Annexes: Guidance to help development of 2021/22 proposals for adult and older adult community mental health (CMH) transformation funding

NHS England and NHS Improvement

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Contents

Annex A: Guidance to help development of proposals for adult and older adult community mental health (CMH) transformation funding

1. Overview of process and principles for allocation of funding

As set out in the [NHS Mental Health Implementation Plan 2019/20 – 2023/24](), all STPs in England will receive their 'fair share' of central transformation funding to deliver new models of integrated primary and community mental health care for adults and older adults with severe mental health problems.

This is not a competitive process between STPs. Funding will be provided in 2021/22, 2022/23, and 2023/24, and will be subject to the submission of high-quality plans to regional NHS England/Improvement (NHSE/I) mental health (MH) teams and the national NHSE/I Adult MH Team (AMH Team). Allocation of transformation funding is contingent upon STPs, CCGs and MH providers investing the LTP CCG baseline funding uplifts for community mental health to improve adult and older adult mental health services.

This guidance document sets out detailed information to support STPs in planning for the receipt of 2021/22 transformation funding and should be regarded by STPs, and their local constituent organisations, as the key reference resource.

The need to dedicate time to laying the groundwork for delivery has been a key learning point from the early implementer phase of the transformation programme, and will help to ensure that systems do not struggle to spend their funding allocations in full.

STP leads who receive this documentation from their regional MH leads should disseminate it immediately to the identified proposal development lead(s) and writer(s) within their systems to maximise the time available for proposal development itself.

1.0 Transformation funding amounts

All CCGs have continued to receive substantial year-on-year increases in baseline funding uplifts for community mental health since 2019/20. In addition, all STPs will benefit from three years of transformation funding to deliver these new models between 2021/22 and 2023/24.

The total amounts of transformation funding available nationally for the delivery of new models are listed below, confirming that this is the biggest transformation area and the biggest priority area across the entire national MH programme.

Table 1: National LTP transformation funding profile for community mental health:

Year	National total of transformation funding available to all STPs in each year (NB – these figures are NOT cumulative)
2021/22	£121m
2022/23	£295m
2023/24	£366m
Total over the 3 years	*£782m*

The proportions of this transformation funding available to each STP on a 'fair shares' basis over 2021/22, 2022/23 and 2023/24 are set out in the NHSE/I MH Long Term Plan (LTP) Analytical Tool available on the FutureNHS Collaboration Platform. All STP MH leads should access the [LTP Analytical Tool workspace on the Platform](via the link) to see their breakdown by STP if they have not already done so.

This planning process ahead of 2021/22 seeks system plans for the three years of community mental health transformation, with a particular focus on how 21/22 monies will be spent. STPs are expected to plan accordingly and will be asked to submit refreshed, updated plans ahead of 2022/23 and 2023/24 in order to access their funding in those years.

1.1 Expectations regarding CCG baseline funding

It is critical that STPs and CCGs use transformation funding as a 'top up' to the CCG baseline funding uplifts for community mental health that all CCGs in England have been in receipt of over 2019/20 and 2020/21, and will be in receipt of from 2021/22-2023/24.

As per the Analytical Tool, the NHS Mental Health Implementation Plan 2019/20 – 2023/24 and all planning documentation, these CCG baseline funding uplifts have increased and will increase in value each year. This means that since 2019/20, CCGs should have increased the amount of funding they are investing in adult & older adult community mental health services.

Table 2: National LTP CCG baseline funding uplift profile for community mental health:

Year	National total of CCG baseline uplifts in each year from 2021/22 (NB – these figures ARE cumulative and relative to an 18/19 baseline of £0)
2021/22	£279m
2022/23	£326m
2023/24	£519m

From 2021/22, transformation funding should complement baseline funding uplifts and these two sources of funding should, taken together, form the basis of significant increases in STP investment to transform adult & older adult community mental health care up to and including 2023/24.

Transformation funding cannot fill gaps in investment from CCG baselines. STPs whose CCGs fail to invest adequately from their baselines will be unable to meet the ambitions of the LTP.

In order to unlock its 'fair share' of transformation funding, each STP's transformation funding plan will therefore need to set out:

- **Clear, detailed evidence of planned spend of CCG baseline funding uplifts for adult & older adult community MH in 2020/21 as per contract offers – building on 2020/21 overall MH programme planning returns**
- **Planned spend of uplifts from 2021/22. Setting this out at a high level will put CCGs, providers and systems in a stronger position ahead of 21/22 operational planning.**

This should include evidence of how staffing levels in adult & older adult community mental health services have increased since 2019/20 and what, if any, new VCSE contracts have been put in place using the baseline funding. This should also include evidence of planned spend on improving physical health care for people with SMI. Plans that fail to set out this evidence satisfactorily, or that fail to set out how CCGs plan to 'recover' to reach sufficient levels of baseline uplift investment in 2021/22, will not be approved. Transformation funding will not be confirmed and may be delayed or entirely withheld if such issues remain unaddressed.

A separate but related finance process to re-baseline crisis community MH spend from 2018/19 and 2019/20 using updated spend category definitions will follow shortly, with information to be shared via regional teams in due course.

1.2 Use of funding

The **vast majority of this funding should be spent on employing new mental health provider staff and contracting with VCSE organisations**. STPs may wish to include some minor infrastructure costs around, for example, communications, staff training, organisational development work, IT, or estates.

Systems should establish a dedicated transformation project & programme delivery function to drive forward their transformation programmes, and consider setting aside an appropriate proportion of available transformation funding for this.

Funding across other health initiatives:

It is **important that STPs/ICSs also draw on other sources of complementary funding that may also be directly relevant to this transformation programme** e.g.

- digital transformation[1]
- Ageing Well
- Personalised Care
- core primary care / PCN business funded via primary care contracts, including for primary care transformation, such as the PCN Additional Roles Reimbursement Scheme (which in 2021/22 will introduce a 'mental health practitioner' role)[2].

Adult & older adult community mental health transformation funding **should not** be diverted and used to fund any of the following:

- crisis care – although connectivity with urgent & emergency MH and acute MH care pathways is of course critical
- IAPT services

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[1] For example, we would expect resources to drive important digital enablers that will facilitate this transformation, such as interoperability between IT systems, and the establishment of full shared care records, to come from systems' digital transformation budgets, not this mental health funding.

[2] PCNs will be reimbursed for the costs of employing these roles – which are yet to be defined – as per the 2021/22 Network Contract Directed Enhanced Service (DES) Contract Specification (the 2020/21 version is available here). At the time of writing, these roles are subject to ongoing confidential negotiations between NHS England and the British Medical Association's General Practice Committee. Further information will be made available once these negotiations are concluded later in the financial year 2020/21. It is, however, expected that STPs/ICSs should factor in the potential planning for and recruitment of these roles by PCNs as part of their wider community MH transformation planning.

- standalone learning disability / autism / ADHD services or other standalone services for neurodevelopmental conditions, noting that your new models <u>should</u> provide care to people with <u>co-existing</u> severe MH problems and neurodevelopmental conditions
- memory services or other dementia care, noting that your new models <u>should</u> provide care to people with <u>co-existing</u> severe functional MH problems and cognitive issues.

<u>Funding initiatives in collaboration with local authorities:</u>

Transformation funding released to nominated CCGs in successful STPs should be used to bring about whole system change across local health & care partnerships, enabling people with severe mental health problems to live well in their communities. This would involve partnering closely with local authorities, and using complementary investment from local authority funding, e.g. from adult social care budgets. While we acknowledge the financial pressures that local authorities are facing, **this LTP transformation funding cannot be expected to subsidise shortfalls in such investment**.

Pooled funding between CCGs and local authorities to facilitate joint, integrated commissioning e.g. via VCSE alliance long-term contracting, can lead to successful population outcomes, and we encourage partners to avoid recurrent short-term tendering cycles and complex contract management processes. Proposals should therefore evidence strategic buy-in from local authority commissioners – including where possible their financial commitments via separate budgets and funding streams (adult social care, public health including drug & alcohol, housing) to facilitate integrated approaches.

This LTP transformation funding can be used to recruit, for example, mental health social work roles[3], housing support worker roles, and substance use worker roles[4]. These roles should:

a) ideally be agreed between NHS and local authority partners;
b) be directly engaged in working with service users as part of your new CMH model; and either:
c) act as key links interfacing between NHS-commissioned or -provided and local authority-commissioned or -provided services;
d) or ideally work in jointly commissioned, Section 75 Health and Social Care Act 2012, or other formal or informal partnership arrangements as appropriate.

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[3] Health Education England resources on mental health social work are available here: https://www.hee.nhs.uk/our-work/mental-health/new-roles-mental-health/social-workers

[4] Improving care for people with co-occurring severe mental health problems and drug & alcohol needs is a key requirement of these new models. For more information about providing better care for people with co-occurring mental health and substance use needs, see Public Health England's publication, *Better Care for People with Co-occurring Mental Health, and Alcohol and Drug Use Conditions*. See also p8 of the Community Mental Health Framework for Adults & Older Adults and recently-published PHE guidance on using the ASSIST-Lite screening tool to identify alcohol and drug use, and tobacco smoking, by mental health service users.

1.3 Role of nominated CCG

Every STP must nominate one CCG to receive and distribute transformation funding on its behalf. The national AMH team will then allocate transformation funding to this CCG in-year as below.

Table 3: Planned allocation dates for transformation funding to nominated CCGs in 2021/22:

Target date for nominated CCG allocation	Proportion of year total funding to be allocated by national AMH team to nominated CCG
June 2021	50% (for Quarters 1 & 2)
September 2021	25% (for Q3)
December 2021	25% (for Q4)

Accepting their nomination as CCGs to receive this funding, and taking receipt of this funding, automatically constitutes a commitment by these CCGs to:

- Distribute this funding across the STP footprint as per locally agreed plans that have been approved by regional and national teams;
- Release funding to providers with minimum delay;
- Use 100% of the funding allocated for the express and intended purposes only i.e. the transformation of community mental health services for adults and older adults with severe mental health problems, and not divert its use for other means, programmes or to plug gaps in financial bottom lines;
- Raise as soon as possible with the relevant regional team and the national AMH team any risks to achieving the above.

Please note that we reserve the right to withhold or delay transformation funding at any time on account of specific planning or delivery concerns. Any transformation funding underspend cannot be used to meet system control totals.

1.4 Commitments denoted by acceptance of this funding

All systems in receipt of monies will automatically commit to submitting specific quarterly qualitative and quantitative assurance and performance metrics (to be shared in due course) **related to their new models routinely to regional and national MH teams**, including collecting and reporting new primary data items. National and regional teams will through the MH programme operating model use this information as appropriate, including raising performance issues with systems through formal and informal means as necessary.

All systems will also be expected to participate in regionally-coordinated **learning collaboratives or networks** to share learning among themselves and to inform wider learning across England, and to respond to bespoke requests from the national MH team, such as with regards to best practice or communications relating to the programme.

All systems will, by accepting this funding, **commit to ensuring that this transformational change enabled by the effective spend of baseline and transformation funding will be at**

least reinvested to the same levels from April 2024, and be made sustainable within their local systems in future years beyond the current NHS funding settlement.

1.5 Process timeline

We are very aware that due to the Covid-19 pandemic, 2020/21 Phase 3 planning and operational pressures with the upcoming winter period, systems and their constituent organisations are facing unprecedented challenges and competing pressures.

However, it is vital that systems recognise that investing in and transforming community mental health services for adults & older adults with severe mental health problems will play a significant role in alleviating pressures in their crisis and acute pathways.

In addition, given the significant quantities of funding available, we want to give systems reasonable lead-in time ahead of the 2021/22 financial year to put in place recruitment processes, contracts, governance and related infrastructure to give themselves the best chance of mobilising and beginning to deliver successfully as quickly as possible from 1 April 2021. **As mentioned previously, the need to dedicate time to laying the groundwork for delivery has been a key learning point from the early implementer phase of the transformation programme, and will help to ensure that systems successfully spend their funding allocations in full.**

STP/ICS leads who receive this documentation from their regional MH leads should disseminate it immediately to the identified proposal development lead(s) and writer(s) within their systems to maximise efficiency and the time available for proposal development itself. STPs/ICSs will of course need to factor in internal sign-off processes to their own timelines; this should be done as soon as possible following receipt of this documentation and communicated clearly and immediately to all involved. Sign-off time should not unduly infringe on STP/ICS proposal development itself, which should constitute the majority of dedicated time within the overall national timeline.

