A decrease in attendances for dementia patients and patients with other mental health needs
  - A decrease in admissions for patients
  - A decrease physical health care cost for those people with long term conditions, by supporting their resilience through IAPT

* A&E attendances with a primary mental health diagnosis; ** Due to increase IAPT activity

Source: Implementing the mental health five year forward view, Carnall Farrar analysis

Our opportunities eliminate the system deficit in mental health and contribute savings of £11.7m in the acute sector



Included in the bridge are:

- Saving to mental health trusts due to impact of opportunities
- A 20% saving to local authorities due to the impact of opportunities on reducing physical deterioration, hence social care spend on on home care and residential care
- Investments 35% of total savings from local authority and CCGs

Source: Carnall Farrar analysis

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The delivery roadmap lays out who should lead on what action, and the proposed timelines to deliver the opportunities

Responsibility for taking forward an opportunity covers planning and ensuring delivery, not necessarily delivery itself. Lead responsibility for the opportunities sit across five types of organisation. Just as the places are taking on the lead responsibility, within an accountable care system, for those with less complex common conditions and dementia, the mental health trusts should lead accountable care systems for those with complex conditions and psychosis.

The places should integrate further opportunities for common mental health conditions and dementia into their plans.

Immediate planning and early implementation activities are required for integrated physical and mental health and reductions of specialist placements to support early implementation work in 2017/18.

Crisis support, recovery care model and suicide prevention are the three opportunities with the greatest potential to deliver swiftly as full projects beyond an early implementation phase from 2018/19

- Implementing crisis support swiftly will relieve pressure on other parts of the system, improve care and meet five year forward view
- The existing recovery colleges in Sussex and Surrey can be expanded
- Coordinating and sharing resource could improve the implementation of existing local authority plans to reduce suicide

The remaining nine opportunities will take longer to scope, plan and roll out, and will be supported by four enablers. Support from Health Education England NHS England will be requested for workforce development activities.

Financial benefits associated with the phased approach to 2020/21 show a £15.9m improvement compared with the do nothing scenario. This is net of investment required to deliver each opportunity area.

To ensure successful and rapid implementation from 2017/18, governance for mental health will be revised to link more closely with place based planning and STP governance structures. A delivery and implementation subgroup should support the mental health steering group.

Responsibility for taking forward an opportunity covers planning and ensuring delivery, not necessarily delivery itself

Responsibility

- Sets out which organisation is responsible for planning, and ensuring the delivery of, each opportunity identified in the strategic framework. That lead organisation should:
  - Define standards and outcomes
  - Lay out how the opportunity complements and coordinates with other opportunities for each cohort of service users (e.g., how the opportunities fit into pathways)
  - Balance local customisation of the opportunity for local circumstances with the scale benefits of a standardised approach
  - Ensure that, where lead responsibility for an opportunity differs between cohorts, a coordinated approach is taken for implementing that opportunity (e.g., specifications for housing and employment services are as similar as possible for those with dementia and those with psychosis)
- Will follow national guidelines (where these exist) and evidence

Supports

Delivery

- Creates detailed planning and interventions to provide care per commissioning parameters
- Makes use of economies of scale for services that are similar across the STP
- Takes advantage of population knowledge and engagement to tailor local services
- Reports to accountable organisation(s)

Source: Carnall Farrar analysis

Lead responsibility for the opportunities sit across five types of organisation

Responsibility

1. STP

For all mental health clusters

- Crisis support
- Recovery care

For complex conditions and psychosis

- Access to whole pathway psychological therapy

2. Place based ACS

For all mental health conditions

- Primary prevention and resilience
- Early identification and intervention

For less complex common conditions and dementia

- Proactive care coordination planning and support
- Single point of access
- Integrated physical and mental health care
- Housing and employment

For less complex common conditions

- Access to whole pathway psychological therapy

3. Mental health trust led ACS

For all mental health clusters

- Eliminate out of area acute placements

For complex conditions and psychosis

- Proactive care coordination planning and support
- Single point of access
- Integrated physical and mental health care
- Housing and employment

4. Local authorities

For all mental health clusters

- Suicide prevention

5. CCGs

For all mental health clusters

- Reduce out of area specialist placements

Supports

Delivery

uses local knowledge, tailored delivery and economies of scale to meet requirements

Source: Carnall Farrar analysis

The four places will need to integrate opportunities for common mental health problems and dementia into their plans

	Description	Place based interventions	Mental Health additional opportunities
Ageing population	Focuses on dementia	• Falls prevention • Reablement • Care coordination • Timely access to diagnostics • Access to expert opinion • Facilitation of transitions of care	• Recovery college - Support development of dementia specific courses, e.g., understanding dementia; living with memory loss - Refer into relevant courses • Housing and employment
Urgent Care	Creates integrated 24/7 urgent care	• Rapid response • Single point of access • Mental health liaison	• Rapid response - Set protocols to triage to/ refer into crisis teams • Single point of access - Set protocols to triage to/ refer into mental health services - Train/ recruit appropriately skilled staff
Prevention and community development	Takes life course approach to prevention	• Build knowledge and change behaviours • Falls prevention	• Primary prevention and resilience - Use mental health expertise to support MH early wellbeing & support and loneliness & isolation interventions
Local Community Networks	Develops and implements an LCN framework that: • Defines priorities • Describes outcomes • Identifies opportunities	• Bring integrated health and social care into the home	• Access to whole pathway psychological therapy • Refer into Recovery College courses for common mental health conditions • Integrated physical and mental health care - Offer psychological therapies to those at risk of anxiety/ depression (e.g., those with physical comorbidities)

Note: Additional opportunities complement Coastal Care's delivery plan; assumed that the mental health trusts continue to deliver Recovery College
Source: Coastal Care Delivery Plan; Carnall Farrar analysis

Our workshop session on place support for dementia highlighted four cross cutting themes

Theme	Activity
People using services	• Provide access to a named worker, who is a single point of contact across primary, secondary and social care • Help carers by providing services to support their own mental health • Reduce stigma associated with dementia diagnosis, by offering positive support and advice from day one • Educate service users, carers and the wider public about care available in the community • Provide accessible information including signposting to information
Service access	• Facilitate quick and ready access to GPs for patients with dementia • Create dementia friendly communities with dementia friends • Provide cognitive behaviour therapy and physiological therapies for patients and carers • Offer respite care to carers • Improve post-diagnosis support
Whole system approach	• Enable early discharge planning and care planning for patients with dementia, which incorporates primary and secondary care • Incorporate end of life planning into care plans developed from diagnosis with the person • Encourage self-care and signposting to support and advice to self-care • Educate care homes so they are held to account on the level of care they provide, and support them to provide effective care to people with complex needs • Work with frailty and emergency pathways to include dementia support • Reduce the bureaucracy that patients and carers face
System support	• Commission strategic dementia services consistently • Understand services currently available, who provides them and their differences • Plan services for the future predicted demand beyond 2020/21 • Incorporate mental health needs into risk stratification

