Bath & North East Somerset Council

NHS
Bath and North East Somerset Clinical Commissioning Group

Adult Mental Health and Social Care Commissioning Strategy 2015-2020

1. Introduction

Getting mental health and social care services right for local people revolves around the simple premise that feeling mentally well is important to everyone and that a community that promotes, supports and maintains the mental health of its population from its children onwards builds community, as well as individual, wellbeing and its social, as well as financial, resilience.

This strategy describes what we want of our Mental Health, Social Care and Community services for adults in Bath and North East Somerset (B&NES) over the next five years. It has been written after a sustained period, since 2008, of increasing service user involvement, service improvement and demonstrable partnership working across all sectors and organisations. We have re-designed and changed the focus of services on the basis of this initial commitment and ability to keep talking.

As a result, and most importantly, we have realised our aim of amplifying the local service user and carer voice in order to influence mental health strategy and services - demonstrated in the Bridging the Gap report (Appendix 1). It is intended that this joint commissioning strategy should be read in conjunction with Bridging the Gap – the two reports are equal partners. We have also been able to influence the provision of local wellbeing, early intervention and general community services during this time and used the national agendas (2014-15) of Parity of Esteem for mental health and the associated Crisis Care Concordat to articulate and extend this influence (Appendix 2). **Ensuring that people with serious mental health problems are not disadvantaged in their access to and experience of physical healthcare services is a key expectation in all local commissioning strategies in Banes.**

Together these documents aim to articulate our shared long term ambitions and intentions, enabling us to hold steady philosophically and practically when things may be difficult. We hope to provide a strategic framework that enables us to consolidate and build upon what has worked so far. We are also planning closer alignment with Children, Families and Maternity commissioning strategies evident in our joint work in the Early Help and Children and Young People's Emotional Health and Wellbeing Strategies and future perinatal mental health plans.

We want to provide a joint commissioning approach that dynamically shapes and tests out changes through a partnership approach to practice that develops our skills in co-produced planning. Ultimately we want to continue to improve outcomes for

mental health service users and their families using a recovery and reablement approach that is supported by specialist health intervention.

Whilst the statutory responsibility for commissioning a range of services that enable people to have choice and control over their support rests with the BaNES Clinical Commissioning Group (CCG) and the Local Authority, our strength locally lies in our willingness to deliver services collaboratively within the resources that we have available to us. Ultimately we hope to have sent a clear signal about where we want to go and "the way we do things around here" in order to support improved mental health and wellbeing for the citizens of B&NES.

2. What leads and supports commissioning for service development?

2.1 Having a vision for local mental health services

Our vision in B&NES is to develop and deliver best value, accessible and effective high quality mental health and wellbeing services and networks in B&NES. In addition we will support carers and enable people who experience mental health problems to recover and lead self-directed, personally satisfying, physically safe and socially meaningful lives as valued members of our local communities.

2.2 Listening to local stakeholders

The intentions of the local B&NES Mental Wellbeing Forum (previously the Mental Health Provider Forum) – a dynamic collaborative forum of service users, carers, service providers and commissioners shaping and delivering local mental health services – are that we work together in B&NES to:

- Build a wellbeing community
- Evidence our ongoing commitment to co-production and joint service delivery
- Further raise the service user and carer voice in order to advocate for what works and contribute to evidence based practice
- Increase peer-led initiatives in order to develop communities of support
- Focus on people's resilience and their strengths rather than disability – giving people tools that enable them to better keep themselves well
- Involve carers and the family
- Promote recovery through high quality information, education, early intervention and long term support.

2.3 Embedding the service users' experience in design and development.

The peer research report **Bridging the Gap** (Appendix 1) examines what helps and what hinders people affected by mental health issues when accessing groups and support which would improve their overall wellbeing. This work with local service users emphasised the importance of:
- Improving wellbeing
- Connections between people
- Good care from statutory services
- Motivation and the importance of "doing" to improve motivation
- Ensuring access to services
- Being able to find out about services and activities

They came up with recommendations that underpin this strategy, namely:

- **Bridging the wellbeing 'gap'**
  - ➢ Build services on the assumption that improving wellbeing for people living with mental health issues and their supporters is both possible and worthwhile.

> ➢ Value flexibility and continuity. They are the key to meeting the needs and aspirations of people who have variable mental health. This is particularly important for people who may reject support because of their low mental health.

- **Building connections between people**
  - ➢ Create accessible group and activity opportunities for people, that provide a sense of purpose, build confidence and reduce isolation
  - ➢ Develop opportunities for people with similar health or caring issues to spend meaningful time together and develop further peer support opportunities
  - ➢ Maximise client involvement, including in service design, review and implementation
  - ➢ Train staff and volunteers to model friendly, welcoming behaviour from the top-down. Even the tiniest of gestures can make a big difference to someone struggling with low wellbeing.

- **Improving statutory services**
  - ➢ Develop closer working relationships between statutory mental health services and community organisations
  - ➢ Work as closely as possible with the individual's friends and family as they will be there when statutory services are not
  - ➢ Request and utilise feedback from current and former services users via voluntary organisations
  - ➢ Ensure people don't feel 'abandoned' when they are discharged. Peer support could be especially valuable here
  - ➢ Promote the positive stories/outcomes you've had.
  - ➢ For all services including informal groups - pay attention to the way groups and services end don't allow people to end up feeling abandoned. Understanding and information will go a long way.

- **Service providers can help with motivation**
  - ➢ Flexible services, as recommended under the 'wellbeing' heading will accommodate people's fluctuating motivation
  - ➢ Design services to overcome low motivation – attractive, based around people's aspirations, easy to use. People will be attracted above all by the 'purpose' of the group.
  - ➢ Develop involvement and volunteering opportunities for and with people affected by mental health issues. People want to get involved, so ensure your offer is as good as it can be.

- **Service providers can break down the barriers to accessing services**
  - ➢ **Cost.** Think about ways you can reduce, offset or subsidise the cost of your activities to make it more manageable for people on low incomes. Look for any grants that may be available or offer income-based charging scales. Consider ways in which you could get people to connect with each other and share the costs, or let people pay 'in kind', by contributing in some other way
  - ➢ **Transport.** Consider how people will get to your group or activity, ensure there is access to good public transport, look into transport schemes in

your area or organise lift sharing, this has the added benefit of putting people in contact with each other

➢ **Someone to go with.** Half of our respondents said they'd like someone to accompany them the first time they attend a group. Where appropriate, allow people to bring a friend to the first session, or support them to find someone who can accompany them. Befriending schemes are useful in matching up people in need of support with someone who can help

➢ **Be welcoming.** Train your staff and volunteers to be welcoming, friendly and non-judgemental and encourage them to explain the group clearly to newcomers.

- **Inform people about services**
    ➢ People find out about groups and activities from other people. Ensure that information about your service is available. Encourage word of mouth, perhaps by encouraging existing members to talk about their experiences at different places
    ➢ Do not rely exclusively on any one format, and particularly not the internet. Although limited in their reach, leaflets, noticeboards and local press are definitely useful
    ➢ People very frequently find out about groups and activities at the places they already attend, and from professionals involved in their support – target these
    ➢ Remember that people with mental health issues may not proactively seek out information at all, they may only react to information provided to them. Don't always expect people to look for information about your service/group, get out there and deliver it to them
    ➢ Make sure your information reaches carers too.

2.4   Having some guiding approaches, principles and standards.

2.4.1   **In B&NES we intend to take an Assets, Recovery & Strengths Based Approach.** This involves moving away from a focus on deficits (which can apply to people/systems/organisations) and therefore represents a paradigm shift from the traditional way of providing support.

This does not mean that the pathogenic (medical) model of understanding the causes and treatment of mental illness is not important – on the contrary, it is vital – but that we are seeking a wider approach within which to frame specialist medical and health based interventions.

2.4.1.1 **Asset based practice** allows us to focus on what supports and underpins health and wellbeing including the social, mental, physical and community resources people can draw on to influence and maintain their wellbeing. It also encourages us to determine the assets, skills and capacities of citizens and organisations in order to build communities and networks of support (Hopkins and Rippon 2015).

2.4.1.2 **In using a strengths based**, solution focused approach the basic building blocks of good recovery practice are taken as being fundamental, i.e.

- Belief that recovery is a possibility
- Respect
- Encouragement
- Optimism
- Empathy
- Anti-oppressive practice
- Self-awareness and reflective practice
- Understanding the principles of recovery
- Clear boundaries
- Accepting the persons definition of the problem
- Objectifying not personalising the persons behaviour

2.4.1.3 **Rapp & Gosha (**2006), propose six recovery principles, which include:-
- The focus is on individual strengths rather than deficits
- The community is viewed as an oasis of resources
- The client is the director of the helping process
- The primary setting for the work is the community

2.4.2 To support this approach our guiding principles will be to:
- Support the practice of co-production – where services are planned and delivered via an equal and reciprocal relationship between professionals and people using services, their families and neighbours.
- Support people to realise their potential and be active citizens
- Continue to tackle the inequalities and social exclusion – including in ability to access mainstream health services, housing and employment - that leads to poor mental health
- Prioritise better prevention services, with early intervention, alongside improved information and support to maintain good health and emotional wellbeing in the community.
- Improve access to the services people may require.
- Ensure that all services positively focus on recovery from mental health problems
- Ensure people have the choice and influence they need to exercise control over the way they want to live their lives and the services they need to support them to do this.
- Provide more support in the community for people with long-term mental health conditions in order that they can manage their condition themselves with the right help from integrated health, social care and voluntary services.
- Recognise that poor parental mental health can have a significant impact on the health and wellbeing of children in the family along with other contributory factors and support ways of working which understands and supports attachment between the parents and their children and helps parents access additional family support where needed.

2.4.3 The standards that underpin these principles
- All services promote social inclusion
- All services adhere to equality and human rights legislation

- People who use our services and the people who support them, are fully involved in the planning, development, delivery and evaluation of care and services
- Care and services are based on evidence of what works best to achieve individual, local and national outcomes
- Systems and structures fully support the delivery and monitoring of safe, high quality care
- A commitment to a continuous improvement in quality
- Staff are appropriately and professionally trained, supervised, supported and developed in order that they maintain professional standards and associated regulation requirements
- We get the best services we can afford and can demonstrate value for money

2.5   Being clear what outcomes you want to achieve

2.5.1   Strengthening individuals: increasing mental health and emotional resilience through providing high quality health interventions, acting to promote self-esteem and develop communication, negotiation, relationships and parenting skills.

2.5.2   Strengthening communities: increasing social support, inclusion and participation to protect mental wellbeing. Tackling the stigma and discrimination associated with mental health will be critical to promoting increased participation.

2.5.3   Reducing social barriers to good mental health: increasing access to opportunities like employment that protect mental wellbeing.

2.5.4   Supported Service users who can purchase some or all of their social care services through Direct Payments or an Individual Budget.

2.5.5   Best value for money services where we can demonstrate that funding supports the people in the most need as well as facilitating best use of the whole communities' resources.

These local outcomes reflect the following national outcomes :-

2.5.6   Adult Social Care Outcomes Framework 15-16
- **Domain 1**: Enhancing quality of life for people with care & support needs.
- **Domain 2**: Delaying and reducing the need for care and support.
- **Domain 3**: Ensuring people have a positive experience of care and support
- **Domain 4**: Safeguarding People whose circumstances make them vulnerable and protecting them from avoidable harm

2.5.7   Public Health Outcomes Framework 15-16
- **Improving the wider determinants of health indicators** - employment for people with long term conditions; social contentedness; people with mental illness in settled accommodation
- **Health improvement indicators** - self-reported wellbeing; smoking prevalence in adults; alcohol related admission to hospital
- **Public healthcare and preventing premature mortality (reducing the gap between communities) indicators** - mortality from causes considered

preventable; excess mortality in adults with serious mental illness; suicide; health related quality of life for older people

2.5.8 NHS Outcomes Framework 15-16
- **Domain 1:** preventing people from dying prematurely
- **Domain 2:** enhancing quality of life for people with long term conditions
- **Domain 3:** helping people recover from episodes of ill health/following injury
- **Domain 4:** ensuring people have a positive experience of care
- **Domain 5:** treating and caring for people in a safe environment and protecting them from avoidable harm

2.6   Understanding the context in which you are working

Much of the national context surrounding services from the last 5 years is relevant to this strategy and many of our original aims and objectives for the development of mental wellbeing and mental health and social care services continues to be of importance. Some context however has changed – most notably the national policy direction and associated financial imperatives that influence how we best organize our collective resources. This should not be a distraction however: we can still realise our ambitions – we just need to be flexible in our ways of behaving.

It has always been the case that the commissioning and delivery of all mental health and social services takes place within a framework of:

2.6.1 National and local priorities, guidance and quality requirements
There are key strategies that assist us in designing and delivering mental health services. These are listed in depth at *Appendix 3* and include:

- **Five Year Forward View 2014**
  Emphasised the need for:
  - ➢ New collaborative models of care,
  - ➢ An improvement in the quality of care
  - ➢ The empowerment of people using health and social care services.

- **No Health without Mental Health 2011**
  Sets a clear national vision for mental health with six main objectives and strong references to maternal mental health:
  - ➢ More people will have good mental health
  - ➢ More people with mental health problems will recover
  - ➢ More people with mental health problems will have good physical health
  - ➢ More people will have a positive experience of care and support
  - ➢ Fewer people will suffer avoidable harm
  - ➢ Fewer people will experience stigma and discrimination
  - ➢ Improve recognition of the impact better maternal mental health can have - not only on the individual but also the outcomes for the child and wider family

- **Closing The Gap 2014 – Priorities for Essential Change in mental health**

Re-emphasised 25 key priorities to:
 - Increase access to mental health support
 - Integrate physical and mental health care
 - Starting early to promote mental wellbeing and prevent mental health problems
 - Improving the quality of life of people with mental health problems
 - Ensure that mental health is everyone's business

- **Guidance for Commissioning Public Mental Health Services**
  - **Objective 1:** More people will have good mental health
  - **Objective 3:** More people with mental health problems will have good physical health
  - **Objective 6:** Fewer people will experience stigma and discrimination

- **The Care Act 2014**
  Significant new legislation that, in brief:
  - Emphasises the primary responsibility of local authorities to promote the individual's wellbeing
  - Strengthens the duty to assess, meet and review people's needs (personalisation) to prevent, delay and reduce their need for services
  - Ensures carers are assessed and supported to maintain their caring role
  - Indicates that the provision of advice and information to the whole community is a duty
  - Emphasises commissioning to be a co-produced process
  - Promotes integration with health
  - Ensures the provision of independent advocacy services
  - Ensures all safeguarding duties are maintained.

- **Seizing Opportunities – a Five Year Plan. BaNES CCG 2014-15/18-19**
  Aims to deliver a programme of changes that delivers:
  - Enhanced primary, community and mental health services provided 7 days a week, where required, and focused on practice clusters of populations
  - Specialist and hospital based services supporting community based services with their expertise and providing care for those with complex needs
  - Innovative pathways of care with self-care and personalised care planning at their core
  - Patients and their carers feeling able to navigate their way around the health and social care system supported by their local community, navigators and volunteers.
  - The challenges of a significantly tougher financial environment being met by alternative and more efficient models of care and a greater reliance on self-care and personal responsibility.

- **Redesign of B&NES Mental Health Support services Nov 2010**
  In line with this strategy the aim in the redesign of mental health support services was to focus on better facilitating -
  - the expansion of peer led and localised support activities,
  - the centralisation of local information accessible to all,
  - access to the support needed for people to remain in their own homes,

- engagement with creative & practical activities that develop confidence & skills
- individual's access to mainstream community education, training, leisure and employment opportunities

2.6.2 The needs of the local population

- The 2013 ONS mid-year estimate for the 2013 resident population was 180,097 which was an increase of 2,545 residents from the 2012 mid-year estimate. And the population is estimated to increase to 199,100 by 2037. There is a significantly higher proportion of residents in the 20-24 age range which is likely to relate to the student population. In March 2014 the number of people registered with a GP in B&NES was 199,660.