1.6 Indicative full timeline

Date	Milestone
9 October	National team sends documentation to regional MH leads
	Regional MH leads disseminate documentation immediately to nominated STP/ICS leads
Protected time for local proposal development	STP/ICS leads disseminate documentation immediately to nominated individuals involved in proposal development & writing
	STP/ICS leads & nominated individuals develop proposals, ensuring involvement from all constituent organisations listed at …[5]
Wednesday 18 November 5pm	Deadline for STPs/ICSs to send their first draft proposals to relevant regional team (list of email addresses below)
Friday 20 November 12 midday tbc	Deadline for regional teams to compile and forward first draft proposals for all STPs/ICSs to national team at england.adultmh@nhs.net
w/c 23 November & w/c 30 November tbc	Joint regional-national panel reviews of first draft proposals
	National review of collated feedback on first draft proposals from all regional panel reviews
w/c 7 December tbc	Regional teams to provide agreed feedback to STPs/ICSs on first draft proposals
Protected time for local proposal development	STPs/ICSs to begin reworking draft proposals into final versions based on feedback
Wednesday 20 January 5pm	Deadline for STPs/ICSs to send their final proposals to relevant regional team (list of email addresses below)
Friday 22 January 2021 12 midday	Deadline for regional teams to compile and forward final proposals for all STPs/ICSs to national team at england.adultmh@nhs.net
w/c 25 January (& w/c 1 February 2021 if required)	Regional and national team reviews to agree recommendations as to whether to approve final proposals
w/c 1 (& 8 February 2021 if required)	Recommendations reviewed by national MH SRO & Leadership Group, and agreed with Regional Directors

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[5] Please note we strongly encourage STP/ICS leads to maximise the time that they give to proposal developers and writers to engage with this documentation and to draw on it in developing proposals. Any internal sign-off processes that STPs/ICSs put in place should take this into account.

	Confirmations of provisional award communicated to those STPs/ICSs whose proposals are approved
	Further feedback provided to those STPs/ICSs whose proposals are deemed to need more work[6]
Early February-31 March 2021	STPs/ICSs who have received confirmations of award immediately begin preparatory work ahead of mobilisation of their new models, including beginning recruitment and VCSE contracting processes
From 1 April 2021	New models begin to mobilise in every STP/ICS

Quarterly assurance & monitoring process set up by national and regional teams begins |
| **End June 2021** | First two tranches of quarterly funding (i.e. half year total) released to nominated CCGs on behalf of STPs/ICSs |

Table 4: List of regional team email addresses – for queries and proposal submissions

Region	Email address
East of England	england.mentalhealthclinicalnetwork@nhs.net
London	england.londonmentalhealth@nhs.net
North East & Yorkshire	england.mentalhealth-North@nhs.net
North West	england.mentalhealth-North@nhs.net
South West	england.southwestmh@nhs.net
South East	england.southeastmh@nhs.net
Midlands	england.midlandsmentalhealth@nhs.net

Table 5: List of early implementer sites by region – regional teams as listed above can facilitate contact for you to gain further insights

Region	Early implementer STPs/ICSs (and MH provider(s) involved)
East of England	Cambridgeshire and Peterborough (C&P)

Hertfordshire and West Essex (HPFT; EPUT) |
| London | North West London (CNWL; West London)
North East London (ELFT) |
| North East & Yorkshire | Humber, Coast and Vale (Humber Teaching)

South Yorkshire and Bassetlaw (Sheffield) |
| North West | Cheshire and Merseyside (Mersey Care) |
| South West | Somerset (Somerset) |
| South East | Frimley (Berkshire; Surrey & Borders)

Surrey Heartlands (Surrey & Borders) |
| Midlands | Herefordshire and Worcestershire (Worcestershire Health and Care NHS Trust)
Lincolnshire (LPFT) |

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[6] While our aim is to have every STP/ICS proposal approved by early February, some proposals may need further work before they are deemed approvable by national and regional teams.

1.7 TF proposals for early implementer sites

Twelve STP/ICS 'early implementer' sites have already been in receipt of transformation funding over 2019/20 and 2020/21. The STPs/ICSs in which these sites are situated will also receive their 'fair shares' of national transformation funding from 2021/22-2023/24, subject to them having made satisfactory progress in delivering their new models.

The plans for 2021/22 transformation funding from these STPs/ICSs will be unique in that they will benefit from the planning and implementation knowledge, learning and experience acquired from spring 2019 onwards. These STPs/ICSs will therefore be expected to demonstrate in their plans:

- How they will build on progress made to date and refine their new models to fulfil LTP ambitions, the CMH Framework vision, and the expectations set out in this guidance document;
- How they will use 2021/22 to address any concerns raised by regional and national teams, as well as learning gained through the nationally commissioned King's Fund site support offer[7];
- How they will use this funding to expand geographical coverage of their new models;
- How this expansion will further increase access and improve quality for people in need of services, as evidenced through outcomes measurement;
- How they will use this funding to begin, or continue, to address the dedicated focus areas of specific groups i.e. AED, 'PD', MH rehab;
- How they will do more to focus on the needs of specific age groups e.g. older adults;
- How they will draw on specific learning about recruitment and staffing to inform planned spend of 2021/22 funding on new staff;
- How they will use this funding to further build VCSE sector capacity within their footprints, including creating or expanding alliance models;
- How they will improve integrated working with all local partners, including PCNs and local authorities;
- How they will develop specific plans to do more to advance MH equalities;
- How they will use intelligence, feedback and further engagement opportunities with patients, families, carers and communities to build on their existing new models.

All EI sites will be expected to confirm in their plans:

- activity achieved in terms of numbers of patients seen
- the dedicated focus areas they have focussed on to date
- growth in staffing by role, number and WTE
- current contracts held
- current geographical coverage.

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[7] For example, where current new models appear to only consist of primary care mental health teams, as opposed to what is expected i.e. a fully transformational model encompassing and spanning primary care **and** existing secondary care community mental health services, focussed on adults & older adults with severe mental health problems.

1.8 Learning for CMH services from the Covid-19 pandemic

Community care for adults and older adults with SMI was the biggest LTP MH priority and had the largest new funding pot because of historic timely access and quality gaps.

Covid has exacerbated the inequalities faced by people with SMI and action to address them is now even more imperative. Systems should apply lessons learnt about SMI care during the pandemic, drawing on feedback from local users and carers as to what has worked well and less well, to their transformation planning.

Service changes during the pandemic have meant:

➢ Reduced capacity in inpatient settings leading to many discharges
➢ Crisis services and inpatient settings reporting significant new demand, and increasing out-of-area placements in many areas
➢ Worse experiences of lockdown being widely reported for people with existing MH problems, especially SMI
➢ CMHT staff redeployment and service reconfiguration, with a significant reduction in CMHT care contacts over several months, significant reductions in caseload numbers, and reduced offers of face-to-face contacts in many CMH services
➢ People with SMI, particularly severe and complex SMI, and older people, facing digital exclusion, and requiring further support to enable virtual / remote contacts or to pursue face-to-face options.

The social determinants and inequalities associated with pandemic and effects of lockdown are reported to have worsened the disadvantages people with SMI face, e.g. trauma, financial hardship, loneliness, poor physical health, substance use, self-harm.

In order to alleviate system-wide pressures, reduce or prevent OAPs, and manage demand in their crisis and acute pathways, STPs must invest in community-based care to keep people with SMI well in their homes. The transformation of community-based SMI care should therefore play a major part in systems' responses to their own concerns about crisis and acute pressures.

The experiences of people with SMI during the Covid pandemic, and the ways in which CMH services have responded have generated significant learning points for the mental health system. In many ways this has proved the necessity of community change, and incorporating learning into the next steps of LTP implementation will help local services and systems to better meet the needs of their populations with severe mental health needs.

1.9 What benefits will this transformation bring?

For people with SMI:

What do many people with SMI experience now?	What should they experience by 23/24?
Siloed care pathways, with a 'cliff-edge' of care between secondary mental health services and primary care	Enhanced, integrated support with primary-secondary care boundaries removed to help manage fluctuating needs, with flexible 'stepping up' / 'stepping down' of care based on intensity of input required An end to blanket discharges that leave people with SMI feeling unsupported
Long waits for access to CMHTs and rejected referrals Multiple teams with thresholds & different exclusion criteria: 'a team for everything but a place for no one' Repeated hand-offs between teams with care constructed around services, not users	Shorter waiting times, with potential to introduce a formal nationally-mandated waiting time standard Removal of arbitrary exclusion criteria; proactive and inclusive care including for co-existing needs Single, coherent integrated model with seamless, clear offer and a named key worker for all
Lack of evidence-based treatment & long SMI psychological therapy waiting lists	Improved timely access to psychological therapies in secondary care
Minimal meaningful care contacts, with people treated as 'risk' entities Left to find support for social needs People and their carers feel like they are left to cope alone	A personalised approach that addresses needs, offers hope and helps someone to live as healthy and fulfilling a life as possible Joined up, accessible support as the norm – for both users and carers
Lack of responsive, accessible, high quality care leading to avoidable crises, admissions, detentions Limited support for people with complex or specific mental health needs, including adults with an eating disorder, adults with rehabilitation support needs and people with needs associated with a diagnosis of 'personality disorder'	A flexible, easily accessible and varied biopsychosocial community-based offer to keep people with SMI well in their own homes and communities Improved timely access to evidence-based holistic care for specific and complex needs

For primary care:

What do many primary care services currently experience for SMI patients?	What should they experience by 23/24?
Gaps in service provision between primary and secondary care for people with complex mental health needs, results in increased utilisation of primary care by people with SMI	Reduced rates of people with SMI who attend general practice frequently
Lack of system integration across primary, secondary, and health and social care, and mental and physical health care support	Seamless care pathways in an integrated model that dissolve barriers between primary and secondary care, and address wider social determinants of mental health, by involving social workers, VCSE, substance misuse peer support workers, etc
Long waiting lists and waiting times for access to specialist mental health opinion and treatment	Timely access to advice and support from specialist mental health staff working in local, place-based primary care settings
Complex and long referral processes with a high proportion of referrals rejected by MH services Limited support for people who are discharged back to primary care from MH services	Removal of complex referral processes, supported by shared patient records Increased support for individuals whose care is 'stepped down' from secondary care
Lack of primary care mental health training time to access CPD opportunities to adequately support people with SMI and eating disorders	Integration of mental health staff and support within PCNs will free up time for core primary care staff to access relevant CPD opportunities including nationally funded training opportunities for e.g. for eating disorders and 'personality disorder'

For mental health services:

What do many mental health services currently experience for SMI patients?	What should they experience by 23/24?
CMHTs lacking a clear sense of purpose and identity, expected to do too much with too little	Renewed sense of purpose for community-based services operating in line with the CMH Framework, working in an integrated and multi-disciplinary 'whole system' with partners across and outside of the NHS to improve the lives of people with severe MH problems
Massive pressures on CMHTs, with high vacancy rates and low staff morale Poorly resourced CMHTs with internal policies based on exclusion and large treatment gaps for specific needs; staff frustrated by limitations placed on them	CMH services seen as a great place to work with new funding used to successfully recruit significant numbers of new staff Internal policies based on a progressive approach to inclusive care, based on national policy direction and listening to local CMHT staff about changes needed Treatment gaps filled for groups with specific needs
Staff overburdened with bureaucracy, limiting time for care Lack of meaningful CPD training opportunities for CMHT staff to improve confidence and skills, and lack of protected time to practice	Shift away from CPA and generic care coordination to use of professional skills and qualifications in daily practice, with focus on meaningful personalised care and interventions Take-up of nationally-funded training opportunities in e.g. psychological therapies, 'personality disorder', eating disorders, which staff are supported to apply in practice
Avoidable pressures on crisis care, acute care including MHA detentions and OAPs	Well-resourced, transformed community-based services able to keep people well in their homes and communities, reducing avoidable pressures on crisis and acute services

2. Criteria and expectations for proposals

This section sets out the criteria that proposals from STPs will need to meet in order to be approved. The various criteria relating to the different questions in the proposal template that STPs have been asked to complete are set out in labelled sections below.