Source: System wide mental health workshop 25 September 2017

Crisis support, recovery care model and suicide prevention have the greatest potential to deliver swiftly following early implementation of other opportunities

Early planning and implementation

- **Integrated physical and mental health care –** expand psychological therapies to provide evidence based IAPT treatments for common mental health conditions and long term conditions; expand innovations to co-locate psychological provision within physical health care services per parity of esteem (e.g. Time to Talk and Health in Mind)
- **Reduce out of area specialist placements –** begin early work to reduce specialised placements; determine housing options
- **Reduce out of area (non-specialist) placements –** commence capacity planning with early implementation in 2018/19

Crisis support with improved out of hours access

- Identify high risk groups and design and co-produce crisis plans with individuals and professional teams
- Design joint crisis plan to mitigate consequences of relapse, including admission to hospital and use of the Mental Health Act
- Help people get appropriate psychological treatment and care and help carers get support in the community
- Ensure equity of access
- Provide out of hours help to people and their carers acting as an alternative to A&E and/or hospital admission
- Expand 24 hour access and existing models (e.g. street triage, crisis café, crisis houses)

Recovery care model

- Adopt the recovery and discovery college model with the involvement of peers, carers and family to support people
- Provide educational courses and promote self management
- Involve carers more actively involved in the wider team that provides treatment and observation
- Secure greater involvement of peer and peer support within services and pathways to support a recovery model
- Provide accessible information with clear routes to obtain it
- Create real time user feedback using a “tripadvisor” approach

Suicide prevention

- Work with health and wellbeing boards to support existing plan delivery for each local authority
- Determine barriers to implementation and demographic differences across the STP
- Deliver existing suicide prevention plans led by local authorities
- Train gatekeepers, (e.g. teachers/ police officers) and training for workers in physical health to embed suicide prevention activity
- Target support for high-risk people in the community
- Train and support professionals in primary care settings to identify and refer people at risk

Source: Carnall Farrar analysis

Implementing crisis support swiftly will relieve pressure on other parts of the system, improve care and meet five year forward view (1/2)

Model

- Crisis support:
  - Provide support in a crisis through crisis home treatment teams
  - Provide triage (to be linked later to the single point of access) for those not in contact with secondary care, including expansion of street triage
- Crisis home treatment teams:
  - Consist of multidisciplinary teams, so the most appropriate person can be contacted in a crisis
  - Operate 24/7 by expanding current services
  - Support carers of those in crisis, by having appropriately trained staff
  - Cover an area of approximately 150,000 people; depending on the geography and the local population needs
- Crisis plans (for those in regular contact with secondary care that require dedicated access):
  - Involve patient and carers in their development, including dementia planning supported by the places
  - Make plans accessible to all those involved in the persons care
- Development of electronic care records will allow for the MDT and mental health practitioners to support each other

Approach and Specification

- Crisis Support
  - Develop a service specification and outcome metrics for crisis service
- The crisis home treatment teams:
  - Operate in a local area, that is local enough so the team is able to access all patients and large enough to create the demand for the service
  - Plan to work in ways that allow teams to link with acute trusts and their liaison services, to allow for flexibility in team size
  - Commission teams to a single standard, service specification and unit price
- Crisis plans:
  - Make plans understandable all by those involved in a person care, so they can be used by the appropriate person
  - Standardise plans across the system so they can be used by anyone within the system

Source: Implementing the Five Year Forward View, Carnall Farrar analysis

Implementing crisis support swiftly will relieve pressure on other parts of the system, improve care and meet five year forward view (1/2)

Funding

- For crisis home treatment teams:
  - Fund teams based on the population which will be served by that team
  - Determine the cost of providing a team
  - Agree on a system unit price which will apply to all CCGs and ensure accountability to the standards
  - Distinguish additional costs that a team occurs due to local factors from the unit costs to allow for a differentiation between the two
- For crisis planning:
  - Determine the additional time that is spent with patients in developing plans, and the costs associated with this

Workforce

- For crisis home treatment teams:
  - Determine a workforce model for the MDT, expecting that a team will consist of consultant psychiatrist, mental health nurses, approved mental health professionals, occupational therapist and peer supporters
  - Support the mental health of its own staff to increase their resilience
  - Network to allow for the sharing of best practice and learning opportunities
  - Recruit new staff and train existing staff with support from the workforce development enabler (e.g. Health Education England)
- For crisis planning:
  - Determine who will be involved in the development of crisis plans
  - Determine what additional time will be required to create and review crisis plans

Implement

- For crisis home treatment teams:
  - Roll out new ways of working in known geographical areas
  - Review the current crisis teams and meet additional staffing required to provide a 24 hour service
- For crisis planning:
  - Roll out the template for crisis plans that can be used across the system
  - Review use of crisis plans to meet required outcomes and revise as required over the course of the project
- Initiate pilot and review outcomes
- Begin monthly reporting

Source: Implementing the Five Year Forward View, Carnall Farrar analysis

Crisis support: high level workplan

2017/18		2018/19				2019/20				2020/21			
Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4

Model

- *Create model for crisis support, home treatment teams, crisis plans, triage*
- *Determine care record requirements*
- *Agree 24 hour services to roll out/ expand*

Approach and specification

- *Develop common service specifications with standard unit costs*
- *Link home treatment teams with acute trusts and liaison services*
- *Create standard crisis plan templates*

Funding

- *Agree unit prices and costs to apply across CCGs*
- *Agree funding for crisis teams based on expected served populations*

Workforce

- *Determine workforce model – link to workforce development enabler*
- *Determine roles for crisis plan development with people who need them*
- *Provide support to maintain staff resilience*
- *Recruit new staff and train existing staff*

Implement

- *Begin operation in agreed geographical areas*
- *Begin 24 hour service provision*
- *Begin monthly reporting*

Transition to business as usual

Source: Carnall Farrar analysis

The existing recovery colleges in Sussex and Surrey can be expanded

Model	• Create an easy to access prospectus to allow potential students to determine what courses are suitable for them • Provide access to same courses across Sussex and East Surrey, to minimise service variation • Allow students to easily register and book on courses, using phone, post or email • Develop individual learning plans with students to allow them to get the most from their course • Support students in attending the course and understanding the material, if they would have difficulties • Run courses which are co-produced and co-facilitated, including for people with dementia • Reward students on the successful completion of a course • Provide courses for across all ages ranges and all conditions (e.g. Discovery College)
Approach and Specification	• Decide what additional courses (e.g. for dementia) or expansion of existing courses are required • Provide courses to services users (primary and secondary care), carers and the mental health workforce • Co-produce courses with those with lived experience, including content and logistics • Create working partnerships between the secondary sector and other organisations to produce a broad service • Enable those who would benefit from the services access to the service • Provide the infrastructure required to deliver courses • Develop a quality framework to measure the impact of the courses
Funding	• Decide what addition funding is required for core staff, clinical and peer trainers • Agree a funding model with CCGs to provide an expanded service • Determine what available space can be used to deliver courses
Workforce	• Establish what additional staffing and/or training is required – link with the workforce development enabler • Employ core staff to oversee the college • Prepare peer trainers, occupational therapist and psychologists to run courses • Design and run training for peer trainers, to help them better deliver courses
Implement	• Roll out based on additional courses required and geographies to be served • Make use of additional space required to deliver courses • Begin monthly reporting