The authority is made up of both urban and rural communities, with the city being a world heritage site attracting visitors from diverse backgrounds. The CCG, whilst sharing the same boundaries as B&NES Council is additionally responsible for all the people who are registered with General Practitioners (GPs) in the area (the registered population) which means there are health services delivered to some 199,660 people in all. There is therefore an additional 19,563 people using local health services who are not resident within the county boundaries.

National statistics
Some estimated mental health prevalence figures are very well understood nationally and indicate that:

- The Joint Commissioning Panel for Mental Health's [1] guidance for young people making transition into adult services, shows mental illness frequently starts in childhood and the teenage years.
- 1 in 10 children between the ages of 5 and 16 have a diagnosable mental health problem and many more have behavioural issues. There is evidence this is increasing.
- Approximately 50% of people with enduring mental health problems will have symptoms by the time they are 14 and many at a much younger age, demonstrating that mental illness can affect people across the course of their lives.
- The ages of 16-18 years are a particularly vulnerable time when a young person is more susceptible to mental illness.
- Additionally, there are groups of teenagers and young adults who are at much higher risk of developing mental disorder and are therefore at a higher risk of mental ill-health. E.g.
  - Looked after children have a 5 fold increased risk of any childhood mental disorder and a 4-5 fold increased risk of suicide attempt as an adult
  - Children with learning disabilities have a 6.5 fold increased risk of mental health problems
  - Young homeless have an 8 fold increased risk
  - Young male offenders (age 15-17) have an 18 fold increased risk of suicide
  - Women in custody who are under 25 years have a 40 fold increased risk of suicide

- Mental ill-health forms at least 23% of burden of disease in UK compared to 16% for cancer and 16% for cardiovascular disease (WHO, 2008).
- 1 in 4 adults experiences mental health problems or illness at some point during their lifetime.
- 1 in 6 of us will be experiencing symptoms at any one time. At a time of recession, when levels of stress and anxiety inevitably rise, more people may be affected.
- 2 in 100 people will have a severe mental illness such as schizophrenia or bipolar disorder at any one time.
- Between 1 in 10 and 1 in 15 new mothers' experience post-natal depression.
- 9 in 10 prisoners have a diagnosable mental health and/or substance misuse
- Nationally, 40% of people in prison suffer from mental illness and substance abuse. (Schneider 2007)[6]
- In B&NES 26%[7] of drug users new to treatment during 2013-14 had a dual diagnosis of mental illness and substance misuse.
- 1 in 16 people over 65 and 1 in 8 over the age of 80 will be affected by dementia.

The impacts of having poor mental health in adulthood include:

- Physical illness
- Reduced life expectancy
- Suicide and self- harm
- Range of health risk behaviour including alcohol, drug misuse and smoking*
- Unemployment
- Homelessness
- Stigma and discrimination

Dual diagnosis
In addition a major factor for consideration in assessing needs relates to people who have a dual diagnosis of mental health and substance misuse problems. Dual diagnosis is everybody's business and is the term used which the 'Ministry of Justice' (2009) states as 'a wide range of problems that have both mental health and substance misuse in common.'[3] Dual Diagnosis can be further understood as:

- A primary psychiatric illness which may precipitate or lead to substance misuse
- Substance misuse may worsen or alter the path of a psychiatric illness
- Intoxication and/or substance dependence may lead to psychological symptoms
- Substance misuse and/or withdrawal may lead to psychiatric symptoms or illness. It may act as a trigger in those who are predisposed[4]

In B&NES, our joint needs assessment with detailed mental health information can be found at: http://www.bathnes.gov.uk/services/your-council-and-democracy/local-research-and-statistics/wiki/mental-health-and-illness

In the simplest of terms, if we use the national estimate of 1 in 4 people experiencing mental health problems and apply this to the B&NES adult resident population aged 18-64 yrs. (approx. 180,000) these estimates give a potential total working age

caseload of 45,000 people. An estimate provided by PANSI (Projecting Adult Needs and Service Information system suggests that 16% of the working age population - 28,800 - had a common mental illness in 2010/2011.

In terms of serious and enduring mental illness, 1595 people in the 2012/13 financial year registered with a serious mental illness in GP practices in B&NES with care being provided in hospitals and by community mental health teams.

In addition to these figures the B&NES projected population over-65 growth rate (2008 – 2025) is 28.47%. We understand that the incidence of mental health problems in the older people will increase in line with this growth. This equates to 1,545 people in B&NES in 2008 having diagnosed dementia rising to 1,955 by 2025.

The incidence of dementia increases with age for the population over 85 years to 1: 8. Out of the 4,600 people in Banes over 85 years in 2008, 575 suffered from dementia. By 2025 this figure will rise to 828.

2.6.3   Local commissioning structures

Mental health services for adults are commissioned jointly across health and social care by a joint commissioner. The range of services commissioned include primary care talking therapies, all adult health and social care services, packages and placements and specialist dementia health and social care provision. There are growing overlaps between mental health, maternity, acute and community health and social care adult services' commissioning.

In addition substance misuse services are commissioned under the same portfolio thereby enabling joined up working across the spectrum of dual diagnosis conditions and experiences.

Currently, although children's mental health services are also jointly commissioned they are not as a matter of routine connected to adult service commissioning except at particular interfaces such as the Crisis Care Concordat. Improving this commissioning relationship, without diluting the attention given to children's services (a common experience in the past) will be a key aim of this strategy.

A diagram showing the inter-relatedness and governance of mental health commissioning is contained at Appendix 4.

3. Acknowledging our current position

3.1 Recent improvements

B&NES has been reshaping its Mental Health Services incrementally and engaging with both the community and professionals to identify where change needs to take place.

An explicit review and description of this work is contained in the B&NES Mental Health Crisis Care Concordat. We were one of the first areas to complete, sign off and upload our review and action plan onto the national website. This is a reflection of the fact that the work described within it is our business as usual practice of improvement.

Recent improvements described include:

- Mental Health liaison services available and operating effectively at primary care, acute hospital, community hospital and care home interfaces.
- Primary Care Talking Therapies services closely aligned to Primary Care Liaison and other community services with excellent access and recovery rates.
- STEPPS programme introduced to support people with personality disorders in Primary Care.
- Increase in funding for Approved Mental Health Practitioners to improve the speed of response if some requires an assessment under the Mental Health Act.
- Creation of a peer development program, enabling peers to recognise their progression and be supported in the process.
- A new social prescribing service. Starting in January 2015 the service works with frequent attendees at GP Practices (first phase) and improves access to community based support and learning to improve quality of life.
- B&NES Wellbeing College – offering 95 different learning opportunities.
- Increased individual control of personal budgets. Allowing people to have more control and choice over their recovery and encouraging creativity and signposting in services.
- Continuing to strengthen successful partnership working e.g. World Mental Health Day, Fresh Arts activities, opening of the Wellbeing House (providing an early intervention service in the form of brief respite to prevent crises).
- Providing mental health support and training to emergency services such as the police and ambulance service.
- RMNs trained in physical health to be able to better look after patients' whole needs.
- The Court Assessment and Referral Service (CARS) which works across adult and young people's services supporting offenders with mental health issues.
- A dual diagnosis supervision group where clinical discussions are held to ensure the needs of complex mental health and substance misuse clients are met.

3.2 Challenges

Throughout the reshaping process partners in the Mental Health and Wellbeing Forum have recognised gaps or challenges in services that need to be taken into consideration and addressed.

The main challenges identified are:

- Continuing to build on early intervention and self-care initiatives in order to reduce long term serious mental health problems.
- Ensuring children and young people's services are more closely commissioned with adult services in order to increase more jointly provided pathways of care especially for families.
- Improving the perinatal mental health pathways for accessing treatment and support.
- Producing a clearer model of mental health services that allows a more joined up way of working with other non-specialist community and hospital services (including with GPs and maternity services). This would incorporate a clear navigational path for service users, standardization between services and shared notes. This is especially important for perinatal services and people with long term conditions such as dementia or diabetes.
- Working closely with police and ambulance colleagues to evidence the benefits of mental health liaison and triage systems in improving the service user experience of emergency services.
- Improving access and working protocols/practice between statutory services for urgent mental health care to include s136 detentions and identified places of safety.
- Ensuring there is capacity within frontline teams to manage, in a timely fashion, statutory responsibilities in relation to safeguarding, mental health act, mental capacity act and Care Act implementation and duties.
- Making group work accessible throughout the whole of B&NES, including those living in rural areas, and engaging service users in group work
- Improving the understanding and availability of supported living and accommodation based services.
- Introducing innovative ways to combat potential reduced funding such as having rewards for collaborative working and shared budgets. Support has also been requested to ensure smaller partners are not lost in the competitive tendering process.

4. Our commissioning priorities 2015-18

4.1   In-Patient health provision.

We require mental health in-patient services that offer clearly focused, safe and effective intensive assessment and treatment for people experiencing severe mental distress and who display challenging behaviour because of their illness. We want these in-patient wards to be designed and built to a standard that supports people to feel better and staff to be able to provide the best clinical care. In B&NES this will involve a rebuild of our acute in-patient facilities.

4.2   Rehabilitation and reablement care including placements and packages (including long term, out of area and step down provision).

Our goal is to ensure that local people with mental health problems who do not require acute in-patient assessment and treatment are in the right "bed" at the right time with the right support to deliver quality of care improvements as well as potential savings in line with local and national requirements.

4.3   Joined up general, Primary Care and specialist MH provision

In order to realise the full benefit of the specialist mental health approach for individuals and communities using GP practices, general acute services and community health and social care teams a joined up approach is required. This will be particularly important for people who have one or more long term conditions or where psychological support improves the recovery from another condition

4.4   Prevention

We want to tackle and reduce the stigma of mental health in B&NES and enable people to act sooner themselves and together to improve the health and wellbeing of people with and without mental health problems.

4.5   Parity of Esteem

Mental health services will work much more closely with other mainstream NHS and public services (maternity, police and ambulance services for instance) so that people get their physical and mental health needs met more successfully and in a less fragmented way for both routine and crisis care.

4.6   Criminal justice/prison population.

Our goal is to develop a coherent criminal justice and mental health pathway that acknowledges the impact of a person's substance use and mental health needs upon their behaviour and subsequent legal/health and social care responses.

4.7   Strengthening transitions from Young People's services to adult services.

Commissioning an effective transitional pathway leads to reduced numbers of young people lost to services at this critical time, reduced periods of untreated illness and poorer outcomes, leading to reduced morbidity and downstream demand on generic services. We have begun work on the transitional pathway in B&NES and aim to continue this work.

Good commissioning practice will be to self-assess[2] key aspects of transition to identify particular gaps and actions alongside having an effective transitional protocol which:

- Promotes person centred planning
- Enables continuity of care
- Offers flexibility and decision making
- Has sufficient detail of operational procedures to ensure efficacy and consistency

4.8   Developing a dual diagnosis strategy

Drug Misuse and Dependence – UK Guidelines on Clinical Management' (2007) referred to as the 'Orange book' concluded that 'there is still a need for more collaborative planning, delivery and accountability of services for people with co-morbidity, including those with mild-to-moderate mental ill-health, early traumatic experiences and personality traits and disorders'.[5] It expressed concern about lack of specified core competencies, inadequate assessment and co-ordination of services, and only limited progress on the development of integrated care.

Although work has progressed since this time there is still a need to build upon this, and in particular develop a dual diagnosis strategy which includes integrated training across the mental health and substance misuse workforce.

5. Next steps for 2016-17

- Implement the B&NES Crisis Concordat action plan which also addresses some aspects of our Parity of Esteem work.
- Continue with the mental health community services review and re-commissioning work taking place as part of the Your Care Your Way programme in B&NES.
- Continue with the design, planning and implementation the re-provision of local mental health in-patient facilities.
- Review the rehabilitation and reablement pathway including both health and social care funded placements and packages of care.
- Ensure national priorities are fulfilled – access, waiting times, Care Act and choice agendas.
- Progress work on a dual diagnosis strategy
- Contribute to the development of a B&NES perinatal mental health pathway
- Update this strategy with children's services colleagues in order to produce a single ageless mental health and social care commissioning strategy for B&NES
- As part of the development of the B&NES/Swindon/Wiltshire (BSW) Sustainability and Transformation Plan, consider the opportunities for further partnership working to meet local and national priorities.

Bridging the Gap

Peer research on people with mental health issues accessing
community activities and groups | Bath and NE Somerset

Research and report prepared by peer researchers, Helen Bilton and Robyn Williams
Executive Summary | November 2012

This report examines what helps and what hinders people
affected by mental health issues when accessing groups and
support which would improve their overall wellbeing.
The research was carried out in Bath and NE Somerset
by peer researchers who are clients and carers affected by
mental health issues themselves and trained by St Mungo's
Bridges to Wellbeing project to do the research. These
researchers were particularly keen to research access to
peer support groups and statutory mental health services.

However the findings and recommendations can be
applied to any form of group or service.

Five New Hope peer researchers conducted 42
interviews for this project and we used the data from
the interviews to come up with suggested solutions
based around six 'gaps' where there was clear room
for improvement and we could recommend bridges to
better wellbeing.

BaNES Mental Health Strategy 2015-2020
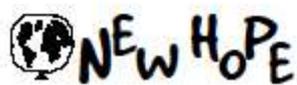
Finding out about services

People found out about groups and activities in a number of different ways, with quite a large number of people who said they wouldn't know where to look at all. Only a quarter of people used the Internet to find groups, and most people relied on getting information through word of mouth (from professional, groups, friends and family).

Ensuring that information is available in a variety of different ways and places is important to increase the likelihood of it being found. Be aware that people with mental health issues may not proactively seek information, and be sure to include carers and professionals when promoting group/activity information.

Recommendations for informing people about services

• People find out about groups and activities from other people. Ensure that information about your service is available. Encourage word of mouth, perhaps by encouraging existing members to talk about their experiences at different places.

• Do not rely exclusively on any one format, and particularly not the internet. Leaflets, noticeboards and local press are definitely useful but limited in their reach.

• People very frequently find out about groups and activities at the places they already attend, and from professionals involved in their support – target these.

• Remember that people with mental health issues may not proactively seek out information at all, they may only react to information provided to them. Don't always expect people to look for information about your service/group, get out there and deliver it to them.

• Make sure your information reaches carers too.

Conclusion

We organised our findings into six 'gaps' and suggested ways to build bridges. But what we also found is that the gaps are all intertwined with each other. In particular, a strong theme which came out of the data is that overarching everything is the need to improve connections between people. There are many, many things we can and should be doing towards improving wellbeing for those affected by mental health issues in B&NES but building social relationships, networks and ties underpins anything else we might do.

We found that people are motivated by interest, by enjoying something and by getting something out of it (including a very strong desire to 'put something back' into society). Offering opportunities for people to do things they are interested in, and building ways for as many people as possible to access them, is working towards improving wellbeing.

In conclusion, we say that our study found sub-optimum wellbeing amongst our study population and identified many areas where changes could be made to achieve better wellbeing. We found that there is no magic silver bullet which will instantly transform people's lives; instead a wide and deep ranging approach is needed, reaching across 'service' boundaries and being prepared to delve into

profound topics such as loneliness, friendships, community, motivation, client involvement, what really works and what wellbeing actually means. Our evidence suggests that the benefits of making these changes and building the bridges to wellbeing would be immense.

St Mungo's Bridges to Wellbeing works with people affected by mental health issues in Bath &NE Somerset. It enables people to have more independent and fulfilling lives by developing peer support networks and groups with volunteers. It also supports and collaborates with:

New Hope a forum for those who have been affected by mental health issues (inclusive of clients, carers and supporters) who are involved in improving and setting up local groups and services, and reducing stigma surrounding mental health.