2.0 Essential criteria for a successful proposal

Proposals will be reviewed based on how well they are meeting the objectives for community MH transformation as set out in the NHS LTP, the Community MH Framework and this Annex. The review process will lead to the approval of plans that demonstrate the following:

- Outline service model for primary and community care for people with SMI that demonstrates a fully transformative model across primary and secondary care, which ensures continuity of care and no prospect for patients of cliff-edge of lost care and support

- Governance and cross-sector collaboration in the transformation programme including with STP/ICS, MH providers, CCGs, PCN, local authorities, VCS and lived experience representatives

- Confirmation that the model has specific focus on:
    - young adults and improving transitions
    - older adults (as well as working age adults)

- Confirmation that over the course of three years, there will be a dedicated focus on pathways of care for all of the following:
    - People with community-based rehabilitation needs
    - People with eating disorders, including clarity on arrangements for medical monitoring
    - People with complex mental health difficulties associated with a diagnosis of 'personality disorder'

- Approaches that improve the physical health of people with SMI, following up on physical health checks to ensure follow up interventions are delivered

- Development and recruitment of workforce, including exploring innovative workforce configurations, expanding MDT approaches across clinical and non-clinical roles, new roles, and advancing equalities

- Measuring and monitoring change, including outcome and experience measurement and MHSDS data submission

- Addressing inequalities in terms of access, experience and outcomes of mental health services and developing an approach which demonstrates a systematic approach to the social determinants of severe mental ill-health

- Co-production of the plans with experts by experience including carers

- Improving access and waiting times, and ensuring care is flexible, timely and easy to access

- Improving quality, including:
    - Access to psychological therapies for people with SMI
    - Moving away from CPA to co-produced and personalised care planning
    - Trauma-informed care
    - Support for people who self-harm
    - Support for people with coexisting severe MH problems and substance use
    - Employment support, including continued expansion of IPS
    - Addressing social needs

2.1 Transformation plan

Systems should use the [LTP Analytical Tool workspace on the Platform mentioned above to populate some of these cells.](#)

2.1.1 Access expectations

The LTP sets out a commitment that, by 2023/24, new models across England will provide care for at least 370,000 adults and older adults with severe mental health problems per year.

Each STP/ICS needs to contribute to this national figure in each year, from 2021/22-2023/24. Minimum expectations are set out in the Analytical Tool up to 2023/24 for each STP.

While systems will be asked to set out their proposed minimum trajectories in these plans, it is critical that these numbers are seen as just that – minimum expectations rather than absolute targets. All STPs will be expected to use this transformation funding along with CCG baseline funding to improve access and quality equitably across their full geographical footprints over the lifetime of the LTP.

2.1.2 Geographical coverage

The 2021/22 funding should allow for coverage of a selected geography within each STP, with the new model covering an identifiable number of Primary Care Networks (PCNs) by March 2022, which can then be expanded in 2022/23 and 2023/24. STPs/ICSs should plan across whole systems with a view to full PCN coverage by March 2024.

STPs/ICSs are therefore expected to name those PCNs they intend the new model to cover in 2021/22, and to set out the proportion of total PCNs within their footprint that this corresponds to. This is with a view to using the increased amounts of funding available in the subsequent two years (2022/23 & 2023/24) to expand PCN coverage, with new models achieving coverage of 100% of PCNs within every STP by March 2024.

Decisions on which PCNs to prioritise for coverage in 2021/22 should be informed by:

- **Readiness to mobilise** e.g.
    - confidence in ability of MH provider to spend and recruit/contract with local VCSE sector successfully;
    - preparatory transformation work already undertaken with local CMHTs;
    - maturity of individual PCNs, including preparedness to share learning with further PCNs to be covered in 22/23 and 23/24.

    Systems will need to mobilise quickly so should select those areas that have the best chance to implement the new model successfully.

- **Inequalities, mental health needs and deprivation** – systems may wish to prioritise in year 1 (2021/22) the areas in which there are specific populations and communities with higher levels of need, and/or who have faced historic inequalities in access, experience and / or outcomes.

2.2 Service model (Question 1)

2.2.1 Criteria for the core, integrated community offer

Integrated community care services are expected to function at 'neighbourhood' level (i.e. at 30-50k PCN populations).

Mental health providers are being asked to lead transformation of community mental health services (CMHS) in partnership with PCNs and CCGs, as well as local authorities and the Voluntary, Community and Social Enterprise sector (VCSE), service users, families, carers and communities, to create a new, flexible, proactive model of community-based mental health care for people with moderate to severe mental illnesses across a range of diagnoses and needs, in line with the [Community Mental Health Framework for Adults & Older Adults](#).

Specifically, proposals should set out how the new 'core' model will meet the following key criteria:

- Be a **fully transformational model across primary care and secondary care community mental health services** – this is *not* about creating new or expanding existing primary care or enhanced primary care MH services;
- **Remove the barriers that patients currently experience between primary and secondary care** – including to improve physical health care for people with severe mental illnesses – and between different secondary care community teams[8];
- Be based on **cross-sector collaboration and integrated working** with local authorities and VCSE services. This should include how local mental health VCSE sector alliances will be built and invested in in every STP as part of this transformation. Alliances should incorporate smaller / micro-VCSE, grassroots, local community / faith and user-led organisations, all of whose sustainability should be supported through new robust approaches to contracting, without recurrent short-term tendering cycles and complex contract management processes;
- **Optimise data and information sharing** across organisations (including support to enable VCSE and smaller providers) in line with information governance law and practice, with interoperability between IT systems and full shared care records;

New 'core' models should also seek to:

- Create and improve **flexible, easy and clear means of access** e.g. through co-location (including virtual) with primary care and self-referral;
- Ensure **timely access**, working towards **a four-week maximum waiting time** from initial contact with any primary, secondary care or other service to appropriate mental health care (e.g. the creation of a comprehensive, integrated and co-produced personalised care & support plan; someone with bipolar disorder beginning a course of NICE-recommended psychological therapy)[9];

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[8] Teams that have a clear evidence base underpinning them should remain as separate teams – the obvious example is EIP teams. However, while separate, none should not operate independently of the new 'core' model and should form an important part of a coherent overall community MH model. In terms of our three additional focus areas (AED, 'PD', MH rehab), we may talk about the need for dedicated *functions* or services, but these should be strongly interconnected with the new 'core' model, and the new 'core' model means that they should not be expected to pick up all 'demand' relating to their respective patient groups. For older people's CMHTs, see section 1.2.3.

[9] In line with the Clinically-led Review of NHS Access Standards, the 12 early implementer sites currently testing new models of integrated primary and community mental health care for adults & older adults with severe mental illnesses are also testing

- Adopt a **single assessor / trusted assessment** approach, avoiding structures that oblige service users to repeat their stories;
- **Maximise continuity of care**;
- Ensure there is **no prospect for patients of cliff-edge of lost care and support** by **moving away** from current approaches based on referrals to and discharge from secondary care, with lengthy waiting lists and long waiting times;
- Work for people with **the most complex, debilitating longer-term care needs** and keep them as well as possible in the community (e.g. those who are on Mental Health Act (MHA) Community Treatment Orders (CTOs), those under section 117 MHA aftercare, those coming out of hospital settings, those in supported housing, those in need of assertive care, at risk of crisis relapse, detention, re-detention or repeat assessments under the MHA, including particular demographic groups[10]).

Successful delivery of the new 'core' model will need partners to come together to:

- Improve mental health outcomes in local communities, by demonstrating **a systematic approach which addresses the social determinants of severe mental ill-health;**
- Address non-clinical and social needs (e.g. housing, advocacy, financial support, social isolation, employment, education or training) alongside clinical needs, using innovative commissioning across the NHS and local authorities, and cultivating and making full use of community assets;
- Leverage and maximise **opportunities brought about by other sources of national and local funding and policy impetus** where possible, such as through the development of PCNs, Ageing Well, digital transformation, and the adoption of the Comprehensive Model of Personalised Care[11];
- **Co-produce** with people with lived experience;
- **Address inequalities and advance MH equalities**;
- Have **full local system buy-in** based on genuine partnership and **formal sign-off of plans** by PCNs (i.e. Clinical Directors), local authorities (Director(s) of Adult Social Services, Director(s) of Public Health, housing lead(s), Director of Children's Services for young adult care), VCSE sector representatives, and lived experience representatives (as well as lead mental health providers and CCGs).

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maximum waiting times. While this is not yet a formal standard enshrined in the NHS Constitution, all systems are expected to work towards this from 2021/22. All testing has been delayed due to Covid and further information regarding formal next steps will be made available in due course. In the meantime, the Appendix below will support systems to design their approaches.

[10] NHS England, the Association of Directors of Adult Social Services (ADASS) and the NHS Benchmarking Network collaborated to produce a national report on Approved Mental Health Professional (AMHP) MHA assessments in 2018; the report includes information about the demographic profiles of people assessed under the MHA.

[11] STPs should align all local transformation plans across policy priority areas as far as is possible, including other mental health transformation such as urgent and emergency mental health, children and young people's mental health, primary care transformation and others mentioned above.

All proposals for new 'core' models will need to adopt **the principle of inclusivity** as opposed to exclusions and assess/address workforce gaps accordingly, with specific considerations and plans for:

a) Older adults;

b) Young adults up to 25 – please note this requires demonstration of partnership working between adult and CYP MH commissioners and providers[12];

c) People with complex mental health difficulties who are diagnosed with a 'personality disorder' – please see Annex D;

d) People with eating disorders – with dedicated services not expected to pick up all need;

e) People with co-existing substance use;

f) People with co-existing neurodevelopmental conditions, and co-existing cognitive issues, including co-existing dementia;

g) People transitioning back into their local communities (e.g. from the criminal justice system, from out-of-area care, or people who have experienced homelessness and been under the care of a rough sleeping MDT);

h) People who self-harm.

Other helpful resources:

- NHS England, *Improving physical healthcare for people living with severe mental illness (SMI) in primary care: Guidance for CCGs*
- NHS England & NHS Improvement, *Community Mental Health Framework for Adults & Older Adults*
- NHS England & NHS Improvement Comprehensive Model of Personalised Care

2.2.2 Patient cohorts

The NHS Mental Health Implementation Plan 2019/20 – 2023/24 set out that the following patient cohorts are in scope for this transformation and therefore form the target cohort for appropriate use of these transformation monies:

In this context 'SMI' covers a range of needs and diagnoses, including but not limited to: psychosis, bipolar disorder, 'personality disorder' diagnosis, eating disorders, severe depression and mental health rehabilitation needs – some of which may be co-existing with other conditions such as frailty, cognitive impairment, neurodevelopmental conditions or substance use. New and integrated primary and community services should remove thresholds to ensure people can access the care, treatment and support at the earliest point of need, so that they can live as well as possible in their communities. (p. 26)

The transformation we want new models to deliver is applicable to two broad cohorts:

1. A new and inclusive 'core' model, which is for all of the above;

2. Dedicated services or functions for cohorts with the following specific needs, which may also be co-existing with others:

    a. Adults & older adults with eating disorders (AED);

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[12] Please note that as per the NHS MH Implementation Plan and LTP Analytical Tool, separate specific CCG baseline uplift funding is available to improve care for young adults aged 18-25 within the CYP financial profiles.

b. Adults & older adults with complex mental health difficulties associated with a diagnosis of 'personality disorder' ('PD');
c. Adults & older adults in need of mental health rehabilitation services (MH rehab).

Systems should ensure that care for these groups with specific needs should form part of **a single, well-connected coherent model of community mental health care** as opposed to being siloed off separately. New 'core' models should be inclusive, and not divert all care for these groups exclusively to dedicated services or functions. Dedicated services play an important role in providing evidence-based care to those people within these groups, including people with related or other co-existing needs.