Source: Carnall Farrar analysis

Recovery College: high level workplan

2017/18		2018/19				2019/20				2020/21			
Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4

Model

- *Create prospectus for expanded recovery model support across the STP footprint*
- *Develop expanded registration and learning materials*
- *Co-produce any new course models required*

Approach and specification

- *Specify roles for people receiving courses and their carers*
- *Create working partnerships with the third sector*
- *Develop a quality framework to measure service impact*

Funding

- *Confirm additional funding required for staff, peer trainers and venues*
- *Agree CCG funded model for expanded recovery service*

Workforce

- *Employ core staff to oversee expanded college activities/ geography*
- *Prepare peer trainers and staff to run courses – link to workforce development enabler*
- *Support peer trainers to help other people provide support*

Implement

- *Roll out based on expected demand for new courses/ locations*
- *Agree and use additional space required for expanded delivery model*
- *Begin monthly reporting*

Transition to business as usual

Source: Carnall Farrar analysis

Coordinating and sharing resource could improve the implementation of existing local authority plans to reduce suicide

Model	• Bring together existing suicide prevention plans and coordinate planning between local authorities, including roles for public health (including improvements to signposting, support access and referral options) • Quality assure current plans, ensuring the best outcome measures are in place • Ensure that there is suitable workstream support to deliver suicide prevention plans
Approach and Specification	• Appoint a lead for Sussex and East Surrey to co-ordinate delivery of existing suicide prevention plans • Develop links with SECAMB/ 999 to provide alternatives to ambulance use • Create a local media approach, including TV, radio and local publications to raised awareness of suicide • Develop a training programme for local gatekeepers • Focus on preventing suicide for people with dual diagnosis and/or those in contact with mental health services • Determine what targeted support can be provided to reduce self harm and improve support for people affected by suicide • Develop training and support to those in mental health settings • Follow agreed governance for suicide prevention to allow for whole system implementation of plans
Funding	• Implement plans per agreed funding mechanisms at local authority level • Agree requirements for implementation support from the STP
Workforce	• Determine training needs across sectors for those in physical healthcare settings and gatekeepers in the community • Provide a system wide network for suicide prevention, to allow for sharing of learning experiences and improve resilience
Implement	• Implement per existing local authority plans, with coordinated support across the STP to avoid duplication of effort • Follow annual action plans set out in existing suicide prevention plans for each local authority • Develop local networks with representative groups, individuals and organisations to support delivery • Track action plans to monitor suicide patterns and begin impact assessments, revisiting approach as required

Source: Local authority suicide prevention plans and Carnall Farrar analysis

Suicide prevention: high level workplan (based on existing local authority plans)

2017/18		2018/19				2019/20				2020/21			
Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4

Model

- *Bring together existing local authority suicide prevention plans to improve signposting, support access and referrals*
- *Quality assure current plans with health and wellbeing boards and determine barriers to implementation*
- *Determine STP workstream support to deliver each plan*

Approach and specification

- *Appoint suicide prevention lead to support links with SECAMB*
- *Determine targeted support options, including training needs*
- *Determine media campaign and awareness raising approach*

Funding

- *Implement suicide prevention plans per agreed funding mechanisms at local authority level*
- *Agree requirements for implementation support*

Workforce

- *Determine training needs across care settings*
- *Determine roles and training needs of gatekeepers*
- *Create system network for colleague and peer shared learning*

Implement

- *Follow existing local authority implementation plans*
- *Use annual action plans with existing suicide prevention strategies*
- *Develop local networks across representative groups and organisations*
- *Track progress with monthly reporting*

Transition to business as usual and continue to follow local authority plans to 2020/21

Source: Carnall Farrar analysis

The remaining nine opportunities will take longer to scope, plan and roll out

In 2017/18 early implementation work will begin (or continue) for integrated physical and mental health care plus reductions in specialist placements

Crisis support, recovery care model and suicide prevention are the three opportunities with the greatest potential to deliver swiftly, and hence should be implemented from early 2018/19

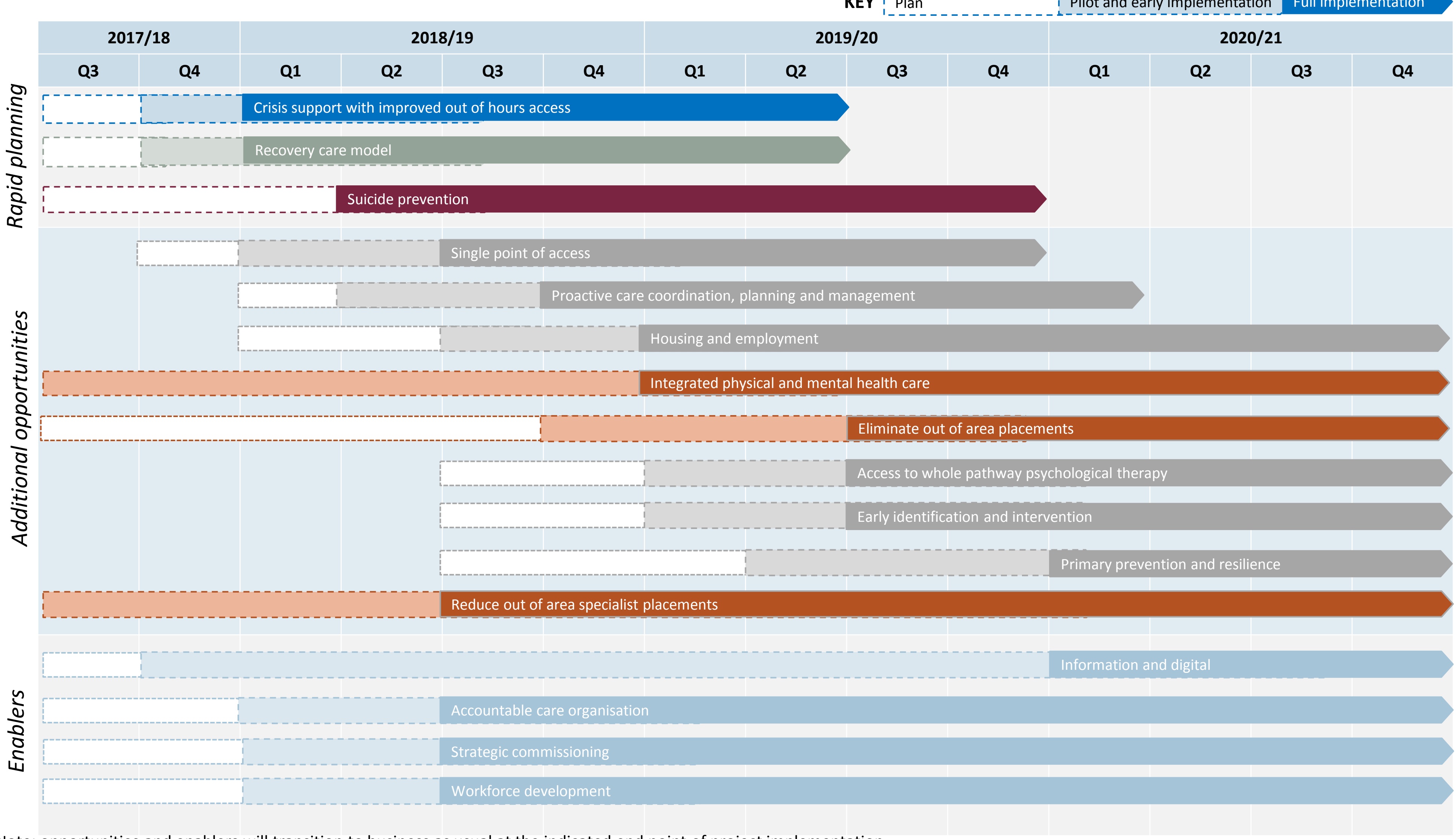
During 2017/18 and 2018/19, work should start to further scope and plan implementation of the remaining nine opportunities. Implementation of these nine should begin from mid 2018/19:

- In 2018/19 delivery will begin for single point of access; proactive care coordination; reduced out of area specialist placements
- In 2019/20 delivery will begin for housing and employment; integrated physical and mental health care; eliminate out of area placements; access to whole pathway psychological therapy; early identification and intervention
- In 2020/21 delivery will begin for primary prevention and resilience

The next page outlines the high level workplan plan for all opportunities from 2017/18 to 2020/21 and is followed by enabling activities.

Source: Carnall Farrar analysis

Opportunity planning and delivery will be carried out to 2020/21 for all 12 areas, supported by four enablers



Note: opportunities and enablers will transition to business as usual at the indicated end point of project implementation

Source: NHSE five year forward view for mental health; Carnall Farrar analysis

Our STP is organised into four places that will share savings and investments for areas included in their plans

The nature of our STP is built on four places that will take responsibility to oversee delivery of relevant opportunities for dementia and common mental health:

For all mental health clusters
- Primary prevention and resilience
- Early identification and intervention

For common conditions and dementia
- Proactive care coordination planning and support
- Single point of access
- Integrated physical and mental health care

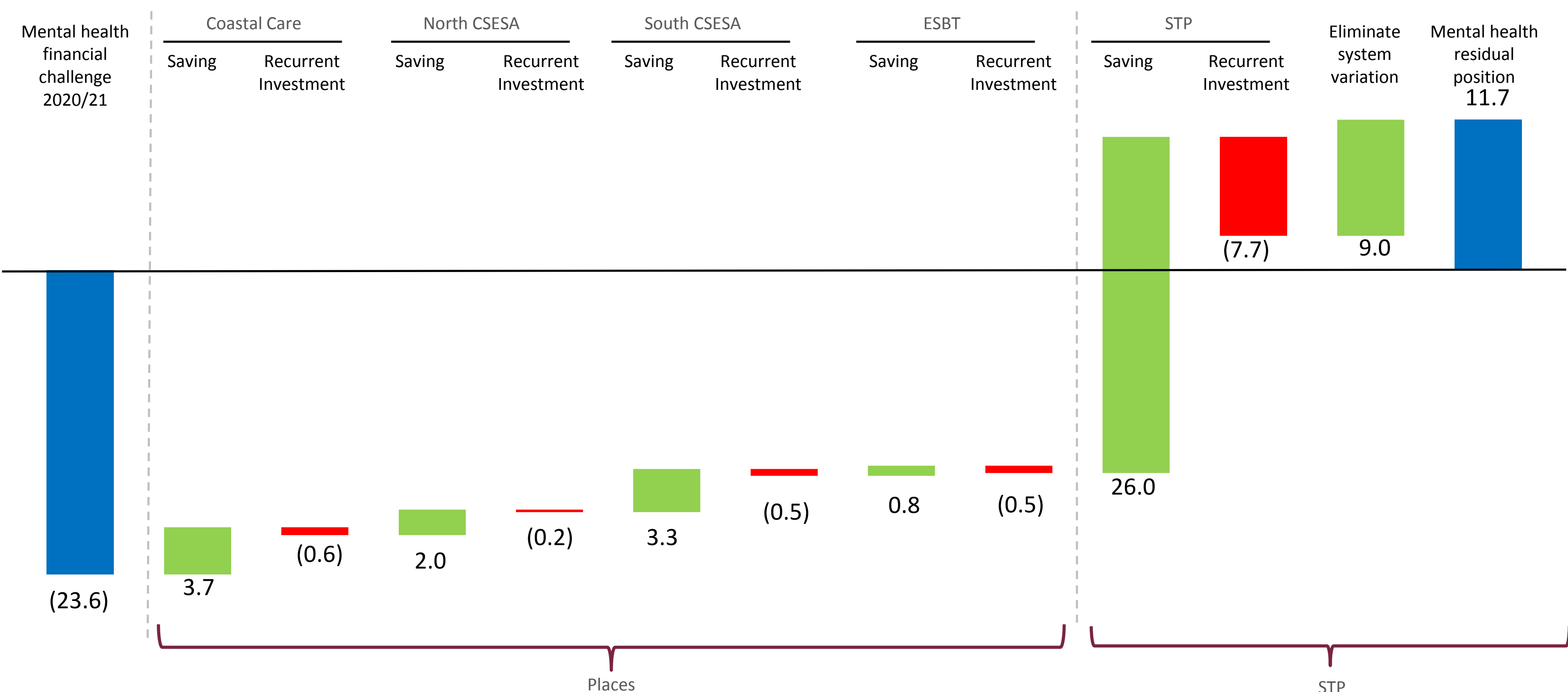
For common conditions only
- Access to whole pathway psychological therapy

Savings generated and investments required for these relevant opportunities in the “do something” scenario will be realised in the four places.

The following slide indicates the breakdown of savings and investments by place to 2020/21 against the ”do nothing” challenge of £23.6m. Remaining savings and investments relate to opportunity areas where responsibility lies across the STP as a whole. In addition, system variation reductions contribute to the forecast net position of £11.7m surplus.