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Housing Association No. LH0279

Appendix 2

We have also been able to influence the provision of local wellbeing, early intervention and general community services during this time and used the national agendas (2014-15) of Parity of Esteem for mental health and the associated Crisis Care Concordat to articulate and extend this influence.

A) Parity of Esteem

There is good evidence that people with mental health problems often suffer lower levels of physical health and wellbeing and are more likely to lead less healthy lifestyles. There is also evidence that people with poor physical health, especially long term conditions such as diabetes; cardio-vascular disease; stroke, often have poor mental health. The aim is to improve both the mental and physical wellbeing of these groups through early intervention and prevention.

Why is it important?

- Mental illnesses are very common
- Among people under 65, nearly half of all ill health is mental illness
- Mental illness is generally more debilitating than most chronic physical conditions.
- Mental health problems impose a total economic and social cost of over £105bn a year
- Yet, only a quarter of all those with mental illness such as depression are in treatment
- We tend to view physical and mental health treatment in separate silos in health services
- People with poor physical health are at higher risk of experiencing mental health problems…
- …and people with poor mental health are more likely to have poor physical health

What is NHS England doing?

NHS England has established a Parity of Esteem Programme in order to focus effort and resources on improving clinical services and health outcomes. The Parity of Esteem programme is currently being developed through discussions with stakeholders but we have identified three areas as initial priorities for urgent focus during 2013/14. These are:

- **Improving Access to Psychological Therapies (IAPT)** – This is a national programme to roll out access to talking therapies for people suffering from depression and anxiety disorders. Whilst we have made good progress in this area we also know that there is more to provide good access to these invaluable therapies which help patients manage their conditions and improve their quality of life. We have a national ambition by end March 2015 to increase access so that at least 15% of those with anxiety or depression have access to clinically proven talking therapies services, and that those services will achieve 50% recovery rates.

- **Improving awareness and focus on the duties within the Mental Capacity Act** – Concerns have been raised that there is a low level of appreciation of the duties and expectations of CCGs explicit in the Mental Capacity Act, a concern that spans patients groups such as those with enduring mental illness and people with dementia. The Act is of central importance in delivering healthcare. Where difficult decisions may need to be made in balancing the patients' rights to make decisions about their care and treatment with the right to be protected from harm, and requiring others to act in the patient's 'best interests' where they lack capacity for a particular decision.

- **Working with Time to Change to tackle stigma and discrimination** – In 2015/16 we worked with Time to Change, England's biggest programme to challenge mental health stigma and discrimination, to better understand the dynamics of relationships between people who use services and NHS professionals. Insight from research, focus groups and individual interviews, demonstrated that a high number of people using mental health services felt they experienced stigma and discrimination. We worked with mental health professionals based in trusts and service users to identify good practice and the barriers which sometimes stand in the way of positive interactions. The resulting training pack focuses on the positive changes which can improve both team culture and working practices and is available to all mental health trusts in England.

Time to Change

It's quite likely that one day you, one of your friends, colleagues or family members will experience a mental health problem. Yet, mental illness is still surrounded by prejudice, ignorance and fear. The attitudes people have towards those of us with mental health problems mean it is harder for them to work, make friends and in short, live a normal life.

What effect does stigma have?

Making friends, holding down a job, keeping fit, staying healthy… these are all normal parts of life. But the stigma that surrounds mental illness makes all these things harder for people who have mental health problems.

Stigma isolates people. People often find it hard to tell others about a mental health problem they have, because they fear a negative reaction. And when they do speak up, the overwhelming majority says they are misunderstood by family members, shunned and ignored by friends, work colleagues and neighbours.

Stigma excludes people from day to day activities. Everyday activities like going shopping, going to the pub, going on holiday or joining a club are far harder for people with mental health problems. What's more, about a quarter of people with a mental health illness have been refused by insurance or finance companies, making it hard to travel, own property or run a business.

Stigma stops people getting and keeping jobs. People with mental health problems have the highest 'want to work' rate of any disability group – but have the

lowest in-work rate. One third report having been dismissed or forced to resign from their job and 70% have been put off applying for jobs, fearing unfair treatment.

Stigma prevents people seeking help. We know that when people first experience a mental health problem they tend not to seek help early and tend to come into contact with mental health services only when a crisis has developed.

Stigma has a negative impact on physical health. We know that people with mental health problems tend to have poorer than average physical health and their physical health problems are misdiagnosed. As a result, people with the most severe mental health problems die on average ten years younger.

How widespread is stigma?

Despite attitudes about sexuality, ethnicity and other similar issues improving, and despite some improvements since the launch of Time to Change, discrimination against people with mental health problems is still widespread.

The *Stigma Shout* survey that we carried out at the beginning of Time to Change showed that **almost nine out of ten people with mental health problems** (87%) reported the negative impact of stigma and discrimination on their lives.

The research also showed that the way family, friends, neighbours and colleagues behave can have a big impact on the lives of people with mental health problems.

https://www.england.nhs.uk/mentalhealth/parity/

B) The Mental Health Crisis Care Concordat & Action Plan

The Mental Health Crisis Care Concordat is a national agreement between services and agencies involved in the care and support of people in crisis. It sets out how organisations will work together better to make sure that people get the help they need when they are having a mental health crisis.

In February 2014, 22 national bodies involved in health, policing, social care, housing, local government and the third sector came together and signed the Crisis Care Concordat. Since then five more bodies have signed the Concordat, making a total of 27 national signatories.

The Concordat focuses on four main areas:
- **Access to support before crisis point** – making sure people with mental health problems can get help 24 hours a day and that when they ask for help, they are taken seriously.
- **Urgent and emergency access to crisis care** – making sure that a mental health crisis is treated with the same urgency as a physical health emergency.
- **Quality of treatment and care when in crisis** – making sure that people are treated with dignity and respect, in a therapeutic environment.
- **Recovery and staying well** – preventing future crises by making sure people are referred to appropriate services.

Although the Crisis Care Concordat focuses on the responses to acute mental health crises, it also includes a section on prevention and intervention. The Concordat builds on and does not replace existing guidance. Current service provision should continue while the Action Plan is being devised.

http://www.crisiscareconcordat.org.uk/about/

See also attached document – Appendix 2a

Bath & North East Somerset Council

NHS
Bath and North East Somerset Clinical Commissioning Group

Mental Health Crisis Concordat
Review, Action Plan and Declaration
Bath and North East Somerset
Updated June 2016

Multi-agency forums that support delivery of services/review crisis concordat plan					
Forum name	**Membership**	**Frequency**	**Discussed**	**Seen plan**	**Commented**
Adult Mental Health and Learning Disability Offenders Forum	**AWP** – Intensive team; CARS; **Commissioners (CCG/LA/NHS England):** MH, LD, substance misuse, health and justice (MH)**; Probation; Sirona –** complex health needs/LD/adult autism services**; Police; Bath MIND DHI** (criminal justice/substance misuse); **and Julian House (Criminal Justice and Housing)**	Quarterly	✓	✓	✓
Mental Health and Wellbeing Provider Forum	**Commissioners (CCG/LA) –** MH; **AWP –** various; **Sirona –** various; **St Mungos Broadway; Bath MIND; Rethink; Soundwell; New Hope** (SU group); **Keep Safe Keep sane** (carers group); **Creativity Works; Knightstone Housing; CAB; The Care Forum; Second Step; Julian House. Commentary provided by Homeless health care team even though they are not represented at this meeting. (see action plan)**	Bi-monthly	✓	✓	✓
Mental Health Care Pathways Group	**GP –** St Chads**,** St James**,** Catherine Cottage **AWP –** Clinical Director, Managing Director, Head of Professions **Commissioners (CCG/LA) –** GP Lead and MH CSM **Sirona; MH &W Forum** - rep; **Practice Manager** - rep	Bi-monthly	✓	✓	✓
Mental Health Collaborative meeting	**RUH –** Director/Assistant Director of Nursing/LD Lead/ A&E consultant; **CCG –** Director of Nursing/MH SCM; **AWP –** Clinical Director/managing Director/Access and liaison services lead/Liaison team manager.	Bi-monthly	✓	✓	✓
Crisis Concordat Task group	**AWP –** Clinical Director/managing Director/Access and liaison services lead; **RUH –** A&E Consultant; **Police; Commissioner (CCG/LA); AMPH Lead, SWAST clinical lead.**	Monthly	✓	✓	✓

Positive practice				
Service	**Background and need it addressed**	**Resources**	**Impact and challenges**	**Sustainability**
Mental health liaison services in the acute trust – A&E and across wards – dementia and AOWA	The core service has been established for at least 8 years in the RUH. It has been expanded over that time to include older adults and is now joint funded with Wiltshire CCG. In addition the Intensive team in provides overnight cover (for last two years) Enabled joint development of risk matrix for mental health clients. Provided training for general staff	NHS funding (PCT/CCG) into the specialist mental health trust. Consultant nurse, psychiatrist, psychiatric nurses, admin. Joint working with A&E consultants.	**Impact:** Has enabled the earlier identification and treatment of people with mental health problems and supported diagnosis and care of older clients with dementia (with or without co-morbidity) as well as supporting discharge. Increased staff skills and understanding. **Challenges:** the consistent implementation of processes with aligned capacity to provide care within the A&E 4 hour target. Managing risk (and hospital capacity/flow) for those clients needing a MH Act assessment – especially out of	Continued lack of clarity nationally about how much of this function should be supported through the acute tariff. Therefore growth of service to meet demand reliant upon mental health funding stream only. Needs national clarification. Future work around Parity of Esteem will require workforce initiatives to increase skill sets of staff. Recruitment of staff will affect sustainability. Reciprocal arrangement for medical liaison into mental health facilities needs to be developed for true sustainability and parity of esteem.

Positive practice				
Service	**Background and need it addressed**	**Resources**	**Impact and challenges**	**Sustainability**
			hours. Provision of a suitable environment for those clients waiting for a MH Act assessment.	
Community Hospital and Care Home liaison service	Initially started with psychiatrist input into specialist dementia care home - a "ward round" every 6 weeks with GP (providing weekly "ward rounds" under LES). Supported with close relationship with MH team leader (LA social worker as part of integrated MH team). Further development 4 years ago to increase support into the community sector – especially to improve the care of older people with dementia in order to prevent crisis and hospital admission. Dementia challenge fund monies supported programme of training into Care Home sector on dementia and dementia	Psychiatrist. Team leader (SW qualified) 2 Band 6 nurses. Recurring CCG funding. Dementia challenge money used for training element currently annual.	Increased capacity in the care home sector to manage complex clients thereby preventing admission into or delay in hospital beds. Prevented older adults being admitted to hospital in crisis. Enabled more people to end their lives in the care home. Increased awareness in the care home sector of dementia and how to care for people. Improved discharge form community hospitals.	This is built into the block contract arrangements for specialist mental health services. More support put into this service by targeted resilience monies (see action plan) for people with a secondary diagnosis of dementia with the aim of employing RGNs and social workers into the team.

Positive practice				
Service	**Background and need it addressed**	**Resources**	**Impact and challenges**	**Sustainability**
	care.			
Care Home Local Enhanced Service - GP	Provision of GP support into "attached" care homes in order to support health, manage long-term conditions, prevent admission to hospital in a crisis and enable a good death	Funding provided to GP practices by CCG on a fixed term basis currently Recurrent funding agreed for three years from April 2015.	Improved quality and continuity of care and interventions. Prevented people being admitted to A&E. Enabled people to die in the 'home' where they are residing.	Funding agreed for three years from April 2015.
Alcohol liaison team in the RUH	Alcohol Liaison Service was set up at the Royal United Hospital (RUH) from April 2013. The aim of this integrated (3rd sector/specialist) service is to stem the rise in alcohol related hospital admissions by reducing bed days and frequency of attendance and admission of high impact users as well as increasing detection of alcohol misuse across the hospital and engaging people in treatment services.	Funded by BaNES CCG and Wiltshire Drug and Alcohol Team: 2 Alcohol Liaison Nurses 2 Recovery Workers 0.5 FTE Hepatology Nurse funded by RUH An additional community detoxification bed for the sole use by the RUH is being piloted for 12 months. Within the first 6 months of operation the bed has had 60% occupancy.	**Impact** 4.4% drop in the Alcohol Specific Hospital Admissions from 765 in 12/13 to 731 in 13/14 63% reduction in client hospital spells 3 months post contact with the service compared to 3 months before contact 1,315 fewer bed day usage amongst the client group 3 months post contact with the service.	Recurrent CCG funding is in place. Sustainability more dependent on widening the preventative initiatives available to us and thinking nationally about how to manage the market.

Positive practice				
Service	**Background and need it addressed**	**Resources**	**Impact and challenges**	**Sustainability**
			£399,134 tariff savings from the reduction in client hospital spells An alcohol withdrawal protocol has been introduced and training provided to staff. This has led to a reported reduction in aggression amongst patients. Significant rise in number of people accessing treatment. <u>Challenges</u> Roll out the use of AUDIT tool in the emergency department Managing capacity within RUH and in community alcohol treatment. The team is respected for their expertise by RUH staff.	

Positive practice				
Service	**Background and need it addressed**	**Resources**	**Impact and challenges**	**Sustainability**
Primary Care Mental Health liaison service	To build upon the recognition that the majority of people who experience mental health difficulties will have their needs met within primary care and not within secondary specialist mental health services. PCLS Teams set up with a view to improve mental health for individuals and society as a whole and work collaboratively with others to aim to improving care in the six outcomes identified within DoH's publication, No Health Without Mental Health" (2011). These are: •More people will have good mental health. •More people with mental health problems will recover. •More people with mental health problems will have good physical health. •More people will have a positive experience of care and support. •Fewer people will suffer	Psychiatrist Team leader Band 6 mental health professionals	**Impact:** Improved access for professional advice and support for on a spectrum of mental health issues. Improved communication between mental health, third sector and statutory services Inclusion of mental health professionals within primary care pathways, e.g. community ward rounds to enable timely interventions/ identify that potential mental health issue are considered at the same time as physical health issues (parity of esteem) **Challenges:** Prescribing accountabilities Adaptation of the model from a	Review and redesign of wider mental health "access service" to streamline process to ensure that right interventions are delivered in a timely manner

Positive practice				
Service	**Background and need it addressed**	**Resources**	**Impact and challenges**	**Sustainability**
	avoidable harm. •Fewer people will experience stigma and discrimination. Team work closely with other health, social care providers and third sector.		primarily GP referral based system to an open access model. Delivering sustainable service delivery within an open access model	
Court Assessment and Referral Service (CARS) team	Service in situ since 2007 but expanded considerably in 2014 in the context of Lord Bradley's report. Function is to assess the mental health and learning disability needs of those coming into contact with the criminal justice system across Avon and Wiltshire, regardless of age, with a view to diverting those appropriate for diversion, out of the criminal justice system and liaising with the criminal justice system (assuming capacitated client consent) to inform that system of service users assessed needs and arrangements in place to meet those needs be that within or without of the criminal justice system.	Across the whole service, that includes B&NES: Team leader. Administration. 2 children and young people nurses band 6. 1 learning disability nurse band 6. 6 mental health nurses band 6 1 social worker band 6 7 mental health nurses band 5 1 OT band 5 1 social worker band 5 2 engagement workers band 4.	**Impact:** Improved and timelier outcomes for people with mental health and learning disability needs involved in the criminal justice system regardless of age. Reduction in clients being remanded into custody for want of appropriate diversion. Reduction in need for mental health act transfers from prison. Criminal Justice system (we see people in police custody, we see voluntary attenders and see people in	Commissioned by specialist commissioning (NHS England). Funding also gratefully received from BaNES CCG NHS England contract due for review 2017.