Systems should therefore set out how their transformation plans will focus on:

- First and foremost, people with a range of (functional) severe mental illnesses, including where those severe mental health problems co-exist with other needs as above. Transformation must include improving care for adults & older adults with the highest levels of complexity and severity, including those in need of intensive and assertive support, as set out in the [Community Mental Health Framework for Adults & Older Adults](#)
- Then, people with mental health problems and other co-existing needs who currently fall through the gaps between:
    - o primary and secondary mental health care;
    - o different secondary care community MH teams;
    - o CYP MH and adult MH services; and
    - o IAPT services operating optimally in line with [the national IAPT Manual](#), and secondary mental health care.

  This includes people deemed to not meet current 'thresholds' for treatment by secondary care teams.

This must include a specific focus on younger and older adults.

The following patient cohorts are **out of scope** for this transformation, and therefore this funding, which has been negotiated for and committed to the above, should not be used for these groups:

- People with common mental health problems treatable within IAPT services, unless co-existing with a severe mental health problem;
- People with dementia or cognitive impairment;
- Neurodevelopmental conditions, including ADHD and autism, unless co-existing with a severe mental health problem.

In developing and delivering plans, it is critical that systems step back and take a 'whole system' view, explicitly linking the aims of this community MH transformation to their strategic aims to address the systemic pressures in their crisis and acute pathways, including out-of-area placements (for all CCG-commissioned inpatient services, including acute MH and MH rehabilitation). This includes joining up with the work of Provider Collaboratives where possible and appropriate.

2.3 Local governance (Question 2)

Systems should set out how robust local governance with appropriate Board-level representation and Executive-level oversight will be established to oversee and steer the delivery of local transformation plans. This will include adequate representation from all relevant NHS and non-NHS partners and people with lived experience.

This section should also include:

- A brief timeline and milestones setting out how activity will be phased over the three years from April 2021 to March 2024, with specific details for 2021/22
- delivery risks and mitigations. This could include specific risks and planned mitigations relating to e.g.
    - recruitment strategies and delays
    - ability to successfully spend allocated funding
    - workforce availability
    - procurement processes
    - IT system interoperability
    - stakeholder buy-in and partnership working
    - staff engagement and consultation
    - change fatigue
    - Covid-19 fatigue
    - specific inequalities
    - lack of co-production.

2.4 Young adults & older adults (Question 3)

2.4.1 Improving care for young adults as part of overall CMH transformation

All proposals should set out how services and systems will deliver a new integrated approach to young adult mental health services for people aged 18-25. This should be through partnership between adult and CYP mental health commissioners and services. Please note that CYP CCG baseline uplift funding is available to support this ambition.

Transformation proposals should demonstrate plans to improve outcomes, extend access and provide a choice of coordinated, developmentally appropriate, and flexible support.

Specifically, proposals should meet the following key criteria:

- Improving existing pathways across both adult and children and young people's mental health services, with **joint governance** to drive improvement efforts and improve necessary transitions across services;
- Understanding local levels of need and demand for young adults, with a plan for how these can be met through service transformation. This may include, though is not limited to:
  - young adults with needs currently deemed 'sub-threshold' for access to adult secondary mental health services, who **fall through the gaps** between services;
  - young adults with severe mental health problems **and** mild to moderate learning or neurodevelopmental conditions, including ADHD;
  - young people with severe mental health problems **leaving care**.
- Improving **early intervention** in parallel with the transformation of relevant adult services, for example, for young adults with:
  - an 'at risk mental state' (at risk of a first episode of psychosis);
  - emerging difficulties (that may in future lead to a 'personality disorder' diagnosis);
  - eating disorders (including young adults transitioning from CYP eating disorder services, those with an eating disorder or those suspected of developing an eating disorder for the first time);
- **Co-production** at all stages including design, delivery and any local evaluation;
- Commitment to promote **equality** in access to services, outcomes and plans to address health inequalities and advance MH equalities, including consideration of young adults from vulnerable groups.

Transformation plans should also consider the need for:

- Workforce development to increase the number of staff with the right skills, competence, and knowledge to provide age appropriate care for young adults; access to appropriately skilled clinical supervisors; innovative approaches to employ young adults to support the target user cohort, for example via peer mentoring, peer support and apprenticeships
- Clear systems leadership and governance from all partners relevant to the young adult cohort, including regional NHS England Specialised Commissioning teams, local authorities, regional NHS England Health and Justice teams, local VCSE, primary care, education, training and employment services, and other relevant community groups
- Personalised, holistic care provided through easily accessible and flexible services, with the promotion of user choice;
- Effective management of any necessary transitions to ensure continuity of care.

2.4.2 Improving care for older adults as part of overall CMH transformation[13]

All proposals should set out how services and systems will, as part of all elements of CMH transformation, better meet the needs of older adults. This should factor in the historic underinvestment in OPMH community services, the need to address age equality and general lack of awareness around the prevalence and needs of older adults with severe mental health problems and older adults who fall through the gaps between services.

Specifically, proposals should meet the following key criteria:

- Dedicate **proportional increases in funding allocation to improve care, support and treatment for older adults** considering the ageing population and in line with a) local demographic profiles, and b) assessment of current demand for/capacity in older people's mental health (OPMH) services[14].
- Use this funding to **increase and redeploy the OPMH workforce** by:
  - o recruiting new OPMH-specific expert staff to work in new neighbourhood MDTs as part of the new 'core' MH model – job plans could also include a small proportion of WTE time dedicated to working across other integrated MDTs e.g. PCN care home MDTs;
  - o employing older adult peer support workers;
  - o employing other older adult mental health new roles including e.g. OPMH advanced clinical practitioners;
  - o beginning to implement HEE's interim OPMH core competency framework for all CMH staff across all disciplines, and potentially with social care, VCSE and colleagues outside of the MH sector;
  - o recruiting new OPMH-specific expert staff to work in older adult CMHTs while recasting these teams' function. In most cases older adult CMHTs will likely need to adopt a more consultative, educational role while still providing some direct care provision to more severe, complex cases. This recognises the current relative shortage of OPMH-specific expert staff and the simultaneous need to grow, spread and share this expertise.
- Use this funding to contract with **VCSE organisations to improve the mental health care of older adults specifically**. There may be underdeveloped VCSE infrastructure in local systems geared towards older people with MH problems, so resource may need to be dedicated to building this. Systems could also ensure that all contracts clearly define and reflect the need to work with older adults;
- How transformation will drive integrated working **with Ageing Well/Frailty teams** locally, including through joint management and shared care approaches with OPMH community services e.g. in ensuring mental health support for older people in care homes as part of the PCN- and community physical health services-led Enhanced Health in Care Homes (EHCH) model; linking with reablement. This is likely to include direct in-reach work with individuals as well as group work, team consultation and formulation.

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[13] This transformation funding is for adults including older adults with *functional* mental health problems, who may have *co-existing* cognitive issues, or co-existing dementia, as well as other co-existing health issues e.g. frailty, substance use.

[14] Systems should draw on MH providers' submissions to the 2020 NHS Benchmarking Network stocktake of OPMH services.

Transformation plans should also consider the need to:

- Act based on clear evidence of **engagement with OPMH clinical experts** including MH provider OPMH clinical directors and older adult CMHT staff across all professional discipline
- **Co-produce** their OPMH community transformation plans with **older people themselves**, their carers and families, and OPMH VCSE organisations
- Establish, depending on the size of your system, **at least one named STP-wide lead for improving OPMH care** as part of this community MH transformation (e.g. a MH provider clinical director to work across STP/ICS Mental Health and Ageing Well programmes);
- Deliver plans **jointly** with public health, PCNs and care home providers;
- Tailor care and test / build the evidence base around **psychological therapies for older people** with severe MH problems, including presentations consistent with a diagnosis of 'personality disorder' and trauma;
- Work in an integrated way with other partners, including PCNs, acute and community providers to address the **physical health co-morbidities** of older adults with severe mental health problems, and **multimorbidity**, and to ensure that mental health needs are considered alongside ongoing physical health needs e.g. during discharge planning following acute hospital admission;
- Ensure access to specialist OPMH support is **based on needs** i.e. **co-existing SMI and** e.g. physical health needs, cognitive issues including dementia, frailty, end of life care needs, recognising those factors that can put people at higher risk of being affected e.g. older carers and older people from BAME groups;
- **Tackle digital exclusion** among older adults so they can benefit from use of digital technologies for e.g. virtual / remote appointments, drawing on other sources of local funding for digital development or using Personal Health Budgets;
- Work particularly closely with primary care to improve OPMH care through strong links with PCNs, public health teams and the VCSE to use **personalised care approaches to tackle loneliness and social isolation**, and to improve the accessibility of services (e.g. for people with limited mobility);
- **Join up** their community MH transformation work for older people with the parallel MH crisis transformation work for older people e.g. consideration of step-up / step-down care for older people.

Other helpful resources:

- Health Education England, *Older People's Mental Health Competency Framework*
- NHS England & NHS Improvement, *The Framework for Enhanced Health in Care Homes*
- Royal College of Psychiatrists: Faculty of Old Age Psychiatry resources

2.5 Partnership working (Question 4)

2.5.1 Primary care engagement

Local primary care stakeholders, and especially PCNs, are essential partners in the local delivery of this transformation.

Systems should consider establishing lead GPs in each practice and / or PCN who would provide strategic leadership on mental health, and build and maintain strategic relationships with mental health providers. Systems should also set out within plans:

- Which other local primary stakeholders they are engaging with e.g. GP Federations, Local Medical Committees;
- How their mental health programme delivery governance structure(s) support(s) robust primary care representation;
- How to achieve joint ownership of the community MH transformation agenda between primary care and mental health at system level;
- How those leading transformation plans will ensure continuing two-way communication with PCNs regarding the new service model;
- With regard to SMI physical health checks and medical monitoring for people with eating disorders: how local partners will work with primary care and the whole system to ensure effective delivery and improved physical health outcomes for these patients with the highest risks of morbidity and mortality.

2.5.2 Local authority engagement

Local authorities are key partners whom systems should involve from the outset of the proposal development process, as well in the delivery of new transformed models. Systems should set out within plans:

- Which named senior local authority figures have been engaged and involved in developing proposals and will be involved in delivery, including Directors of Adult Social Care, Directors of Public Health and housing leads;
- How all NHS and non-NHS system partners will work together to strengthen or improve formal or informal partnership arrangements, including integrated commissioning and integrated workforce planning;
- How partners will work together to facilitate integrated, Care Act-compliant care and support planning for these groups;
- How MH social work and the principles of strengths- / asset-based approaches for people with severe MH problems will be embedded within new models;
- How local authority engagement and involvement will translate into representation in formal governance structures;
- How partners will work together to ensure new models address social needs including e.g. housing, financial advice, substance use issues, carers' support.

2.5.3 VCSE engagement

Local VCSE organisations are key partners whom systems should involve from the outset of the proposal development process, as well in the delivery of new transformed models. Systems should set out within plans:

- How engagement with the local VCSE sector has been undertaken, including with smaller / micro-VCSE, grassroots, local community / faith and user-led organisations that provide

care and support to people with severe MH problems. The sustainability of these organisations should be supported, especially in light of the Covid-19 pandemic;

- The proposed amount of transformation funding committed to commissioning VCSE services, and on what types of initiatives for people with severe MH problems;
- How local VCSE MH sector engagement and involvement will translate into representation in formal governance structures;
- How commissioners – including NHS and local authority commissioners jointly contracting – will move from recurrent short-term tendering cycles to longer-term contracting, avoiding overly burdensome performance management and complex contract management processes;
- How statutory commissioners will create dynamic, flexible and transformative procurement practices that support local VCSE MH organisations;
- How local partners will create or expand an existing local VCSE MH organisation alliance model, or work towards creating one.

2.6 Dedicated focus groups (Question 5)

2.6.1 Patient cohorts – groups with specific needs

While the majority of transformation funding is expected to go towards improving the 'core' offer, as set out above, all STPs must also offer improved access and quality for specific cohorts of patients.