Source: Carnall Farrar analysis

Each place and the STP as a whole will share investment and savings associated with the mental health opportunities

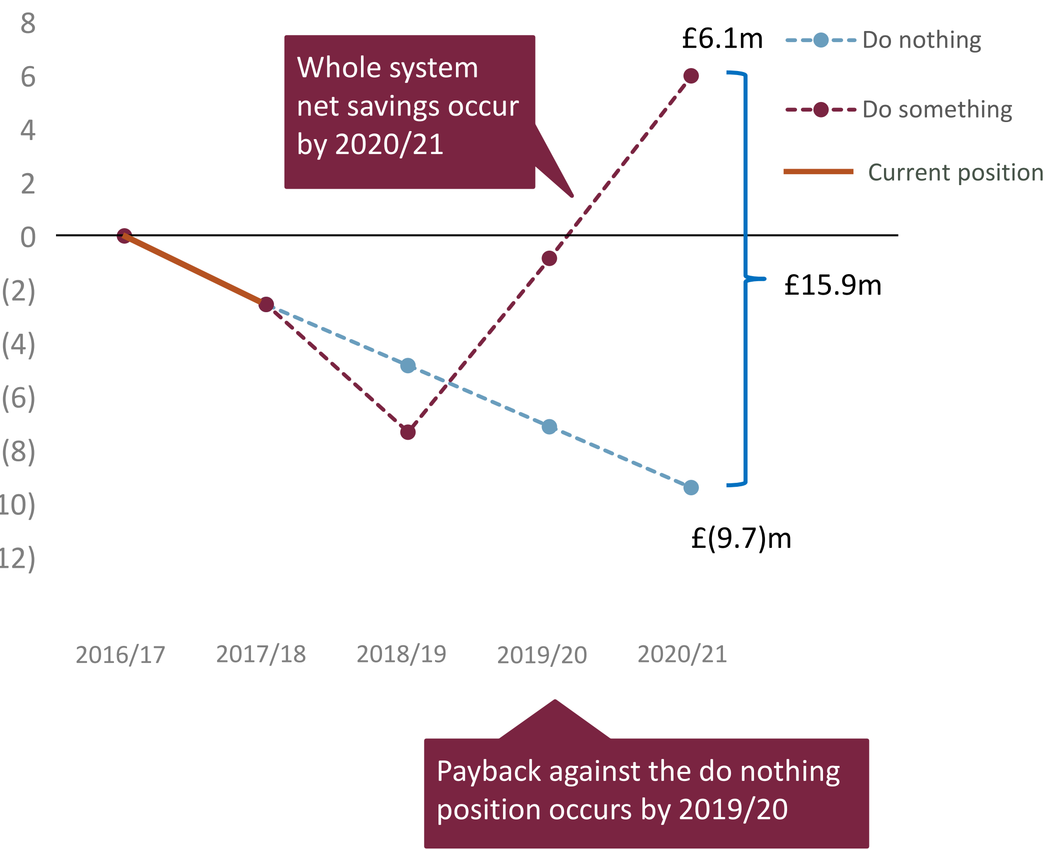


Places: Includes opportunities which are accountable at place or local authority level, including 1) early identification and intervention (all conditions) 2) proactive care co-ordination, single point of access ,integration (common conditions and dementia) 3) psychological therapy (common conditions), 4) impact in mental health trusts from suicide prevention, 6) Acute savings from 11 place based intervention (excluding ESBT)

STP level: Includes opportunities which are accountable at the STP level or accountable care organisation 1) crisis support, recovery care (all conditions) 2) psychological therapy (complex conditions and psychosis), 3) out of area placements 4) housing and employment 5) proactive care co-ordination, single point of access, integration (severe and enduring mental illness) 6) local authority savings on adult mental health (assumed saving are from those with complex condition and psychosis) 7) Impact in physical health care setting from IAPT services and reduction in A&E attendances

Upfront investment is required to deliver savings that will be realised by 2020/21

System return on investment phasing
(£m)



- Between all the CCGs, an investment of £15.7m (average £2.0 for each CCG) is needed in 2018/19
- From 2020/21 there will be a net benefit in each year, as the cumulative impact will outweigh the cumulative investment

Source: Carnall Farrar analysis

The four enablers will support opportunity development and delivery for mental health

Information and digital activities will based on existing STP plans, including the digital roadmap. This will include:

- Includes implementation of the digital roadmap, analytics requirements, payment considerations and information capability

An accountable care system for severe and enduring mental illness needs to be agreed to support relevant opportunity areas

- Includes phases to move from scope to roll out with the need for an agreed care model and use of pilots

Strategic commissioning requires collective agreement of relevant opportunities with standardised planning and strong decision making

- Includes STP establishment of a joint commissioning strategy, design of joint governance and role definition requirements

Workforce development will draw on multiple areas of support with planning based on necessary skills before staffing requirements are determined

- Includes development of actions plans, support from Health Education England, upskilling and retention activities

Further detail on each enabler can be found on the following pages

Source: Carnall Farrar analysis

Information and digital activities will be based on existing STP plans, including the digital roadmap

Data

- Implement the STP digital roadmap
- Establish information governance to permit data sharing at patient/ user level
- Extract mental health data (including primary and secondary provider/ community/ social care)
- Create re-identification ability for direct care and update data monthly
- Follow existing STP process to produce a static one year snapshot of patient level data

Information use

- Undertake advanced analytics for segmentation, planning and benchmarking
- Identify front end users and deploy to mental health professionals to support transformation opportunities
- Follow STP digital roadmap to create shared health and care records that include mental health
- Redeploy front end to support named individuals for targeted opportunities (e.g. care coordination, planning and support)