Positive practice				
Service	**Background and need it addressed**	**Resources**	**Impact and challenges**	**Sustainability**
	(We are currently working with SOMPAR to enable them to come up to Lord Bradley's spec in Somerset also. I note some B&NES clients have been taken to Bridgwater super custody suite).		Courts) better informed and informed in a more cost effective and timely manner about the mental health / learning disability needs of our clients (assuming capacitated consent). As AWP also provide the mental health and learning disability provision in the 5 prisons in our cluster, timely handovers of the needs of those coming into prison and a reduction in the need to re-triage those already screened out by CARS (unless presentation changes significantly once incarcerated). **Challenges:** The large geographical area we	

Positive practice				
Service	**Background and need it addressed**	**Resources**	**Impact and challenges**	**Sustainability**
			cover and being able to consistently provide practitioners often at short notice given PACE timeframes. To meet the Lord Bradley Spec the Team has been required to make a significant number of developments over a short period of time although the team is now fully compliant with the spec and so can now consolidate. Sometimes the prompt identification of Psychiatric beds for those detained under the mental health act while in police / court custody A potential challenge maybe working out how street triage and CARS interface in a way that ensures our	

Positive practice				
Service	**Background and need it addressed**	**Resources**	**Impact and challenges**	**Sustainability**
			criminal justice partners get a clear and consistent message	
Julian House Homeless Hospital Discharge Service,	The JH service will be working with people who are likely to have on-going and potentially crisis MH needs in addition to current physical health needs. Will work alongside the Liaison Teams (alcohol, A&E and Primary Care)	Funded by the local authority.

Update June 2016: Homeless Hospital Discharge Service funded by Julian House until late 2015. Funding (and service) has ceased. | Challenges are to ensure the service is well integrated into local provision. | Funded on a 3- year basis |
| **Gypsy and Traveller Outreach and Engagement Pilot Service** | Pilot to find out the best ways of engaging with this client group – which include high numbers of "boaters" – in order that they can design service responses, the outcomes they want from services and how to ensure good out of hours access | CCG funded | **To be determined with service users.** | Pilot project for 17 months until April 2016 |

Positive practice				
Service	**Background and need it addressed**	**Resources**	**Impact and challenges**	**Sustainability**
Mental Health adult of working age reablement team	The Reablement service provides a pre and post crisis intervention – depending on where in the MH system service users are. It undertakes an initial assessment, develops a support plan and then implements the plan. The episode of support is normally completed within 6-8 weeks and the case is closed once the service user's needs have been met and any onward signposting – i.e. to community networks or another provider – has been completed.	Funded via Sirona's main service contract	**Impacts:** The service helps to prevent people escalating into acute clinical need. It also helps people who are recovering from an acute episode to reintegrate into the community. **Challenges:** In some cases support is required beyond the time-limited service – i.e. for more than 6-8 weeks. However this can be managed through signposting. There are also occasions when a client is registered with a GP but resident in another local authority area and so pathways of care can be complicated.	The service has recently been redesigned (effective July 1) and so far it seems to be achieving its expected outcomes within the agreed timescales. Performance in relation to the redesign specification will be kept under review.

Positive practice				
Service	**Background and need it addressed**	**Resources**	**Impact and challenges**	**Sustainability**
Respite beds pilot (Wellbeing House)	A respite house is being developed to offer short stays. The aim is to provide a therapeutic experience that will help people manage their mental health and keep them out of states of acute need. The respite pilot model will be developed in conjunction with the MH service teams to ensure there is a safe staffing model focused on supporting the individual pre or post crisis. The service will be jointly run with Curo and will include a peer support worker and support from peers. The Wellbeing House has opened in July 2015 after extensive refurbishment.	Quality Innovation Productivity and Prevention (QIPP) investment funds.	**Impacts:** The service will be one of the few of its kind in the country. Demand for it is expected to be high. Links to other services will be numerous. The scope for innovation is considerable. The therapeutic value of the service to the user should be substantial – which should result in reduced demand for other MH services. **Challenges:** The main challenge so far has been finding a suitable location for what is a sensitive service. However a Curo owned property was found in Bath and its previous supported living use may mitigate challenges in the	The respite project is a pilot. Its continued funding is entirely dependent upon its performance during the pilot phase.

Positive practice				
Service	**Background and need it addressed**	**Resources**	**Impact and challenges**	**Sustainability**
			reception of the new service within its host community.	
In-patient peer support worker – acute mental health services	This is a year's pilot with a partnership arrangement between AWP and St Mungo's Broadway To improve discharge processes by using the 'Move On ' methodology To prevent delays and preparing people for change	Funding via CCG	Impact on length of stay A more coordinated approach to discharge planning better and supported approach This is a new way of working for both organisations and identifying pathways quickly	One year's pilot so request for recurring funding to be made if services appears to be cost effective.
AMHP Service – LA	Need to ensure collaboration between services in situations which require a Mental Health Act assessment or related interventions.	AMHP office co-located with AWP services with LA and AWP computer access. Dedicated AMHPs and Lead plus Rota staffing.	**Impact**: Enables close collaboration between AWP's Intensive Service, MH Liaison Service, PCLS and Hillview Lodge Inpatient Unit. **Challenges:** The increased rates of Mental Health Act assessments and geographical barriers such as out-of-area	AWP has agreed a move to a larger office space within HVL. These developments will help ensure sustainability.

Positive practice				
Service	**Background and need it addressed**	**Resources**	**Impact and challenges**	**Sustainability**
			placement for beds and location of the Place of Safety Suite at Southmead Hospital put pressure on the AMHP service and collaborative working	
AMPH service	LA recently agreed funding for increased AMHP staffing	LA recently agreed funding for increased AMHP staffing. I team leader F/T; Ix Deputy F?T. All AMPHs rota-ed on during the week	As above. Extra capacity is in line with national indicators	Continued funding from the local authority.

Positive practice				
Service	**Background and need it addressed**	**Resources**	**Impact and challenges**	**Sustainability**
SWASFT – South West regional Mental Health Joint protocol	The South West Regional Mental Health Joint Protocol has been created and agreed with the 5 police forces that cover the South West region to allow for an agreed understanding with our emergency colleagues across the South West. The Mental Health Clinical Guideline is also attached.	Mental Health Clinical Guideline 2014 Final.c South West Regional Mental Health Joint Pr	**Challenges** Integrating knowledge of this police/ambulance service agreement into local practice.	Review in 12 months.

Positive practice				
Service	**Background and need it addressed**	**Resources**	**Impact and challenges**	**Sustainability**
Standard Operating Procedure for Mental Health A&E Liaison response times	There was a need to ensure that people receive mental health assessments within the urgent care quality standards of four hours in the ED department. As it was also crucial that the Royal College of Psychiatrists Guidance on Best Practice Liaison Services was followed, our local services agreed a SOP.	*SOP to be embedded.*	**Impact** This has a positive impact in terms of ensuring a shared understanding of protocol and practice.	Review in 12 months.

Positive practice				
Service	**Background and need it addressed**	**Resources**	**Impact and challenges**	**Sustainability**
Section 136 protocol facility and funding	There was insufficient capacity for assessments under 136. The Avon Commissioners and all associated provider organisations agreed a shared protocol and the CCGs provided increased funding to operate a 4 bedded assessment suite based in Southmead.	135k for 0.67% occupied bed base	**Challenges** The suite is receiving many clients who are assessed as having no mental health problems where there is no further follow up and a proportion of these clients are intoxicated. (Please see action plan). Positively the numbers of assessments in police cells has reduced.	Recurrent funding.

Positive practice				
Service	**Background and need it addressed**	**Resources**	**Impact and challenges**	**Sustainability**
Work force development in the RUH – mental health training.	The RUH and AWP recognise the need to increase competence and confidence in managing people's mental health problems which has resulted in the training of emergency department staff, their development of a risk matrix and bespoke training for healthcare assistants across the hospital. Training was provided by the liaison team and for the HCAs gives skills for health accreditation.	Delivered within the funded liaison service envelope.	**Impact** Increased awareness and skills in managing mental health problems.	Part of an on-going drive for workforce development (See action plan).

Positive practice				
Service	**Background and need it addressed**	**Resources**	**Impact and challenges**	**Sustainability**
Production by service users and community staff of the Hope Guide	It was recognised that there was no single source of information on mental health services and points of contact. The service user and carer groups alongside community organisation have developed and distributed the Hope Guide which is updated quarterly.	St Mungo's Building Bridges Service, which is funded via Local Authority, supports the New Hope Group which produces the Hope Guide.	The impact has been huge in terms of an increased awareness of what is available. **Challenges** The challenge is to keep it live and connected to other forms of information.	

Positive practice				
Service	**Background and need it addressed**	**Resources**	**Impact and challenges**	**Sustainability**
Oxford Health NHS Foundation Trust. CAMHS paediatric liaison service to the Royal United Hospital.	All young people up to the age of 18 who present at the Royal United Hospital following an act of deliberate self-harm and who are admitted to either the Paediatric ward or the Observation Ward are assessed the following day by a clinician from the CAMHS Team. A full assessment of their mental health needs and mental state is undertaken and follow up assessment / intervention offered as appropriate to their needs. Where a child / young person does not live in BANES a referral on is made to the most appropriate agency to support the young person. This is in compliance with the RUH protocol.	Liaison rota in place. Senior Mental Health Practitioner available each day to carry out assessment on the ward. Consultant Child and Adolescent Psychiatrist is available to offer consultation and joint assessment if needed	All young people admitted to the RUH following DSH including alcohol / illicit drug poisoning are given a comprehensive mental health assessment and offered appropriate follow up / intervention. There are some times difficulties arranging follow up care when young people live outside the catchment area for Banes CAMH Services	

Positive practice				
Service	**Background and need it addressed**	**Resources**	**Impact and challenges**	**Sustainability**
Oxford Health NHS Foundation Trust CAMHS Out Of Hours Service.	CAMHS have a 7 day a week 24 hours a day service. Out of hours a Senior Mental Health Practitioner and Consultant Child and Adolescent Psychiatrist are available to offer advice to professionals who have urgent concerns about a child or young person's mental health. Where necessary mental health assessments can be carried out in a place of safety.	Senior Mental Health Practitioners, Consultant Child and Adolescent Psychiatrist, Team Manager, Service Managers, Directors.	Professionals have access to mental health advice 24 hours a day ensuring that young people's mental health needs are appropriately addressed.	
136 Diversion	Work has recently begun in developing a similar agreement to that held in Wiltshire between the local police force and CAMHS. This is a formal agreement whereby OHFT CAMHS provide front line officers with direct contact to a Duty Clinician within CAMHS. This is available both in and out of hours whereby officers can contact the duty person	Senior Mental Health Practitioners, Consultant Child and Adolescent Psychiatrist, Team Manager, Service Managers, Police officers	The impact of using the protocol in a neighbouring area has been to provide a supported service to the police force in the management of young people with mental health issues in an effective and appropriate way and has seen a significant reduction in the	

Positive practice				
Service	**Background and need it addressed**	**Resources**	**Impact and challenges**	**Sustainability**
	for advice when a young person is picked up in a state of distress and presenting with apparent mental health issues.

Following discussion on the phone an appropriate course of action between the Mental Health clinician and the officer can be agreed. This may be a recommendation to take the young person to a safe place for a mental health assessment which the Duty person can arrange or may require a Place of Safety whereby a Mental Health **Act** Assessment will take place (if it is thought the young person needs to be detained for mental health reasons).

A further recent development is a Standard Operating Procedure agreement between AWP, police, CAMHS and other agencies | | number of Section 136s in the county.

It is anticipated that a similar working protocol being agreed in the Banes area will also support police officers and help to reduce the inappropriate use of S136 with those young people under the age of 18.

The impact will be to enable young people appropriate and safe care when they are detained on a S136 in the community with facilities that are fit for | |

Positive practice				
Service	**Background and need it addressed**	**Resources**	**Impact and challenges**	**Sustainability**
	which sets out terms of provision for young people under 18 and under 16 to enable access to the 136 facilities provided at Southmead Hospital in Bristol. This will enable young people access to a place of safety with clear protocols about their care for the duration of their stay to ensure appropriate and effective interventions are available.		purpose. The challenge will be to ensure adequate and appropriate resources are readily available as required and managing risk and flow for those clients needing a MH Act assessment	

Action plan					
Section 1 - Commissioning to allow earlier intervention and responsive crisis services. To include: **A:** Matching local need and demand with a suitable range of services; **B:** Improving mental health crisis services; **C:** Ensuring the right numbers of high quality staff; **D:** Improved partnership working in					
Scheme	**Includes**	**Action**	**Timescales**	**Led by**	**Outcomes**
Mental health commissioning – widen organisational engagement/involvement structures	A,B,C,D	**a)** Ensure that the homeless healthcare team is involved in the mental health and wellbeing forum as well as the offenders mental health meetings. **b)** In addition to the local SRG meeting ensure that local contacts are made with SWAST for the development of services. This rep will be attached to the crisis concordat task group.	From January 2015. **Complete**	**AM**	The homeless healthcare team are more influential in shaping commissioning for this homeless and marginally housed client group who often have unstable and/or untreated mental health needs who can often slip into crisis That the links to the front line ambulance staff in terms of understanding and influencing local mental health service commissioning are strengthened.

Action plan					

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Scheme	Includes	Action	Timescales	Led by	Outcomes
Intensive Team – AWP Review the notion of a "virtual ward" with a capacity of 20 people in.	A, B, C	Completion of review of role and function of intensive service within context of service provision and delivery	6 months - review to inception. **Update 15/05/2015**: on-going. Waiting to recruit a Band 6 worker. **Update 30/09/2015**: Band 6 vacancy is changing to a police and homeless liaison post. **Update 20/10/2015**: At present the capacity of team to provide "virtual ward" is approx. 17-25 people. Currently In the process of recruiting 2 days per week psychology dedicated to intensive. Also recruiting to 2 WTE band 6 equivalents. Providing care teams to from	JE	Increase capacity of intensive team to deliver home treatment in the context of a virtual ward Improve the quality of home treatment delivered To develop care teams to enable service users to have care from named individuals. To increase access to psychological therapeutic intervention in home treatment To review point of access to home treatment with a view to earlier intervention

Action plan					
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Scheme	**Includes**	**Action**	**Timescales**	**Led by**	**Outcomes**
			named individuals is challenging in the context of reduced staffing levels. We recently recruited to a band 5 rotational post. To develop internal training opportunities, post to commence within the intensive team. Update June 2016: Recruitment challenges are on-going. Team have successfully recruited a Psychologist. Police and Homeless Liaison post is now in situ.		

Action plan					

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Scheme	Includes	Action	Timescales	Led by	Outcomes
Dual Diagnosis Support To provide a dedicated mental health nurse giving OOH advice and support to Police, Ambulance service and to 3rd sector organisations with focus on dual diagnosis and transitions. This is an ageless service which will include the Early Intervention service, Psychiatric Liaison and Intensive Services Targeted Resilience Funding B&NES Scher	A, D	Recruitment of Band 6 Nurse with substance misuse expertise to provide OOH advice and support to the Police, Ambulance and B&NES Street Homeless project (run by Julian House) also provide assistance with referrals on appropriate pathways to other services.	Recruitment – January/February 2015 Training Implementation: February/March 2015 Full implementation and review of service: March 2015 onwards **Update 15/05/2015:** Unsuccessful in targeted resilience money bid. Continuing to try and get funding. Researching and investigating how to evidence that service will pay for itself. **Update 30/09/2015:** Band 6 Intensive team vacancy being converted into a police and homeless liaison post within contracted	**JE**	Increase number of contact with services related to substance misuse. Increased confidence in local providers with providing advice and assisting with/ managing issues regarding dual diagnosis. Longer term reduction in the presentation of services users to ED/ 136 suites. Reduction in attendance times for ambulance and police services for service users with mental health problems Only people with mental health problems are detained in 136 suites

Action plan					

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Scheme	Includes	Action	Timescales	Led by	Outcomes
			budget as part of a local model. **Update 29/04/2016:** Police and Homeless Liaison role has strengthened relationships between organisations and more positive relationships are building. Need to develop the role further and explore possible alternate funding streams to develop provision further.		
Development of workforce in RUH	C, D	A sub group of the RUH nursing workforce group is meeting to discuss training and skill sharing opportunities with	January 2015 onwards Also optimising care for physical needs of patients in Sycamore and Ward 4 without having to transfer to an acute setting. A	**ML/RR**	Increased confidence in physical healthcare staffs' ability to manage mental health problems and vice versa.