By 2023/24, all new models should include improved care for <u>all three</u> of the following groups:

- Adults & older adults with eating disorders (AED);
- Adults & older adults with complex mental health difficulties associated with a diagnosis of 'personality disorder' ('PD');
- Adults & older adults in need of mental health rehabilitation services (MH rehab).

STPs/ICSs have the **flexibility to choose in which of the three years** of transformation – 2021/22, 2022/23, and 2023/24 – they will include a focus on each of these specific groups as part of the implementation of their transformation plans.

We expect all systems to include a focus on <u>at least two of these three</u> specific groups as part of their 2021/22 transformation plans, also drawing on available CCG baseline funding uplifts as necessary. It is likely that systems will realistically need at least two (if not three) years over which they need to invest and focus implementation efforts on improving care for each of these specific groups. Systems should be mindful of the significant efforts required to get their overall transformation programmes off the ground locally and ensure their plans for 2021/22 are therefore realistic and achievable.

In deciding over which timeframes to include improvements in care for each of these groups, systems should consider:

- local needs and circumstances, including historic treatment gaps, and particular access and / or quality concerns for each of these groups;
- the current state and level of development of existing services and pathways for each of these groups; and
- their overall funding profiles over the three years.

Illustrative examples of how (fictional) systems may choose to go about this are set out below:

Oldtown ICS:

Year	Focus
2021/22	Core AED 'PD'
2022/23	Core AED 'PD' MH rehab
2023/24	Core MH rehab

Barnard STP

Year	Focus
2021/22	Core 'PD' MH rehab
2022/23	Core AED 'PD' MH rehab
2023/24	Core AED 'PD'

We are aware that some systems may have relatively well-developed services and models for one or more of these specific groups already, and therefore may not require additional transformation funding. Where that is the case, evidence should be provided to justify such a position, including current levels of investment in these services and models, and benefits for patients in terms of access and quality. These services and models should meet national policy goals as articulated (e.g. for AED, NHS England & Improvement's Adult Eating Disorders: Community, Inpatient and Intensive Day Patient Care – Guidance for commissioners and providers (2019); see Annex D and section 2.6 for 'PD', and section 2.6 for MH rehab).

2.6.2 Criteria for mental health rehabilitation as part of overall CMH transformation

Services for groups with more specific needs should potentially function at geographies up to 'place' level (i.e. around 250-500k population, which may be typically council/borough level).

Proposals should set out how the delivery of new integrated models will translate into improved timely access to high quality, evidence-based care and reduced waits for adults & older adults in need of community-based mental health rehabilitation care.

Specifically, proposals should meet the following key criteria:

- **Put investment into and drive the transformation of dedicated community MH rehab functions** (as part of the wider new CMH model) to allow local systems to end out-of-area placements and minimise the need for restrictive inpatient care, including so-called 'locked rehabilitation' placements;
- Implement with local authority partners a **supported housing strategy** for this cohort;
- Evidence **an understanding of their local population currently placed out of area** and the **cross-sector partnership working** required to address this (with local authority adult social care, housing, public health (drug & alcohol), VCSE);
- Embody **partnership working across mental health teams and services themselves** i.e. inpatient and all community MH, including rehab, services;
- **Be fully linked to 'core' CMH transformation**, not separate and fragmented from it, with the community MH rehab function providing support, advice and consultation to e.g. primary care, local authority services, VCSE;
- **No hand-offs:** a strong MDT approach with qualified staff using their core clinical skills to deliver meaningful, therapeutic interventions including e.g. psychology, OT, social care, psychiatry, peer support, MH nursing, MH pharmacy;
- Focus on **maximising people's independence and supporting them to self-manage as far as is possible via addressing complexity and severity** for people with the most severe and enduring long-term mental health problems across a range of diagnoses and co-existing needs. This includes **avoiding harmful approaches** which perpetuate the myth that this cohort should have "insight" and that interventions should be dependent on a "willingness to engage";
- Undertake **co-produced, personalised care & support care planning** with service users where goals and interventions are based on **each individual's strengths, assets and sense of what will make a more meaningful life for themselves**. This may include supporting service users to be 'gainfully' engaged as per their goals e.g. education, employment, volunteering, training, recovery college activity or other meaningful occupation of time, and should include relevant **collaborative complex risk and safety planning that seeks to empower the individual**.

Transformation plans should also consider the need to:

- Adopt **trauma-informed ways of working** (see resources elsewhere in this document);
- Take an **inclusive and flexible approach** to provision, advancing equalities by tailoring approaches for specific groups, such as those with co-existing substance use, and not excluding any specific groups from care (either due to diagnosis or any other characteristic e.g. age);
- Consider the potential need for enhancing or creating new services or functions that aim to optimise the likelihood of inpatient service users with complex needs being able to reside in the community and access care in the **least restrictive setting** to meet their needs, stopping patients escalating on the (bedded) rehab pathway, and ensuring their care is 'stepped down' back into the community after a long inpatient stay;
- Commit to securing the **best value, high quality care and to reinvesting any financial savings** resulting from transformation into local mental health services;
- Commit to work with **experts by experience and carers** to co-produce and co-deliver all aspects of local transformation and demonstrate action to **address relevant inequalities and advance MH equalities** in line with guidance set out elsewhere in this document;
- Use a **data-driven approach** e.g. drawing on local GIRFT MH rehab programme data, and establish local information standards that can be shared with all stakeholders (e.g. CCG, local authority, inpatient bed managers);
- Work to optimise **staff wellbeing** so that staff and teams are best able to maintain compassionate, personalised care, deliver effective support in the community and feel supported with positive risk and safety planning. This would include ready access to training, supervision, staff reflection and team formulation;
- Create and maintain **a culture of psychological safety within teams, systems and organisations** for all staff and users of rehabilitation services, understanding the connection between team psychological safety and effective and therapeutic outcomes**.**

Other helpful resources:

- Rethink Mental Illness: In sight and in mind: Making good on the promise of mental health rehabilitation
- NHS Confederation Mental Health Network supported housing briefing
- NHS Improvement, Getting It Right First Time: mental health rehabilitation
- NICE guidance on rehabilitation for adults with complex psychosis only
- Royal College of Psychiatrists: Faculty of Rehabilitation Psychiatry resources

2.6.3 Criteria for eating disorders as part of overall CMH transformation

Proposals for funding for adults & older adults with eating disorders should set out how STPs will establish or expand **dedicated community-based (including outreach) adult eating disorder services in line with [published NHS England & Improvement guidance on improving community-based care for adults & older adults with eating disorders](#)** (please note that this transformation funding should be used to improve community-based eating disorder care for adults & older adults only, and should not be used for inpatient and intensive day care).

Specifically, proposals should meet the following key criteria:

- **Ensure timely direct access for all levels of need,** by maximising access and minimising waits to improve patient care, and facilitating self-referral and carer-referral (i.e. offering direct access to expert advice);
- Meet [NICE guidance](#) and **pathways**;
- Embed an **early intervention model** within their overall adult & older adult community eating disorder model i.e. the [First Episode Rapid Early Intervention for Eating Disorders (FREED)](#) model for young adults aged 18-25 year olds;
- Provide **consultation** and **support, supervision** and **training** to primary care and generic community mental health services;
- Be clear on the arrangements for **medical monitoring** in partnership with primary care to manage the physical health needs of people with eating disorders;
- **Not employ or will eliminate treatment thresholds** (e.g. based on BMI or weight);
- Embed **experts by experience** in service development and delivery;
- Commission **VCSE partners** to deliver integrated services within the model; this could include joint work to deliver treatments or support services while people prepare to enter statutory services or after they have been discharged[15].

Transformation plans should also consider the need to:

- Consider and cater for the needs of **young and older adults**, and people with **co-existing needs** (e.g. substance use);
- Implement a **specific service user, carer and family co-production plan** for this group;
- **Align care pathways** and models with 'Tier 4' inpatient services and Provider Collaborative sites where appropriate;
- Promote joint working **with CYP eating disorder services** (which should be operating to an acceptable level and be adequately funded);
- Improve the **quality and completeness of MHSDS adult & older adult community eating disorder data** relating to access and activity, as well as interventions and outcomes via SNOMED;
- demonstrate action to **advance MH equalities** in line with guidance set out elsewhere in this document.

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[15] This could include local, regional or nationally-available services (e.g. from [BEAT](#)).

Other helpful resources:

- NHS England & NHS Improvement, *Adult Eating Disorders: Community, Inpatient and Intensive Day Patient Care – Guidance for commissioners and providers*
- NICE guidance on Eating disorders: recognition and treatment
- NICE Quality Standard (QS175) for Eating Disorders
- Royal College of Psychiatrists and Royal College of Physicians, MARSIPAN: Management of Really Sick Patients with Anorexia Nervosa CR189
- King's College London, First Episode Rapid Early Intervention for Eating Disorders (FREED)
- Early Intervention Eating Disorders Programme run by the AHSN Network
- BEAT Eating disorders

2.6.4 Criteria for complex mental health difficulties who are diagnosed with a 'personality disorder' as part of overall CMH transformation

Proposals for funding for adults with complex mental health difficulties who are diagnosed with a 'personality disorder' should set out how STPs will implement models of **dedicated community-based personality disorder functions or services in line with the detailed guidance set out at Annex D**. Functions or services should address whole population needs, i.e. provide direct care for people with more complex needs, as well as improving care for people with less complex needs who are being cared for within the new 'core' model. This includes young adults and older adults.

Specifically, proposals should meet the following key criteria:

- **Dedicated functions or services** for this cohort;
- Provide **consultation** and **support, supervision** and **training** to generic services (as opposed to merely increasing the caseload capacity of specialist community teams) and primary care services;
- **Co-production** from design to delivery with people from this cohort, recognising particular sensitivities around diagnostic labelling;
- Embed **paid lived experience roles at varying degrees of seniority** within the MDT;
- Improve **timely access to evidence-based psychological therapies** and tackle long waiting lists by ensuring staff take up CPD training opportunities;
- Provide care for **co-existing needs** including substance use;
- Embed a **compassionate, trauma-informed ethos** and reject punitive approaches to care.

Transformation plans should also consider the need to:

- Drive take-up of **KUF training** for all relevant staff across the system (not just 'PD' 'specialist' staff);
- Meet **NICE guidance** and **pathways**, including providing evidence-based self-harm care;
- Draw on MH providers' submissions to the 2020 **NHS Benchmarking Network stocktake of 'PD' services**;
- Address concerns raised by **the National Confidential Inquiry into Suicide and Safety in Mental Health** report, 'Safer care for patients with personality disorder'.

Other helpful resources:

- Knowledge & Understanding Framework training resources
- NICE Quality Standard (QS88) for Personality disorders: borderline and antisocial
- National Confidential Inquiry into Suicide and Safety in Mental Health, *Safer care for patients with personality disorder*

2.7 Integrating physical health care within new models (Question 6)

We expect proposals to set out how further increases in CCG baseline funding will be used in 21/22 to ensure improved physical health for people with SMI, specifically to achieve the LTP target to ensure that 60% of people with SMI receive an annual physical health check.

Systems should also set out how they may use a proportion of this transformation funding, and other funding sources[16], as a 'top up' to CCG baseline funding, to pilot new delivery models and explore innovative solutions to improve physical health care for people with SMI and reduce the mortality gap. This should focus on what teams will do to ensure people get access to follow-up interventions and could include:

- Partnership with the VCSE sector to commission holistic health and wellbeing services for people with SMI e.g. healthy eating support, team sports, gym memberships, home exercises;
- Real-time integration of data and care records across primary and secondary care to ensure full interoperability;
- Co-ownership of this transformation programme with primary care, to establish strong partnership and joint accountability, including co-location where possible and appropriate;
- Service user outreach and engagement relating to holistic physical and mental health care, especially for BAME communities and other groups whom services struggle to reach;
- Exploration of digital tools and other innovative ways for delivering physical health checks and physical monitoring.

Systems may also wish to consider using baseline funding for Personal Health Budgets (PHBs) for people with SMI to improve their physical health care.