Payment

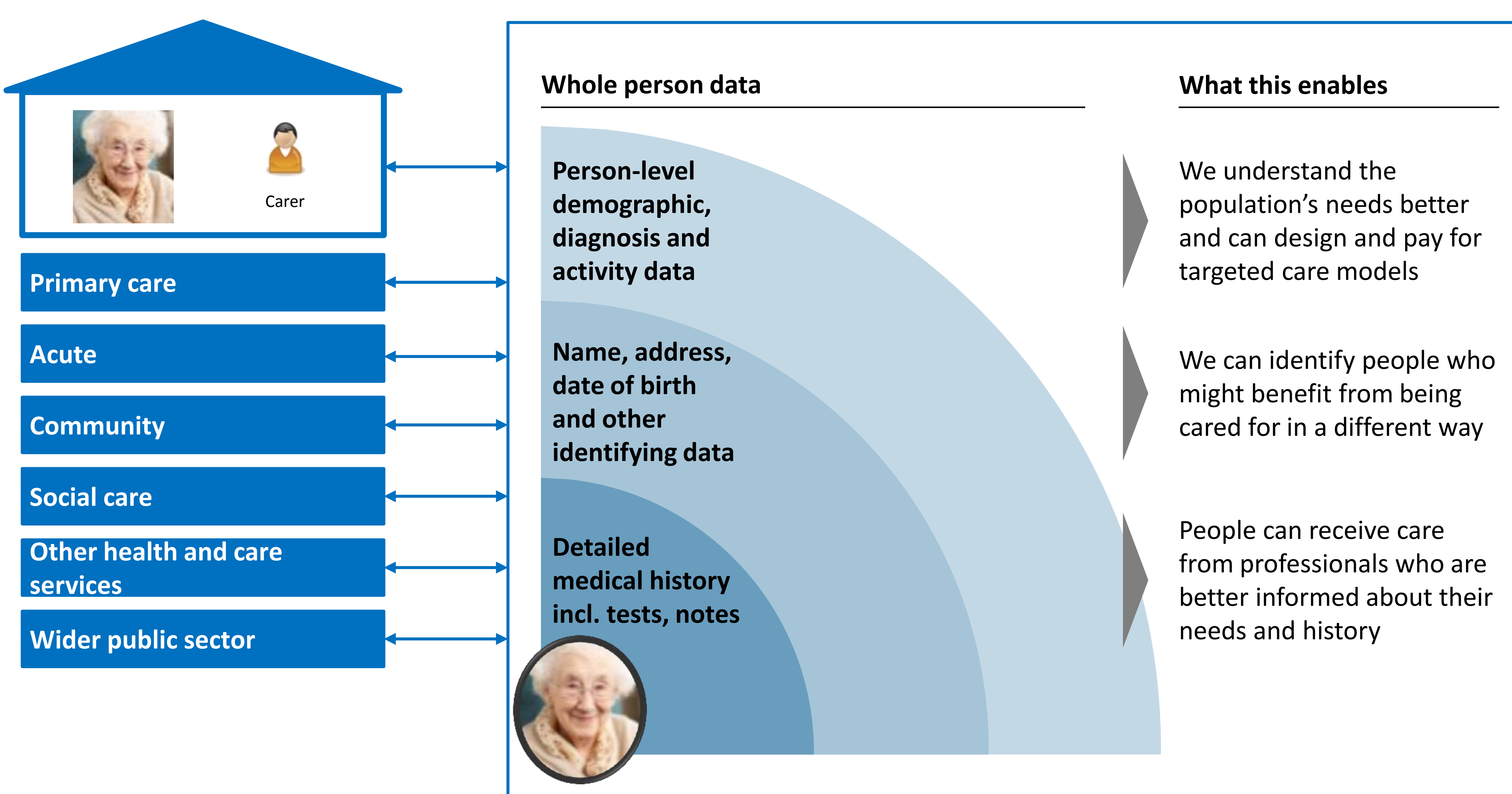
- Support STP illustrative capitation by segment, including common disorders, SMI and dementia
- Engage in shadow capitation calculations and sharing via dashboards
- Link mental health to wider STP transition from shadow to actual capitation

Capability

- Identify information users, clinical champions and non-clinical support
- Assess and build information and data sharing capabilities in the mental health system
- Link mental health data reporting to a mature STP analytics team

Source: Carnall Farrar analysis

Building a 'whole person' view from every part of the mental health and care system will enable core activities of accountable care



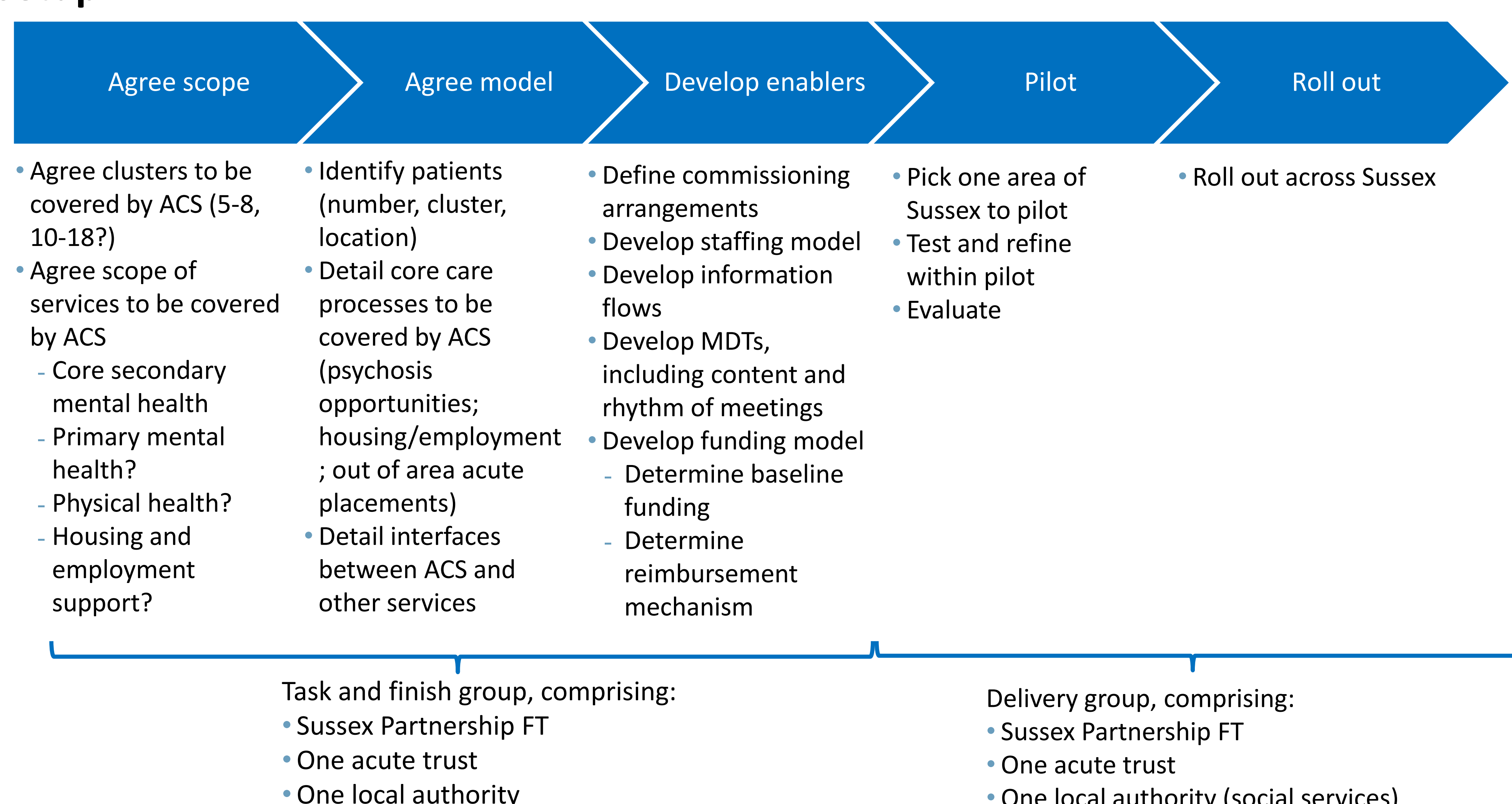
Source: Carnall Farrar

Once data requirements have been determined, decisions about how and when data needs will be accessed impact on the complexity of the solution

	Key choices to make in delivering whole-person data	Complexity: Low		Complexity: High	Drivers of complexity
What information is needed?	Person level outputs?	Person level only	Person + aggregated outputs		• Need for aggregated analysis rules out ad-hoc data retrieval or some approaches e.g. blockchain
	Named records?	Pseudonymised		Identified	• Greater public and clinical engagement and IG work needed for identified data
	Detailed medical history?	Summary data		Detailed care records	• Detail may require deeper integration with clinical systems and more IG + engagement work
How and when will it be accessed?	Regular data refresh?	One-off	Monthly	Live data	• More frequent work with providers to obtain extracts and assure data quality
	Central repository?	Static data		Data warehouse	• Data warehouse requires infrastructure spend and specialist team to maintain
	Accessible user interface?	None	Separate dashboard	Integrated w. systems	• Integrating with e.g. clinical systems requires specialist technology capabilities