Action plan					
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Scheme	**Includes**	**Action**	**Timescales**	**Led by**	**Outcomes**
		AWP.	consultant physician will be available from 8am-8pm to call and help with making decisions on pathways. Potential go live date: 1st June 2015. Pilot has already been carried out to give mental health training to healthcare assistants. There has been a joint bid from RUH and AWP to the South West Education Fund for a competency framework development allowing staff training on Ward 4 and Sycamore for physical health needs. Awaiting decision. **Update 15/05/2015:**		

Action plan					
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Scheme	**Includes**	**Action**	**Timescales**	**Led by**	**Outcomes**
			RMNs to be supported with training in physical needs to allow RMNs to look after a patient's whole needs. Supervised by AWP Mental Health Team. **Update 30/09/2015**: 7 month pilot to start once person is in post. This will allow a senior mental health practitioner to work within the senior nursing team at the RUH. This will allow mental health needs and challenging behaviour to be addressed. The mental health practitioner will also help with training, raising awareness of mental health and		

Action plan					
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Scheme	**Includes**	**Action**	**Timescales**	**Led by**	**Outcomes**
			support staff with risk matrixes. A project manager is in place to look at expediting discharges. 12 healthcare assistants and a further 12 are undertaking mental health awareness training. Pilot is being run with simulation training and liaison staff to target attitudes to dementia. Combe Ward has received the National Quality Mark for Elderly Care. **Update 29/04/2016:** Simulation training has commenced in the RUH. The pilot post was		

Action plan					

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Scheme	Includes	Action	Timescales	Led by	Outcomes
			working well and has been extended for a year. The previous post holder has left and we are currently recruiting for a replacement. The healthcare assistant training is completed. The liaison services are currently rolling out Dementia training for healthcare assistants.		
Support for the Police through supervision	B, D	Understand and then replicate a South Gloucestershire initiative to provide mental health case supervision to the police. This would be in line	2015/16 **Update 15/05/2015:** Considering having mental health champions within the Police service and this would allow for cascade training or offering a point of	**CS/AM/Paul Bunt**	Increased confidence and competence in police to manage people presenting with mental health problems in an appropriate way. *(We will enter into discussions about the possibilities of doing this for ambulance*

Action plan					
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Scheme	**Includes**	**Action**	**Timescales**	**Led by**	**Outcomes**
		with our current dual diagnosis supervision support provided by AWP to community services.	contact for advice **Update 30/09/2015**: AWP are looking at providing police training on rotation. There are 5 teams that can be offered training every 10 weeks. Meeting to take place in November to look at rolling this out. Information sharing has improved. Early intervention has improved. Sarah Treweek and Will Stephens have become local mental health champions within the Police. 120 people have undertaken Mental Health Awareness Level 2 training. A further 40 (with a		*staff, although recognise their capacity to attend training is stretched).*

Action plan					

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Scheme	Includes	Action	Timescales	Led by	Outcomes
			potential extra 30) people are to also undertake the training in 2016. A national training package is being finalised. B&NES mental health training will be supplementary to this. **Training 29/04/2016**: Local training package has been developed in conjunction with AWP, Local Authority AMHP service and there is also the possibility to have service user involvement. The training has started to be delivered to local police officers. In addition the Police		

Action plan

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Scheme	Includes	Action	Timescales	Led by	Outcomes
			Liaison and Homeless Nurse spends time with local officers to provide specialist mental health advice, support and guidance.		

Section 2 - Access to support before crisis point. To include:
A: Improve access to support via primary care; **B:** Improve access to and experience of mental health services

Scheme	Includes	Action	Timescales	Led by	Outcomes
Personality disorder community support (AWP – UJ) Targeted Resilience Funding B&NES Scher	A	Investment bid to be submitted to CCG by December 1st Once approved staff training to be completed as per timescales opposite Ensure that, given the high prevalence of Borderline and other Personality Disorders within the homeless population, the Homeless Health Care Team are involved.	(Subject to CCG funding approval for scheme) December 2014 on earlier if funds are available STEPPs training will be available January 2015. The First course to start February 2015. **Update 15/05/2015:** First cohort have started STEPPs programme. All going ahead although not all materials have been delivered by training body. **Update 30/09/15:** Delivery of the programme continuing. All materials have now been delivered to deliver training. **Update 29/04/2016:** Programme continues to be delivered on a quarterly basis with all courses fully attended.	**Ursula James**	Increased liaison with CAMHS and children's services for young people therefore earlier intervention. Increased awareness of other support the community for service users. Increased confidence in staff across organisations in supporting people with personality disorder. Reduction of repeat presentation within primary care services.
Improving level of resilience through increasing self-management	A	Implement the Wellbeing College pilot in B&NES.	January 2015-2017 Update 15/05/2015: All going ahead. 95 different learning opportunities on	**AM/BW**	Increased ability of the B&NES population to manage their long

Scheme	Includes	Action	Timescales	Led by	Outcomes
initiatives in the community			offer. **http://wellbeingcollegebanes.co.uk/** **Update 10/10/15:** Continuation of an extra year to 2017 agreed in order to evaluate effectiveness. Project now linked to social prescribing initiative (local) and data integration project and funded by Innovate UK		term conditions as well as their mental health at an earlier stage than is currently possible and before people need to use health services.
Mental health support in perinatal pathway	B	Improve the perinatal pathway	**Update 30/09/2015:** Looking at developing the perinatal pathway to include mental health support. Still awaiting details of funding to support. Referrals to be accepted from midwives. Consideration to be given to how the pathway will look in a crisis situation and where would a crisis occur? To align with pathway developed in Wiltshire as shared services. **Update 29/04/2016:** Local perinatal pathway has been reviewed and provisional pathway has been developed which shares many similarities with Wiltshire, but takes into account local perinatal healthcare	**AWP**	Improved services for women receiving perinatal services and support.

Section 2 - Access to support before crisis point. To include:					
A: Improve access to support via primary care; **B:** Improve access to and experience of mental health services					
Scheme	**Includes**	**Action**	**Timescales**	**Led by**	**Outcomes**
			provision. Currently there is an AWP trust-wide review of perinatal mental health.		
CAMHS	A, B	Improve services for children and young people experiencing mental health problems.	**Update 30/09/2015**: There is national funding available for CAMHS transformation. A ring-fenced proportion of this is to be spent on eating disorders and the rest is available for spending on other areas. Funding will be provided for 5 years. B&NES has a higher incidence of eating disorders than in neighbouring areas. Looking to develop both preventative and specialist work – including supporting children to eat in their own homes. Service will provide early intervention, including giving better advice to GPs and school education. Looking into joint commissioning a service with Swindon and Wiltshire. Also considering using some of the funds to facilitate training around the new assessment protocol for young people under the mental health act.	**Margaret Fairbairn**	Improved services in line with national expectations. Liaison and crisis services in B&NES able to provide appropriately timed and high quality response. Improve early intervention and specialist mental health approaches in order to prevent or smooth out transition into adult services where able.

Section 3 – Urgent and Emergency access to crisis care. To include:
A: Improve NHS emergency response to mental health crisis; **B:** Social services' contribution to mental health crisis services; **C:** Improved quality of response when people are detained under Section 135 and 136 of the Mental Health Act 1983; **D:** Improved information and advice available to front line staff to enable better response to individuals; **E:** Improved training and guidance for police officers; **F:** Improved services for those with co-existing mental health and substance misuse issues

Scheme	Includes	Action	Timescales	Led by	Outcomes
Street Triage (AWP – JE) Targeted Resilience Funding B&NES Scher	A, D, F	Submit bid for investment to CCG as the request to NHS England was unsuccessful. Learn from the Devon Partnership/SWASFT Partnership initiative in order to improve practice. Continue work with other commissioners to ascertain whether a single AWP/ SWASFT initiative can be developed in the longer term. **To include 111 providers**	**2015/16 depending on funding agreement.** **Update 15/05/2015**: Did not get targeted resilience monies. Continuing to try and get funding. Researching and investigating how to evidence that service will pay for itself. **Update 30/09/2015**: Found that there were no cost benefits of having a street triage service as the numbers in B&NES are small. Instead looking to increase training and supervision and looking at implementing control room triage. Also found that activity and need with s136 admissions, ED admissions and 111 calls in relation to mental health, is in OOH during	**AM/JE/AMPH Lead/EDT Lead**	**Links to rapid response service redesign.** Patient receives specialist service response at the point of presentation rather than needing further assessment (unless clinically indicated that further specialist assessment needed). Greater partnership will reduce multiple hands-offs and improve patient experience. Holistic approach taken to need therefore improvement in joint care planning and outcomes.

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Scheme	**Includes**	**Action**	**Timescales**	**Led by**	**Outcomes**
			weekdays. At the moment, most services are following the GP working pattern (opening 9-5pm). Rotas are being looked at by ED staff to reflect need. Services have been encouraged to think about changing their hours of working in accordance with service need. **Update 29/04/2016:** The Police and Homeless Liaison post has highlighted that there is a demand for this service and there is scope to develop the service further. Currently the plan is to identify further areas of development within the current post and to explore alternate funding streams to further develop service provision.		

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Scheme	Includes	Action	Timescales	Led by	Outcomes
Improve urgent care pathway	A, F, D	Although local SOP in place there remains work to be done supporting discharge especially in terms of locating appropriate placements as well as mental health acute bed provision. We want to continue the DTOC review and action plan and request regional information on mental health bed state. Consider CQUIN to support transformation	December/Jan 2014-15 **Update 15/05/2015**: Improved flow through system though there are still issues with Ward 4, timescales for moving to community placements, patients being transferred out of area and placements for children and young people. **Update 30/09/15:** DTOCs have returned to under 7% for mental health service users although current issues still reside with older adult populations and the need for specialist dementia nursing home beds. Plans in place to review accommodation pathway for adults of working age. Acute care pathway work in the acute trust has improved bed	**AM/BB-J/ML/DC**	Improve the experience of people with dementia and mental health problems in both mainstream and mental health urgent care pathways. Reduce the number of delayed transfers of care. Reduce length of stay in the acute mental health wards.

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Scheme	**Includes**	**Action**	**Timescales**	**Led by**	**Outcomes**
			management and patient flow.		
Working in collaboration with SWASFT as regular 1st point of contact for those in crisis.	A, C, D	SWASFT keen to involve partnership working in improving mental health care. We aim to develop: *direct referral pathways *Access to mental health advice (see street triage project) *Access to care plans and escalation plans (see single patient notes project) *Access to health based places of safety	2015-16 **Update 15/05/2015**: AWP have looked at documents that David had produced. Work is on-going. Mental health is included on annual mandatory training. **Update 30/09/2015:** AWP have received Trust agreement to have paramedics spend time with the mental health team if they would like to.	**David Partlow**	Improved level of care. Lower the number of Emergency Department admissions.
AMPH service	B	Review arrangements for out of hours AMHP provision and ensure this is effective and meets need	**2015/16** **Update 30/09/2015:** All 4 counties are looking at OOH AMPH provision. At the moment there are 3 AMPH members of staff	**TL/AM/LH**	A more responsive out of hours emergency duty service so that coverage over 24 hours is equitable

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Scheme	Includes	Action	Timescales	Led by	Outcomes
		As we have combined the OOH services with children's safeguarding and across 4 counties we need to, in consultation with the police and mental health providers, ensure that AMHPs can be available within locally agreed response times. Explore the potential for better integration of AMHP and EDT services with out of hours crisis provision of health and other partners.	working until 1am. The team are prioritising their response as best as possible. The team find that their options are very limited OOH as there are very few services that are open or professionals that are available. There is a growing culture of working together. The team are also working with the police on individuals and identifying any mental health issues. **Update 01/06/2016:** Service level agreement for Emergency duty service has been agreed by all four Local Authorities. There are no changes to out of hours. Lack of resources out of hours continues to present a challenge.		and efficient.

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Scheme	Includes	Action	Timescales	Led by	Outcomes
Identify the frequent attenders at services with alcohol usage as part of their presenting features. (See Section 4, scheme 1)	A, F	To combine the information we have from the Blue Light data with other sources of information e.g. from community services to identify the size of client group for a revised pathway response.	**Q1 2015/16** Update 20/10/15: Cost of Blue Light clients in B&NES has been scoped. Of the total cost, 37% is attributed to mental health services. Also found that 14% of people with a mental health disorder are likely to be a dependent drinker. Currently exploring how a multiagency response to support and planning for Blue Light clients might operate locally.	**CS/AM**	More targeted and tailored responses to the needs of clients with co-existing mental health and alcohol issues.

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Scheme	**Includes**	**Action**	**Timescales**	**Led by**	**Outcomes**
Avon and Somerset Police response to s135/136	C, D, E	Review of suitable places of safety and patient transport	**26/3/15** – "Think Ambulance" protocol launched force-wide to ensure that persons detained under s135/6 are conveyed to a place of safety in an Ambulance in all but the most exceptional circumstances. Since introduction Ambulance use for conveyance has increased hugely (350% increase in the first month alone), with figures continuing to improve. **11/5/15** – Police introduced a protocol that under 18's detained under s135/6 MHA would no longer be accepted into police cells. Negotiations between partners across the force area have identified alternatives to the 136 suites should they be	**Avon and Somerset Police**	Improved quality of response and level of care for those who are detained under Section 135 and 136.

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Scheme	**Includes**	**Action**	**Timescales**	**Led by**	**Outcomes**
			full/unavailable. Since that date, no children have entered the cells whilst detained under the Act. The Office of the Police and Crime Commissioner has arranged a meeting with force-wide acute hospital representatives on 18/9/15 to ensure Hospital involvement in negotiations around S136 use. **23/7/15** - Under 18 S136 protocol being developed for BANES in conjunction with BANES CAMHS (Oxford Health). Aide memoir and Memorandum of Understanding (MOU) has been adapted from Wiltshire Police documents, in use already by Oxford Health. Awaiting signoff by partners and then to be		

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Scheme	Includes	Action	Timescales	Led by	Outcomes
			rolled out to officers in the BANES district. The MOU will ensure that CAMHS are consulted prior to the use of S136 MHA, with the aim of reducing unnecessary detentions that could have been diverted to a less restrictive option. **Update 30/09/2015:** Criminal justice suites will have a single point of contact for partners to be identified. New protocol being used for u18's which has been signed off by the assistant Chief Constable. Where young people are detained, a consultation will take place with CAMHS where possible. Training is due to be delivered and an aide memoire has been		

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Scheme	Includes	Action	Timescales	Led by	Outcomes
			produced. Work is being carried out by Tom Lochhead and Fiona Beech to look at having wrap around services to give an individual response. CAMHS are looking at where u16s are able to go when they are detained by the police. Discussions taking place with Oxford Health taking into consideration the legislation. B&NES have some extra capacity with Priory beds. Wiltshire have declined B&NES use of their s136 suite.		