Other helpful resources:

- NHS England, *Improving physical healthcare for people living with severe mental illness (SMI) in primary care: Guidance for CCGs*
- NHS England & NHS Improvement resources on Personal Health Budgets (PHBs) for mental health

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[16] This could include, for example, via primary care contracts, or via digital transformation funding.

2.8 Workforce development (Question 7)

Developing and recruiting to the CMH workforce will be a major part of implementing these transformation plans. Services and systems should set out in their plans how they will:

- Draw on innovative workforce configurations and expand MDT approaches across clinical and non-clinical roles. This includes psychological professions, occupational therapists, mental health pharmacists, mental health social workers, substance use expertise, new roles, advanced MH clinical practitioners and the paid employment of peer support workers / senior lived experience practitioner / expert by experience roles at varying degrees of seniority;
- Create a tailored recruitment strategy for rapid, inclusive recruitment processes reflecting the high profile and excitement of this transformation, including mitigations for risks and delays;
- Work towards the workforce reflecting and able to work with the diversity of local communities;
- Adopt integrated or other partnership approaches to workforce planning with local authorities and the VCSE that result in integrated service delivery;
- Draw on timely engagement and consultation with existing CMHT staff well ahead of new model mobilisation;
- Establish local GP leadership in mental health or strengthen where it is pre-existing e.g. for this transformation programme as well as within each PCN;
- Support staff working across the system to take up and then apply in practice relevant local, regional and national CPD training opportunities. This includes nationally-available CPD training opportunities in psychological therapies for psychosis, bipolar disorder, 'personality disorder', eating disorders, other opportunities around eating disorders and the Knowledge & Understanding Framework for 'personality disorder' (KUF);
- Build a more psychologically informed workforce;
- Develop, educate and train a CMH MDT workforce able to cater for relevant specific needs as well as all relevant co-existing needs;
- Consider how transformation will impact on all professional roles e.g. what it means for job descriptions and job plans in light of moving away from a task-focussed, risk-oriented generic care coordination / case management approach, to much more values-based, outcomes-focussed meaningful care based delivering a range of biopsychosocial interventions to individuals in the context of their communities, as set out in the CMH Framework;
- Allow patients and staff to reap the benefits of positive risk taking, moving away from conventional secondary care clinical approaches to a greater rehabilitative/social/educational/occupational approach. This should release time for care and lead to the delivery of timely interventions by staff who are empowered to use their professional skills and qualifications by eliminating unhelpful processes, generic care coordination roles and bureaucratic paperwork that in many cases add little value to patient care, such as CPA processes. Services should ensure that positive risk taking is not misappropriated as a means to leave users feeling unsupported.

<u>Other helpful resources</u>

- Health Education England resources on new roles in mental health
- Health Education England, *Advanced Practice Mental Health Curriculum and Capabilities Framework*
- Public Health England, *Better Care for People with Co-occurring Mental Health, and Alcohol and Drug Use Conditions*
- Public Health England guidance on using the ASSIST-Lite screening tool to identify alcohol and drug use, and tobacco smoking, by mental health service users
- Knowledge & Understanding Framework training resources

2.9 Measuring & monitoring change (Question 8)

As part of this transformation, we expect all services to commit to maximising the quality and completeness of their provider data on community mental health activity and outcomes submitted to the MHSDS, and will be supported by national and regional NHS teams as appropriate. This includes supporting CCG-commissioned services provided by VCSE organisations to submit relevant data to the MHSDS.

All systems should design specific methods to systematically collect and analyse user and carer experience data, which is used to drive improvements in the development and delivery of new models – this may include quantitative, qualitative or narrative methods.

All systems should set out how they will draw on wider STP or regional based digital transformation initiatives and funding sources to:

- Drive interoperability between different IT systems – specifically primary care and secondary MH care, plus local authorities and the VCSE where possible / appropriate;
- Ensure that users of community mental health services benefit from the implementation of full shared care records across all local systems by 2021/22, as set out by NHSX. Systems should ensure through this transformation that high-quality, personalised and co-produced care and support plans for people with severe MH problems are integrated within these full shared care records.

2.10 Addressing inequalities and advancing MH equalities (Question 9)

All system plans must set out **a systematic approach to addressing health inequalities experienced by the population with severe MH problems, based on protected characteristics. This includes addressing racial disparities and [advancing MH equalities](#) within specific local populations**. Plans can be based on, for example, relevant content from local Joint Strategic Needs Assessments (JSNAs), and other public health intelligence such as the Public Health England [Public Health Profiles](#) and Mental Health Intelligence Network.

Systems should include **co-commission and co-design accessible, culturally tailored and culturally appropriate services with communities to meet the needs of people with whom conventional services struggle to engage, and groups who do not access traditional services through conventional means e.g. general practice.** This will not only prepare systems for the roll-out of the Patient and Carer Race Equality Framework (currently in development), but will provide the opportunity to cultivate learnings on advancing mental health equalities in line with the forthcoming national strategy.

Local engagement, planning, commissioning and service delivery should include **smaller / micro-VCSE, grassroots, local community / faith and user-led organisations** who are often better placed to engage with and meet the needs of certain groups of service users with severe MH problems.

In order to address inequalities and advance MH equalities, and in the context of a renewed focus across the NHS and all health & care systems in light of Covid-19 and the #BlackLivesMatter movement, we are therefore asking all STPs/ICSs to:

- **proactively ringfence a proportion of their allocated funding in line with local demographic profiles to directly target at addressing inequalities, particularly ethnic & racial inequalities**;
- use this ringfenced funding to:
  - ensure recruitment processes for all new staff are inclusive and reflect the diversity of local patient and general populations;
  - commission local organisations who can address the needs of specific demographic groups and ethnic communities – some resource and 2021/22 efforts may need to be directed towards building up infrastructure and capacity where such organisations are non-existent or under-developed;
  - engage in specific co-production activities with these groups / communities that directly shape service delivery;
  - recruit specific peer support / lived experience roles from minority groups with protected characteristics, ensuring these roles receive appropriate support, supervision, and fair remuneration;
  - undertake training and related initiatives around, for example, peer mentoring, inclusion, and cultural competency. This could include culturally competent advocacy, LGBTQ+ specific support (particularly for AED and 'PD' transformation), and culturally specific peer support, advocacy and housing for MH rehab; and
- develop metrics to help measure the demonstrable impact on advancing MH equalities and/or to help highlight some of the issues encountered.

[The Independent Review of the Mental Health Act](#) and its [supporting documentation](#) (e.g. on addressing rising detention rates) sets out some clear evidence and ideas for how community-based care for people with severe mental health problems from minority ethnic communities can be overhauled in order to reduce the likelihood of detention and inpatient admission, helping to address the disproportionately high representation of some minority ethnic communities within the detained patient population.

Other helpful resources:

- National Collaborating Centre for Mental Health, *Advancing Mental Health Equality*
- Public Health England [Fingertips profiles](#) and [mental health system profiling tools](#)
- [The Independent Review of the Mental Health Act](#) and [supporting documentation](#)

2.11 Co-production (Question 10)

Systems and MH providers should utilise learnings from credible co-production activities that have already taken place to inform existing local plans and prepare for this transformation. STPs should use this formal proposal development process to further involve service users, carers, families and local communities in co-developing and co-designing their proposals.

STPs should recognise that the principles of the new model have been tested extensively with service users and carers through national policy work that began in 2017 leading to the co-production of the CMH Framework, and LTP-related engagement from spring 2018.

Recognising the relatively limited timeframe available to undertake comprehensive co-production work during this proposal development process itself, STPs should continue to engage in co-production efforts with service users, carers and communities during as well as after the proposal development phase, including in the period following confirmation of funding to help shape delivery (i.e. from February 2021). It is critical that systems and their constituent organisations recognise the need for co-production to be an iterative and ongoing process from design to delivery. It should continue once models have mobilised and begun delivering improved care in the financial year 2021/22.

Systems are therefore asked to evidence:

- What, if any, engagement, involvement, and co-production activity they had undertaken up to the beginning of the formal proposal development process;
- What engagement, involvement, and co-production activity they have undertaken to inform proposal development;
- What engagement, involvement, and co-production activity they intend to undertake immediately after funding is confirmed to inform new models mobilisation and subsequent delivery phase;
- How lived experience voices will be incorporated into governance structures underpinning and overseeing the mobilisation and delivery of new models, including senior / Executive-level structures;
- The specific funding they intend to dedicate to co-production;
- Their plans for a specific strategy as part of this transformation to involve and improve the
- lives of carers of people with severe mental health problems based on best practice.

Other helpful resources:

- National Collaborating Centre for Mental Health, *Working Well Together*
- The Carers Trust, *Triangle of Care*
- NHS England and NHS Improvement, *Supporting carers in general practice: a framework of quality markers*
- NICE guideline NG150, *Supporting adult carers*
- Values and steps to enable co-production developed by the Coalition for Collaborative Care
- National Survivor User Network (NSUN), *4Pi National Involvement Standards*

2.12 Improving access and waiting times (Question 11)

As part of the NHS Long Term Plan and the [Clinically-led Review of NHS Access Standards](#) (CRS), NHS England and NHS Improvement have committed to testing 4 week maximum waiting times (WT) for patients from initial contact with any service for core adult and older adult community mental health services, as part of the wider testing of new models of integrated primary and community mental health care for adults and older adults with severe mental health problems.

All STPs/ICSs are expected to work towards achieving four-week waiting times in the context of the development of their new models from April 2021. This will support delivery of the MH CRS in light of Covid-19-related delays and ensure all systems are prepared for any next steps.

Proposals should set out existing known waiting times as well as how systems will work towards delivery of a four-week maximum waiting time from first patient contact in primary care within new models.

General principles set out in CRS publications:

From the March 2019 ['Interim Report from the NHS National Medical Director'](#)

The overall purpose of the CRS is "to ensure that NHS standards:

- promote safety and outcomes;
- drive improvement in patient experience;
- are clinically meaningful, accurate and practically achievable;
- ensure the sickest and most urgent patients are given priority;
- ensure patients get the right service in the right place;
- are simple and easy to understand for patients and the public; and
- do not worsen inequalities." (p7)

Principles for working towards four-week waiting times

Integration
- Address rather than maintain or entrench primary-secondary care divide
- Mitigate any negative impact on specialist community MH evidence and standards (e.g. rapid access for AED and 2-wk WT for EIP)
- Integrate with local authorities e.g. social care and the VCSE

Robustness
- Ensure applicability to ALL adults & older adults with SMIs, not just subsets
- Seek to address inequalities
- Establish accurate baselines, and discourage gaming or workarounds
- Consider follow-up approach to DNAs; appropriateness of f2f vs. non-f2f

User-centricity
- Ensure transparency around creation of potential internal waits
- Avoid creation of perverse incentives
- Prioritise "need" over "risk", and consider personalised approaches
- Retain focus on meaningful interactions and interventions for users

Collaboration
- Involve professionals to ensure clinically meaningful standards
- Heavily engage service users, family members, and carers across design and testing, and ensure genuine co-production
- Ensure clear communication and regular updates to all stakeholders

Adaptiveness
- Prepare for iterative testing
- Consider simultaneous testing of different approaches for different patient subsets e.g. specifically for psychological therapies
- Interoperability will support successful delivery

<u>Measurement and reporting</u>

As part of routine assurance and data returns, we will ask sites to report on progress against setting a WT, establishing a baseline, and performance against it. WT implementation should commence at the point at which new models go live to maximise the potential for learning.

Information is likely to need to be supplemented with a local interrogation of data sources. We will attempt to validate the quantitative data that sites send to us against MHSDS where possible / appropriate. However, as new models will not cover full mental health provider footprints in 2021/22, any use of MHSDS in this context would be dependent on the ability of analysts to cut aggregate provider-level data by new model footprints.

Overall, this work will help NHSE/I and NHS Digital to assess the maturity of existing national datasets, particularly the MHSDS, to routinely aggregate and report on waiting times from new models and new ways of working. It will also feed into formal next steps relating to the CRS and the creation of a potential new constitutional standard.

2.13 Improving quality (Question 12)

Systems and services should set out how proposals will improve the quality of care that people under the care of new integrated models will receive.