Source: Carnall Farrar analysis

An accountable care system for severe and enduring mental illness needs to be setup



Source: Carnall Farrar analysis

Strategic commissioning requires collective agreement of relevant opportunities with standard specifications

Establish joint commissioning strategy	• Create memorandum of understanding across Sussex and East Surrey CCGs • Define collaborative commissioning principles, including standardisation and reduction in service variation • Determine integrated service potential for opportunity areas • Agree areas for health and social care integration
Agree opportunities to be commissioned strategically	• Create standards required from accountable care organisation and/or local delivery partners (for crisis and recovery care) • Determine strategic commissioning requirements at STP-wide and place levels • Work with STP places to support local delivery planning
Design governance for joint decision making	• Determine scheme of delegation and identify any changes required to CCG constitutions • Agree statutory form and standing financial instructions • Set terms of reference, membership and voting arrangements • Determine changes required to existing CCG committee structures • Link commissioning governance with STP-wide and STP mental health governance
Define executive management team and CCG resource implications	• Establish "as is" CCG workforce baseline • Define executive roles (such as shared accountable officer, managing directors, CFO, transformation lead and corporate affairs) • Agree local versus shared functions • Assess costs of future arrangements compared to existing structures • Determine accountability to workforce and roles required (including flexibility for existing posts and sites)
Ensure payments, budgets and enablers are in place	• Determine budget pool(s) and agree risk and investment areas • Update QIPP planning • Design commissioning and contracting arrangements with the accountable care organisation and local delivery partners • Support the workforce enabler and ensure regular staff updates are issued

Source: Carnall Farrar analysis

Workforce development will draw on multiple areas of available support (1/2)

Plan

(providers deliver with HEE support)

- Develop a short and medium term action plan to attract and retain people to work in mental health in Sussex and East Surrey
- Commission focus groups and polls to understand support needs required to increase role attractiveness
- Replicate aspects of the Health Education England return to practice programme to attract people back to mental health
- Create campaigns in advance of annual recruiting rounds to attract newly qualified staff (and people from other sectors)
- Determine and produce mechanisms to ensure individuals provide non-discriminatory care
- *See next slide for further detail on workforce development planning stages*

Upskill

(providers deliver with HEE support)

- Follow NHS England guidance for diverse and highly multi-disciplinary teams with highly skilled specialists
- Work with Health Education England to continue expansion of recently created and new roles (e.g. early intervention workers)
- Promote Leadership Academy courses for psychiatrists/ nurse and AHP consultants/ clinical psychologists and others
- Offer staff resilience training and encourage peer resilience and coaching sessions
- Signal and support working across organisational boundaries to encourage skill sharing
- Provide training for carers to take on responsibilities that do not require specialist training

Source: Stepping forward to 2020/21: the mental health workforce plan for England (2017) – HEE/NHSE

Workforce development will draw on multiple areas of available support (2/2)

Retain

(providers deliver with HEE support)

- Access support from the Health Education England workforce development budget for mental health priority areas
- Review team skill mix across services, ensuring they are fit for purpose and complementary
- Engage with the NHS Employers national retention program (including work with charities to improve staff and carer mental health) and sign up to retention masterclasses for nursing/HR directors
- Determine appropriate activities from the emerging NHS Improvement retention program
- Request support from the Department of Health for improved staff accommodation access (per Naylor review)
- Explore flexible retirement options to retain staff and/or create transition options for junior staff to access skills of retirees

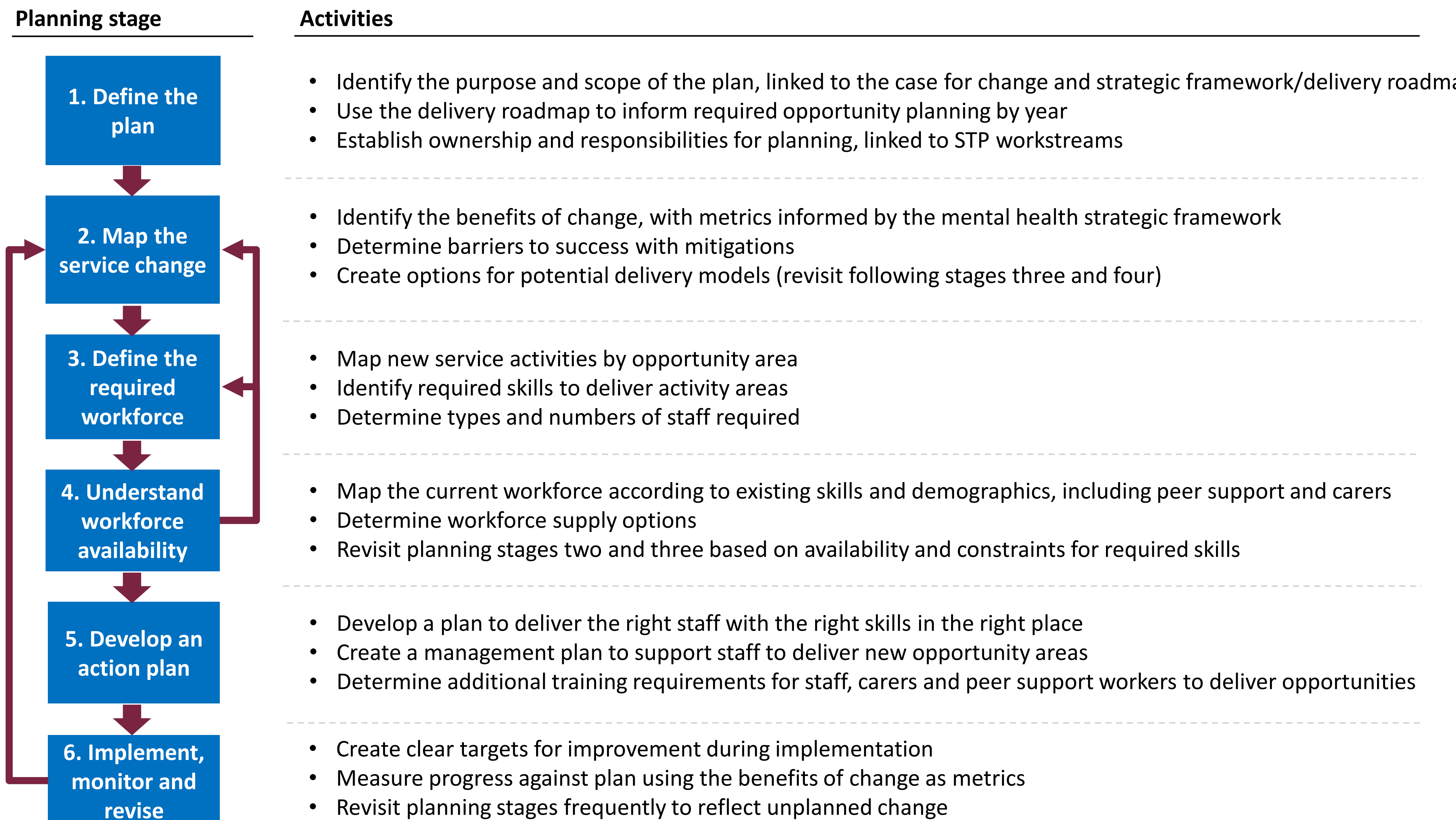
Support

(accountable care organisation delivers with HEE support)