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Scheme	Includes	Action	Timescales	Led by	Outcomes
Mental health support in Police Control room/ Control room triage	C,D,E	Other areas have seen benefits from having mental health staff available in control rooms. This allows access to patient medical records and mental health expertise to give those in crisis the best possible support.	**3/6/15** - A meeting was held between CCG senior leaders, NHS England, senior leaders from AWP and Somerset Partnership, the PCC and Chief Constable whereby unanimous support was given to exploration of a control room triage scheme within the force area. **23/6/15** – Norfolk Police gave a presentation on control room triage to local Police/NHS/Fire/Ambulance partners, proposal to create a business plan to obtain funding to introduce locally. Information being sought on possible benefits to all partners to be incorporated into a force-wide business case, for presentation to each CCG in the next funding cycle.	**Avon and Somerset Police**	Increased support for police staff allowing for forces to respond in the most appropriate way. Improved quality of care received from the police when responding to crises with advice from mental health professionals.

Section 3 – Urgent and Emergency access to crisis care. To include:

A: Improve NHS emergency response to mental health crisis; **B:** Social services' contribution to mental health crisis services; **C:** Improved quality of response when people are detained under Section 135 and 136 of the Mental Health Act 1983; **D:** Improved information and advice available to front line staff to enable better response to individuals; **E:** Improved training and guidance for police officers; **F:** Improved services for those with co-existing mental health and substance misuse issues

Scheme	Includes	Action	Timescales	Led by	Outcomes
			Update 30/09/2015: Business case draft has been put through SRG for non-recurring funds to be used specifically for liaison purposes. Considering using the monies to implement control room triage. The liaison role will feed into PCLS. **Update 29/04/2016:** Final business case for control room triage nearly completed with all partner agencies. Financial contributions from all agencies have been tentatively agreed. Further analysis also required as street triage schemes appear to have been successful in reducing		

Section 3 – Urgent and Emergency access to crisis care. To include:				
**A:** Improve NHS emergency response to mental health crisis; **B:** Social services' contribution to mental health crisis services; **C:** Improved quality of response when people are detained under Section 135 and 136 of the Mental Health Act 1983; **D:** Improved information and advice available to front line staff to enable better response to individuals; **E:** Improved training and guidance for police officers; **F:** Improved services for those with co-existing mental health and substance misuse issues

Scheme	Includes	Action	Timescales	Led by	Outcomes
			the number of s136/diverting from custody. However there appears to have been an increase in the number of mental health attendances to the emergency department.		
Raising staff awareness of Mental Health	D, F	Mental health awareness training to be rolled out amongst Sirona staff.	**Update 30/09/2015:** Sirona mental health training is underway. Aiming to train 98% of staff. 100s of staff have already been through the training and training is now included in the corporate induction. Now starting to consider how the training will be utilised going forward.		

Section 4 - Quality of treatment and care when in crisis. To include:
A: Review police use of places of safety under the Mental Health Act 1983 and results of local monitoring; **B:** Service User/Patient safety and safeguarding; **C:** Staff safety; **D:** Primary care response

Scheme	Includes	Action	Timescales	Led by	Outcomes
Investigate new provision/ pathway for intoxicated clients.	A,	Explore need; look at existing services (s136 suite and RUH) and community; SDAS/DHI/Julian House. Scope for pathway, services and facilities for rapid and intensive support to address around 200 individual impact alcohol clients, on top of work that is already happening for high impact patients. Specifically addressing 20-25 people that attend ED once a month on average. Explore the service provided by street marshals/	**Pathway for Intoxicated/Mental health clients meeting set for 22/12/2014. Complete.** **Update 30/09/2015:** There has been a lot of work taking place around 'blue light' clients. Looking at the possibility of providing blue light information and training to the police. Harm reduction work has also taken place and training can be provided. There is a 'damp' house provision with 4 beds to help clients who have relapsed.	**CS/AM**	**± 200 individual clients = £10m per annum cost. 20-25 Mental Health /Alcohol patients = £3.7m cost. Averaging 1 visit to ED per month. Improved pathway/facilities will look to reduce number of ED visits.**

Section 4 - Quality of treatment and care when in crisis. To include:
A: Review police use of places of safety under the Mental Health Act 1983 and results of local monitoring; **B:** Service User/Patient safety and safeguarding; **C:** Staff safety; **D:** Primary care response

Scheme	Includes	Action	Timescales	Led by	Outcomes
		street pastors/ fast ambulance. Discuss potential for bidding to expand service. Investigate numbers for s136 suite. Alcohol related ED attendance = ±15% of all ED attendances. Investigate number of those intoxicated. (Piece of work being done by Wiltshire to estimate numbers).			
Review ability to provide S136 suite in area in the longer term	A	Scope into re-design for in-patient beds. Include in impact assessment process	December 2014

December 2014 | **AM/BB-J** | |

Section 4 - Quality of treatment and care when in crisis. To include: **A:** Review police use of places of safety under the Mental Health Act 1983 and results of local monitoring; **B:** Service User/Patient safety and safeguarding; **C:** Staff safety; **D:** Primary care response					
Scheme	**Includes**	**Action**	**Timescales**	**Led by**	**Outcomes**
		Present to Wellbeing PDS as part of impact assessment and proposal paper Define next steps if approval gained. Consider whether this can be part of a wider assessment suite that could also work with children and young people.	January 2015 **Update 15/05/2015**: work on-going looking into having a s136 suite in B&NES and addressing issues with access for under 18s and under 16s.		
Instigate rapid response service in existing Specialist mental health services	D, B	Produce paper analysing opportunities within existing service configuration- paper in draft format at this time Currently we are near to completing the review of access service function which is	January 2015 **Update 15/05/2015**: Paper has been completed and this is now being piloted with PCLS. This will be reviewed in June 2015 with the intention of including the intensive team as well. **Update 30/09/2015**: Rapid access is	**JE**	**The model is potentially linked to street triage investment bid** Patient receives specialist service response at the point of presentation rather than needing further assessment (unless clinically indicated that further specialist assessment needed).

Section 4 - Quality of treatment and care when in crisis. To include: **A:** Review police use of places of safety under the Mental Health Act 1983 and results of local monitoring; **B:** Service User/Patient safety and safeguarding; **C:** Staff safety; **D:** Primary care response					
Scheme	**Includes**	**Action**	**Timescales**	**Led by**	**Outcomes**
		likely to separate assessment and home treatment functions of intensive and more closely align the assessment functions across PCLS, intensive, with some linking to the intensive hospital liaison interface. Meeting timetabled for December to agree on final model. Pathway might look something like this: pathway edit.docx Also work to commence in 2015 to explore if we	underway and is no longer a pilot. Improvements to be made to joint working between PCLS and Recovery teams. **Update 29/04/2016:** Rapid access is now fully integrated into PCLS core business.		Greater partnership will reduce multiple hand-offs and improve patient experience. Holistic approach taken to need therefore improvement in joint care planning and outcomes.

Scheme	Includes	Action	Timescales	Led by	Outcomes
Section 4 - Quality of treatment and care when in crisis. To include: **A:** Review police use of places of safety under the Mental Health Act 1983 and results of local monitoring; **B:** Service User/Patient safety and safeguarding; **C:** Staff safety; **D:** Primary care response					
		can increase productivity of assessment functions of access service though a reduction of the "burden" of RiO system.			
Working in collaboration with SWASFT	B, C, D	SWASFT want to be engaged with work in relation to conveyance of PoS. Have committed to 30min response time for section 136 requests. In addition we need to discuss with SWASFT the numbers of private transport conveyances for patients detained under section of the Mental Health Act.	**Currently in operation as green 2 response time.** **Update 15/05/2015:** David Partlow has been in contact with Liz Richards at AWP. Scoping exercise is being carried out to look at demand and develop a model. **Update 30/09/2015:** Agreement is currently in place with private ambulances for conveyance. To be reviewed when contract is due for renewal.	**SWASFT**	**This needs to be assessed in light of SWASFT ability to respond to all green 2 priorities in the face of capacity demands.**

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Section 4 - Quality of treatment and care when in crisis. To include: A: Review police use of places of safety under the Mental Health Act 1983 and results of local monitoring; B: Service User/Patient safety and safeguarding; C: Staff safety; D: Primary care response					
Scheme	**Includes**	**Action**	**Timescales**	**Led by**	**Outcomes**
Service User Charter	B	Document is being developed in partnership between New Hope/St Mungos, Healthwatch and Making it Real. Providing 'I' statements that service users can apply to practice.	Document is in draft form. Focus groups are being held between August and October 2015.	New Hope/St Mungos, Healthwatch, Making It Real	Supporting service users to gain an insight into their wellbeing.

Section 5 - Recovery and staying well / preventing future crisis. To include: A: Joint planning for prevention of crises						

Scheme	Includes	Action	Timescales	Led by	Outcomes
Liaison for older adults. Targeted Resilience Funding B&NES Scher	A	Funding approved. Negotiation/ exploration of roles with Sirona. Development of job description for RN (adult)/ RGN.	***November / December*** *Liaison with partner organisations regarding model implementation.* ***December/January:*** *Recruitment* ***February onwards:*** *Full implementation and review/evaluation* **Update 15/05/2015:** Recurring funds received. **Update 29/04/2016:** Funding was fixed term and has now come to an end. Some aspects of this role have been developed and incorporated into the pilot project post with	JE/KG	Parity of esteem for people with physical and mental health problems. More people treated by services with which they are familiar. Reduced admission to hospitals.

Section 5 - Recovery and staying well / preventing future crisis. To include:					
A: Joint planning for prevention of crises					
Scheme	**Includes**	**Action**	**Timescales**	**Led by**	**Outcomes**
			the RUH.		
Working in collaboration with SWASFT		Plan to develop a facility to feedback into primary care and secondary mental health services with appropriate patient contacts made by SWASFT. This will involve presentation on the SWASFT electronic clinical record due to be rolled out in B&NES in the summer of 2015.	**Update 15/05/2015**: Looking at how to link in EPCR with other systems. Implementation date: Autumn 2015	**David Partlow**	Often patients will present and not be conveyed, this may be an early indication of a degree of instability which could be managed earlier. The ability to feedback into services will allow for continuity and a higher level of care.
Further develop shared patient notes to join up GP, Acute, ambulance and MH services	**A**	Special patient notes project in moving forward and mental health is part of that project. Again, this could link in the future to SWASFT	2015-16 **Update 10/10/15:** Next phase of work on special notes for people with mental health problems has begun with Katia Montella leading it in	**AM/CP/DP**	Ensure that all services have access to appropriate care plans for people who use services in an emergency or crisis situation

Section 5 - Recovery and staying well / preventing future crisis. To include:					
A: Joint planning for prevention of crises					
Scheme	**Includes**	**Action**	**Timescales**	**Led by**	**Outcomes**
		work with the enhanced summary care record and their ability to access this via the SWASFT electronic record. Already being used in some instances.	B&NES		
Implement social prescribing project to prevent escalation of non-medical conditions		The aim of this service is to redirect suitable patients away from the NHS and towards opportunities in the local community which can support their needs. People referred to the service may have mental health needs, long term conditions or other practical issues	The new commissioned service will start on 1 Jan 2015 and will aim to begin effective delivery by April 1st 2015. The commission initially is for 27 months to 31 March 2017 and any extension is dependent on good outcomes and continued CCG funding. **Update 15/05/2015:** Service has now	**AM/BW**	Be responsive in addressing health, practical and social issues that may negatively impact on the health and wellbeing of people who frequently make use of local GP practices. Reduce the demand on costly health services and enable funds to be better targeted on people whose needs are purely clinical rather than practical or social. Improve the patient's

Section 5 - Recovery and staying well / preventing future crisis. To include:					
A: Joint planning for prevention of crises					
Scheme	**Includes**	**Action**	**Timescales**	**Led by**	**Outcomes**
		which affect their mental and physical wellbeing. This service will operate mainly within GP practices, as well as links to, e.g. A&E and Health visitors. Priority will be given to people who are identified by GPs as frequent attendees, or those identified where the involvement of the service may reduce future health service attendance.	been implemented on a two year pilot. **Update 20/10/15:** uptake by GPs very positive. It is already clear that moving forward capacity will be an issue. Initially concentrating on high attenders at GP practices.		quality of life Encourage and enable people to better manage their conditions, take up of prescribed health related activities and access to mainstream services and community resources.
Support the revised multi-organisational approach to addressing social isolation in people	**A**	On a general level, the Mental Health & Wellbeing Forum provides a bi-	Service specifications were revised between April-July 2014, with commissions ending March 2016. It is the	**AM, BW, Providers, community groups, service users, carers**	To develop networks of support for social interaction within the community, outside of services, in order to

Section 5 - Recovery and staying well / preventing future crisis. To include: A: Joint planning for prevention of crises					
Scheme	**Includes**	**Action**	**Timescales**	**Led by**	**Outcomes**
with mental health problems		monthly opportunity for commissioners, providers, service users and carers to meet together and discuss issues and future developments. E.g., the Wellbeing College specification was developed by Forum members. The Social Prescribing Service (above) and Sirona Community Links Service (social prescribing element) both link and support people into a wide range of local funded and unfunded groups,	commissioners' intention at that point to put out to tender an overarching specification to provide a flexible and responsive multi-organisational approach to mental health and wellbeing support in the community. Social isolation will be an important element of this. A Wellbeing College, if demonstrated to be successful, could be a central part of this overarching specification. It is currently being considered as to whether a Wellbeing College would take on a role as a commissioning body in terms of		improve health and wellbeing. To support people to self-manage their conditions To reduce social isolation within an appropriate supported environment. To value and make use of shared experience in helping people to support themselves and manage their long term conditions. To increase the range of people's skills and interests and to support them to develop peer-led groups which meet those interests To train and support people to become peer mentors to provide a positive experience for themselves and in helping others. To provide a wide range

Section 5 - Recovery and staying well / preventing future crisis. To include:					
A: Joint planning for prevention of crises					
Scheme	**Includes**	**Action**	**Timescales**	**Led by**	**Outcomes**
		activities & services in order to address their holistic needs. (E.g. unfunded groups like Bath City Farm and Greenlinks). New Hope (service user group) produce a 'Hope Guide' detailing opportunities that people can take up. To further develop a multi-organisational approach in supporting people with mental health needs, service specifications were revised in 2014. A Building	purchasing and developing early intervention, prevention, and self-management courses and activities from 3rd party organisations. This aspect will be consulted on during 2015. Wide ranging discussions will take place during 2015 with all interested parties to develop an agreed and effective specification for the proposed overarching commission. The Wellbeing College and such developments as the Building Bridges Forum can be viewed as forerunners of the overarching commission,		of information and support to enable people to take up opportunities which increase their wellbeing and reduce social isolation

Section 5 - Recovery and staying well / preventing future crisis. To include:
A: Joint planning for prevention of crises

Scheme	Includes	Action	Timescales	Led by	Outcomes
		Bridges Forum was established, supporting services to work together, and meet monthly to share views and experiences, discuss issues and developments. Current members include - **Sirona Community Links** -supporting networks in the community, to build resilience and help people live independently, with a strong social prescribing element. **St Mungos Broadway** - Peer	providing an opportunity in 2014-16 to gather evidence, experience and best practice in order to effectively support people and offer social interaction opportunities in the community. Update October 2015: The Your Care Your Way consultation process is currently underway, which will shape how future services are commissioned for the B&NES community. It is anticipated that a draft model will be determined by November 2015, with the model being operational by 2017. It is being proposed		

Section 5 - Recovery and staying well / preventing future crisis. To include: A: Joint planning for prevention of crises					
Scheme	**Includes**	**Action**	**Timescales**	**Led by**	**Outcomes**
		Mentoring Service trains and supports peers to support people within the networks and the wider community. This service is delivered collaboratively with **Sirona** and **Bath Mind** **Creativity Works** - provide "taster sessions" in creative, supported activities. Creativity Works works with the groups to see how they can develop on a sustainable, peer led and supported basis. **Bath Mind** - work	to extend existing contracts for 1 year to fall in line with the Your Care Your Way process. **Update 29/04/2016:** A local mental health alliance has been formed and development is underway around the mechanism to involve third sector and carer/service users as a part of this. Your Care Your Way has progressed with multiple work streams. There is mental health representation within these to ensure that parity of esteem is achieved.		