Specifically, proposals should set out how systems will:

- Overhaul the current offer of care to people on CMHT caseloads, moving from transactional contacts to meaningful, therapeutic, goal- and outcome-oriented care. This should include **a specific focus on significantly improving access to a range of evidence-based psychological therapies for people with severe mental health problems**, by:
    - o Ensuring staff are released to take up new nationally-funded training opportunities, and supported to deliver evidence-based therapies once trained within their job plans through having protected time and adequate supervision, in line with the May 2020 PT-SMHP implementation guidance[17];
    - o Understanding current access and waiting times, and tackling long waiting lists, including through improving the completeness and quality of SNOMED data that provider teams submit to the MHSDS regarding psychological therapies[18];
    - o Measuring and recording outcomes as well as interventions relating to psychological therapies via SNOMED in the MHSDS[19];
    - o Ensuring psychological professions with the potential to take up training opportunities and then deliver therapies are a group that make up a sizeable proportion of the new staff planned to be recruited using this funding;
- Radically improve care planning processes by moving away from the CPA and implementing **fully co-produced, integrated, personalised care & support planning** based on individual goals and outcomes, with dynamic, regular review and updating as needed rather than review within blanket, arbitrary timeframes;
- Work towards adopting trauma-informed approaches and providing **trauma-informed care**[20];
- Radically improve care for people with **co-existing substance use**, including older adults. Plans should include embedding specific expertise within your new community mental health offer and should set out how this expertise will take the lead in establishing / strengthening formal links and partnerships with statutorily local authority-commissioned drug and alcohol services;
- Radically improve care for people who **self-harm**, including testing and exploring aftercare follow-up interventions[21];
- Embed IPS **employment support** within new models, as well as wider employment and welfare support, considering other options service users may choose to take up or benefit from such as part-time employment, education, training, volunteering and apprenticeship opportunities.

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[17] Available here: https://future.nhs.uk/AdultMH/view?objectId=82150501.

[18] This should build on the outputs of the NHSE/I Psychological Therapies for Severe Mental Illnesses Baselining Exercise. These are available via the FutureNHS Collaboration Platform: https://future.nhs.uk/AdultMH/view?objectId=21605552.

[19] NHSE/I is developing guidance to help providers use SNOMED coding in the MHSDS to record key psychological therapies data items relating to access, interventions and outcomes. This will be made available in due course.

[20] NHSE/I has funded the establishment of a Trauma-Informed Care Community of Change hosted by the NHS Northern Clinical Network. To request access to the FutureNHS Collaboration Platform workspace, please visit https://future.nhs.uk/TICC/grouphome.

[21] NHSE/I has commissioned the National Confidential Inquiry for Suicide and Safety to generate and share evidence and best practice in more detail around improving care for people who self-harm in the community. Emerging learning will be shared with all systems in due course.

- NHS England & NHS Improvement, *Psychological Therapies for Severe Mental Health Problems: 2020 Implementation Guidance*
- NHS England & NHS Improvement resources on personalised care and support planning
- The Personalised Care Institute
- NHS England & NHS Improvement psychological therapies for severe mental health problems baselining exercise
- NHS England & NHS Improvement and NHS Northern Clinical Network Trauma-Informed Care Community of Change
- Public Health England, *Better Care for People with Co-occurring Mental Health, and Alcohol and Drug Use Conditions*
- Public Health England guidance on using the ASSIST-Lite screening tool to identify alcohol and drug use, and tobacco smoking, by mental health service users
- NICE Quality standard [QS188] on Coexisting severe mental illness and substance misuse
- National Confidential Inquiry into Suicide and Safety in Mental Health, *Services for self-harm: A toolkit based on the NICE Quality Standard*
- Samaritans, *Pushed from pillar to post: improving the availability and quality of support after self-harm in England*
- IPS Grow

3. Appendix

3.0 Other helpful resources

- Social Care Institute for Excellence [slides on building asset-based places](#)
- Rethink Mental Illness report, *[Building communities that care: A blueprint for supporting people severely affected by mental illness in their local communities by 2024](#)*
- Rethink Mental Illness [guide for STPs on transforming community mental health care](#)
- King's Fund publication, *[Mental health and primary care networks: understanding the opportunities](#)*:

3.1 Additional annexes available

Annex B: [Community Mental Health Framework for Adults & Older Adults](#)

Annex C: [Adult Eating Disorders: Community, Inpatient and Intensive Day Patient Care - Guidance for commissioners and providers](#)

Annex D: 'PD' guidance slides – see below

Annex D

Improving community-based care for people with a diagnosis of 'personality disorder': guidance help development of transformation funding proposals for FY 2021/2022

Contents

NHS

Item	Section	Slide #
1	Introduction: • Policy context • Guidance purpose • The case for change	3-7
2	Proposed model	8-9
3	Guidance for improving community-based care: • Effective and diverse workforce • Access to the right care, in the right place at the right time • Therapeutic relationships • Learning organisations	10-14
4	Community Mental Health Transformation Funding Early Implementer (CMHTFEI) site case study: • Recruiting people with Lived Experience in Central and North West London (CNWL) Trust	15

Introduction

Introduction: policy context

NHS

- As part of the _NHS Long Term Plan_, the NHS has committed to developing '_new and integrated models of primary and community mental health care to support adults and older adults with severe mental illnesses'._

- As part of the transformation, all areas are also required to ensure that dedicated care, support and treatment is provided to individuals with specific needs, including people with complex mental health difficulties associated with a diagnosis of 'personality disorder'.

- In 2019/20 transformation funding was awarded to 12 community mental health transformation funding early implementer sites (EI sites) who are currently delivering new models of care in line with the Community Mental Health Framework for Adults and Older Adults.

- From 2021/22 onwards, significant transformation funding is available to all STPs / ICSs to transform community mental health services, including dedicated provision for people with a diagnosis of 'personality disorder'.

- We have worked with clinical and lived experience experts, including from EI sites, to co-produce this guidance. It will help STPs / ICSs set out in their proposals how they will deliver as part of these new integrated models of primary and community mental health the care, support, and treatment which people who have complex MH difficulties associated with a diagnosis of 'personality disorder' should expect to receive.

NHS

NHS Mental Health Implementation Plan 2019/20 – 2023/24

July 2019

NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH
NHS

The Community Mental Health Framework for Adults and Older Adults
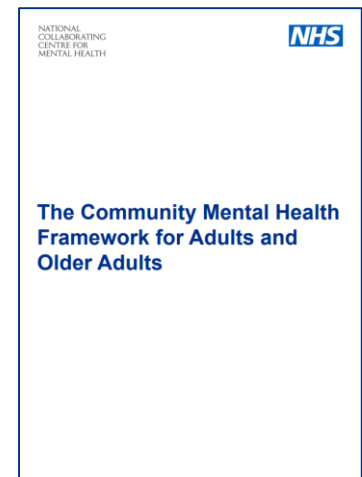
Introduction: guidance purpose

- From 2021/22 onwards, significant transformation funding will be available to all STPs / ICSs to transform community mental health services, including dedicated provision for people with a diagnosis of 'personality disorder'.

- While all STPs / ICSs need to ensure this provision is in place within their new models by 2023/24, they may choose to begin this work in 2021/22 or 2022/23. This guidance supports those STPs / ICSs who choose to include the transformation of 'personality disorder' care in their 2021/22 plans to develop high-quality proposals.

- The purpose of this guidance is to:

    - Re-cap the policy context for improving community-based care for people with a diagnosis of 'personality disorder';

    - Review the key drivers for change;

    - Share a proposed model for community-based care for people with a diagnosis of a 'personality disorder';

    - Set out the actions systems need to take to secure improvements in care for people with this diagnosis and associated needs;

    - Share some positive practice examples from the EI sites; and

    - Share useful resources to support improved outcomes and experience for people with a diagnosis of 'personality disorder'.

Introduction: the 'case for change'

- People with a diagnosis of 'personality disorder' are some of the most **vulnerable and marginalised members of society** and we know that care and support is highly variable across England.

- Not all mental health trusts have a dedicated service for people with this diagnosis and, of those trusts that do, a small proportion provide equal access to provision across all catchment areas.

- People with this diagnosis are often left unsupported in primary care, or are **denied support** from generic community mental health teams, as they do not meet current **thresholds** for care or because teams lack the confidence, knowledge and skills to care for them adequately. Generic services may also feel it is not their job, expecting small and often highly-stretched dedicated services to provide all care.

- As documented in the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) report, *Safer care for patients with personality disorder*, people with this diagnosis are at high risk of suicide when compared to the general population and commonly feel marginalised from mainstream mental health services.

- The NCISH report highlighted that among people who die by suicide, more than half are likely to have received a diagnosis of 'personality disorder' and many individuals with this diagnosis are not receiving psychological therapies recommended by NICE.

- Current models of care mean that people with a diagnosis experience 're-referrals' between different parts of the system, which does not support continuity of care, and can be **extremely distressing** for the individual, as **they 'bounce between' services, rather than a seamless transition.**

- The next section of the guidance includes some experiences of care from people who have received a diagnosis of 'personality disorder'. It is important to recognise there are disparate views regarding the construct of a diagnosis of 'personality disorder'. The experience of some people with lived experience is that the label can lead to a change in the care and support offered, leading to harmful care. Others feel that the diagnosis has supported them to access life-changing care and support. It is important to consider these sensitivities and differences in opinion when developing your model and (re)naming services. We acknowledge the use of alternative terms such as 'trauma' and 'complex emotional needs'.

What have people told us about their current experiences accessing care and support when they have a diagnosis of 'personality disorder?'

Long waiting lists for access to specialist psychological therapies and a focus on medication – which cannot be used to 'treat' 'personality disorder', but can be used to help manage co-existing needs – can exacerbate feelings of crisis

The diagnosis can be seen as a label to exclude people from care and support they need to access and can be highly stigmatising

People can be seen as too unwell for some services but not well enough to access others – leaving them stranded
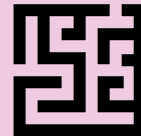
People can feel trapped between various care pathways and services, with a continued need to re explain their life & care story

Marginalised groups feel excluded from services and lack of cultural sensitivity can obstruct people from accessing care and support
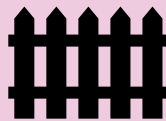
Models of care which do not acknowledge the potential role of trauma, neglect and Adverse Childhood Experiences drive away people who would benefit from care and support, often resulting in harm via re-traumatisation

The new and integrated model will support people with a diagnosis of 'PD' to live well in their communities, accessing a truly personalised care and support offer which is flexible and responsive to changing needs

NHS

2 The core community mental health function encompasses primary and secondary care, the VCSE sector and social care; within the core there is a dedicated 'PD' function.

3 The dedicated function offer is truly co-produced with people with lived experience at the heart of service development & delivery

Crisis and acute

Dedicated function

Core

Responsive to changing needs

Supported to live well in the community, drawing on assets within the community

CMH offer

1
- Access to a truly personalised trauma-informed care, treatment and support offer, which is flexible to respond to increasing needs.
- People are empowered to define their pathway, which support they would like to access and when
- They are provided with advice and guidance about options for care and support available.

4 There is seamless 'stepping up / down' of care between different services that may be involved in an individual's care offer, eliminating fragmentation.

What is the dedicated function?

- A core group of staff who understand **the impact of trauma and build a core relationship** with people for whom they are providing care.
- **Works alongside people** to ensure they access the right care in the right place at the right time.
- Part of the **same system of care and plugs into the 'core' model** to provide expertise to other staff, and capacity to deliver care and support.
- There is **strong clinical & lived experience leadership** which empowers the workforce and people accessing care and support to reach their potential.

Key components: dedicated function

Founded on trauma-informed principles of care and support, providing a safe space which does not re-traumatise

Provides space for thinking, reflection and continual learning for people accessing care and support and the workforce.

Facilitate access to evidence-based care in line with NICE guidance, particularly psychological therapies

Single point of contact in the core community offer, facilitating engagement with mainstream services – providing direct care for people when they need it but also supporting improvements in the new generic offer.