- Access solutions (from NHS England, Health Education England and others) to increase personal assistant support to professionals, reducing admin burden
- Support carers to maintain their own wellbeing and independence, with help from a wider team of professionals
- Create joint working arrangements between pharmacists and consultants to offer prescription advice, support and services
- Include physician associates, peer workers and support workers in teams to focus specialist time on specialist work
- Support senior nurses to work at the top of their licence and use the full range of their skills
- Create board level support roles to develop a learning organisation that encourages progression to leadership roles
- Access alternative training support via Health Education England such as the return to training programme

Source: Stepping forward to 2020/21: the mental health workforce plan for England (2017) – HEE/NHSE

Workforce planning will begin with necessary skills before detailed staffing requirements are determined



Source: Skillsforhealth.org.uk and Carnall Farrar analysis

Existing STP governance structures and each place will support and work alongside the mental health steering group

Opportunity delivery requires momentum supported by wider STP bodies to oversee and ensure successful implementation with the mental health steering group.

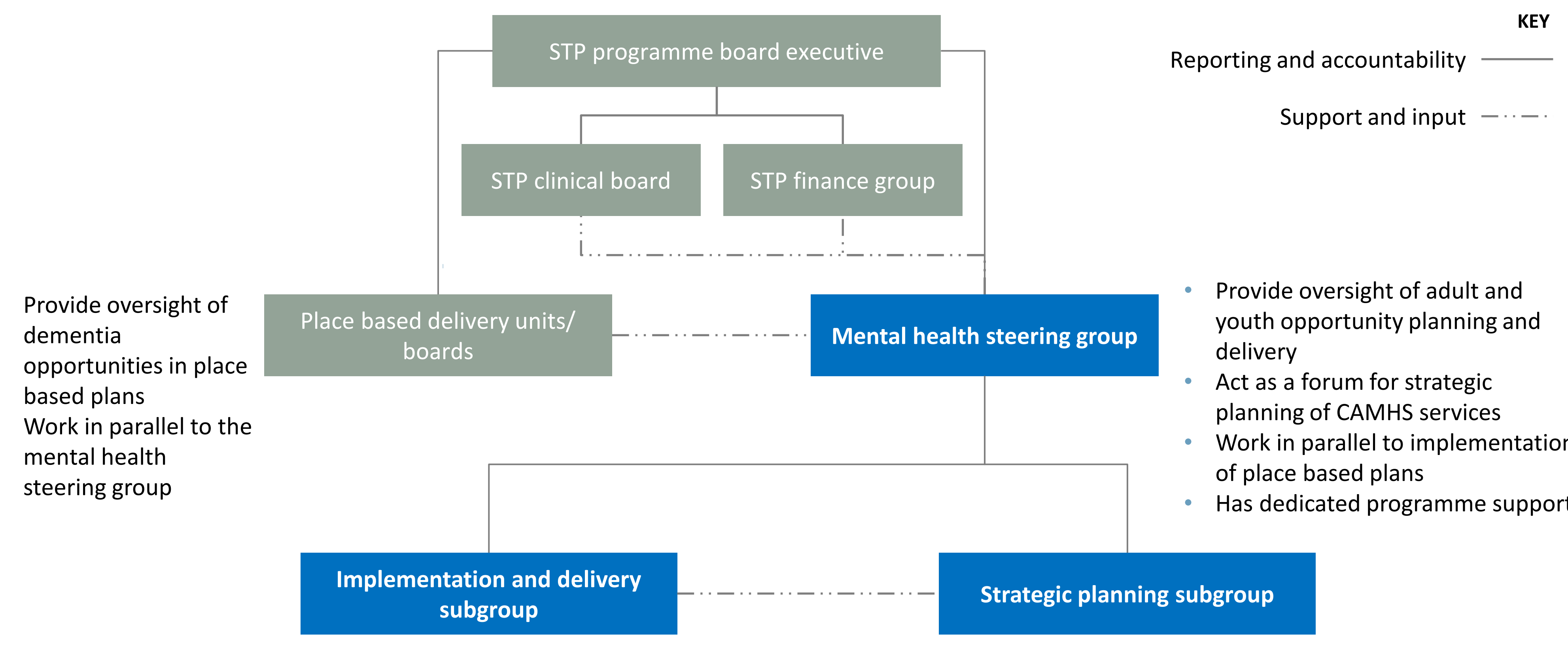
To achieve this we will:

- Work alongside the places to deliver opportunity areas that relate to dementia
- Continue with mental health SRO arrangements to provide leadership and delivery focus
- Update mental health steering group membership to include place based leads
- Form an implementation and delivery subgroup to plan and monitor delivery progress, starting with the three immediate priorities for delivery
- Form a strategic planning subgroup to for CAMHS and regular reporting to NHS England on mental health plan development
- NHS England will provide support to five year forward view delivery (project and programme management)

Proposed governance arrangements involving the places and mental health steering group are outlined on the following page.

Source: Carnall Farrar analysis

Governance arrangements will be linked to wider STP structures and place based planning



- Create detailed implementation plans to meet the delivery roadmap and mental health components of place based plans
- Act as the delivery team for each opportunity area
- Provide ongoing monitoring of delivery metrics to the steering group

- Continue mental health strategic development (including CAMHS) with support from NHS England
- Link strategic planning with place based planning
- Support ongoing NHSE reporting for mental health
- Inform future work for the implementation and delivery subgroup

Source: Carnall Farrar analysis

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Next steps

Our strategic framework and delivery roadmap will support detailed planning and delivery of the opportunities. This will begin with the three immediate priorities for delivery and continue with other opportunities to 2020/21. The three immediate priorities for delivery require focused planning now:

1. Crisis support with improved out of hours access
2. Recovery care model
3. Suicide prevention

To achieve this we will:

- Sign off this framework and delivery roadmap document at the STP programme executive
- Update governance structures for STP mental health and steering group membership
- Setup the implementation and delivery subgroup to plan and support implementation of the three immediate priorities for delivery
- Begin development of an accountable care organisation for mental health, led by mental health trusts
- Seek support from NHS England to develop our strategic review and subsequent plan for CAMHS services
- Request support from Health Education England for workforce development
- Continue to engage with STP information/digital and commissioning workstreams
- Link future work of our steering group with the national transforming care agenda

Source: Carnall Farrar analysis