Section 5 - Recovery and staying well / preventing future crisis. To include:						
A: Joint planning for prevention of crises						
Scheme	**Includes**	**Action**	**Timescales**	**Led by**	**Outcomes**
		collaboratively with St Mungo's to develop peer mentors. They also facilitate MOSAIC, a community focused club where people from diverse ethnic backgrounds living with mental distress are supported to achieve their personal wellbeing goals and become involved in community activities. **Soundwell Music Therapy -** provides therapeutic music based activities across the community for people with mental			

Section 5 - Recovery and staying well / preventing future crisis. To include:					
A: Joint planning for prevention of crises					
Scheme	**Includes**	**Action**	**Timescales**	**Led by**	**Outcomes**
		health issues and works with a range of other organisations to achieve this. ***It should be noted that there are many other organisations and groups working successfully in partnership across the locality to address peoples' social isolation and wellbeing.*** The **Wellbeing College** (below and set 2 above) takes a multi-organisational approach, developing and promoting a wide			

Section 5 - Recovery and staying well / preventing future crisis. To include:
A: Joint planning for prevention of crises

Scheme	Includes	Action	Timescales	Led by	Outcomes
		range of courses and activities from many providers, which support people's wellbeing and promote prevention. In developing new courses and activities it will effectively act to bring people together with shared interests from the whole community, not just those meeting service criteria.			

Section 5 - Recovery and staying well / preventing future crisis. To include:					
A: Joint planning for prevention of crises					
Scheme	**Includes**	**Action**	**Timescales**	**Led by**	**Outcomes**
Assess elements of preventative self-management that can be delivered through Wellbeing College – 2 year pilot.	A	Independent evaluation taking into account both health and social outcomes – incorporating 5 ways to wellbeing, e.g. into more health based outcomes. College will also assess courses themselves for style, content and effectiveness, getting feedback from participants. Evaluation will inform a business plan for the format of any future Wellbeing College to be commissioned in 2016. Link with social prescribing and social options into the community support.	The college is a 2 year pilot (2014-2016) with an independent evaluation spanning approximately 12 months. The college monitoring will take place over full 2 year period. Update October 2015: The Wellbeing College contract is being extended for 1 year to allow developments to take place and more effectively evaluate the model.	**All WC providers/LA/PH/CCG.**	People to self-manage their long term conditions and through peer support, enable them to share experiences and solutions and support. To assess whether the educative, short term intervention approach to self-management enables people to avoid accessing higher level services - GPs, acute, MH services in crisis To assess whether early intervention, through mainstreaming and appealing to the whole community, reduces the need for people to take up services subsequently.

Section 5 - Recovery and staying well / preventing future crisis. To include:
A: Joint planning for prevention of crises

Scheme	Includes	Action	Timescales	Led by	Outcomes
Housing need for high risk offenders, sex offenders and IRIS clients.	A	To research, develop and consider partnership working within B&NES and also across authorities to address a need for housing where high risk offenders, sex offenders and IRIS clients are considered too high risk for the current supported housing options but do not meet the criteria for the dangerous offender protocol scheme, Homesearch. This can result in individuals being homeless posing challenges with monitoring and managing risk in the community. From conversations with Probation these clients pose a high		**Andy Busfield – Julian House**	To have appropriate supportive housing for high risk offenders allowing better monitoring and support resulting in reducing the risk, severity and escalation of offending and helping to create safer communities.

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Section 5 - Recovery and staying well / preventing future crisis. To include:
A: Joint planning for prevention of crises

Scheme	Includes	Action	Timescales	Led by	Outcomes
Wellbeing House	A	To provide short term respite beds within a safe environment and provide therapeutic interventions throughout their stay to prevent crisis and help people to better manage environments and situations that may cause stress and lead to crisis.	To be in operation by Summer 2015. 1 year pilot. **Update 30/09/2015:** Wellbeing House is now open for referrals. Feedback on the house has been positive so far. Those in the house have received meaningful interventions. A holistic practitioner is working at the house and using a wellbeing options tool that uses the 5 Ways to Wellbeing. Also linking in with outside agencies, looking at what client's would like to do and supporting their journey. Looking at how to maintain the service in the longer term.	**PW/Sirona**	To provide short term respite to individuals, enabling them to be removed from stressful environments as a way of preventing people from reaching crisis.

Appendix 3

The Mental Health Commissioning strategy is based on national guidance and standards developed and delivered within the context of local needs and priorities which, in turn, are informed by the views of local people, carers, service users and staff.

The key reference documents that guide our work are listed in detail below:

1. Mental Health Policy Context

1.1 Mental Health National Service Framework (NSF) for Adults of Working Age, 1999

10 year national strategy to improve adult mental health services for people against 7 standards.

These include a focus on improved mental health promotion, specialist primary care mental health services, specialist secondary mental health services, services for carers and suicide prevention. Health and social care organisations have been monitored against their local delivery on the NSF through the Autumn Assessment and key service deliverables have formed a major part of the organisational star rating of the PCT and Mental Health Trust.

The NSF is largely silent on mental health services provided by the Local Authority, particularly day opportunities, accommodation with support and self-directed care.

1.2 NSF Five Years On, 2005

Recast the last five years of the NSF. The years 2005-2010 will not focus on new developments within specialist mental health services but should bring mental health into the wider health and social care policy agenda.

The priorities for future work are choice, social inclusion, care of long term conditions, dual diagnosis and improved access to services in a primary care setting.

The performance assessment framework for mental health over the final years of the delivery of the NSF will reflect this shift in focus.

1.3 Mental Health and Social Exclusion Report 2004

Adults with mental health problems are the most disadvantaged and socially excluded group in society. This forms the local authority's agenda for mental health services, addressing the areas that were silent in the National Service Framework.

It is everyone's agenda to address the barriers that lead to social exclusion.

There is a 27 point national action plan, the responsibility for the delivery of this sits with the Director of Social Services locally.

The Layard Report published in 2005 by the Prime Minister's Policy Unit identified that 'mental health is the biggest social problem of our country' as it affects people with mild and moderate mental health problems. This led to the establishment of Pathways to Work pilots to provide psychological therapy support for people on incapacity benefit to enable them to return to work.

1.4 The Future of Mental Health: A Vision for 2015

By 2015 mental wellbeing will be a concern of all public services.

- There will still be people who live with debilitating mental health conditions, but the focus of public services will be on mental wellbeing rather than mental ill health.

- The balance of power will no longer be so much with the system, but instead there will be more of an equal partnership between services and the individuals who have used or even choose them.

2 Mainstream Health and Social Care Policy Context

2.1 Choosing Health White Paper (DH 2004):

- Acknowledges the key role of mental health promotion "because mental wellbeing is crucial to good physical health and making healthy choices";

- States that stress is the commonest reported cause of sickness absence and a major cause of incapacity;

- Reconfirms the need to focus on suicide prevention. This is a key performance indicator for mental health trust.

2.2 Our Health, Our Care, Our Say White Paper (DH 2006):

- Sets a new direction for health and social care community service systems.

- Focuses on providing services closer to people's homes or work places.

- Requires health and social care services to integrate to meet people's needs at different stages of their lives. For mental health this means integrated specialist and primary care services.

- Helping people to help themselves and involving people in shaping local services.

2.3 Change Up 2002:

This is the cross-Government framework on capacity building and infrastructure.

The role of the voluntary sector is pivotal in the delivery of mental health services as the 'third sector', hence implementation of the Change Up framework will be required to support the development of the Voluntary Service Organisations.

2.4   A New Deal for Welfare – Empowering People to Work (DWP, 2006)

Aims to end benefit dependency and deprivation.

Rolling out Pathways to Work by 2008 is aimed to get people with mental health problems on incapacity benefit into paid employment.

Target to reduce the number of people on incapacity benefit by one million.

3   Equalities

Public Sector organisations have a statutory responsibility to promote race and disability equality. The development and implementation of this strategy provides a real opportunity to address equalities issues as they relate to mental health.

3.1   Delivering Race Equality in Mental Health (2005)

A five year action plan was published by the Department of Health in 2005 in response to the Independent Inquiry into the death of David Bennett. This states that black and minority ethnic (BME) communities in England do not get the quality of mental health care that they are entitled to. BME patients are more likely than their white British counterparts to be detained compulsorily, to be admitted to hospital rather than treated in the community, to be subject to measures like seclusion in hospital, and to come into contact with services through the criminal justice system.

This fuels a vicious circle that can deter BME people from seeking care early in their illness. Delivering Race Equality in Mental Health Care identifies that there are three building blocks for delivering race equality:-

- **More appropriate and responsive services –** achieved through action to develop organisations and the workforce, to improve clinical services and to improve services for specific groups, such as older people, asylum seekers and refugees, and children.

- **Community engagement –** delivered through healthier communities and by action to engage communities in planning services, supported by 500 new Community Development Workers (nationally).

- **Better Information** – from improved monitoring of ethnicity, better dissemination of information and good practice, and improved knowledge about effective services.

This includes a regular census of mental health patients.

3.2   Equal Treatment: Closing the Gap (2006)

The Disability Rights Commission in September 2006 published a report entitled 'Equal Treatment: Closing the Gap' following a formal 18 month investigation into physical health inequalities experienced by people with learning disabilities and/or mental health problems. The report highlights the scale of inequalities they face and calls for urgent action on a range of fronts.

The evidence of inequalities is overwhelming as a result of systemic problems. The introduction of the Disability Equality Duty in December 2006 offers a key opportunity to ensure that all public sector organisations promote equal opportunities for, and do not discriminate against, people with mental health problems.

This strategy must not be solely a blueprint for action for health and social care services but needs to be taken forward across all council departments, through voluntary and community groups to promote race and disability equality.

4   The Centrality of Commissioning to Drive Improvement

Commissioning competence for the first time is now formally being assessed. Across both health and social care, there is an increased emphasis on the role of effective commissioning to drive improvement and change.

- For the NHS, these changes are being driven through the policy of 'Commissioning a Patient Led NHS'.

- For social care, the new Social Care outcomes framework has commissioning as one of the seven areas of focus.

- For health and social care commissioning competence will be assessed against Joint Commissioning and Contracting frameworks to underpin 'Our Health, Our Care, Our Say'. These were published early in 2007. New commissioning mechanisms are being established and a competent commissioning system will need to demonstrate use of these. These commissioning mechanisms are:-

4.1   Practice Based Commissioning

- PCT retains the strategic commissioning responsibility.

- Practices are given an indicative budget for commissioning services on behalf of the PCT for their practice population based on an agreed set of priorities with the PCT.

- Practices have the opportunity to develop alternative services to secondary care within primary care utilising a range of providers including the private and voluntary sector. This is the contestability test. Practice Based Commissioning will be effective when there are real alternatives in the market place.

4.2 Payment by Results

- A tariff (price) for specific healthcare activity is paid by the PCT to healthcare providers. This is determined nationally.

- Payment by results complements practice based commissioning as it enables a unit cost calculation to develop the indicative practice level budgets for practice based commissioning.

- For mental health, payment by results is not operational. A national target date for the introduction of payment by results for mental health is 2008.

4.3 Foundation Trusts

By 2008, all provider NHS Trusts to become Foundation Trusts. This affects the commissioning / provider relationship for the following reasons:-

- Foundation Trusts are able to borrow money and invest money without some of the current restrictions.

- Foundations Trusts require that the service level agreement with commissioner is a legally binding contract for a three year period. This differs from the current arrangement of a one year service level agreement which has no legal status.

- Foundation Trusts have greater flexibility to commission the voluntary and private sector directly to provide services on their behalf.

- The Local Authority through integrated services will need to have a robust governance structure in place with the Trust for service provision and with health commissioners to manage demand and cost.

- Provide for greater accountability at a local level through revised governance arrangements.

4.4 Individualised Budgets

- Changes in the way in which social care packages are costed and managed through providing an individualised budget from which services are commissioned.

- Power shifts from the Council to the individual to manage the social care market with the support of effective information, advice and brokerage systems.

- Individualised budgets can include other streams of funding including supporting people, independent living fund, access to work in addition to social care budgets.

4.5 Health Act Flexibilities (referred to as Section 75 partnership agreements)

- Enable health and local authorities to delegate responsibility to either party.

- The three flexibilities of integrated provision, pooled budgets and lead commissioning can be used on their own or in combination to integrate services.

- The flexibilities enable the establishment of clear governance arrangements for integration underpinned through a legally binding agreement.

- Health and social care will be monitored on their use of Health Act flexibilities.

4.6 Local Area Agreements

- Provide the opportunity to set out whole system budgets to support improvements in health and wellbeing.
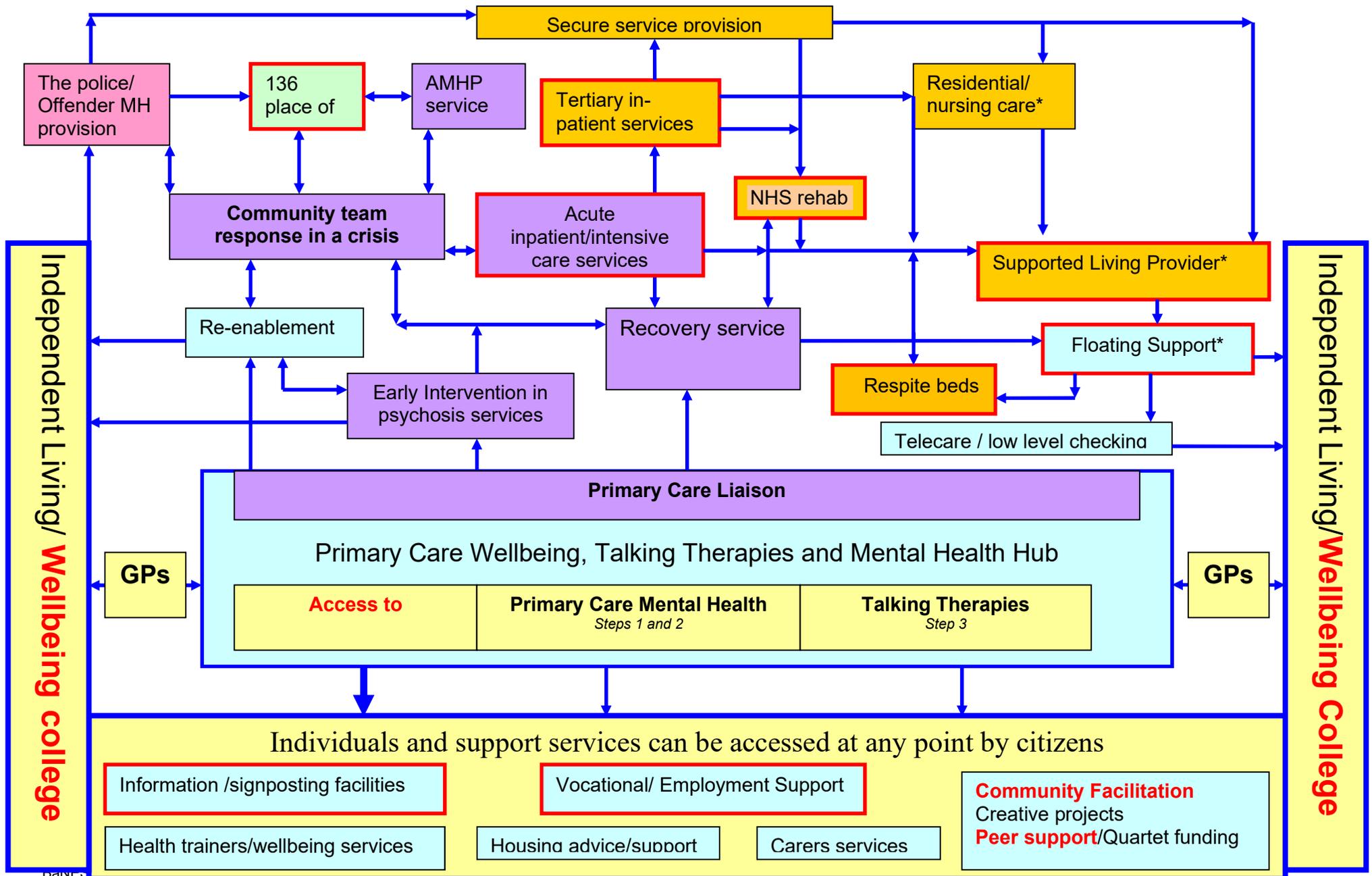
5 Involvement

5.1 Section 11 and 7 of the Health and Social Care Act 2001

Requires all NHS organisations (including Foundation Trusts) to develop their public accountability processes by:

- Involving users, carers and patients in service planning and development.