Facilitate engagement with wider sector, including DVA, women's services and homelessness services

Facilitates support for carers and families where there is an identified need

Dedicated consultation, engagement and support function to the core offer

Support and promote physical health of this cohort including working with other professionals to ensure safe prescribing and tackle polypharmacy

Co-produce offers which deliver beyond traditional therapies e.g. social prescribing

Co-produce crisis plans which focus on proactive support actions to keep people well in the community

The NHSE/I Adult MH, Provider Collaboratives and Specialised Commissioning programmes are working together to explore the potential of applying a "Provider Collaborative" approach across the whole pathway to care for those with the most complex needs within this cohort. Further information will be provided as this work develops.

- The new model is delivered at PCN level i.e. 30-50k people, with close links to local communities.
- Targeted, more intensive and longer-term input may be provided at a wider community or 'place'-based level of 250-500k population

NHS

Joined up services support seamless transition between services, removing the need to 're-refer' for new elements of care and support

Paid, substantive lived experience specific roles at varying levels of seniority are central to building effective teams
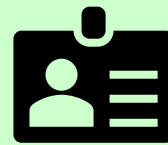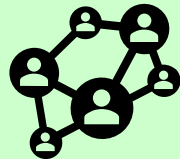
Timely access to evidence-based psychological therapies

Removal of barriers to accessing services, support better patient experience and outcomes.

Assets-based approaches focus on supporting the individual to access the most appropriate care and support in the community

Trauma-informed care focusses on working alongside people to truly understand how they can be supported to live well in their communities

- *Practitioners working in the dedicated and core functions access training and development opportunities to ensure they have the confidence and competence to provide safe, compassionate and truly person-centred care, treatment and support to this cohort.*

- *There is strong collaboration between the multi-disciplinary workforce across primary and secondary care.*

- *The workforce is reflective of the population it serves, and should incorporate paid roles for people with lived experience at varying levels of seniority, including peer support workers and lived experience practitioners.*

What does success look like?

- Practitioners are supported to access training to deliver evidence-based psychological therapies for 'personality disorder' in line with NICE guidelines, the UCL Competence Framework and the NHSE/I Psychological Therapies for Severe MH Problems Implementation Guidance.

- There is uptake of Knowledge and Understanding Framework (KUF) for 'personality disorder' one- and three-day awareness training across the new model of care, including staff that work within dedicated, generic and mainstream services. There is a commitment to ensuring that staff across the range of roles within models and organisations, including leadership roles, are supported to access KUF training.

- The values and behaviours of staff are clear and co-produced to ensure care is trauma-informed and compassionate, with stigma and bias actively tackled. Staff are culturally competent and teams understand how inequalities present for people they serve. Active attention is paid to the needs of LGBTQ+, BAME and other marginalised communities.

- Teams have embedded expertise, skills and knowledge to provide care for co-existing needs, particularly substance use, and to provide non-judgemental self-harm care.

- Peer Support Workers and Lived Experience Practitioners are employed in substantive roles within the dedicated model at varying levels of seniority, and are integral to service delivery and development.

- Support and structured supervision is in place for all staff within the dedicated function, in line with NICE guidelines where appropriate. This includes specific support for peer support and lived experience roles.

- Strong collaboration between primary and secondary care is supported by regular MDT meetings, incorporating the VCSE sector and social care where relevant.

What is Trauma-Informed Care?

- *Listening* – enabling people to share their stories in their own words.

- *Understanding* – receiving people's stories with insight and empathy.

- *Responding* – offering people support that is timely, holistic and tailored to their individual needs.

- *Checking* – ensuring that services are listening, understanding and responding in a meaningful way.

[Adapted from *Engaging with complexity – providing effective trauma-informed care for women* (Centre for Mental Health, 2019)]

> *"The human response to psychological trauma is one of the most important public health problems in the world"*
>
> **(Van Der Kolk, 2000)**

- *The dedicated function facilitates individuals' engagement with care and support across the 'core' offer and all other services.*

- *New models of community-based care span multiple services and pathways, including any specialist, planned and acute services with any necessary transitions between services experienced seamlessly by the individual.*

- *Models meet people's needs by ensuring they can access safe, high-quality care which doesn't discriminate.*

- *Regardless of the setting, care provided to this cohort is enabling, non-punitive and inclusive.*

What does success look like?

- Practitioners from the dedicated function proactively facilitate individuals' engagement with mainstream and generic services by providing a dedicated consultation and education function. Consultation and support, supervision and training is provided to generic services.

- Shared care protocols exist between dedicated, generic and other mainstream services, so that individuals have the flexibility to access different care and support when they need to.

- Policies and procedures are reviewed to ensure they minimise the risk of re-traumatisation of those who have experienced trauma.

- Every individual is provided with dignity and respect, and staff work with individuals to support them to stay safe. The voices of marginalised groups are amplified.

- Services work collaboratively with individuals, considering their individual needs to undertake safety planning, which takes into account risks and minimises harm. Services are considered by individual service users as a safe environment, adapting to their changing needs and helping to keep them feel safe.

- Identification of 'risk' is neither used to deny people care, nor used as a justification for teams to avoid working proactively with people under their care to help keep them safe. Service users are not treated as 'risk entities', and notions of 'choice', 'capacity' and 'taking responsibility' are not deployed punitively by staff as a means to dismiss their duty of care to vulnerable individuals, including those who are suicidal and / or self-harming. Care and support by all staff, including in generic services, is provided based on compassion, understanding, and personalised, therapeutic relationships.

- There is a focus on preventing harm, including reducing iatrogenic harm – which is not used as a means to exclude people from services – and preventing re-traumatisation.

- There are clear routes to engage with partners to provide the most relevant care and support, for example via social prescribing link workers based in PCNs or VCSE services integrated within the new model of care.

Theme	Therapeutic care	Theme	Learning organisations

Therapeutic relationships and relational continuity are central tenets of care and support.

Therapies, care and support are trauma-informed.

There is a focus on psychosocial approaches within all care and support.

Therapeutic relationships provide opportunities for collaboration.

Reflective organisations amplify the voice of people who access services to support continuous learning and improvement

Organisations focus on learning from mistakes and continual innovation to further improve the user experience and care outcomes.

What does success look like?

- Dedicated community provision acts as a single point of contact for the individual, which supports relational continuity of care.

- Therapeutic input is based around working alongside people across their life-course to understand the best care and support that can be offered to them at any given time.

- Trauma-informed principles are embedded in care and support, spanning across the dedicated function, as well as wider core and mainstream services.

What does success look like?

- Mechanisms are in place to collect user feedback from all individuals accessing care in the new model, including agreed processes to respond and learn from feedback.

- Lived experience practitioner and peer support roles are supported to access coaching and mentoring opportunities with colleagues across the health sector.

- The insights and wisdom of lived experience are reflected in the skill-mix of the MDT via peer and lived experience practitioner roles, 'bridging the gap'

- Mechanisms to address concerns in National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) report, *Safer care for patients with personality disorder:* people with this diagnosis are at high risk of suicide when compared to the general population and commonly feel marginalised from mainstream mental health services.

- Reflectively review changes as the model develops with a commitment to continually review service delivery.

Co-production should:
- **flatten hierarchies and promote respect**, while acknowledging and making the most of the experiences and skills of people with mental health problems, and of their families, friends and carers.
- provide everyone with an **equal opportunity** to contribute value to decision-making throughout the co-production process.
- provide everyone involved with the same **level of control and choice, throughout the process**, where appropriate and required.
- be a continuous journey over which the successes and mistakes of individuals and the whole group lead to learning.
- **take a flexible approach when engaging people** and working together as a team.
- provide all people involved with access to support, training, resources, recognition and reward.

Working Well Together

Evidence and tools to enable co-production in mental health commissioning

NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Implementing Recovery Through Organisational Change (IMROC) have developed some underpinning principles for co-production:

- *People are assets:* building on the strengths within the team / service by utilising both the expertise of people using / providing services and the other skills, resources and networks that they can bring.

- *Mutuality and reciprocity:* breaking down barriers, blurring roles, valuing what everyone brings, and enabling staff and people using services to share responsibility for both design and delivery.

- *Extending the resource base by engaging peer, personal and professional networks.*

- *Regard teams / services as catalysts for change rather than the creators of change:* enabling people to lead their own recovery journey and empowering them to develop a range of resources in peer networks and communities to support these journeys.

ImROC
Implementing Recovery through Organisational Change
Briefing

- *Service design, development and delivery involves people with lived experience from the outset.*
- *Paid employment roles are made available to people with lived experience at varying levels of seniority so they can work within the dedicated function.*

What does success look like?

- Strong leadership advocates the importance of true and meaningful co-production at all levels of the service: design, delivery, evaluation and improvement.

- Teams and services are provided with adequate training around co-production, including the benefits and the challenges.

- Structures are in place to support co-production, including training, supervision and support to grow people's capabilities and onward career progression, and to embed coproduction throughout the model of care.

- People with lived experience are valued as equal members of the dedicated function and are supported to develop their expertise within a range of roles including clear routes to formal career progression.

- Systems are developed to respond to a diverse, varied workforce (including procurement, HR and financial systems).

- Barriers to involvement are removed and people with lived experience are supported to be involved and reach their potential.

A Lived Experience Perspective

- *Training – for the whole team prior to the induction of a peer worker, setting out the benefits of peer-based roles and the addition of peer perspectives in the workplace.*

- *Clinical management and professional (peer-to-peer) supervision – for the peer worker, which is embedded into the organisation.*

- *Sponsorship – from another organisation serving the same client group, ideally sharing a theoretical approach, who have successfully incorporated peer workers into their team.*

- *Recruitment in pairs or time to create networks provided – to reduce the chances of peer workers experiencing isolation.*

- *Reflection – on how the theoretical and philosophical framework of how the service fits with, or might be antagonistic to, the role and place of peer workers in the clinical MDT.*

[Adapted from Ball, M, 2017. *Walking the tightrope: incorporating the voice of lived experience into a personality disorder service*]

Case study: Professionalising Lived Experience roles in the Complex Emotional Needs Pathway

Organisation:
Central and North West London Foundation Trust

Location:
London

Aim:
To embed the *NHS Long Term Plan* ambition: *'service planning and development should include engagement and co-production with local communities'* in the development of the Complex Emotional Needs (CEN) pathway.

Rationale: Co-production can be used to improve service provision via empowering and enabling people who use services to shape their development. The presence of peer support can instil hope in a recovery based model of care.

Solution:
- CNWL established a trust-wide mandate to promote co-production as a priority within the CEN pathway, ensuring that lived experience was at the heart of service development and delivery. This was supported by Peer Support Workers (PSW's) who had expressed the importance of professionalising the voice of Lived Experience in CEN pathway. The Trust made funding available to create the Band 7 Lived Experience role in the CEN pathway.
- From development to delivery, engaging with a range of stakeholders, including Peer Support Workers was vital to shaping the scope of the role. For example, the Trust conducted a focus group with local stakeholders, including service users and the voluntary sector to shape the professionalised role.
- In addition to this, CNWL's recovery college, with a history of expertise in co-production provided vital input into the approach to co-production and embedding Lived Experience.

Outcomes:
- March 2020: Recruitment of a Band 7 PD Pathway Lived Experience Practitioner (Westminster service)
- June 2020: Hillingdon secured Lived Experience Consultant for two days per week to codesign CEN pathway.
- July 2020: Funding secured for an Expert-by-Experience to support in the development of Trust wide pathway
- Outcome measures in development to look at efficacy of interventions and experience across the pathway.

Recommendations to others:
- *Recruitment* – recruitment to posts usually takes a minimum of 13 weeks, there may be a need to explore flexible employment solutions to support people with Lived Experience to take up employment in new models.
- *Staff culture* - Encourage staff to be open and flexible to new model and 'honest feedback of service user experience', as well as challenging 'traditional pathological' views, this could be overcome by supporting staff to access KUF training.
- Regular *support and supervision* should be available for people working in Lived Experience roles.
- *Covid-19* – embrace new models of working including remote working and conducting interviews on Teams
- *Language* – ensure to use language which promotes parity and is empowering.