- Consulting the public on substantial service changes

- Participating in independent scrutiny of the Trust's business through Local Authority Overview and Scrutiny Committees and Patient and Public Involvement Forums (PPIFS) and their successor bodies (LINks – Local Involvement Networks).

Appendix 4

Independent Living/ Wellbeing college

Independent Living/ Wellbeing College

Secure service provision

The police/ Offender MH provision

136 place of

AMHP service

Tertiary in-patient services

Residential/ nursing care*

NHS rehab

Community team response in a crisis

Acute inpatient/intensive care services

Supported Living Provider*

Re-enablement

Recovery service

Floating Support*

Respite beds

Early Intervention in psychosis services

Telecare / low level checking

Primary Care Liaison

Primary Care Wellbeing, Talking Therapies and Mental Health Hub

GPs

Access to	**Primary Care Mental Health** *Steps 1 and 2*	**Talking Therapies** *Step 3*

GPs

Individuals and support services can be accessed at any point by citizens

Information /signposting facilities

Vocational/ Employment Support

Community Facilitation
Creative projects
Peer support/Quartet funding

Health trainers/wellbeing services

Housing advice/support

Carers services

BaNEO

Appendix 6 – References

[1] Bridging the Gap report
This report examines what helps and what hinders people affected by mental health issues when accessing groups and support which would improve their overall wellbeing. The research was carried out in Bath and NE Somerset by peer researchers who are clients and carers affected by mental health issues themselves and trained by St Mungo's Broadway Bridges to Wellbeing project to do the research.

www.mungos.org/services/health/specialist_mental_health_services/building_bridges_wellbeing

[2] Early Help Strategy
Our vision is that all children, young people and families have access to well-coordinated, good quality and timely Early Help when it is required, so needs can be identified and addressed to promote fulfilling family lives.

The concept of Early Help is that by working together with children, young people and families we can often prevent problems occurring, or provide better support when they do in order to stop them getting worse.

www.bathnes.gov.uk/sites/default/files/sitedocuments/Children-and-Young-People/ChildProtection/early_help_strategy_jan_2016_final.pdf

[3] The Children and Young People's Plan (CYPP) 2014-17
This plan describes how Bath & North East Somerset's Children's Trust Board and other agencies will provide a coordinated approach to delivering services for children and young people. It also sets out the vision and priorities agreed by those agencies in supporting children and young people to achieve the best possible outcome as follows:

'We want all children and young people to enjoy childhood and to be well prepared for adult life.'

The 3 outcomes that have been agreed are that children and young people:
- are safe
- are healthy
- have equal life chances

The Early Help Strategy sets out our priorities for the development of Early Help to ensure that the right children, young people and families get the right Early Help, at the right time.

www.bathnes.gov.uk/sites/default/files/sitedocuments/Children-and-Young-People/cypp_summary_2014-2017.docx

4 Improving Access to Perinatal Mental Health Services in England - A Review

This publication by NHS IQ presents the results of a three month scoping exercise to identify current guidance and practice relating to Perinatal Mental Health services.

www.nhsiq.nhs.uk/news-events/news/improving-access-to-perinatal-mental-health-services-in-england-a-review.aspx#sthash.ksna04jI.dpuf

5 The Mental Health and Wellbeing Charter

The charter provides a clear set of principles to guide people who require mental health support on their wellbeing journey.

http://www.newhopebanes.org/#!charter---mental-health---wellbeing/ry2ju

Carers' Charter

AWP worked in collaboration with Keep Safe Keep Sane and carers to produce a carers' charter to improve the working relationship for carers within the mental health services. This document is their commitment towards carers.

https://drive.google.com/file/d/0ByZOX2BJzVJ3bnJzbkdCc2VuOEU/edit?usp=sharing

6 Improving the physical health of people with mental health problems: Actions for mental health nurses (NHS England May 2016)

Improving outcomes for people living with mental health problems -
There is overwhelming evidence from the Marmot Review on health inequalities that addressing lifestyle factors alone will not increase the life expectancy of people with mental health problems. Mental health nurses have an important role in addressing all determinants of health through assessing, referring, delivering and facilitating psychosocial, psychological and physical interventions.

Recovery oriented services and peer-led approaches that address underpinning factors of health inequalities will help individuals to maintain social relationships, access good housing, employment and improve wellbeing and resilience, which will have a major impact on physical and mental health.

Interventions that optimise physical, mental and social elements of health and wellbeing include health promotion to maximise prevention and reduce the risks associated with the onset of illness, and ultimately lead to a reduction in premature mortality.

Eight key areas for action to improve health outcomes have been identified. Each of these areas is associated with particular risk factors that can have a detrimental effect on physical health and reduce life expectancy.

www.gov.uk/government/uploads/system/uploads/attachment_data/file/524571/Improving_physical_health_A.pdf

[7] Head, hands and heart: asset-based approaches in health care - The Health Foundation, April 2015.
The aim of asset-based practice is to promote and strengthen the factors that support good health and wellbeing, protect against poor health and foster communities and networks that sustain health. The vision is to improve people's life chances by focusing on what improves their health and wellbeing and reduces preventable health inequalities.

The NHS five year forward view,[4] which does not pull its punches in setting out the consequences of failing to tackle the issues of the health and wellbeing gap, the care and quality gap and the funding and efficiency gap. This context is driving an urgent need to look at different approaches to providing health and social care, the position of these services in society and the relative role of 'professionals' and individuals who use services.

www.health.org.uk/sites/default/files/HeadHandsAndHeartAssetBasedApproachesInHealthCare_InBrief.pdf

[8] The Strengths Model (Oxford University Press, Nov 2011).
A Recovery-Oriented Approach to Mental Health Services

https://global.oup.com/academic/product/the-strengths-model-9780199764082?cc=gb&lang=en&

[9] Social work for better mental health (DoH Jan 2016)
The World Health Organisation (WHO) has recently recommended all national plans for mental health should take a lifespan, intergenerational and family approach, rooted in public and primary mental health improvements. This is the preventive counterbalance to the equally important need to improve timely access to clinical assessment, treatment and crisis and recovery support.

Social workers provide a distinctive contribution to mental health that focuses on the social determinants and social solutions to mental health problems and distress. Working with the principles of personalisation and the opportunities of the Care Act 2014, social workers are crucial to ensuring people with mental health needs are seen first and foremost as citizens with equal rights, rather than exclusively through a diagnostic or clinical lens.

Social workers work holistically, with the person and their social network, helping to strengthen and build sustainable family and social capital.
 - Defining the roles of social workers and raising their confidence as a workforce will contribute to better practice and better mental health outcomes.
 - More innovation in effective social models in mental health – tackling the social determinants of health and wellbeing and addressing the social trauma that underlies a lot of mental health need – are needed to create sustainable, relevant and affordable mental health services in the future.

www.gov.uk/government/uploads/system/uploads/attachment_data/file/495500/Strategic_statement_-_social_work_adult_mental_health_A.pdf

[10] Arts on Prescription – Research Report (City Arts Nottingham 2011)

Arts on Prescription: Arts-based social prescribing for better mental wellbeing (Cultural Commissioning Programme)

Key Outcomes of Arts on Prescription
• Increased treatment options available to those experiencing mental wellbeing issues
• Reduced reliance on antidepressant or tranquiliser medications
• Reduced amount of GP contact time devoted to people experiencing mental wellbeing issues
• Increased self---esteem and confidence amongst participants and improved quality of life
• Increased transferable skills for participants, including employability skills
• Increased participation in arts and cultural activities

http://cdn.city-arts.org.uk/wp-content/uploads/2013/03/Arts-on-Perscription-Report.pdf

[11] Sustaining and spreading self-management support (The Health Foundation Sept 2013)

Through the Co-creating Health programme, the Health Foundation tested out how to embed and sustain self-management support in primary and secondary care across a range of long-term conditions. The Co-creating Health model incorporates self-management training for people with long-term conditions, training in self-management support skills for clinicians, and a service improvement programme to put systems and processes in place to support patients and clinicians in their self-management activities.

The evaluation of the programme concludes that to have the best chance of success there needs to be a strategic, whole-system approach to implementation of self-management support.

This report contains the independent evaluation of the second phase of the Co-creating Health improvement programme. The evaluation, conducted by Firefly, provides valuable insight into how to sustain changes in clinical practice to more effectively support people with long-term conditions.

www.health.org.uk/publication/sustaining-and-spreading-self-management-support#sthash.d9JXaqMQ.dpuf

[12] The Five Year Forward View for Mental Health (A report from the independent Mental Health Taskforce to the NHS in England, February 2016)

This report highlights that improvements in access to high quality services, choice of interventions, integrated physical and mental health care, prevention

initiatives, funding and challenging stigma were people's top priorities as to how the system needs to change by 2020.

People with lived experience of mental health problems, carers and health and social care professionals told the Taskforce that prevention was a top priority. Specific themes raised included support for new mothers and babies, mental health promotion within schools and workplaces, being able to self-manage mental health, ensuring good overall physical and mental health and wellbeing, and getting help early to stop mental health problems escalating. Many people discussed the importance of addressing the wider determinants of mental health, such as good quality housing, debt, poverty, employment, education, access to green space and tough life experiences such as abuse, bullying and bereavement. It was suggested that while it is particularly important to recognise loneliness in older people, these issues can affect people of any age.

Mental health has not had the priority awarded to physical health, has been short of qualified staff and has been deprived of funds. We must provide equal status to mental and physical health, equal status to mental health staff and equal funding for mental health services as part of a triple approach to improve mental health care – a fresh mind set for mental health within the NHS and beyond.
An integrated mental and physical health approach. Promoting good mental health and preventing poor mental health– helping people lead better lives as equal citizens. Creating mentally healthy communities

www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

[13] No Health Without Mental Health 2011
The national strategy for mental health, *No Health Without Mental Health*: a cross-governmental mental health outcomes strategy for people of all ages (DoH 2012) shows why tackling mental illness and promoting mental wellbeing is essential for individuals, their families, their communities and for society as a whole.

If we are to build a healthier, more productive and fairer society in which we recognise difference, we have to build resilience, promote mental health and wellbeing, and challenge health inequalities. We need to prevent mental ill health, intervene early when it occurs, and improve the quality of life of people with mental health problems and their families.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf

[14] Closing the Gap: Priorities for essential change in mental health DoH Feb 2014
In the mental health strategy, *No Health Without Mental Health*, we set ourselves – and society as a whole – some big challenges. We stated that mental health must have equal priority with physical health, that discrimination

associated with mental health problems must end and that everyone who needs mental health care should get the right support, at the right time. We made it clear that tackling premature mortality of people with mental health problems is a priority. And we recognised that more must be done to prevent mental ill health and promote mental wellbeing.

People who use mental health services, and those that care for them, continue to report gaps in provision and long waits for services. There is still insufficient support within communities for people with mental health problems. In some areas there have been stories of people of all ages being transferred sometimes hundreds of miles to access a bed. We are not yet making an impact on the enormous gap in physical health outcomes for those with mental health problems. And so much more could be done to promote good mental health and prevent mental ill health.

That's why we are challenging the health and social care community to go further and faster to transform the support and care available to people with mental health problems – both children and adults. And we are challenging the public health community, with local government in the lead, to help give mental health and wellbeing promotion and prevention the long overdue attention it needs and deserves.

This document sets out that challenge. It identifies 25 aspects of mental health care and support where government – along with health and social care leaders, academics and a range of representative organisations – expect to see tangible changes *in the next couple of years*: changes that will directly affect millions of lives for the better.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281250/Closing_the_gap_V2_-_17_Feb_2014.pdf

[15] Guidance for commissioning public mental health services (Joint Commissioning Panel for Mental Health, Dec 2013)
This is the second version of the public mental health guide. It has been revised and updated to include new sources of data and information.

The guide is about the commissioning of public mental health interventions to reduce the burden of mental disorder, enhance mental wellbeing, and support the delivery of a broad range of outcomes relating to health, education and employment.

http://www.jcpmh.info/wp-content/uploads/jcpmh-publicmentalhealth-guide.pdf

[16] Care Act 2014 (DoH June 2014 and March 2016)

What role do local authorities play in care and support?
Under the Care Act, local authorities have new functions. This is to make sure that people who live in their areas:
- receive services that prevent their care needs from becoming more serious, or delay the impact of their needs

- can get the information and advice they need to make good decisions about care and support
- have a range of provision of high quality, appropriate services to choose from

How does the Act help prevent people developing care and support needs?

The Care Act helps to improve people's independence and wellbeing. It makes clear that local authorities must provide or arrange services that help prevent people developing needs for care and support or delay people deteriorating such that they would need on-going care and support.

Local authorities have to consider various factors:
- what services, facilities and resources are already available in the area (for example local voluntary and community groups), and how these might help local people
- identifying people in the local area who might have care and support needs that are not being met
- identifying carers in the area who might have support needs that are not being met

In taking on this role, local authorities need to work with their communities and provide or arrange services that help to keep people well and independent. This should include identifying the local support and resources already available and helping people to access them.

Local authorities should also provide or arrange a range of services which are aimed at reducing needs and helping people regain skills, for instance after a spell in hospital. They should work with other partners, like the NHS, to think about what types of service local people may need now and in the future.

https://www.gov.uk/government/publications/care-act-2014-part-1-factsheets/care-act-factsheets

And the update:

https://www.gov.uk/government/publications/care-act-2014-part-1-factsheets/care-and-support-statutory-guidance-changes-in-march-2016

[17] **Five Year Strategic Plan: Seizing Opportunities 2014-19** (BaNES CCG) http://www.bathandnortheastsomersetccg.nhs.uk/assets/uploads/2015/06/BaNES-CCG-5-year-plan.pdf?b3cb5a

18 Redesign of B&NES Mental Health Support services Nov 2010 (Bath & NE Somerset Council)
https://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&cad=rja&uact=8&ved=0ahUKEwjByouSzozNAhUsKcAKHfu_C3IQFggfMAA&url=https%3A%2F%2Fwww.whatdotheyknow.com%2Frequest%2F70170%2Fresponse%2F189202%2Fattach%2F5%2FSCT%2520Commissioning%2520Strategy%2520Review%252012%2520May%25202011.pdf&usg=AFQjCNGDqHljM-fsKGr-83i65it0XUvO1A&bvm=bv.123664746,d.ZGg

19 Guidance for Commissioners of mental health services for young people making the transition from child and adolescent to adult services. (Feb 2012 Joint Commissioning Panel for Mental Health)

20 Schneider (2007) *Better outcomes for the most excluded* (University of Nottingham and Nottinghamshire Healthcare NHS Trust p.16.)

21 Public Health England National Drug Treatment Monitoring System (NDTMS, 2013-14)

22 www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/virtuallibrary/DualDiagnosisPrisons.pdf

23 http://www.patient.co.uk/doctor/dual-diagnosis-drug-abuse-with-other-psychiatric-conditions

24 http://www.chimat.org.uk/selfassessmenttools)

25 Drug Misuse and Dependence – UK Guidelines on Clinical Management (2007)